Strategic Business, Financial and Regulatory Analysis of the Health Insurance Industry

Health Plan Weekly

Nov. 13, 2020
VOLUME 30 | NUMBER 46

Managing Editor
Leslie Small
lsmall@aishealth.com

Senior Reporter
Peter Johnson

Data Reporter
Jinghong Chen

Executive Editor
Jill Brown Kettler

Biden Regs Could Target Payer Testing Liability, Medicaid

Now that the presidential race has been called for Joe Biden, policy experts are predicting that his administration's health care agenda will be accomplished mainly through executive action. That's a consequence of the likelihood of a divided Congress, along with the Trump administration's reliance on executive authority to implement its health care policies, many of which the new administration will want to reverse.

Naturally, the most pressing issue for Biden will be the increasingly out-of-control COVID-19 pandemic. Along with vaccine planning and distribution, experts say that other areas of employer concern like testing and workplace safety are certain to see significant action from the White House. The new administration will also step up efforts to mitigate the devastation the pandemic has wrought on communities of color and low-income workers. Experts also predict the Biden administration will assess which Trump administration executive actions to revise or reverse, a process that could include Medicaid work requirements.

Avalere Health Founder Dan Mendelson suggests health insurers would do well to reach out to the new administration, especially since most carriers are sitting on unusually large cash reserves due to low care utilization early in the pandemic *(HPW 10/30/20, p. 1)*.

continued on p. 6

SCOTUS Skepticism Toward ACA Suit Gives Insurers a Boost

Although a constitutional challenge to the Affordable Care Act (ACA) has been winding its way through the court system for more than two years — fueling ongoing concerns about the law's future — the Supreme Court during a Nov. 10 hearing appeared highly skeptical that the case has much merit. That's welcome news for the health insurance industry, as analysts have long pointed out that the sector is eager to move past the uncertainty that the lawsuit has created.

The suit in question, now known as *California v. Texas*, was first brought by a Texas-led coalition of conservative states in 2018. It argues that the ACA's individual mandate — which compels people to purchase health insurance — is unconstitutional because Congress removed the mandate's tax penalty via a budget bill in 2017. The states' argument relies upon a 2012 Supreme Court decision in the case *National Federal of Independent Businesses (NFIB) v. Sebelius*, when the justices ruled that the mandate was constitutional because it fell under Congress' taxing authority. So if the mandate is only permissible as a tax, and the tax is now zero, the conservative states argue that the mandate itself is now unconstitutional — and with it, the rest of the law.

While legal scholars across the ideological spectrum have been dubious of those claims, U.S. District Court Judge Reed O'Connor nonetheless agreed that the whole ACA should fall in a December 2018 ruling *(HPW 12/24/18, p. 1)*. Democratic at-

Published by AIS Health, Washington, DC. An independent publication not affiliated with insurers, vendors, manufacturers or associations.

torneys general who intervened in the case to defend the ACA appealed that decision, and in December 2019 the Fifth Circuit Court of Appeals ruled that, while the mandate is unconstitutional, O'Connor needs to better articulate why he thinks that part of the ACA is "inseverable" from the rest of the law. Rather than let the case continue to drag on in the lower courts, a California-led group of blue states asked the Supreme Court to weigh in, and the high court agreed.

In interviews with AIS Health following the Nov. 10 oral arguments in *California v. Texas*, experts say they were intrigued to find that a significant portion of justices' questions centered on whether the Texas-led coalition of states even had the right to bring its lawsuit — a legal question known as standing.

As Bill Jordan, a partner and co-leader of Alston & Bird's Health Care Litigation Group, put it: "there's a real question as to whether the court will find that the states have standing here."

Joel Ario, managing director of Manatt Health, points out that justices seemed to favor the term "inoperative provision" when describing the mandate — meaning they were skeptical that states could be harmed by a requirement that carried no penalty for noncompliance. Texas Solicitor General Kyle D. Hawkins, for his part, argued that states were still burdened by the reporting requirements associated with the mandate and therefore have the right to challenge it.

If the court decides the states don't have standing, it would simply dismiss the lawsuit without even having to consider the other legal arguments, Ario says — which would be a rather unexpected outcome. "I think the reason why people were surprised [by the focus on standing] is because the lower court didn't seem to have trouble with the standing issue," he adds.

