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Beleaguered Hospitals Seek Advance Payment From Insurers

In a series of open letters dated April 1, the American Hospital Association (AHA) asked payers to consider moving temporarily to an advance or scheduled payments model because hospitals' cash flow is strained by the COVID-19 pandemic. Experts say the need for liquidity is very real, but what hospitals are requesting may not be feasible.

"We ask that insurers support stable cash flow by allowing providers to opt into periodic interim payments and/or accelerated payments for the duration of the public health emergency," wrote Richard Pollack, AHA's president and CEO, in a letter that was copied to the heads of several large payers, including CVS Health Corp.'s Aetna, Anthem, Inc., Cigna Corp., Humana Inc. and UnitedHealth Group, plus the Blue Cross Blue Shield Association and America's Health Insurance Plans (AHIP).

Some insurers are already offering advanced payments to independent practices and primary care physicians (see brief, p. 8), and Blue Cross and Blue Shield of North Carolina, Blue Shield of California, Premera Blue Cross and UnitedHealth are all taking steps to speed up payments or offer financial help to providers.

In addition to seeking accelerated payments for hospitals, Pollack also requested that insurers speed up their claims processing.

continued on p. 5

HCSC Coverage Is a Win for New-Gen Cardiac Telemetry Device

Ten years after the launch of a mobile outpatient cardiac telemetry device from medtech company BioTelemetry, Inc., insurer Health Care Service Corp. (HCSC) has included it in its medical coverage policy. Pennsylvania-based manufacturer BioTelemetry revealed the coverage decision in a February earnings call, saying that the move was the result of a non-stop effort to flip a small holdout of insurers. BioTelemetry says about 95% of payers cover the diagnostic device, and many without step therapy requirements that mandate patients try other devices first.

The mobile outpatient cardiac telemetry (MOCT) device is perhaps one of the most recent medical developments used for diagnosing heart rhythm and rate abnormalities. These problems — the heart pumping too slow or too fast — can cause sudden cardiac arrest, stroke and/or death.

The MOCT device is a diagnostic tool for cardiologists to figure out what exactly is happening to a patient. A patient might come in with complaints of chest pain, shortness of breath or a fluttering in the chest area. A patch is put on a patient's chest, and the sensor inside the patch continuously logs data. That data is then sent to BioTelemetry's data hub, where it's analyzed and given to a patient's health care provider.

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Dhanunjaya Lakkireddy, M.D., is a fan of this new generation of devices; he's a cardiologist and the medical director of Kansas City Heart Rhythm Institute at hospital system HCA Midwest Health. He says for a number of years, payers wouldn't cover MOCT from any manufacturer, labeling the devices as investigative.

"Insurance companies are typically about three to four years behind technological evolution, so we had a lot of struggles to get it approved [for patients]," Lakkireddy tells AIS Health.

These devices are part of a growing industry, because as more Americans develop heart disease, there's a rising demand to identify the symptoms earlier and mitigate bigger costs down the road. According to technology research firm Technavio, the global mobile cardiac telemetry market is expected to reach $246 million by 2023, with a large number of competitors. Companies like Medicomp Inc., Welch Allyn, Applied Cardiac Systems, Inc., Biotricity Inc. and BioTelemetry lead the market.

Until the mid-2000s, cardiologists monitoring heart rhythm data had two choices: a Holter heart monitor or a cardiac event monitor. The Holter monitor is the oldest, and is only worn for about 24 hours. The event monitor, meanwhile, has a 30-day window to measure arrhythmias. Both monitors have lower rates of making an accurate diagnosis and can produce false negatives.

As Lakkireddy says, "sometimes the arrhythmia doesn't happen within the 30 days or 24-hour period you're watching."

The MOCT, and other devices like it, can be worn for much longer periods of time, and sends data in real time to be analyzed. Patients push a button if they feel a symptom, but the device also analyzes heart rate and rhythms and stores that data, unlike older generation monitors.

The MOCT from BioTelemetry picks up 100% of all heart arrhythmias that are 30 seconds or longer, according to Wayne Derkac, M.D., the senior vice president of medical affairs at BioTelemetry.

