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Is Trump's Executive Order All for Show, Or Could It Topple Key ACA Provisions?

If there's one thing health insurers like, it's predictability. So far, they're not getting a whole lot of that from the fledgling Trump administration.

As Republican lawmakers craft potential Affordable Care Act replacement bills (see story, p. 4), they have vowed that people who gained coverage through the ACA are in no danger of losing it. But an executive order signed by the president just hours after taking the oath of office has left health insurers, providers and even Republican lawmakers scratching their heads.

At this point, it's unclear if the executive order is just a symbolic gesture meant to appease Trump's base by taking immediate action against the ACA, as promised. Or is it a powerful tool that will let Trump's administration and agency heads pull the law apart before Republican lawmakers come up with legislation to replace it?

Seven Critical Words

The executive order contains fewer than 500 words and leaves much room for interpretation. The document directs U.S. agencies to "waive, defer, grant exemptions from, or delay the implementation" of any ACA requirement that would negatively impact states, insurance enrollees, providers, carriers and other groups. However, most sections of the order are prefaced with the seven-word phrase "to the maximum extent permitted by law." It appears to acknowledge that as long as the ACA remains in place, federal agencies can't violate it. And until new regulations are issued, agencies must continue to enforce existing ones.

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Streamlining Provider Data Management Could Save Billions…but Is It Possible?

For health insurance companies, an accurate, easy-to-update standardized database for network provider data is the Holy Grail. Along with being a major source of frustration for members, inaccurate provider information negatively impacts claims processing, provider credentialing and the ability to ensure compliance with network adequacy rules. It also can create obstacles for providers that want to create a value-based benefit approach.

Collectively, hospitals, doctors and health insurers spend more than $2.1 billion a year on inefficient and redundant tasks aimed at ensuring the accuracy of provider data — about two-thirds of that cost is incurred by insurance carriers, according to an estimate from CAQH, a non-profit alliance of health plans and trade associations that also works with providers and their trade groups. But maintaining vast amounts of ever-fluctuating data, and ensuring its accuracy, is critical for carriers when performing essential business functions.

The costs are so high because health insurers have very few trusted sources of high-quality provider information. And that causes disparate efforts to gather information. It also creates a variety of approaches and expectations, explains Atul Pathiyal, managing

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director of CAQH Solutions. The biggest issue to overcome is building consensus and creating a shared vision across the industry, he says.

The provider community has viewed data collection as burdensome because historically they had to submit nearly identical information to multiple health plans through a variety of formats. And they are regularly asked to update it, adds CAQH Executive Director Robin Thomashauer.

Provider data management encompasses a health plan's supply chain of physicians, hospitals and care providers. To effectively manage their provider relationships, health insurers rely on credentialing data, contracting information, practice profiles and information about dispute resolution. But because no central database exists to house such information, each health plan maintains its own unique database. And each physician and hospital has its own way of contributing information, which increases administrative costs on both sides, explains Robert Booz, director of Healthcare IT & Initiatives at the University of Connecticut School of Business. He points to one large carrier that has more than 1,500 employees dedicated solely to provider-data management issues. "It's a significant, but often underemphasized problem for carriers. It's the supply chain for a health plan, and if you mess it up, you are in deep trouble," he says.

Historically, provider directories have never been entirely accurate, and they never really had to be. In the wholesale world, the insurer sold directly to an employer's human resources department. If an employee complained that a provider wasn't in network, the human resources department would ask that that provider be added to the network, or give the employee other options. But directories have come under scrutiny from state and federal regulators, particularly as insurance carriers have trimmed provider networks to keep premiums in check. A spotlight was shined on the problem in 2014 when carriers began selling individual coverage through public exchanges. As those consumers — along with Medicaid managed care and Medicare Advantage beneficiaries — became more responsible for their health care decisions, provider networks became an important tool for evaluating coverage options.

