**2017 ‘Landscape’ Files Show Stability of MA Program as Premiums Continue to Drop**

The most telling observation from CMS’s annual release of Medicare Advantage and Part D “landscape files” for the coming plan year may be how little things will change from 2016 to 2017. Industry observers say their preliminary analyses of the market snapshot posted by CMS on Sept. 22 indicate stability in premiums and product offerings — including products with $0 premiums — and few service area reductions.

“Overall, we’re seeing across the board signs of an extraordinarily stable program that continues growth trends that are way beyond what anybody imagined seven years ago,” remarks John Gorman, founder and executive chairman of Gorman Health Group (GHG). “Medicare Advantage and Part D really keep the lights on now for most large insurers, and new insurers, especially provider-sponsored plans, have learned that Medicare Advantage is the safest path to growth.”

While the total number of contracts dropped 8% from 401 in 2016 to 369 in 2017, the number of plan benefit packages remains virtually the same, according to GHG. However, the firm observes that there are more PPOs offering prescription drug coverage with $0 premiums, which Gorman suggests is designed to compete with Medigap since this was “the first year that Medigap actually scored more net enrollment than Medicare Advantage did.”

And an early look at the data from Avalere Health LLC showed that there are 1,857 MA plans available for 2017, down slightly from 1,894 for 2016. Local HMOs continue to be the dominant product, although they will decrease from 1,332 in 2016 to 1,294 in 2017, while local PPOs will go up from 454 to 462, according to Avalere Vice President Tom Kornfield. All in all, these are not huge shifts in the MA market, he tells MAN.

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**As 2017 AEP Nears, MA Plans Seek Cheap Channels, Maximizing Digital Campaigns**

As Medicare Advantage insurers prepare to win over beneficiaries during the 2017 Annual Election Period (AEP) that starts on Oct. 15, marketing campaigns that may kick off as early as Oct. 1 are likely to involve lower-cost channels such as ads in Facebook feeds and increased use of data and analytics to focus their efforts, according to two MA marketing experts interviewed by MAN. At the same time, large insurers may continue to rely on branded partnerships and/or the continued success of converting enrollees in their Prescription Drug Plan (PDP) products to MA, suggests a leading consultant.

While television continues to be a component of Medicare marketing, the digital portion of marketing budgets is growing, observes Linda Armstrong, executive vice president and practice leader at Chesterbrook, Pa.-based DMW Direct. In particular, the use of Facebook ads has been “tremendously successful” with baby boomers, so clients are putting more dollars toward that than toward banner ads, as well as ensuring that they’re at the top of Internet search results. “The boomers are people who like to look...”
around and get some information before they call a company,” she remarks.

A recent Kaiser Family Foundation report observed that on average, 10% of MA enrollees voluntarily switch plans each year, and switching rates were somewhat higher among those who were between the ages of 65 and 75. And the more their premiums increase, the more likely they are to switch, suggested the report (see chart, p. 3). At an average of 13%, switching rates are slightly higher among PDP enrollees (excluding low-income subsidy beneficiaries who are auto-assigned to PDPs), added Kaiser.

Given some of those statistics, Armstrong says plans are focusing on making themselves visible to “the people we know are more likely to switch in the media that they now feel comfortable with, and at the same time, making sure that everything is mobile friendly.”

“One noteworthy trend is the growing use of data and analytics to maximize ROI and minimize spend,” observes Peter Rodes, senior vice president of strategy and consulting with Wunderman Health, a division of Wunderman. “Our roots are in data and we have always used it to guide our work. It’s exciting to see the health insurance industry increasingly recognizing its importance. More and more insurers are shifting media dollars to accountable, lower-cost marketing campaigns and channels and using front- and back-end data analytics to more precisely target certain audiences and measure performance.”

Wunderman Health also encourages clients to “stand out by starting early” and is seeing many companies this year doing some “market warming” before the Annual Notice of Coverage documents are sent to members by Sept. 30. At the same time, the firm stresses the importance of retaining members. “Many more insurers are paying attention to and putting resources against retention and engagement initiatives, especially given the increasing importance of Stars revenue,” observes Rodes. “Along with this shift, insurers are recognizing that to keep customers and to compete, they must reach and engage people in brand-authentic ways. This means strategically creating strong customer experiences that are consistent across platforms, linking direct and brand marketing, and building robust content strategies that are equally effective on- and off-line.”