"Which means if it's there, it is there and we're 100% correct," Derkac says.

Older Devices Can Miss Problems

Lakkireddy at HCA Midwest Health explains that the older generation devices often produce results that show a patient has no heart problems, even though the patient is still presenting with symptoms. And often insurers will have step-therapy processes to manage utilization.

"I'm looking at a negative Holter, a negative event monitor, so we put in for the loop monitor," another device that is a newer generation and can be more expensive, Lakkireddy says. The results of that monitor, he says, are much more likely to be definitive and give him the confidence that a patient is not having arrhythmia.

"But we go through the expense of covering a Holter and event monitor, and we could have gotten the answer faster and save a few thousand dollars worth of resources," Lakkireddy says.

Medicare paid $734 for the MOCT device from BioTelemetry in 2012, according to a 2013 SEC filing, which is the most recent cost information publicly available about the device.

When an insurer does approve coverage for a device like the MOCT, the manufacturer charges the payer a technical fee for the data acquisition and analysis, and providers charge payers an interpretive fee that will trigger clinical action.

BioTelemetry has also used the MOCT to start a remote monitoring program for health care providers treating patients with COVID-19. Some drugs used to treat the virus that's caused a global pandemic can cause a

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

dramatic speeding up of the heartbeat and potential cardiac arrest.

HCSC might have delayed coverage of BioTelemetry's MOCT in part because of evidence standards in medical coverage decisions. Sean Vander Linde is the vice president at Kx Advisors, a health care consulting firm that recently conducted product development research for a medtech company's cardiac device.

Coverage Decisions Vary

"When we talk to payers, it almost always comes back to clinical evidence and what's the outcomes data, and that's usually in the form of some type of study," Vander Linde tells AIS Health. "This could be a company showing a device reduces the total cost of care, improving length of hospital stays or improving quality-of-life indicators."

But he also says payers are becoming open to evidence outside of the gold-standard randomized control trial.

"That could be smaller-scale studies that show significant outcomes. Instead of 500,000-plus patients, you might have 400 patients," Vander Linde says. An insurer may also use post-market surveillance data.

Derkac at BioTelemetry says the company submitted a study to HCSC about seven months before the recent coverage change. The study was of about 70,000 patients and compared the MOCT to another device, showing the MOCT was more cost and medically effective.

"We have no idea if that was the thing that did it," Derkac says. "It's a matter of their evidence evaluation."

HCSC said in a statement that it is committed to increasing access to safe, appropriate and effective health care based on the best available research.

"At HCSC, we partner with health care professionals and continuously review new clinical research to confirm the medical care our members receive is supported by scientific evidence and the broad medical community," the statement read.

BioTelemetry said it still has to work with the five Blue Cross Blue Shield companies within HCSC to establish contracts in Illinois, Montana, New Mexico, Oklahoma and Texas.

> **"When we talk to payers, it almost always comes back to clinical evidence and what's the outcomes data, and that's usually in the form of some type of study.**

Payers often will tag newer devices as emerging or investigational as a reason for noncoverage. That's still the case for members of Blue Cross and Blue Shield of North Carolina. The insurer says in its corporate medical policy, updated in late 2019, that it considers outpatient cardiac telemetry investigational, and that it does not cover services in that category.

Some payers cover MOCT and similar devices, but with processes similar to step therapy. For instance, CVS Health Corp.-owned insurer Aetna requires that members have a Holter monitor, other 48-hour telemetry or infrequent symptoms of arrhythmia to qualify for the MOCT device.

"In some cases, we've heard from physicians that they get a lot of patients who are 'worried-well,' and maybe they don't even merit a Holter monitor," Vander Linde says.

Derkac also acknowledges the MOCT isn't for all patients who have symptoms.

"If I'm a 28-year-old, there are a few palpitations, and I want to check it out, maybe I just need a Holter," Derkac said. "If you prescribe MOCT, maybe that's not appropriate."

