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HEALTH PLAN WEEK

Strategic Business, Financial and Regulatory News of the Health Insurance Industry

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Anthem, Others Report Strong 1Q Results Amid 'Disruption on Multiple Fronts'

Amid a flurry of strong first-quarter earnings results for several managed care companies, Anthem Inc. also beat Wall Street's expectations. But, along with glowing reports of growing membership for its commercial and government-sponsored lines of business, Anthem's CEO stressed in an April 26 earnings call that the industry "continues to face disruption on multiple fronts" that requires "corporate agility." Apart from worries over market-stability issues related to the Affordable Care Act (ACA), he didn't shy away from controversies over Anthem's ongoing efforts to improve its pharmacy management (see box, p. 7) and acquire Cigna Corp.

Anthem reported quarterly net income of $1,009.9 million, or $3.73 per share, on operating revenue of $22.3 billion, all figures up year-over-year. Its medical enrollment increased by 715,000 over the quarter, to total about 40.6 million members as of March 31.

CEO Joseph Swedish led off Anthem's recent earnings call by discussing the company's growth in Medicare Advantage and Medicaid, even touching on its dental and vision lines of business before addressing the Affordable Care Act (ACA)'s individual-market exchanges.

Anthem is pleased with exchange membership growth, he said, but its claims experience was "slightly higher than anticipated." He said nearly 50% of the population is new to Anthem, so full-year implications of this should become clearer in the second quarter ending June 30.

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States Push Back 2018 Rate Filings To Give Unsure Insurers More Time

With the federal rate filing deadline extended to June 21 for health insurance carriers considering whether to participate in next year's Affordable Care Act (ACA) individual market exchanges, some states, including Colorado and Kentucky, are squeezing out more time for insurers to submit preliminary 2018 rates. Yet other states, like Georgia, are moving deadlines earlier to give state regulators more time to review filings.

Whatever states do with their own timelines, they must send final plan recommendations to CMS by Sept. 21. The 2018 open-enrollment period is set to begin Nov. 1.

States opting to push back deadlines anticipate that their flexibility will give plans extra weeks to gather data for calculating new rates and digest CMS's final market stabilization rule — and also allow more time for Capitol Hill to address continued funding of cost-sharing reduction (CSR) payments to plans for covering low-income exchange enrollees *(HPW 4/24/17, p. 1)*.

Colorado extended its deadline from May 15 to June 19 for carriers to file their 2018 individual and small-group plans and premiums, says spokesperson Vincent Plymell of the Colorado Division of Insurance, part of the state's Dept. of Regulatory Agencies.

Typically, Colorado's department of insurance (DOI) releases filings to the public about two weeks post-deadline, once it conducts a cursory review, Plymell says. But

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A Monthly Update for *Health Plan Week* Subscribers

*The AIS Report on Blue Cross and Blue Shield Plans**

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CMS, Blues Plans, Other Carriers and Providers Partner on CPC+ Value-Based Care Program

CMS kicked off its most advanced primary care value-based payment program last month, with participants — including multiple Blue Cross and Blue Shield plans — agreeing to pay physicians care management fees and provide them with data and other assistance in exchange for what hopefully will be improved outcomes and lower costs.

The five-year Comprehensive Primary Care Plus (CPC+) program comprises 54 aligned payers, including Medicare and some state Medicaid programs, in 14 states and regions working with nearly 3,000 practices. CMS unveiled it in 2016 as a successor to the Comprehensive Primary Care program, and many of the same health plans participating in that program have joined the new effort.

Blue Cross Blue Shield of Michigan, an early adopter of patient-centered medical homes that now sees some 85% of covered medical services provided to patients who are attributed to PCMHs, believes the program is another way to shift the paradigm toward value-based care, says Thomas Simmer, M.D., senior vice president and chief medical officer.

The Michigan Blues plan works with around 500 primary care practices that are participating in CPC+. These practices care for between 1 million and 2 million patients who are members — "it's between one-quarter and one-third of our total membership," he tells AIS Health. "We wanted to do this on as broad a scale as possible."

Primary care practices will make changes in the way they deliver care, with goals of improving access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, and planned care and population health.

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Blues Plans Have Mixed Results, Lower Overall Participation in Managed Medicaid Programs

Medicaid enrollment has increased over the past year, especially in the managed care market, making it the fastest growing sector in the health insurance industry. Even states like Florida and Texas that did not expand Medicaid eligibility via the Affordable Care Act have seen healthy gains in participation, according to preliminary results from *AIS's Directory of Health Plans: 2017*.

