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## With Megamerger Saga Finally Over, What's Next in M&A?

The climate for payer mergers and acquisitions (M&A) has cooled substantially at a national level ever since the collapse of the proposed deals between Anthem, Inc. and Cigna Corp. and between Aetna Inc. and Humana Inc., and experts say transactions of that scale and type are unlikely to return. However, consolidation in the provider sector has increased since the start of the COVID-19 pandemic as such firms grapple with the rapid collapse of fee-for-service revenue — and experts say that cash-rich payers may start to expand their businesses into areas including care delivery, technology and retail.

Unlike Aetna and Humana, which amicably ended their deal after losing an antitrust challenge brought by the Dept. of Justice, the breakdown of Anthem's bid to acquire Cigna got ugly — resulting in a public spat and dueling lawsuits over Cigna's attempt to exit their agreement before exhausting the firms' option to appeal a federal ruling against the transaction.

That legal battle reached an end point on Aug. 31, as the Delaware Court of Chancery ruled that neither firms had to pay damages to the other over the failed deal, including a $1.8 billion breakup fee that had been part of the terms of the proposed transaction.

*continued on p. 5*

## As Transparency Rule Deadline Looms, CMS Doubles Down

The Trump administration — which has made price transparency one of its signature health care initiatives — recently finalized a rule that one expert warns is a signal that CMS is serious about requiring hospitals to reveal rates negotiated with health insurers.

Buried deep within the 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital final rule is a provision that would require hospitals to annually report the median rates they negotiate with Medicare Advantage plans, explains Mark Polston, who co-chairs the life sciences and health care industry group at the law firm King & Spalding.

The main purpose of the new requirement is to ensure that the Medicare fee-for-service program "adopts pricing strategies based on real world market forces," according to CMS. But Polston observes that the provision can also be viewed as an addendum to a separate transparency rule finalized in November, which the American Hospital Association unsuccessfully challenged in federal court *(HPW 7/6/20, p. 1)*.

That rule requires hospitals, beginning on Jan. 1, 2021, to disclose the rates they negotiate with payers for all items and services they offer — with the goal of helping consumers become savvier health care shoppers. A companion rule, requiring health insurers to publish rates they've negotiated with providers, has been

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proposed but not yet finalized. Both provider and payer trade groups have lobbied against the rules, arguing that they would do little to help consumers shop for care.

Hospitals have been scrambling to comply with the transparency regulation targeting their industry before the looming deadline, says Polston, who previously served as HHS's deputy associate general counsel for litigation. Some organizations — with their resources stretched thin amid the ongoing public health emergency — may have been prepared to accept the civil monetary penalty for noncompliance, he suggests. (CMS has said it can impose a penalty of no more than $300 per day for failing to adhere to the hospital transparency rule.)

"There was a 'hope springs eternal' [outlook] with, perhaps the rule will be struck down [in court], perhaps the agency will agree to delay it in light of the COVID pandemic," Polston says. "Neither one of those has come to pass thus far, so I think the third option of, 'Perhaps we'll just need to incur the penalty because we have to do all these other things like provide patient care in the pandemic,' I think now CMS is indicating that you may not have that option on the table either."

That's because the just-finalized IPPS rule requires hospitals to include median rates negotiated with MA plans on their Medicare hospital cost reports — and if they fail to do so, they risk not being reimbursed by Medicare at all, according to Polston. "It is possible for a hospital to comply with the cost-reporting requirement of providing the median negotiated rates with Medicare Advantage payers and not comply with the transparency rule, but the burden of doing the former is part of the burden of doing the latter, so they have an additional incentive to go ahead and get this all done," he explains.

Ultimately, "I think this could be interpreted as a shot across the bow to the hospital industry by the agency, basically saying something to the effect of, 'Don't think you can avoid complying with this,'" he concludes. In fact, since the final IPPS rule came out, King & Spalding has seen "an uptick in interest in legal services associated with compliance with the price transparency rule."

The move by CMS is also noteworthy for private insurers, as it suggests the administration is committed to following through with the transparency rule targeting that side of the industry, Polston says. "It means CMS is very serious about transparency in both contexts — it's serious about hospital price transparency and it's going to be serious about transparency from the payers as well."

