HealthPlanMarkets 2018 Issue #1
An Independent View On Markets And Finance
Published By Interpro Publications Inc. In Washington D.C.

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markets...

Investors Boost HP Stocks On Tax Cut

Health insurer stocks are jamming even more than the overall market as investors rush to buy "healthcare" in the rally. Anthem was amazing with a 68.6% increase in its recent stock price. United led the earnings fest and as expected will enjoy a huge windfall from the new Tax Reform act, but the other firms are expected to report similar one-time gold coins. Medical trend and pricing are steady and Medicare remains strong, but valuations are way up by historical standards.

Stock	Price > Last 4 Wks	52 Wks	PE Ratio
AET	2.6%	51.3%	34
ANTM	10.9%	68.6%	23
CI	7.4%	52.4%	24
HUM	14.7%	35.7%	22
UNH	9.7%	53.2%	23

United Backs Allowing AHPs To Contract

United became the first large health insurer to back the proposal to eliminate roadblocks to small employers and the self-employed forming **Association Health Plans**. United told investors it sees a good market for the new plans -- if contracting is allowed -- and said that it would open coverage to a large number of potential members. The pending **DOL** reg estimates that 11 million Americans would be free to pick a plan, reducing the uninsured and allowing consumers to choose benefits coverage and premiums they can afford. Other large insurers and associations are expected to back the move, despite a massive PR campaign by state insurance regulators and actuaries losing control.

UnitedHealth Group (UNH) (NYSE: UNH) was the top-ranking company in the insurance and managed care sector for ***Fortune***'s 2018 "World's Most Admired Companies" list for the 8th year.

AMA Lobbies To Neuter MIPS Payments

The AMA 2018 political agenda includes convincing Congress to delay or kill the MIPS provisions of the **MACRA** payment law, AMA President David O. Barbe, M.D. told *FierceHealthcare* Jan. 12. In 2019, a fully implemented MIPS program takes effect, but "The AMA is lobbying for legislation that would allow CMS the flexibility to transition more gradually to the full payment system," Barbe said. **MedPAC** also wants to kill MIPS and replace it with a voluntary scheme.

The last straw is a CMS change in the MIPS formula that weights the "cost" category at 10% instead of zero this year. In conjunction, CMS will decrease the quality portion of doctors' performance score from 60% to 50%. The cost weight—based on total per-patient cost and total spending around a hospital admission—will make up even more of the score in 2019 and beyond, when it will rise to 30%.

Support Strong For New CMS Bundled Payments

A new and improved Medicare bundled payments program is being strongly endorsed by a large segment of health plans, provider groups, and even hospitals despite strong criticism by some that a mandatory program forcing participation is better. The new program is voluntary, but it makes *huge changes* in the early version that was cancelled, like exploding the number of episodes from two to 32, and allowing Medicare Advantage plan providers to receive bonuses under the MACRA law that creates a Medicare provider risk option.

Early reaction on the day it was announced was negative, given the sudden cancellation of the previous programs by the Administration in October. But in the week after the details were released, criticism was muted and multiple major groups now back the new approach, with the caveat that it could make national cost baselines more difficult.

Will ACA Tax Repeal Die With Budget Deal?

Fighters against the Cadillac Tax and HI tax won the battle but may have lost the war as the House bill to extend the budget, which had deleted the taxes, was stuck at press time. If it fails or passes there was no discussion of repeating the failed attempt to lure House and Senate Democrats to the hated budget deal by attaching the popular tax repeal to future budget deals. The biggest barriers to a deal were not related to the tax repeal at all, but if there were a deal it would still face the budget nerds this year when the whole mess starts again.

U.S. Senate Leader Applauds Humana Tax Break

Senate Majority Leader Mitch McConnell applauded Humana on the Senate floor yesterday for sharing some of the tax windfall with its employees. "Just yesterday, I was pleased to announce that Humana—which employs more than 12,000 Kentuckians—is accelerating pay incentives and increasing its minimum hourly wage because of tax reform… Like many U.S. companies, Humana will begin benefitting this year from a lower corporate income tax rate," the Senator said. "This provides Humana with the opportunity to make an investment in our employees, using the proceeds from tax reform to further the long-term financial health and well-being of our employee population."