This month, CMS announced results from the first phase of its directory accuracy pilot. Of the 54 Medicare Advantage organizations whose online provider directories were reviewed, 21 received letters warning that if they fail to correct the deficiencies, they could be subject to enforcement actions such as fines, *HPW*'s sister publication *Medicare Advantage News* reported Jan. 26.

CAQH Envisions Road Map

Provider data is an issue that CAQH has been working on for the past 15 years. At its 2016 Provider Data Summit last September, CAQH began sketching out a "road map" that outlines the organization's vision for a standardized and accurate set of data that carriers need from providers.

To remove the burden for providers, requests for information need to be easy to complete, and the format must be consistent across all carriers. "Building up that handshake between providers and health plans around data quality is a first step," says Pathiyal. "Providers and health plans need to develop a shared understanding of what is high quality data and their respective roles in pursuing the goal."

CAQH is now convening a task force to begin building a roadmap to harmonize existing data sets, create a universal standard data set and build consensus thresholds for quality.

Asking the Right Questions Is Key

Availity, a health care information technology company that serves health plans and providers, began looking into provider data management solutions about two years ago, says Mark Martin, director of payer solutions and provider data management. "Getting the right infor-

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mation to the right person at the right time is hindered when you are dealing with provider data that is often old and stale," he says.

Provider information is continually changing, and administrative staffs can become overwhelmed by constant requests from carriers. Availity estimates a typical physician has contracts with between 15 and 25 health plans. And each carrier has different questions and unique ways of accepting information. After receiving updated information from a provider, an insurance company rep might call to verify that information. "Do it 15 or 25 times for the same information, and you see what a huge burden it is for providers," says Martin, adding that providers sometimes don't know how to accurately answer questions about their own businesses.

"You won't get the right information unless you get really good at asking the question correctly."

But creating a standardized format is no easy feat (see box, below). In provider data management, there can be a variety of contexts for identical data. Asking where a doctor performs services might seem like a straightforward question. But a doctor might see only Medicare patients on Mondays at a downtown office, and might see Medicaid patients on Tuesdays and Thursdays at another office. And maybe two of a doctor's three offices aren't accepting new patients.

"The permutations start to get really ugly really fast," says Booz. Health plans, he says, need to be better at managing the information, and the industry has to come up with a common format that providers can use to submit and update information, he adds.

continued

AHIP Pilot Identifies Provider Directory Challenges

Last spring, trade group America's Health Insurance Plans (AHIP) launched a 12-insurer, three-state pilot program to identify ways to improve the accuracy of provider directories and enhance collaboration with their provider networks. The six-month pilot, which ended in September, offered some insight into how the processes of updating directory information can be made less daunting to providers and more useful to consumers.

Provider directories have come under increased scrutiny at the federal and state level for lacking accurate information, which leaves consumers in the dark about which providers are actually available when seeking in-network care.

Availity, one of two information technology firms that participated in the program, worked with five carriers in Florida. A workflow created by the company whittled more than 700 data elements down to about 40 that were important for the directories. Consolidated information from each of the five carriers was compiled and used to populate a record for providers throughout the state. Providers were allowed to validate and update the record in real time, 24 hours a day, says Mark Martin, director of payer solutions and provider data management at Availity. Each time a provider updated a record, the carriers moved closer to having the same record for that provider. While he says he was pleased with the progress, he admits "this isn't going to be magic overnight where databases automatically get in sync. It takes time," he says.

Rather than receiving requests or inquiries from multiple health plans, the pilot was designed to facilitate one primary point of contact for providers. The results are being shared with federal and state policymakers, insurance commissioners, Medicaid directors and others, AHIP spokesperson Kristine Grow tells AIS Health. Health plans will use the findings to inform their own plans for improvement. Here's a look at some of the key findings:

◆ ***Accurate data depends on a strong partnership*** between doctors and health plans. Health plans depend on doctors to submit accurate and up-to-date information, and doctors depend on insurers to educate them on how to keep the information updated.

◆ ***Standard formats help make it easier for doctors*** to submit and update information.

◆ ***No one channel works best for all.*** Doctors have different preferences (e.g., phone, email, electronic portal, fax) when it comes to how they submit information.

