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Payers Are Poised to See Changes From Hospital Transparency

In another blow to an industry already beleaguered by the COVID-19 pandemic, a federal judge recently upheld a federal rule that requires hospitals to engage in unprecedented price transparency measures. Health systems are likely preparing to comply with the new requirements even as they await the outcome of an appeal — but health insurers, too, are poised to feel an impact if the regulations go into effect.

The rule, which the administration proposed in July 2019 and finalized in November, would require hospitals to disclose the rates they negotiate with payers for all items and services they offer *(HPW 8/5/19, p. 1)*. That comprehensive set of rates must be available in a machine-readable file online, and hospitals also must display payer-specific negotiated charges for a limited set of "shoppable" services in a consumer-friendly format. The rule is slated to go into effect on Jan. 1, 2021, but the American Hospital Association (AHA) and other trade groups and health systems sued to block it.

The crux of the plaintiffs' argument in *American Hospital Association v. Azar* is that CMS exceeded its authority by redefining the "standard charges" that hospitals must disclose under the Affordable Care Act to include negotiated rates — rather than just the often-inflated chargemaster rates that serve as a starting point when negotiating prices with payers. But in a decision issued June 23, U.S. District Court Judge Carl Nichols sided with the Trump administration, pointing out that "had Congress intended to require the publication of just a hospital's chargemaster or chargemaster rates, it could easily have done so" by using that term, instead of the more ambiguous "standard charges."

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House Committee Paints Damning Picture of Short-Term Plans

More than a year after they began probing health insurers and brokers for information to fuel an investigation of short-term, limited-duration insurance (STLDI) plans, Democratic leaders of the House Energy & Commerce Committee released a report concluding that this market's growth has come at the expense of consumers who are often duped into purchasing bare-bones coverage.

Policy experts, however, disagree about what conclusions can actually be drawn from the latest salvo in an ongoing debate over alternatives to Affordable Care Act (ACA) exchange plans.

Under a 2018 rule from the Trump administration, STLDI plans are permitted to cover individuals for up to 364 days and can be renewed up to 36 months — a policy that reversed an Obama-era regulation that limited their duration to three months. Such plans offer lower premiums than ACA exchange plans, made possible because they can conduct medical underwriting and generally offer less robust coverage.

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"The nutshell of the report is it confirms everything that these sort of smaller studies that have been highly imperfect have showed about this market," including misleading marketing, various benefit gaps, the use of pre-existing condition exclusions and plan rescissions (i.e. canceling coverage after a claim), says Katie Keith, an attorney, research professor at Georgetown University's Center on Health Insurance Reforms and principal at Keith Policy Solutions, LLC.

But Chris Pope, a senior fellow at the right-leaning Manhattan Institute, sees it differently. "I think it's of limited value to have an analysis that's kind of saying, 'Well, what is the worst thing that we can find about this market and judge a market by the worst possible thing that's out there,'" Pope tells AIS Health. "You kind of want to see the distribution — what are the best effects, what are the average effects, what is the typical consumer's experience, what is the prudent shopper's experience, what are the best plans out there, [and] how do the best STLDI plans compare with the best ACA plans?"

The report, released June 25, is the result of an investigation that House Democrats began in March 2019. To compile it, the lawmakers requested information from Blue Cross of Idaho Health Service, Inc., Arkansas Blue Cross Blue Shield, Cambia Health Solutions, National General Accident and Health, Everest Reinsurance Co., Independence Holding Co., LifeShield National Insurance Co., and United-Health Group — comprising "most of the companies with the greatest market share" in STLDI plans. They also sought information from major brokers of such plans and spoke to insurance commissioners.

Here are some of the committee's main findings:

✦ ***During the 2018 plan year, there were about 2.36 million consumers enrolled in STLDI plans across the nine companies included in the investigation***. That number swelled to 3 million for the 2019 plan year.

✦ ***Enrollment in STLDI plans facilitated by brokers rose during December 2018 and January 2019*** — time periods that coincided with ACA open enrollment.

✦ ***The broker commission rate for STLDI plans ranges between 10% and 40%, with an average rate of 23%***, while the commission rate for ACA-compliant plans was approximately 2% in 2018.

