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California Law Aims to Boost Behavioral Health Pay Parity

California recently passed a law requiring health plans to follow a more expansive definition of behavioral health reimbursement parity starting in 2021. Experts say that plans will have to spend more on behavioral health care than they did before, as payers' utilization management practices will have to follow a more generous standard for medical necessity.

The new law, which passed the California Assembly as S.B. 855 on Sept. 23, expands the requirements of existing behavioral health parity statutes to require that plans reimburse all "medically necessary" behavioral health treatment, including substance use disorder treatment. The law also includes a provision that requires plans to limit cost sharing to in-network levels for members who are only able to access out-of-network providers.

Plans will be required to base their decisions about medical necessity on evidence-based standards developed by nonprofit professional associations like the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Previously, under Section 1374.72 of the California Health and Safety Code, plans were only required to provide coverage at parity for nine behavioral health disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa.

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Major Insurers Tap Breaks on Telehealth Cost-Sharing Waivers

When the coronavirus pandemic bore down on the U.S., health insurers not only moved to waive cost sharing for COVID-19 testing and treatment but also for telehealth visits of all varieties, as shutdowns and fears of contracting the virus kept most Americans out of traditional clinical settings. And there's clear evidence that consumers embraced virtual care with gusto: a recent analysis from FAIR Health found that telehealth claim lines (an individual service or procedure listed on an insurance claim) in the privately insured population increased 3,806% between July 2019 and July 2020.

However, some major insurers have now ended their across-the-board cost-sharing waivers for non-coronavirus-related telehealth visits, putting certain members on the hook again for copays, coinsurance and/or deductibles if they opt for a virtual appointment.

"I think what they're trying to do is transition to a more sustainable model where the televisit is really an alternative to the in-person visit," says Dan Mendelson, founder of consulting firm Avalere Health. "They need some kind of a copay there to limit unnecessary utilization. If something is free, you can bet that consum-

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ers are going to use it without thinking about it, and they want people to think about it."

Yet Shawn Martin, CEO of the American Academy of Family Physicians, tells AIS Health that reinstituting financial barriers to virtual care may not be the wisest move as the pandemic continues and flu season ramps up.

"You want to incentivize timely, appropriate care — and I think all these plans want to do that, and what they're missing is that by eliminating the availability of this modality of care, they are essentially incentivizing a higher risk modality, or they are incentivizing the most risky behavior, which is people don't seek care at all," Martin says. "In the big scheme of things… let's say it's an $85 telemedicine visit, that is a manageable cost for these plans as compared to a $3,000 emergency room admission because somebody continues to have a deteriorating health condition."

CVS Health Corp.'s Aetna is one health insurer that has recalibrated its telehealth coverage policy. For its members in fully insured commercial plans, Aetna will continue waiving cost sharing for virtual and in-person coronavirus-related diagnosis and treatment, as well as for outpatient behavioral and mental-health counseling, through Dec. 31. But its previous policy of waiving fees for all types of telehealth visits ended as of June 4, an Aetna spokesperson tells AIS Health.

"When the pandemic started in the U.S. in March, we waived cost sharing for any covered telemedicine visit and encouraged our members to use telemedicine as their first line of defense in order to avoid gaps in care and limit potential exposure in physician offices," the spokesperson says. "As physician offices have re-opened across the country, members are now seeking care both through telemedicine and directly in offices."

Aetna chose to continue waiving cost sharing for outpatient behavioral health visits, the spokesperson says, because "we have seen an escalating mental health crisis resulting from or amplified by the pandemic across all populations." For its Medicare Advantage members, the insurer will continue waiving cost sharing for in-network virtual specialist visits (including for behavioral health) and for primary care visits conducted virtually or in-person, through Dec. 31. Aetna went this route because "many senior populations have been understandably more reluctant to return to face-to-face encounters," the spokesperson says.

Insurers Keep Waivers for MA Members

Like Aetna, Anthem, Inc. cited members' increased willingness to visit providers in-person as the reason it adjusted its telehealth coverage policies. "As care providers' offices have been able to reopen, we have aligned our cost-sharing for telehealth and in-person care for treatment not related to COVID-19 cases," a spokesperson tells AIS Health. That means for members of Anthem's individual market or fully insured employer plans, waived cost sharing for non-coronavirus-related telehealth ended Sept. 30. Anthem's Medicare members will continue to receive telehealth cost-sharing waivers for all types of visits through Dec. 31.