◆ ***Data management solutions can help.*** Vendors are working on solutions that show promise. More work needs to be done to encourage effective use of these solutions by providers and plans, says Grow.

The pilot took place in California, Florida and Indiana. Participating AHIP members were Anthem, Inc. (California and Indiana), AvMed (Florida), Blue Shield of California, Cigna Corp. (Florida), Florida Blue, Health Net, Inc. (California), Humana Inc. (California, Indiana and Florida), L.A. Care Health Plan (California), Molina Healthcare of California, SCAN Health Plan (California), WellCare Health Plans, Inc. (Florida) and Western Health Advantage (California).

Feds, States Add Regs

In October 2015, California Gov. Jerry Brown (D) signed legislation (SB137) that required the Dept. of Managed Health Care (DMHC) and the Dept. of Insurance to develop provider directory standards. Carriers now must update directories every other week, rather than 90 days as CMS requires. Both carriers and providers face penalties if directories are inaccurate or incomplete.

Carriers that sell coverage in California and in other states must comply with federal in addition to state regulations. That can result in carriers maintaining multiple parallel processes that require the collection and posting of data in different formats and on different timelines.

The California Association of Health Plans lobbied for providers to be held accountable for their role in ensuring directory accuracy. Unlike in federal law, California health plans have a stick that allows them to hold onto a payment if the provider fail to update the information, says Martin. Texas also enacted such rules, but they aren't as strong as California's. Other states are considering similar action.

California also is attempting to create a centralized repository for all provider data, which in theory would let anyone log onto a state-run website and find information about network doctors and hospitals without having to go to the health plan.

See CAQH's whitepaper, "Defining the Provider Data Dilemma: Challenges, Opportunities and Call for Industry Collaboration," at http://tinyurl.com/jv3dnr3.

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Judge Says Aetna Tried to Duck Antitrust Scrutiny; Investors Sue

It was a rough week for Aetna Inc. On Jan. 26, just three days after a court blocked its proposed $37 billion takeover of Humana Inc., investors filed a class-action lawsuit against the company — prompted by U.S. District Judge John D. Bates opinion that Aetna had pulled out of some profitable public exchange markets to avoid judicial scrutiny (Civil Action No. 16-1494). Aetna did not respond to AIS Health's request for comment on Bates' ruling.

The suit was filed by Gainey McKenna & Egleston on behalf of investors who acquired Aetna stock between Aug. 15, 2016, and Jan. 20, 2017. The complaint alleges that the company misled investors and threatened to limit its participation on the exchanges if DOJ attempted to block the merger.

The judge also determined the resulting merged company would likely "substantially lessen competition" for Medicare Advantage (MA) in areas where the two companies now compete. Bates said the merged entity would have had unprecedented market power.

Moody's Investors Service views the ruling as having a potentially negative impact on both companies. If an appeal is unsuccessful, both firms would lose the chance to be part of a larger organization with expanded market share, more members and expanded product offerings, says Pano Karambelas, vice president and senior credit officer at Moody's. Humana's ratings would be upgraded if the merger succeeds, he adds. However, the court's decision seems to signal a more challenging process for the merger going forward, Karambelas notes.

Appeal Is Possible

Aetna is now required to pay Humana a $1 billion breakup fee under terms of their agreement. It is too soon to know if Aetna will appeal the court's decision. In a joint statement, Aetna Chairman and CEO Mark Bertolini and Humana CEO Bruce Broussard said they were disappointed with the ruling. While they didn't say they would appeal, they did say they will "carefully consider all available options."

It's unclear if the companies have grounds to appeal the court's decision. If they do, it will mean new legal expenses and, based on the court's blockage, a lower probability of success, Karambelas says. Credit Suisse equities analyst Scott Fidel agrees that an appeal is unlikely to succeed. In fact, in a Jan. 24 note to investors, he suggested an appeal could negatively impact Aetna's stock price. "We think the stock will likely perform better if Aetna now admits defeat and moves on with its Plan B strategy as a stand-alone company," he wrote. A repeal, he added, would restrict the company's ability to deploy capital in 2017.

