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2021 Outlook

Impact of Pandemic Utilization Trends Remains Unclear

Since the start of the COVID-19 pandemic, the managed care industry has wrestled with how to project utilization of normal care and assess the risk of funding care related to the virus, especially since most carriers have elected to waive cost sharing for COVID-19 treatment. While insurers generally seem to be in good financial shape, experts say that plans face continuing uncertainty — and one actuary suggests that pandemic-related financial risk has met or exceeded the conditions of his modeling's worst-case scenario.

In the early days of 2021, the U.S. confronted a grim milestone when the tally of Americans who died from COVID-19 reached 400,000. Meanwhile, the Trump administration was criticized for how it handled vaccine rollout and denounced critical public health tactics including mask wearing, while states reopened their economies and public spaces to varying degrees, despite the objections of public health officials.

"It's looking as if the numbers are going to be closer to the most severe of the scenarios that we looked at [in September]," Trevis Parson, the chief actuary for health and benefits at Willis Towers Watson, tells AIS Health. "We didn't assign any particular probability to any of those scenarios, recognizing that so many things were up in the air, from the policy perspective [to] adherence to policy to mutations of the virus — so many different things that could impact what we would ultimately see. Over the last three months or so, it's becoming clear that infection levels did not taper off as some of those other scenarios had expected, but in fact had continued to increase."

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For Michigan Payer's New President, Technology Is a 'Priority'

Health insurers face dozens of technological challenges in coming years, as federal regulations mandating electronic health record interoperability and price transparency mean that every health insurer has had to start developing new information technology and data capabilities.

Praveen Thadani, the new president of Priority Health, has the background to do just that. Priority is a nonprofit payer with nearly 900,000 members, according to AIS Health's Directory of Health Plans, making it the carrier with the second-highest membership in the state of Michigan. Thadani says he was drawn to Priority's "amazing heritage of innovation" in accepting the role.

Thadani comes to Priority from Humana Inc., where he most recently served as senior vice president for product and innovation, starting in 2014. He was previously the head of the carrier's operations in Illinois. Thadani also serves on the boards of technology startups Machinify, Inc. and Help-Full.

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In a recent interview with AIS Health, Thadani explained the myriad ways virtual care and data analytics have shaped the way Priority does business — and emphasized how the COVID-19 pandemic will accelerate the ongoing technological transformation in health care. The following interview has been edited for length and clarity:

AIS Health: What are your goals, and what's the company's outlook for the first year of your tenure?

Praveen Thadani: In the first 90 days [I'm focused on] really understanding, at a pretty deep level, all the elements around Priority Health, its priorities, a strategy, all the different stakeholders, internal and external. Meeting with key constituents, ensuring that there's alignment of all the strategies and that it is supplemented by the right culture and the right talent. And that we're doing the right thing for the community.

Ultimately, coming into this role, the orientation will be around continuing to drive differentiation in the community, and accelerating momentum, especially around deepening the alignment between [parent company and integrated care organization] Spectrum [Health] and Priority [Health], in addition to the other providers in the community.

AIS Health: Priority is a leader with value-based and outcomes-oriented contracting in its network agreements with providers. Is that something that you're going to emphasize in the next year?

Thadani: One of the things that attracted me to Priority Health was some really great work [in that space] that's already taking place. So, as you think about our next best actions as an example, we've done some really compelling work around enabling consumers to make some decisions about what makes sense to enable better health and wellbeing for them.

There's certainly been a lot of great work around social determinants and Priority Health as a leader in that space as well. And those are prerequisites for success in a value-based environment. I've certainly witnessed substantial success around value-based relationships in different markets. So I do think that's an area of opportunity and potentially an area of alignment.

I think I'd want to make sure that we do a thorough assessment of readiness for continued acceleration of value-based relationships and where it makes sense. It sustains Priority Health's mission around creating more affordability and higher quality of health care as well.

AIS Health: It sounds like when you talk about deepening alignments, it's not just limited to that sort of contracting. Are there other components to your strategy there?