UnitedHealthcare, meanwhile, says in a recent update on its website that for its individual and fully insured group health plan members, "there is $0 cost-share for non-COVID-19 related telehealth visits with network providers through Sept. 30, 2020. After that date, members will be responsible for any copay, coinsurance and deductible, according to their benefits plan." The insurer also ended "expanded access to out-of-network telehealth" as of Sept. 30.

For its Medicare Advantage (MA) members, though, UnitedHealth will waive cost sharing for "in-network and covered out-of-network" telehealth

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visits through Dec. 31, regardless of whether they're related to COVID-19 testing. "UnitedHealthcare has chosen to extend this cost-share waiver to help you get the routine medical care you need," the insurer said on its website.

UnitedHealth and many other insurers are also touting $0 copays for telehealth in 2021 as part of their MA plan offerings. Humana Inc., for example, will offer $0 telehealth copays for primary care, urgent care and outpatient behavioral health visits to its Medicare Advantage-Prescription Drug Plan members. And Cigna Corp. says it's "offering telehealth services to all MA customers, including no-cost access to behavioral health providers via audio and video." In addition, for the first time, the insurer is adding virtual physical therapy services to its MA plans.

> **The telehealth experience with the pandemic was an unqualified shot in the arm for growth in virtual medical visits, and in order for it to be sustainable, this kind of intervention has to be cost-effective relative to a face-to-face visit.**

According to FAIR Health's analysis, which was released Oct. 6, the surge in telehealth's popularity is showing some signs of waning. "While increasing greatly from 2019 to 2020, telehealth claim lines fell 12 percent nationally on a month-to-month basis, from 6.85 percent of medical claim lines in June 2020 to 6.00 percent in July 2020," stated a press release summarizing the findings.

Whether that trend will continue as winter approaches, however, is still unclear. In an Oct. 2 note to investors, Leerink SVB analyst Stephen Tanal suggested that President Donald Trump's COVID-19 diagnosis might also deter some patients from seeking in-person care. To Tanal, that news "could serve to increase the public's awareness of the threat and pervasiveness of this virus, which has the potential to have important behavioral consequences. If the past six and a half months are any indication, we would expect healthcare utilization to retrench, especially for seniors." For managed care organizations, such an effect would further dampen medical loss ratios and boost medical cost reserves, he added.

Indeed, "the reality of COVID is the plans are doing very well right now — utilization is down by and large, and it is fair to say that they're benefitting from that financially," Mendelson says. "So, it kind of makes sense that they will engage on the telehealth side kind of more aggressively right now, and that's what we see them doing."

However, "the telehealth experience with the pandemic was an unqualified shot in the arm for growth in virtual medical visits, and in order for it to be sustainable, this kind of intervention has to be cost-effective relative to a face-to-face visit," Mendelson adds.

Will More Consumers Avoid Care?

But Martin wonders if ending broad-based cost-sharing waivers will wind up being more expensive for insurers. "When you have an individual with comorbid chronic conditions, or potentially immunosuppressant-type conditions, and you create a financial burden to accessing telemedicine by reinstating the cost-sharing provisions, you essentially are incentivizing them to navigate the health care system in person," he says. With the increase in the number of cases of COVID-19 and with the flu season ramping up, "I just really question why we would do that at this time."

Some Blues Plans Extend Waivers

Some health insurers are in fact choosing to continue their broad telehealth cost-sharing waivers, according to a running list of pandemic-related insurer actions compiled by America's Health Insurance Plans. BlueShield of Northeastern New York and BlueCross BlueShield of Western New York, for example, will waive cost sharing for telehealth visits for both fully insured commercial and MA members through Dec. 31.

Pittsburgh-based Highmark Inc. — which struck a deal this summer to absorb those two smaller New York insurers *(HPW 6/22/20, p. 1)* — will also extend its broad telehealth cost-sharing waiver through Dec. 31, though its self-funded employer groups can opt out.

And on the other end of the state, Philadelphia-based Independence Blue Cross is waiving cost-sharing for telemedicine services with primary care doctors or specialists through Dec. 31, as well as telemedicine visits for behavioral health.

