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Armed With More Data, Analysts Alter COVID-19 Cost Forecasts

As the COVID-19 pandemic ramped up in the U.S. in early spring, actuaries and analysts raced to develop estimates of how the disease associated with this new coronavirus would impact health care costs. Now, with cases declining in some areas and rising in others — and crucially, much more data available — some of those estimates are changing.

One analysis that recently received an update is a Wakely Consulting Group report, which was prepared at the request of America's Health Insurance Plans and originally released March 30. That report estimated that the direct impact of COVID-19 treatment costs — for commercial, Medicare Advantage and Medicaid managed care insurers — would be in the range of $56 billion to $556 billion for 2020 and 2021 combined. Now, Wakely is estimating a range of $30 billion to $547 billion for those two years, with the former figure representing a low infection rate of 10% and the latter representing a high infection rate of 60%.

Michael Cohen, Ph.D., an author of the analysis and senior consultant for policy analytics at Wakely, tells AIS Health that the two reports differ in three key ways:

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So Far, Only New York Sees Double-Digit Rate Requests

Six states in the Northeast and Pacific Northwest have now released initial premium rate requests from individual and small-group health plans. And although both regions have been hit hard by the COVID-19 pandemic, only New York insurers asked for rate increases dramatically above industry expectations from the beginning of the year.

The nation's worst outbreak took place in New York City and surrounding region, with New York City alone recording more than 380,000 recorded infections and 24,404 attributed deaths as of June 10. Because of that maelstrom, insurers operating in New York state requested a weighted average increase of 11.7% for individual market premiums and 11.4% for small-group premiums.

Payers on the other five exchanges — the District of Columbia, Maryland, Oregon, Vermont and Washington — mostly requested rate increases below 10%. Maryland and Washington's insurers collectively asked for aggregate negative rate changes.

The rate filings are the first broad indication of the health insurance industry's perception of its own financial health going forward. Analysts, consultants and insurance company executives generally agree that, despite the pandemic, payers are on strong financial footing at present *(HPW 6/8/20, p. 1)*. The steep decline in care utilization caused by social distancing means insurers are paying out far fewer claims than normal, giving them usually large cash reserves. Some payers have also taken advantage of low interest rates to consolidate debt or increase liquidity.

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According to Credit Suisse analyst A.J. Rice, the rate filings and their attached documentation demonstrate payers' confidence that their present healthy financial position will insulate them from a resurgence of the virus in the fall — though their impressions of the risk scenario differ, with some organizations taking a more cautious approach.

"Based on our review of publicly available rate filings in D.C. and WA, it is apparent that MCOs are either not including a rate adjustment in their 2021 filings for COVID-19 (with the caveat that this is an evolving situation and could be revisited) or applying a low-to high single digit cost assumption for COVID-19 in their filings (depending on state)," Rice wrote in a June 10 note.

Still, while New York is an outlier, it could serve as an example for the kind of adjustments plans will make if more states experience a severe outbreak. Rice's comments on Centene Corp.'s New York rate filing is indicative of some of the expansive impacts of rapid regional spread of the virus.

Rice wrote that Centene's filing cited the "direct cost of acute COVID-19 treatment, testing, and vaccination, pent-up demand, enrollment shifts from employer sponsored coverage…lasting population health changes including healthcare complications following recovery from severe cases of COVID-19, and worsened health outcomes due to deferred or avoided preventive care and maintenance care for chronic conditions during social distancing lockdown periods."

Notably, the payers that asked for the highest increases in New York's individual market were mostly national carriers. The largest request came from Oscar Insurance Corp. at 19.1%. Fidelis, the New York division of Centene, requested an 18.8% increase. UnitedHealthcare of New York Inc., a division of UnitedHealth Group, requested the third-highest increase at 13.8%.

By contrast, regional insurers with limited business in the New York City area requested negative rate increases in the individual market. HealthNow New York, Inc. and Independent Health Benefits Corp., payers based in Buffalo serving upstate memberships, requested 1.9% and 3.7% decreases respectively.

Kathy Hempstead, a senior policy adviser at the Robert Wood Johnson Foundation, observes that the need for emergent care related to COVID-19 has so far been less than was initially feared. In a June 10 issue brief about how the COVID-19 pandemic may influence 2021 health insurance premium rates, American Academy of Actuaries senior health fellow Cori Uccello made a similar observation.