Humana

Few Economies of Scale in Health Insurance

Size matters in most industries and health financing seems ripe. But health plan administrative economies of scale in real markets "cannot create an overwhelming competitive advantage," the latest **Sherlock Company** analysis of administrative expenses concludes. Health plan overhead is "not significantly subject to economies of scale." However, a narrow range of 21.2% to 24.7% of costs reported by the health plans were subject to big economies of scale. For these scalable costs, a doubling of their size led to costs that were 80.4% to 90.2% of their pre-doubling value…" The study tracks 34 health insurers serving 48 million people. It analyzed each of the nearly sixty functions individually, eliminating the effects of product mix differences.

Medicaid Capitation Boom Still Rising

Medicaid capitation payments reached 48.9% of fiscal 2016 Medicaid expenditures, according to **The Menges Group,** versus 27% as of 2010. "It is highly likely that we have now crossed a threshold where the majority of Medicaid expenditures occur via capitation payments. This is an encouraging trend given all that the Medicaid MCOs do to systematically facilitate access to care, measure and improve quality, and steer care towards cost-effective settings and treatments."

However, the researchers warn that "Our one caution is that for the Medicaid MCO model to achieve taxpayer savings, unit prices need to be held closely in line with *Medicaid fee-for-service prices*. When providers with strong negotiating leverage secure payments from MCOs well above Medicaid fee-for-service rates, the Medicaid managed care program in that state is probably adding to taxpayer costs rather than yielding savings."

An separate analysis of Medicaid MCOs in each state shows the degree to which the health plans are collectively experiencing gains or losses. "During 2015 and 2016, about two-thirds of states with MCO capitation programs landed in what we would consider an optimal place – with the health plans collectively earning a positive margin on their Medicaid business but with that margin not exceeding 5%."

reg notes...

❖ **Network Adequacy Reviews** The Office of Management and Budget (OMB) just approved a CMS move to put *network adequacy reviews* on a three-year cycle, unless there is a triggering event that would reset the timing of a MA organization's triennial review. The new plan was applauded by MA consultants and groups. "Initially, CMS will pull a sample of active contracts, including those that have not had a full network review since contract initiation, and provided the plans at least 60 days' notice before the June deadline to submit their networks," Gorman advisor **Elena Martin** notes.

❖ **Molina Loses NM Medicaid, Gains Higher Margins** Medicaid behemoth Molina HC revealed last week that it lost the New Mexico Medicaid contract that provided about $1 billion in revenue -- but that was running a high single-digit loss through the first 3Qs of 2017. MOH had approximately 225,000 Medicaid lives in the state as of 3Q17, and the contract was expected to be unprofitable on a GAAP basis for the full year. Molina told investors last week that its new objective is to maximize margins and investment returns versus growing its 4.5 million member base and boosting up revenue.

MedPAC Votes To Dump MIPS The Medicare Payment Advisory Commission (MedPAC) formally voted to ask Congress to dump the MIPS payment system that is part of the popular MACRA law, but is primarily aimed at fee-for-service physicians. Staff told the geek-dominated committee that MIPS is "burdensome and complex," focused on reporting information which isn't meaningful and resulting in scores which aren't comparable across clinicians.

"MIPS will not succeed in helping beneficiaries choose clinicians, helping clinicians change practice patterns to improve value or helping the Medicare program to reward clinicians on value," the presentation read, according to *HealthExec*. By a 14-2 vote, commissioners recommended that Congress eliminate MIPS entirely.

In its place, MedPAC has proposed the Voluntary Value Program (VVP), where 2 percent of clinician payment would be withheld unless clinicians either joined an Advanced Alternative Payment Model (AAPM) or elect to be measured as part of larger group on "population-based measures assessing clinical quality, patient experience and value." The VVP, MedPAC analysts wrote, would provide an "on-ramp" to prepare clinicians to participate in the AAPM track of MACRA.