✦ ***About 28% of the overall STLDI enrollment in 2018 and 2019 was concentrated in Florida and Texas, which haven't restricted the sale and duration of such plans***. Twenty-four states, however, have banned or restricted the sale of STLDI plans.

✦ ***Taking advantage of the loosened federal regulations, a majority of the STLDI plans offer policies with a plan duration of up to 364 days***. Many are also renewable for up to 24 to 36 months.

✦ ***Six of the insurers included in the investigation offer STLDI plans through "associations," with 1.7 million consumers enrolled in this fashion in 2018 and 2.2 million in 2019***. Such associations are not required to have a relationship with a particular employer, and some states lack the authority to regulate plans issued by out-of-state associations.

✦ ***Some STLDI brokers "engage in misleading and fraudulent marketing practices."*** One in particular, known under the trade name Health Insurance Innovations, was the subject of a 43-state investigation in 2016 and subsequent settlement. That company, per the committee's report, "incentivizes third-party agents and brokers to actively target vulnerable consumers seeking comprehensive health coverage and deceive them into purchasing STLDI plans."

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✦ ***When the committee reviewed marketing brochures from some major STLDI insurers, it found some do in fact disclose STLDI plans' limitations and exclusions***. "However, the Committee finds that some marketing materials fail to properly disclose all of STLDI plans' limitations and exclusions," the report added.

✦ ***On average, less than half of the premium dollars that STLDI plans collect from consumers are spent on medical care, and the median medical loss ratio was 48% across eight companies that offer STLDI products.*** The ACA requires insurers to spend at least 80% or 85% of premium dollars on consumers' medical care and rebate consumers if they spend less than that.

✦ ***Five out of eight STLDI insurers "deny coverage outright" to people with preexisting conditions such as cancer, diabetes or a mental health condition***. But some STLDI plans, including those offered by the Arkansas Blues and UnitedHealth-owned Golden Rule Insurance Co., "do offer limited coverage" for preexisting conditions.

✦ ***STLDI plans often exclude coverage for a range of other conditions — including pregnancy — regardless of whether they arise during the term of coverage or were preexisting***. Some also don't cover "basic services" such as prescription drugs, maternity/newborn care and hospitalization, and they typically impose lifetime coverage caps and waiting periods for coverage.

✦ ***In a process known as post-claims underwriting, STLDI insurers "often deny claims following a lengthy medical investigation" if they determine that the expenses occurred as a result of a preexisting condition that a consumer should have disclosed when applying for the plan***. Most STLDI issuers will also use that as a basis for rescinding a consumer's health plan.

In light of those findings, the report calls for federal legislation that subjects STLDI plans to all of the ACA's protections. In the absence of that, it recommends that states limit STLDI plan duration to 90 days, prohibit renewability, ban the sale of STLDI plans during ACA open enrollment, require such plans to be sold only in person to stymie aggressive marketing tactics, and comply with the ACA's consumer protection provisions.

Enrollment Figures Show Plans' Popularity

In Pope's view, the most interesting finding from the House committee's report was the fact that 3 million people were enrolled in STLDI plans in 2019. "It's somewhat toward the top end of estimates that had been put out previously — clearly a lot of people do value these plans," says Pope, who authored a report in May 2019 for the Manhattan Institute that argued the merits of STLDI plans.

That said, "insurance regulators should absolutely protect consumers and make sure they're not being defrauded in any kind of way — that, I think, is very uncontroversial," he says. "Are there cases in which they should be doing more? That's absolutely a legitimate argument that one can make, and the insurance commissioners at the state level should step up to the plate and do what they're supposed to do in that respect."

To Keith, the most striking aspect of the report was how many STLDI plans are being sold through associations, which makes it more difficult for individual states to regulate them. "I say that because this report highlights some of the gaps that even the most well-intentioned states that want to go after this stuff face," she tells AIS Health. "It does to me suggest, more than we thought before, you need some sort of strong federal [standard]."

Keith also highlights one business practice of STLDIs as particularly troublesome.

> **"They're taking your money full well knowing they're never going to pay out anything big.**

"What I think makes these products the worst is the rescission," she says. "You could do what you're supposed to do, pay your premiums every month and think you're protected, and then when you really need it, when you have that big claim, they go through and find any reason they can to pull it back and just cancel your policy. That to me is such an abuse — they're taking your money full well knowing they're never going to pay out anything big."