Thadani: Based on my early assessment, what I'd say is consumers are very eager to not only have higher affordability and higher quality, but also create a level of simplicity, and a better experience in health care. That would be another area I potentially look toward to ensure that whether it's a combination of digital solutions, or it's a combination of different experiential moves, we want to make health care easier and more simple for consumers.

That includes working with providers. And we want to make sure that we're thinking about all those nuances across the board, and also with Spectrum Health.

AIS Health: You mentioned digital tools and consumer-facing programs in that space. With interoperability and electronic health record portability deadlines coming down the pike, is that something you're trying to use as a differentiator? Can you use those tools to help members shop for care?

Thadani: First and foremost, Priority Health already is a leader when it comes to transparency, I think they

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

have been a market leader for a very long time. Certainly, as we think about affordability, and as you think about consumer engagement, transparency surely is one of those initiatives that matters to consumers — there's a lot of discussion around shoppable services as well that's taking place in the marketplace. We're very supportive of ensuring that momentum continues around that.

I also think COVID has been quite an accelerant in terms of digital medicine and virtual care. So that's another example where there could be substantial potential. Thinking about chronically ill members, there might be some opportunity related to digital remote monitoring.

The ultimate goal of any digital solution is to make it easier for consumers to seek care, to think about their next best action that helps them maintain their health and improve the quality of health care, which ultimately results in affordability.

So following those principles, there are probably several use cases that come to mind whether it's related to access, or quality, or even related to making it easier for consumers to seek [virtual] care.

AIS Health: We've been tracking all of the ways that payers across the industry are trying to help members with cost sharing and expenses related to COVID-19 treatment (see infographic, p. 7). Are those waivers going to continue for Priority indefinitely?

Thadani: I actually don't know the answer to that question [yet]. Priority held a very strong leadership role in 2020 around cost-sharing waivers and also enabling virtual care and telemedicine for free, and getting premiums back to certain consumers and employer groups as well.

My belief is there's continued discussion and some initial decisions that some of those cost waivers would continue, at least to the initial part of 2021....I think it's fair to say that we're going to continue evaluating that situation and ensuring that we make COVID care accessible to our members. But through the end of March... [we are going to] continue to waive those costs.

AIS Health: What kind of role is Priority taking with the coronavirus vaccine rollout?

Thadani: If you think about a payer's role, and especially our partnership with Spectrum, our orientation is to ensure that there is access to the right diagnostics and into the right treatment. We have a very important role in ensuring that we measure the risk profile of our members and that we reach out to those members at the highest risk and ensure that they have access. Priority, through very sophisticated algorithms and digital means, has done a great job of doing much of that already. Also, we're doing everything proactively, leveraging data analytics, reachouts, digital means and physical means to ensure that our members are taken care of.

We're [also] in very regular touch with the state government to ensure that we're doing the right thing for our consumers in the state of Michigan.

AIS Health: Last year, Priority struck a network reciprocity agreement with Cigna Corp., giving Cigna access to Priority's network in Michigan and Priority members in-network benefits with Cigna's nationwide network. What synergies do you see in lining up relations with Cigna, and what do you expect with that going forward?

Thadani: I'm still getting my arms underneath that entire relationship. I'll have my first formal meeting with Cigna here in a couple of weeks.

[However,] we have a strong relationship. It's oriented toward ensuring access is further enhanced for our consumers, especially when they're seeking care outside of the Michigan marketplace. So it's a very important addition of a core capability.

Ultimately, I think what the residents of Michigan are worried about is when they're traveling — or if they have some associates or employees that are outside of the Michigan marketplace — is ensuring that there's an adequate level of coverage available for them. And that's really what this relationship empowers.

I fully expect that we'll continue exploring further opportunities to continue enhancing that relationship.

AIS Health: Priority's other major deal in recent years was the acquisition of Total Healthcare in 2019. Do you have any thoughts about the process of integrating Total Healthcare into your overall organization? And, looking forward, do you see any other opportunities to acquire other payers around Michigan?

