Jury’s Still Out on Effect of Risk Adjustment Freeze on Payers

In a move swiftly criticized by the health insurance industry, CMS said on July 7 that it would freeze $10.4 billion worth of collections and payments under the federal risk adjustment program, citing a February ruling in a New Mexico court case that challenged how the program calculates those transfers.

“We are very discouraged by the new market disruption brought about by the decision to freeze risk adjustment payments,” America’s Health Insurance Plans (AHIP) said in a statement. The decision “comes at a critical time when insurance providers are developing premiums for 2019 and states are reviewing rates,” AHIP added, warning that the move will “create more market uncertainty and increase premiums for many health plans.”

Yet experts tell AIS Health it may be too soon for insurers to panic.

“It really does depend on what the administration does and says over the coming weeks,” says Larry Levitt, senior vice president for health reform at the Kaiser Family Foundation. “If this results in just a short delay in payments, then I think the effect will largely be just a blip.” But if those payments are delayed too long or don’t come at all, “significant uncertainty” could result.

Payers Use Claims, Coding Reviews to Trim ER Spending

Insurers trying to contain the costs of unnecessary emergency room utilization have faced strong pushback in recent weeks. Anthem, Inc.’s controversial year-old “avoidable ER program” (HPW 7/24/17, p. 5) led state lawmakers in Missouri to pass a bill reinforcing the “prudent layperson” standard; it was signed into law in June and is set to take effect in late August.

Separately, Texas state regulators have been wrangling with Texas Blue Cross and Blue Shield over its approach, initially set to begin June 1, denying coverage for out-of-network ER visits determined after the fact not to be true emergencies. The Texas Blues insurer agreed to a two-month delay as it answers the state’s questions on why the program is needed and how it will be implemented.

Starting Aug. 6, “Blue Cross and Blue Shield of Texas retail and group HMO members may be required to pay the entire ER bill if they go to an out-of-network ER as a convenience for a condition they don’t think is serious or life-threatening. Examples include head lice or a school physical,” Chris Callahan, a Texas Blues spokesman, tells AIS Health.

“It’s important to understand these claims will be reviewed accounting for how the member presents to the ER, not the diagnosis,” Callahan adds.

Callahan describes this as a change in the insurer’s claims review process, not a policy change. “We will thoroughly review the medical records for all out-of-network emergency rooms claims for our HMO members,” he says. “The purpose of
this review process is to address billing for services not performed or not medically necessary, inaccurate billings, and excessive and unconscionable charges for routine services.”

The Texas Blues insurer also will review the medical record to determine the reason the HMO member sought emergency care out-of-network, Callahan says. “This means HMO members who seek care at out-of-network emergency rooms for symptoms that any person, with an average understanding of health care, would acknowledge as non-emergent may have to pay for part or all the bill. No claim will be denied without a review by a physician.”

Callahan cites the proliferation of freestanding emergency facilities as another reason for escalating emergency care costs in Texas. He points to recent price tags of $45,000 to treat tonsillitis and $23,000 for “a simple underarm cyst” at such facilities.

In Massachusetts, Commonwealth Care Alliance (CCA) is tackling the ER issue through its Mobile Integrated Health program, launched in 2014 to respond to members’ urgent care needs. The program’s specially trained paramedics provide high-intensity care in the home, thus avoiding unnecessary emergency department visits and hospital admissions, plan officials say.

“CCA has deep expertise in serving populations that have excessive historical emergency department utilization,” President and CEO Christopher Palmieri tells AIS Health. The insurer serves nearly 28,000 Medicare/Medicaid dually eligible members with complex medical, behavioral health and social needs through its two health plans, he notes.

CCA’s Mobile Integrated Health program has responded to 2,300 requests for service since its inception in October 2014, plan officials say. Most calls were related to respiratory illnesses, including chronic obstructive pulmonary disease, upper respiratory tract infection and flu; cardiac illnesses, including congestive heart failure and chest pain; gastrointestinal illnesses, including nausea and vomiting/dehydration/diarrhea; and infectious diseases,

including cellulitis, wound evaluation and urinary tract infection.