"I think ultimately, given the tenor of the questions, they will find standing, but the bulk of the argument was discussing the standing issue," Jordan weighs in. "So we've been describing it to clients as, 'expect the decision to kind of be a nothingburger. The Affordable Care Act will survive and we'll go on.'"

Even if the court rules that the states have standing to sue and agrees that the individual mandate is unconstitutional, both Ario and Jordan say they expect the rest of the ACA to remain intact. They cite the fact that Justice Brett Kavanaugh and Chief Justice John Roberts — both of whom are right-leaning — expressed skepticism about the mandate being inseverable from the rest of the law.

Roberts, Kavanaugh May Join Liberals

"So I think you put those two together with the three liberals on the court, and you have at least five votes — if they were to strike the mandate — for not striking any other part of the law," Ario says. (After the death of Justice Ruth Bader Ginsburg, the remaining left-leaning justices are Elena Kagan, Stephen Breyer and Sonia Sotomayor.)

Roberts, who served as the swing vote in *NFIB v. Sebelius* to uphold the mandate's constitutionality, said in a telling exchange with Texas' Hawkins that "it's hard for you to argue that Congress intended the entire act to fall if the mandate were struck down when the same Congress that lowered the penalty to zero did not even try to repeal the rest of the act. I think, frankly, that they wanted the court to do that, but that's not our job."

During his own questioning of Hawkins, Kavanaugh argued that previously set court precedents on the issue of severability make it "fairly clear that the proper remedy would be to sever the mandate provision and leave the rest of the act in place — the provisions regarding preexisting conditions and the rest."

Health Plan Weekly (ISSN: 2576-4365) is published 52 times a year by AIS Health, 2101 L Street, NW, Suite 300, Washington, D.C. 20037, 800-521-4323, www.AISHealth.com.

Subscriptions to ***HPW*** include free electronic delivery and access to all content online at www.AISHealth.com. To renew your annual subscription, please order online at www.AISHealth.com. For subscriptions for five or more users, contact sales@aishealth.com.

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

And Justice Samuel Alito, another conservative, pointed out that in years since the court ruled in *NFIB v. Sebelius*, the conventional wisdom around the individual mandate has changed.

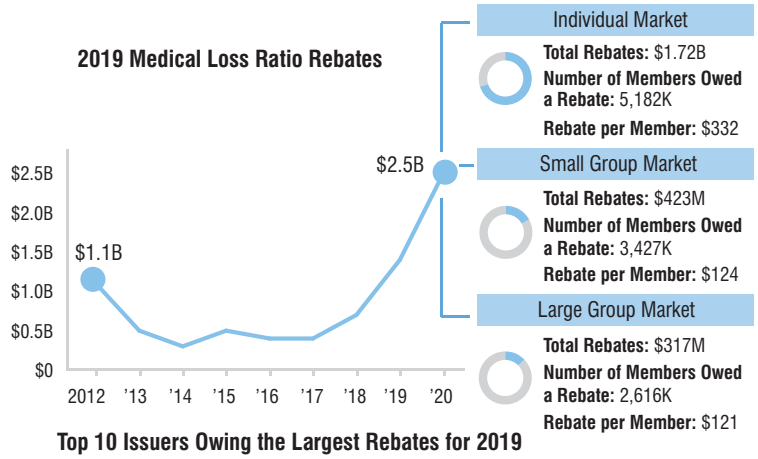
"At the time of the first case, there was strong reason to believe that the individual mandate was like a part in an airplane that was essential to keep the plane flying so that if that part was taken out, the plane would crash," Alito said. "But now the part has been taken out and the plane has not crashed."