### AHIP, Think Tanks Criticize Rule

Nevertheless, America's Health Insurance Plans (AHIP) is still making its case that the "forced disclosure of privately and competitively negotiated rates will undermine competition, push prices higher, and ultimately reduce affordability." In a Sept. 8 email to reporters, the trade group highlighted a recent analysis from George Mason University's Mercatus Center that concluded: "policymakers should be highly selective in issuing transparency mandates" in health care.

Past research had suggested that just a small fraction of consumers' health care dollars goes toward shoppable services such as outpatient services and radiology, the report noted. And even for such services, studies have shown that consumer uptake of private health insurers' price-shopping tools is very low. So not only might transparency have little effect on health care prices in many markets, it "could even push prices upward via tacit collusion" on the part of providers, the researchers added.

In a Sept. 10 post, the right-leaning group Americans for Tax Reform also helps make insurers' case, arguing that: "Negotiated rates are the proprietary financial information of the

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Senior Reporter, Peter Johnson; Managing Editor, Leslie Small; Executive Editor, Jill Brown Kettler

parties to the contract — healthcare providers and insurers, so this proposed rule is akin to using government power to force companies to release their intellectual property to competitors. The biggest beneficiary of disclosing negotiated rates would be third parties and consultants, who could stand to receive a windfall using the proprietary financial information of healthcare plans to game the system and make profit."

Rather than having the federal government mandate the rollout of internet-based price transparency tools that would "place onerous burdens on insurers," resources could be better spent by ensuring that more consumers use existing price-shopping tools, the post added.

Contact Polston at mpolston@kslaw.com. View the Mercatus report at https://bit.ly/2ZnyEJS and the Americans for Tax Reform post at https://bit.ly/3k9tpVN. ✧

*by Leslie Small*

## Georgia Revises Proposal to Decentralize ACA Marketplace

Georgia recently reaffirmed its proposal to make dramatic changes in its individual market, saying it plans to abandon the Affordable Care Act (ACA) marketplace in favor of a new state program despite the widespread disruptions in health care and health insurance brought by the coronavirus pandemic.

In its revised Section 1332 waiver request to CMS, Georgia said it wanted to push back the start date for part of its plan, meaning the proposal's two parts — the new state marketplace and a new reinsurance program — wouldn't take effect until 2022.

However, Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, tells AIS Health that it's not clear whether CMS will move to approve it, or will wait to consider it until after the election. He thinks a long wait is more likely.

"This is lined up the way the Trump administration, I think, would agree could be approved," Antos says. However, since it's September of an election year, the proposal becomes more of a potential liability for the administration.

"It raises a political question in my mind: 'Do you have CMS approve this thing?' And then get into another court battle with the headline being, 'Trump administration approves taking away good coverage for low-income people in Georgia,'" Antos says. "This doesn't have the feel of a sure approval."

### State Embraces New Guidelines

CMS issued controversial new guidelines last October for the ACA's Section 1332 waivers, with the goal of giving states much greater latitude than the Obama administration had permitted to experiment with their individual insurance markets *(HPW 11/11/19, p. 1)*. Georgia was the first state to take CMS up on that increased flexibility, with a two-pronged waiver request.

First, a reinsurance program would help insurers pay high-cost claims, with the goal of lowering premiums. Second, the "Georgia Access Model" would make more drastic changes to the individual market. These changes would include:

✦ ***Directing consumers to buy coverage through private broker or insurer websites, rather than via HealthCare.gov;***

✦ ***Putting the state in control of ACA subsidies***; and

✦ ***Allowing health plans that don't cover all 10 of the ACA's essential health benefits categories to be sold alongside qualified health plans (QHPs).***

"By enabling all plans licensed in the state to be offered side-by-side with QHPs and Catastrophic Plans, consumers will be able to view the full range of options available to them within the state and select the plan that best suits their needs and price point," the state said in its revised waiver request. "The goal is to increase healthcare coverage across the state, without eroding the QHP market to provide consumers expanded options."

### Coinsurance Amounts Would Vary

Under Georgia's revised waiver request, the reinsurance program would begin in 2022, instead of in 2021 as previously envisioned. The state's individual market would transition to the Georgia Access Model in 2022, as well.

According to Georgia's calculations, the reinsurance program would reduce premiums for the individual market statewide by 10.2% and as a result would increase enrollment by 0.4% in 2022.