"To date, it appears likely that the impact of deferred and avoided care has outweighed cost increases in the commercial market related to direct COVID-19 diagnosis and treatment costs, including cost-sharing waivers in most areas," Uccello wrote.

Testing Costs Loom Large

Hempstead argues that testing represents the largest risk to payers on a national scale going forward.

"One of the things that no one knows how to price is what's going to be the impact of a lot of long-term, repeated testing," Hempstead tells AIS Health. "Who's going to actually pay for that?"

The nature of the need for testing has begun to change. Hempstead observes that initially, testing was thought of as a diagnostic measure to locate infected patients in need of acute care. Going forward, employers may demand regular testing for employees to return to onsite work, which will create a high ongoing demand for testing.

"If you think about a long-term scenario where people need to be repeatedly tested just to return to normal activities and they're not necessarily symptomatic, then I think that creates a very different kind of expenditure

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

profile. It's not clear how much that could cost and how it might ultimately be financed," Hempstead says. Given that potentially massive cost going forward, and the obvious public benefit, Hempstead says she wouldn't be surprised if widespread testing was publicly funded.

In any case, Hempstead says that the evolving nature of the pandemic means rate filings are likely to change.

"I think there will be some revisions. I think everybody's going to file once and then file again," she says.

Read the Academy of Actuaries brief at https://bit.ly/2AuTyNR. Contact Hempstead at khempstead@rwjf.org. ✧

by Peter Johnson

Indiana Subsidy for Private Insurance 'Doesn't Go Very Far'

Indiana on May 29 received CMS approval for a Section 1115 waiver demo that allows residents moving from Medicaid expansion to commercial plans to spend up to $1,000 of funds stored in quasi-HSA accounts on insurance premiums or cost-sharing expenses. State officials describe the plan as a way to help former Medicaid members whose income has grown stay insured. However, experts say that the program, which is related to Indiana's push for Medicaid work requirements, isn't likely to improve access to coverage for those eligible.

The program allows former members of the Medicaid expansion program, the Healthy Indiana Plan (HIP), who have joined an employer-backed or individual exchange commercial plan to spend up to $1,000 in Medicaid funds on expenses including premiums, copays, prescription drugs and other cost sharing for the 12 months after their transition from Medicaid.

The $1,000 comes from the individual's POWER account, an HSA-style cost-sharing instrument that is replenished every year with up to $2,500 in Medicaid funds, with scaled contributions from HIP members depending on their income and contribution to the POWER account over a 12-month period. Indiana does not require the outgoing $1,000 to be spent on plans that meet minimum essential coverage standards, meaning the funds can be used to pay for short-term health plans. The portable $1,000 program is limited to the first 9,000 Medicaid members who opt into the benefit.

Down Economy May Limit Impact

Kathy Hempstead, a senior policy adviser at the Robert Wood Johnson Foundation, says she's skeptical that many people will use the program given the depressed state of the economy. She points out that the low-income people the program aims to benefit, such as service industry workers, are likely unemployed, and employers in their industries are unlikely to offer health benefits in the first place.

"It'll be interesting to see in this economy — in the here and now — how often is that going to come up? Obviously there's a super high unemployment rate, so you can kind of imagine that there's not going to be as many opportunities to check that out as there might have been when the unemployment rate was low," Hempstead tells AIS Health. "I don't think this is going to be a time when we're going to see more employers offering coverage. We're probably going to see fewer employers offering coverage."

For their part, in a June 3 press release, Indiana officials positioned the program as an element of the state's pandemic recovery plan, though the state applied for the waiver in 2019.

"The HIP Workforce Bridge program will be especially important during our state's recovery from the COVID pandemic and as Indiana's economy evolves," said Gov. Eric Holcomb, a Republican, in the press release. "As Hoosiers skill up, go back to school and go back to work, HIP Workforce Bridge will make that transition from HIP to marketplace insurance or employer-based coverage easier to navigate and afford."

States Can't Kick People Off Medicaid

Judy Solomon, a senior fellow at the Center for Budget and Policy Priorities, a left-leaning think tank, tells AIS Health that the emergency changes to Medicaid made for the COVID-19 pandemic makes Indiana's program somewhat redundant. States can't disenroll any Medicaid members for the duration of the public health emergency.