As for the strengths of the products that MA plan sponsors will be touting, many will look to use $0 premiums or low premiums as selling points, suggests Armstrong. More than 94% of Medicare beneficiaries will have access to a zero-premium plan in 2017, according to CMS (see story, p. 1). “I think everyone is still focused on keeping that zero and keeping everything as low as possible for now,” she says. And while most of her clients have been able to maintain $0 or low premiums, many have had to make adjustments such as moving to a limited provider network or raising deductibles as a result.

**Will Election Impact AEP Marketing?**

As with any election year, insurers tend to worry about available airtime and whether politicians will “take up all the space,” Armstrong adds. But in her experience working with MA clients on their direct mail, newspaper, television and Web campaigns, there hasn’t been much crossover since insurers typically advertise during the day when people most likely to enroll are at home, and avoid the evening hours when “a lot of politicians want to be out there reaching as many people as possible.”

“We don’t see that the election is going to be a problem for us, but I know it’s a concern to a lot of health insurers since they only have that short limited time in the AEP to be out there advertising,” she observes. Another common fear is that the election may prevent people from making a change for one reason or another, but Armstrong suggests that if beneficiaries are facing changes in their prescription drug coverage or higher premiums or are simply unhappy with their current plan, they will be motivated to make a change during the AEP.
While John Gorman, founder and executive chairman of Gorman Health Group, suggests that plans are marketing less aggressively than in recent years, they are relying more on Web-based sales. Nevertheless, his firm has seen no reduction in the number of agents it certifies for marketing MA products. “Online is a much cheaper way of selling, but it is hard to do it really well,” asserts Gorman. What also works well, he says, is retail partnerships like the one Humana Inc. has with Wal-Mart Corp. or a branded strategy like what UnitedHealth Group offers with AARP.

Another strategy that large insurers rely on is using their PDP products to convert enrollees to MA. “Humana does at least 100,000 enrollees a year that way, so the strategy of using a drug plan as the feeder for the MA business, and basically getting them comfortable with you as an insurer with a really cheap drug plan and then saying, ‘If you like this, how about our one-stop shop?’ is very, very effective,” Gorman suggests.

**New Nondiscrimination Notice Posed Challenge**

Armstrong says one late-breaking development that had plans “scrambling” before the AEP was an Aug. 8 memo implementing Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs. Released two months after CMS’s annual update of the Medicare Marketing Guidelines (MAN 6/16/16, p. 4), the memo provided guidance on the steps MA and Part D plan sponsors must take to notify enrollees and prospective members about their rights under Section 1557. Specifically, they must post a nondiscrimination notice in English accompanied by “taglines in at least the top 15 non-English languages spoken by individuals with limited English proficiency of the relevant State or States.” The memo outlined the various forms of communication to which the requirements apply.

“That was a little bit of a surprise that it was going to be implemented now, so there was a lot of scurrying around to get that insert into kits and then in some smaller kits you can’t get it in because you can’t fit the physical piece of paper in there,” she observes. So that was an added challenge, she says, although it was implemented in “enough time to make sure things got through OK.”

Contact Armstrong at larmstrong@dmwdirect.com, Gorman via Kristina D’Ambrosio at kdambrosio@gormanhealthgroup.com or Rodes via Heidi Kreamer at heidi.kreamer@wunderman.com. View the Kaiser report at http://kff.org/report-section/medicare-advantage-plan-switching-exception-or-norm-issue-brief.

### Share of MA Enrollees Voluntarily Switching Plans, by Share of Premiums

The following chart illustrates the share of MA enrollees who voluntarily switched plans, by change in premiums absent switching, between 2013 and 2014. Switching rates were higher among those who faced higher increases in premiums, observed the Kaiser Family Foundation.

![Share of MA Enrollees Voluntarily Switching Plans, by Share of Premiums](chart)

Two-Thirds of Providers Aren’t At Listed Locations, CMS Finds

The first phase of a new provider directory accuracy pilot conducted by CMS’s Medicare Drug & Health Plan Contract Administration Group (MCAG) has turned up some concerning findings, namely the “excessive number” of providers listed in online directories that aren’t at those locations, according to officials who spoke at the Medicare Advantage and Prescription Drug Plan fall conference on Sept. 8. And if those deficiencies aren’t corrected, plans could be subject to enforcement actions once the verification portion of the project is completed.

