2017 Outlook

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Nevertheless, “something as fundamental as changing Medicaid financing” would require numerous Democrats to get on board, points out Atlas. And he doesn’t view that as likely, nor does he give block granting high odds of being approved via legislation this year given that the current Republican majority is not sufficient to overcome a Democratic filibuster in the Senate. “I think block granting is something that conservatives want to do as a long-term strategy to get federal deficits under control, but it will take more than one or two attempts to get there,” he predicts.

Block granting was one of two financing approaches laid out in the “A Better Way” proposal released by Ryan and the GOP last June. That plan promised states “new freedoms and flexibilities to run their Medicaid programs” by providing them a choice of either a block grant or a per-capita allotment. Reforming Medicaid’s financing with the latter, which basically translates to a per-member per-month amount, would not only reduce federal funding but incentivize states, plans and providers to “better manage dollars as they help provide care to vulnerable patients,” argued the GOP.

“The issue on block grants obviously is how much money is going to be there,” says Atlas. And while state Medicaid directors may look favorably on the idea of enhanced flexibility, “block grants over time would entail a greater squeeze on funding,” he suggests. As a result, “states with fixed resources are much more likely to delegate the risk to managed care companies.” The risk for the MCOs, therefore, is that with limited funding states will be “much more tight-fisted” with the plans, and since states would essentially be released from federal requirements by taking block grants, they wouldn't have to adhere to the actuarial soundness requirement included in the Medicaid managed care rule that CMS published last year (MAN 5/5/16, p. 1).

**States, Plans Need Flexibility, Argues MHPA**

Nevertheless, Jeff Myers, president and CEO of Medicaid Health Plans of America (MHPA), says the national trade association is “generally optimistic” about the potential move away from federal medical assistance percentages (FMAPs) and the opportunity for innovation. “I think it’s clear that the current financing mechanism for Medicaid creates a lot of instability in the states, and makes it very challenging for state policymakers to think about their health care system in a holistic way,” he remarks in an interview with AIS Health.

But any replacement in financing must not only be actuarially sound and sustainable, it must be innovative “so that states can think through ways to provide access to care for the disadvantaged that give them a better opportunity to move up the economic ladder,” asserts Myers. For example, being able to integrate state resources like food stamps, job banks and housing into their Medicaid programs would help address some of the socioeconomic determinants of health that impact Medicaid beneficiaries and is something the plans would embrace, he suggests.

Furthermore, plans would welcome the opportunity to have more flexibility to control rising drug costs, and MHPA is currently putting together a set of recommendations for policymakers on this issue. “All of our plans are incredibly concerned about the pricing model that the life sciences community have taken to pricing both generic and branded medications,” Myers tells AIS Health. “It seems to me to be a reasonable question to ask, if you’re going to change the fundamental nature of Title XIX [Medicaid], why do the states need to still be in the position of determining formularies? That’s something that managed care plans do really well.”

Republican congressional leaders last week began laying the groundwork for ACA repeal when the Senate Budget Committee introduced a concurrent budget resolution that in part establishes a reserve fund for future health care legislation. That reserve would likely come from savings associated with repealing the ACA, similar to a 2015 reconciliation bill that called for a two-year...
phase-out of federal funding for Medicaid expansion but was ultimately vetoed by President Obama.

“The question that’s really unanswerable is, will states that haven’t already expanded have an opportunity to expand?” poses Atlas. “And it’s possible that Congress passes some kind of ACA repeal that says, ‘We’re going to delay the repeal of exchanges and they will continue to be open and all those rules will continue to operate for at least three years until we come up with a replacement.’ But they might say, ‘However, any state that hasn’t already expanded its Medicaid program as of Dec. 31, 2016, is forbidden to do so, and there will be no federal support for that.’”

**Does Medicaid Expansion Stand a Chance?**

Under the fixed funding proposal in “A Better Way,” states that did not expand Medicaid under Obamacare as of Jan. 1, 2016, would not have an opportunity to do so, while states that have already expanded would in 2019 have the enhanced FMAP for their expansion adult population phased down until it reached the state’s “normal FMAP level,” facilitating the transition of more “able-bodied adults” from Medicaid into commercial coverage.