"The thing that I think is very strange about [the program] is it was approved for essentially seven months, which is the term of the underlying waiver," Solomon explains. "Right now, we're talking about a seven-month period during which people are not losing Medicaid, because we have a maintenance of effort requirement tied to increased federal funds for Medicaid that was part of the [Families First Coronavirus Response Act]….The premise that there are people coming off Medicaid during [the public health emergency] period — it's unlikely that [the emergency] is going to end by the end of the year."

In the state's press release, Indiana Family and Social Services Administration Secretary Jennifer Sullivan, M.D., didn't mention the federal emergency measures despite voicing concern that residents would face a coverage gap due to the crisis.

"Now more than ever, it is critical that we provide stability and peace of mind for Hoosiers, especially when it comes to matters of their health. We anticipate that more Hoosiers may need HIP health coverage during the emergency, and we want to make sure that everyone can safely transition as they are able. This is one of our first efforts to mitigate the eligibility cliff effect in Indiana, which is a priority across all of our programs now more than ever," Sullivan said.

Solomon says the program was initially meant to assist members affected by Indiana's Medicaid work requirement policy, by ensuring that those who earned too much to qualify for Medicaid but didn't earn enough to afford commercial plans would have some sort of stopgap. For the moment, that point is moot, since the work requirement policy has been suspended by the state government due to successful court challenges.

Other States Took Different Route

She adds that the program is different from other states' subsidies of commercial insurance for low-income residents. "From the perspective of Medicaid and how you use Medicaid dollars, it's not something that normally would be allowed. We've seen some states do some things like subsidize [private coverage] using waiver savings — Massachusetts and Vermont, for example — because before the Affordable Care Act they had been providing coverage to people at higher incomes, [so] they've continued to provide some subsidies in addition to what's available from the premium subsidies. That's helpful," Solomon says, explaining that the subsidies in those states are indefinite and scaled to income. "My concern about this is…this is sort of a one-time thing, and a thousand dollars doesn't go very far."

Hempstead also emphasized that point, observing that for someone at the low end of the commercial insurance market, $1,000 won't cover a worst-case scenario.

"I think a thousand dollars is not necessarily going to cover that person's cost sharing. Plus, it's a gamble — what if you're halfway through your plan and you realize you need to take a specialty-tier drug? Then all of a sudden you have a whole lot of out-of-pocket costs, and your thousand dollars doesn't come close to paying," she says. "It doesn't generally seem like it's a great deal, and I think the timing's off."

Read the Indiana release at https://bit.ly/37opTBK and the CMS approval letter at https://bit.ly/2XUbB9e. Contact Hempstead at khempstead@rwjf.org and solomon@cbpp.org. ✧

by Peter Johnson

COVID-19 Posed Challenges for 2021 Medicare Advantage Bids

There are always uncertainties when it comes to projecting plan costs for the year ahead, but Medicare Advantage and Part D organizations in the most recent bid cycle faced a particularly unpredictable set of circumstances created by the COVID-19 pandemic.

"I think we will all look back on the 2021 bids as the year of COVID-19," says Brad Piper, a principal and consulting actuary in Milliman's Milwaukee office, who recently helped MA clients prepare bids that were due June 1. "That was a big challenge for the organizations that are in the Medicare Advantage program — [perhaps more so] than on the Part D side — and it impacted both sides of the coin: costs and revenue."

From a cost perspective, unknowns include whether there will be pent-up demand for health care services next year given that many beneficiaries have deferred doctors' appointments and elective/non-urgent procedures to avoid the risk of coronavirus exposure.

> **"It's a challenge to project medical costs in a 'normal' year, and then you throw this on top of it and it becomes a [greater] challenge.**

"There are arguments to be made that health care costs could be lower next year if we're still in the midst of a pandemic, or even if the pandemic is slowing down but there's just some hesitancy among seniors to go back to the doctor or go to the hospital," observes Piper. "So it's hard to know exactly what direction 2021 is going to take as far as medical costs. It's a challenge to project medical costs in a 'normal' year, and then you throw this on top of it and it becomes a [greater] challenge."

Adding to that is the question of whether there will be a second wave of COVID-19 "and how much COVID-related utilization and services will occur that plans will have to bear," points out Matt Kazan, principal with Avalere Health and a former senior health policy adviser for the Senate Committee on Finance. A third concern is "how much of the cost of all the things Congress is saying plans will need to cover in terms of testing, vaccines…will impact plans," Kazan told AIS Health before the bid deadline.

