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Slower Growth for Carriers Is Only Certainty Amid Murky Outcome of ACA Repeal Efforts

With action on Affordable Care Act (ACA) repeal-and-replace legislation fluid and fast changing, the only certainty for health insurers — and their investors — is that carriers will see lower volume in future years. That is likely whether the American Health Care Act (AHCA) proposal backed by House Republicans is enacted, a different bill wins passage, or the GOP instead falls back to an Obamacare collapse-and-replace strategy. The latter outcome looks increasingly likely after the nonpartisan Congressional Budget Office (CBO) on March 13 jolted Washington, D.C.'s political and policy worlds with a dramatically negative take (in terms of enrollment) on the AHCA.

The uncertainty leaves Wall Street trading health insurance stocks in tight ranges until the smoke clears. Securities analysts tell *HPW* that the sheer number of possible outcomes has made selling and buying health plan equities too far in one direction an impossibility, considering the complexities of the politics where even the Republican-dominated Congress and the White House are not settled on a path forward.

The AHCA is increasingly under threat from both conservative Republicans who call it "Obamacare Lite" and moderates within the party who cannot stomach projected increases in the uninsured.

CBO predicted that some 24 million Americans would lose health insurance over a 10-year period from 2017 to 2026 if the AHCA were enacted, including 14 million next year alone as the individual coverage mandate is eliminated.

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Aetna Wages 'Scorched-Earth' Litigation Against Outlier Out-of-Network Providers

High-stakes lawsuits filed by insurers against out-of-network providers continue to keep plan litigators busy a year after Aetna Inc. won a landmark $37 million victory in a California state court against Bay Area Surgical Management LLC (BASM) *(HPW 5/9/16, p. 1)*. More recently, Aetna was awarded $51 million in a Dec. 31 judgment that sent a tiny out-of-network Texas hospital spiraling into bankruptcy protection in late February *(HPW 3/6/17, p. 8)*, and such cases show no sign of letting up, Aetna's chief litigator says.

Ed Neugebauer, Aetna's chief litigation officer, tells AIS Health that the cases taken to court by the plan over the past several years, since its proactive provider litigation program began, involve "a very small group of outliers trying to find ways to maximize their revenue" — by using in-network physicians in schemes to funnel patients to out-of-network facilities.

"You've got to grab the genie in the bottle and run with that…and hope it stops some of the behaviors," Neugebauer says, noting that it can be "frustrating for us to catch this, find it and bring it to court."

He explains that Aetna is "continually farming data" to analyze providers, searching for dramatic changes in referral patterns and significant upticks in charges and

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volume. And he asserts that Aetna has found effective ways to present legal cases, applying lessons learned to subsequent litigation and gaining momentum along the way.

Aetna currently is involved in the bankruptcy proceedings of Humble Surgical Hospital LLC in Houston and expects collateral litigation from that, Neugebauer says. The insurer also is working out payment with BASM, which Aetna alleged conducted a wide-ranging conspiracy to defraud the insurer via the use of out-of-network benefits. And Aetna has appealed its loss in a $120 million fraud claim against out-of-network North Cyprus Medical Center, also in Houston, in which the judge took the case away from the jury. Aetna alleges that North Cypress promised ownership stakes in the company to physicians for recommending the hospital to patients over less costly, in-network facilities.

BASM, Humble and North Cypress represent the first cases filed under Aetna's proactive provider litigation program, and are what Neugebauer describes as hard-fought, "scorched earth" litigation. In addition, Aetna has about 22 out-of-network fraud cases pending across the U.S., he says.

Aetna is not alone. Cigna, UnitedHealthcare and other carriers also have filed lawsuits alleging improper out-of-network billing practices. In November, Cigna appealed a $13 million award in Humble's favor in what Neugebauer describes as bad luck in the way claims were characterized by the court. (Aetna had a different Houston-based judge in its own case against Humble.)

Aetna is getting queries about its out-of-network cases from other plans and discusses issues at seminars, Neugebauer says. Conversely, he says he has attended seminars where lawyers presented strategies on how out-of-network providers can maximize their revenues.

Insurers Redefine Networks

It's all happening amid significant changes in insurers' contracting strategies over the past couple of years, says Bill De Marco, president of Pendulum HealthCare Development Corp., a consulting firm in Rockford, Ill. Now insurers likely won't honor a network if it is "a loose-knit club" of affiliated providers without performance improvement built in, he says, and there is what he calls "a constant network churn."