Wellmark Blue Cross and Blue Shield, meanwhile, is "extending the same reimbursement fee to Iowa providers for virtual visits as is paid for in-person visits until Feb.1, 2021." That policy "applies to all appropriate medical and behavioral health virtual visits with any Wellmark in-network provider in Iowa," the insurer said.

View AHIP's list of insurer actions at https://bit.ly/3jI45qj. Contact Mendelson at dmendelson@avalere.com and Martin via Megan Moriarty mmoriarty@aafp.org. ✧

by Leslie Small

Average MA Star Ratings Fall; United, Anthem See Big Drops

Star ratings for Medicare Advantage plans declined across the board for 2022, signaling an overall drop of around 5.5% in the number of members enrolled in contracts with 4 or more stars, according to an analysis of MA data.

The CMS data file, released Oct. 8, indicates that 74% of MA members are in contracts with 4 or more stars for 2022, down 5.5% from 80% for the 2021 plan year and "essentially reversing the 2021 tailwind," Evercore ISI equities analyst Michael Newshel wrote in an Oct. 8 investor note.

"Not only did the enrollment weighted average rating drop, which is alarming and like everything else in 2020, almost unprecedented, but there were also noteworthy drops in the percent of contracts at or above 4 stars and the percent of members in contracts at or above 4 stars," Melissa Newton Smith, executive vice president, consulting and professional services at Healthmine, Inc., tells AIS Health.

Still, "despite these headwinds in the 2021 ratings, we are pleased to see that highly rated plans remain available to beneficiaries in substantially all counties as we head into AEP," Smith says. The Medicare Annual Election Period runs from Oct. 15 through Dec. 7.

Among the larger MA insurers, Cigna Corp. is the only one with an increase in enrollment in bonus-eligible contracts, with a year-over-year change of 3.8%, Newshel calculated. Cigna continued its improvement from last year, when it saw a 7.2% increase in enrollment in plans with 4 stars or higher. Some 86% of Cigna enrollees are in plans with 4 stars or better.

UnitedHealth Group and Anthem, Inc., didn't fare as well, seeing outsized drops compared to other insurers, Newshel said. Current MA enrollment in contracts with 4 or more stars dropped 9.9% for UnitedHealth, more than wiping out its 9.2% increase from last year. Enrollment in plans with 4 stars or better dropped from 82% to 72% for UnitedHealth. And enrollment in quality-bonus-eligible contracts fell 7.1% for Anthem, continuing a slide that began last year with a 3.6% drop, Newshel said. Only 51% of Anthem's MA enrollees are in plans with 4 stars or better.

Three Plans Saw 2% Decline

Centene Corp., CVS Health Corp.-owned Aetna and Humana Inc. each saw declines of around 2%, Newshel said. "On a relative basis, that means the modest declines in the 2% range [for Centene, Aetna and Humana] are still better than the industry overall," Newshel wrote.

Still, the percentage of enrollment in bonus-eligible MA plans differs widely between those three insurers: at Humana, 89% of MA members are enrolled in plans rated 4 stars or better, compared with 76% at Aetna and only 28% at Centene.

The star ratings affect payments for the 2022 plan year, so enrollment may change between now and then. Contracts with 4 stars or higher receive 5% payment bonuses from CMS.

Smith notes that enrollment in highly rated plans fell even though CMS agreed to accommodations on quality measures due to the COVID-19 pandemic. "With the con-

MCO Stock Performance, September 2020

	Closing Stock Price on 9/30/2020	September Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2020 EPS*
COMMERCIAL				
Cigna Corp.	$169.41	(4.5%)	(17.3%)	$18.54
UnitedHealth Group	$311.77	(0.2%)	6.6%	$16.53
Anthem, Inc.	$268.59	(4.6%)	(10.7%)	$22.48
Commercial Mean		**(3.1%)**	**(7.2%)**	
MEDICARE				
Humana Inc.	$413.89	(0.3%)	13.9%	$18.93
Medicare Mean		**(0.3%)**	**13.9%**	
MEDICAID				
Centene Corp.	$58.33	(4.9%)	(5.7%)	$4.88
Molina Healthcare, Inc.	$183.04	(1.0%)	37.2%	$11.84
Medicaid Mean		**(3.0%)**	**15.8%**	
Industry Mean		**(2.6%)**	**4.0%**	

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

SOURCE: Bank of America Merrill Lynch.

tinued changes in both the measures included in the program and in measure weights, this makes it abundantly clear that plans must evolve their stars strategies and tactics to maintain strong ratings," she says. Starting in 2021, CMS increased the weight of member-experience measures — areas in which plans historically have struggled.