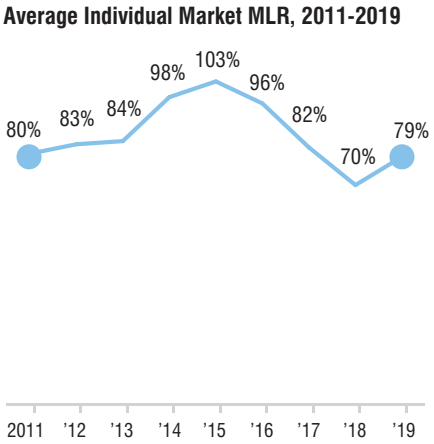
Indeed, contrary to some predictions, the individual market did not collapse when the mandate was zeroed out in 2017 — in fact, it has become increasingly stable. That led some experts to theorize that it is the ACA's generous subsidies, not a tax penalty

Health Insurers Owe $2.5 Billion in MLR Rebates This Year

by Jinghong Chen

Insurers that participate in the individual, small-group and large-group markets will issue a record high $2.5 billion in medical loss ratio (MLR) rebates to more than 11.2 million customers this year, an increase of almost $1.1 billion from rebates issued last year, according to CMS. Because health care utilization remains depressed, many health insurers are thriving amid the coronavirus pandemic. Several insurers have waived costs for COVID-19 treatments and offered up premium credits to lower the MLR rebates they could owe over the next couple of years *(HPW 10/30/20, p. 1)*, as MLR rebate amounts are calculated on a rolling three-year average.

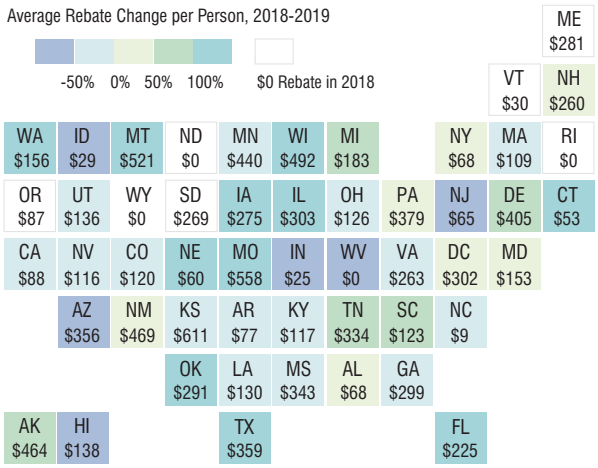




Top 10 Issuers Owing the Largest Rebates for 2019

Insurer	State	MLR Rebates (Individual / Small Group / Large Group)
Health Care Service Corp.	TX	$251M
BCBS of Florida	FL	$186M
Celtic Insurance Company	MO	$141M
Health Care Service Corp.	IL	$105M
BCBS of Tennessee	TN	$88M
Health Care Service Corp.	OK	$85M
Ambetter of Peach State	GA	$81M
QCC Insurance Company	PA	$70M
Health Net of Arizona	AZ	$54M
Blue Cross of California	CA	$53M

Average MLR Rebate per Person for 2019



NOTE: Rebates for 2019 are based on MLR reports filed through Oct. 16, 2020.

SOURCES: "2020 Medical Loss Ratio Rebates," Kaiser Family Foundation. Visit https://bit.ly/2zosGOH. CMS, visit https://go.cms.gov/38B1bky, https://go.cms.gov/36suLWz and https://go.cms.gov/3loeY1n.

for remaining uninsured, that attracts enough people to have a functioning market even when insurers are not allowed to medically underwrite *(HPW 6/11/18, p. 4)*.

Ario points out that because the mandate's tax penalty is already gone, it won't matter much to individual market insurers how the court rules on the constitutionality of the provision itself. "As the stock market people like to say, it's already priced into the marketplace," he tells AIS Health. "People are basically assuming there isn't a mandate."

Leerink SVB analyst Stephen Tanal, in a Nov. 10 note to investors, emphasized that the court's decision on severability is the most critical.

"If the mandate is deemed to be severable from ACA, then, regardless of the SCOTUS decision on the constitutionality of the individual mandate itself, the rest of the law will remain intact, including key provisions that have been helpful to MCOs — notably [Centene Corp. and Molina Healthcare, Inc.] — including the creation of ACA exchanges and the expansion of Medicaid," he wrote.

AHIP Says ACA Should Stay Intact

America's Health Insurance Plans said in a Nov. 10 statement that it's hoping the court will reject this latest ACA challenge. "Invalidating the law would be misguided and wrong and unleash chaos on the entire health care system," the trade group said.

Citi analyst Ralph Giacobbe noted that health care stocks rose following the hearing, an unsurprising outcome since "this case would clear a big hurdle in being the 'last' overhang for the sector among recent headlines/fears." Still, while the justices seemed to be leaning toward keeping the ACA intact, "we acknowledge that oral arguments are not a perfect indicator of how the justices may eventually rule," Giacobbe added.