Pope, though, argues that better regulation of STLDI plans shouldn't mean enacting restrictions that make them less attractive to consumers — such as the report's recommendation that states ban STLDI renewability. "The Energy & Commerce Committee is not interested in making this market work better, it just wants to get rid of it," he says. "And I think that's ultimately not a particularly helpful point of view."

When asked for comment about the report, UnitedHealth — the country's largest health insurer — offered the following statement:

"Short-term health plans are a flexible, affordable option that can help people bridge a gap to longer-term coverage — especially at a time when tens of millions of Americans are losing access to employer-based coverage due to COVID-19," the company said. "The

plans, which are regulated by both the Federal and State governments, are a small part of the range of health insurance solutions that can help achieve the goal of universal coverage for all Americans. Such plans do not meet the needs of everyone, so people should assess what health coverage makes most sense for them and their families."

Read the report at https://bit.ly/2VBJYjH. Contact Keith at kmk82@georgetown.edu and Pope at cpope@manhattan-institute.org. ✧

by Leslie Small

Cigna Taps Priority Health, Oscar to Bolster Offerings

Cigna Corp. has now partnered with two smaller insurers, Priority Health in Grand Rapids, Mich., and New York-based Oscar, in an effort to increase its share of commercial group business, particularly small groups.

The alliances, which take effect next year and later this year, respectively, widen available offerings for both Cigna and its partners: Cigna gets access to stronger provider networks and more advanced online tools than it has in-house, while Priority Health and Oscar get access to Cigna's national platform.

"Both are niche insurance plays that attract select populations," says F. Randy Vogenberg, Ph.D., principal of Institute for Integrated Healthcare in Greenville, S.C. "Insured entities are doing the same thing as we see with other manufacturing sectors in spreading their investments into stronger growing revenue opportunities that are complimentary to their main product lines (either insurance risk or administrative services)."

William DeMarco, president of Pendulum HealthCare Development Corporation, tells AIS Health that these partnerships can help Cigna's products gain a broader following among small businesses in Priority Health and Oscar service areas.

"What Cigna's doing isn't unusual," DeMarco says. "I think they have started to realize that their small business product is pretty pricey and wasn't selling well, plus, as I recall, the Cigna people cut their broker commissions considerably." For Priority Health and Oscar, meanwhile, the partnerships provide access to Cigna's broader network, he says.

In Cigna's strategic alliance with Priority Health, unveiled on June 22, the two insurers will offer what they term "a competitive network solution for employer groups in the state, leveraging the best capabilities of each organization and the strength of their provider relationships."

Deal Will Expand Insurers' Networks

Beginning on Jan. 1, 2021, Cigna clients and customers will have access to Priority Health's network of Michigan providers, which includes 97% of primary care physicians in Michigan, a wide variety of specialists and the vast majority of hospitals, labs and ancillary care services in the state.

Meanwhile, Priority Health members who live, work or travel outside of Priority Health's service area will have access to Cigna's national network of providers, including primary care physicians, specialists, hospitals, labs and facilities.

The two insurers say the alliance between them will make it simpler for customers to find in-network providers in Michigan and around the country. They also say clients and providers will benefit from shared programs and analytics.

Priority Health and Cigna have partnered since 2018 on network solutions for Michigan employers with workers based outside of the state, and this new alliance takes "a more coordinated approach," Priority Health says. As part of the arrangement, both Priority Health and Cigna will continue to work with Upper Peninsula Health Plan to provide network access in the Upper Peninsula region of Michigan.

Oscar and Cigna first said in January that they would partner to jointly provide coverage to small businesses in select markets, and they unveiled the name of the venture — Cigna + Oscar — as well as the available markets on June 23.

The two insurers will offer small-group coverage in Atlanta, the San Francisco Bay area and across Tennessee beginning in the fourth quarter of 2020. The coverage includes broad network access, 24/7 telemedicine and online tools, and support from a dedicated concierge team.

Cigna and Oscar share risk equally under a reinsurance agreement for the partnership, the companies said.

