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Cigna's MDLive Deal Arrives in Telehealth's Big Moment

Health insurers have begun to consolidate their position in the telehealth market, as indicated by a recent move by Cigna Corp. to acquire MDLive Inc. Meanwhile, lawmakers are beginning to consider the future of telehealth regulation and payment, which could include a new Medicare reimbursement scheme and a new national licensing regime for practitioners.

Cigna's Evernorth health services arm announced on Feb. 26 that it had reached an agreement with MDLive to acquire the virtual care provider, which offers video visits for medical care, dermatology, psychology and psychiatry, according to MDLive's website. While the financial terms of the deal were not disclosed, private equity news outlet and business intelligence firm PitchBook said on March 1 that MDLive "was valued at $1 billion." Cigna and MDLive have an existing relationship: MDLive has been available in-network as a primary care option to all members of Cigna's commercial members since January 2020.

Ashraf Shehata, national sector leader for health care and life sciences at KPMG, has worked with both firms, and says he expects even more efforts by payers to offer telehealth benefits directly to members.

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Oscar Becomes Latest Startup to Draw Scrutiny After IPO

Oscar Health Inc., the perennially buzzy startup health insurer, saw its shares slide almost 11% during its first day as a publicly traded company on March 3. But Oscar's underwhelming debut doesn't come as a surprise to some industry consultants, who observe that the firm's technology- and customer-experience-driven business model may be a poor fit for an individual health insurance market where customers tend to flock to the lowest-premium plans.

And that scrutiny comes as another startup insurer — Medicare Advantage-focused Clover Health — released its first quarterly earnings results since it went public, all while trying to shake off the cloud of controversy stirred up by a critical short-seller report that caused its stock prices to plummet *(HPW 2/12/21/ p. 1)*.

Ari Gottlieb, a principal with the health care consulting firm A2 Strategy Group, has been one of Oscar's fiercest critics for years. Recently, he dug into disclosure filings related to the insurer's initial public offering (IPO) to produce a series of LinkedIn posts explaining why he believes Oscar is "built to fail." Gottlieb, who says he has nothing to gain from scrutinizing the startup insurer other than a desire to set the record straight, tells AIS Health that he sees some parallels between Oscar and Clover.

Regarding Oscar, Gottlieb says, "They make up metrics; they make up standards that don't exist." As an example, he points to Oscar touting in 2018 that it had "generated an underwriting profit" for the first time the year before. But that

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just means the insurer's medical loss ratio [MLR] finally dipped below 100, "which is not a term that any health plan has ever had to use because honestly that's bad — that's not something you celebrate," Gottlieb says. "You never should have been over 100 to start with."

Similarly, when Clover reported its fourth-quarter and full-year 2020 earnings on March 2, its executives used the term "normalized MLR" — essentially removing the net effect of COVID-19. "It's just a made-up term," Gottlieb says. "And it encapsulates a trend with the start-up plans, particularly Clover and Oscar, where they use new metrics to mask weakness in the underlying business."

Clover, which promotes open-network MA offerings and in-house technology platforms aimed at optimizing care management, reported a net loss of $91.6 million in 2020, compared with a net loss of $363.7 million the year prior. At least one equities analyst seemed underwhelmed by Clover's first earnings report, but remained optimistic about its business prospects.

"We acknowledge the difficult start out of the gates with results that fell shy of expectations, and a short report that has created an overhang," Citi analyst Ralph Giacobbe wrote in a March 3 note to investors. (Clover issued a lengthy rebuttal to the Feb. 4 short report from Hindenburg Research, which accused the insurer of hiding a Dept. of Justice investigation from shareholders and alleged various questionable business practices.) Giacobbe added that "it will likely take some time for [management] to build credibility and a track record. That said, we believe it premature to throw in the towel…as we remain optimistic around the [CMS Center for Medicare and Medicaid Innovation] direct contracting opportunity, which has yet to begin, and remains a main pillar to our more positive outlook."

Oscar, meanwhile, bills itself as "the first health insurance company built around a full-stack technology platform and a relentless focus on serving its members." As explained in a 2018 press release, the company says it "has a proven, replicable growth playbook: secure competitive prices with new health systems, acquire and engage membership in significant volumes, build market share for our provider partners, and begin to drive health care costs down."