Preparing bids on the revenue side was equally challenging, since it's the 2020 diagnosis information that drives reimbursement for next year, adds Piper. "As we're trying to forecast what 2021

revenue will look like, we've got to look at what's going on in today's environment and understand if we're not seeing our members as often, because of stay-at-home orders or because of a general hesitancy to not go get medical care or just the fact that many noncritical services were not offered or were canceled, that potentially creates a challenge for health plans to capture all that diagnosis information in 2020, which in turn drives their 2021 revenue amount."

Piper says Milliman worked closely with clients, who understand their markets best and may be impacted differently depending on where they are located. "There are some areas of the country that are getting hit much harder than others [by the pandemic], and so we would have a dialogue with each of the organizations that we assist and talk through all the different items that could be impacted on both the cost side and the revenue side," he says.

Those items include coverage of testing and a vaccine when it becomes available. A provision in the Heroes Act, which is up for consideration in the Senate, would require MA plans to provide COVID-19 treatment (including prescription drugs) and testing without any cost-sharing obligations. And as per the CARES Act, if a vaccine becomes available for COVID-19, MA plans and traditional fee-for-service Medicare must cover it with no cost sharing.

by Lauren Flynn Kelly

This story originally appeared in AIS Health's RADAR on Medicare Advantage. *Visit https://aishealth.com/product/medicare-advantage.*

MCO Stock Performance, May 2020

	Closing Stock Price on 5/29/2020	May Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2020 EPS*
COMMERCIAL				
Cigna Corp.	$197.32	2.1%	(3.7%)	$18.28
UnitedHealth Group	$304.85	11.7%	4.2%	$16.16
Anthem, Inc.	$294.11	11.0%	(2.2%)	$22.15
Commercial Mean		**8.3%**	**(0.6%)**	
MEDICARE				
Humana Inc.	$410.65	22.2%	13.1%	$18.59
Medicare Mean		**22.2%**	**13.1%**	
MEDICAID				
Centene Corp.	$66.25	5.8%	7.1%	$4.72
Molina Healthcare, Inc.	$185.82	50.2%	39.3%	$11.99
Medicaid Mean		**28.0%**	**23.2%**	
Industry Mean		**17.2%**	**9.6%**	

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

SOURCE: Bank of America Merrill Lynch.

Analysts Revise Cost Estimates

continued from p. 1

✦ ***The cost of COVID-19-associated hospitalizations*** "were generally higher" than the initial report estimated;

✦ ***Hospitalization rates*** were lower than Wakely originally estimated; and

✦ ***The new analysis factors in the financial impact of health care services deferred due to the pandemic,*** "which pushed overall costs facing insurers lower but did not impact the direct COVID treatment costs."

Asked why COVID-19-associated hospitalizations were more expensive than the firm originally estimated, Cohen explains that "as in many things with COVID, more time gave us new insights and new data we could use."

"The initial analysis was conducted before there was sufficient actual claims cost data on COVID costs to be used for our initial estimates," he says. "Consequentially we estimated COVID costs based on historical costs for conditions that, at the time, represented a similar cost profile. Since that initial report was finalized, new data — namely actual COVID claims experience — became available."

Notably, when combining the estimated savings from deferred health care services with the projected cost of treating COVID-19 patients, Wakely's analysis suggests that insurers could see a net benefit from the pandemic. Under a "baseline infection rate" of 20%, for example, the report estimates that the total allowed costs for insurers will be in the range of -$71.0 billion to $13.8 billion. For 2020 alone, the analysis predicts a net cost impact of -$101.2 billion to -$10.6 billion. However, the estimated net impact of COVID-19 in 2021, ranging from

$3.6 billion to $44.2 billion, suggests those financial benefits won't last long.

Deep Banerjee, a health care sector analyst at S&P Global Ratings, tells AIS Health that his firm is also predicting a rosy financial picture for health insurers this year.

"Our view is for 2020, the net impact — that would be taking into account COVID-related claims and the benefit that the industry is receiving from deferred costs — would be either slightly positive or effectively offset[ing] each other," he says. "So you'll end up at close to your expectations or slightly better for the year."

Second Wave May Bring Déjà Vu

While there's currently "a lot of debate" about the possibility of a second wave of coronavirus infections in the fall, Banerjee adds, S&P analysts aren't expecting such a scenario to change their 2020 outlook.