Did Suit Prompt Exchange Exit?

In his ruling, Bates concluded that Aetna withdrew from the public insurance exchanges in some markets to evade judicial scrutiny of the proposed merger. When the DOJ filed its complaint last July, Aetna sold coverage through exchanges in 15 states, and had described itself as being "highly successful" in enrollment, Bates noted in his ruling. While Aetna indicated an intention to expand into new markets as late as July 19, 2016, the company decided to reverse course a month later, he wrote.

The two insurers have MA plans in 364 counties in 21 states that do not meet antitrust requirements, according to the DOJ. They also competed in 17 counties across three states (Florida, Georgia and Missouri) on the exchanges. "Aetna's decision not to offer on-exchange

plans in the 17 counties for 2017 was a strategy to improve its litigation position," Bates wrote.

During court proceedings, which wrapped up Dec. 30, DOJ warned combining the nation's largest seller of MA plans (Humana) with the fastest growing commercial MA carrier (Aetna) would harm competition and boost coverage costs for seniors. The insurers argued that since MA directly competes with traditional Medicare, the government cannot presume that the merger will unlawfully hurt competition.

The American Medical Association applauded the court's ruling and said it sets a legal precedent by recognizing MA as a separate and distinct market that does not compete with traditional Medicare, according to a prepared statement.

The decision does not bode well for Anthem, Inc.'s efforts to acquire rival Cigna Corp. While industry analysts expect the court will side with the DOJ and block the proposed $48 billion deal, many thought the Aetna deal might be allowed, given that the two health insurance giants tend to dominate different insurance markets.

"Humana is an attractive acquisition target, and from a general credit perspective, [insurance] companies are always interested in improving efficiencies. Mergers make sense to expand scale," says Karambelas. But now there is a question whether DOJ will continue to challenge large health plan acquisitions. Historically Republican and Democratic administrations have pursued antitrust cases with equal measure. But the Aetna-Humana decision, combined with an unfavorable ruling for Anthem's proposed acquisition of Cigna, could dissuade large companies from pursuing larger merger targets, he adds.

See the 158-page ruling at http://tinyurl.com/jmenfm4. For information about the class-action suit, visit http://tinyurl.com/jxtjped.

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Medicare Advantage Enrollment by State for Aetna and Humana, January 2017

State	Aetna	Humana	Montana	193	6,560
Alabama	3,786	51,703	Nebraska	11,013	5,550
Alaska	557	0	Nevada	7,796	51,848
Arizona	7,388	58,697	New Hampshire	447	3,420
Arkansas	9,462	41,132	New Jersey	82,028	645
California	27,079	60,887	New Mexico	513	17,154
Colorado	3,449	40,606	New York	63,815	22,620
Connecticut	34,736	248	North Carolina	63,386	135,371
Delaware	9,232	1,977	North Dakota	123	1,608
District of Columbia	832	NA	Ohio	192,999	124,438
Florida	85,850	510,313	Oklahoma	5,612	32,708
Georgia	71,336	107,923	Oregon	729	5,013
Hawaii	178	15,384	Pennsylvania	217,060	42,877
Idaho	179	5,834	Puerto Rico	0	11,627
Illinois	52,692	109,784	Rhode Island	199	NA
Indiana	13,118	99,412	South Carolina	7,708	90,937
Iowa	37,109	19,228	South Dakota	1,964	5,051
Kansas	33,535	25,130	Tennessee	5,193	127,700
Kentucky	5,340	141,733	Texas	84,048	385,908
Louisiana	3,163	155,159	Utah	10,637	6,391
Maine	17,038	3,442	Vermont	214	17
Maryland	8,673	1,725	Virginia	15,588	131,032
Massachusetts	1,737	291	Washington	3,758	28,890
Michigan	10,963	60,359	West Virginia	15,577	75,816
Minnesota	881	33,269	Wisconsin	2,230	71,334
Mississippi	664	53,996	Wyoming	589	63
Missouri	98,327	58,426	**Total**	**1,330,723**	**3,014,236**

NA=Insurer had fewer than 10 enrollees in state.
SOURCE: Calculated by AIS from January 2017 CMS data.