However, Oscar has yet to turn a profit. It reported a $402 million loss in 2020, on the heels of a $261 million loss in 2019. The insurer, which does business primarily in the Affordable Care Act exchanges, has now accumulated more than $1.4 billion in losses since its inception in 2013, an amount that exceeds the annual gross domestic product of Somalia, Samoa, St. Kitts and Nevis, Guinea-Bissau, or Turks and Caicos, Gottlieb pointed out in one of his LinkedIn posts. That's despite raising over $1 billion from venture capital funds, including Google Ventures and other Alphabet-affiliated entities.

> **The majority of subsidy-eligible consumers shop almost entirely on the basis of price.**

Gottlieb theorizes that Oscar's financial woes stem primarily from elevated medical spend and poor risk adjustment for non-subsidized members, excessive investments and spending on sales and administrative costs for subsidized members, and limited success retaining members and growing in less commoditized businesses like Medicare Advantage.

Despite that, the insurer has grown. As of 2021, it had 416,998 members, according to AIS Health's Directory of Health Plans, and Gottlieb points out that Oscar posted 75% growth in 2020. But he argues that Oscar — despite having a lot of consumer-friendly appeal — wasn't

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built to accommodate its play for more subsidized ACA enrollees.

"The majority of subsidy-eligible consumers shop almost entirely on the basis of price, as reflected in market after market where plans that have the lowest effective premiums have the highest share," Gottlieb wrote. "In a commoditized, price-driven market (where Oscar's higher-cost network may not be fully valued), Oscar's marketing, consumer experience, and other SG&A [selling, general and administrative expenses] investments — running at more than twice the level of competitors at 26% of premiums — reflect unsustainable levels of spend that does little to actually attract and retain consumers."

Startups Often Lack Leverage

Gottlieb isn't the only one who views Oscar's business model critically.

"At a very basic level, health insurance is almost all about the 'Cost of Goods Sold' — in this case, medical costs," says Joe Paduda, founder and principal of Health Strategy Associates. "Health insurance start-ups don't have the membership leverage to negotiate good prices with providers, nor the providers necessary to attract members.

"Oscar chose to enter the business aggressively, losing a lot of money by attracting name-brand providers by paying them well, hoping that this would attract consumers," Paduda continues. "It looks like that worked — but reality is most insurance buyers are extremely price sensitive, so the name-brand providers (Cedars Sinai et al) are really driving up cost while not helping to retain members.

"One wonders if Oscar's founders and investors got all caught up in cool technology, great branding, and the whole 'addressable' market thing and didn't understand that's all nonsense — the fundamental driver of success in commercial health insurance is simple — low cost wins."

Oscar did not respond to AIS Health's request for comment on Gottlieb's posts as of press time.

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by Leslie Small

Practical Barriers Obstruct Patient Price Shopping

Patients are likely to follow referrals made by their physicians even if they have sufficient information to make a choice between providers based on price, according to a new study by published in the Journal of Health Economics by authors including Michael Chernew, Ph.D., a Harvard Medical School economist and chair of the Medicare Payment Advisory Commission. The study adds another wrinkle to the ongoing debate about whether health care services can be shopped for like a commercial service.

According to an abstract of the study published by the National Institute for Health Care Management (NIHCM) Foundation, "this study examines the factors that influence where patients receive elective lower-limb MRIs and the potential for patients to shop for this care. Results highlight the very important role that referring physicians play in patients' choice of MRI provider and the lack of patient price shopping. Lower-limb MRIs should be highly shoppable because they are scheduled in advance, clinical quality does not vary meaningfully across providers and prices are widely variable. The fact that patients struggle to shop in this favorable setting makes it unlikely that greater cost sharing and price transparency will lead them to shop for more complex services."

"A more promising avenue," the abstract concludes, "may be to harness the power exerted by referring physicians and help them to help their patients select better value providers."

Jeff Levin-Scherz, M.D., national co-leader of the health management practice at Willis Towers Watson and an assistant professor at Harvard's schools of medicine and public health, tells AIS Health that there are some practical considerations that make it challenging to shop for MRIs, which have long been considered among the most shoppable medical services by health care experts.

