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Will Insurers Reinvest Tax Windfall in Benefits, Premiums?

The health insurance industry last week got its first view of the real-life impact of the Tax Cuts and Jobs Act as UnitedHealth Group estimated the law will improve its 2018 earnings and cash flow by $1.7 billion (see story, p. 3). And more good news may be on the way, if GOP lawmakers succeed in delaying the health insurer fee (HIF) until 2019.

UnitedHealth's windfall comes "after an estimated $400 to $500 million reduction in premium revenues due to minimum loss ratio and lower net health insurers fee recapture effects and a $200 to $300 million additional investment in operating costs, as we accelerate existing initiatives in artificial intelligence, data analytics, individual health record custodianship, digital health, Net Promoter Score improvements and health-related initiatives in local communities," said CEO David Wichmann during a Jan. 16 conference call to discuss fourth-quarter and full-year 2017 financial results.

The Tax Cuts and Jobs Act, signed into law Dec. 22, provides for sweeping tax reform and repeals the individual mandate penalty. Analysts at the Tax Foundation say the broad effect of the law on the U.S. economy will be to "significantly lower marginal tax rates and the cost of capital, which would lead to a 1.7 percent increase in [gross domestic product] over the long term, 1.5 percent higher wages, and an additional 339,000 full-time equivalent jobs." America's Health Insurance Plans (AHIP) has not yet developed a public take on the law, according to a spokesperson.

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Molina Returns to Fundamentals Amid Loss of N.M. Contract

Struggling Molina Healthcare, Inc. intends to be "tactical and practical" in the coming year, focusing on managed care fundamentals like operational execution and financial discipline, "because that's what's missing from the Molina story," the company's new head recently told the J.P. Morgan Healthcare Conference.

"There's a lot to work with here," added Joseph Zubretsky, who was named Molina's president and CEO in October 2017, describing Molina as "well scaled and well diversified." The Long Beach, Calif.-based company posted a $97 million loss in the third quarter of 2017 following the ouster of two namesake executives and the launch of a corporate restructuring effort. The company said it will release fourth quarter and full-year 2017 earnings results on Feb.12.

Zubretsky, who previously worked at Aetna Inc. and The Hanover Group, among other companies, made it clear in his Jan. 8 conference presentation that Molina has major challenges to overcome. He outlined a plan for "margin recovery and sustainability" that will focus on Molina's underperforming business to improve margins. He cited the need to improve specific markets — naming Florida, Illinois, Puerto Rico and New Mexico — as well as specific lines of business: Medicaid for

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the aged, blind and disabled (ABD) and the Affordable Care Act's (ACA) health insurance marketplace for individuals (see table, p. 3).

Ironically, later on the same day as Zubretsky's presentation, the New Mexico Human Services Department notified Molina Healthcare of New Mexico, Inc. that it had not been selected for "the tentative award of a contract" under a request for proposal (RFP) issued on Sept. 1, 2017, according to Molina's SEC Form 8-K filed on Jan. 10.

The New Mexico RFP covers the state's new Centennial Care contract, Centennial Care 2.0, which is scheduled to start Jan. 1, 2019. Molina noted that the tentative Medicaid RFP award won't affect its plan's current contract with New Mexico Medicaid, which runs through Dec. 31, 2018.

Molina's regulatory filing says that its New Mexico health plan had 225,000 Medicaid members as of Sept. 30, 2017. "The aggregate Medicaid premium revenue of the New Mexico plan, under the existing Centennial Care contract, amounted to $893 million for the nine months ended September 30, 2017, or 6.3% of our total premium revenue," Molina said in its Jan. 10 filing. "For fiscal year 2017 [which ended Dec. 31], the Company expects that the New Mexico health plan will not be profitable."

Subsequently, on Jan. 11, Molina said in another SEC filing that Terry Bayer, its chief operating officer, had notified the company "of her intent to retire from her position in the next several weeks." Molina said that, following Bayer's departure, "the corporate chief operating officer role will no longer be a part of the Company's organizational structure." The insurer said terms of her "retirement arrangement with the Company, including the effective date of her retirement, will be disclosed in an amendment…once an agreement has been reached between the parties."