The program would set different coinsurance percentages by region in the state: 15% for claims in the Atlanta metro area (deemed a low-cost region), 45% in a mid-cost region, and 80% in a more rural, high-cost region. In July 2019, Colorado became the first state to receive CMS approval for a reinsurance program that varies reimbursement amounts depending on where individuals live.

Georgia's reinsurance proposal sets a low bar for the cost of a claim it helps insurers pay for: $20,000, compared with an "attachment point" of around $40,000 or $50,000 in other states. Georgia also sets the cap at which it

stops subsidizing a claim at $500,000 — a higher point than in other states.

The Georgia Access Model would be more potentially disruptive than the reinsurance part of the waiver request.

According to the state, it would provide better access, improved customer service and expanded choice of affordable coverage options. The state estimates it would increase enrollment in the individual market by 25,000 members in 2022, and would decrease marketplace premiums by 3.5%. The state is asking the federal government to pass through any savings it realizes from the reinsurance program and from the Georgia Access model.

Tara Straw, senior policy analyst at the left-leaning Center on Budget and Policy Priorities, warned in a Sept. 1 report that the Georgia plan would reinstate the difficult-to-navigate pre-ACA system of selling individual coverage via private brokers and insurance companies, putting coverage for the 500,000 state residents who currently use the federal marketplace at risk. This could raise premiums and lead more Georgians "to enroll in substandard plans instead of comprehensive coverage," she said.

"Evidence from past, far simpler transitions between federal and state marketplaces suggests that tens of thousands of Georgians might lose coverage simply because of the disrup-

## Report: Employer-Sponsored Insurance Strained by Pandemic

A Sept. 9 report by the nonpartisan health care policy group United States of Care highlights the challenges posed to the government, private firms and health plan members by the country's reliance on employer-sponsored insurance — and points out that COVID-19 has made existing problems worse.

However, while the report identifies some public policy limitations of the employer-sponsored health system, it stops short of advocating for universal health coverage.

The report's author, United States of Care Director of Policy, Federal Affairs and Partnerships Andrew Schwab, tells AIS Health that reticence is an intentional choice. Schwab says the organization wants to initiate a depoliticized conversation about health care reform by focusing on stakeholder engagement.

"This report is intended to begin a conversation," Schwab says. "That conversation centers on the fragility of the job-connected health insurance system. U.S. of Care would like to begin a conversation with all stakeholders in this paradigm — with regular people, with employers large and small, with policymakers, and the larger business community that provides these health benefits for their employees…Our goal is to try to find consensus on the big health care problems facing our country. This report is aimed at raising the big questions that I think are lost in the larger health policy debate."

Schwab says that posture has helped United States of Care bring in stakeholders from both political parties. The organization's board includes prominent Democrats like former CMS Acting Administrator Andy Slavitt, former Kentucky Gov. Steve Beshear and former Deputy White House Chief of Staff Kristie Canegallo; the board's Republicans include former Vermont Gov. Jim Douglas and former Senate Majority Leader Bill Frist, M.D., of Tennessee.

In the report, Schwab notes that tax write-offs of employer insurance are the largest type of tax expenditure in the federal budget — and the total cost of that expenditure has grown rapaciously. The report adds that employers and payers have struggled to keep up with the rising cost of care and passed that cost onto plan members in the form of high deductibles and rising premiums. Schwab also emphasizes the potentially devastating costs of medical debt for working- and middle-class families.

In addition, the paper features case studies of employers that have managed health care costs through aggressive negotiations with providers, including Boeing, Wal-Mart and the state of Montana. And the report advocates for price transparency — Schwab tells AIS Health that the Trump administration's proposed transparency rules (see story, p. 1) are "a step in the right direction" — along with an increased emphasis on and investment in primary care and preventive medicine.

Read the report at https://bit.ly/32exPVs and contact Schwab via Chris Fleming at chris@redhorse-strategies.com.

*by Peter Johnson*

tion from the state's transition away from HealthCare.gov," Straw argued. "That's especially likely given that Georgia has allocated minimal funding for the transition — about one-third of the already low amount the state itself previously estimated would be needed."

#### Proposal May Violate Federal Law

The proposal also would "give insurers and brokers new opportunities to steer healthier consumers toward substandard plans that expose them to catastrophic costs if they get sick," Straw wrote. "The resulting adverse selection could make comprehensive coverage more expensive for those who need it, reducing their enrollment as well."

Straw concluded that "because it would harm consumers, Georgia's proposal is not approvable under federal law."