In the past year, a new generation of cardiac monitors has exploded with the Apple Watch and similar user-facing devices offering such functionality. Vander Linde says payers for the most part don't see enough evidence to cover these devices from a medical diagnostic standpoint. Some payers, like Aetna and Medicare Advantage insurer Devotion Health, are offering the watches to members as a wellness benefit.

"When you talk to payers about those types of devices, they think they're interesting to watch, but they haven't shown clear outcomes and cost savings that they merit any kind of coverage," Vander Linde says.

Analyzing Data Won't Be Easy

Lakkireddy says he sees promise with these commercial monitors. But a big problem still exists: Who analyzes all the data from an Apple Watch heart monitor? About a year ago he ran a small experiment with two friends over two weeks who used the Apple monitor for heart symptoms.

"In two weeks' time, there were 1,200 transmissions; whenever they had a symptom, they would push a button, and it would transmit 1,200 emails," Lakkireddy says. "Imagine you put the same tool in the hands of a patient, they are worried, they check their pulse, and they transmit all that data. Who's going to manage the data, and help the health care professionals to manage this data? That's the piece that's completely missing."

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by Lisa Gillespie

Insurers, Lawmakers Continue Calls for HealthCare.gov SEP

Facing mounting criticism for deciding not to allow a special enrollment period (SEP) on the federal health insurance exchange amid the COVID-19 crisis, the Trump administration offered up a different strategy to help the uninsured get the care they need if stricken by the disease caused by the new coronavirus. In short, the administration will funnel a portion of the $100 billion in funding earmarked for U.S. hospitals in the latest emergency stimulus bill "to cover providers' costs of delivering COVID-19 care for the uninsured," HHS Secretary Alex Azar explained during an April 3 White House press briefing.

Admin's Plan May Not Be Enough

But according to a recent letter to Congress from the insurance industry's two main trade groups — as well as health policy experts who spoke with AIS Health — lessening hospitals' uncompensated care costs isn't a real substitute for allowing people to sign up for comprehensive health coverage.

On the one hand, "covering hospital treatment costs for uninsured patients would provide them important peace of mind and hopefully discourage people from delaying care," says Larry Levitt, the executive vice president for health policy at the Kaiser Family Foundation. "Even opening up the enrollment period [on HealthCare.gov] would likely mean that a lot of people would still be uninsured, so it certainly wouldn't eliminate uncompensated care for uninsured patients."

"That said, covering only hospital costs for COVID-19 for people who are uninsured is hardly a replacement for health insurance," he adds.

People who have lost their employer-sponsored coverage are already eligible for an SEP under the Affordable Care Act (ACA), but that option isn't available to people who lose a job where insurance wasn't offered. To allow such individuals — or anyone else who hasn't been insured but now wants to be — to sign up for coverage amid the ongoing public health crisis, all but one of the state-based ACA marketplaces have opened up special enrollment windows for the uninsured, according to an April 6 blog post from the Georgetown University Health Policy Institute's Center on Health Insurance Reforms.

The author of that post, research professor Sabrina Corlette, tells AIS Health that she shares Levitt's views about funding care for the uninsured in lieu of an SEP that would apply to the 38 states that rely on the federal exchange, HealthCare.gov. "In general, I take the view that where possible, it's better to get people comprehensive coverage," she tells AIS Health. Still, compensating hospitals for caring for the uninsured population "is going to be important." Ideally, she adds, the federal government would both allow a federal SEP for HealthCare.gov and reimburse hospitals for uncompensated care related to COVID-19.

Medicaid Can Help Fill Coverage Gaps

People who lose their jobs who aren't eligible for an ACA marketplace plan may qualify for Medicaid coverage, depending on their previous income level and whether their state has expanded Medicaid eligibility. A recent analysis by Health Management Associates estimated that in a scenario where 21 million people lose their jobs due to a pandemic-related recession, Medicaid enrollment will rise by 17 million, while ACA marketplace enrollment will grow by 1.5 million (see infographic, p. 7).