Also on Jan. 11, in a news release, Molina said eliminating the COO role "is consistent with the Company's shift to a flatter organizational structure that will enable the chief executive to be more directly involved with business and health plan operations."

Ashraf Shehata, a principal in KPMG's health care life sciences advisory practice and in its Global Healthcare Center of Excellence, sees a larger trend afoot. Health plans now must focus on the profitability of their products as they are designed in each market and region, and, if products are not profitable, "you'll see more actions like re-evaluating whether to remain in particular contracts or states," he says. "The Medicaid players like Molina and others have been in this space for a long time…and the core business is generally well run, so the question is recalibrated around the new business, like new markets around the ACA."

"The way I look at it is, if your core business is intact and you're re-evaluating your new business, that's good business practice," Shehata tells AIS Health.

Medicaid Plans Must Adjust to Exchanges

Shehata explains that so-called Medicaid "pure play" plans are just now settling into a different pricing model as they gain claims experience on the ACA's large Medicaid expansion population — essentially a new book of business. The buying and utilization patterns of this population generally take three to five years to "settle in," allowing Molina and others to understand better how to manage members, he says.

Unlike Blue Cross and Blue Shield plans, which have a history of strong provider contracts and a solid commercial base, Molina and others must acquire claims and provider experience over time to know whether state contracts are viable, Shehata says. States, which are looking more at a collaborative contracting model and not just at low cost bids, will probably have to renegotiate Medicaid rates with carriers.

"With Molina, you have a CEO coming in from a commercial background…who understands pricing [and] contract discipline," he says, "so you'll see more and more of that kind of correction in the market."

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Molina Tightens, Flattens Structure

In his conference presentation, Zubretsky noted that Molina's peers are profitable and growing, and Molina's portfolio is similar to theirs in terms of products and geographies. He said Molina will "re-establish margins and reduce volatility" prior to participating in growth opportunities. And he cited $200 million in savings achieved through Molina's organizational restructuring that slashed the workforce by about 1,750 employees and reduced the number of management layers across the organization from 12 to eight.

Molina sees an opportunity to simplify networks that are too broad, too costly and not tightly controlled, the company's CEO said. This strategy will include terminating or renegotiating agreements with high-cost providers, using narrow networks in certain geographies and utilizing value-based contracting. He also cited the need for more effective utilization review and care management, along with an improved claims payment process.

Contact Shehata via William Borden at wborden@kpmg.com. ✧

by Judy Packer-Tursman

Investors See Optimism in UnitedHealth Earnings

Citing growth momentum entering 2018, UnitedHealth Group reported strong fourth-quarter and full-year 2017 earnings Jan. 16. Its solid performance came on the heels of its two multi-billion-dollar acquisition deals in December — one in the U.S. *(HPW 12/11/17, p. 3)* and one international (see box, p. 4) — to bolster its piece-by-piece vertical integration process. As the bellwether of publicly traded managed care companies' quarterly financial health, the nation's largest health insurer again beat Wall Street's expectations, and its earnings report subsequently buoyed other managed care companies' stock prices in mid-January.

Minnesota-based UnitedHealth posted quarterly operating earnings of $4.0 billion on revenues of $52.1 billion, the latter up from $47.5 billion in the fourth quarter of 2016. Full-year 2017 revenues of $201.2 billion grew 8.8%, or $16.3 billion, year-over-year. The company described its revenue growth as broad-based and balanced across businesses.

Company management began the recent earnings call by discussing the impact of corporate tax reform (see story, p. 1), which UnitedHealth CEO David Wichmann said is expected to improve the company's earnings and cash flow by $1.7 billion in 2018. He added that UnitedHealth continues to advocate strongly for multi-year defer-