For his part, Jordan says he wouldn't completely discount the possibility of an unexpected ruling. But even that might not be as much of a disaster as some have predicted — at least not right away.

"Let's assume that a majority finds that the mandate is unconstitutional, which I think is likely, assuming there's standing," he says. "Then, to our surprise, a majority finds that the mandate is inseverable — I think that instead of simply taking the approach of finding the entire Affordable Care Act would fall, the court most likely would send the case back for a hearing at the district court [to decide] truly whether all of the other provisions of the Affordable Care Act should fall."

Contact Jordan at bill.jordan@alston.com and Ario at jario@manatt.com. View a transcript of the hearing at https://bit.ly/3pmv4Ll. ✧

by Leslie Small

Centene Acquires Apixio in Bid To Improve Data Analytics

Centene Corp. on Nov. 9 said it will acquire health care analytics company Apixio Inc., a move that industry insiders say will help the insurer leverage electronic health record (EHR) and population health data. That strategy, they suggest, is especially important with the industrywide implementation of EHR interoperability regulations, which will release a flood of patient data.

In a Nov. 9 investor note, Citi analyst Ralph Giacobbe cited the increasing importance of analytics in managed care.

"[Centene's] acquisition of Apixio speaks to the continued focus across the healthcare industry and at [Centene] specifically on digitization and leveraging technology to provide actionable insights for payors and providers," Giacobbe wrote. "We view [Centene's] acquisition of Apixio as complementing and further enhancing [Centene's] existing suite of data and analytics products."

"Apixio's capabilities are closely aligned with our plans to digitize the administration of healthcare and to leverage comprehensive data to help improve the lives of our members," said Centene CEO Michael F. Neidorff in a Nov. 9 press release. "Apixio's technology will complement existing data analytics products including Interpreta, creating a differentiated platform to broaden support for value-based healthcare payment and delivery with actionable intelligence."

Apixio Will Remain 'Independent Entity'

According to the release, Apixio will continue to pursue business outside of its relationship with Centene as an "operationally independent entity."

"We are very excited about this transaction. With Centene, we will be able to accelerate the use of our [artificial intelligence] technology to improve the way that healthcare is measured, administered, and delivered, and to help enable new discoveries," added Apixio CEO Darren Schulte, M.D. "This partnership positions Apixio to extract insights from digital data to help millions of individuals receive higher quality care around the world."

Vast amounts of patient data will soon become available as insurers implement federal EHR interoperability regulations *(HPW 9/18/20, p. 1)*, and analysts say using that data effectively will be a must for payers going forward.

"Interoperability has always had business value," Ashraf Shehata, KPMG national sector leader for health care and life sciences, tells AIS Health.

"The whole purpose of automation is not just to digitize the records for medical safety and better billing practices. Really what it was about was to create better, more discrete analytics to help us understand population health, population risk, pricing and getting more discrete views on where the delivery of care was going, and potentially looking at value drivers."

Joe Paduda, founder of consultancy Health Strategy Associates, makes a similar point — though he emphasizes that analytics must be actionable to have value.

"With a highly-fragmented EHR market and often multiple providers

CMS Delivers Wins to Medicaid MCOs in Final Rule

The Trump administration has finalized its long-awaited rewrite of an Obama-era Medicaid rule, delivering wins on network adequacy and rate adjustments to managed care organizations (MCOs) operating in state Medicaid programs.

The final rule, released Nov. 9, was four years in the making and is intended to reduce administrative and regulatory burdens on Medicaid/CHIP managed care agencies and plans while offering states additional flexibility, according to CMS.

The final rule likely was pushed out the door so that it would be in place before the President-elect Joe Biden's administration takes over, says Jeff Myers, senior vice president, reimbursement strategy and market access, at Catalyst Healthcare Consulting. The majority of the provisions will take effect in December.

One main win for MCOs is a provision in the rule that allows states to adjust risk scores only by a "de minimis" amount without review by CMS, Myers says. This provision takes effect with rating periods beginning on or after July 1, 2021. "That's important because the plans really didn't get hit by COVID, and so their profit margin this year is insane," Myers says. Meanwhile, "states have the largest deficit ever, so the states are in desperate need of money," he says.