According to De Marco, networks are being redefined by the plan and attached to the product. This is necessitating very specific, complex value-based contract negotiations with providers, some of whom may work to find loopholes to get paid until the payer catches up and says they're ineligible. And consumers' expectations may be affected by voluminous, at times inaccurate, online information on participating network providers.

"Once a plan has paid [out-of-network providers] a couple of times, it's hard for the plan to say they're not in-network," he says. "It's tough for the third-party administrators, coders and everyone else….For them, the insurer might say, 'It looks like one of ours. They're billing right.'"

Out-of-network fraud "is an issue with my clients," he says. "It's becoming more and more of an issue because of the redefinition of networks and the ability of technology to track down claims."

De Marco explains that insurers' software now has fraud detection capability, identifying members using out-of-network providers who charge inappropriate rates. If fraud is detected, providers often demur and say they won't do it again because they worry about being banned from networks. It seldom advances to costly, lengthy litigation, he says.

"In addition to the litigation that's taking place, I also think…[that] payers are putting more diligence into business strategies, especially post-Affordable Care Act, to try to reduce costs of care overall," says attorney Deborah Dorman-Rodriguez, principal of Chicago-based Laurus Advisors LLC, and former chief legal officer for Health Care Service Corp., parent of Blue Cross and Blue Shield plans in five states.

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Executive Editor, Jill Brown; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Atwood

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Dorman-Rodriguez says her clients, as smaller carriers, often stick to HMO products and don't offer PPOs with out-of-network benefits. But in general, payers have wrangled with out-of-network billing rates for a long time, she says, noting how "incredibly off the charts" the facility charges were in the Aetna/Humble case.

She agrees that only a small number of outliers are trying to game the system, with most providers operating in good faith and seeking to have good business relationships with providers. Yet "payers can't ignore these situations," she says. "If the provider doesn't enter into a contract with the payer and you don't require the patient to pay the rest, you're taking away the whole concept of managed care."

> **"M&A lawyers look at the BASM case and freak out. [It requires] a lot of due diligence to convince investors that not all out-of-network providers are crooks.**

She says she expects to see more retrospective reviews and self-audits on what insurers paid out, followed by their attempts to recover funds. If payers cannot reach a business resolution, she predicts that many might head to court given the potential financial impact on the insurer and on the health care system as a whole. But she concedes that smaller carriers in this situation probably would think long and hard about the resources required to pursue a lengthy, complicated lawsuit — and while payers are evolving their strategies to present such cases, there still are few cases in the courts and scant legal precedent.

"In my mind, litigation isn't the first option," she says, "but it's also a deterrent to file these types of cases against outliers so they know payers are being diligent…. To the extent there's an understanding [that] insurance companies are going to challenge these business practices, I think that's the deterrent. I'd hope a small percentage of providers would be dissuaded" from out-of-network fraud schemes.

Dorman-Rodriguez describes Humble's activity in the Aetna case as particularly egregious, boxing in the payer and forcing action to address it. But she says other out-of-network billing issues might not stand out. "It would be interesting to know how much is resolved through provider-payer discussion," she says. "In my experience, there certainly is a desire" to resolve issues out of court.

Carol Lucas, chair of law firm Buchalter PC's Health Care Practice Group in Los Angeles, represents surgery centers, physicians and other providers, both in and out of network. She says such providers typically have scant bargaining power in negotiations with insurers, and many say they can't get a reasonable contract with rates to cover their expenses.

Lucas says it is unclear how much Aetna's case against Humble, the tiny Texas hospital, was based on the merits since it was a default judgment in the payer's favor — a case that never got to trial — and based on what the judge viewed as poor behavior by Humble's lawyers during litigation. She notes that Humble had said it intended to appeal, but also is unclear what will happen now that the facility has filed for bankruptcy protection.

However, Lucas says that Aetna's closing arguments in its earlier out-of-network case against BASM in California "were just stunning." In fact, she says Aetna's legal victory over BASM has had a lasting effect in California. "Every out-of-network surgery center is concerned about this and addressing issues like the routine waiver," she says, explaining that facilities are carefully documenting their efforts to assess a patient's level of hardship and other factors to explain any reduced copay for any individual. They also review what are considered reasonable charges by similar local providers "to avoid being tarred with the BASM brush," she says.