Molina Healthcare, Inc. Enrollment, by State and Sector

State	Commercial	Medicare	SCHIP	Medicaid HMO	Dual Eligibles	Total
California	0	0	0	477,602	16,027	493,629
Florida	300,000	0	0	342,222	2,554	644,776
Illinois	100	0	0	158,113	4,644	162,857
Michigan	28,000	0	0	354,800	21,934	404,734
New Mexico	19,600	0	0	224,271	4,942	248,813
New York	24,000	0	31,575	30,439	0	86,014
Ohio	22,000	0	0	301,065	13,226	336,291
Puerto Rico	300,000	0	0	0	0	300,000
South Carolina	800	0	0	110,631	2,967	114,398
Texas	200,000	0	26,885	182,872	14,359	424,116
Utah	60,000	764	8,396	75,391	8,156	152,707
Washington	42,600	0	23,035	692,389	9,451	767,475
Wisconsin	60,000	0	0	62,810	949	123,759
National	1,057,100	764	89,891	3,012,605	99,209	4,259,569

METHODOLOGY/SOURCES: Commercial enrollment is as of first quarter 2017, as calculated for *AIS's Directory of Health Plans*. Public-sector enrollment is the most recent available as of December 2017, as calculated for MMM, Medicare and Medicaid Market Data, AIS's interactive database and newsfeed on the public-sector markets. To order either product, visit https://aishealthdata.com or email Sales@AISHealth.com.

ral and, ultimately, repeal of the health insurer fee (HIF).

While UnitedHealth's financial trends, including the strength of its Optum subsidiary's market, are similar to previous earnings reports, there is also broader "optimism in the industry on the commercial space, because of the potentially strong economy," explains Ashraf Shehata, a principal in KPMG's health care life sciences advisory practice and in its Global Healthcare Center of Excellence. "This could be an exciting year for health care overall…because we've seen prosperity in the health care economy is tied to prosperity in the overall economy," he says. Indeed, Shehata says that he sees "indications of a very good year" for managed care in 2018. "I think if we start to see mergers and acquisitions on the corporate side, that could be favorable to commercial business," he

UnitedHealth Invests to Expand Global Reach in South America

UnitedHealth Group is accelerating its global strategy with the $2.7 billion pending acquisition of Empresas Banmédica, a leading health care provider and insurer serving Chile, Colombia and Peru, the insurer said on a Jan. 16 earnings call to discuss the company's fourth-quarter and full-year 2017 earnings (see story, p. 3).

UnitedHealth made inroads into the Brazilian market in 2012 when it acquired Amil Participações S.A., the largest health care company in the country, providing health and dental benefits, hospital and clinical services, and advanced care management resources.

CEO David Wichmann said UnitedHealth is pursuing global growth for 2018 and "establishing a foundation for growth in South America for decades to come," according to UnitedHealth's prepared remarks for the call.

Steve Nelson, executive vice president at UnitedHealth and CEO of the UnitedHealthcare unit, said the company's businesses in Brazil "had strong positive 2017 performance and carried that momentum into 2018," according to a Seeking Alpha transcript of the call.

UnitedHealth will add Banmédica in the first quarter of this year, Nelson said. Banmédica provides health care services and health benefits to 2.1 million people and operates 13 hospitals with 1,900 beds and 143 medical centers in South America.

Molly Joseph, chief executive of international business, said UnitedHealth started in 2017 with ambitious expectations for margin improvement in its South American ventures, and has "fully executed on that plan." She added, "The improvements are really being driven by a combination of a very strong local management team that focused on innovation and quality and increasing, the localized application of our enterprise capabilities and competencies in clinical, in technology, in data and analytics."

UnitedHealth began 2018 in Brazil "with really strong momentum for continued margin expansion and quality advancement," Joseph said. The insurer chose to acquire Banmédica because it has "a really strong local management team with a proven track record in delivering very consistent high margin growth across both lines of their business and across all three of those countries."

Latin America has "attractive healthcare dynamics and characterized by a growing demand for affordable private healthcare," according to Joseph. UnitedHealth's Banmédica purchase will put the company in a leading position in four of the largest economies across that region, she said. "These countries have a population roughly equal to that of the U.S., but perhaps more growth opportunity in these emerging private healthcare markets, as well as a broader and longer term opportunity to serve the systems more holistically by also serving public markets."

Banmédica had 2,155,749 total beneficiaries on Sept. 30, 2017, according to Credit Suisse, an increase of 2.7% from the same date in 2016. Of the insurer's three countries, the steepest growth was seen in Peru, where enrollment rose 3.1% over the period to reach 857,995 total enrollees.