However, Antos says he doesn't expect CMS to rush to approve the waiver application, since it's a potential political hot potato. Georgia Gov. Brian Kemp (R), who is not running for re-election this year, wants "to prove to his voters that he did something about health care," Antos says. The Trump administration, meanwhile, doesn't want negative headlines, so "the White House and CMS can say, 'We're doing our due diligence on this. Obviously, we're taking it seriously, but we want to hear from everybody.'"

If President Donald Trump wins the election, then it still may take CMS well into next year before approving this waiver request proposal, Antos says, and if former Vice President Joe Biden wins, his administration can ask for more information.

In the meantime, while Antos says he doesn't know of any other states aside from Georgia seeking permission to drop the marketplace exchange structure, there are numerous states interested in pursuing reinsurance: "I don't know that any state has an active proposal right now, but this is not going to go away. We'll see it again next year."

Download Georgia's Section 1332 waiver request public notice at https://bit.ly/3hmga2A and view Straw's analysis at https://bit.ly/2GMdgra. Contact Antos at jantos@aei.org. ✧

*by Jane Anderson*

## Megamerger Saga Comes to Close

*continued from p. 1*

"We always viewed the outsized damages as unlikely, with the more relevant question around the $1.8B break-up fee," Citi analyst Ralph Giacobbe wrote in an Aug. 31 research note. "We view today's news more favorably for [Anthem], as it removes some overhang around a potential hefty break-up fee payment. We note that the remaining suit between [Anthem] and [Cigna PBM subsidiary Express Scripts] remains outstanding, without much visibility around timing at this point." Anthem filed suit against Express Scripts in 2016, alleging that the PBM had overcharged the payer by billions of dollars for prescription drugs.

Apart from the dramatics, the failed Anthem-Cigna deal was a catalyst for the slowing pace of health care consolidation at the national scale, according to antitrust lawyer and former Federal Trade Commission official David Balto.

The Obama administration's challenges of the two major insurer deals "created critical precedents to show why competition in health insurance was so important, not only in terms of services to consumers, but making sure that providers had access to competitive markets and were not coerced by the market power of dominant health insurers," Balto explains. He adds that a potential Biden administration would probably take the same view of payer consolidation, though a second Trump administration might open the door to more transactions.

#### Payer-PBM Deals Are New Standard

Ashraf Shehata, KPMG national sector leader for health care and life sciences, agrees with Balto's assertion that federal intervention in the Anthem-Cigna and Aetna-Humana deals cooled enthusiasm for blockbuster transactions in the payer space. He tells AIS Health that Cigna's acquisition of Express Scripts, a transaction that the firm pursued partly because of the failed Anthem merger, set a precedent of its own.

"I would say what that has spawned instead of the health plan integration, it's spawned…the PBM integration. Rather than health plan to health plan, it was health plan plus PBM. And we saw that across the board with all the commercial entities," he says.

Shehata says he sees three likely types of payer transactions and reorganizations going forward. The first is the PBM-payer integration along the lines of Cigna and Express Scripts. Second, Shehata says that horizontal coordination between regional payers like Blue Cross Blue Shield plans, if not outright mergers, is likely to accelerate. Finally, he's tracking the emerging model of "health plan plus retail plus PBM," following the example of CVS Health Corp., which now owns Aetna.

Shehata also observes that payers are increasingly interested in technology acquisitions, even of smaller firms: "I would say the future is going to be how technology fits into this, and it may not need to be a big merger."

Even as payer consolidation has slowed, transactions in the provider space are likely to speed up. According to a Sept. 2 report by the Kaiser Family Foundation (KFF), a major factor is that the fee-for-service revenue from elective procedures that providers rely on dried up during the height of the pandemic as patients sheltered in place.

While federal assistance to providers has made up some of that difference, the report notes that "some hospitals and physician practices may find it difficult to operate independently, which could increase the rate of consolidation among health care providers. Lower margins among some providers may create new opportunities for large chains to acquire smaller providers….[F]inancial assistance to providers may not be sufficient to prevent an increase in the pace of consolidation."

Michael Abrams, co-founder and managing partner of consultancy Numerof & Associates, says that large regional hospital systems with healthy balance sheets — or, at least, those that had high margins before the pandemic — are likely to speed up their vertical acquisition of independent hospitals or horizontal consolidation with local peers. He observes that metropolitan hospital systems that were thriving before the pandemic have that capacity.