Interestingly, she says, issues related to the Aetna/BASM litigation are arising in merger and acquisition transactions. "M&A lawyers look at the BASM case and freak out," she says, which requires "a lot of due diligence to convince investors that not all out-of-network providers are crooks." The upshot, she says, is that out-of-network surgery centers "are trying to improve their documentation and processes…and prove they're not BASM."

Contact Neugebauer via Anjie Coplin at coplina@aetna.com, De Marco at bill.demarco@pendulumhealth.com and Lucas at clucas@buchalter.com. ✧

Individual Market and Uninsured Will Affect Employer Coverage

The House Republican proposal to unravel key provisions of the Affordable Care Act (ACA) would increase the nation's uninsured population by 24 million people by 2026, according to the Congressional Budget Office's March 12 estimate (see story, p. 1). And that has employers concerned about the effect such changes could have on employer-sponsored benefits (see story, p. 4). Employers provide health insurance to 177 million people, or 61% of covered Americans, and collectively spend more on health insurance than the federal government spends on Medicare, according to 2015 CMS data.

The future of the ACA has created uncertainty among employers, says Adam Solander, a member of

the life sciences practice at the law firm Epstein Becker Green. According to CBO, the House's American Health Care Act (AHCA), if enacted, would mean less federal funding for state Medicaid programs and lower federal subsidies for low-income people who buy coverage through the public insurance exchanges. A higher uninsured population would translate to more uncompensated care for hospitals and providers.

Republican lawmakers have long advocated giving states more control over their Medicaid programs through block grants or an enrollment-based per capita cap model. Both strategies would gradually reduce federal funding for the program *(HPW 12/12/16, p. 1)*. "What hospitals don't get paid by virtue of servicing patients without insurance has the potential to percolate over to employer costs due to cost shifting by hospitals" to commercial business, says Julie Stone, a national health care practice leader at Willis Towers Watson.

Tracy Watts, senior partner and national leader for health reform at Mercer, agrees and says employers have a vested interest in a thriving individual market and Medicaid programs that help low-income and disabled people receive the care they need. "Whatever happens with Medicaid could put additional pressure on the states to either cover fewer people or to pay providers less for services provided to Medicaid beneficiaries. And that would shift costs to employers," she says. "Any policy that shifts cost to the private market is of concern to employers."

What keeps large employers up at night? "Taxes," says James Gelfand, senior vice president of health policy for the ERISA Industry Committee, which advocates on behalf of very large self-insured employers. Employee benefits consultants contacted by AIS Health agree that taxes on employee benefits are always a top concern.

Late last year, Congress delayed implementation of the so-called Cadillac tax, a 40% excise tax on rich benefit plans enacted by the ACA, from 2018 to 2020 *(e-News Alert 2/10/16).* The AHCA kicks it down the road even further — to 2025.

Mercer surveyed employers shortly after the ACA was enacted. At the time, and for several years after, the Cadillac tax remained the top concern. In recent years, that anxiety has been replaced by worries over reporting requirements, Watts says.

Since 2010, large employers gradually have been lowering the valuation of employee benefits to bring them in line with the excise tax by 2020 and avoid the penalty. "People ask why deductibles or premiums are going up….It's the Cadillac tax," Gelfand says.

Contact Bruce Lee for Watts at bruce.lee@mercer.com, Solander at asolander@ebglaw.com, Rob Wyse for Stone at rob@capital-content.com or Gelfand at jgelfand@eric.org. ✧

Six Health Reform Changes Could Have Major Impact on Employers

The debate over repealing or reforming the Affordable Care Act (ACA) will have immediate consequences for individual market policyholders and Medicaid beneficiaries. But large employers also are bracing for potential fallout in their own employee benefit plans. Here's a look at six health reform issues that could impact employers and the coverage they offer to employees:

(1) Caps on employee benefits: The idea of capping employer-sponsored health benefits isn't included in the American Health Care Act (AHCA), the House Republican proposal to replace the ACA, but it was part of an early draft. Steve Wojcik, vice president of public policy at the National Business Group on Health, says his members were happy to see the AHCA didn't include a change in the tax-favored status of employees' health benefits. But some employers are concerned that changes to the way employee benefits are taxed could wind up in final legislation, benefits consultants tell *HPW*. While in the House, HHS Sec. Tom Price, M.D. (R-Ga.) proposed capping the tax deductibility of employer-sponsored coverage at $8,000 per worker ($20,000 for families).