During the April 3 White House briefing, Azar said that as a condition of receiving funds under the new program, "providers will be forbidden from balance billing the uninsured for the cost of their care," and providers will be reimbursed at Medicare rates.

On April 10, HHS released more details about the first round of stimulus funding for hospitals, saying it partnered with UnitedHealth Group "to provide rapid payment to providers eligible for the distribution of the initial $30 billion in funds." HHS said it's working on "additional targeted distributions" for particularly hard-hit providers, adding that "this supplemental funding will also be used to reimburse providers for COVID-19 care for uninsured Americans."

A recent analysis from the Kaiser Family Foundation estimated that total payments to hospitals for treating uninsured patients under the Trump administration's policy would range from $13.9 billion to $41.8 billion. "So in the worst case, it could cover a substantial portion of the emergency fund, which I suspect hospitals were expecting to be used for other things," says Levitt, who co-authored the analysis.

Questions Remain About Details

Both Levitt and Corlette point out that the administration's plan doesn't appear to address bills that uninsured patients might receive from physicians or other services rendered in the hospital, which typically arrive separately from the hospital bill itself. Further, they note that uninsured patients could face steep bills if they're treated for a condition that turns out not to be COVID-19. Some of the disease's symptoms, including coughing and

fever, are similar to other illnesses like influenza.

At a more philosophical level, Levitt says it's curious that the administration wants to directly reimburse providers, at Medicare rates, for some Americans' care — a policy generally opposed by private insurers, health care providers and Republicans alike. "It certainly is ironic that the president is proposing a program that looks like at least a narrow version of Medicare for All when he has in the past criticized it as socialism," he tells AIS Health.

America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA) say they still want to see an SEP for HealthCare.gov.

In a letter sent on April 8 to congressional leaders, the trade groups expand upon a previous letter *(HPW 4/6/20, p. 1)* outlining what lawmakers should do to maintain "strength, stability and continuity across all types of coverage."

Among their recommendations was for Congress to implement a one-time SEP in the federally facilitated exchanges. "In order for a federal SEP to be effective in meeting people's needs at this extraordinary time, it must have a prospective effective date, be limited (30 days), and not be limited to people diagnosed with COVID-19," AHIP and BCBSA wrote.

On April 7, 65 Democratic members of the House of Representatives sent their own letter to HHS's Azar and CMS Administrator Seema Verma, urging them to use their regulatory power to enact a federal SEP. "The federal government has opened special enrollment periods in the past during previous declared major disasters or emergencies, claiming exceptional circumstances," the lawmakers wrote, and the COVID-19 pandemic "should be considered an exceptional circumstance."

Contact Levitt at LarryL@kff.org and Corlette at Sabrina.Corlette@georgetown.edu. View the AHIP/BCBSA letter at https://bit.ly/3c9KCux and the KFF analysis at https://bit.ly/2UZec05. ✧

by Leslie Small

MCO Stock Performance, March 2020

	Closing Stock Price on 3/31/2020	March Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2020 EPS*
COMMERCIAL				
Cigna Corp.	$177.18	(8.3%)	(13.5%)	$18.55
UnitedHealth Group	$249.38	(8.6%)	(14.7%)	$16.43
Anthem, Inc.	$227.04	(14.3%)	(24.5%)	$22.44
Commercial Mean		**(10.4%)**	**(17.6%)**	
MEDICARE				
Humana Inc.	$314.02	(6.6%)	(13.6%)	$18.57
Medicare Mean		**(6.6%)**	**(13.6%)**	
MEDICAID				
Centene Corp.	$59.41	(5.1%)	(4.0%)	$4.70
Molina Healthcare, Inc.	$139.71	12.9%	4.8%	$11.82
Medicaid Mean		**3.9%**	**0.4%**	
Industry Mean		**(5.0%)**	**(10.9%)**	

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

SOURCE: Bank of America Merrill Lynch.