Overall, emergency department visits were avoided in 82% of cases under the program, according to CCA. And those avoided ER visits and inpatient admissions resulted in estimated total savings exceeding $6 million.

**Provider-Driven Efforts Work Best**

Joe Paduda, principal with Health Strategy Associates, LLC, tells AIS Health the most effective emergency department (ED) usage management programs seem to be provider-driven. “Health systems, particularly large ones with big indigent or Medicaid populations, are justifiably quite concerned about un- or low-compensated ED usage,” he says, “and some have developed long-term oriented approaches that seek to divert ‘future’ ED visits by connecting patients with community and primary care.” He cites NYC Health+Hospitals’ program, which includes multidisciplinary ED-based care management teams, as a fairly well-known example.

“The issue for insurers is they don’t have the ability to divert the patient at point of service, while health systems and hospitals love the high revenue from privately insured patients,” Paduda says. UnitedHealthcare’s solution, for one, “appears to be in part coding review,” he says. “It is reviewing all ED bills with Level 4 or 5 codes and, where they can, down-coding those bills. Inherently this makes sense as facilities appear to be billing more visits at those higher intensity levels than they did in years past.”

According to Paduda, the optimal solution is for insurers and health systems to work together. But he concedes this is unlikely to occur or won’t be effectively implemented “unless both have financial skin in the game.”
Some version of a shared savings model around ED visits might be a good place to start.”

Read more on CCA’s efforts at https://tinyurl.com/yaezpqbb, and NYC Health+Hospitals’ program at https://tinyurl.com/ydxp932v. Contact Paduda at jpaduda@healthstrategyassoc.com and Callahan at chris_callahan@bcbstx.com.

by Judy Packer-Tursman

To Care for High-Need Members, Puerto Rico Payer Gets Creative

MMM Holdings, Inc., a subsidiary of InnovaCare Health Solutions, LLC, has some unique challenges to contend with as one of Puerto Rico’s largest Medicare Advantage insurers.

“We basically have a lot of needs — because of socioeconomic conditions — a lot of participation [and] less reimbursement” than do insurers that operate on the mainland, MMM Healthcare President Orlando González told AIS Health in an interview at the America’s Health Insurance Plans Institute & Expo in San Diego.

On top of that, the insurer’s enrollees — many of whom are Medicare/Medicaid dual eligibles — have higher morbidity levels compared with the population in the states, he says. MMM has 94,590 dual-eligible members in Puerto Rico, according to AIS’s Directory of Health Plans.

All those factors, González says, “forced us to be very creative in order to deliver the care that the people need that we serve, and in order for us to be successful as a company.”

Thus, MMM has been focusing heavily on quality, both to improve member health and maximize reimbursement, he says. And to drive higher quality, the plan has learned it needs to blur the lines between payer and provider.

To that end, the insurer owns management services organizations, independent practice associations (IPAs) and its own chronic care clinics — plus it leases out floors in hospitals, according to González.

Richard Shinto, M.D., president and CEO of InnovaCare Health Solutions, explains the strategy this way: Instead of building or buying hospitals, MMM is trying to transform into a Kaiser Permanente-like model. “But instead of battling all the hospitals and battling all the medical groups, we’re trying to take parts of them, and then we put our whole model of care inside the hospital.”

“The hospitals need us because they want the revenue, but then from the flip side of it, we’re able to really start managing, more systematically, the entire continuum of care,” Shinto adds.

Clinics Are Aimed at Chronically Ill

MMM originally wasn’t in the clinic business at all, but soon realized it needed a better way to take care of its many chronically ill patients, according to Shinto. Thus, the insurer launched its Vita Care clinics, which feature multidisciplinary teams that coordinate care, help close care gaps, improve documentation, encourage members to take ownership of their conditions, and integrate behavioral services with specialized chronic care. For the 4,000 members in the program, hospital admissions have dropped 49%, and per-member per-month revenue had grown by 13%, the company says.