(2) Reporting requirements: The AHCA would eliminate penalties tied to the individual mandate and the employer mandate, and it appears employers wouldn't need to abide by the arduous reporting requirements of the ACA. Instead, reporting would likely be limited to a box added to W-2 income tax forms.

Tracy Watts, senior partner and national leader for health reform at Mercer, says employers would be happy

to see that requirement go away. "For the past seven years, employers have been jumping through hoops to comply with the ACA…just to continue to cover the same people they've been covering all along," she says.

Julie Stone, a national health care practice leader at Willis Towers Watson, agrees and says the ACA's reporting requirements are administratively burdensome and time consuming. Adam Solander, a member of the life sciences practice at the law firm Epstein Becker Green, notes that employers have spent considerable amounts of money over the years complying with the ACA's reporting requirements. He says they want certainty about what will be required. If a Republican replacement bill is enacted, employers will probably need to report information about the coverage they offer to workers so that tax-credit eligibility can be determined. And that will require additional system changes, he says.

(3) Coverage for adult children to age 26: The ability for parents to extend health coverage to adult children up to age 26 is an ACA feature supported by Democratic and Republican lawmakers. But 22% of employers say they would lower that age limit if allowed to under an ACA replacement, according to a survey of 666 mid-sized and large employers conducted by Willis Towers Watson in January. "One of the myths out there is that adult children under 26 don't cost anything. But there are costs associated with accidental injuries, behavioral health, substance abuse and maternity. It is not a zero-cost population," says Stone.

(4) Age-rating bands: Allowing carriers to charge older members five times what they charge their youngest members — rather than three times as allowed under the ACA — would mean lower costs for young adults, but much bigger premiums for older participants. That could keep people from retiring early. "You don't want benefits to be the deciding factor in how people live their lives," says James Gelfand, senior vice president of health policy for the ERISA Industry Committee. "Unwinding the age bands is a gambit on behalf of lawmakers to stabilize the individual market. And so far, in all the time I've been in health policy, no effort to stabilize the individual market has ever been successful." Watts notes there has been a decline in employers offering pre-65 retiree coverage because it was believed the ACA would create affordable insurance options in the individual market.

(5) Expanded HSAs: Several Republican proposals call for expanded health savings accounts, but HSAs have been expanding rapidly among employers without new legislation or regulatory guidance. "Employers are moving down that path on their own. It feels like [Congress] is playing catch-up to where employers are on this," Stone says, adding that further expansion will be received favorably. But she notes that low-income people might not be willing or able to contribute to an HSA,

Rhode Island Exchange Sees Enrollment Decline, Technical Problems

During the 2017 open-enrollment period (OEP), state-based exchanges increased membership between 3.5% and 31.5%, with one exception: Rhode Island. HealthSource RI, Rhode Island's health exchange, saw enrollment drop more than 20% from 2016. At the end of the 2016 OEP, HealthSource RI reported 37,608 enrollees, but for 2017, the state reported only 29,420 enrollees — 27,295 of whom had paid and were therefore confirmed.

In a statement to AIS Health, HealthSource RI said there was not one single cause for the issue, instead tracing the decline to a few key factors:

(1) System and service issues. "Just before the start of open enrollment," HealthSource RI explained in its statement, "Rhode Island launched a new integrated eligibility system to improve the way it delivers health and human services programs." In the future, the system will offer residents access to several benefit programs, but throughout the OEP "this new technology presented challenges," according to the exchange. The new system prevented many Rhode Island residents from enrolling, HealthSource spokesperson Kyrie Perry tells AIS Health.

(2) Eligibility changes due to Medicaid. Many residents who purchased commercial health insurance last year now qualify for Medicaid, accounting for a portion of the decrease since Medicaid is not included in the exchange's enrollment numbers.

(3) The exit of UnitedHealthcare from the marketplace. After UnitedHealthcare said in April 2016 that it would no longer offer health plans on HealthSource RI, all customers who purchased United products in 2016 were not qualified for automatic enrollment in 2017, forcing them to once again visit the exchange website, which was experiencing serious technical difficulties.