Thadani: I am not ready to comment on the latter part of the question. But I think the Total Healthcare partnership is one of our top priorities. It was one of our top priorities for 2020, and will continue being a top priority for 2021. As you think about Total Healthcare, they were certainly a leader, especially in the Medicaid space. And that's an area that Priority Health is deeply committed to.

So, as I was interviewing for the role, I saw the possible synergies

between Total Healthcare and Priority Health. And I give [the previous leaders of] Priority Health a lot of kudos for recognizing that synergy. My understanding, again, coming into this role in the last couple of days is that the integration's on track and going well. It's well on target for us to continue bringing an integrated value proposition to the marketplace moving forward.

Contact Thadani via Jeremy Bakken at Jeremy.Bakken@priorityhealth.com. ✧

by Peter Johnson

UnitedHealth Saw COVID Costs, Care Deferral Rise in 4Q

In the fourth quarter of 2020, health care spending patterns experienced by the country's largest health insurer "returned to seasonal baselines" even as COVID-19 cases surged all over the U.S. Such is one major takeaway from UnitedHealth Group's fourth-quarter 2020 earnings report, which offers an instructive look at the unique ways that the pandemic continues to affect health care economics.

During a Jan. 20 conference call with investors, UnitedHealth Chief Financial Officer John Rex explained that two opposing forces caused health care spending to align with historical levels. While the amount that UnitedHealth spent on COVID-19-related care increased compared with the third quarter, overall outpatient activity dipped below baseline as the end of the year drew closer, reflecting the fact that more people started deferring routine and elective care as coronavirus cases rose.

Generally speaking, "the cadence of non-COVID and COVID costs will fluctuate, but tend to offset," observed Jefferies analysts David Windley and David Styblo in a Jan. 20 note to investors.

Direct COVID-related care comprised about 11% of UnitedHealth's total health care spending in the fourth quarter, up from 6% in the third quarter, Rex said. He also noted that "people with commercial benefits continue to exhibit overall higher levels of care activity, with less deferral than those served in public sector programs such as Medicare and Medicaid," per a transcript from The Motley Fool.

Commercial Enrollment Dips Slightly

UnitedHealth had other good news to share about its commercial book of business, as Rex noted that "we concluded 2020 with commercial membership about 100,000 people ahead of the outlook we provided at our investor conference." In fact, the firm's commercial enrollment "is down only 3% since Q1 despite the spike in unemployment," noted Evercore ISI analyst Michael Newshel.

During the question-and-answer portion of the call, Bill Golden, CEO of UnitedHealthcare's Employer & Individual segment, attributed those results to "really strong persistency across really all lines of coverage, and then less-than-anticipated attrition." But Golden also made sure to temper expectations. "Obviously, in the current economic environment, it's created some challenges," he said, referring to the economic downturn's effect on employer-sponsored coverage take-up.

UnitedHealth's management continues to expect enrollment in its commercial plans to "modestly increase 1% this year as new wins more than offset in-group attrition," Windley and Styblo noted.

UnitedHealth was much more bullish about its government-sponsored lines of business. "The UnitedHealthcare Medicare Advantage offerings are off to an excellent start" this year, UnitedHealth Group CEO David Wichmann said during his prepared remarks, adding that "2021 will be one of our strongest years of growth, now expected to approach 900,000 more people served across individual and group Medicare Advantage and dual Special Needs Plans."

Firm Expects Medicaid Growth

Wichmann also expressed optimism about the firm's Medicaid managed care business, noting that UnitedHealth entered three new states this year. "New business opportunities are substantial, with momentum toward managed care adoption by states and RFP [request for proposal] activity accelerating this year and next," he said.

That part of UnitedHealth's business isn't immune from pandemic-related negative impacts, though. Tim Spilker, CEO of UnitedHealthcare Community & State segment, acknowledged during the call that cash-poor states are continuing to leverage risk corridors and medical loss ratio structures to claw back excess profits from MCOs. While UnitedHealth anticipated those moves, Spilker also pointed out that CMS recently established "rules requiring [risk] corridors to be implemented proactively" rather than retrospectively, which is expected to improve "predictability and visibility" for Medicaid plans.