Senate Replacement Proposal Would Let States Keep Obamacare

In an effort to appease their Democratic counterparts — and woo at least eight of them across the aisle — a pair of Senate Republicans have proposed an Affordable Care Act replacement that would give states the option of keeping the ACA intact. States also could opt to cover their uninsured population with a federally funded health savings account (HSA) combined with a high-deductible health plan (HDHP). But industry observers say there are flaws within the proposal. Moreover, some key elements already are allowed under the ACA through 1332 waivers or 1115 Medicaid waivers.

On Jan. 23, the first working day for the new president, Sens. Bill Cassidy, M.D. (R-La.) and Susan Collins (R-Maine) held a press conference at the U.S. Capitol Building to tout the Patient Freedom Act (PFA) of 2017. On the Senate floor later that day, they urged their colleagues to support it.

In a Jan. 24 *Health Affairs* blog post, Timothy Jost, Ph.D., emeritus professor at the Washington and Lee University School of Law, said he was struck by the 73-page bill's complexity. The proposal would maintain popular elements of the ACA such as the ban on lifetime and annual coverage limits, the ability for a parent to cover an adult child to age 26 and guaranteed coverage for people with pre-existing conditions. It also would create risk pools and allow people to buy coverage across state lines. Collins suggested the proposal would drive significant cost savings from mandated price transparency. Reducing coverage costs through comparison shopping was touted by the George W. Bush administration, but consumers generally don't like shopping for medical services and have limited tools to do it efficiently.

William Pewen, Ph.D., who served as senior health policy advisor to former Sen. Olympia Snowe (R-Maine) during the crafting of the ACA, was critical of the bill. "It's striking that the sponsors propose spending at ACA levels without assuring meaningful outcomes. Under the PFA, there's no accountability to meet individual needs nor provide quality coverage. States could even shift some Medicaid beneficiaries to plans lacking current core benefits," he tells AIS Health.

The advocacy group Families USA warned the bill would cause deductibles to skyrocket, erode protections for people with pre-existing conditions and shred the Medicaid safety net. The Center for American Progress cautioned that such legislation would make the access and quality of health care dependent on the state in which one lives.

HSAs for Everyone

President Trump and Republican lawmakers have made it clear that they want to expand the use of HSAs and make them a central part of any Obamacare replacement *(HPW 1/23/17, p. 1)*. That's at the heart of the Cassidy-Collins bill. Uninsured people would be automatically enrolled in a catastrophic HDHP, which would be paired with a taxable Roth HSA. The deposits, which would be based on earnings, would begin phasing out for people with incomes of $90,000 ($150,000 for families). Jost said the accounts would provide more help for higher-income individuals and less for lower-income individuals, as compared to the ACA. Pewen agrees and says "most Americans would be unlikely to obtain needed coverage which is affordable, while a few would realize a fiscal windfall."

The accounts would be funded with federal dollars, which are currently used for advance premium tax credits and cost-sharing subsidies. Cassidy noted that high deductibles for many ACA plans make medical services unaffordable. The HSA dollars could be used to cover premiums as well as some medical expenses. But chronically ill people and those hit by unexpected medical costs would likely run through their HSAs quickly.

If You Like Your Obamacare, Keep It

Unlike other replacement bills that have been floating around Congress for years, this proposal would let states to continue with Obamacare if they choose. A state such as California could continue to operate an exchange to distribute subsidies, and maintain an individual mandate and expanded Medicaid program.

"Republicans think if you like your insurance, you should keep it," Cassidy quipped at the briefing. He said a health insurer that modeled the proposal estimated the expanded risk pool created by automatically enrolling all qualified residents would reduce premiums by 20%.