To remedy that issue, Perry says, HealthSource RI will continue to assist customers affected by technical issues during a special enrollment period that might continue through March. The exchange expects that "when those issues are resolved there will be a rise in HealthSource RI's total enrollment numbers."

and employers know they need to spend more time educating their workforce on how to effectively use the accounts, she adds.

While HSAs won't work well for everyone, they are a powerful tool for some employee populations because it gives them a financial incentive to become better shoppers of health care, Gelfand says. For those people, doubling the annual contribution limit "could be a game changer" because it would let new members save enough in pre-tax dollars to cover the full deductible. He suggests legislation could go further and allow prescription drugs to be covered outside of the annual deductible. That, he says, could keep members out of the hospital. Moreover, prescription drugs considered preventive could be covered with first dollar coverage. One of the problems with HSAs, and the high-deductible health plans (HDHPs) that they must be paired with, is they limit what can be paid for outside of the deductible. Along with expanding contribution limits for HSAs, Watts says employers would like their workers to be able to use the accounts to pay for telehealth visits outside of the deductible. More than half of large employers and 70% of jumbo employers offer access to telehealth. Telehealth visits typically cost about $50. Some employers make the first visit free or charge a $20 copay, she says.

(6) Freedom to innovate: Beyond cost, employers would like more freedom to design health benefits that are better suited to the needs of their workers. Employers see the ACA as being too prescriptive about the benefits that need to be covered, Gelfand says. "You have very different groups of workers who all had to be offered very similar types of plans. Large employers," he adds, "are at the forefront of innovation.

For more information, contact Bruce Lee for Watts at bruce.lee@mercer.com, Solander at asolander@ebglaw.com, Rob Wyse for Stone at rob@capital-content.com, Gelfand at jgelfand@eric.org and Wojcik at wojcik@businessgrouphealth.org. ✧

Public Exchange Open-Enrollment Results, 2016-2017, by State

State	Exchange Enrollment 2017	Exchange Enrollment 2016	% Difference	State	Exchange Enrollment 2017	Exchange Enrollment 2016	% Difference
Alabama	178,414	195,055	-8.53%	Montana	52,473	58,114	-9.71%
Alaska	19,145	23,029	-16.87%	Nebraska	84,371	87,835	-3.94%
Arizona	196,291	203,066	-3.34%	Nevada	89,061	75,365	18.17%
Arkansas	70,404	73,648	-4.40%	New Hampshire	53,024	55,183	-3.91%
California	1,556,676	1,411,664	10.27%	New Jersey	295,067	288,573	2.25%
Colorado	161,568	153,583	5.20%	New Mexico	54,653	46,816	16.74%
Connecticut	111,542	102,066	9.28%	New York	242,880	665,772	-63.52%
Delaware	27,584	28,256	-2.38%	North Carolina	549,158	613,487	-10.49%
District of Columbia	21,248	19,299	10.10%	North Dakota	21,982	21,604	1.75%
Florida	1,760,025	1,742,819	0.99%	Ohio	238,843	243,715	-2.00%
Georgia	493,880	587,845	-15.98%	Oklahoma	146,286	145,329	0.66%
Hawaii	18,938	11,057	71.28%	Oregon	155,430	147,000	5.73%
Idaho	100,082	96,662	3.54%	Pennsylvania	426,059	439,238	-3.00%
Illinois	356,403	388,179	-8.19%	Rhode Island	29,456	37,608	-21.68%
Indiana	174,611	196,242	-11.02%	South Carolina	230,211	231,849	-0.71%
Iowa	51,573	55,089	-6.38%	South Dakota	29,622	25,999	13.94%
Kansas	98,780	101,555	-2.73%	Tennessee	234,125	268,867	-12.92%
Kentucky	81,155	81,121	0.04%	Texas	1,227,290	1,306,208	-6.04%
Louisiana	143,577	214,148	-32.95%	Utah	197,187	175,637	12.27%
Maine	79,407	84,059	-5.53%	Vermont	30,682	28,258	8.58%
Maryland	157,832	148,943	5.97%	Virginia	410,726	421,897	-2.65%
Massachusetts	266,664	196,647	35.61%	Washington	225,594	171,045	31.89%
Michigan	321,451	345,813	-7.04%	West Virginia	34,045	37,284	-8.69%
Minnesota	109,974	112,259	-2.04%	Wisconsin	242,863	239,034	1.60%
Mississippi	88,483	108,672	-18.58%	Wyoming	24,826	23,770	4.44%
Missouri	244,382	290,201	-15.79%				