Now MMM is also planning to have clinics dedicated solely to diabetes patients, who comprise a significant portion of its covered population, Shinto says.

Overall, the insurer essentially has three clinic types: those it owns outright, those it co-owns with medical groups and those where it simply has a contract with the medical-group owner. That approach is strategic, because Puerto Rico is dominated by individual practices that are part of IPAs, “so for us to go in there and build a freestanding hotel, all the other hotels are going to start fighting us,” Shinto says.

Instead, MMM is working with such clinics to systematically implement standards of care rather than competing with them or buying them, according to Shinto. Eventually, though, “we’re going to roll them all up,” he says, adding that the company is “boiling the frogs real slow here until they’re all cooked.”

Not only does MMM want to build a staffed-clinic model in Puerto Rico, it soon plans to expand to the mainland, Shinto adds.

Hurricane Brings New Challenges

Last September, when Hurricane Maria hit Puerto Rico with devastating force, MMM and other insurers on the island (HPW 12/18/17, p. 1) faced perhaps their biggest challenge yet.

MMM’s priorities were threefold: make sure its employees were safe and could come to work, ensure its providers were able to take care of patients, and help its members, González says.

For its employees, the insurer started an outreach program to contact all of its 2,400 associates, a process that due to widespread power outages took almost two weeks. MMM also offered them financial assistance, food — an effort that involved setting up a make-shift grocery store — generators and even laundry services.

“When you're in the service industry, you've got to have your people...
motivated [and] aligned, and even though they were going through their own challenges, we wanted to keep it as easy as possible,” González says.

MMM helped ensure providers had the cash they needed to operate and provided hospitals with generators when necessary. Through InnovaCare’s headquarters in New Jersey, the company also chartered planes full of supplies for both employees and providers, according to González. The planes also ferried patients and employees’ family members off the island, Shinto adds.

Insurer Coordinated Mobile Clinics

To help both members and non-members, MMM brought mobile clinics to isolated parts of Puerto Rico, offering triage areas, health care services and a makeshift pharmacy.

The insurer also helped bring in entertainment like music and theater for children and even a barbershop, according to Shinto and González.

“I think we went beyond the typical health plan functions to really serve our members. And we feel very proud of what we have done,” González says.

Yet MMM also learned from the experience, Shinto adds.

“We were ready, but one of the things we realized is you’ve got to really work on your supply chain,” he says. “Because think about it — I mean, you’re ready to go but you don’t have a DME [durable medical equipment] company, or you don’t have home health or you don’t have transportation. If your supply chain isn’t intact, you’re going to have more problems.”

Contact González at orlando.gonzalez@mmmhc.com and Shinto at rick.shinto@mmmhc.com.

CMS Ties Navigator Funds to Promoting Non-Compliant Plans

Three days after putting risk adjustment payments to Affordable Care Act marketplace plans “on hold” (see story, p. 1), the Trump administration again slashed funding for the ACA’s navigator programs, used to provide in-person enrollment assistance. For the enrollment season starting in November, CMS will provide up to $10 million spread across the 34 federally facilitated exchanges (FFE).

That’s far below last year’s funding level just shy of $37 million — which fell from nearly $63 million for the previous year under the Obama administration (HPW 9/18/17, p. 1).

Move Could Be a ‘Mild Negative’ for Plans

“I think for plans this is probably a mild negative,” Michael Adelberg, a principal with Faegre Baker Daniels Consulting in Washington, D.C., tells AIS Health. “The plans are much more reliant on their own advertising and their own distribution…than they are on navigators.”

“Of all the things for plans to be outraged about, this is going to be very low on the list,” adds Adelberg, a former senior official in CMS’s Center for Consumer Information and Insurance Oversight (CCIIO).

Rosemarie Day, founder and president of Day Health Strategies LLC, says she partially agrees, given that plans already had to absorb and adjust to even bigger cuts in federal outreach funding last year. In addition to lost navigator money, the Trump administration slashed ACA exchange advertising from the $100 million spent by the Obama administration for 2017 open enrollment to about $10 million last fall. “I think at this point probably no one is surprised at what’s coming out.