The pilot was launched this year in response to beneficiary complaints, congressional inquiries and other sources prompting the agency to enhance its oversight of provider networks, including the accuracy of directory information provided to beneficiaries (MAN 4/7/16, p. 1).

“Provider directories are simple tools used to connect beneficiaries and their caregivers to your contracted providers so that they can get the care that they need,” asserted Jeremy Willard, technical advisor with the Division of Surveillance, Compliance, and Marketing within MCAG, at the conference. “The accuracy of that information is paramount for that happening. If any of that information is wrong, they’re not able to get to that contracted provider.” But based on its recent review, CMS found that when a beneficiary chooses a provider via a plan’s online directory, there is a 46% chance that something is inaccurate.

MCAG selected 54 parent organizations to review, and focused on 108 providers evenly split between four provider types (primary care physicians, oncologists, ophthalmologists and cardiologists) for one randomly selected contract per organization, or more than 5,800 providers with multiple locations for a total of 11,646 locations. Contractor Booz Allen Hamilton contacted nearly 6,000 providers to verify certain information such as provider names, practice names, street addresses and whether the provider works at the location listed and accepts the selected plan at that location.

The CMS contractor conducted the review in a transparent manner, explaining the purpose of the call to the providers, stated Willard. The information collected by the contractor was then sent back to CMS via a spreadsheet containing all the data elements, which CMS reviewed. CMS then shared the initial deficiencies identified with the plans. Plans were given two weeks to issue a response, in which they were asked to concur or disagree and provide additional information in areas with which they did not concur.

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CMS found some common problems with the plan responses, such as failing to actually verify the information that was flagged as inaccurate, relying on source data alone and issuing “cut and paste” responses for the sake of time, said Willard. Furthermore, he suggested that plans improve their provider-level data vs. simply including information about the location of a group practice. “Our expectation is that plans put their best foot forward as far as reviewing the data,” he said. “We really want you to do what is necessary to hear from the provider themselves, [to] get solid responses if you are disagreeing with us.”

Once a final determination on the deficiencies is made, plans are notified and have 30 calendar days to make the requested changes, such as removing a provider from the online directory if the entity is not at that location or accepting new patients. In Phase II of the pilot, CMS will validate that the deficiencies have been corrected and the directory has been properly updated, and when applicable, will look at Health Services and Delivery tables “to see if providers have been removed appropriately,” said Willard.

Nearly Half of Locations Had Errors

Of the 11,646 total locations reviewed, CMS identified 5,257 locations (46%) with deficiencies, meaning at least one or more items in the directory pertaining to that location was inaccurate, and a total of 5,352 final deficiencies disclosed Christine Reinhard, health insurance specialist and technical advisor with the same division at CMS. While there were a couple of outlier organizations that did extremely well or had an extraordinary number of deficiencies, the bulk of organizations had online directories that were 20% to 60% inaccurate.

CMS excluded practice names from its report on the final deficiencies. Reinhard said the initial review turned up “hundreds if not thousands of inaccurate practice names,” but pointed out that CMS doesn’t have firm requirements on the exact meaning of “practice name” and that it’s rather nuanced considering there could be four doctors at a practice but it’s not necessarily misleading to list the names of all four doctors instead of its proper practice name.

One finding that was particularly surprising to Reinhard and her team was the abundance of listed providers that were found not to be at their locations. This occurred in 3,544 instances, accounting for 66.2% of all deficiencies. “We had providers that had been retired for years still in the directory, providers that had passed away over a year ago or more, [and] we had a lot of provider practices that said, ‘I don’t even know who this person is. He or she has never worked here,’ so that was a surprise to us,” she revealed.

The other four most common errors, in descending order, were:

- **Inaccurate phone number, which occurred 521 times, or 9.7% of all deficiencies.** And CMS found that in most instances these were disconnected or out-of-service phone numbers. In some cases, the number turned out to be a physician’s cell phone and there were even a few calls that went to beneficiaries.
- **Incorrect address, which happened 450 times, or 8.4% of all deficiencies.** Reinhard suggested this was potentially more egregious than a wrong suite number, because in the case of the former, the patient is at least in the right building.
- **Provider is not accepting new patients, which happened 338 times, or 6.3% of all deficiencies.**
- **Incorrect address-suite number, which occurred 221 times, or 4.1% of all deficiencies.**

In addition, CMS is concerned about the number of providers who were not aware of their contracted status with the provider organization. “Especially when you expand or add providers to your network, please make sure you educate those providers about the acceptance of your plan,” she advised.