"Before we knew about this massive [amount of] deferred care that was taking place, we would have been worried about it more," he says. Now, as it's clear that a rise in COVID-19 cases generally triggers a drop-off in other types of health care services, analysts expect the same phenomenon to occur in the event of a second wave.

Banerjee says he's less certain about predictions for 2021, however. "I appreciate that they have these wide ranges" of estimated financial impact, he says of Wakely's report, adding that "the biggest variable is how much of the deferred services are completed in 2020, how much come back in 2021 and how much never come back."

Insurers are not all in agreement about how that will play out, Banerjee says, pointing out that early Affordable Care Act premium rate requests have demonstrated some carriers are expecting the pandemic to raise costs and others expect costs to be lowered (see story, p. 1).

Meanwhile, S&P — like Wakely — has seen the pandemic play out differently than it originally predicted.

"We had assumed, based on a historical pandemic, a much higher infection rate than actually happened," Banerjee says. The U.S. recently passed the 2 million mark of confirmed COVID-19 cases, but that's still a very small percentage (less than 1%) of the country's total population.

On the other hand, there appears to be a higher rate of hospitalization than what S&P initially predicted — which Banerjee attributes to the fact that the current infection rate is considerably underreported since it's much harder to track cases where people have less severe or no symptoms and don't end up in the hospital. The overall cumulative COVID-19 hospitalization rate in the U.S. is 82 per 100,000, according to the latest data from the Centers for Disease Control and Prevention.

Analysis Considers Enrollment Shifts

The latest Wakely analysis also estimates the impact of millions of Americans moving from employer-sponsored insurance to other forms of coverage, which many analysts predict will happen if unemployment levels remain elevated. Relying on a 20% unemployment rate scenario modeled recently by the Urban Institute, Wakely said it "shifted individuals from Commercial insurance to Medicaid and uninsured status" in its analysis.

"The result of this was a decrease of almost 5% of spending to the baseline scenario with no change to Medicare Advantage, a more than 10% decrease to Commercial, and a more than 20% increase to Medicaid," the report stated. The analysis noted, however, that this is probably an overestimate of the cost increase Medicaid will see, since people shifting from commercial plans to Medicaid coverage will likely be a healthier population than Medicaid typically sees.

"While further analysis would be needed to fully account for demographic and morbidity shifts, the overall impact of shifting individuals out of Commercial insurance to other forms of coverage (or uninsured) should directionally reduce overall spending for private insurers," the report added.

Should Insurers Get a 'Backstop'?

While acknowledging that some people predict reductions in non-coronavirus health care services will "more than offset" the pandemic's cost burden, a Health Affairs blog post published in early May by Gregg Bloche, M.D., a Georgetown University law professor, and Daniel Wikler, a professor of ethics and population health at the Harvard T.H. Chan School of Public Health, argued that "we have no evidence base for predicting the myriad decisions by both doctors and patients that will determine this."

"Insurance giants like Anthem and UnitedHealth Group are well-positioned to weather a COVID wave," Bloche and Wikler wrote. "But not only does this surge threaten smaller carriers (and the hospitals they pay); our country's already-stressed employers are at risk for much of this burden."

They suggested Congress should create "a federally guaranteed, low-interest loan program for health insurers and self-insured employers at high risk" of financial collapse. The plan includes eligibility restrictions, using factors like existing metrics of health plan instability and ceilings on executive compensation.

With this proposal, "basically the government is going to be stepping up to the plate and saying, 'We're the reinsurer of last resort,'" Wikler said during a recent panel discussion hosted by Georgetown University Law Center and its O'Neill Institute for National & Global Health Law. "When everything else fails, when the ledgers turn from looking great for the insurance companies to looking grim, rather than deny care to anybody, the government will start providing financing."

Asked whether such a program might be necessary, Banerjee says that "it's an interesting point; not everybody has same size or diversification to handle an event like this."

While S&P maintains a "stable" outlook for the U.S. health insurance sector *(HPW 5/18/20, p. 4)* — reckoning publicly traded insurers and Blue Cross Blue Shield plans can weather the pandemic — that might not be the case for smaller regional insurers that are in areas particularly hard-hit by COVID-19, he says. Even so, "we just wouldn't expect an earnings loss big enough that a company would go under because of what we have seen so far, and that is primarily based on the fact that COVID claims are coming at a time when you're also seeing deferred services."