“The political facts on the ground make it highly unlikely that the Republicans are just going to blow up Medicaid,” adds Myers. He points out that 14 Republican-led states have expanded Medicaid, including Kentucky, which now has a Section 1115 demonstration waiver pending CMS approval that would require most adult beneficiaries to pay monthly premiums of $1 to $15 and many members to engage in community service, job training or other activities to gain additional vision and dental benefits (MAN 8/18/16, p. 1). Or take Indiana, where Vice President-elect Mike Pence worked with Seema Verma, a top health policy consultant and Trump’s choice for CMS administrator, to secure a waiver that required Medicaid beneficiaries to contribute to “Personal Wellness and Responsibility” accounts to cover deductible expenses.

If Medicaid expansion is allowed to continue, more of these types of “personal responsibility” requirements or even coverage conditions based on employment may get pushed through in Republican-led states, suggests Atlas. Ohio Gov. John Kasich (R), for example, last April proposed to link work requirements directly to Medicaid participation. That waiver request was rejected by CMS (MAN 4/7/16, p. 1) but CMS under the new administration “may not draw that line,” he says. “And that ought to be a plus for the managed care industry because you now have people who are currently uninsured added to the Medicaid rolls, and the Medicaid programs would put those people into managed care plans, as most states did with their expansion populations.”

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**2017 Outlook**

**SNPs Hope for Permanency, Stars Fix, Enhanced Dual Integration**

A major change in risk-adjustment methodology that went into effect for 2017 alleviated a deep concern of many Medicare Advantage plans with large percentages of dual eligibles. But topping their wish list this year is permanent authorization of the Special Needs Plan program, better alignment of the Medicare and Medicaid programs as they apply to dual eligible SNPs (D-SNPs) — which comprise 90% of SNP enrollees overall — and additional adjustments to star quality ratings to account for social risk factors, according to trade groups and consultants that work with many duals plans.

Originally unveiled in an October 2015 memo and finalized in the 2017 payment notice and Call Letter released by CMS last April, the agency instituted a new six-category risk-adjustment system designed to pay more for MA plans’ members who are disabled or full Medicare-Medicaid dual eligibles and less for other enrollees (MAN 4/7/16, p. 1). “For full benefit duals in particular, if CMS had not made that adjustment, I think we would have seen a number of D-SNPs increasingly in trouble and some beginning to leave the market,” remarks The SNP Alliance’s Rich Bringewatt. Moreover, 2016 showed sustained growth in SNP enrollment, with an overall increase of 8.5% to more than 2.3 million SNP enrollees (see table, below).

Institutional SNPs (I-SNPs), however, took a big hit on payment due to a recalibration of the institutional segment of the MA coding model for 2017. “One thing that caught us by surprise last year is there weren’t any fundamental changes being made to the institutional risk model, but beside restructuring how they did the risk model CMS also updated it with data that was

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<th>SNP Type</th>
<th>January 2016</th>
<th>December 2016</th>
<th>Increase</th>
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<tr>
<td>Dual SNP</td>
<td>1,732,123</td>
<td>1,892,613</td>
<td>8.5%</td>
</tr>
<tr>
<td>Chronic SNP</td>
<td>323,778</td>
<td>351,424</td>
<td>7.9%</td>
</tr>
<tr>
<td>Institutional SNP</td>
<td>54,643</td>
<td>63,458</td>
<td>13.9%</td>
</tr>
<tr>
<td>Total SNP</td>
<td>2,110,544</td>
<td>2,307,495</td>
<td>8.5%</td>
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three years more current, and that new data ended up basically creating a 10% reduction in institutional risk scores,” explains Eric Goetsch, a principal and consulting actuary with the Milwaukee office of Milliman. As a result, I-SNPs had to make some “pretty fundamental changes” to account for the reduction, he says. But the change didn’t result in a large exodus of I-SNPs from the market, and the number of I-SNPs offered actually grew from 79 in 2016 to 81 this year, points out Bringewatt (see table, below).

**Trade Groups Hope for SNP Permanency**

Meanwhile, trade groups like The SNP Alliance, which is an initiative of the National Health Policy Group, and the Association for Community Affiliated Plans (ACAP), which has many SNP operators, identify their members’ main priority as SNP permanency. SNPs were authorized under the Medicare Modernization Act of 2003 to serve institutionalized, dual-eligible or severe/disabled chronically ill patients through 2008, and have since gone through a series of brief reauthorizations, most recently with a provision in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 that allows them to operate through 2018.