Study Group Had Tools to Shop

"It's super research, because they look at a group that is fully moved to a high-deductible health plan, so they have every incentive to shop. They have transparency tools, so they have the ability to look to see what an MRI would cost, and still they go past six less expensive places before they go to the place their doctor recommended," Levin-Scherz explains. "The people who wrote this are economists, and they're sort of scratching their heads a little bit and saying, 'This does show that shopping is a little harder than we'd think.'"

"If a lot of people started shopping for their MRIs, it would really gum up the works in the health care delivery system," Levin-Scherz continues. "Most physicians are now ordering through a computerized physician ordering program because of electronic medical records. The radiology centers that they use — they're already set up. If I was ordering an MRI and someone said, 'please don't order it where you're practicing — could you order it at another MRI center a few blocks away

because it's $100 cheaper?' it would actually be really hard for me to do it, because the MRI probably wouldn't be in my ordering system. Then, after I succeeded in ordering it, after I get the MRI from this other place, the orthopedist that I refer the person to couldn't actually see it in the EMR [electronic medical record] because it's somewhere else. So they have to ask the patient to get a disc and hope they have the right software to be able to view it."

Uninsured Populations Shop for Services

Ashraf Shehata, national sector leader for health care and life sciences at KPMG, observes that shopping for services like MRIs is more common in parts of the health care system that cater to un- and underinsured populations, particularly clinics serving immigrant communities. He adds that big cities in Texas — where Medicaid has not been expanded, and there is a large immigrant population — fit that profile.

"[Shopping for services] just hasn't made its way over to the more traditional, enterprise [health care] world yet," Shehata tells AIS Health. "Part of it is the insurance benefit. It masks the true costs, and obviously the EOB complicates the fact of what the actual true cost is. So I think one segment would be anywhere we would see transactions that are insurance-based. I think the health care systems in many markets are still built that way. But I think as we start to look at inner-city communities, underinsured immigrants that might be fearing getting profiled in the system for a variety of immigration concerns — those are all kind of reasonable marketplaces that are quite lucrative. Quality and coordination of care may not be there, but clearly the market exists and it's been pretty successful in many places."

"For many of us who acquire health care through the traditional system — imagine all the questions they always ask," Shehata says. "Provide your insurance card, provide your ID, provide your primary and secondary sources of payment — those are all very tactical questions that move us away from transparency and shopability. But there is an economy out there, clearly, that doesn't ask those questions."

Read the study at http://bit.ly/38aCVEW. Contact Levin-Scherz via Ed Emerman at eemerman@eaglepr.com and Shehata via Bill Borden at wborden@kpmg.com. ✧

by Peter Johnson

Research Revives Debate on Regulated Private-Plan Rates

Two new analyses from prominent health care research groups argue that huge savings could be realized if private insurers paid providers at roughly the same rate as Medicare does. However, industry experts point out that the political will to do so may not be strong enough — even with a public option supporter in the White House — and such a move could also have very problematic consequences.

First, a research report from RAND Corp. examined three policy options that could reduce hospital prices: regulating prices, improving price transparency and increasing hospital competition. Of those three, researchers found that "price regulation could have the largest impact on hospital prices and spending but would likely face political challenges." Specifically, hospital spending could be reduced by $61.9 billion to $236.6 billion if reimbursement rates for private plans were capped at 100% to 150% of Medicare rates, creating a 1.7% to 6.5% reduction in national health spending.

Following that report from RAND was an issue brief published March 1 by the Kaiser Family Foundation (KFF), which used data from MarketScan and FAIR Health to estimate the total annual reduction in health care spending by employers and privately insured people that would result from having private insurers reimburse health care providers at Medicare rates.

"A variety of policy levers could be used to move the health system in this direction, including Medicare for all, a public option, or regulatory controls over private prices," noted the analysis. Ultimately, it found that total health care spending for privately insured Americans would decrease by an estimated $352 billion, or 41%, this year if private plans reimbursed health care providers at Medicare rates (see infographic, p. 5).