During the earnings call, UnitedHealth executives also offered some telling insights into how they're thinking about the pandemic's last effects on telehealth use. Wyatt Decker, M.D., CEO of OptumHealth, said in response to an analyst's question that UnitedHealth is finding "not all telehealth offerings are created equal."

Not only do patients "appreciate being connected to their own personal providers," he said, but virtual care providers also benefit immensely from having access to real-time clinical data when taking care of patients. Decker also pointed out that certain types of services are proving to be tailor-made for telehealth — noting that throughout 2020, "we have seen approximately 50% of our...behavioral health care being delivered in a telehealth setting."

Overall in the quarter, UnitedHealth reported an adjusted earnings per share (EPS) of $2.52, a figure that beat the Wall Street consensus estimate of $2.41 but represented a decline from the $3.60 per share that the company earned in the fourth quarter of 2019. In a note to investors, Citi analyst Ralph Giacobbe observed that the quarterly results "reflected the culmination of a unique year as the company saw higher COVID cost, the continued recovery of core utilization, and the impact of self-imposed initiatives to assist members and providers (waiving out-of-pocket, premium rebates, etc)."

The company reaffirmed its 2021 full-year outlook to predict net earnings of $16.90 to $17.40 per share and adjusted net earnings of $17.75 to $18.25 per share. "As previously discussed, this outlook includes approximately $1.80 per share in potential net unfavorable impact to accommodate continuing COVID-19 effects, such as: testing and treatment costs; the residual impact of people deferring care in 2020; and unemployment and other economy-driven factors," UnitedHealth noted in its earnings press release.

View UnitedHealth's earnings release at https://bit.ly/36iOtFd and a transcript of its earnings call at https://bit.ly/3qFAe4P. ✧

by Leslie Small

Trump Administration Gives MA Plans a Parting Gift With Hefty Payment Boost

As one of its final moves before the Trump administration officially ended, CMS on Jan. 15 gave Medicare Advantage (MA) plans a 2022 payment increase that impressed Wall Street analysts.

The 2022 Medicare Advantage and Part D Rate Announcement — which the administration released early in order to offer some additional guidance to plan sponsors during the COVID-19 pandemic — indicated that MA organizations will see an average reimbursement boost of 4.08% next year. That's a significant improvement from the 2.8% rate increase that CMS projected in October, which Citi analyst Ralph Giacobbe suggested "represents a positive final parting shot by CMS and the Trump administration for the MA program, and de-risks any rate concerns for 2022."

MA plans factor in payment rates as they set their design, benefits and pricing, he noted, and higher rates allow them to offer richer benefits that can then fuel higher enrollment.

"The healthy payment bump in 2022 should provide a strong building block for continued and potentially accelerating top-line growth," Giacobbe continued. "This should bode well for MA players, particularly coming off 2021 where there are more moving parts/uncertainties stemming from COVID."

The more generous rates relative to the advance notice, added Jefferies analysts David Windley and David Styblo, "give MCOs protection against higher claims intensity that may occur from seniors who deferred care during COVID." In fact, "CMS acknowledged the timing of these more intense claims may occur later (i.e. into 2022) than it originally expected in the Advance Notice," they wrote in a research note.

Credit Suisse analyst A.J. Rice advised investors that the 126 basis-point improvement between the projected and finalized MA payment rate is "positive relative to investor expectations and a slightly better improvement than what we have seen from Advance Notice to Final Rule over the last couple years." The 2021 final rate was up 73 basis points relative to what was in the Advance Notice, he noted, and the 2020 final rate increased by 94 basis points.

Rice's firm estimated that for Anthem, Inc., Centene Corp. and UnitedHealth Group, the rate update will be "largely in-line with the overall industry estimates." Credit Suisse expects Cigna Corp.'s star ratings-related tailwind to be 50 basis points better than the industry average, and CVS Health Corp.'s to be 20 points better, "while we estimate a 20 [basis point] headwind for [Humana Inc.] relative to the industry," Rice wrote.