“That may seem far in the future, but [it] represents considerable uncertainty for managed care organizations that are trying to plan their business in advance,” asserts Meg Murray, CEO of ACAP. “Given the general atmosphere of bipartisan support for D-SNPs we expect that Congress will, in fact, reauthorize the program. But this bears a discomfiting resemblance to the annual ‘doc fix’ which the last Congress brought to a merciful end [through MACRA]. We’d hope that they would do likewise for D-SNPs and grant the program permanent authorization.”

A Senate Finance Committee bill introduced in the last Congress sought to permanently authorize the program, and Bringewatt says The SNP Alliance is confident that it will be reintroduced in some form this year, pointing out that Senate Finance Committee Chairman Orrin Hatch (R-Utah) and Ranking Member Ron Wyden (D-Ore.) are “very committed to this” and the Alliance doesn’t see “any reason for them backing off.”

In addition, a priority cited by both organizations is advancing dual integration. “We’d like to see the Medicare-Medicaid Coordination Office [MMCO] at CMS be dedicated by the agency to address misalignments between the Medicare and Medicaid programs as they apply to D-SNPs,” says Murray. “The staff there have a strong understanding of the points of friction between the two programs and under Tim Engelhardt’s leadership they have really become a terrific resource for all of us with an interest in better alignment of the two programs.”

**Plans Need Better Integration**

MMCO currently administers the Financial Alignment Initiative, in which plans in 10 states entered into a three-way contract with CMS and state Medicaid agencies to test the coordination of care for dual-eligible beneficiaries in Medicare-Medicaid plans (MMPs) through 2020. “There’s been some good work done by the MMPs, which we also represent, and I think there’s been some good progress on the administrative alignment,” remarks Bringewatt. “But we still have a long ways to go before there’s really the infrastructure that’s necessary to serve that population in an efficient way and provide ease of enrollment and navigation for the beneficiary.”

The CMS-backed duals demo is authorized by the Center for Medicare and Medicaid Innovation (CMMI), which is under threat of being removed by House Speaker Paul Ryan (R) and congressional Republicans. If that happens, however, CMS would theoretically lose its authority to make the demonstrations permanent without action from Congress, suggests Bob Atlas, president of the EBG Advisors unit of health care law firm Epstein Becker & Green, PC.

“States are going to continue to look for ways to get the duals population into Medicare managed care plans,” Atlas predicts. And while states can’t mandate that a Medicare beneficiary join a Medicare managed care plan — leading to uninspiring enrollment figures in the CMS-backed duals demonstrations — another trend that’s likely to continue is “mandatory enrollment of Medicaid beneficiaries, including dual eligibles, into Medicaid managed long-term supports and services [MLTSS] plans,” he says. Once dual eligibles are in the MLTSS plans, they can be encouraged or enticed to enroll in companion MA plans, he explains. For example, states could add a few extra benefits to the Medicaid plans for

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**Special Needs Plans (SNPs) Operating in 2017**

<table>
<thead>
<tr>
<th>SNP Type</th>
<th>2016* Number of Contracts</th>
<th>2016* Number of Plans</th>
<th>2017** Number of Contracts</th>
<th>2017** Number of Plans</th>
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<tr>
<td>Chronic or Disabled</td>
<td>51</td>
<td>139</td>
<td>49</td>
<td>118</td>
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<tr>
<td>Dual-Eligible</td>
<td>192</td>
<td>350</td>
<td>180</td>
<td>359</td>
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<tr>
<td>Institutional</td>
<td>37</td>
<td>79</td>
<td>39</td>
<td>81</td>
</tr>
<tr>
<td>Total</td>
<td>280</td>
<td>568</td>
<td>268</td>
<td>558</td>
</tr>
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</table>

**Does not include sanctioned contracts or plans. 2017 SNP Landscape File: http://tinyurl.com/zafsgja
SOURCE: The SNP Alliance

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people who enroll voluntarily in D-SNPs operated by the same sponsors.

Murray adds that ACAP would like to see a “number of other fixes” for the D-SNP program. These include “apples-to-apples comparisons and better-refined quality measures for the purposes of star ratings, reporting out ratings at the plan level rather than the contract level and unified appeals and grievance procedures.”