Meanwhile, MA enrollment is projected to accelerate next year, according to CMS. Based on filings from insurers, CMS estimated that MA enrollment in 2021 will increase to 26.9 million, a 10.2% year-over-year bump that's slightly faster than the 9.3% year-over-year growth clocked as of September. According to Credit Suisse analyst A.J. Rice, if that 2021 growth rate materializes, it would represent the strongest year-over-year MA enrollment gain since 2008.

Centene, Cigna Widen Footprints

Premiums will decline 11% with the repeal of the Affordable Care Act's health insurer fee, CMS said. In addition, beneficiaries will have more plan choices, with around 2,100 more MA plans operating in 2021 than in 2017. Both Cigna and Centene are expanding their county footprints significantly: Cigna will offer plans in 369 counties spanning 23 states, representing a 22% increase, while Centene will operate in 1,249 counties across 33 states, a 30% increase. Aetna also is expanding its footprint, offering plans in 115 new counties for a new total of 1,793. That will provide an additional 1.9 million beneficiaries access to an Aetna plan, for a total of 54.7 million beneficiaries, the insurer said.

Citi equities analyst Ralph Giacobbe said in an Oct. 6 investor note that he anticipates "outsized MA growth from [Centene] in 2021 considering expansion of plans/territories, albeit off of a relatively smaller base than competitors. Furthermore, we noted that among the larger players, we see healthy growth for CVS [Aetna] given increased plan offerings and county expansion."

Overall, beneficiaries can choose from more than 4,800 MA plans during 2021 open enrollment, and the average number of MA plan choices per county will increase by eight plans to around 47 plans per county. MA premiums will average around $21 per month, according to CMS.

Multiple insurers are touting affordability and convenience in their 2021 plan offerings, with many citing the pandemic as a reason to add telehealth and other benefits (see story, p. 1). For example, Humana's MA benefits include $0 copays for COVID-19 treatment, plus 14 days of home-delivered meals for those diagnosed with COVID-19.

UnitedHealth said that around 38% of its 6.5 million MA plan members would be enrolled in plans with $0 copayments, and all plans will offer telehealth visits with a $0 copay. In addition, all Aetna MA plans will offer an annual in-home assessment at no charge.

Clover Health Aims to Go Public

Finally, Clover Health Investments, Corp., which operates what it calls "next generation" MA plans in seven states, has announced plans to go public via a merger with Social Capital Hedosophia Holdings Corp. III, which is a special purpose acquisition company. The transaction values Clover at $3.7 billion and will provide up to $1.2 billion in cash for the newly constituted company.

Clover currently serves more than 57,000 MA members across 34 counties and is capturing an outsized share of market growth in its territories, according to the company.

The insurer plans to expand into an additional 74 counties and an eighth state in 2021, and recently announced a partnership with Walmart to make joint Clover-Walmart plans available to 500,000 Medicare beneficiaries in eight Georgia counties. Clover's platform aggregates health data points such as claims, diagnostic information and medical chart data and then uses machine learning to provide physicians with insights and suggestions at the point of care.

Contact Newshel at michael.newshel@evercoreisi.com, Smith at Melissa.smith@healthmine.com, Giacobbe at ralph.giacobbe@citi.com and Tori Goodell for Clover Health at tgoodell@sardverb.com. ✧

by Jane Anderson

Calif. Aims for Greater Parity

continued from p. 1

Advocates say the new definition is intended to move the focus of care from acute treatment to more preventive, holistic care. One expert observes that clinicians are not always able to diagnose a specific behavioral health disorder immediately upon engaging a new client.

"To cover everything that's in the DSM-5, that's a major step," says Benjamin Miller, Psy.D., the chief strategy officer of the Well Being Trust, a mental health advocacy group. Miller is also an adjunct professor in the Department of Psychiatry and Behavioral Sciences in the Stanford School of Medicine and was the founding director of the University of Colorado's Eugene S. Farley, Jr. Health Policy Center. "It's going to provide so much more coverage for those folks with this

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language because they don't meet criteria for [a] certain diagnosis."