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Investors Seek Haven in Diversity

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Health insurer stocks weren't jolted by the CBO report or the March 9 party-line votes in the House Energy and Commerce and Ways and Means committees to approve the AHCA. That's not surprising, Vishnu Lekraj, securities analyst for Morningstar, Inc., tells AIS Health. The AHCA proposal as it stands now is "pretty much going to be a loss of volume for these insurers for sure, which is going to be less growth for them moving forward." But, he adds, the Republican plan is just that right now: a plan.

"A couple of things [are holding stock prices steady]. One is the skepticism that the plan will even pass, and No. 2 is even if it does pass there will be some level of subsidized health care in the U.S. for the uninsured," he says. "Until we get some movement in Congress, or at least some visible outlook that it is going to pass, that is the only time we will see movement in stocks."

'Safer' Bets Are Diversified Insurers

Larger health insurers with multiple product lines will be most insulated from the coming changes, said Fitch Ratings in a March 9 analysis. "Large diversified health insurers' credit profiles should not be significantly affected by changes proposed under the AHCA," the agency said. "However, smaller, less diverse players could be materially affected over the long term by some proposals, including changes to Medicaid funding."

The Republican proposal's focus on changes to the individual and Medicaid markets relieved potential stress on national carriers like Aetna Inc. and UnitedHealth Group, Fitch said, since these carriers realize only a small portion of overall revenues from those two market segments. "The employer-provided group and Medicare markets represent a much larger share of revenues for most Fitch-rated insurers. As such, the fundamental outlook for the health insurance sector is likely to be unchanged should the current form of the AHCA be implemented," the agency said.

But, Fitch continued, "in a bill of this scale, unintended and unforeseen consequences are also likely to create some level of uncertainty as to the net effect for health insurers." For example, the proposed change to age-rating bands from 3:1 to 5:1 is intended to attract younger, healthier customers, but it could result in lower enrollment and a still dicey risk pool.

"Ultimately, how the AHCA's approach to incentivize continuous coverage will compare to the ACA's in drawing healthier individuals to buy coverage will be difficult to predict," said Mark Rouck, senior director of insurance for Fitch. "This is important to risk and pricing adequacy, as the AHCA retains the ban on the denial of coverage for pre-existing conditions, which has created an underwriting challenge for insurers and underscored the importance of bringing healthier individuals into health insurance plans."

Health insurers may be in limbo for some time, warned Wall Street securities analyst Thomas Carroll of Stifel in investor notes on March 6 and March 7. "This is just a first step in what is likely going to be an intense and noisy process….There is talk of having bills through both House and Senate by Easter Break (April 7) — a goal that may require divine intervention reminiscent of the season. To us — this all seems very rushed."

> **"We see increased adverse selection in the individual market, reduced Medicaid funding in the long term, collapse of exchanges that currently work and soaring numbers of uninsured.**

Indeed, House Speaker Paul Ryan (R-Wis.) and HHS Sec. Tom Price have repeatedly said the AHCA is the first of three bills to undo Obama-era health care policies. But the three-pronged approach has drawn skepticism from Republicans led by Sen. Tom Cotton (R-Ark.), who dismissed Ryan and Price's designs as a "myth."

Carroll agreed that larger insurers like UnitedHealth are less vulnerable in this climate. "UnitedHealth offers size, diversity and stable financial performance," he said. Centene Corp. also may be well-positioned if the Republican plan to place per-capita caps on federal outlays for Medicaid is enacted *(HPW 2/13/17, p. 5)*.

Another analyst, Sheryl Skolnick, Ph.D., managing director and director of U.S. equity research for Mizuho Securities USA Inc., in a March 10 note said her bank expects a deal to get done. "We'll reiterate our stand: We think that repeal/replace gets done...and what we're seeing now is just the normal messiness of tribal politics at its worst."

But, she warned, the AHCA could hold big risks for hospitals as well as insurers. "If it does [get done], we see increased adverse selection in the individual market, reduced Medicaid funding in the long term, collapse of exchanges that currently work and soaring numbers of uninsured as creating real potential for pressure on hospital cash flows that likely hit hospital valuations in the next two years," Skolnick said.