Partnerships Bring New Tech Capabilities

Vogenberg notes that other insurers are interested in forming these types of partnerships. "Such short-term arrangements also allow old-line insurance firms to get access to new IT solutions and risk mitigation solutions that would be too costly for them to develop in-house," Vogenberg says. "Such alignments are a win-win for the old and newer firms as they can leverage each other's strengths while not increasing their own costs of doing business."

In the case of Cigna and Oscar, the partnership gives Cigna access to Oscar's strong suite of online tools, which appeal to younger members, DeMarco adds. The partnerships also may benefit employers who are looking for provider networks that will cover

geographically dispersed workers in the new COVID-19 world, he points out.

Citi equities analyst Ralph Giacobbe said in a research note that Cigna's Priority Health partnership indicates the insurer is well-positioned for growth. "While we don't expect this announcement in and of itself to be overly material, it provides another example of Cigna's partnership strategy, and continued push for collaboration across the health spectrum," Giacobbe said.

Contact DeMarco at bill.demarco@pendulumhealth.com, Vogenberg at randy@iih-online.com, Cigna spokesperson Ellie Polack at Elinor.Polack@cigna.com and Giacobbe at ralph.giacobbe@investmentresearch.citi.com. ✧

by Jane Anderson

Transparency Rule Is Upheld

continued from p. 1

The AHA has already appealed the decision, and depending on how the D.C. Circuit Court rules on that appeal, the case could make it to the Supreme Court, says David Kaufman, a partner at Laurus Law Group LLC and former general counsel of Blue Cross Blue Shield of Illinois.

"If the solicitor general of the United States asks the Supreme Court to review a decision, that's one of the types of cases where it's more likely to get Supreme Court review," Kaufman tells AIS Health. "If the lower court decision is upheld and the hospital association seeks Supreme Court review, they also have that option — but I don't think they have as strong a chance of getting review as if the government loses and then seeks review of the Supreme Court."

Meanwhile, hospitals and insurers alike are facing the possibility of an altered rate-negotiation landscape.

"Insurers today actually do have a pretty good sense of how hospitals are charging, but this is going to be a quantum leap forward for them in understanding the strategy that hospitals take in negotiating across insurance markets," says Dan Mendelson, founder of Avalere Health.

> **"The insurer will have more information, but I question whether they will have more leverage.**

However, while insurers may try to use that information to negotiate better deals with hospitals, the ramifications of the new transparency requirements might not be that simple. "The insurer will have more information, but I question whether they will have more leverage," Mendelson says, pointing out that rate negotiations involve a variety of variables.

For example, an insurer "might need that hospital to be competitive in a market, or it might be a very competitive market where you don't need that hospital," he says. "What drives lower prices is if you don't really have a need for that hospital in the network and you can really leverage some competition."

"The other thing that I think is really important here is, increasingly plans are interested in more than just costs — they're also interested in quality," Mendelson continues. "If a plan has a relationship with a hospital and that hospital is really good about keeping readmits down or eliminating readmits because they have fantastic

MCO Stock Performance, June 2020

	Closing Stock Price on 6/30/2020	June Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2020 EPS*
COMMERCIAL				
Cigna Corp.	$187.65	(2.9%)	(8.4%)	$18.39
UnitedHealth Group	$294.95	8.1%	0.8%	$16.22
Anthem, Inc.	$262.98	(0.7%)	(12.6%)	$22.16
Commercial Mean		**1.5%**	**(6.7%)**	
MEDICARE				
Humana Inc.	$387.75	15.4%	6.7%	$18.58
Medicare Mean		**15.4%**	**6.7%**	
MEDICAID				
Centene Corp.	$63.55	1.5%	2.7%	$4.82
Molina Healthcare, Inc.	$177.98	43.9%	33.4%	$11.99
Medicaid Mean		**22.7%**	**18.1%**	
Industry Mean		**10.9%**	**3.8%**	

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

SOURCE: Bank of America Merrill Lynch.

infection control, that's not going to be highlighted in the data disclosure, the way that it's structured."

Ultimately, "I think over time what this [rule] is likely to do is to drive more consistency in pricing — not necessarily lower prices across the board."