The DSM-5, considered to be the gold standard of psychiatric diagnostic criteria, contains hundreds of mental health disorders — which means that California plans will need to drastically expand their coding for behavioral health treatment. While the scale of that challenge might seem daunting, Miller points out that plans have already had to confront it to a large degree.

Insurers Are 'Well-Intended'

"The writing's been on the wall for some time," Miller says. "This legislation has been around for over 10 years. It's time that we had some transparency in the health insurance industry. Mental health has been a black box for too long, so this is a moment of reckoning. But I actually think a lot of [health insurance] folks are well-intended, and are trying to address things that are probably just legacy systems that are not doing it well."

Miller says the lack of specific guidance in most states has inhibited true behavioral health coverage parity. He says the Affordable Care Act mandates parity for plans offered on the individual market, but does not get into specifics like the California law.

"I think there are a lot of times that health insurers themselves don't even know if they're necessarily at parity, or maintaining parity," Miller says. "There's thousands of lines of benefits that go into your medical [plan], and to match them up at every step of the way with mental health is really hard. I think that's what we've been really fighting for over the last couple of years, is just to make sure that people are even aware of what their health insurance is so they can know there's an improper denied claim for mental health."

California payers opposed the legislation. Charles Bacchi, the CEO of the California Association of Health Plans, wrote in a Sept. 10 editorial in the San Francisco Chronicle that "the bill writes into California law a narrow definition of medical necessity that will disrupt the ability of physicians and therapists to determine what is clinically appropriate for their patients."

Providers Say Payer Rules Are Arbitrary

However, providers have said the opposite problem exists — that insurers have turned down medically necessary care due to the payers' internal standards. California behavioral health care providers and patients have found reimbursement rules arbitrary, and acute services like emergent care have not been reimbursed at proper levels, according to a September 2020 study prepared by Georgetown University Professor JoAnn Volk for the California Health Care Foundation, a health care access advocacy group. The study also suggests that the lack of standardization across payers has created administrative headaches for behavioral health providers and blocked access to care.

"Most providers and patients also expressed frustration over the administrative burdens that these requirements impose," Volk wrote. "Providers found that procedures vary widely, with some plans and insurers approving care day by day and others allowing for three days of care or one to two visits at a time. Providers' representatives said a significant amount of their time at work is spent keeping track of the different requirements each plan and insurer imposes and going through appeals processes for denials."

In her study, Volk cites a November 2019 report prepared by Milliman Inc. for the Bowman Family Foundation, a behavioral health advocacy group, for financial evidence of a lack of parity. The Milliman study found that in 2017, the average behavioral health visit in California was compensated by plans at a rate of 14.9% less than primary care visits and 16.9% less than physical specialist and surgical visits.

Expert Points to Limited Evidence

A managed care policy expert who spoke to AIS Health on background says that insurers opposed the legislation out of concern that they would have to pay for indefinite care of chronic behavioral health conditions. The expert pointed out that there's limited data on the efficacy of long-term treatment for behavioral health conditions, and as a result, plans will struggle to implement the kind of quality and efficacy metrics for behavioral health providers that are standard practice in network design for physical care.

Volk agrees that the literature on chronic behavioral health care is still emerging, but she points out that plans cover a wide variety of chronic physical conditions. "There are chronic care issues here, and issuers may say that it seems like a really open-ended treatment plan," Volk tells AIS Health. "But that's what they do with diabetes and other lifelong illnesses. In that regard, it's not different."

"They've figured out that it's much smarter — and cost-effective — to get people the care they need to manage their chronic illness than to deal with the costly complications that come with not getting the care you need," Volk explains.

One stakeholder who works as an intermediary between payers and providers expects that payers will adjust to the new reality.

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"I fully understand the plans' concerns with the bill as written, but as a physician, I also see the dire need for treatment for those suffering from behavioral health conditions, especially during the COVID-19 pandemic," Vikram D. Bakhru, M.D., tells AIS Health. Bakhru is chief operating officer of ConsejoSano, a Los Angeles-based health care tech startup that provides culturally competent and multilingual patient communications.

"However, I am an optimist at heart and believe there are often ways to accomplish multi-way wins by expanding the pie," Bakhru adds. "Therein lies the role of innovation, which can be adopted by plans, providers and lawmakers alike to reach our common goal: the health of the patient."