"MGMA shares MedPAC's concern that aspects of the current MIPS program are unduly burdensome and impede patient-centered care and innovation. However, we believe its recommendation to eliminate the program fails to adequately address the problem and does not reflect the current value-based landscape," Anders Gilberg, senior vice president of government affairs at the Medical Group Management Association (MGMA), said in a statement to HealthExec.

"MedPAC's alternative that would conscript physician groups into virtual groups and evaluate them on broad claims-based measures is inconsistent with the congressional intent in MACRA to put physicians in the driver seat of Medicare's transition from volume to value."

The MedPAC decision doesn't come with any binding authority, the article notes. MedPAC is supposed to be an oversight panel like the GAO, but its members are dominated by interest groups.

The group is tasked with providing Congress and CMS with guidance and analysis, but its recommendations are usually arcane and have been ignored before, such as when it supported making accrediting organization surveys of hospitals public or recommended a larger increase in Medicare payments to hospitals.

Legal Experts Say AHPs Are Not Tehnically Health Insurance

New Association Health Plans Likely To Survive

Some top law firms and independent policy experts are saying that the new Administration reg proposing to open up AHPs is not at risk of a legal challenge, despite major opposition and legal threats.

"The expansion of the commonality-of-interest test signals a departure from prior DOL guidance, something that may raise some eyebrows," Bradford P. Campbell, who was assistant secretary for DOL's Employee Benefits Security Administration under President George W. Bush, told *Bloomberg Law*. But that's not illegal.

"The changes made in the proposal are "long overdue," he said. The previous limitations on forming association health plans were "unnecessarily limiting and convoluted and complex."

A senior DOL official added in the article that the new regs also acknowledge that prior guidance never said there was only one way to think about the commonality or nexus requirement. The commonality-of-interest test isn't a "creature of statute, it's solely from advisory opinions." Because advisory opinions are interpretive guidance, the DOL is well within its bounds to change course, and there is not much chance a court will disagree.

A flurry of negative press after the change was announced two weeks ago created a totally polarized reaction, with the proposal described only as a Trump idea with purely political motivation. Critics focused almost entirely on the ability of AHPs to avoid the mandate for "essential health benefits" as something consumers don't want, even though it will lower premiums and given them more choices.

The controversy focused entirely on whether state regulators will control AHPs and force them to have state-mandated benefits.

But under the ACA an Association Health Plan may be established within a single state and, if fully insured, subject to the insurance laws of that state. Since *an AHP is not itself an insurance product*, the particular regulation of an AHP varies depending on the state and how the AHP is structured. The new reg does not change this.

Health plans as an industry are split on whether AHPs will be a good thing or impact the small group and individual markets negatively. In effect, health plans enjoy a form of monopoly under the state-

regulatory system and local plans have no choice. But the ACA also hurts the individual markets and gives regulators too much control.

If an AHP markets to individuals today, it is treated by the ACA as individual insurance, subject to the requirements of the ACA for nongroup coverage, which is richer and more expensive than the ERISA type AHPs. ERISA Association Health Plans are associations that sell health insurance as an ERISA "bona fide group or association of employers," according to standards established by the DOL interpreting the ERISA Act. AHPs that are subject to ERISA are governed by both the state in which they operate and the U.S. Department of Labor.

market notes...

United's New User Tech Tools Are First To Market

UnitedHealthcare is showcasing three consumer-driven digital health innovations that our HPM advisory experts tell us are not new, but are the first to be offered by a health plan to its entire membership. The tools were released at the CES 2018 in Las Vegas.

The new features are not just window dressing: United announced last week it will dedicate most of its massive tax $1.7 billion windfall from the new tax law to things like data analytics, block chain technology and innovation. This could boost the Optum division of United to even higher levels and increase industry-wide adoption. The new list:

• **Digital Onboarding**: Employers with 101 to 3,000 employees have access to digital onboarding, which can help people select an appropriate health plan based on their personal health and financial preferences. The step-by-step process helps make plan enrollment simple and straightforward, with an online health survey that enables people to identify and select relevant clinical, wellness or financial programs available to them, such as behavioral health, weight loss, pregnancy support, spending accounts and others.