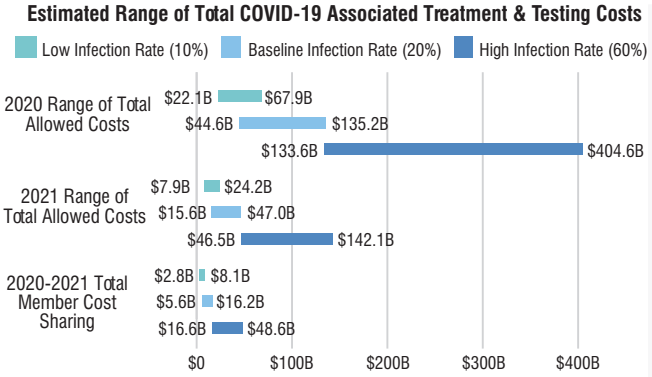
View the updated Wakely analysis at https://bit.ly/30y6wVK and the Health Affairs blog post at https://bit.ly/2MRls9m. Contact Banerjee at shiladitya.banerjee@spglobal.com. ✧

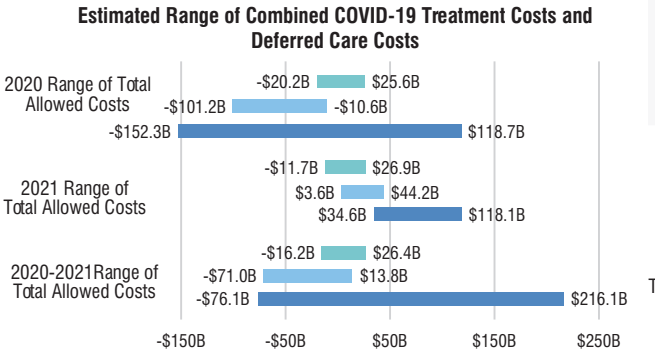
by Leslie Small

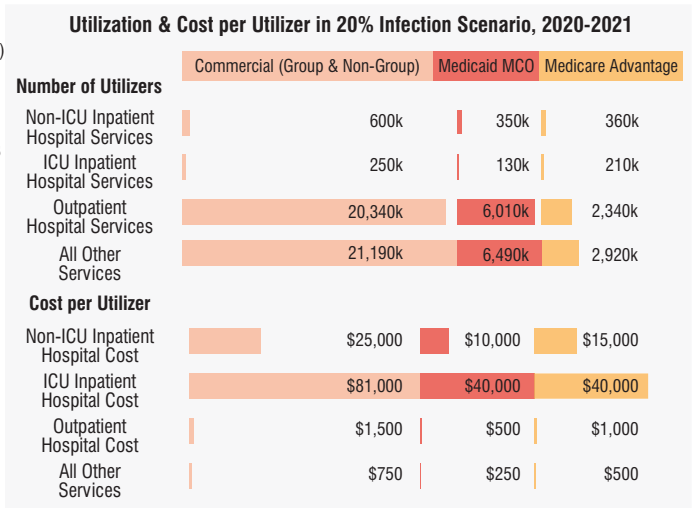
Health Insurers Could See Net Gain From COVID-19 Pandemic

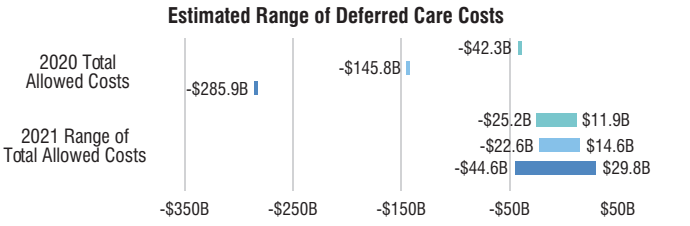
by Jinghong Chen

The estimated costs for treating COVID-19 could range from $60.2 billion to $182.2 billion over 2020 and 2021 combined, under a baseline risk scenario with a U.S. infection rate of 20%, according to an updated analysis prepared by Wakely Consulting Group on behalf of America's Health Insurance Plans. The actuarial firm reduced the assumed rates of hospitalization and raised the estimated cost of a hospital admission based on new COVID-19 costs and utilization data. Factoring in the effect of care deferred by patients due to the pandemic, Wakely estimated that the net cost of COVID-19, under a 20% infection-rate scenario, would be -$71.0 billion to $13.8 billion for 2020 and 2021 combined.