Read S.B. 855 at https://bit.ly/2SCNQPn, the op-ed at https://bit.ly/36Odp8m, the Georgetown report at https://bit.ly/3nuKCvn and the Milliman report at https://bit.ly/3iBL73i. Contact Bakhru via Joe Reblando at joe@joereblando.com, Miller via Matthew Dick at matthew.dick@pinkston.co and Volk at joann.volk@georgetown.edu. ✧

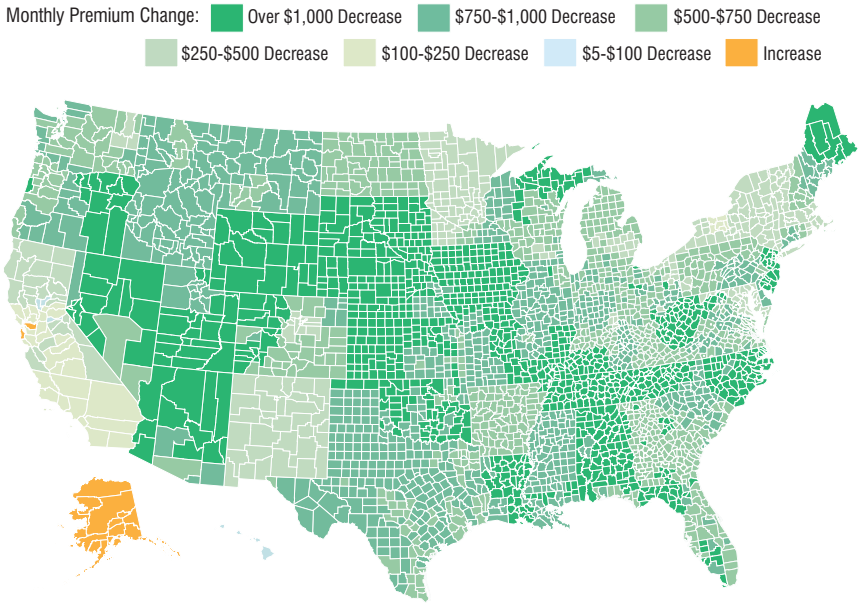
by Peter Johnson

A Biden-Like Health Plan Proposal Could Improve Affordability, Lower Premiums

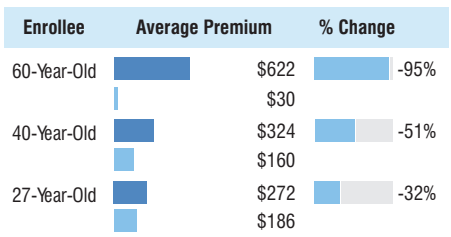
by Jinghong Chen

Expanding Affordable Care Act (ACA) premium subsidies beyond the current range of 100-400% of the federal poverty level for potential enrollees, as proposed by Democratic presidential nominee Joe Biden, would lower costs for almost all exchange enrollees, according to a recent Kaiser Family Foundation analysis. Biden also wants to tie ACA subsidies to the second-lowest-cost gold plan rather than the second-lowest-cost silver plan and reduce the maximum premium contribution to 8.5% of an enrollee's income for a benchmark gold plan. Under his proposal, older people making $50,000 annually would save the most on their monthly premiums. A 60-year-old would pay $354 on average per month for the second-lowest-cost gold plan instead of the current premium of $1,029. With the expanded subsidies, Biden's campaign estimated that federal spending on the ACA exchanges would increase significantly.

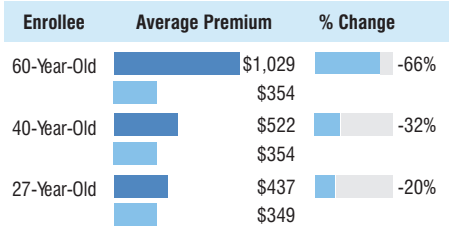
Projected Monthly Premium Changes Under A Proposal Like Joe Biden's (60-Year-Old Enrollees With $50K Income, Second-Lowest-Cost Gold Plan)



National Average Change in Monthly Premium for Enrollees With $50K Income (Bronze Plan: Deductible of $6,500)



National Average Change in Monthly Premium for Enrollees With $50K Income (Gold Plan: Deductible of $1,500)



NOTES: The projected monthly premium changes include plans that are offered on the exchanges. The premiums shown for California, Massachusetts and Vermont take into account extra subsidies currently offered in those states. Individuals with an income of $20,000 in Alaska are eligible for Medicaid.