There’s an ongoing theme of chipping away” at the ACA, she says.

What is more troubling, Day asserts, is that this year CMS says it wants those groups seeking federal navigator money to promote non-ACA-compliant options as well as exchange plans.

“Applicants will also be encouraged to demonstrate how they provide information to people who may be unaware of the range of available coverage options in addition to qualified health plans (QHPs), such as association health plans, short-term, limited-duration insurance, and health reimbursement arrangements (HRAs),” CMS said in its July 10 “funding opportunity announcement.” (In June the Dept. of Labor issued the rule to broaden the use of AHPs (HPW 6/25/18, p. 1), and the rule on short-term insurance policies is expected soon.)

“You’re speaking with a forked tongue. You’re working at cross purposes with people” by counseling them about plans that sidestep the ACA’s required benefits and consumer protections, says Day, who was founding deputy director and chief operating officer of the Massachusetts Health Connector, a state-based model for ACA exchanges. She adds: “It makes no sense when you think about who navigators are talking to — the HRA is tied to a job. You’re not talking to people with employer-sponsored insurance.”

Of all the things for plans to be outraged about, this is going to be very low on the list.

In its announcement, CMS says enrollment data from the past couple of years show navigators brought in less than 1% of total FFE enrollment — “not nearly enough to justify the
millions of federal dollars spent on the program.”

Adelberg disputes this, explaining agents and brokers are far likelier to include “producer numbers,” which allow CMS to track their enrollments, because that’s how they get paid commissions. But navigators aren’t paid, he says, so there’s going to be an underreporting of navigator-assisted activity.

Robert Laszewski, president of Health Policy and Strategy Associates, LLC, a Virginia-based policy and marketplace consulting firm, offers a blunter assessment of lost federal navigator dollars for the coming exchange enrollment season. “This is just another example of the Trump administration never missing an opportunity to sabotage Obamacare,” he asserts.

Plans have already battened down the hatches “by assuming the vast majority of their business will come from the lower income people who get the biggest subsidies and therefore raising the rates to very high levels knowing their rate base is now high enough to make money even with a pool that is very sick,” he says. “The health plan response [to reduced federal dollars] will be what it was last year: do what they can from an outreach standpoint and keep raising the rates to even higher levels. That strategy will assure their profitability even as people who get smaller subsidies, or no subsidy at all, will be more and more left outside the Obamacare system.”

Contact Adelberg at michael.adelberg@faegrebd.com, Day at rosemarie@dayhealthstrategies.com and Laszewski at robert.laszewski@healthpol.com. ✷

by Judy Packer-Tursman

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**Most Insurers’ Share Prices Gained in June**

<table>
<thead>
<tr>
<th></th>
<th>Closing Stock Price</th>
<th>June Gain (Loss)</th>
<th>Full-Year Gain (Loss)</th>
<th>Consensus 2018 EPS*</th>
<th>Consensus 2018 P/E Ratio*</th>
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<td></td>
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</tr>
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*Estimates are based on analysts’ consensus estimates for full-year 2018.

SOURCE: Bank of America Merrill Lynch.
a Consumer Operated and Oriented Plan, was not the only CO-OP-initiated lawsuit challenging risk adjustment that saw a ruling this year — in the other, brought by New England-based Minuteman Health, a judge sided with the government.

CMS said that because of the split rulings, it asked the New Mexico district court to reconsider its decision. The agency is currently awaiting a ruling on that matter.

**Could Feds Have Done More?**

One health policy expert, though, isn't buying the administration's argument that the New Mexico ruling prevents it from making risk adjustment payments and collections.

“Thats wrong,” Nicholas Bagley, a law professor at the University of Michigan, wrote in a post on The Incidental Economist blog. “The truth is that the Trump administration has lots of options. It's just choosing not to exercise them.”

For example, the Justice Department could have filed a notice of appeal and sought a stay pending that appeal, he wrote. Or it could have “moved quickly to adopt a rule to address the judge’s concerns.”

