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Health Plan Week

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

Contents

Maverick Zenefits CEO Is Out, but Brokers May Want to Curb Their Enthusiasm for Now

Well, that was quick. Parker Conrad, whose name seemed to demand the words "high-flying" in front of it, has resigned as CEO of Zenefits, the nearly three-year-old Silicon Valley-based, high-tech HR and health insurance brokerage solution he co-founded and promoted to the hilt, attracting a torrent of venture capital funding that valued the startup at $4.5 billion last May *(HPW 5/18/15, p. 1)*. That valuation, according to recent media reports, may now be down to the $2.3 billion level.

But the same Conrad who said in 2013, "if you're an insurance broker, we're going to drink your milkshake," will no longer be leading Zenefits, because of what appears to be a rather important detail if you are in the insurance sales business: you need licenses. That issue and what new CEO David Sacks (a former PayPal exec) called faulty compliance and internal controls led to Conrad's resignation on Feb. 8 as well as a new emphasis by the company on getting serious. After all, as one broker tells *HPW*, "serious money demands serious people," and carriers will not work with unlicensed brokers.

Even before the news broke about Conrad's swan song, traditional brokers sensed the fire he lit was not as hot as it once was. "My personal opinion is that Zenefits is becoming a non-trend issue," Rick Bailey, president of Rick Bailey & Company, Inc., based in Woodstock, Ga., tells *HPW*. "I was recently reminded of the agent contracts that we have all signed with the carriers. Maybe the big guys like Zenefits had leverage to not sign the same contracts. The carriers also have the power to not approve of a particular agent being able to represent their company with clients. I see the employee benefit space harder for tech companies to raise investor money going forward. I hear they are now looking at how to add Property & Casualty insurance to their mix."

continued on p. 5

Humana Takes ACA Exchange Hit, While Medicaid Specialist Molina Charts Big Gain

In the final wave of fourth-quarter 2015 earnings reports, the theme for health insurers continues to be that losses on Affordable Care Act (ACA) marketplaces are hitting national carriers hard, but the core business of these insurers remains strong even if there have been slight misses in targeted growth segments and in some cases in meeting medical loss ratio (MLR) expectations.

A case in point is Humana Inc., which on Feb. 10 told investors it failed to meet Wall Street forecasts for earnings and revenue in the final stanza of last year, mainly on the back of a 74 cents per share write down to account for ACA marketplace losses and errant pricing for its Medicare Advantage (MA) business. The exchanges are performing so poorly for Humana that it is considering whether to remain a player in 2017, joining UnitedHealth Group and other carriers in reassessing how long they want to be involved in what has become a money pit for numerous health plans *(HPW 11/23/15, p. 1)*. Presumably, Humana's decision will come after it is made part of Aetna, Inc., whose acquisition of Humana remains on track for a second-half 2016 close.

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"Cigna (which reported fourth-quarter losses as well on Feb. 4) and Humana are doing pretty well, with strong top-line growth and good cost management driving profits," David E. Williams, president of Boston-based Health Business Group, tells *HPW*. "In some cases they have missed the most optimistic projections in certain segments, but both companies are in a strong position to take advantage of continued changes in the market."

For the fourth quarter, Humana said net income declined to $101 million, or 67 cents per share, from $145 million, or 94 cents per share, a year earlier. But on a brighter note, the insurer said it expects adjusted earnings of at least $8.85 in 2016, topping the average Wall Street analyst estimate of $8.73 per share.

At the same time, government program specialists Molina Health Care, Inc., Centene Corp. and WellCare Health Plans, Inc. logged sharp profit gains in the fourth quarter of 2015 as they reported earnings over the Feb. 8-9 time frame. And in the case of WellCare there is much financial and strategic alignment in place to spend billions on mergers and acquisitions of smaller Medicare and Medicaid plans to help meets its goal of doubling revenue over the next five years. Company leadership went out of its way during a Feb. 9 earnings conference call to say WellCare will be a significant player in the M&A space, not unlike Medicaid expert Molina, which has been on a buying spree in recent months *(HPW 11/23/15, p. 1).*

"We have been working on improving our cash and credit position over the past six quarters and currently have over $600 million in cash deployable at the parent plus the $650 million of available credit facility for a total of $1.25 billion of dry powder," WellCare Chief Financial Officer Andrew Lynn Asher said during the earnings call. "From an operational standpoint, we are in the process of putting over 30 of our functional experts through formal M&A training this month and we have built a dedicated integration team for both organic growth and acquisitions. We expect there to be significant growth opportunities in both Medicaid and Medicare over the next five years and have energized the team at WellCare to seek out and seize those opportunities in our quest to double our revenue."