"They're getting federal money, and they have access to credit that smaller organizations don't have. They can float bonds with the benefit of their state and local municipalities backing them up," Abrams says. "They have lots and lots of advantages in that regard. Most of them have many different kinds of resources they can call on."

Abrams says he does not expect private equity to make a major play in the metropolitan hospital space, but some investors might consider struggling rural and small-town hospitals.

### Consolidation Could Push Up Prices

Both the KFF report and Abrams point out that this wave of consolidation will compound or accelerate the rising cost of health care.

"A wide body of research has shown that provider consolidation leads to higher health care prices for private insurance; this is true for both horizontal and vertical consolidation," the KFF report notes.

Abrams says this continual rise in prices will eventually drain the generous margins that payers have enjoyed over the course of the pandemic, and suggests that forward-thinking payers might do well to use that capital creatively to intervene directly in the provider space while they have the opportunity. "That's where I expect the M&A activity to be…more verticals, selectively, in region[al markets] between payers and health care providers. The advantage of that is it does help to bring some alignment to the incentives involved," Abrams explains. "It offers the payer the prospect of more control over cost and quality."

Both Shehata and Abrams agree that the pandemic's financial devastation and payers' balance sheets allow for more creative transactions than the last decade's proposed megamergers. Shehata emphasizes that technology platforms could be a differentiator when the dust settles.

"The thing about the pandemic is it's accelerating the modernization capabilities. So to me, it's less about

**MCO Stock Performance, August 2020**

| | Closing Stock Price on 8/31/2020 | August Gain (Loss) | Year-to-Date Gain (Loss) | Consensus 2020 EPS* |
|---|---|---|---|---|
| **COMMERCIAL** | | | | |
| Cigna Corp. | $177.37 | 2.7% | (13.5%) | $18.54 |
| UnitedHealth Group | $312.55 | 3.2% | 6.9% | $16.49 |
| Anthem, Inc. | $281.52 | 2.8% | (6.4%) | $22.46 |
| **Commercial Mean** | | **2.9%** | **(4.3%)** | |
| **MEDICARE** | | | | |
| Humana Inc. | $415.17 | 5.8% | 14.3% | $18.86 |
| **Medicare Mean** | | **5.8%** | **14.3%** | |
| **MEDICAID** | | | | |
| Centene Corp. | $61.32 | (-6.0%) | (0.9%) | $4.83 |
| Molina Healthcare, Inc. | $184.97 | 0.1% | 38.7% | $11.85 |
| **Medicaid Mean** | | **(2.9%)** | **18.9%** | |
| **Industry Mean** | | **1.4%** | **6.5%** | |

*Estimates are based on analysts' consensus estimates for full-year 2020.

SOURCE: Bank of America Merrill Lynch.

mergers — it's [more] about how fast can I get the modern tools that are going to kind of lead us to the better consumer experience," Shehata says.

"Now, ironically, that could spur a new wave of mergers and acquisitions. Like if you need a new portal, who's going to emerge as the new portal capability? If you need a new capability that allows you online scheduling with your provider network on the health plan side, who's going to offer that?"

"A lot of payers are cash-rich and looking for growth and looking at this as an opportunity," Abrams says. "The worst financial disasters sometimes are great opportunities for the right entrepreneur. If you have the cash and you have the right idea — maybe something good will come out of it."

Read the decision regarding the Anthem-Cigna case at https://bit.ly/3hiUQuz and the KFF report at https://bit.ly/2RgopCB. Contact Abrams via spokesperson Matthew Dick at matthew.dick@pinkston.co, Balto at david.balto@dcantitrustlaw.com and Shehata via Bill Borden at wborden@kpmg.com. ✧

*by Peter Johnson*

## News Briefs

✦ ***Cigna Corp. will offer Affordable Care Act exchange plans in 80 new counties in 2021, reaching 27% more customers in that market, the company said on Sept. 9.*** The insurer's ACA marketplace footprint will comprise 10 states: Arizona, Colorado, Florida, Illinois, Kansas, Missouri, North Carolina, Tennessee, Utah and Virginia. Cigna said its 2021 marketplace plans will feature $0 virtual care "that now includes behavioral health providers," a new plan that offers no-cost diabetes equipment and supplies, and "coverage for holistic services including acupuncture in select counties." Read more at https://bit.ly/35nrkBx.