Kaufman observes that the disclosure of hospitals' negotiated rates may not have a uniform impact across different types of insurers.

"In certain ways, it's a procompetitive kind of rule by providing more transparency," he says. "However, large established insurers that have the advantage of broad networks with lower prices based on their large membership benefit by keeping their prices confidential. It helps them with providing better prices to large employers, etc. So by making those prices more transparent, it might ease barriers to entry [for] other insurers."

AHA Bemoans Burden on Hospitals

In a statement issued after the federal court's ruling, AHA argued that CMS's "flawed proposal to mandate disclosure of privately negotiated rates" fails to help patients understand their out-of-pocket costs. It also "imposes significant burdens on hospitals at a time when resources are stretched thin and need to be devoted to patient care," the group said. But HHS Secretary Alex Azar applauded the decision, arguing the pandemic actually makes the administration's proposal all the more important.

"With today's win, we will continue delivering on the President's promise to give patients easy access to healthcare prices," Azar said in a statement. "Especially when patients are seeking needed care during a public health emergency, it is more important than ever that they have ready access to the actual prices of healthcare."

Meanwhile, a group of Republican senators led by Iowa's Chuck Grassley on June 30 introduced legislation that would "codify the two health care price transparency rules" issued by the Trump administration. The other, not-yet-finalized rule would require nearly all group and individual health plans to (1) create an internet-based "self-service tool" that provides consumers with personalized out-of-pocket cost information for all covered health care items and services, and (2) publish their negotiated rates with in-network providers and historical allowed amounts to out-of-network providers in a regularly updated, machine-readable format *(HPW 3/2/20, p. 1)*. Insurers have opposed both rules, though no lawsuit has yet been filed to challenge the proposal targeting health plans.

> **One of the claims that the hospitals made is that these are proprietary, confidential prices, and I think that's what the insurers would argue [if they filed a lawsuit].**

If a lawsuit is ever filed attempting to block the insurer transparency rule, Kaufman says the outcome of the AHA's case may play a role.

"One of the claims that the hospitals made is that these are proprietary, confidential prices, and I think that's what the insurers would argue — that they have contracts with confidentiality provisions and it's proprietary and it's what enables them to market their products successfully," he says. "The district court sort of addressed that same issue; another judge might not agree with it, but that's what this judge found."

Indeed, Nichols wrote in his opinion that while the plaintiffs "argue that the publication of payer-specific negotiated rates will chill negotiations between hospitals and insurers," in reality the rule "requires only the publication of the final agreed-upon price — which is also provided to each patient in the insurance-provided explanation of benefits — and not any information about the negotiations themselves."

Will Consumers Actually Benefit?

But while the goal of the rule is to increase transparency for consumers by revealing negotiated rates for health care services before they get a bill, Mendelson questions whether such requirements will achieve their intended effect.

"This is not going to affect most consumers much at all because most consumers pay based on a fixed-dollar cost share in the hospital," he says. "If the patient has coinsurance for a hospital service or if they are not carrying insurance, then they would have transparency [under this rule], but having transparency does not negotiate a lower price for the consumer."

Citi analyst Ralph Giacobbe went even further, writing in a June 24 note to investors that "generally speaking, neither providers nor payors support these broader efforts on disclosure of privately negotiated rates. Moreover, while the notion of price transparency has its merits in most industries and within selective 'shoppable' healthcare categories, we continue to believe that broader efforts are misguided and could backfire and cause prices to rise."

And from a business standpoint, "price transparency represents another headline that could create volatility for the healthcare sector when in focus," Giacobbe added.

View the court opinion at https://bit.ly/3dQgHrA. Contact Kaufman at dkaufman@laurusllc.net and Mendelson at dmendelson@avalere.com. ✧

by Leslie Small

Blues Plans Dominate Marketplaces; Medicaid Plans Increase Presence

by Jinghong Chen

Between 2016 and 2018, Medicaid-focused insurers expanded their footprint into the Affordable Care Act (ACA) marketplaces by offering lower premiums for silver plans, according to a recent analysis by the Robert Wood Johnson Foundation. Blue Cross Blue Shield plans remained the dominant players, accounting for almost half of marketplace enrollment nationally in 2018. In 20 states, Blues plans had all or the majority of enrollment, yet some Medicaid insurers have increased their share of the market in some of these states. In another eight states, Medicaid plans enrolled most of the marketplace consumers.