Contact Lekraj at vishnu.lekraj@morningstar.com, Rouck via Hannah James at hannah.james@fitchratings.com or Carroll at tacarroll@stifel.com. ✧

HEALTH PLAN BRIEFS

◆ **Anthem, Inc. is backing the House Republican plan to repeal and replace major parts of the Affordable Care Act (ACA) and wants the bill to be approved as quickly as possible,** *Politico* reported. In a letter to top House lawmakers, Anthem CEO Joseph Swedish expressed support for provisions that would repeal the ACA's health insurance tax, temporarily continue the law's cost-sharing subsidies and provide consumers buying insurance on the individual market with tax credits. Anthem is the top insurer on the individual market exchanges, but says it may pull out in 2018 if changes aren't made. See the article at https://tinyurl.com/gta8v6b.

◆ **Horizon Blue Cross Blue Shield of New Jersey agreed to pay a $1.1 million fine, submit a corrective action plan and improve data security practices following an incident in which two laptops were stolen from the insurer's Newark headquarters.** The laptops, which contained personal information that included medical information and Social Security numbers in some cases, were password-protected but not encrypted, according to the New Jersey Division of Consumer Affairs. The theft occurred in November 2013 when someone cut the cables securing the devices to a desk. Learn more at https://tinyurl.com/zsaw3tv.

◆ **Allowing individuals to purchase insurance across state lines will start a "race to the bottom by allowing companies to choose their regulator," says the National Association of Insurance Commissioners (NAIC).** Some GOP lawmakers are advocating including a provision in their planned health reform package that would allow policies to be sold across state lines *(HPW 12/19/16, p. 1)*. However, the NAIC says mandated benefits in certain states aren't the reason insurance is more expensive in some states than in others. Approving legislation that would allow cross-border insurance sales would reduce the options available to consumers and restrict the ability of insurance regulators to help consumers, the group says. "While those individuals in pristine health may be able to find cheaper policies, everyone else would face steep premium hikes if they can find coverage at all," the group said. Read the full statement at https://tinyurl.com/j226zgg.

◆ **About 12.2 million consumers signed up for health care coverage for 2017 through the individual marketplaces, down from 12.7 million in 2016,** according to CMS. Some 83% of those enrolled received subsidies, about the same percentage as last year, CMS says, and most consumers — 71% — chose silver plans, while 23% chose bronze plans. Just 4% chose gold-level plans, 1% picked platinum plans and 1% chose catastrophic plans. Nearly one-third of those who enrolled via the marketplaces were new consumers, CMS says, and about half of people who had enrolled via the marketplaces previously chose new plans for 2017. See CMS's data at https://tinyurl.com/jdpl83m.

◆ **New Jersey Gov. Chris Christie (R) is pressuring Horizon Blue Cross Blue Shield of New Jersey to establish a "permanent fund" with money from its surplus to support health care and drug rehab for New Jersey's poorest residents,** *Politico* reported. In a speech March 14, Christie said he wasn't pushing the insurer to convert to a for-profit company, nor was he planning to use Horizon's surplus only to fill budget gaps. "What I propose today was that we work urgently to establish a permanent fund that Horizon would fund every year through their abundant surplus," Christie said. He called for the fund to be set up by June 30. Horizon had a $2.9 billion surplus on $12 billion in revenue in 2015. It's not clear how much traction Christie's plan has. Horizon issued a statement saying it wouldn't provide the money to the state voluntarily, and none of the state's top Democratic lawmakers have pledged support. Read more at https://tinyurl.com/jdkxmqb.

◆ **The three insurers managing the Iowa Medicaid program lost hundreds of millions of dollars during their first year of operation,** the Cedar Rapids, Iowa, *Gazette* reports. AmeriHealth Caritas Iowa lost nearly $300 million, while Amerigroup Iowa lost more than $133 million and UnitedHealthcare of the River Valley anticipates losing more than $100 million. The state said in October that it would boost payments to the insurers by $33 million to cover rising prescription drug costs and expenses in the Medicaid expansion population. But state officials also said the rates were actuarially sound and that some of the losses incurred by the insurers were anticipated start-up costs. The three companies have said they're committed to staying in Iowa's Medicaid program. See the article at https://tinyurl.com/zc7aw7p.

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