During the first three quarters of 2017, health insurance business revenues rose 16.4% from $1.084 billion to $1.263 billion, while health provider business revenues rose 13.7% from $807.2 million to $917.9 million, Credit Suisse said.

Read the Seeking Alpha transcript at http://bit.ly/2mS04UN.

by Diana Manos

tells AIS Health, citing KPMG's strong economic forecast on national employment in 2018.

"So, I think in the commercial space, we'll see a very favorable upside for a lot of these [managed care] plans…in the large group market and even a potential uptick in the mid-market," Shehata says.

He predicts that OptumRx "also will expand in a growing market economy."

But Shehata points out that not every company is placing itself in UnitedHealth's position. "When you have a commercial player not doing all that vertical integration, you may not see all of that upside," he says.

As for UnitedHealth's recent $2.7 billion tender offer for Empresas Banmédica, a major health care provider and insurer serving Chile, Colombia and Peru (see story, p. 4), Shehata notes that prosperity in the U.S. tends to drive prosperity internationally — which is favorable for organizations set up for global expansion.

He explains that global deals are chosen carefully, with companies seeking growth markets with similar characteristics to the U.S. health care market, including strong private-sector involvement and services available from the government.

UnitedHealth Touts Enrollment Growth

Last year the company's UnitedHealthcare subsidiary grew to serve 2 million more people across U.S. employer-sponsored, Medicare and Medicaid products. UnitedHealthcare covered 480,000 more consumers in the fourth quarter of 2017, helping to lift its revenues by 9.6% year-over-year to $41.6 billion.

UnitedHealthcare covered nearly 9 million seniors as of Dec. 31, and its total commercial enrollment, including employer groups and individual policyholders, was just shy of 30 million. The subsidiary's full year 2017 revenues of $52.1 billion fell $1 billion year-over-year, including nearly $200 million in the fourth quarter, due to the effects of the Affordable Care Act (ACA) individual market withdrawals and HIF deferral, company officials said.

They noted that these factors offset revenue increases from strong year-over-year growth of 465,000 enrollees in commercial risk-based group benefit offerings, including 130,000 people in the fourth quarter.

> **"In the commercial space, we'll see a very favorable upside for a lot of these [managed care] plans…in the large group market and even a potential uptick in the mid-market.**

Steve Nelson, UnitedHealthcare's CEO, said Medicaid enrollment grew by more than 800,000 in 2017, and the company expects continued strong growth in Medicare this year — "based on performance in the annual enrollment period, high customer retention, and continued success serving employer group retirees through our national 4-star quality plan."

Nelson cited "strong interest" from multi-site employers in the Nexus ACO product, which he described as the first national ACO product targeting large, self-funded customers. He also noted UnitedHealthcare's expansion into several new markets, including Colorado's Western Slope and upstate New York, and said the insurer plans to enter Minnesota and the Northern Plains in the second half of 2018.

In 2017, UnitedHealth's Optum subsidiary's revenues grew by $7.6 billion, or 9.1%, to $91.2 billion; in the fourth quarter, revenues climbed to $24.4 billion, up 10% year-over-year.

Oppenheimer analyst Michael Wiederhorn said in an investor note that UnitedHealth's results were solid across each business line, but the key topic of discussion during the earnings call was the impact of the GOP tax overhaul.

He noted that tax changes caused the company to "massively raise" its 2018 earnings per share (EPS) guidance range from $12.30 to $12.60, up from $10.55 to $10.85. "Furthermore, management is hopeful that this benefit will be sustainable in 2019 and beyond," he said.