Pay Reform Would Hit Hospital Margins

"While the data and savings is interesting, it's not surprising given what we already know about government underpayment, and commercial payors serving to essentially subsidize that dynamic," Citi equities analyst Ralph Giacobbe wrote in a March 1 note to investors regarding the KFF analysis. In fact, previous research from RAND found that employers and private insurers pay hospital prices that are an average of 247% higher than the rates paid by Medicare.

"As a result, we see it highly unlikely that any new payment reform would tie to Medicare, as provider groups would significantly push back as it could cause many that already hover at [a] low margin to fall into the red," Giacobbe continued. "We continue to see reforms for things like Medicare for All, a public option, or

regulatory controls over private prices as low probability, and instead look to the Biden administration to build out/tweak the current system with a particular focus on trying to shore up the ACA [Affordable Care Act]."

Michael Abrams, principal and co-founder at health care consulting firm Numerof & Associates, tells AIS Health that the RAND report's suggestion of capping private reimbursement rates is unrealistic.

"It strikes me as really surprising that with all the examples that are out there of the destructive impact of government price setting for essential goods and services, it's just shocking that any research organization would seriously treat that as an option," he says.

"Aside from that, I think it's safe to say that the American Hospital Association and the rest of the health care lobby has been extraordinarily effective at blocking anything that would threaten the status quo, so the odds of this idea ever seeing the light of day are slim to none," Abrams adds.

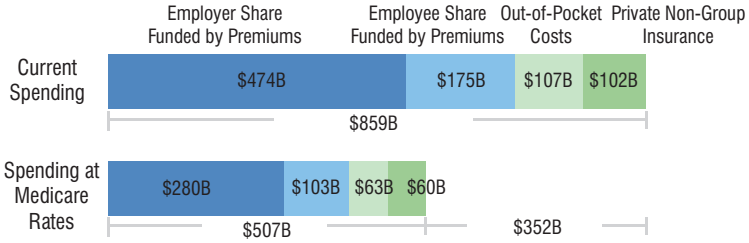
The RAND report does make it clear that hospital rate regulation has historically faced strong opposition. "Although many states established hospital rate-setting systems in the 1960s and 1970s, most deregulated this process in the 1980s and 1990s," researchers explain, adding that Maryland's all-payer system is the only one left. Some states in recent years have tried to cap reimbursement rates for their state employee health plans, but they faced fierce pushback from hospital groups. In addition, Washington and Colorado are pursuing public option programs that would pay providers at a set percentage of Medicare rates, but both states "rolled back or delayed their

Health Care Spending Could Be $350B Less If Private Insurance Uses Medicare Rates

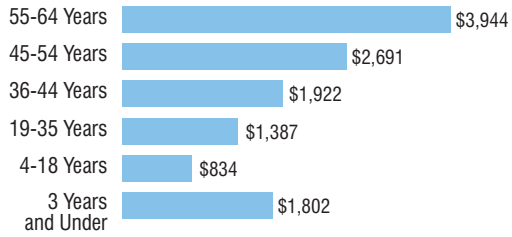
by Jinghong Chen

Total health care spending for the privately insured population could drop by an estimated $352 billion in 2021 if insurers reimburse health care providers at Medicare rates, a 41% decrease from the $859 billion in projected private health insurance spending this year, according to a recent Kaiser Family Foundation analysis. Nearly half of the total savings would be on outpatient hospital services, while inpatient services would account for 27% of the reduction. About one-third of the savings ($115 billion) would come from adults ages 55 to 64. On average, per-person health care spending for adults ages 19 to 64 with private insurance would be an estimated $2,096 less if Medicare rates were applied. For people ages 55-64, the potential reduction per person would reach $3,944 on average.