✦ ***Humana Inc. on Sept. 10 rolled out two value-based programs that will be available for select Medicare Advantage plans.*** The Coronary Artery Bypass Grafting Episode-Based Model is a bundled payment initiative designed to improve quality, outcomes and cost across an entire episode of care for patients undergoing heart bypass surgery. And the Total Shoulder Specialist Rewards Program offers clinicians additional payment for achieving better health outcomes and for lowering costs by incentivizing independent surgeons to perform shoulder replacement procedures at ambulatory surgical centers when it's clinically appropriate. Humana already has two other orthopedic value-based programs: one for total hip and knee replacement surgeries and one for spinal fusion procedures. See https://bwnews.pr/3m8Rkqd.

✦ ***Anthem, Inc. named Jeffrey Alter executive vice president of Anthem Health Solutions and IngenioRx, the payer's PBM subsidiary.*** Alter previously worked as president of Arcturus One Consulting, a consultancy for private equity firms. Before that role, Alter was CEO of UnitedHealthcare's commercial insurance group. Visit https://bit.ly/3igz2B4.

✦ ***In part because of the stress and pressure of their role, caregivers have 26% poorer health than the regular population, according to a new report from the Blue Cross Blue Shield Association.*** The report, which was based on claims data from Blues plan members in the Philadelphia region, found that rates of hypertension and obesity among people with a spouse or child in need of caregiving were 60% and 41% higher than non-caregivers, respectively. "Being a caregiver is often a difficult job, and the stresses and responsibilities can seriously affect our physical and mental health. This becomes even more challenging during a pandemic," said Richard Snyder, M.D., chief medical officer and executive president at Independence Blue Cross, said in a statement about the findings. Read more at https://bit.ly/2FmDEXR.

✦ ***Among U.S. adults, 62% said they would be likely to seek a COVID-19 test if they thought they'd been exposed to the coronavirus but didn't have any symptoms, according to a recent Morning Consult poll.*** And 80% of survey respondents said they'd be likely to get a test if they did exhibit symptoms. Meanwhile, a Sept. 9 article from The New York Times — for which the publication reviewed dozens of reader-submitted medical bills — found that "nationwide, people have been hit with unexpected fees and denied claims related to coronavirus tests," despite federal legislation mandating that private insurers provide the tests to their members for free. Visit https://bit.ly/2ZnZDVG and https://nyti.ms/3imjKL6.

## 2021 ACA Rate Changes and COVID-19 Impact: At a Glance

*by Jinghong Chen*

Early individual market premium rate filings for 2021 show insurers requesting moderate premium changes across the nation, though many have not yet included a rate impact from the COVID-19 pandemic. Charts below detail the proposed or approved year-over-year rate changes in 13 states in alphabetical order. Graphics detailing rate filings in the remaining states will appear in future issues of HPW.

### Arkansas

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| Celtic Insurance Company | 13.3% | X |
| QCA Health Plan, Inc. | 11.3% | X |
| QualChoice Life & Health Insurance Company, Inc. | 11.2% | X |
| USAble Mutual Insurance Company | 2.9% | X |
| HMO Partners, Inc. | New Entrant | X |
| Oscar Insurance Company | New Entrant | X |

**Total Enrollment in 2020: 64,360**

### California

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| Anthem Blue Cross | 6% | X |
| Blue Shield of California | -2.4% | X |
| Chinese Community Health Plan | -1.3% | X |
| Health Net | 3.4% | X |
| Kaiser Permanente | 1.0% | X |
| LA Care Health Plan | -4.6% | X |
| Molina Healthcare | -3.8% | X |
| Oscar Health Plan of California | 7.6% | X |
| Sharp Health Plan | -0.5% | X |
| Valley Health Plan | 9.0% | X |
| Western Health Advantage | -2.6% | X |

**Total Enrollment in 2020: 1,538,819**

NOTE: As of July 25, **231,040** people enrolled in marketplace coverage during COVID-related SEPs and other SEPs.

### Colorado

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| Anthem (HMO Colorado) | 6.4% | X |
| Bright Health | 1.8% | X |
| Cigna Health & Life Insurance Co. | 8.3% | 1.0% |
| Denver Health Medical Plan | -4.4% | 6.4% |
| Friday Health Plans | -12.2% | X |
| Kaiser Foundation Health Plan of CO | -1.5% | X |
| Oscar Insurance Co. | -3.8% | 0.2% |
| Rocky Mountain HMO | 5.3% | X |

**Total Enrollment in 2020: 166,852**

NOTE: Between March 20 and April 30, **14,263** people enrolled in marketplace coverage through the COVID-19 SEP and the loss of minimum essential coverage (MEC) SEP.