WellCare Makes M&A Statement

Williams says the mega-deals in the sector are opening up acquisitions by other insurers as companies like Aetna and Humana make expected asset divestitures *(HPW 7/13/15, p. 1)*. "The pending mergers of the largest carriers are presenting opportunities for mid-sized and smaller health plans. Of particular interest is the emerging segment of provider-sponsored MA plans. Many of these plans are demonstrating excellent star ratings results and building local market share."

For the fourth quarter of 2015, WellCare said net income was $13 million, or 29 cents per share. Adjusted net income for the fourth quarter of 2015 was $26.9 million, or 60 cents per share, compared with adjusted net income of $18 million, or 41 cents per share, for the fourth quarter of 2014. Positive MLR results have boosted the insurer in recent quarters. For instance, WellCare's Medicare Health Plans segment MLR for full-year 2015 was 87.2%, an improvement of 130 basis points compared with full-year 2014.

Meanwhile, Molina on Feb. 8 reported net income for 2015 at $143 million, or $2.57 per share, up 131% from $62 million, or $1.30 per share, for 2014, fueled by increased revenue brought on by its strong Medicaid performance and acquisitions. Centene on Feb. 9 reported net earnings of $355 million, or $2.88 cents per share, for the year ended Dec. 31, 2015, compared with $271 million, or $2.25 cents per share, for the full-year 2014. For the fourth quarter, Centene said net earnings were $111 million or 90 cents per share, versus $107 million or 88 cents per share for the same period of 2014.

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Obama Budget for 2017 Seeks to Make Cadillac Tax a Regional Affair

A number of health insurance-related provisions made it into President Obama's $4.1 trillion 2017 fiscal year budget released on Feb. 9. Among them was the expected tweak to the Cadillac tax, which if approved by Congress would make the excise tax on rich coverage dependent on geography, among other changes. Any of the measures the president wants in his final budget are likely to be a tough sell on Capitol Hill where Republicans remain in control of the House and Senate, legislative sources tell *HPW*.

In a sneak peak of what was actually in the budget, Jason Furman, Ph.D., chief economic adviser for Obama, on Feb. 3 wrote in *The New England Journal of Medicine* that the president would seek an increase to the threshold for the excise tax in locales where health insurance premiums are the most costly *(HPW 2/8/16, p. 7)*. The unpopular tax, which is one of the few issues that Republicans and Democrats can seemingly agree on in disliking it, was shoved off to a 2020 start year from its original implementation date of 2018 to appease critics when Obama signed an omnibus tax package on Dec. 18.

In the budget proposal, in states where the average premium for "gold" metal tier coverage (based on public exchange tiering) surpasses the existing Cadillac-tax threshold, that benchmark would be raised to the average gold premium. The Cadillac tax would have imposed a 40% excise tax on the portion of group plan premiums that top $10,200 for single coverage and $27,500 for family coverage for 2018.

To Chris Condeluci, a principal at CC Law and Policy, the proposed change to the gold metal tiering is akin to an "actuarial value" (AV) measure, "in particular, an 80% AV measure (i.e., a 'gold' plan is 80% AV). So, it would appear that the White House supports an AV-based measure, and the basis for determining AV is governed by all of the algorithms HHS has developed for the current AV calculator. If this proposal was ever enacted, over time, the Cadillac Tax thresholds would become based on the 80% AV measure."

He says this is because the statutory dollar thresholds will grow very slowly (based on the Consumer Price Index, which recently has only grown by 1% or 2% annually). "But, premiums will grow much faster (historically, premiums grow by around 7% a year, and the way the current individual market is shaping up, those premium increases may exceed 10% per year). So, at some point in the near future, the dollar thresholds under the Cadillac Tax would be obsolete, because in every state the cost of the 'gold' plan would be greater. And, the Cadillac Tax would finally vary based on geography."