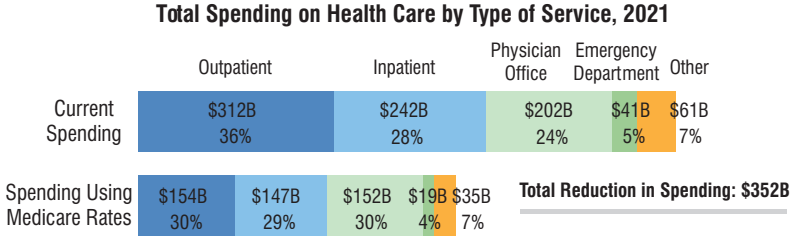
Current Spending & Reduction in Spending for Employer-Sponsored & Private Non-Group Insurance, 2021



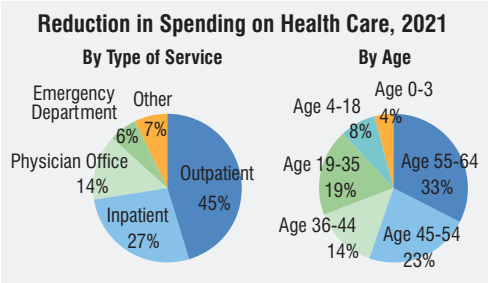
Average Reduction in Spending Per Person by Age, 2021



Total Spending on Health Care by Type of Service, 2021



Reduction in Spending on Health Care, 2021



NOTES: Data results do not include changes in administration costs or loading fees. Other spending categories include laboratory, urgent care and skilled nursing facility.

SOURCE: "Limiting Private Insurance Reimbursement to Medicare Rates Would Reduce Health Spending by About $350 Billion in 2021," Kaiser Family Foundation. Visit https://bit.ly/3dZcZ2J.

plans" during the COVID-19 pandemic, the report noted.

Abrams argues that regulating private-plan reimbursement has been so difficult because it would be extremely damaging to many health systems' finances. "The low reimbursement that is paid by Medicare and Medicaid is such that most hospitals break even at best, and if they don't have commercially insured patients on whom to put the burden of their profitability, they're operating at a loss," he says.

On a more philosophical note, Abrams says he isn't convinced that hospital price regulation is a good idea even if it got enough political support.

"Think about what that means [for] the services that you're buying — if every provider gets paid exactly the same, which is how Medicare and Medicaid operate right now, the underlying message is: 'Health care is health care; doesn't matter where you go, you're always getting the same thing,'" he says.

"If that were the same and providers all got paid exactly the same, what incentive would there be for them to try and recruit the most talented physicians and surgeons, or to demonstrate the best outcomes?"

Find the RAND analysis at https://bit.ly/2NW9DCM and KFF report at https://bit.ly/2PvHxyR. Contact Abrams via Matthew Dick at matthew.dick@pinkston.co. ✧

by Leslie Small

MCO Stock Performance, February 2021

	Closing Stock Price on 2/25/2021	February Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2021 EPS*
COMMERCIAL				
Cigna Corp.	$209.34	(3.6%)	0.6%	$20.31
UnitedHealth Group	$328.87	(1.4%)	(6.2%)	$18.17
Anthem, Inc.	$300.24	1.1%	(6.5%)	$24.68
Commercial Mean		**(1.3%)**	**(4.1%)**	
MEDICARE				
Humana Inc.	$380.59	(0.7%)	(7.2%)	$21.66
Clover Health	$9.71	(30.4%)		($0.31)
Medicare Mean		**(0.7%)**	**(7.2%)**	
MEDICAID				
Centene Corp.	$58.76	(2.6%)	(2.1%)	$5.19
Molina Healthcare, Inc.	$218.76	2.4%	2.9%	$13.14
Medicaid Mean		**(0.1%)**	**0.4%**	
Industry Mean ex-CLOV		**(0.8%)**	**(3.1%)**	

*Estimates are based on analysts' consensus estimates for full-year 2021.

SOURCE: Bank of America Merrill Lynch.

Cigna Makes Telehealth Deal

continued from p. 1

"Most of the affiliations we've seen with health plans and telemedicine providers has been through strategic alliances. Obviously, we've seen the whole category of companies that MDLive represents have done that through building a platform and then building relationships with payers and even providers. So I think that the idea that they were going to go beyond a strategic relationship is inevitable," Shehata tells AIS Health.

Shehata adds that the COVID-19 pandemic has acted as an accelerant for telemedicine use. He expects patients will continue to demand telemedicine options even after the pandemic subsides, and that payers will see that demand as an opportunity to narrow the gap between themselves and members.