### Connecticut

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| Anthem Health Plans | 9.9% | 2.3% |
| CTCare Benefits Inc. | 5.5% | 1.6% |

**Total Enrollment in 2020: 107,833**

NOTE: Between March 19 and April 17, more than **37,000** Connecticut residents enrolled during COVID-19 crisis.

### Delaware

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| Highmark BCBS of DE | -0.5% | X |

**Total Enrollment in 2020: 23,961**

### DC

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| CareFirst HMO (Blue Choice) | 14.7% | X |
| CareFirst PPO | -0.6% | X |
| Kaiser Foundation Health Plan | -2.0% | X |

**Total Enrollment in 2020: 17,538**

NOTE: As of April 19, **2,072** people enrolled in marketplace coverage through the COVID-19 SEP and the loss-of-MEC SEP.

### Hawaii

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| Hawaii Medical Service Association | -2.0% | X |
| Kaiser Foundation Health Plan | -1.1% | X |

**Total Enrollment in 2020: 20,073**

### Idaho

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| Blue Cross of Idaho Health Service | -4.0% | X |
| Mountain Health CO-OP | 2.0% | X |
| PacificSource Health Plans | -7.0% | X |
| Regence BlueShield of Idaho | -1.0% | X |
| SelectHealth | 5.0% | X |

**Total Enrollment in 2020: 78,431**

### Kentucky

| Insurer | Approved Rate Change | COVID Impact |
|---|---|---|
| Anthem Health Plans of Kentucky, Inc. | 5.7% | 4.5% |
| CareSource Kentucky Co. | 4.0% | X |

**Total Enrollment in 2020: 83,139**

### Maine

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| Anthem Healthplans of Maine | -12.5% | 2.5% |
| Harvard Pilgrim Health Care | -13.0% | X |
| Maine Community Health Options | -13.7% | -1.2% |

**Total Enrollment in 2020: 62,031**

### Maryland

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| CareFirst CFMI | -12.0% | X |
| CareFirst (Blue Choice) | -1.1% | X |
| CareFirst GHMS | -12.0% | X |
| Kaiser Foundation Health Plan | -11.0% | X |
| Optimum Choice | New Entrant | X |

**Total Enrollment in 2020: 158,934**

NOTE: Between March 16 and July 15, more than **54,000** people enrolled in marketplace coverage during COVID-related SEPs. On August 7, the state announced the reopening of COVID-related SEP until December 15.

### Michigan

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| Blue Care Network of Michigan | 2.5% | X |
| BCBS of Michigan | 1.7% | X |
| Oscar Insurance Company | 6.0% | 4.0% |
| McLaren Health Plan Community | -2.0% | X |
| Meridian Health Plan of Michigan | 2.7% | 8.6% |
| Molina Healthcare of Michigan | 0.4% | X |
| Physicians Health Plan | 3.1% | 3.0% |
| Priority Health Insurance | -0.1% | X |
| Total Health Care USA | -0.4% | X |

**Total Enrollment in 2020: 262,919**

### Minnesota

| Insurer | Proposed Rate Change | COVID Impact |
|---|---|---|
| Blue Plus (HMO MN) | 7.1% | X |
| Group Health Plan Inc | 4.2% | X |
| Medica Insurance Company | 7.1% | X |
| UCare MN | -1.4% | X |
| PreferredOne Community Health Plan | New Entrant | X |
| Quartz Health Plan MN | New Entrant | X |

**Total Enrollment in 2020: 110,042**

NOTE: Between March 23 and April 21, **6,023** people enrolled in marketplace coverage through the COVID-19 SEP and **3,459** people enrolled through other SEPs.

NOTE: "X" under "COVID Impact" stands for "not mentioned," "redacted" or "not factored in."

SOURCES: CMS. Visit https://go.cms.gov/2QNNYKZ. "An Early Look at 2021 Premium Changes on ACA Exchanges and the Impact of COVID-19 on Rates," Kaiser Family Foundation. Visit https://bit.ly/2GiX0NX. State marketplace news releases.