Timothy Jost, a law professor at Washington and Lee University, tells *HPW* that the Obama budget recognizes three of the problems with the tax: the significant discrepancies in the cost of health care between different geographic areas, the higher costs faced by groups with sicker enrollees and the complexity of having to make individualized determinations as to the application of the tax based on employee contributions to FSAs. "Even if these changes were adopted, however, the tax would remain a very blunt instrument for addressing the complex problem of high health care expenditures," he says.

continued

In other budget points that are of interest to health plans, the president wants to:

◆ Provide any state that expands its Medicaid program three full years of federal aid no matter when the state decides to expand eligibility;

◆ Create an integrated appeals process for dual-eligible beneficiaries;

◆ Expand telehealth capabilities for Medicare Advantage plans;

◆ Devise a competitive bidding system for MA that changes the way payments are based to estimate for the cost of beneficiaries' care; and

◆ Implement drug cost reduction policies such as giving the HHS secretary the power to require drug manufacturers to publicly disclose information including research and development costs and discounts.

Visit http://tinyurl.com/zx47vxp for the 2017 Obama budget. Contact Jost at jostt@wlu.edu and Condeluci at chris@cclawandpolicy.com. ✧

Medicare Payment Reform May Be Strategy Game Changer for Plans

MACRA, not ACA, should be the acronym health plans and other stakeholders focus on in 2016, according to Anne Phelps, principal and U.S. health care regulatory leader for Deloitte LLP. She has co-authored a new primer ("Top Regulatory Trends for 2016 in Life Sciences & Health Care") on issues like Medicare reform, the Cadillac tax, drug pricing, Medicaid managed care and final Obama-era Affordable Care Act rules and tweaks.

But it's the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, that she thinks should draw the most attention because of its long-term promise. The law, which replaced the "doc fix" or Sustainable Growth Rate (SGR) model last spring when it was enacted with overwhelming approval in Congress and the support of the president, could set in motion powerful incentives, making it a real disruptor of the traditional fee-for-service (FFS) health care revenue model.

The law provides a 5% annual bonus for medical providers who participate in Alternative Payment Models (APMs), risk-bearing coordinated-care models that move physicians away from FFS. Under MACRA, provider groups can qualify if they take downside risk for at least 25% of their payments (the 25% figure will increase to 50% in 2021).

"Health care professionals who opt to stay out of the new risk-bearing coordinated care models will receive lower payment updates and will be subject to significant new reporting requirements under the Merit-based Incentive Payment System," the Deloitte paper explains. This program offers bonuses based on quality, use of resources, use of electronic health records and practice improvement.

And unlike other reforms, MACRA has the potential to force health plans to rethink strategies in the way they work with providers, first in Medicare, then possibly across Medicaid, Medicare Advantage (MA) and commercial segments, Phelps tells *HPW*.

"The reason, in a nutshell, why I think it is so incredibly important is that for a long time and in the ACA and in general we have been moving toward these trends of value-based care. And all of those things that you hear about, like moving from volume to value and sharing risk and population health, it's been very voluntary, regional-based and more of a carrot approach," she says. "We've had all different kinds of delivery models. We've had ACOs, some of which have fared better than others. We've had medical homes. We have demonstrations around bundled payments. So we are moving in that direction but in fits and starts, and it has not been national in scope."

New Statute Breaks Fresh Ground

But MACRA is such a game changer "because it kind of goes in underneath at the very basic level all the way down to the individual practitioner/physician," Phelps says.

Physicians who opt for the Merit-based Incentive Payment System will be scored at an individual level, which is new for CMS. "You are going to get a new composite score based on new measures that will be made public and then that will be tied to your updates. And those updates could be positive, they could be zero or they could be negative. And we have never had that before in Medicare. So if they stay on a certain path there is a risk associated with it to their revenue and or reputation," she says.

The other path is to join an APM, Phelps continues, "and the reason why the distinction between the payment models and the delivery model is so critical is it really gets at the underlying driving financial incentives at the very base level of the individual practitioner and the hospital." MACRA is also large in scope at the national level in its approach. "And I think we all know so much of our health care delivery reform or models are driven

by the payment model. MACRA fundamentally changes the payment model. Because it is about individual physicians and other providers along with their hospitals and plans figuring out the payment model, which is three things: You have to share risk [upside and downside] that is more than nominal, you have to have a certified electronic health record that is interoperable and third you have to meet certain quality measures."