Hospitals Seek Payers' Aid

continued from p. 1

"We also ask that insurers eliminate administrative processes that cause delays in payment, such as prior authorization and certain payment edits, and provide adequate coverage and reimbursement of services in hospitals and alternative sites of care, including by covering cost-sharing for COVID-19 treatment," Pollack wrote. "In addition, we urge insurers to expedite processing of outstanding claims that have resulted in billions of dollars in accounts receivables."

Some of Pollack's requests are a tough lift for insurers, according to Joe Paduda, principal of Health Strategy Associates LLC.

"This is one of those 'no one wins' situations, where two massive industries are in serious trouble due to the failure of our nation's elected leaders to anticipate, plan for, recognize, and respond to a crisis," Paduda tells AIS Health via email. According to Paduda, hospitals are rightly concerned, but insurers are constrained by the nature of their business. He says the broad, public request by providers is a negotiating tactic.

"Insurers' fiduciary responsibility to their policyholders likely prohibits many of the other actions requested by the AHA," Paduda says. "The AHA attributes facilities' financial difficulties in part to fewer elective procedures; as these are most impacted by [prior authorizations] and claim edits, it isn't at all clear how this would materially help facilities' financials. This appears to be more of a 'let's ask for the stars and settle for the moon' than a realistic ask."

Ashraf Shehata, KPMG's national sector leader for health care and life sciences, told AIS Health before the AHA letter was released that he had heard rumors of advance-payment negotiations between payers and providers. But Shehata points out that payers aren't going to give hospitals a blank check.

"We're hearing the way that works is [payers will] look at historical data, and essentially they'll advance 30, 60, 90 days forward to be able to help with cash flow constraints. And I think [keeping beneficiaries] in-network is an important provision — it's important to carriers to maintain some degree of the network design that was initially in place," Shehata says.

Shehata also expects public funds from the federal government and states will plug budgetary holes for providers before a crisis payment system is fully fleshed out.

Expedited Claims Processing Can Help

In a March 6 response to Pollack's letter, AHIP President and CEO Matthew Eyles stopped short of agreeing to provide advance payments to hospitals, but emphasized the insurance industry's support of providers. Eyles began the letter by praising the dedication and sacrifice of frontline health care workers, calling them "genuine health care heroes." He added that "it is clear that hospitals are under enormous clinical and financial stress, and health insurance providers stand strong with you."

Eyles listed some measures payers have taken to address hospitals' financial challenges, citing AHIP's lobbying in support of federal stimulus funds for hospitals, payers' moves to waive patient cost sharing for COVID-19 testing and treatment *(HPW 4/6/20, p. 1)*, streamlining paperwork requirements and building up claims-processing capacity.

"We are partnering with hospitals to accelerate the pace of patient treatment, transfers, discharges, and payments," Eyles wrote. "Health insurance providers are also eliminating administrative work to ensure hospitals and providers can deliver care to more patients quickly and effectively. We are committed to expediting claims processing to ensure that payments are paid as quickly as possible."

Paduda says that's an easy move insurers can make to help hospitals.

"There should be room for compromise in one area: facility accounts receivable for contested bills should be settled in bulk, using historical reimbursement percentages as the guide," he says. "This would generate billions in cash flow while eliminating administrative expense for both payers and providers."

Financial Risk Also Looms for Payers

In addition to the financial challenges hospitals face, a new analysis underscores that the COVID-19 crisis will bring high costs for payers.

According to a March 30 paper prepared by actuarial firm Wakely on behalf of AHIP, the lowest-risk scenario, in which the United States' infection rate would reach 10% of the population, the range of allowed costs would be $56.2 billion to $92.7 billion over 2020 and 2021 combined. The baseline risk scenario, with a U.S. infection rate of 20%, would yield $112.5 billion to $185.4 billion in allowed costs over 2020 and 2021. And a 60% infection rate scenario would cost in the range of $337.5 billion to $556.1 billion over those two years. The Wakely analysis only accounts for commercial carrier risk; risk to traditional Medicare and Medicaid is not included.

Some Firms Will 'Rise to the Challenge'

Even at this early point, Shehata says, payers and providers will be obliged to take a more collaborative approach to adjudicating claims. He says he's heard of firms adding increased claims capacity through hiring or third-party contracting.