Read about the final rate notice at https://go.cms.gov/3sH3FFu.

by Leslie Small

Pandemic Uncertainty Continues

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Meanwhile, care utilization went through wild swings over the course of 2020, cratering in the second quarter before bouncing back. Patients were afraid to visit providers during the spring, when many state governments shut down nonessential businesses. Evidence grew that, even as utilization rebounded, many patients were forgoing preventive care such as cancer screenings. Some of that utilization has returned, but experts are still working to determine how much. It also seems that missed care has not, so far, been replaced with procedures later in the year.

"When I look at the most recent data, we had expected that as infection levels would taper, that as demand would return to the system that would eclipse the curve that would have otherwise expected to be normal," Parson explains. "In other words, we'd have seen this dip, and then this rise above expected because of all of the care that would have been there anyway plus this returning care. And that's just not happening yet. We're seeing a return to normal, but we're not seeing this way above normal, and that makes everything neutral. The claims that we're looking at through November now are showing October and November right in line with what we would have otherwise projected anyway. There isn't this rebound, or balancing out, that I would have expected to see at the end of 2020. In fact, for 2020, I'm strongly expecting we'll see a reduction in cost. There was the big dip [in the second quarter], and then it got back to the line, but it didn't breach the line to the point where it was going to completely offset the dip."

MCO Stock Performance, December 2020

	Closing Stock Price on 12/31/2020	December Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2020 EPS*
COMMERCIAL				
Cigna Corp.	$208.18	(0.5%)	1.6%	$18.59
UnitedHealth Group	$350.68	4.3%	19.9%	$16.76
Anthem, Inc.	$321.09	3.1%	6.7%	$22.45
Commercial Mean		**2.3%**	**9.4%**	
MEDICARE				
Humana Inc.	$410.27	2.4%	12.9%	$18.65
Medicare Mean		**2.4%**	**12.9%**	
MEDICAID				
Centene Corp.	$60.03	(2.6%)	(3.0%)	$4.99
Molina Healthcare, Inc.	$212.68	4.2%	59.5%	$12.55
Medicaid Mean		**0.8%**	**28.2%**	
Industry Mean		**1.8%**	**16.3%**	

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

SOURCE: Bank of America Merrill Lynch.

Oncology Data Tells Story of Deferral

John Linnehan, the practice director for health economics and advanced analytics at Avalere Health, has also found that preventive care has dropped and not rebounded, citing proprietary claims data collected by Avalere's parent company, Inovalon Inc.

"We published some data at the end of last year specific to oncology… which really showed that at the beginning of the pandemic, oncology-related evaluation and management services were down over 70%," Linnehan said during a Jan. 7 Avalere webinar. "And that's rebounded a little bit, but still significantly down. In fourth quarter of 2020 versus fourth quarter of 2019, utilization of these services was down 25-40%, for instance."

"That really has continued throughout the spectrum of oncology care," Linnehan added. "For instance, we've seen similar declines year over year in utilization for screening for key cancers like lung, prostate, breast and colon. We've seen decreases in rates of biopsies, rates of physician-administered drug administrations, surgeries — and it's really not limited to oncology. We've seen similar data in the primary care space, in cardiovascular disease, and we've seen similar data in other specialty conditions like rheumatoid arthritis."

However, Linnehan said that the impact of care deferral has not been consistent across all sectors of the health care industry. "From the provider revenue and utilization perspective, it's a mixed story," he says. "So if we continue the oncology example that I

provided, certainly — especially — in fee-for-service models, the math doesn't look good when you consider the utilization that I talked about. But it hasn't been consistent....Home health has actually rebounded to pre-pandemic levels. But similar services that are provided in skilled nursing facilities have not."

What this means going forward isn't clear, according to Parson. While all the deferred care hasn't yet returned, it still could be coming — but Parson isn't sure when that might happen.

When Will Postponed Care Return?