If providers achieve these marks, then they receive higher payments, higher bonus payments and higher Medicare reimbursement in the future.

Health Plans Enter the Picture

What about the role of insurers? Phelps says the reason health plans are going to care so much about MACRA is because an insurer is only as good as its network and its strategic alliances, so providers have to be able to manage that risk both on the revenue side and the clinical side. "The other critical piece is that the law envisions expanding beyond Medicare to what is called an all-payer model," she says. "And if a health plan can help drive revenue and help meet these new payment models across Medicare, and then potentially Medicaid, MA and the commercial market, they are going to be able to help their providers and their doctors achieve more toward those new payment models. And that is why in my mind it is a huge strategic play for health plans."

Health plans can aid providers through their data expertise, Phelps says. "It is a new opportunity for health plans [because of the granular nature of MACRA] to look at these payment models and go back and look at their delivery models too. Many of them have a lot of really good strategic alliances and joint ventures already with hospitals…and now they will be helping them dive down a little deeper to the individual practitioner level to say 'how can we help you manage the risk on clinical and revenue side?'"

In the short term, MACRA will be about shoring up their health plan alliances and maintaining or building their reputation. But in the long run with a possible all-payer model in place, it will be about how insurers can capitalize on strategies to help providers reach clinical success and bring in more revenue across each segment of the marketplace, she says. "For example, plans focused on high-value narrow networks find out individual doctors are not scoring so well. Say they are struggling with a reporting score and not doing well versus others nationally. If, like on a bell curve, they fall on the lower end or middle it may affect your brand and revenue for a hospital," Phelps adds.

Visit http://tinyurl.com/gv3am3x for the Deloitte report. Contact Phelps via Ellen Conti at elconti@deloitte.com. ✧

Zenefits Takes Fresh Direction

continued from p. 1

To rewind a bit, Zenefits burst onto the scene in 2013 with a new business model centered on its ability to transform what Conrad considered the stolid world of HR, benefits and brokering by giving away software to companies to manage all of these functions. Zenefits would make money in turn by becoming the company's insurance broker, collecting commissions from carriers. The attraction of this free cloud HR automation platform allowed Zenefits to grow fast and expand nationally.

The original market for Zenefits was small and medium-size businesses with fewer than 1,000 employees, especially in the under-100 slice. As of last May, the company said it had 10,000 clients and is the broker for 100,000 group members. Zenefits would not return emails or calls for comment on this article.

Michael Lujan, co-founder and chief strategy officer for Limelight Health, Inc. and president of the California Association of Health Underwriters, is able to put a unique perspective on the Conrad departure. Lujan, whose San Francisco office sits across the street from that of Zenefits and who has interviewed Conrad twice, tells *HPW* that first and foremost, one needs to separate Conrad's attacks on traditional brokers and their business model from the company he built. One may be gone but the other will likely thrive once outstanding licensing and other issues are resolved.

continued

New Data Show State Performances For Insuring Children, Types of Coverage

A new report by the Robert Wood Johnson Foundation released on Feb. 11 examines the rates of health insurance coverage for children. "State Level Trades in Children's Health Insurance Coverage" details the public and private options for insuring children. And according to the report, five states had private coverage rates for children in 2014 that were more than 70%. In the same year, three states had such rates below 50%. For a copy of the research, see http://tinyurl.com/zyqqnh6.

	State	Percent
Top Five States	North Dakota	77.9
	Minnesota	74.0
	Utah	73.9
	Wyoming	71.1
	Massachusetts	70.9
Bottom Five States	New Mexico	41.8
	Mississippi	47.0
	Arkansas	47.0
	Louisiana	50.7
	Florida	51.1

SOURCE: Robert Wood Johnson Foundation, www.rwjf.org.

"Under David Sacks, they will likely take on a more disciplined culture and less like a fun and edgy startup. Parker [Conrad] was a talented marketing guy and fundraiser…great skills for an early stage startup. Now as a fully funded and more mature business, I think Sacks is what they need. Anyone who thinks this means the end of Zenefits is mistaken," he says.