Therefore, states would be tempted to adjust actuarial tables downward, reducing payments to states, Myers says. "And so I think the win for the plans is that if [the states] want to get outside a very small change to the actuarial table, it requires submitting it back to CMS," he adds.

In a nod to the increasing importance of telehealth, particularly during the COVID-19 pandemic, CMS also scrapped "time and distance" requirements for network adequacy, establishing "quantitative" standards that allow states to use alternative metrics such as a "provider to enrollee ratio." CMS also is clarifying that states have the authority to define "specialists" in whatever way they deem most appropriate for their programs.

"Insurers will be happy with the final rule's provision on network adequacy," says Abner Mason, CEO of ConsejoSano, a health tech startup that specializes in linguistically and culturally aligned Medicaid and Medicare patient outreach for health plans and health systems. "States being allowed to set standards like using provider-to-enrollee ratios instead of minimum time-and-distance can facilitate plans and states adopting innovations like telemedicine," Mason tells AIS Health.

The final rule also makes changes to the Medicaid and CHIP (MAC) Quality Rating System (QRS). It adds a requirement that CMS develop a minimum set of mandatory performance measures that will apply equally whether a state chooses to implement the CMS-developed QRS or a state alternative QRS, and also expands the "scope of alignment of the MAC QRS and this minimum measure set with the Medicaid Scorecard initiative and other CMS managed care rating systems, as appropriate, such as Medicare Advantage," CMS said.

Myers says it's possible that this final rule could see additional regulatory changes once the Biden administration takes over (see story, p.1). However, he says adjustments may come as part of broader shifts in Medicaid and health care policy, which would require federal legislation.

View a fact sheet on the CMS Medicaid managed care rule at https://go.cms.gov/32Doq9U. Contact Myers and Mason via Joe Reblando at joe@joereblando.com.

by Jane Anderson

serving patients, aggregating data into a format that can be analyzed and evaluated is a major obstacle to effective patient health management," Paduda tells AIS Health via email. "If Apixio's technology is able to help Centene know a lot more about its members, Centene may be able to identify health issues early on and more quickly evaluate the effectiveness of treatment. The more Centene knows about its members and the sooner it knows it, the better. Of course, as the payer, Centene has to get its provider partners to take action."

Centene Ran Tests in Florida

According to Credit Suisse analyst A.J. Rice, Centene executives claim that sort of operational benefit is a driver of the deal. Rice wrote in a Nov. 10 investor note that "in initial tests in Florida, [Centene] found average pre-authorizations decline to 3.5 seconds from the average 18 minutes it [otherwise] takes a nurse to complete the process."

Giacobbe wrote that, though terms were not disclosed, he did not expect the deal to impact Centene's bottom line.

"Although Apixio is a growing healthcare analytics company, it remains small relative to [Centene] and therefore although financial metrics of the deal have not been disclosed, we do not view the transaction as having a material impact on [earnings]. Nonetheless, the deal is a nice tuck-in acquisition that will further enhance [Centene's] technology capabilities and reinforces [management's] commitment to becoming a…technology driven enterprise," he said.

Read more at https://bit.ly/3lqCw-CM. Contact Paduda at jpaduda@healthstrategyassoc.com and Shehata via Bill Borden at wborden@kpmg.com. ✧

by Peter Johnson

New Regulations Loom

continued from p. 1

"Health plans will have to work collaboratively with the federal government to figure out their place in coverage and payment for therapies and vaccines associated with COVID-19," Mendelson says. Having served in the Clinton administration, Mendelson has extensive contacts in the Democratic Party health care policy community. "There are some members of Congress who will be coming into the administration who believe that health plans should be paying for a good portion of these costs through the excess profitability generated during these volume reductions."

> **"I do think there will probably be an opportunity with any new administration to at least hear out the industry a little bit more.**

On a similar note, Ashraf Shehata, KPMG national sector leader for health care and life sciences, says that a change in administrations is an opportunity for the managed care industry to reintroduce itself to policymakers.

"I do think there will probably be an opportunity with any new administration to at least hear out the industry a little bit more," Shehata tells AIS Health. "I think the payers specifically always want to have a more collaborative approach. There is obviously still a big set of activities in managing COVID and managing the vaccine distribution."