"This will probably test the payers and the providers, and you'll start to see which ones have been able to rise to the challenge," Shehata says. "I think certainly the payers have to see how their ability to fund and support medical claims is now helping to keep these providers open — which is our expectation. And I think on the flip side, the other expectation is that the providers will manage a certain degree of claims, are documenting claims that they're requesting, and of course build the business case for the request of their additional funds. Or at least account for the use of the funds."

Read the AHA letters at https://bit.ly/2yG81VM, the AHIP letter at https://bit.ly/39Vfzks and the Wakely report at https://bit.ly/2yNr7ti. Contact Paduda at jpaduda@healthstrategyassoc.com and Shehata via Bill Borden at wborden@kpmg.com. ✧

by Peter Johnson

Medicaid Enrollment Could Soar in Response to COVID-19 Crisis

by Jinghong Chen

More than 6.6 million Americans filed initial unemployment claims for the week that ended April 4, as many businesses were asked to shutter or adjust their operations to slow the spread of the novel coronavirus. Under a medium unemployment scenario in which 21 million people lose their jobs, Medicaid and individual marketplace enrollment could increase by 16.5 million and 1.5 million, respectively, across all states over the next few months, while the number of uninsured could grow by 5.2 million, according to an analysis by Health Management Associates.

State	Initial Unemployment Claims Filed During Week Ending April 4	Estimated Insurance Coverage Change Under Medium Unemployment Scenario		
		Medicaid	Marketplace	Uninsured
Alabama	105,607	200k	13k	151k
Alaska	15,370	39k	4k	6k
Arizona	132,189	386k	36k	45k
Arkansas	60,992	171k	13k	12k
California	925,450	2,211k	165k	179k
Colorado	45,494	309k	32k	60k
Connecticut	33,418	194k	23k	36k
Delaware	18,863	55k	7k	9k
D.C.	15,393	36k		2k
Florida	169,885	778k	-52k	589k
Georgia	388,175	406k	35k	312k
Hawaii	53,082	72k	15k	16k
Idaho	30,022	109k	4k	27k
Illinois	200,940	729k	89k	149k
Indiana	133,639	401k	56k	92k
Iowa	67,334	187k	26k	42k
Kansas	49,756	122k	10k	116k
Kentucky	117,135	264k	28k	29k
Louisiana	102,985	269k	15k	10k
Maine	30,631	69k	7k	15k
Maryland	107,408	312k	48k	61k
Massachusetts	139,582	387k	40k	70k
Michigan	384,844	599k	65k	110k
Minnesota	111,119	317k	47k	74k
Mississippi	46,504	127k	6k	82k
Missouri	82,399	244k	25k	222k
Montana	20,011	61k	3k	10k
Nebraska	26,788	115k	13k	35k
Nevada	79,865	160k	25k	25k
New Hampshire	36,214	73k	14k	21k
New Jersey	213,897	454k	79k	101k
New Mexico	26,606	118k	5k	-4k
New York	345,246	1,068k	103k	103k
North Carolina	137,573	411k	21k	311k
North Dakota	16,093	41k	6k	14k
Ohio	224,182	679k	87k	124k
Oklahoma	51,124	223k	21k	42k
Oregon	56,646	232k	22k	33k
Pennsylvania	283,718	737k	87k	150k
Rhode Island	28,255	60k	6k	11k
South Carolina	85,018	204k	7k	148k
South Dakota	7,916	35k		36k
Tennessee	116,141	277k	12k	195k
Texas	313,832	1,089k	80k	784k
Utah	33,076	224k	17k	86k
Vermont	16,176	37k	2k	7k
Virginia	149,758	448k	56k	132k
Washington	176,827	395k	56k	58k
West Virginia	14,145	105k	12k	11k
Wisconsin	104,776	234k	30k	212k
Wyoming	4,900	22k	3k	25k

NOTES: Advance unemployment claims are reported by the state that is liable for paying the unemployment compensation. Numbers of unemployment claims from California and Pennsylvania are state estimates.