On the licensing of brokers, Lujan asked Conrad about that during a sit-down, public interview he conducted with the former CEO in San Francisco last May 14 before an audience of the Northern California Employee Benefits Council. The question was: "Are all of your marketing and sales folks licensed?" In response, Conrad said: "All of our sales folks are, yeah. In any offer letter for any account manager or sales person there is a line that says you have to have your license by the time you start work in order to start work. Sometimes people have taken the test but they haven't gotten their number back and we still let them start because there is training anyway, but everyone is licensed."

But that statement came before a *BuzzFeed News* investigation of Zenefits created intense scrutiny and raised alarm bells inside and outside the company. In a news article last fall, *BuzzFeed* said it found evidence from sources inside Zenefits that the startup had flouted state insurance laws in as many as seven states dating as far back as summer 2014 through summer 2015. And more recently, on Feb. 6, *BuzzFeed* said in Washington state, 83% of the insurance policies sold or serviced by Zenefits through Aug. 15, 2015, were handled by employees lacking the proper state licenses. Washington state regulators, even before this latest article appeared, were conducting an investigation of their own.

Zenefits Is One of Many, and Will Pivot

Speaking to *HPW* in a separate interview before the Conrad resignation, Lujan says Zenefits is in a fluid situation. "As fun as it might be to stack another log on these guys and say they aren't going to make it, they are going to fail, I don't think that is true at all," he says. "I think there is a new measure of success and failure in Silicon Valley that I think most of us aren't used to. So if a startup with a lot of hubris says we are going to generate $100 million in revenue and misses that goal and only does $80 million, is that a failure?"

Conrad and his "bombastic" manner are part of the swagger factor in Silicon Valley. "And we as brokers look at that and say 'wow, that is a really tall statement. Wow, you are really swinging big elbows here.' And when they fell short of that number, a lot of brokers wagged their finger and said, 'see, I told you you weren't going to make it,' which is totally wrong," Lujan continues. "These guys are very well funded, they are going to pivot. They are going to expand. So understand I am not saying this as a fan of Zenefits, but as a defender of reality. Reality is this trend has been embraced — maybe not at the numbers that Zenefits forecast, but it is real."

Separate from the alleged licensing situation, Zenefits has had issues retaining clients. "Anecdotally and what has been reported is that the retention is not as high as the market standard and that is not a bad thing because I think neither is their cost of acquisition. So they work masses and masses of numbers and have a really efficient acquisition process. A team makes calls,…sets up appointments for closers and they have a really good close ratio, but what might not be as good as the market standard is the retention rate," he says.

Keeping Customers Is a Problem

Lower retetntion likely comes from faulty service or glitches in the operating system, Lujan surmises. "People say, 'I love what you sold me but in the first 90 days that experience wasn't good so I am going back to what I had.' The broker of record, they come and they go and there is sort of an adage in the benefits world which is you live by the broker of record, you die by the broker of record," he adds. "The mid-to-high 80s [percent] is the industry retention standard. For them to operate in the 60s or low 70s means a lot of business falls off because the experience is not as expected."

Meanwhile, the model Zenefits helped to hatch is not theirs alone, with many vendors and startups working as stand-alone brokers/HR/benefits companies (like Namely for one), and as pure technology providers for traditional brokers to use as a way to get up to speed, Lujan says. "There are tons and tons of brokers that have a technology model that equals or betters what Zenefits has," he says.

And for Zenefits, their pivot has already begun. "I think they have already made the move to go upstream and work larger groups. I think there is a challenge there. The larger the group market the more competitive it is and there are also different demands in which the centralized service model may not work," Lujan explains, citing anecdotal evidence and industry conversations. "Let's say I have 1,000 employees or even 200, I am used to having a very high touch, very high caliber experience. I don't sign onto a centralized system or website or a call center. They [Zenefits] are very low touch, high tech in a market that demands high tech and high touch. I think that is the big challenge." He adds that he would not be surprised if they moved into other insurance segments like workers' comp and property in addition to staying in health insurance.