CMS in 2016 made an interim adjustment to address socioeconomic status in the star quality ratings. But the change, which adjusted for within-contract disparities based on an MA contract’s percentages of dual eligible/low-income subsidy beneficiaries, boosted the overall ratings of only 15 out of 364 plans, while 96% of contracts saw no change in their overall star ratings (MAN 11/3/16, p. 1). Bringewatt suggests that new research from the HHS Office of the Assistant Secretary for Planning and Evaluation released last month, which noted key differences in stars performance for duals vs. non-duals, makes a strong case for the influence of social risk factors on health outcomes and could lead to further adjustments in the ratings.

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**OIG Report Highlights Drug Price Hikes, Impact to Part D**

Federal payments for Part D drugs in the catastrophic coverage phase of the Medicare Part D benefit exceeded $33 billion in 2015, nearly triple the amount paid in 2010, according to a new report from the HHS Office of Inspector General (OIG). This increase was largely driven by spending on high-cost therapies to treat hepatitis C, cancer and multiple sclerosis, observed OIG. While the report concludes that CMS should work with Congress to enact changes such as restructuring the Part D benefit that would give CMS more tools to address drug costs, two leading pharmacy consultants suggest to AIS Health that it highlights the bigger issue of drug companies raising prices with little justification.

Part D beneficiaries enter catastrophic coverage when their out-of-pocket costs exceed a certain threshold, which in 2015 was $4,700, and typically pay a 5% coinsurance in this phase. The plan sponsor covers 15% of the price while the federal government picks up the remainder. The federal government pays for catastrophic coverage primarily through the reinsurance subsidy, for which it prospectively pays plans based on estimated costs and then reconciles those payments after the end of the year. That amount is known as the total reinsurance amount, which is the amount of federal payments for catastrophic coverage that OIG refers to in the report.

Analyzing Part D prescription drug event records from 2010 to 2015, OIG found that federal payments for catastrophic coverage in 2015 were $33.2 billion, compared with $10.8 billion in 2010. High-priced drugs (i.e., those with an average price of more than $1,000 per month) in 2015 were responsible for nearly two-thirds of the total spending in catastrophic coverage, while they accounted for just one-third of that spend in 2010. And 10 high-priced drugs, such as those to treat hepatitis C, cancer and multiple sclerosis, accounted for nearly one-third of all drug spending for catastrophic coverage in 2015 (see table, p. 6). Moreover, four of the drugs that year were new to the market, while the remaining six had been on the market and had sharp price increases since 2010.

OIG concluded that the dramatic growth in federal spending in the catastrophic phase and the “underlying issue of high drug prices must be analyzed and addressed to secure the future of the Part D program.” OIG suggested that CMS will need “additional tools” to address the issue of high cost drugs and should thus work with Congress to secure needed changes to the program. Options include “restructuring the Part D benefit so that sponsors have more incentives and opportunities to lower costs,” added the report, referring to a set of recommendations made to Congress last year by the Medicare Payment Advisory Commission (MedPAC) that included raising plans’ share of costs in the catastrophic phase of the Part D benefit from the current 15% to 80%, dropping Medicare’s share to 20% and doing away with beneficiaries’ 5% coinsurance (MAN 4/21/16, p. 3).

MedPAC’s argument was that by carrying more risk in the gap, plans would be incentivized to better manage prescription drug spending below the catastrophic phase. But when a hepatitis C drug costs upwards of $30,000 a month and members typically pay a 20% spe-
cially coinsurance, there’s only so much utilization management that a Part D plan can do to delay entry into the catastrophic phase, sources say. “You don’t put someone on a hepatitis C drug unless they have hepatitis C. It’s not like somebody’s waving their hand in the air and going, ‘I’d really like to be on this!’ So that’s just moving the money around from one bucket to another,” remarks Debra Devereaux, senior vice president of pharmacy and clinical solutions at Gorman Health Group. “And I don’t know what the answer is [other] than the pharmaceutical companies should not be able to increase prices the way they do.” One possibility, however, would be if Congress considered allowing Medicare to receive the same drug prices as the Veterans Administration, she adds.