If such a bill were approved, Congress could repeal the ACA and replace it with this legislation in January 2018. States could implement the ACA-replacement plan of their choice in 2019 "and by the time 2020 rolls around, it's all done," Collins told reporters.

Jost suggested such a timeline was overly ambitious. Pewen says the legislation goes in the wrong direction. "It is reducing the value of taxpayer spending by unwinding some critical health reforms, and creating an even more expensive and convoluted health care system," he says.

But lawmakers are just getting started in their ACA-replacement building, and several other bills have been introduced.

"I would expect to see many lawmakers over the coming weeks and months put forth their vision for the future of the ACA, and those proposals will serve as a basis for ongoing debate," says Elizabeth Carpenter, senior vice president at Avalere Health. "No one proposal will be the final answer, but the proposals that come out will help to further the dialog."

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Executive Order Raises Questions

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Those seven words are important, says Michael Adelberg, a former senior official in CMS's Center for Consumer Information and Insurance Oversight (CCIIO). The language demonstrates that the new administration "wants to unspool the ACA, to the degree it can, right away." But it also acknowledges that it is limited in its unspooling capability without first going through legislative and regulatory processes. Adelberg is a senior director at FaegreBD Consulting.

The language is so broad "that it effectively amounts to a nuthin'-burger or a license to kill," quips John Gorman, founder and executive chairman of Gorman Health Group. He calls the order "an inherently destabilizing document," and notes that it could allow the Trump administration to tear down key provisions of the law without Congress.

Once confirmed, the new HHS secretary could direct the Health Resources & Services Administration to reconfigure the essential health benefits, which were defined in regulations. Coverage for contraception or long-term care drug benefits, for example, could be removed. "That could wreak havoc on whole sectors of the industry," says Gorman. The president also could instruct the Dept. of Justice to abandon President Obama's appeal of *House v. Burwell*. That lawsuit, filed by House Republicans in late 2014, contends federal funding for cost-sharing reduction (CSR) payments is illegal without an appropriation from Congress. The Obama administration appealed it, but following the election, the House sought a stay of the appeal. The court agreed to stay the appeal until late February *(HPW 5/23/16, p. 1)*. Eliminating CSR payments "would be like a neutron bomb going off" within the insurance industry because it would shift the liability for $8 billion in subsidies this year to the plans, Gorman warns.

What Happens to the Mandate?

In an interview with ABC News two days after the inauguration, Trump advisor Kellyanne Conway said the president intends to get rid of the individual mandate "almost immediately." Most insurance carriers will bail from the exchanges if the mandate is removed, says industry consultant Joseph Paduda. However, a more immediate impact will be felt if the administration reduces or limits federal premium subsidies and cost-sharing, he predicts.

As long as the ACA is the law of the land, federal agencies have to continue to enforce the mandate and assess penalties to people who indicate they are uninsured on their income taxes. In a Jan. 23 blog, Christopher Condeluci suggested the executive order was more about messaging than about real action. Trump and Republican lawmakers understand that individual market enrollment could drop if the IRS no longer enforces the penalty. "Republicans recognize that they need the insurance carriers to stay in the markets throughout 2018 and 2019 so as to avoid disruption….Announcing a non-enforcement period is one of those actions not to do," he explained.

Some carriers might not wait to see how it all plays out, according to a report released Jan. 26 by the Urban Institute. Based on interviews with executives from 13 health insurance companies that sell individual coverage in 28 states, researchers from Georgetown University's Center for Health Insurance Reforms found that an immediate repeal of the individual mandate would prompt carriers to consider exiting the market for 2018. Those that remain could look to substantially boost premiums. A "repeal and delay" strategy, without a concurrent replacement for the ACA, would "destabilize the individual market," the surveyed insurers reported.

America's Health Insurance Plans (AHIP) has come up with a raft of proposals to ensure any replacement plans don't destabilize the market. The "reconciliation stabilization package" includes CSRs, a restructured tax credit that would be age-adjusted to incentivize younger enrollees, a transitional risk pool, incentives for continuous coverage and industry relief from the ACA's taxes, according to AHIP. The group says lawmakers have been receptive to its ideas.