Condeluci, though, points out that it’s still an option for CMS to issue such a rule. “I actually think it is highly likely that they do that,” he says, pointing out that the 2019 Notice of Benefit and Payment Parameters already included an explanation as to why CMS felt the program was budget neutral.

Levitt says he agrees that an interim final rule could fix the problem. However, “one of the perplexing things here is why CMS issued a rule clarifying their justification for 2019 but not for the previous years that were at issue in the case,” he adds. “They may have their reasons for doing so, but they haven’t fully explained them if they do.”

The way Levitt sees it, “insurers are going to be spending a lot of time reading tea leaves from CMS” on the risk-adjustment issue.

“The Trump administration is fighting the lawsuit in court, but it’s not so clear how aggressively the administration is pushing back,” he says. “So that, I think, is what insurers are going to be looking for — is whether the Trump administration is using this legal case as a hook to create confusion in the marketplace, or is really making a good-faith effort to try and make the risk adjustment system work.”

Condeluci, though, says he thinks the Trump administration’s move “is more driven by the lawyers as opposed to the political system.”

**Uncertainty May Not Affect 2019 Rates**

That said, “it is true that [freezing risk adjustment transfers] adds a level of uncertainty that is not desirable,” according to Condeluci. Still, he says he doubts it will impact 2019 premiums, as insurance commissioners aren’t likely to allow rate hikes based on those unfunded liabilities.

But Levitt argues that if risk adjustment transfers are halted permanently or if there’s a long delay in making them, insurers that were due to receive significant payments will find a way to make up for it.

“Prior-year losses technically can’t be made up for in future premiums, but actuaries have all kinds of tricks up their sleeves to shade assumptions more conservatively to try and build a cushion,” he says.

Some Wall Street analysts agreed that the halted transfers will likely impact individual market insurers.

“The announcement is likely to drive a meaningful increase in premiums given [that] the repeal of the individual mandate compounds the uncertainty, and it’s likely to keep insurers such as Anthem, Inc. and Molina Healthcare, Inc. from increasing their exposure to the exchanges in 2019, Leerink analyst Ana Gupte wrote in a research note.

Similarly, Credit Suisse analyst A.J. Rice wrote: “With the future of the risk adjustment program uncertain, participating insurers will have to reassess their ACA compliant small group and individual markets approach for 2019. We believe this could also discourage potential new market entrants for next year as there would be no risk adjustment program to fall back on in case of adverse plan selections.”

A July 9 report from CMS, detailing expected risk adjustment transfers for 2017, sheds further light on which insurers have the most to lose from the frozen payments (see chart, p. 7).

Blue Shield of California, for example, is expected to receive $696 million, followed closely by Health Care Service Corp. at $640 million. On the other end of the spectrum, Molina is slated to pay $853 million into the program, and Centene owes $607 million.

**Risk Adjustment Controversy Continues**

The risk adjustment program — which seeks to discourage insurers from cherry-picking healthier enrollees in the individual and small-group markets by transferring funds from plans with lower-risk members to plans with higher-risk members — has long been criticized by some who claim it unfairly punishes small and startup plans.

Take Martin Hickey, M.D., former CEO of New Mexico Health Connections and current CEO of True Connections and current CEO of True
Health New Mexico, who seemed to take a swipe at AHIP’s reaction to the freeze of risk-adjustment transfers.

“Contrary to what is being said by large insurance companies and their lobbyists who disproportionately benefited from the Risk Adjuster, this federal court decision is GOOD for small and new health insurance companies, and therefore to anyone who purchases health insurance,” he said in a statement to AIS Health.

“Getting this program fixed will lead to a more stable market,” Hickey contended.

Condeluci says he thinks those criticisms have some weight.

“I do buy the argument that the formula is producing some interesting results where the more established, long-standing carriers have been benefiting from the program by receiving payments” while many startups or new market entrants must pay in, he says.

“It’s almost skewed — like each end of the spectrum is getting too great of an impact,” he adds.