President-elect Donald Trump in a TIME Magazine interview last month promised to “bring down drug prices.” Although he didn’t share details on how he’d achieve that goal, he talked during his campaign about allowing Medicare to directly negotiate drug prices.

“I do think that drug costs are a huge issue, and I think the new administration will attempt to do something around that,” weighs in Babette Edgar, Pharm.D., a principal at BluePeak Advisors and a former Part D official at CMS. “Now what that something is it’s hard to say, without sort of touching the whole issue of the free market and competition. Catastrophic coverage being 5% [for beneficiaries] was in the Medicare Modernization Act, but the Affordable Care Act filled in the doughnut hole, where there was more payment from plans covering the gap, so I guess that’s a piece of it that they could unwind [as part of the ACA repeal],” she suggests.

Edgar points out that it’s often harder to control spending on the Part B side than it is on the Part D side. “At least in Part D we have tools such as formularies, prior authorization, step therapy and differential cost sharing. So you can sort of drive patients to particular drugs that are lower cost…where we don’t have that necessarily on the Part B side. But there’s not a lot that’s done now to control the way that physicians prescribe those medications,” she says.

In general, MA plans have been challenged in managing these high-cost drugs due to numerous Part D requirements, argues Mark Owen, president of government programs with Health Care Service Corp. (HCSC), which offers MA plans in Illinois and stand-alone Part D products in Texas. “Most notable are the protected class drug categories and the requirement for only one specialty tier. Both of these may create a disincentive for [the] manufacturers of these high-cost or protected-class drugs to negotiate discounts and rebates,” he says. “We believe that the addition of a sixth tier (allowing for separate ‘preferred’ and ‘non-preferred’ specialty drug tiers) would allow us to negotiate better pricing and drive savings for the beneficiaries, the Part D program and the plans.”

Additionally, HCSC would like to see the existing manufacturer discount that applies to brand drugs in the doughnut hole apply to biosimilar products, which Owen points out is a concept supported by MedPAC.

Contact Devereaux at ddevereaux@gormanhealthgroup.com, Edgar at bedgar@bluepeak.com or Owen via Erika Callahan at erika_callahan@bcbsil.com.

View the OIG report at https://oig.hhs.gov/oei/reports/oei-02-16-00270.asp.

### 10 Drugs Accounted for Nearly One-Third of Catastrophic Coverage, 2015

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Company*</th>
<th>Key Indications</th>
<th>FDA Approval Year</th>
<th>Average Price per Month**</th>
<th>Total Spending in Catastrophic Coverage</th>
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<tr>
<td>Harvoni</td>
<td>Gilead Sciences</td>
<td>Hepatitis C</td>
<td>2014</td>
<td>$33,811</td>
<td>$6,284,357,265</td>
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<td>Revlimid</td>
<td>Celgene</td>
<td>Cancers of the blood</td>
<td>2005</td>
<td>$11,516</td>
<td>$1,718,263,750</td>
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<td>Sovaldi</td>
<td>Gilead Sciences</td>
<td>Hepatitis C</td>
<td>2013</td>
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<td>Humira</td>
<td>AbbVie, Inc.</td>
<td>Inflammatory conditions</td>
<td>2002</td>
<td>$3,930</td>
<td>$1,205,270,252</td>
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<td>Copaxone</td>
<td>Teva Pharmas USA</td>
<td>Multiple sclerosis</td>
<td>1996</td>
<td>$5,642</td>
<td>$1,143,986,768</td>
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<td>Gleevec</td>
<td>Novartis</td>
<td>Various cancers</td>
<td>2001</td>
<td>$9,299</td>
<td>$1,021,721,929</td>
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<td>Enbrel</td>
<td>Amgen</td>
<td>Inflammatory conditions</td>
<td>1998</td>
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<td>Tecfidera</td>
<td>Biogen Idec, Inc.</td>
<td>Multiple sclerosis</td>
<td>2013</td>
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<td>Renvela</td>
<td>Sanofi</td>
<td>Chronic kidney disease</td>
<td>2007</td>
<td>$1,158</td>
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<td>Xiandi</td>
<td>Astellas</td>
<td>Prostate cancer</td>
<td>2012</td>
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<td><strong>Total</strong></td>
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*The term “company” refers to New Drug Application holder or Biologics License Application holder.