**CMS Considered Link to Network Adequacy**

CMS in its review also considered the implications of provider directory errors on network adequacy, and asked the parent organizations if they used the same underlying database for their online provider directories as for their HSD tables. The majority of plans said they do, reported Reinhard. “With so many providers not being where they’re listed, we are concerned that that’s going to have an effect on HSD tables,” she told attendees.

“Given that a provider may practice at five locations and four of them are correct and one is incorrect, that’s going to have less of an effect vs. a provider that’s listed at 10 locations and eight of them are incorrect and the provider’s not actually there. So it’s something to consider and be aware of.”

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CMS Is Still Weighing Compliance Approach

According to the March 16 memo that told plan sponsors of the pilot, if the selected plans’ directories continue to show deficiencies, they may be “subject to possible enforcement action, including civil money penalties or enrollment sanctions.” Reinhard said CMS has not taken any actions, but that it will weight the deficiencies based on egregiousness (i.e., reflecting CMS concerns about a provider not being at a location vs. an inaccurate suite number). “If there’s more than one deficiency, we are not making a cumulative weighting. We’re taking the most egregious deficiency and counting it as the weight of that most egregious [finding] and not adding other deficiencies,” she explained. Compliance actions can result from Phase I or Phase II and CMS is “still working on that,” she added.

Moreover, CMS recognizes that there are challenges with keeping online provider directories up-to-date and that not all data are going to be 100% accurate all of the time, said Reinhard. But a 46% inaccurate rate is “unacceptable,” she said, and given the importance of the directory for beneficiaries, CMS expects that accuracy must improve.

View a replay of the session at www.youtube.com/watch?v=TPgv9k0TZCc.

Aggravated by Repeat Violations, CMS Fined Plans on Average $500K

CMS in 2015 and early 2016 imposed 25 enforcement actions on Medicare Advantage and Part D sponsors that included five intermediate sanctions and 20 civil money penalties totaling $10.3 million, with an average of $516,163 per CMP, according to CMS’s annual report summarizing activities for the 2015 audit year. That’s up from $7.8 million imposed in 2014 and early 2015, when CMS fined 41 organizations with an average CMP of $190,390. Contributing to the change were sizable fines levied against Humana Inc. ($3.1 million), Envision Insurance Company ($2.6 million) and Aetna Inc. ($1 million). By contrast, the highest penalty CMS imposed based on 2014 audits and related items was $689,800.

While the majority of fines were the result of compliance failures detected in 2015 program audits, six related to erroneous or late Annual Notice of Change/Evidence of Coverage documents. Comparing CMPs based on audit results alone, CMS imposed $3.7 million in fines for the 2014 program audit year and $8.5 million for 2015, according to the report. CMS explained that after witnessing the same problems year after year despite its efforts to assist plans by providing best practices, it applied an “aggravating factor/amount” to the standard penalty “in an effort to increase compliance.” In addition, CMS said

<table>
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<th>Date of Imposition</th>
<th>Organization Name</th>
<th>Basis for Referral</th>
<th>CMP Amount</th>
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<tr>
<td>April 16, 2015</td>
<td>Aetna Inc.</td>
<td>Inaccurate Network Pharmacy Information</td>
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<td>New West Health Services</td>
<td>2014 Program Audit Validation</td>
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<td>Atrio Health Plans</td>
<td>Inaccurate ANOC/EOC</td>
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ANOC/EOC = Annual Notice of Change/Evidence of Coverage

SOURCE: Annual Report from CMS’s Medicare Parts C and D Oversight and Enforcement Group, Published Sept. 6, 2016

Web addresses cited in this issue are live links in the PDF version, which is accessible at MAN’s subscriber-only page at http://aishealth.com/newsletters/medicareadvantagenews.
it took steps to obtain more accurate beneficiary impact data from sponsors.