But Blue Cross and Blue Shield plans have had mixed results with Medicaid operations and vary widely on their approaches to, and fortunes with, the program. Overall, Blues plans are less likely to participate in managed Medicaid than are other insurers (see table, p. 12). And more carriers may exit managed Medicaid programs if states' reimbursement rates don't keep up with costs, a Blue Cross Blue Shield actuary warned in a recent Society of Actuaries report.

West Virginia's Medicaid program, for example, is growing rapidly. "The state is actively carving new populations into managed care and recently expanded Medicaid to include the residents below 138% of the FPL [federal poverty level]," Jason Land-

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ers, president of West Virginia Family Health, tells AIS Health. "The expansion (coupled with the focus on the [Affordable Care Act] Exchange) has actually caused a rise in the number of Medicaid recipients, even in those already existing populations," he says.

West Virginia Family Health is a provider-sponsored health plan that is minority owned by Highmark Inc.'s West Virginia subsidiary. The Blues licensee is responsible for managing West Virginia Family Health's operations. Other owners include 22 federally qualified health centers, two primary care clinics and the West Virginia Primary Care Association.

The plan is closely watching efforts to repeal and replace the Affordable Care Act. West Virginia, facing a $600 million shortfall, would have to find funding for beneficiaries who received coverage under the expansion. "But also, if there is a move to a different funding model (block, etc.), there will be a reshuffling of how members are covered and expenses are paid," he says.

Horizon Is All In

Horizon Blue Cross Blue Shield of New Jersey is among Blues plans with strong Medicaid participation. "Unlike other carriers, Horizon offers Medicaid plans in every county. That contributes to growth, but so does Medicaid expansion, our new Managed Long-Term Services and Supports program, and increased demand from the core Medicaid and Medicare programs," Kevin McArdle, the plan's public affairs manager, tells AIS Health.

Blue Cross and Blue Shield of Minnesota has had a less positive experience. Its Blue Plus HMO subsidiary saw its Medicaid enrollment triple in 2016 — but suffered $167 million in operating losses in that state's Medicaid program *(HPW 4/10/17, p. 8)*. In 2016, Blue Plus reported an overall operating loss of $174.7 million on revenues of $1.8 billion, resulting in a negative operating margin of 9.6%.

"With unprecedented growth in Medicaid utilization levels, current reimbursement rates are not sustainable for the marketplace. As a key Medicaid insurer, Blue Plus is working with health care providers to strengthen efforts to contain costs in the face of rapidly rising per-enrollee spending," said CEO Michael Guyette in a prepared statement.

Facing budget pressures, some states don't reimbursing Medicaid managed care plans adequately, pulling down insurers' overall margins. "Actual performance over the past few years has varied widely among MCOs and states, but the average margin in 2015 was 1.8% for for-profits and 1.5% for nonprofits," according to the Society of Actuaries report, "Medicaid Managed Care Organizations: Considerations for Calculating Margin in Rate Setting."

"The report suggests that MCOs require a certain level of margin, above the allowance for administrative expense. If this level is not built into the rates from the states, the MCOs may not stay in the business because it was not sustainable for them to do so," says one of the report's authors, Sara Teppema, a divisional vice president and actuary at Health Care Service Corp., parent of Blues plans in Illinois, Montana, New Mexico, Oklahoma and Texas.

Meanwhile, carriers have expanded the types of covered services they provide, including long-term care and behavioral health. This, coupled with more challenging populations, "add uncertainty, and therefore cost volatility and the potential for excess or insufficient margins in the short term," the authors concluded.

Traditionally low Medicaid reimbursement rates also make it difficult for plans to attract providers to Medicaid networks. Deb Mabari, CEO of Cody Consulting, points to Anthem Blue Cross of California as an example of a plan that leverages its commercial provider networks to serve Medicaid. Plans with the right combination of Medicare and commercial networks can achieve this by telling doctors: "If you want to join, you'll have to take on X number of Medicaid patients."

"This way, you can push Medicaid members into those networks and successfully expand the program," Mabari says.

She acknowledges that Medicaid isn't an easy space to work in, even for Blues plans. "The problem is Medicaid is not typically very profitable, especially with high MLR [medical loss ratio] rates. It's difficult to do it right and do it well. Plans must be able to balance out the appropriate network in order for them to not lose their shirts," she said.

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by Jennifer Lubell

Blues Plans Join Next-Gen CPC+

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Participating practices receive care management fees and performance-based payments in exchange for providing advanced team-based care to members and beneficiaries. They can choose between various options offered by the payers — for example, Medicare has two payment tracks, including one that offers physicians the chance to trade a reduction in their traditional fee-for-service Medicare reimbursement for higher up-front care management fees.

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