SOURCES: Health Management Associates Health Insurance Coverage Model. U.S. Dept. of Labor. Visit https://bit.ly/34mL3yZ.

News Briefs

✦ ***Insurance companies that sustain heavy losses during the COVID-19 pandemic can access tax relief through the recently passed Coronavirus Aid, Relief and Economic Security (CARES) Act, building on policies established in the 2017 Tax Cut and Jobs Act.*** That's according to a new report from credit rating firm A.M. Best, which writes in a news release that "the $2 trillion CARES Act provides a special rule applicable for all companies' net operating losses in 2018 to year-end 2020, allowing these to be carried back to each of the five tax years prior to the year of loss, which could help all insurance segments." Read the full analysis at https://bit.ly/2VjoK9d.

✦ ***New York state will require insurers to pay claims on behalf of beneficiaries who can't pay their premiums due to the COVID-19 pandemic and related economic contraction.*** The state also mandated that payers defer premiums due for individual and small group commercial plans to June 1 if plan members lose the ability to pay due to the pandemic, and it banned payers from reporting such missed premiums to credit agencies. Payers in New York cannot impose late fees on premiums. New York's Dept. of Financial Services "will consider any liquidity or solvency concerns of the health plans in giving effect to this directive," said a state press release. Go to https://on.ny.gov/2Rquywr.

✦ ***Highmark Inc. said it will advance payments to primary care providers (PCPs) participating in its True Performance value-based reimbursement program.*** Highmark had planned to pay out reimbursements starting in June, but started to disburse funds on April 6 to support PCPs struggling with the COVID-19 pandemic. Meanwhile, Blue Cross Blue Shield of Idaho unveiled on March 30 a program that gives independent providers, such as private-practice physician groups, "an opportunity to receive advance payments to cover monetary shortfalls due to the COVID-19 pandemic." The Blues plan said it will make advance payments to participating providers once per month in April, May and June, and it will recover the interest-free payments during the fourth quarter of 2020. Read more at https://bit.ly/3b1hQvS and https://bit.ly/2xhnR98.

✦ ***Centene Corp. will grant three months' fully paid leave and benefits to clinical staff who wish to join a medical reserve force during the COVID-19 pandemic.*** To be eligible for the benefit, an employee's assistance must be requested by state officials. The St. Louis-based insurer also created a program designed to match its network providers, particularly PCPs, with CARES Act loans administered by the Small Business Administration. The program features an online portal that includes benefit match workflows and referrals to experts who can assist with loan applications. Read about the leave program at https://bit.ly/34qJuzL and PCP loan assistance at https://bit.ly/3c6lHYQ.

✦ ***Independence Blue Cross unveiled an online COVID-19 preparedness tool through its Quil partnership with Comcast Corp.*** The app is designed "to support healthy living at home and help individuals adjust to new work/life balance realities," according to an Independence press release. The app will feature news, medical best practices, and tips on exercise, home care for sick family members, and home schooling. Visit https://bit.ly/2UZtIJr.

✦ ***Behavioral health providers and patients filed lawsuits against UnitedHealth Group and Cigna Corp., accusing the insurers of systematically underpaying providers for out-of-network claims, according to Modern Healthcare.*** In four lawsuits that are all seeking class-action status, the plaintiffs argue that the payers did not fully pay out mental health and substance abuse benefits, and that the resulting shortfall forced providers to bill beneficiaries for up to 90% of the cost of care. Read more at https://bit.ly/3b09hBm.

✦ ***A joint report by the Robert Wood Johnson Foundation and Urban Institute found both the number of people on Medicaid and the number of those without insurance will increase as a result of mass layoffs caused by COVID-19.*** The study analyzed enrollment data from 2008 to 2018, with an eye toward quantifying the impacts of ACA implementation and the last recession. Between 2011 and 2013, 46% of unemployed people did not have health insurance, but after ACA implementation and economic recovery, 29.8% of unemployed people were uninsured. Read the report at https://rwjf.ws/39xU3SI.