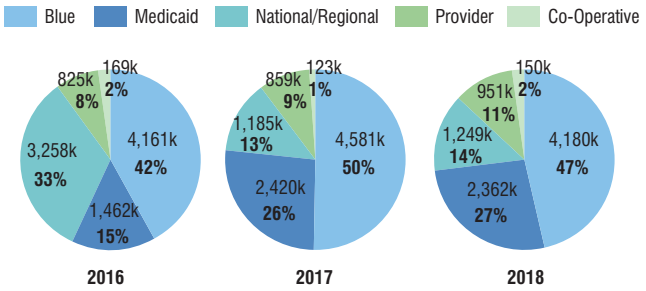
States Where Blue Cross Blue Shield Is Dominant or Largest Insurer

State	Insurer	Market Share in 2016	Market Share in 2018
Alaska	Premera BCBS of Alaska	30%	100%
Alabama	BCBS of Alabama	64%	99%
Delaware	Highmark BCBSD Inc.	90%	100%
Illinois	BCBS of Illinois	58%	72%
Louisiana	HMO Louisiana, Inc.	32%	86%
	Louisiana Health Service & Indemnity Company	4%	15%
North Carolina	BCBS of NC	46%	96%
North Dakota	BCBS of North Dakota	52%	79%
New Hampshire	Matthew Thornton Health Plan	44%	79%
Oklahoma	BCBS of Oklahoma	95%	100%
South Carolina	BCBS of South Carolina	48%	100%
Wyoming	BCBS of Wyoming	100%	100%
Arizona	USAble Mutual Insurance Company	59%	91%
Florida	Health Options, Inc.	15%	42%
	BCBS of Florida	24%	24%
	Florida Health Care Plan, Inc.	1%	2%
Hawaii	Hawaii Medical Service Association	51%	60%
Kansas	BCBS of Kansas, Inc.	13%	63%
Michigan	Blue Care Network of Michigan	35%	48%
	BCBS of Michigan Mutual Insurance Company	12%	19%
New Jersey	Horizon Healthcare Services, Inc.	53%	60%
Pennsylvania	Keystone Health Plan East, Inc	26%	33%
	Capital Advantage Assurance Company	4%	8%
	Independence Blue Cross	5%	7%
	Highmark Health Insurance Company	4%	4%
	First Priority Health	0%	3%
	Highmark Choice Company	0%	1%
Tennessee	BCBS of Tennessee	55%	65%
West Virginia	Highmark BCBS West Virginia	66%	95%

NOTE: The enrollment data include only marketplaces that used the federal HealthCare.gov platform.

SOURCE: "Which Types of Insurance Are Marketplace Enrollees Choosing?" Robert Wood Johnson Foundation, June 2020. Visit https://urbn.is/3eLyvpe.

Enrollment by Insurer Type, 2016-2018



States Where Medicaid Insurer Is Dominant

State	Insurer	Market Share in 2016	Market Share in 2018
Arizona	Health Net of Arizona, Inc.	8%	75%
Georgia	Ambetter of Peach State Inc.	19%	52%
Indiana	CareSource Indiana, Inc.	17%	53%
	Ambetter	10%	47%
Kentucky	CareSource Kentucky Co.	0%	66%
Mississippi	Ambetter of Magnolia Inc.	49%	100%
New Mexico	Molina Healthcare of New Mexico, Inc.	0%	59%
Ohio	CareSource	30%	42%
	Buckeye Community Health Plan	5%	12%
	Molina Healthcare of Ohio, Inc.	0%	11%
Texas	Molina Healthcare of Texas, Inc.	0%	25%
	Ambetter	5%	21%
	Community Health Choice, Inc.	9%	12%

States Where a National or Regional Insurer Have Largest Share

State	Insurer	Market Share in 2016	Market Share in 2018
Iowa	Medica Insurance Company	3%	100%
Missouri	Cigna Health and Life Insurance Company	10%	48%
Nebraska	Medica Insurance Company	7%	100%
Nevada	Health Plan of Nevada, Inc.	56%	64%
South Dakota	Avera Heath Plans, Inc.	50%	73%
Utah	SelectHealth	60%	88%

News Briefs

✦ ***Employer health care spending could grow anywhere from 4% to 10% in 2021 as costs rebound from a dip in utilization tied to the COVID-19 pandemic, according to a new report from PwC's Health Research Institute.*** The two main factors that PwC expects to inflate spending in 2021 are increased mental health services utilization and new and previously approved specialty drugs. Two major potential offsetting factors include the rapid adoption of telehealth and employers increasing their use of narrow networks. Read more at https://pwc.to/2ZCWTTI.