SOURCE: "Affordability in the ACA Marketplace Under a Proposal Like Joe Biden's Health Plan," Kaiser Family Foundation. Visit https://bit.ly/36NRj69.

News Briefs

✦ ***Priority Health, a subsidiary of integrated health system Spectrum Health and Michigan's second-largest payer, announced a new suite of incentives for provider agreements that are intended to improve social determinants of health, while Pennsylvania-based payer Health Partners Plans (HPP) announced plans to expand its own SDOH mitigation program.*** A Priority Health press release claims that the insurer is the first in Michigan to offer such incentives to network members. "We understand that to effectively manage the health and wellness of a patient population, you need to look outside of the clinic walls. Being able to reward providers who are identifying these specific needs based on social factors is a step in the right direction," said Mike Jasperson, senior vice president of provider network strategy at Priority Health. "Having access to this type of data will eventually allow for both providers and payers to increase the quality of care that is delivered, reduce total cost of care for members, and directly address the needs of vulnerable populations." Meanwhile, HPP unveiled plans for an "SDoH Regional Council," which will convene community stakeholders to address social challenges. Read more at https://bwnews.pr/3lvS6N7 and https://bit.ly/3nyODyX.

✦ ***Based on oral arguments before the U.S. Supreme Court, legal experts say that PBMs have a good chance of winning repeal of a 2015 Arkansas law that strictly regulates how drug benefits are managed.*** The case, *Rutledge v. Pharmaceutical Care Management Association*, centers on whether a law known as Act 900 is preempted by the Employee Retirement Income Security Act of 1974 (ERISA), which bars states from enacting laws that "relate to any employee benefit plan" covered by the federal law. "My impression was that Arkansas got the toughest questions from the bench but was bolstered by the Trump administration's response," Katie Keith, a health care attorney and faculty member at Georgetown University's Center on Health Insurance Reforms, tells AIS Health. "And it certainly seems like the Justices are considering the broader impact of their ruling, on PBMs specifically and on ERISA plans and state regulation more broadly." Read more at https://bit.ly/2SADYpg.

✦ ***Recent studies released by the Kaiser Family Foundation (KFF) and benefits consulting firm Willis Towers Watson both concluded that employer-sponsored health benefits got more expensive in 2020, while a survey by supplemental payer Aflac Inc. found that plan sponsors want to maintain current levels of coverage but are struggling with affordability.*** The KFF study concluded that premiums for an average family with an employer-sponsored health plan increased by 4% to an average of $21,342 in 2020, with workers contributing an average of $5,588, though the average deductible of $1,644 did not change from 2019. The report observed that average family premiums have increased by 55% since 2010, "which is at least twice as fast as wages (27%) and inflation (19%)," according to a press release about the study. Meanwhile, the Willis Towers Watson study, a global survey of medical insurers, projected that the cost of health care benefits in North America will increase by 2.8% over 2020 and 8.1% in 2021. Sixty-seven percent of all respondents to the study expect that "medical costs will continue to accelerate over the next three years." The Aflac survey found that 68% of plan sponsors are extremely or very certain that they will be able to maintain their benefits packages, and 23% are somewhat certain. Read the KFF study at https://bit.ly/2SENW96, the Willis Towers Watson study at https://bit.ly/3nv0YUN and the Aflac study at https://bit.ly/3nyoy2Y.

✦ ***A Cigna Corp. survey indicates that COVID-19 recovery varies widely from patient to patient, and that more than half of patients hospitalized for the disease caused by the novel coronavirus have lingering symptoms for up to two months after their inpatient stay.*** According to a Cigna press release, among those with lingering symptoms, one in seven had not yet returned to work, with fatigue and shortness of breath among the most common challenges. "COVID-19 is not simply a serious respiratory virus and this study emphasizes the material change in health experienced by those who are hospitalized," said Saif Rathore, M.D., Ph.D., Cigna's head of data and analytics innovation. "We are committed to continue understanding how COVID-19 impacts our customers after the initial infection has run its course." Visit https://bit.ly/3ls2pSh to read more about the findings.

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