So far, payers have responded warmly to the new administration. America's Health Insurance Plans President and CEO Matt Eyles released a statement on Nov. 7 congratulating Biden on his election, adding that the trade group looks "forward to working with the new Administration to deliver a competitive system that leverages private sector innovation to improve on what is working."

Though Shehata is cognizant of the financial risk to insurers posed by increased requirements for COVID-19 testing, he says a more muscular federal pandemic response — bolstered by payer input and cooperation — can help health plans offset some of that liability.

Coordination with the government will help plans "manage forward potential impacts with medical trend," Shehata explains. "There's still uncertainty: we're seeing spikes again, and concern over infection rates. Certainly we're seeing better management of hospitalizations, which is positive."

Biden May Reconsider Guidance

Mendelson predicts that the Biden administration will likely revisit guidance issued by the Trump administration around testing payment requirements. At present, HHS has determined that only "medically necessary" testing be offered to plan members without cost sharing.

"I think that there will be a willingness to delimit what kind of testing is required, and to only include that as part of a benefit," Mendelson says. "There are people who want to go much further and say up to a test a week is covered. Who's to say what is medically necessary or not in this case? There are a lot of people who would like to be tested weekly because they have a loved one at home who has an issue, or because they are immunocompromised [themselves], and have their employers pay for it. The Biden crew has already said testing should be free. The question now is, who should be paying for it? So, OK, if it's going to be free to the consumer, the choices

are the health plans, the provider, the employer or the government."

Along those lines, Michael Bagel, director of public policy for the Alliance of Community Health Plans, says he hopes the new administration will engage stakeholders as it develops testing policy.

"We look forward to working with the administration on a national testing strategy that brings together the federal government, health plans, providers, labs, employers and patient advocates," Bagel tells AIS Health. That process would ensure "we're not just pushing the burden on one [stakeholder], and we're not leveraging it just for the ability to go back to work, or [only] social reasons or health reasons." He says he hopes that the national testing plan will "divide the liability" for testing across all the stakeholders he mentioned.

Mendelson adds that employers can expect more detailed guidance on workplace safety from the Occupational Safety and Health Administration (OSHA), and that plans should track what sponsors are expected to do in the workplace. He observes that COVID-19 workplace issues are "interconnected," and not solely the responsibility of either plan sponsors or carriers.

James Gelfand, senior vice president for policy for the ERISA Industry Committee (ERIC), also tells AIS Health that he expects action from OSHA, and adds that compliance with comprehensive OSHA guidance could accomplish some of the back-to-work liability protection that employers have sought in Congress.

If employers were sued by employees for catching COVID-19 on the job, Gelfand says "that [OSHA] guidance would potentially be used as a safe harbor."

Focus Will Be on the Vulnerable

Meanwhile, experts say that the new administration will have a more positive view of Medicaid and the communities it serves than the Trump administration. Abner Mason, CEO of ConsejoSano, says that the effectiveness of the pandemic response will depend on how the administration works with vulnerable communities, including communities of color, and that Medicaid managed care plans are a necessary avenue to reach those patients. ConsejoSano is a health tech start-up that specializes in linguistically and culturally aligned Medicaid and Medicare patient outreach for health plans and health systems.

Mason suggests that, by issuing Medicaid guidance, the administration can offset some of the pandemic's disproportionate impact on low-income workers and communities of color without getting new funding from Congress. He also encourages employers to coordinate with Medicaid managed care plans that serve their employees.

"We've got to design a testing strategy that takes into account low-income workers, many of whom are essential workers," Mason says. "[While] the workplace may be a very good place to do that kind of testing for many of them…I think that the Medicaid managed care plans can be a big part of the solution here, because they already have access to that member and [to the] providers that have worked with that member."