“With this report and in other documents, CMS appears to be making two points, to both MA and Part D sponsors and third parties. First, the consequence of repeated or serious non-compliance is going up. Second, the rigor and transparency of the agency’s methodology for levying fines and sanctions is also going up,” Michael Adelberg, a former top CMS MA official who is now senior director at FaegreBD Consulting, suggests to MAN. “This is consistent with a general trend in recent years of the agency becoming a stricter regulator of the MA and Part D markets.”

Most sponsors received CMPs for non-compliance in the program areas of Part D Formulary and Benefit Administration (FA), Part D Coverage Determinations, Appeals, and Grievances (CDAG) and Part C Organization Determinations, Appeals, and Grievances (ODAG), where CMS observed sponsors continued to make the same mistakes. In the FA area, for instance, a sponsor’s failure to properly administer its CMS-approved formulary by applying unapproved quantity limits was cited as a common condition for the sixth year in a row, and affected 63.6% of audited plans in 2015.

The most common CDAG condition, also for the sixth year in a row, was that denial letters did not include adequate rationales, contained incorrect/incomplete information specific to denials, or were written in a manner not easily understandable to enrollees. This condition was cited in 68.1% of 22 program audits that included CDAG. And among those 19 sponsors audited for ODAG, 57.9% were cited for the most common condition: a failure to notify enrollees — and providers if the providers requested the services — of its decisions within 72 hours of receipt of expedited organization determination requests.

Of the five insurers placed on intermediate sanction in 2015 and early 2016, Cigna Corp. is the only one still suspended from enrollment and marketing and is continuing to work on remediating deficiencies uncovered in a 2015 program audit (MAN 9/15/16). The average number of MA plan choices per county also remains relatively unchanged, said CMS.

View the full report at http://tinyurl.com/jc5mz4r. Contact Adelberg at michael.adelberg@faegrebd.com.

2017 MA Snapshot Shows Stability

continued from p. 1

The average monthly MA premium will fall by $1.19 in 2017, from $32.59 in 2016 to $31.40 next year, CMS said in its Sept. 22 press release accompanying the release of the files. This compares with what the agency a year ago said was a 31-cent drop in the monthly MA premium from 2015 to 2016. CMS also said 67% of all MA beneficiaries will not face a premium hike next year, up from 59% for 2016. Moreover, enrollment is expected to grow to an all-time high of 18.5 million beneficiaries in 2017, up 60% from 2010.

“Premiums overall are remarkably stable from 2016 to 2017,” weighs in Stephen Wood, a principal with ClearView Solutions, LLC. The Chicago-based consulting and health care analytics firm observes that most plans kept the same premium, while roughly 20% reduced premiums and about 28% raised them. And among the plans that increased premiums, they were frequently raised by less than $10. “Given the media coverage of premium increases on the exchanges, the MA market looks very mature and stable by comparison,” adds Wood. While the firm did not analyze changes in benefits, he points out that plans may have had to make some reductions “to offset the lack of movement on premiums.”

CMS added that access to MA plans will remain very strong in 2016, with 99% of beneficiaries able to choose such plans, the same figure as for 2015 and 2016, and more MA products will offer supplemental benefits next year than was the case this year. Moreover, more than 94% of Medicare beneficiaries will have access to a $0 premium MA plan, up from 81% in 2016 and 78% in 2015.

Service Areas Should Be Largely Unaffected

And despite rumblings about service area reductions due to CMS’s new policy of reviewing the provider networks of plans requesting service area expansions (MAN 8/4/16, p. 1), the average number of MA plan choices per county remains relatively unchanged, said CMS. GHG did not observe any notable service area reductions and points out that several leading insurers are adding or expanding their service areas. Aetna Inc., Centene Corp. and UnitedHealth Group all expanded their service areas for 2017, says Gorman. Humana, meanwhile, showed a nominal service area reduction, and “really just trimmed the footprint in terms of which counties they’re selling in,” he explains. “And there was little change among the other big nationals.”

“It’s really just a very solid report card on an incredibly stable program that a lot of folks thought was in a death spiral, and I think it’s the clearest model that we can hold out for the Obamacare exchanges,” he adds. “I think all the market fluctuations you’re seeing in Obamacare had everything to do with a lot of these insurers underestimating the business they were getting into there because it works very much like Medicare Advantage, which they all know by now.”