Read UnitedHealth's third-quarter earnings report at https://tinyurl.com/ycdolf7b. Contact Shehata via William Borden at wborden@kpmg.com and Wiederhorn at michael.wiederhorn@opco.com. ✧

by Judy Packer-Tursman

Insurers May Share Tax Benefit

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Analysts are using UnitedHealth's earnings report to project the law's impact on other insurers. According to Citi analyst Ralph Giacobbe, UnitedHealth now expects its tax rate to drop to 24% from the previous 37% estimate. "If we were to use previous midpoint of adjusted EPS [earnings per share] guidance of $10.55-$10.85, share count of 984.5M, and 37% tax rate, pretax income off previous guide would be $16.721B," he said. "Adjusting just for the updated tax rate of 24% would imply EPS of $12.91 [versus] the guidance of $12.30-$12.60. This would imply roughly 80% pull [through] of the full tax benefit based on our estimates and again using previous [UnitedHealth] guidance as the

baseline. We acknowledge this may be an overly simplistic way to approach it and there may be other considerations around operating results (i.e. the difference may not all be reinvestment) that could provide offsets."

Oppenheimer analyst Michael Wiederhorn is not as optimistic. "Although we are significantly raising our FY2018/2019 estimates to $12.45/$13.38 from $10.82/$12.33 and our price target to $260 from $240 to reflect the benefits of tax reform, we remain conservative around our 2019 EPS growth estimate due to questions around the sustainability of the tax benefit through a full pricing cycle," he said in his Jan. 16 post-earnings call note on UnitedHealth.

'We See Tax Reform Benefiting MCOs'

Even before UnitedHealth announced its projections, Credit Suisse's recent report, titled *Year Ahead Outlook & Top 10 Questions Heading into 2018*, said managed care organizations (MCOs) will benefit from the law. "While there are several puts and takes to consider, the key provision included in the tax reform is that, starting in 2018, the corporate tax rate will fall to 21% from 35% currently," it said. "We see tax reform benefiting MCOs, though the companies might be slow to boost their guidance."

Credit Suisse said health care services and the commercial administrative services only (ASO) business should benefit most from the lower tax rate. "With MCOs providing only administrative services in the commercial ASO business and employer clients also receiving a similar benefit from the lower corporate tax rate, we expect MCOs to retain much of the tax rate reduction benefit in this segment," the report said. "Likewise, we see a similar dynamic playing out in healthcare services businesses. Additionally, ASO businesses and healthcare services segments are not exposed to the minimum MLR mandates."

Milliman, Inc. analysts Jason Karcher and Fritz Busch tell AIS Health that they don't have "a great sense" of whether insurers with a large percentage of administrative services revenue will benefit most from tax reform compared with entities like UnitedHealth's Optum unit that also own providers. "On one hand, we would expect that commercial ASO business will receive less benefit as a percentage of profit than other major medical lines since ASO business is not subject to the health insurer fee, and so only receives the benefit of the rate cut and not the additional benefit due to the reduced impact of non-deductibility of the health insurer fee," they tell AIS Health. "On the other hand, ASO services do not incur medical risk and generally have noticeably higher profit margins, so the impact could easily be more visible than in other lines. It's hard to say at this point."

> **"Tax reform benefits to for-profit Medicare Advantage MCOs will exist, but it is too soon to say how much of that will be invested in improved benefits.**

Another question is how much insurers will reinvest tax savings into richer benefits or lower premiums.

Credit Suisse's report predicted that by next year, some MCOs could pass through some of the tax benefit to beneficiaries in the form of lower premiums and better benefits. "This phenomenon is likely to play out over multiple years and will also vary by the competitive landscape in different geographies," it said.

Cowen & Co. analyst Christine Arnold said in an investor note that her firm believes UnitedHealth "could potentially use the tax benefit to increase investment spending in Medicare Advantage (MA) and Optum in order to accelerate '19 growth."

Benefit Investments May Not Move Needle

But "tax rates primarily impact profit, rather than revenue, and MCOs generally price to fairly low profit margins on MA business," Karcher and Busch tell AIS Health. In addition, "CMS monitors pre-tax profit margins rather than post-tax profit margins in the bid review process, and pre-tax margins are less affected by the lower tax rate. As such, tax reform benefits to for-profit MA MCOs will exist, but it is too soon to say how much of that will be invested in improved benefits or if the impact of such investments would be large enough to meaningfully impact perceptions of benefit richness relative to fee-for-service Medicare."

They say it is "certainly possible, and competitive pressures make it likely, that some MCOs will use tax savings to improve their product offerings, but profit margin in insured lines of business exists in part to offset the risk of higher-than-priced-for expenses."