In terms of care utilization, "2020 is going to come in far lower than we would have anticipated in the absence of the pandemic," Parson explains. "Obviously, the presence of the vaccine will terminate many potential ends for the virus to continue to transmit, and the faster we can get the vaccine in arms, the better off we will be in terms of the level of not only infection but subsequent impact on utilization rates. But it's clear that there's still some deferred care out there that would spill over into 2021 from 2020. The question is, how long does that care stay out there? It has a lifetime where it either can't stay out there anymore and it has to get covered, or it just gets skipped."

Praveen Thadani, the new president of Michigan-based nonprofit insurer Priority Health, (see interview, p. 1), says his organization is still making sense of utilization trends.

"There's still a lot of ambiguity around what COVID really is going to mean," Thadani tells AIS Health. "There's two camps. One is our utilization will go up because you've got substantial COVID costs, along with utilization returning back to normal. And certainly there's a possibility that there's additional waves of COVID, which might mean that there is some additional [episodes of] depressed utilization."

Meanwhile, many insurers have elected to waive COVID-19 cost sharing through at least the first quarter of this year (see infographic, right). Parson says the impact of those waivers will mostly be retrospective, since carriers should have been able to account for COVID-19 risk in setting their 2021 rates.

"There's cost associated with the waivers. There's no question about it," Parson says. "It's not as if people were anticipating, in 2019, incurring cost sharing amounts for infections they didn't anticipate. There's no prediction of that. But I think they did the right thing, and eliminated barriers to care for those who got sick.…Obviously, those that built these benefits into their 2021 pricing aren't incurring any new risk that they didn't anticipate before."

Analyst Expects 'Muted' Cost Trends

Citi analyst Ralph Giacobbe has a similar assessment, according to a Jan. 19 investor note previewing fourth quarter results for managed care firms.

"We continue to expect somewhat muted underlying healthcare cost trends in 2021," he wrote. "[UnitedHealth] and other payors [have] priced for normalized trend plus assumption of pent-up demand and higher acuity, without much carrier switching in the COVID-19 backdrop, which should allow for a healthy premium to cost spread (i.e., margin) and a pull-through of upside that was not captured in 2020."

Watch the Avalere webinar at http://bit.ly/3p27J0O. Contact Parson via Ed Emerman at eemerman@eaglepr.com. ✧

by Peter Johnson

Insurers Extend COVID Cost-Sharing Waivers

by Jinghong Chen

Insurer	COVID-19 Treatment Cost-Sharing Waiver Through:
	Jan. 2021 Feb. March April
Aetna	Jan. 31
Arkansas BCBS	Jan. 21
Avera Health Plans	Jan. 21
AvMed	Feb. 28
Blue Shield of California	Jan. 31
BCBS of Idaho	March 23
BCBS of Kansas	March 31
BCBS of Kansas City	Jan. 20
BCBS of Michigan	March 31
BCBS of Minnesota	March 31
BCBS of Nebraska	Jan. 20
BCBS of North Carolina	March 31
BlueShield of NE New York	March 31
BCBS of Wyoming	March 31
Cigna	Feb. 15
CommunityCare	Jan. 31
Harvard Pilgrim Health Care	Jan. 31
Health Alliance Plan	March 31
Highmark	March 31
Horizon BCBS of New Jersey	March 31
Independence Blue Cross	March 31
Medica Health Plan	March 31
PreferredOne	March 31
Premera Blue Cross	March 31
Priority Health	March 31
Providence Health Plan	March 31
SCAN Health Plan	March 31
Security Health Plan	April 20
Sharp Health Plan	Jan. 31
UCare	March 31
UPMC Health Plan	Feb. 28
Wellmark BCBS	March 31
Western Health Advantage	Jan. 31

NOTE: Capital Blue Cross waives cost-sharing for provider visits that result in a COVID-19 test through Jan. 21, 2021.

SOURCES: "Health Insurance Providers Respond to Coronavirus," America's Health Insurance Plans. Visit https://bit.ly/2LPFtjG. Insurers' news releases.