Meanwhile, the number of PDP offerings will continue to decline, but mostly due to consolidation. Shelly Brandel, a principal and consulting actuary in Milliman’s Milwaukee-area office, calculates that there will be 16%...
fewer PDPs next year than in 2016 (746 vs. 886). But similar to changes seen last year, that’s mostly driven by plan mergers, she suggests. CVS Health Corp.’s Silver-Script Insurance Co., for example, bought Torchmark Corp. subsidiaries United American Insurance Co. and First United American Life Insurance Co. earlier this year (MAN 7/21/16, p. 7). Brandel estimates that acquisition accounts for a decrease of 91 plans, and points out that Stonebridge Life Insurance Co. removed its Transamerica PDPs while there were some regional exits as well.

CMS previously said in July 2016 that the Part D average basic premium in 2017 is projected to be $34 per month, or about $1.50 higher than the actual average basic Part D premium in 2016. While most national carriers raised their premiums by a few dollars, observes Brandel, Humana Inc. is the only non-sanctioned carrier that consistently lowered premiums on all of its Part D products. And Humana will offer the lowest cost PDP in 22 out of 34 regions with its $17-per-month Wal-Mart plan, according to GHG.

UnitedHealth, meanwhile, is raising premiums in the second largest Part D plan, AARP MedicareRx Preferred, by about $10, according to Avalere’s analysis. The top 10 most popular Part D plans now represent 88% of PDP enrollment, and will have an average premium increase of 4% in 2017, estimates Avalere.

Gorman adds that UnitedHealth showed the biggest improvement in bidding below the low-income subsidy benchmark and is now eligible to receive auto-assignments in 27 PDP regions. WellCare also showed some improvement and is getting auto-assignments in eight regions, he says. And Envision, which was acquired by Rite Aid Corp. last year, is qualified to receive LIS enrollees in 11 regions.

Contact Brandel at shelly.brandel@milliman.com, Gorman via Kristina D’Ambrosio at kdambrosio@gormanhealthgroup.com, Kornfield at tkornfield@avalere.com or Wood at stephen.wood@clrviewsolutions.com. View the landscape files at http://tinyurl.com/p4lxhlh.

**NEWS BRIEFS**

✧ Four health insurers that lost bids to serve Pennsylvania’s new Community HealthChoices (CHC) program are protesting the awards of contracts worth an estimated $7 billion a year, resulting in a stay of negotiations with the three winning bidders. The Pennsylvania departments of Human Services and Aging on Aug. 30 selected AmeriHealth Caritas, Centene Corp.’s Pennsylvania Health and Wellness, and UPMC for You to coordinate physical health and long-term services and supports (LTSS) for older Pennsylvanians and individuals with physical disabilities (MAN 9/1/16, p. 1). A total of 14 companies submitted bids. The four insurers that have filed bid protests are Aetna Better Health, Gateway Health Plan, Molina Healthcare of Pennsylvania and WellCare of Pennsylvania, according to The Philadelphia Inquirer. Aetna won an injunction earlier this year to block the state from moving forward with contracts for its HealthChoices managed Medicaid program, and won a contract for one of the program’s five zones in a rebid.

✧ The U.S. House of Representatives on Sept. 21 passed a bipartisan bill seeking to allow patients with end-stage renal disease (ESRD) to enroll in Medicare Advantage plans. Introduced in July by Rep. Jason Smith (R-Mo), The ESRD Choice Act (H.R. 5659) would lift restrictions placed on ESRD patients in 1981. More than 640,000 Americans are estimated to be living with kidney failure, or ESRD, and patients with this pre-existing condition are currently the only group barred from enrolling in more flexible care plans such as MA products, said Smith. View the text of the bill at https://www.congress.gov/bill/114th-congress/house-bill/5659.

✧ CMS on Sept. 9 rejected an Ohio waiver request that would have charged premiums to Medicaid beneficiaries regardless of their income level and potentially forced hundreds of thousands of Ohioans to lose coverage. In a letter to Ohio Medicaid Director John McCarthy, CMS acting Administrator Andy Slavitt expressed concern that such premiums would “undermine access to coverage and the affordability of care, and do not support the objectives of the Medicaid program.” The waiver had included a proposal to exclude beneficiaries from enrolling in more flexible care plans such as MA products, said Slavitt. View the text of the bill at https://www.congress.gov/bill/114th-congress/house-bill/5659.
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