"MCOs may weigh reducing profit margins due to tax savings against the correspondingly reduced capacity to absorb poor experience, which could limit how much of any tax benefit they are willing to pass directly on to beneficiaries," they say. "The impact is likely to vary by line of business as well. MCOs would have more incentive to invest tax reform savings in premium reductions or benefit levels when they have lower exposure to risk or where they face greater pressure to remain competitive in the market."

The Milliman analysts say they "don't have a sense" for which geographies and market segments would be more prone to pass-through. "Ultimately, the impact of tax reform is tied to margin, and relatively low profit margins for MCOs mean that the amount of savings is small, and may not be noticed by consumers as the impact is dwarfed by medical trend from year to year for most lines of business," they say.

Meanwhile, insurers are closely watching a provision, proposed at press time as part of a stopgap funding measure, that would provide for a one-year HIF delay for 2019.

"We do not see any of the [managed care organizations] significantly tweaking their 2018 expectations if the HIF is repealed or the moratorium is extended," Credit Suisse said. "However, depending on guidelines and instructions from the administration, legislative action with respect to the HIF could create the potential for upside to our 2018 EPS estimates."

"The Health Insurer Fee has generally been net neutral to EPS to the Commercial business (priced into premiums)," Credit Suisse said. "However, due to the HIF suspension in 2017 and intra-year contract renewals on some commercial contracts, MCOs are facing a timing related HIF headwind in 2018 (over the life of the contract, the impact is still net neutral). If the HIF is repealed for 2018, employers are likely to ask MCOs to reimburse them for the fee. Alternatively, employers might agree to leave the current contracts as is and instead push for some relief (lower premiums) next year."

Karcher and Busch say the HIF repeal will increase effective tax rates for many health insurers. "The increase is pronounced on 2018 premiums due to the moratorium on the HIF for 2017 premiums, and the differential impact in effective tax rates between the two years is driven as much by the end of the moratorium as the non-tax deductibility," they tell AIS Health. "This impact will be reduced but not eliminated due to the reduction in the statutory rate."

And Cowen's Arnold said, "The potential delay of the HIF in 2019 represents a potential source of upside to our 2019 EPS projection, likely offset by MLR floors and competitive dynamics (the HIF is unlikely to be largely incremental to a lower overall tax rate….A suspension of the HIF would be most beneficial to Medicare Advantage and commercial lines of business."

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by Diana Manos

News Briefs

✦ ***Nationwide, 12.2% of U.S. adults lacked health insurance in the fourth quarter of 2017, up from the record low of 10.9% a year earlier, according to a tracking poll by Gallup and Sharecare released Jan. 16.*** That 1.3 percentage point boost in the rate last year — representing roughly 3.2 million additional uninsured Americans — is the largest single-year increase measured since Gallup and Sharecare began to track the rate in 2008, the pollsters said. The increase affected all demographic groups except individuals aged 65 and older. "Implementing policies to erode health reform will erode our gains in coverage — whether it's declining to enforce the individual mandate, forcing plans to cover cost-sharing reductions on their own and raising premiums as a result, or destabilizing the business environment for health insurers," Meg Murray, CEO of the Association for Community Affiliated Plans, a national trade group of safety-net insurers, tells AIS Health. "It's a shame that we're pursuing policies that would re-open the most glaring gap in our health care system." Pollsters conducted 25,000-plus interviews from Oct. 1 to Dec. 31 as part of the Gallup-Sharecare Well-Being Index. Find the report at https://tinyurl.com/ya5qam6o.

✦ ***UnitedHealthcare introduced new digital health resources for 2018, including Apple Pay for consumers with health savings accounts (HSAs), the company said Jan. 12.*** At the Consumer Technology Association's recent CES 2018 technology convention in Las Vegas, the managed care giant also showcased its digital onboarding platform to help enroll certain employer groups and its personalized videos explaining member benefits. Members will be able to access the customized videos in early 2018 via desktop computers and mobile devices, UnitedHealthcare said. See https://tinyurl.com/ycaq4nhb.