Contact Bailey at rick@rickbaileycompany.com and Lujan at michael@limelighthealth.com. ✧

HEALTH PLAN BRIEFS

◆ **Twenty of the country's largest employers are launching an initiative to combat high costs in health benefits,** the group said on Feb. 5. The Health Transformation Alliance includes corporate giants American Express Co., Shell Oil Co., Macy's Inc., Verizon Communications Inc. and IBM, among others. The companies cite data from the American Health Policy Institute that show 23% of Americans' employer-sponsored health care costs are higher than 9.5%, the threshold HHS defines as "unaffordable" coverage. The alliance plans to launch a pilot as early as 2017 focusing on affordable prescriptions. Other programs are expected to follow. Visit http://tinyurl.com/zb7u5c2.

◆ **Novartis AG signed value-based agreements with Aetna Inc. and Cigna Corp. for its heart failure drug Entresto,** Reuters reported on Feb. 9. Cigna said in a statement that the "primary metric" for the drug's effectiveness will be the number of heart failure hospitalizations. Reuters said the drug costs $4,560 per year, approximately 9% above what analysts had projected. Further terms of the deals were not disclosed. Visit http://tinyurl.com/h76fgwo.

◆ **Incumbents Aetna Inc. and UnitedHealth Group should be able to build on their market strength in the Nebraska Medicaid market after the state on Feb. 5 awarded the two insurers contracts for its Medicaid managed care services program,** according to a research note on Feb. 8 by Christine Arnold, securities analyst for Cowen and Company. A contract was also awarded to Centene Corp., which replaces AmeriHealth Caritas, a unit of AmeriHealth, Inc. Arnold noted that Aetna and UnitedHealth now hold the largest market shares in Nebraska at around 50% and 35%, respectively. The five-year contracts integrate traditional Medicaid, physical and behavioral health services and start on Jan. 1, 2017. "Assuming the incumbents maintain their current market share, the new contract should add about 36,000 lives to Aetna's enrollment and about 25,000 for UnitedHealth Group," she said. Total spend will likely exceed $1 billion annually with blended premium revenue per member per month of approximately $400. Contact Arnold at christine.arnold@cowen.com.

◆ **Even as CMS has promised to eliminate the use of special enrollment periods for HealthCare.gov public exchanges *(HPW 1/18/16, p. 1)*, the agency on Feb. 5 said it would add a SEP.** This new SEP is not expected to generate large numbers of users, since it is limited to consumers who do not currently have exchange coverage because they failed to file a tax return for 2014 in order to reconcile their advance premium tax credits for previous coverage. Enrollees in this SEP must also have reapplied for 2016 coverage while stating that they have since filed a tax return reconciling their 2014 tax credits. Anyone meeting this requirement would be able to enroll in exchange coverage from Feb. 1 through March 31. Visit http://tinyurl.com/hjavscx.

◆ **The number of uninsured people of all ages in the U.S. declined to 29 million, or 9.1% of the population, for the first nine months of 2015, some 7 million fewer people than in 2014 and 16 million fewer than in 2013,** according to a Feb. 9 preliminary survey released by the National Center for Health Statistics, a unit of the Centers for Disease Control and Prevention. "Among adults aged 18-64, the uninsured percentage dropped from 16.3% in 2014 to 12.9% in the first nine months of 2015. A corresponding increase was seen in the percentage with private coverage, from 67.3% to 70.0%, respectively. In 2013, among adults aged 18-64, 20.4% were uninsured and 64.2% had private coverage," the report said. Visit http://tinyurl.com/hos9y42.

◆ **An Oklahoma medical provider on Feb. 2 filed a $40 million antitrust lawsuit against the Blue Cross and Blue Shield Association, Health Care Service Corp. unit Blue Cross and Blue Shield of Oklahoma and two area medical providers for not referring patients to its own care facilities.** The suit (4:16-cv-00057-CVE-PJC) was filed in the U.S. District Court, Northern District of Oklahoma, in Tulsa. The allegations by Bristow Endeavor Healthcare LLC center on the Blues organization and health plan working in conjunction with Hillcrest Healthcare System Inc. and Ardent Health Partners LLC to fix prices and eliminate competition. The Blues association had no comment. Visit https://aishealth.com/sites/all/files/bcbs-oklahoma.pdf.