• **Apple Pay:** UnitedHealthcare plan participants enrolled in individual and employer-sponsored health plans with an **Optum Bank** health savings account (HSA) now have the ability to use Apple Pay, providing people a secure and private way to pay for qualified medical services. The new capability offers consumers more convenience at health care providers' offices and pharmacies, which can help save people time and facilitate payments to care providers.

• **Video EOBs**: Most people enrolled in UnitedHealthcare individual and employer-sponsored plans will be able to view personalized claims videos that help people better understand their benefits and what they owe following a covered medical service. "The brief, personalized claims videos provide a step-by-step breakdown that shows exactly how each claim was processed and how much is owed." Plan participants will be able to access customized videos in early 2018 via desktop computers and mobile devices.

2018 May See Lots Of Thunder Amid The Drizzle
Gorman: Change Abounds In Public Programs

Medicare and Medicaid were largely immune to major changes last year, but the list of potholes grew longer, industry expert John Gorman reveals in his latest annual blog predictions. "The only thing that is certain is 2018 will be another battleground year for government health programs" even if there is stalemate on major legislation.

Republicans keep whining about repealing more of the ACA, but are actually scaling back their brainstorms to overhaul safety-net programs and dismantle the Affordable Care Act following a recent weekend retreat with GOP leaders. Even huge items like the Cadillac Tax, medical device tax and employer mandate are off the burner.

"Medicare promises to be noisy in 2018, but in the end, it seems a long shot for major legislative action in an election year," Gorman says, despite the passions of House leaders like Paul Ryan. But hidden in the weeds are a bunch of regulatory land mines, starting with confusion over what happens next with Medicare value-based purchasing.

"This year promises a return to the drawing board, with greater flexibility given to providers in design of CMS demos. We expect little uptake on new initiatives and expanded participation in those programs already on the books and working: Accountable Care Organizations (ACOs) and Alternative Payment Models (APMs)." Over 550 ACOs contracting with Medicare will continue to expand and evolve in 2018, driven by experience, record shared savings in 2017, and new on-ramps, thanks to the MACRA APMs, Gorman predicts.

Optimism has grown after CMS identified risk contracts with Medicare Advantage (MA) plans as APMs, "providing a 5% boost under Medicare Part B and a significant incentive for sophisticated medical groups to move up the food chain, with an ACO being the next step."

ACOs just got a big makeover in how they are perceived in a study showing they have much broader cost savings than expected, with the biggest savings so far in *outpatient and preventive care*, not just from chronic care conditions and high-risk patients as once believed.

"ACOs have plenty of outstanding opportunities to achieve shared savings with CMS, as much of the savings generated to date have come from ambulatory-sensitive conditions and not high-risk, high-cost beneficiaries. And ACOs haven't begun to scratch the surface of overtreatment and fraud and abuse."

Gorman has been virtually alone in identifying a big change in Medigap. A little-known provision in MACRA banning the sale of Medigap policies with first-dollar coverage in 2020 "will initiate an arms race in MA in 2018 and 2019." The ban on Medigap's most popular plans, especially the Type C and F supplements comprising two-thirds of the supplemental insurance market, will force millions of baby boomers to rethink their coverage, Gorman believes.

Many will be drawn to 'Cadillac' MA Preferred Provider Organizations (PPOs) with broad provider directories, rich benefits, and low out-of-pock et costs, and forward-looking plans are positioning to offer them early. PPOs already comprise almost 6 million of the 20 million MA enrollees, and "the MACRA shift will cement the product as the go-to offering for more affluent seniors. Expect to see PPOs popping up like mushrooms in 2018 and 2019, especially in states with large Medigap populations like Texas and Florida."

Medicare Advantage: "Stuck In Star Ratings Mode"

Medicare Advantage plans are "stuck" in Star Ratings with little improvement in performance, especially among MA plans 5 years old or younger, Gorman notes. This year will demand greater focus on "real intervention and execution" at the member level and in improving the member experience: provider directory accuracy, risk adjustment methodology changes, and other brain-twisting details.

"More plans will insource appeals and grievances from delegates like pharmacy benefit managers (PBMs), seeking to avoid growing

compliance exposure and poor member interactions. We're expecting MA growth of 7% in 2018 year over year, with enrollment accelerating to 8-9% in 2019 and 2020 with the MACRA change."