Transactions Were 'Long Time Coming'

"We saw that with massive and immediate uptake of the platforms — all the platforms, I should say. Not only did [payers] use their existing platform relationships, but they added new platforms because demand is so high," Shehata explains. He points out that telemedicine has been an area of interest to insurers for some time, so there are obvious transactions that could grow out of existing partnerships.

"I definitely think it was a long time coming. I think what's unique about the relationships that we're probably going to see, and the recent move is probably just one of many, is, 'Am I going to go beyond just a strategic alignment with a vendor?'" Shehata says. "Obviously, a lot of proprietary workflows and processes have gone into a lot of these things. But now the question of ownership is a much bigger question: What is a health plan going

to do with this asset? Are there other strategic areas of focus?"

In general, Shehata says, telemedicine offers payers four value propositions. The first is network expansion: payers can bolster the scale and quality of their network everywhere with minimal legwork. Second, virtual care offers "direct-to-consumer capability and a new front door for health plans," Shehata says, comparing those capabilities to a pharmacy discount card: both offer "a direct-to-consumer way to connect to a brand." The third benefit is strategic improvement to care delivery of specific clinical areas, particularly behavioral health and related, lifestyle-based impediments to good health such as nutrition and smoking cessation.

More Deals Could Be on Horizon

"We've seen some transactions over the last year around behavioral health. I think, at the end of the day, this would probably represent one of many more commercial transactions we're probably going to see in this space over the next year," Shehata says.

Finally, Shehata says that robust, internal telemedicine options offer plans an opportunity to exercise leverage in negotiations with provider systems, which have sought to have virtual visits reimbursed at the same rate as traditional visits.

"There is the health system proper, which might have a telemedicine arm, and then there's the overall telemedicine provider and their extended providers," Shehata explains. "So you're going to see a duality: a traditional provider network, and a provider network that's attached to a telemedicine platform. And those may or may not intersect. A lot of the time the traditional providers that are in the more traditional networks are not necessarily represented in the telemedicine track. Now, the issue is going to be, as a health plan begins to own these assets, is the provider network going to be rationalized? Is payment equity going to begin to be achieved?"

The payment equity question is central to the coming regulatory battle over telemedicine, which has been brewing for some time *(HPW 6/25/20, p. 1)*. Payer and plan sponsor lobbying groups will square off against providers in Congress over whether virtual visits should be reimbursed at the same rate as in-person visits. Early in the pandemic, the Trump administration mandated that Medicare must reimburse most telehealth visits at parity with traditional visits.

Providers Still Want Pay Parity

Broadly speaking, provider groups including the American Medical Association (AMA) have argued that reimbursement for telehealth visits should be legally pegged at parity with reimbursement rates for in-person visits. Payers, meanwhile, have argued that a major part of telehealth's appeal is its lower overhead compared to in-person visits — and that future telehealth reimbursement practices should be designed to lower the overall cost of care.

James Gelfand, senior vice president for health policy for the ERISA Industry Committee, says the AMA has pitched model legislation to members in recent weeks that would lock in parity, though he thinks the bill is "very poorly written," and that it "is DOA."

"Everybody knows that telehealth costs less," Gelfand tells AIS Health. "Providers know it, patients know it. It's very obvious that providers are just thinking, 'Hey, we know that this is just basically giving us free money, but still do it.' But I think that, from Congress' standpoint, that doesn't meaningfully improve the situation for the patient. Giving free money to the providers is not going to cause the patients to get better access to care."

Also at issue is whether the full menu of services authorized in response to the pandemic will continue to be eligible for Medicare reimbursement. CMS expanded the types of services that could be delivered via telehealth to Medicare beneficiaries, temporarily adding 135 services, including emergency department visits, initial inpatient and nursing facility visits, and discharge day management services, and made about 45% of those telehealth services permanent benefits in a December 2020 final rule. Unless Congress acts or the Biden administration issues new rules, the remaining expanded services will expire either at the end of 2021, or when the pandemic public health emergency ends.