While CMS has been tweaking the formula for the past couple of years, the only way to truly fix those problems is to come up with an entirely new formula, according to Condeluci. But he adds that CMS is unlikely to do so.

To Levitt, “the risk adjustment system’s design does hurt low-cost plans

2017 Affordable Care Act Risk Adjustment Transfer Amounts by Major Insurer

The Trump administration’s decision to suspend payments and collections in the Affordable Care Act risk adjustment program — which transfers payments from health insurers that cover lower-risk populations to insurers with higher-risk populations — might hit some insurers harder than others. A total of 654 issuers participated in the risk adjustment program for the 2017 benefit year, and 628 of them received a risk adjustment transfer. In the event that the delay in 2017 risk adjustment transfers becomes permanent, Molina Healthcare, Inc. and Centene Corp. — which owe $853 million and $607 million, respectively — stand to gain. On the opposite end of the spectrum, Blue Shield of California is expected to receive $696 million, the largest transfer amount among all insurers. Several other Blue Cross and Blue Shield affiliates are also owed at least $100 million in risk adjustment payments from 2017. The graphic below shows the estimated risk adjustment transfers for several major insurers.

News Briefs

♦ The U.S. Department of Justice (DOJ) is set to approve CVS Health Corp.'s acquisition of Aetna Inc., Bloomberg reported July 12, citing a report from the trade publication Reorg Research. The article said DOJ staff are expected to recommend that senior officials support the transaction, and those officials will have final say at the end of the month. Both CVS and Aetna representatives declined to comment on the matter to Bloomberg, but stocks of both companies rose as multiple news outlets reported that their deal might receive regulatory approval. Read the Bloomberg article at https://bloom.bg/2ufEgpO.

♦ Employers are holding average health benefit cost growth to about 3% annually, according to Mercer’s latest survey of employer-sponsored health plans, released July 10. If not for employers’ actions, yearly increases would have hovered closer to the historical 6%, the firm says. The survey also found that nearly half of employers with 500 or more employees make centers of excellence available to workers for orthopedics, cardiology and oncology. See the report at https://tinyurl.com/y9d-q7ec2.

♦ Fifty-four percent of health plans are “very familiar” with outcomes-based contracting, up from 48% a year ago, and more plans report having conversations within their organizations about OBCs, according to a survey by Avalere Health released July 12. Among plan respondents, 25% have an OBC in place, and 85% of them are considering additional contracts. On July 11, Avalere released a study finding Medicare Advantage (MA) beneficiaries with hypertension, hyperlipidemia and diabetes had far fewer inpatient stays and emergency room visits compared with similar patients in traditional fee-for-service Medicare. Read about Avalere’s OBC survey at https://tinyurl.com/ybctcv7d and MA study at https://tinyurl.com/y739vnjv.

♦ California continues to attract a healthier-than-average mix of enrollees to stabilize its individual insurance market, which is due to significant investments in marketing and outreach by Covered California, the state-based exchange, along with its patient-centered benefits. So concludes a report by Covered California’s chief actuary and Wakely Consulting Group, posted July 11 on Health Affairs’ website, which Covered California Executive Director Peter Lee says “provides new evidence that investing in promoting enrollment is essential and pays off in the form of reduced premiums for those who do not receive subsidies.” Go to https://tinyurl.com/yc5n7cz6.

♦ In 2019, Minneapolis-based Bright Health will double the number of states in which it participates in the Affordable Care Act (ACA) exchanges. The startup insurer, which already sells plans in Alabama, Arizona and Colorado, will expand into New York, Ohio and Tennessee. Read the release at https://prn.to/2LdAwPc.

♦ Medicaid managed care insurers aren’t doing enough to identify and address fraud and abuse, and they don’t always inform states when they take actions against providers suspected of those offenses, according to a new report from the HHS Office of Inspector General (OIG). These weaknesses may limit states’ ability to effectively conduct oversight of their Medicaid programs, OIG said, and it thus recommended several steps CMS should take to fix the problem. Read the report at https://bit.ly/2zvdBuo.