MCO Stock Performance, October 2020

	Closing Stock Price on 10/30/2020	October Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2020 EPS*
COMMERCIAL				
Cigna Corp.	$166.97	(5.9%)	(18.5%)	$18.55
UnitedHealth Group	$305.14	(2.4%)	4.3%	$16.69
Anthem, Inc.	$272.80	(3.1%)	(9.3%)	$22.43
Commercial Mean		**(3.8%)**	**(7.8%)**	
MEDICARE				
Humana Inc.	$399.28	(3.8%)	9.9%	$18.97
Medicare Mean		**(3.8%)**	**9.9%**	
MEDICAID				
Centene Corp.	$59.10	(3.6%)	(4.5%)	$4.98
Molina Healthcare, Inc.	$186.47	0.8%	39.8%	$12.36
Medicaid Mean		**(1.4%)**	**17.7%**	
Industry Mean		**(3.0%)**	**3.6%**	

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

SOURCE: Bank of America Merrill Lynch.

The Biden administration will also likely revisit controversial areas of Trump administration's Medicaid policy, including work requirements. Jerry Vitti, founder and CEO of Healthcare Financial, Inc., tells AIS Health that the Biden administration could have a flexible approach to work requirements, especially if revoking work requirement waivers will lead states to drop Medicaid expansion altogether.

"I'm looking at Medicaid work requirements through the lens of Medicaid expansion, one of the key planks of President-elect Biden's platform," Vitti says. "If his end-game is to get red states to expand, a key part of that strategy is to make it palatable for those states' governors and legislatures to do so. To get buy-in, he will have to show flexibility by allowing states to design Medicaid programs that work for them. In President-elect Biden's remarks so far, we can see that he's not trying to shove everything down the throats of Republicans.…My hunch is that the new administration will leave Medicaid work requirements in place but discourage them going forward."

Gelfand says the administration "could potentially try to develop a framework for partial Medicaid expansions," though he expects the administration to "get rid of the work requirement stuff on day one."

Contact Bagel via Dan Lemle at dlemle@achp.org, Gelfand via Kelly Broadway at kbroadway@eric.org, Mason and Vitti via Joe Reblando at joe@joereblando.com, Mendelson at dmendelson@avalere.com, and Shehata via Bill Borden at wborden@kpmg.com. ✧

by Peter Johnson

News Briefs

✦ ***CVS Health Corp. promoted Daniel Finke to executive vice president of its Health Care Benefits (HCB) Segment effective February 2021, succeeding Karen Lynch, who will become president and CEO of CVS at the same time.*** HCB includes Aetna and, according to a press release announcing the promotion, covers 34 million lives. According to the release, Finke has worked for Aetna since 2014, most recently leading the payer's Commercial Business and Markets division, and previously "spent more than a decade at Anthem in various national executive roles." Read more at https://bit.ly/2Izcij7.

✦ ***A Connecticut primary care practice has sued Cigna Corp. in federal court, alleging that the insurer wrongfully denied over $4.6 million in COVID-19 testing costs for over 4,400 patients.*** While the figures involved are relatively small for a national carrier, the suit could have substantial implications for the managed care industry if successful. According to Bloomberg Law, "the lawsuit is an early instance of the Employee Retirement Income Security Act being used in coronavirus coverage litigation," and it cites new COVID-19 relief laws including the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Read the Bloomberg article at https://bit.ly/32FPCVo and the filing at https://bit.ly/38ExPBQ.

✦ ***Nonprofit organization FAIR Health and researchers from the Johns Hopkins University School of Medicine found in an analysis of claims data that the top three comorbidity risk factors for death from COVID-19 were, in order from highest to lowest risk, developmental disorders, lung cancer, and intellectual disabilities and related conditions.*** The white paper, which was not peer-reviewed, observed that social factors are a likely driver of these comorbidities: "There are several possible reasons for the high COVID-19 mortality risk in people with developmental disorders and intellectual disabilities. These include greater prevalence of comorbid chronic conditions, disproportionate representation as workers in essential services, and increased COVID-19 transmission in group residential settings." The data analyzed in the study was drawn from claims documenting 467,773 patients in FAIR Health's private health care claims database. Read more at https://bit.ly/36yGliO.

✦ ***A federal judge has ordered United Health Group to reprocess approximately 67,000 behavioral health claims from around 50,000 members that the carrier previously denied.*** Judge Joseph Spero of the U.S. District Court for the Northern District of California wrote in his order that the payer's decision-making was "significantly and pervasively more restrictive than generally accepted standards of care." Per the order, UnitedHealth must also change its employee training and coverage guidelines. Read the order at https://bit.ly/2JSS6cj.