✦ ***Blue Cross & Blue Shield of Rhode Island (BCBSRI) said Jan. 11 it certified a skilled nursing facility***

News Briefs *(continued)*

and a psychologist as BCBSRI LGBTQ Safe Zone providers. The Safe Zone certification identifies those health care practices "providing safe, affirming and inclusive care to the LGBTQ community," the plan said, noting the two providers join more than a dozen other practices statewide that have been designated as BCBSRI LGBTQ Safe Zone certified providers. Certification requirements include staff training that is specific to the care of LGBTQ individuals, protection for patients and staff from discrimination based on gender identity or expression, gender neutral bathrooms, inclusive forms and procedures, and a public commitment to connecting with and serving the LGBTQ community, the Blues plan said. Go to https://tinyurl.com/yaqfsd56.

✦ ***On Jan. 10, Regence BlueCross BlueShield of Utah and Aledade, Inc. announced a new partnership that will expand Aledade's Utah Accountable Care Organization (ACO)*** to provide services to 4,000 Regence plan members cared for by its practices. Aledade is a company that partners with primary care physicians, giving them data analytics and technology to build physician-led ACOs. Aledade said this is its first commercial contract in Utah. The firm has established ACOs covering 360,000-plus patients in 15 states: Arkansas, Delaware, Florida, Kansas, Louisiana, Maryland, Michigan, Mississippi, Missouri, New York, Pennsylvania, Tennessee, Utah, Virginia and West Virginia. It expanded to three new states — Ohio, Kentucky, and New Jersey — in 2018. See https://tinyurl.com/y9cquvqy.

✦ ***A new report from the HHS Office of Inspector General estimated that Medicaid may have lost approximately $1.3 billion in base and inflation-adjusted rebates from 2012 to 2016 because of 10 drugs that were "potentially misclassified" by manufacturers.*** OIG performed the evaluation by comparing classifications reported to CMS for the Medicaid Drug Rebate Program (MDRP) with files maintained by the Food and Drug Administration. While 95% of the approximately 30,000 drugs in the MDRP matched FDA data, 3% had classifications that "contraindicated" FDA data. The 10 drugs had the highest total reimbursement and were classified as noninnovator products in the Medicaid file, but as innovator products in FDA data, so drugmakers paid lower base noninnovator rebates and did not pay any inflation-adjusted rebates for these drugs, asserted OIG. The report made several recommendations to CMS on improving MDRP oversight, with which CMS concurred. View the report, OEI-03-17-00100, at http://oig.hhs.gov.

✦ ***Despite numerous issues with Iowa's transition from fee-for-service Medicaid to managed care, Gov. Kim Reynolds (R) in her first Condition of the State address said she has no plans to abandon the privately managed Medicaid system.*** "I still believe managed care is the right decision for Iowa, but it has become very clear that mistakes were made in how it was done," Reynolds said in her Jan. 9 address. She expressed confidence that the state's new Dept. of Human Services (DHS) Director Michael Randol and its Medicaid director will address those issues and continue to work with managed care organizations "to ensure that Iowans are getting the best possible outcomes." DHS under former Gov. Terry Branstad (R) in 2016 contracted with three insurers to manage the state's 580,000 Medicaid enrollees. In addition to problems reported by patients and providers, the contracted MCOs argued that there were fundamental flaws in the cost projections originally given by the state when determining their capitated payments, and in 2017 they spent months negotiating higher renewal rates. One insurer, AmeriHealth Caritas Iowa, has already dropped out of the program. Visit https://tinyurl.com/y9tgg9rt.

✦ ***Mutual of Omaha and Lumeris on Jan. 17 said they are teaming up to enter the Medicare Advantage program in select markets in 2019.*** Mutual of Omaha is a provider of financial, banking and insurance services, including Medicare supplemental insurance. Lumeris, a subsidiary of Essence Group Holdings Corp., operates Medicare Advantage plans such as those owned by sister company Essence Healthcare. Under the agreement, Mutual will own and carry the name of the new Medicare Advantage plans and provide brand, marketing and distribution expertise and capital. Lumeris will work as a strategic operating partner to help evaluate markets, establish networks, align with providers and administer plans, the companies said. Find more at http://bit.ly/2BdjyYc.