Part D looks stable. But "we will begin to see decline in stand-alone Prescription Drug Plans (PDPs), which are often paired with Medigap Plans C and F banned in 2020." Gorman is also looking for the CVS-Aetna merger and "Amazon Rx" to spark greater emphasis on "leveraging narrow networks of retail pharmacies to improve drug spend, the member experience, and Part D Star Ratings."

Medicaid is also in for policy-driven turbulence with the arrival of a new Administrator bent on trimming the rolls. "The "Vermization" of Medicaid will spread quickly in 2018 with a single goal: reducing the rolls. "She will be successful, and Medicaid-focused plans will rightly seek to diversify." This year will also see a rollback of the Obama-era Medicaid "mega-reg," which sought to streamline requirements with the ACA Marketplace and MA. "It's yet to be seen how far Verma will go in erasing the Obama legacy on Medicaid," Gorman cautions.

Health Plans See Shift in Base Compensation

While health plan management bonus and stock options are becoming more powerful each year, the incentives provided by C Suite executive base salaries are stabilizing, *Warren Surveys* tells HPM. Data for Warren Surveys is the most authoritative source and is collected and published twice a year. The information in this report comes from data collected in late fall 2017 and published in December 2017.

CEO salaries, which are often the primary focus of external news reports, in fact did rise significantly through 2013, 2014 and 2015 -- but fell in 2016, and only rose 2% in 2017. In dollar terms, the overall Median Salary of all health plan CEOs is pegged at $438,412 with Median Salary with Bonus at $487,530. CFO salaries also saw a change, and actually saw a decrease of 2% despite a consistent increase over the last several years.

But Finance Director and Internal Auditor salaries are seeing an increase, which might indicate that the CFO is delegating much of the day-to day operations to the Director, along with help from internal audit and accounting process staff, while the CFO is looking at more issues of capital use and investment decisions for the plan.

Meanwhile, the VP of Operations position saw a significant increase (4.84%) as did VP Member Services (4.43%). There was a very large increase for VP Claims (11.14%) according to Warren Surveys.

Barbara Hempy, Warren Surveys Group President, says this continues to represent a leveling of some of the earlier high salaries as well as mixing bonus and stock dollars with base salary as the greater incentive. Positions like CFO and CEO are becoming easier to measure in terms of overall plan effectiveness and profitability."

"Now we are seeing a focus on operations and claims efficiency to get to the goals of the plan's board and investors, so even in the supporting departments we see increases in Legal Compliance and Privacy Coordination as well as new hard to find positions seeing increases such as HCC Coding and Grievance and Appeals Specialists."

William DeMarco, President of DeMarco and Associates (parent company for Warren Surveys), told HPM he noticed areas that were getting much more focus, such as Director of Home Health and Clinical Compliance Specialists along with Market Research Specialists. This, he thinks, signals a move to health plans managing more effectively the long term needs of patients, as well as designing new products to support those needs (such as wellness and digital health).

Warren Surveys continues to be a leader in reporting confidential compensation data and build specialized compensation trends and analyses for the health care industry. www.warrensurveys.com. It claims to be the largest and longest standing independent health care compensation and research company in the United States.

Participants include health plans, health system owned health plans, HMOs, managed care organizations, physician/hospital organizations, university based health plans, SNPs, Patient Center Medical Home Plans, Community Health Centers, insurers, as well as Accountable Care Organizations and similar risk bearing enterprises. Subscribers to this survey also include consulting firms, investment bankers, attorneys, and actuarial firms involved with health care organizations.

Humana Secretly Left AHIP A Year Ago

Humana officially confirmed last week that it had actually dropped out of AHIP participation *almost a year ago* -- even before knowing the outcome of Obamacare repeal. Humana PR execs said publicly that the insurer "has not actively participated in AHIP since early 2017," but added diplomatically that this decision was made for "business reasons." The national carriers including Aetna and United were never happy after former AHIP chief **Karen Ignagni** left and was replaced by former Obama CMS leader Marilyn Tavenner, and ever since the group lost its perception of clout on Capitol Hill in vote after vote. ☯

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