◆ **The Oregon Department of Consumer and Business Services, Division of Financial Regulation, on Feb. 8 issued a consent order outlining a plan for Moda Health Plan, Inc. "to stabilize its financial position and continue to serve its customers."** As part of the arrangement, Moda will sell some

HEALTH PLAN BRIEFS (continued)

assets and provide financial notes to generate more than $170 million for its continued operation. The action results in the regulator lifting a Jan. 27 order of supervision and allows Moda to resume selling and renewing policies to both individual and group customers in Oregon and Alaska. On Jan. 28, Oregon regulators took over supervision of Portland, Ore.-based Moda because of concerns over its financial survival. Alaska officials in turn had limited Moda's business in their state *(HPW 2/8/16, p. 7)*. Visit http://tinyurl.com/za4ax47.

◆ **The average health insurance premium in the federal marketplace is $113 after tax credits,** HHS said recently. Eighty-three percent of applicants qualified for an average tax credit of $294 per month, which equaled 72% of the original premium. Sixty-three percent of returning users switched plans in 2016, saving an average of $43 per month. HHS said that nearly 60% of applicants had an option that cost less than $50 per month after tax credits. Visit http://tinyurl.com/jjlmley.

◆ **The Blue Cross and Blue Shield Association on Feb. 10 said it has developed a new national designation for prospective parents to find high-quality, affordable maternity care at U.S. hospitals.** "The new Blue Distinction Centers for Maternity Care program evaluates hospitals on several quality measures, including the percentage of newborns that fall into the category of early elective delivery, an ongoing concern in the medical community," the association said. Hospitals that receive a Blue Distinction designation also agree to meet requirements that "align with principles that support evidence-based practices of care, as well as having initiated programs to promote successful breastfeeding," the trade group added. Visit http://tinyurl.com/hhqrnbs.

◆ **Health Care Service Corp. and Excellus BlueCross BlueShield now cover Veracyte, Inc.'s Afirma Gene Expression Classifier.** The decisions mean almost 175 million insured lives are covered for the test, which is used to help identify people with benign thyroid nodules whose fine needle aspiration biopsies are indeterminate. Veracyte also said it entered into contracts with Blue Cross Blue Shield of Massachusetts and Blue Cross Blue Shield of North Dakota to become an in-network provider. Contact Veracyte via Pam Lord at (619) 849-6003.

◆ **Henry Aaron, Ph.D., a senior fellow in economic studies at the Brookings Institution, a left-leaning think tank, wrote that presidential candidate Bernie Sanders (I-Vt.) and his support for a single-payer system in this country has always been and will remain a "dream" with no chance of happening.** "Let's be clear: opposing a proposal only because one believes it cannot be passed is usually a dodge. One should judge the merits. Strong leaders prove their skill by persuading people to embrace their visions. But single-payer is different. It is radical in a way that no legislation has ever been in the United States," Aaron said. He explained that the monumental fight to get the ACA through Congress is example enough of how hard it would be to go single-payer, given that the ACA is "actually stunningly incremental" in the changes it makes. Aaron also details the cost, access and other issues that challenge the Sanders view. Visit http://tinyurl.com/hqrfae8.

◆ **Arkansas Blue Cross and Blue Shield, along with New Directions Behavioral Health and Washington Regional Medical Center's Advantage Primary Care, have launched a single-payer integrated clinic.** The 24-month pilot program is aimed at integrating behavioral health and primary care at an Arkansas primary care clinic, the Blues plan said recently. Through the program, New Directions provides a behavioral health consultant to support Advantage Primary Care's lead physician in identifying, managing and treating patients with mental illness and behavioral health conditions. Visit http://tinyurl.com/z7bjznl.

◆ **PEOPLE ON THE MOVE:** Harrisburg, Pa.-based Capital BlueCross named **Chris Davis** vice president of ancillary services. Davis was previously vice president of sales and service at Dominion Dental Services in Alexandria, Va….Memorial Hermann Health System in Houston named **Daniel Styf** senior vice president and CEO in charge of its health plan business. Memorial Hermann Health Plans are backed by Memorial Hermann. Most recently, Styf was an executive with the Piedmont WellStar Health Plans in Atlanta….Human resources company TriNet Group, Inc. named **Edward Griese** senior vice president of insurance services. Griese joins TriNet from Health First, Inc., where he was CEO of Health First Health Plans, a subsidiary providing commercial and Medicare plans for Health First's health system.

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