News Briefs

✦ ***Not long after his inauguration on Jan. 20, President Joe Biden issued a "regulatory freeze" memo to the heads of executive departments and agencies — a routine move for new administrations that temporarily halts last-minute regulations issued by the preceding administration pending review.*** The memo forbids any new rules from being proposed until they are approved by a department head designated by the new president, and it orders those rules not yet published in the Federal Register to be withdrawn for review. For those regulations that have been published but have not yet taken effect, the memo asks the department/agency leaders to consider postponing the rules' effective dates for 60 days in order to review "any questions of fact, law, and policy the rules may raise." Read the memo at https://bit.ly/2KA4VZQ.

✦ ***Also on Jan. 20, Biden unveiled a list of individuals who will serve in acting capacities across his administration until the Senate confirms permanent leaders.*** Norris Cochran, who previously served as HHS deputy assistant secretary of budget, will be the acting HHS secretary pending the confirmation of Biden's pick to lead the department, California Attorney General Xavier Becerra. Citing a Democratic aide familiar with Biden's plans, Bloomberg Law reported that the Senate Finance Committee isn't expected to take up the Becerra nomination until February. Read more at https://bit.ly/3qE0CvY and https://bit.ly/3ixw9Ng.

✦ ***Excellus Health Plan, Inc. agreed to pay the government $5.1 million to settle potential HIPAA violations related to a data breach, according to the HHS Office for Civil Rights.*** Excellus, which serves 1.5 million members in upstate and western New York, filed a breach report in 2015 that revealed hackers infiltrated its IT systems and "installed malware and conducted reconnaissance activities that ultimately resulted in the impermissible disclosure of the protected health information of more than 9.3 million individuals." Read more at https://bit.ly/3iz0sDi.

✦ ***America's Health Insurance Plans on Jan. 15 issued a strongly worded statement in response to CMS finalizing a rule that forces insurers to streamline prior authorization processes and increase data sharing, calling it a "series of empty promises."*** The trade group argued that "this shabbily and hastily constructed rule puts a plane in the air before the wings are bolted on by requiring health insurance providers to build these technologies with incomplete and untested instruction manuals." CMS finalized the rule, titled "Reducing Provider and Patient Burden by Improving Prior Authorization Processes and Promoting Patients' Electronic Access to Health Information," a little more than a month after proposing it *(HPW 12/18/20, p. 1)*. Read more at https://bit.ly/3iu991L.

✦ ***Two prominent Democratic lawmakers are pushing back against a Jan. 4 letter that former CMS Administrator Seema Verma sent to state Medicaid directors, which asked them to quickly sign a "letter of agreement" that makes it harder for administrations to rescind approved Medicaid waivers.*** In a letter to Verma dated Jan. 19, House Committee on Energy and Commerce Chairman Frank Pallone, Jr. (D-N.J.) and Senate Finance Committee Ranking Member Ron Wyden (D-Ore.) called the letter "nothing more than a hastily-drafted, transparent attempt to tie the hands of the Biden Administration for at least nine months, and entrench your shameful Medicaid legacy after your time as CMS Administrator has ended." CMS approved a series of waivers in the Trump administration's final days, including one from Tennessee that would cap Medicaid funding *(HPW 1/15/20, p. 4)*. Read the letters at https://bit.ly/394lK8Q.

✦ ***Stephen Tanal, who until recently was a health care equity research analyst at SVB Leerink, will start a new role as Anthem, Inc.'s vice president of investor relations on Feb. 1.*** Tanal will succeed Chris Rigg, who is now the senior vice president and chief financial officer of Anthem's commercial and specialty business division. Read more at https://bit.ly/2M4eGzU.

✦ ***Health Care Service Corp. said on Jan. 19 that it has promoted several of its executives.*** Opella Ernest, M.D., will serve as executive vice president and chief operating officer, Jeff Tikkanen will be the EVP of commercial markets, James Walsh will take on the role of senior vice president and chief financial officer, and Nathan Linsley will now be HCSC's senior vice president of government programs. Read more at https://bit.ly/3bXGT6s.