**Note: The price is the amount paid to the pharmacy by all payers. It is negotiated between the sponsors and their network pharmacies for the drug, or is the usual and customary price paid to out-of-network pharmacies. It is not adjusted for rebates or other price concessions.


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MA Plans Look to Areas of Growth
continued from p. 1

He continues, “I think you’re going to see health plans start to look at the market itself almost county by county and you’re going to see a lot of varying product offerings [as] plans realize that the diversity of their population warrants more than just an HMO product.” As a result, plans may look to launch new products like PPOs or dual eligible Special Needs Plans (D-SNPs) or vary their offerings with lower premiums, bigger networks and enhanced benefits.

Eric Goetsch, a principal and consulting actuary with the Milwaukee office of Milliman, says he’s seeing more clients requesting feasibility analyses as to whether they can add D-SNPs to their product portfolios. That is partly due to a change in the risk adjustment methodology that went into effect this year and gave plans serving full-benefit duals a boost in pay (see story, p. 3). Moreover, as sponsors start thinking about their bids for 2018, he’s also seeing an increase in MA organizations considering service area expansions as opposed to previous years. Meanwhile, as CMS moves to using encounter data in 50% of a plan’s risk score by 2018, a top priority of organizations this year will be “improving their encounter data capture process,” suggests Goetsch.

America’s Health Insurance Plans (AHIP) says one specific issue it hopes to see addressed in the upcoming 45-day notice and draft Call Letter for MA plans relates to the use of encounter data, which CMS began using to adjust plan payments in 2016. “While we support CMS’s movement toward the use of encounter data, the data are currently incomplete and inaccurate due to a broad range of technical and operational issues,” advises Mark Hamelburg, senior vice president for federal programs with the trade group. “We believe this data source should not be used for payment until these problems have been resolved.” Moreover, Hamelburg says AHIP hopes to see CMS alter its current practice of using audit findings and compliance actions in adjusting the star quality ratings to “create a more equitable and competitive environment, ensure the system accurately reflects the care beneficiaries actually receive, address methodological issues, and avoid assessing duplicative penalties on plans.”

Midsized Plans May Struggle to Compete

Moreover, as MA plans await the outcome of a federal hearing to determine whether Aetna Inc. can proceed with its planned acquisition of Humana Inc. (see brief, p. 8), ongoing insurer consolidation remains in the back of insurers’ minds, points out Goetsch. “We have a lot of clients that are midsized MA plans that have a real presence and are actively engaged in their communities. And they are just going to have a harder time competing as they’re being forced to compete against some of these behemoths that are being created.”

Another possible area of concern for midsized plans is the GOP’s idea of turning Medicare into a premium support program, which was outlined in its “A Better Way” health policy action plan last June. And while all of the industry experts interviewed by AIS Health say there’s very little chance Republicans will make that happen in the near term, the concept is certainly giving their plan clients pause.

Premium Support Creates Plan Anxiety

That’s because the proposal would, starting in 2024, move to a true competitive bidding process in which bids set the benchmark rate, as it works in Part D. “If you have multiple plans bidding and the revenue has nothing to do with the county benchmark in that area, there’s the possibility that huge players who can bid really low could muscle some of the mid and small-sized players out of the market,” predicts Goetsch. “It’s not putting them in a panic mode at this point…but it’s something they’re thinking about regardless.”

“Medicare premium support is still a high level concept,” adds Mike Adelberg, a former top CMS MA official who is now senior director at FaegreBD Consulting. “While it likely opens new doors for Medicare Advantage plans, it could also, conceivably, pivot toward competitive bidding models that might be less positive for the industry.”

From a compliance angle, since CMS over the last few months took steps to more closely monitor Parts C and D appeals (MAN 12/15/16, p. 1) and provider directories (MAN 9/29/16, p. 4), those are two likely areas of continued focus, he adds. “But we don’t yet know what the new administration will consider important; it is possible that new leadership will have different priorities.”

Meanwhile, one market trend many sources agree is likely to continue is providers sponsoring MA plans. Whether a pure-play provider using a TPA or a provider organization teaming up with an insurer, the “provider-sponsored plan segment in terms of market entry appears to continue to be robust,” observes Stephen Wood, a principal with Clear View Solutions, LLC. “Their motivations are varied but I think primarily, protecting their own market share as a provider is key. We’ve seen quite a few provider groups with strong interest in sponsoring MA plans, particularly in segments like long-term care and dual eligible.”