✦ ***The House of Representatives on June 25 passed a bill that aims to strengthen the Affordable Care Act (ACA), incentivize holdout states to expand Medicaid and lower prescription drug prices.*** The Patient Protection and Affordable Care Enhancement Act (HR 1425) advanced on a 230-180 vote, though it has little chance of passing in the Republican-controlled Senate. Among other provisions, the bill would expand ACA subsidies, help states develop their own insurance marketplaces and enact measures included in a drug-pricing bill previously passed by the House, HR 3. Read about the bill at https://bit.ly/2ZAze64.

✦ ***Humana Inc. said on June 30 that it is piloting a program that will give its members access to LabCorp's at-home COVID-19 testing kits,*** and it is partnering with Walmart Inc. and Quest Diagnostics to offer members drive-thru testing at locations across the country. Members in Humana's Medicare Advantage, Medicare Supplement, Medicaid or employer group plans who use the insurer's coronavirus risk-assessment tool and are identified as either having symptoms or exposed to the virus will be given the option of either at-home or drive-thru testing. Read more at https://huma.na/2VH4nDU.

✦ ***A group of health care providers and LGBTQ groups sued the Trump administration on June 24 over its recently finalized HHS rule that stripped gender identity protections from anti-discrimination provisions in the Affordable Care Act*** *(HPW 6/22/20, p. 5)*. The lawsuit argues the HHS rule conflicts with the Supreme Court's June 15 decision in the case *Bostock v. Clayton County*, which found that "discrimination on the basis of a person's transgender status or sexual orientation" qualifies as discrimination on the basis of sex. Read the complaint at https://bit.ly/3dVX3KI.

✦ ***Centene Corp. subsidiary Meridian Health Plan of Illinois, Inc. and NextLevel Health Partners, Inc. entered into a mutual transfer agreement under which Meridian will assume all of NLHP's 54,000 members who are enrolled in the state's Medicaid expansion program, HealthChoice Illinois.*** Centene — which helped NLHP obtain its HMO licensure in 2017 and has since provided operational support for the minority-owned health plan — has also "executed a care coordination agreement with NLHP to ensure continuity of care for a subset of the assigned membership." Read more at https://bit.ly/2An6Sng.

✦ ***Oklahoma voters on June 30 approved a ballot initiative that expands Medicaid eligibility under the Affordable Care Act, making it the 38th state (including the District of Columbia) to expand Medicaid and the fifth to do so with a ballot initiative.*** Because the ballot measure adds Medicaid expansion to the state's constitution, that could stymie Gov. Kevin Stitt's plan to make conservative changes to the program, Politico reported. Stitt, a Republican, championed Oklahoma's effort to apply for a waiver that would cap Medicaid funding in the state, which the Trump administration has encouraged states to do *(HPW 2/3/20, p. 3)*. Read Politico's article at https://politi.co/2Aprz25 and view the ballot initiative at https://bit.ly/2ZCSzDY.

✦ ***Between the end of open enrollment on Dec. 15, 2019, through May 2020, 46% more people signed up for plans on HealthCare.gov through a "loss of minimum essential coverage" special enrollment period (SEP), compared with the same time period the year before.*** That's one of the findings from a recently released CMS report, which comes amid calls for a nationwide SEP that would allow more people who lose or need coverage due to the COVID-19 pandemic to sign up for an Affordable Care Act exchange plan. Looking at SEPs used for all reasons (including job loss or major life events), 892,141 people enrolled in coverage on HealthCare.gov between Dec. 15 and May 2020 — compared with 704,106 people the year prior. Visit https://go.cms.gov/2NSiaTU.