SOURCE: "COVID-19 Cost Scenario Modeling: Treatment, Estimating the Cost of COVID-19 Treatment for U.S. Private Insurer Providers," America's Health Insurance Plans. Visit https://bit.ly/2MJDoCI.

News Briefs

✦ ***The annual estimated cost for COVID-19 diagnostic testing ranges from $6.0 billion to $25.1 billion, while the estimated cost for antibody testing ranges from $5.2 billion to $19.1 billion.*** That's according to a new analysis from Wakely Consulting Group (prepared for America's Health Insurance Plans), which separately updated its previous analysis estimating the cost of treating COVID-19 (see story, p. 1). The testing analysis examined potential costs associated with three types of COVID-19 tests: medically necessary ones used to treat or diagnose COVID-19; public health tests aimed at analyzing the prevalence of COVID-19 in the population on an ongoing basis; and occupational health tests meant to reduce employees' risk of exposure to the coronavirus at their workplaces. Read more at https://bit.ly/2Yjwb1q.

✦ ***A new proposed rule from the Trump administration would let employers use health reimbursement arrangements (HRAs) to reimburse employees who opt for direct primary care arrangements or health care sharing ministry memberships.*** The proposed rule, published in the Federal Register on June 10, would also designate any funds employees spend on those two type of health insurance alternatives as deductible medical expenses. Last summer, the administration released a final rule that allowed companies to use HRAs to reimburse employees for purchasing individual health insurance policies *(HPW 7/1/19, p. 1)*. View the proposed rule at https://bit.ly/3dTKSPn.

✦ ***California's Anthem Blue Cross said on June 10 that in the past six months it has rolled out more than 200 "digital solutions kiosks" in 80 health centers across the state.*** The kiosks include Wi-Fi enabled tablets that allow treating clinicians to quickly engage certified interpreters to help them communicate with patients. The tablets can also be used "to provide comprehensive, whole person care by enabling access to medical specialists via telehealth and information about free community resources to address non-medical needs," according to the health insurer. Read more at https://bwnews.pr/2XQoalE.

✦ ***Patrick Conway, M.D., who previously led the CMS innovation center and served as CEO of Blue Cross and Blue Shield of North Carolina, recently started a new role as CEO of care solutions at UnitedHealth Group's Optum division, a company spokesperson confirmed to AIS Health.*** Conway unveiled his new job on his Twitter account, saying he'll concentrate on home care, mental health care, acute and post-acute care, with a focus on "value-based models and care for populations in need." Conway resigned from his role at the North Carolina Blues plan last fall after news emerged of his arrest in connection with a drunken driving incident *(HPW 10/21/19, p. 1)*. Read his post at https://bit.ly/2AjPG2h.

✦ ***Democratic Kentucky Gov. Andy Beshear on June 8 said his administration will work to ensure 100% of the state's black residents have health insurance, Bloomberg Law reported.*** Beshear said he aims to use state-paid "health insurance connectors" who will reach out to black residents and help them apply for insurance through Kentucky's Medicaid expansion, private plans or federal plans. Read more at https://bit.ly/2BYuIq1.

✦ ***NextLevel Health, a Chicago-based Medicaid managed care plan with about 56,000 members, will close in July, Crain's Chicago Business reported on June 5.*** In a statement sent to the news outlet, CEO Cheryl Whitaker, M.D., explained that "insurance is a very capital-intensive business" and "COVID-19 has exacerbated the difficulty of black-owned businesses to access capital." Molina Healthcare Inc. tried to buy NextLevel for $50 million, the article noted, but the deal fell apart "due to the seller's stated unwillingness to close pursuant to the terms of the acquisition agreement," per a Securities & Exchange Commission filing. Read more at https://bit.ly/3fgkQpO.

✦ ***On June 8, CMS released guidance about how to approach health care appointments as states start to reopen from COVID-19 shutdowns.*** In the guidance, CMS urged patients not to defer urgent care for emergent conditions and advised them to check with their provider about how to safely visit their facility. CMS also urged patients to use telemedicine when possible, and during in-person visits, they should wear a face mask, avoid crowded waiting rooms, be prepared to have their temperature taken and wash their hands often. Read the guidance at https://go.cms.gov/3cT1q98.