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NEWS BRIEFS

♦ Total enrollment in Medicare Advantage and other prepaid Medicare plans rose by 53,848 to 18,657,995 as of the Dec. 1 payment date, compared with the Nov. 1 figures, reflecting enrollment in the period ending Nov. 11, according to the latest data from CMS. With nearly 4 million enrollees, UnitedHealth Group remained the largest MA plan sponsor, followed by Humana Inc. at 3.2 million and Kaiser with 1.4 million members, according to estimates from Stifel Co. Visit http://tinyurl.com/hqdgong.

♦ The Pennsylvania Dept. of Human Services (DHS) on Jan. 5 unveiled its intent to award six managed care organizations (MCOs) contracts to serve 2.2 million Medicaid beneficiaries in its mandatory HealthChoices program across five regions. The new selections were made for the second time since 2016 (MAN 5/19/16, p. 8). After being selected in only one region, incumbent Aetna Inc. last year protested the department’s decision and won an injunction to block the state from moving forward with the contracts. After the recent rebid, Aetna and fellow incumbent UnitedHealth Group — which had been selected to serve the program on a statewide basis — were dropped altogether, while newcomer Centene Corp. will continue to serve three regions. Meanwhile, the five regional MCOs that were originally selected will continue to serve HealthChoices, although some saw their regions shift. Effective June 1, the $12 billion, three-year contracts include a 30% target for provider payments based on value received or outcomes, rather than on the quantity of services provided, according to DHS. Aetna and AmeriHealth (which was awarded three regions vs. its original five) have reportedly already filed protests against the new selections. View the announce-ment at http://tinyurl.com/jj4f5sd.

♦ A federal hearing to determine if the Dept. of Justice (DOJ) can successfully block Aetna Inc.’s planned acquisition of Humana Inc. concluded on Dec. 30 as U.S. District Judge John Bates heard final arguments from both companies. The DOJ over the course of the trial maintained its argument that the deal would harm consumers by restricting competition, particularly in the MA market, while the insurers argued that MA directly competes with traditional Medicare and the government cannot presume that the merger will unlawfully hurt com-
petition. The judge indicated that he would issue a final ruling “in a timely manner,” without specifying an exact date, according to Bloomberg. The two insurers reportedly extended their merger date from Dec. 31 to Feb. 15, and exercised the option in their divestiture agreement with Molina Healthcare, Inc. to extend the deadline for that transaction from Dec. 31 to Aug. 31.

♦ A final rule that took effect Jan. 6 allows beneficiaries in government programs, including Medicare and Medicaid, to take part in pharmacy customer rewards and loyalty programs. Under the rule (81 Fed. Reg. 88368, Dec. 7, 2016), the HHS Office of Inspector General added new safe harbors to the anti-kickback statute to protect certain services it says the industry has expressed an interest in offering and it believes “could be, if properly structured and with appropriate safeguards, low risk to Federal health care programs.” Those included protection for certain cost-sharing waivers, including pharmacy waivers for cost-sharing for financially needy Part D beneficiaries. In addition, OIG proposed five new exceptions to the beneficiary inducements civil monetary penalty, which included coupons, rebates or other retailer reward programs that meet specified requirements. View the rule at http://tinyurl.com/h956ihs.

♦ PEOPLE ON THE MOVE: Humana Inc. promoted Catherine Field to president and Intermountain Region market leader for senior products. She was previously vice president and market leader for senior products for the Intermountain Region, which includes Idaho, Oregon, Utah and Washington.... Warren Murrell was promoted to president and CEO of Peoples Health, which provides MA plans throughout Louisiana. Murrell, who has served as president and chief operating officer since early 2015, succeeds CEO Carol Solomon, who died in December.... John Roberts in February will leave his post as budget director for the state of Michigan to serve as vice president of administration with Blue Cross Blue Shield of Michigan, where he will reportedly focus on growing the company’s MA plans through insurers in other states.... WellCare Health Plans, Inc. named Timothy Trodden senior vice president and chief human resources (HR) officer. He was recently the head of HR and corporate enterprise functions for Johnson & Johnson.
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