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HEALTH PLAN BRIEFS

◆ **With just five days to go until the conclusion of the open-enrollment period, the Trump administration has ordered federal agencies to stop outreach and marketing efforts,** *Politico* reported Jan. 26. The final week of the open-enrollment period tends to be a big enrollment week. Last year, nearly 700,000 plan selections were made in the final weeks, Credit Suisse equities analyst Scott Fidel said in a Jan. 27 note to investors. Kevin J. Counihan, the former chief executive of the federal insurance exchange, accused the Trump administration of trying to "sabotage open enrollment," and called the action "outrageous," according to a *New York Times* article. Visit http://tinyurl.com/h5vquph.

◆ **While the Affordable Care Act expanded enrollment to more than 4 million previously uninsured chronically ill Americans in 2014, it had a limited impact on whether those members sought medical care,** according to a study released Jan. 24 in the *Annals of Internal Medicine*. According to the study, half of Americans have at least one chronic disease. Racial and ethnic minorities with chronic illnesses were more likely than others to lack insurance coverage, according to the study, which is based on 606,000 chronically ill adults. Although racial and ethnic minorities had greater improvements in some outcomes, about 20% of chronically ill black Americans and 33% of Hispanics continued to lack coverage after ACA implementation. Visit http://tinyurl.com/zkt3jcz.

◆ **Cigna Corp. must eliminate a written ban on coverage for medical claims related to neuropsychological testing of psychiatric conditions and autism spectrum disorder,** according to a settlement between the insurer and the New York Attorney General's office. The carrier also must reprocess claims it had denied for autism spectrum disorder. The settlement was announced Jan. 23. Attorney General Eric Schneiderman launched an investigation into Cigna's administration of mental health benefits following a 2016 complaint about the company's written policy for neuropsychological testing. The policy said that "Cigna does not cover neuropsychological testing" for psychiatric conditions and autism spectrum disorder "because such testing is considered educational in nature and/or not medically necessary," according to Schneiderman's office. The settlement requires Cigna to revise its policies, pay autism claims previously rejected and pay a penalty of $50,000. See the announcement at http://tinyurl.com/hmg4khn.

◆ **Several health insurers are pushing for changes in the individual market including stricter enforcement of eligibility rules,** according to interviews of health plan executives and lawmakers conducted by Reuters. Some carriers also have recommended ways to give states more control over insurance markets as the ACA is dismantled, the news service reported Jan. 24. Many investors expect the Republican push to deregulate insurance markets will benefit carriers, according to the article. Visit http://tinyurl.com/gnkrjew.

◆ **Minnesota residents could see their monthly premium bill plummet by 25% for 2017 after Gov. Mark Dayton (D) signed a measure to provide $326 million in premium relief,** *The Star-Tribune* reported Jan. 26. The state legislature overwhelmingly approved the legislation, which was immediately signed by the governor. About 125,000 Minnesotans are enrolled in an individual insurance policy. Rates in the state jumped 50% or more for 2017, according to the article. The rebates should show up on March or April insurance bills, retroactive to Jan. 1. See the article at http://tinyurl.com/jr8j545

◆ **About 50% of health systems receive value-based payments,** according to a survey of health system or health insurance company respondents who participated in a webinar, KPMG said Jan. 23. More than a third of survey respondents said they receive some reimbursement from value-based contracts, while 14% said that they get most of their reimbursement that way. A quarter of respondents said they are planning to enter value-based payment arrangements in the next one-to-three years. Moreover, 44% of surveyed insurers and providers said they have a population health platform in place that is being "utilized efficiently and effectively." Visit http://tinyurl.com/zs2dyn2

◆ **CLARIFICATION:** "Trade Associations Brace for Uncertainty of ACA Repeal," an article in the Jan. 23 issue, included comments from the National Association of Insurance Commissioners, which is not a trade association and doesn't represent any segment of the insurance industry. Rather, it is an association of state regulators.

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