Congress Considers the Options

In a March 2 hearing of the House Committee on Energy and Commerce's Subcommittee on Health, legislators indicated that they are studying both issues. Subcommittee Chair Rep. Anna Eshoo (D-Calif.) said in her opening statement that "it's time to make Medicare reimbursement for telehealth service permanent," and added that "we need to find a way to continue affordable telehealth access for seniors and other Americans." Eshoo also suggested that telehealth could make a big difference in addressing shortages of specialists in large swaths of the country, particularly child psychiatrists.

However, Committee Chair Rep. Frank Pallone (D-N.J.) sounded a more cautious note in his remarks: "While I applaud the work that has been done so far to rapidly expand

telehealth in Medicare and elsewhere during these unprecedented times, I think it's important for the committee to carefully consider the impacts of the current waivers. We must also ensure that the data being collected today informs our decisions going forward."

Another hot topic is interstate licensure. State medical boards exercise control over whether a clinician can practice in their state, and it is typically illegal for a practitioner licensed in one state to care for patients in another.

While many states have waived those requirements to build virtual care capacity as part of their pandemic response, those moves may not be permanent. In normal times, telehealth firms have to spend substantial amounts of money and staff time getting their practitioners licensed in new markets.

Gelfand says there is longstanding interest in Congress in finding some way to make licensure across state lines simpler.

"What's interesting is, if you go back a couple Congresses, Frank Pallone had a pretty significant bill that would have essentially enabled interstate practice for Medicare — and it was bipartisan," Gelfand explains. "They haven't reintroduced that bill, and I think it's probably not the exact way that they would look at doing something this time around, but Congress has known for a while that there are problems associated with confining people to doctors in the state which they are physically in."

Michael Bagel, director of public policy at the Alliance of Community Health Plans, tells AIS Health that he thinks Congress is most likely to pursue licensure by giving financial incentives to states.

"How does the federal government collaborate with the states to have some more compacts? If we don't, that's going to result in an inhibition of the ability to use telehealth, because licensing in every state is very expensive," Bagel explains. "Congress and the federal government actually have more carrots than sticks….I think the most likely path is state and federal partnership tied to funding.…I don't think we're going to get into a position where we have one federal standard that works for everybody. But rather, just like we do for driver's licenses, even if you get it in one state it's recognized in another. There's potentially a way we could do that with provider licensure. But it has to be the federal government taking the lead and enticing states to do it."

Read a release on the MDLive deal at http://bloom.bg/3biOxHy, Eshoo's remarks at https://bit.ly/3uU9SPn and Pallone's at https://bit.ly/2O6224C. Watch the hearing at http://bit.ly/2Pzkrr8. ✧

by Peter Johnson

News Briefs

✦ ***In new guidance, CMS on Feb. 26 expanded the amount and types of COVID-19 testing insurance plans are required to cover without cost sharing.*** Per a CMS press release: "This guidance makes clear that private group health plans and issuers generally cannot use medical screening criteria to deny coverage for COVID-19 diagnostic tests for individuals with health coverage who are asymptomatic, and who have no known or suspected exposure to COVID-19. Such testing must be covered without cost sharing, prior authorization, or other medical management requirements imposed by the plan or issuer." Learn more at http://go.cms.gov/3biz0aV.

✦ ***HealthCare.gov Navigators will have access to $2.3 million in additional marketing funding during the pandemic-related special enrollment period (SEP), which runs through May 15, CMS announced.*** CMS said 30 organizations across 28 states will be allowed to use the funds. The agency also reported that 206,236 new plans have been selected by consumers during the period between Feb. 15 and Feb. 28, the first two weeks of the SEP. Also, the agency reported that 385,864 consumers have filed requests for coverage in the same period. Find the press release at http://go.cms.gov/3rke6xx and enrollment figures at https://go.cms.gov/2NUJcO9.

✦ ***A group of home health care providers including Amazon.com Inc.'s Amazon Care subsidiary have formed a lobbying group called Moving Health Home that will aim to "fundamentally change the way policymakers think about the home as a site of clinical service,"*** according to a March 3 press release. In addition to Amazon Care, founding members of the new coalition include Landmark Health, Signify Health, Dispatch Health, Elara Caring, Intermountain Healthcare, Home Instead and Ascension. Find the release at http://prn.to/30ayghE and the group's website at http://bit.ly/3kMzHwr.