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

Health Plan Weekly

Nov. 24, 2021
VOLUME 31 | NUMBER 46

Managing Editor
Leslie Small
lsmall@aishealth.com

Senior Reporter
Peter Johnson

Data Reporter
Jinghong Chen

Executive Editor
Jill Brown Kettler

'Long COVID' Presents Big Challenges for Health Plans, Patients

As the country continues to grapple with the COVID-19 pandemic, the issue of "long COVID" is becoming increasingly visible — posing thorny challenges not only for the patients suffering from it but also health care providers, payers and policymakers alike.

Known clinically as post-acute sequelae of COVID-19, long COVID can be characterized by a slew of different symptoms, including those that are neurologic (headache, sleep disorders, "brain fog"); cardiopulmonary (exercise intolerance, heart palpitations, chest pain); mental (anxiety, depression, post-traumatic stress disorder); and gastrointestinal (decreased appetite, nausea, abdominal pain).

More than 45 million confirmed coronavirus infections have been reported in the U.S., and over half of COVID-19 patients have experienced long COVID six months after recovery, according to one recent study. Also, it's very likely that the number of long COVID cases — like the number of overall COVID cases — is being significantly undercounted, pointed out Brett Giroir, M.D., during a Nov. 17 webinar hosted by the National Institute for Health Care Management (NIHCM) Foundation. Giroir is a distinguished executive at Leavitt Partners and former member of the White House Coronavirus Task Force.

continued on p. 6

Insurers Applaud New CMMI Push for Risk-Based Contracting

The Biden administration has revamped the strategy of the Center for Medicare and Medicaid Innovation: In the coming years, CMMI will focus on consolidating models, increasing insurer and provider participation in models, and advancing equity — and it aims to have most Medicare and Medicaid members served by value-based payment models by the end of the decade. Health care insiders applauded the new direction, saying the "strategy refresh" should bring the agency closer to its original mission and make its budget go further.

CMMI has tested more than 50 models since its creation in 2010 as part of the Affordable Care Act. Experts outside the agency have criticized the proliferation of models: The Medicare Payment Advisory Commission (MedPAC) recommended in June that HHS "should implement a more harmonized portfolio of fewer alternative payment models that are designed to work together to support the strategic objectives of reducing spending and improving quality."

In addition, MedPAC also called on CMMI to streamline its reporting, recommending "the same set of national provider identifiers to compute both performance-year and baseline assignment for accountable care organizations in the Medicare Shared Savings Program."

"It's pretty bold, to have pretty much everybody in Medicare, and most people in Medicaid, in some kind of value-based payment model by 2030," Katherine Hemp-

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

stead, Ph.D., tells AIS Health, a division of MMIT. Hempstead is a senior policy adviser at the Robert Wood Johnson Foundation. "I think it's doubling down on the original premise. That's the way I read it — to say, 'We definitely think value-based care is the way to go, but we need to make it easier.'"

Hempstead thinks the new approach may "reduce the barriers to participating for providers." In addition, "that focus on equity was definitely something that wasn't as explicit originally."

Hempstead describes the new strategy as, "instead of having 50 different models, have fewer models that more people can participate in. Reduce all the cacophony in the marketplace with a lot of different payment models and a lot of different sorts of signals and incentives to providers — create fewer but stronger signals."

David Ault, an attorney and counsel at Faegre Drinker, tells AIS Health that the new approach draws a contrast between the Trump and Biden administrations' strategies for CMMI. Ault worked at CMMI during both the Obama and Trump administrations.

"This administration is taking an approach more similar to the Obama administration, not surprisingly," Ault says, observing that many Biden administration figures, including CMMI Director Liz Fowler, previously worked in the Obama administration.

He says the Biden administration is "taking this position of, 'We want more providers, and therefore more beneficiaries in value-based care. And even if the amount of savings per provider is not as great, we're still going to end up having more savings.' It's a different approach to getting to greater Medicare savings."

By contrast, Ault explains, the Trump administration "was very heavily focused on reducing expenditures for the Medicare program through competition. What they wanted to do was bring in the participants into models that were going to be the most competitive with each other, and therefore drive down costs. They wanted to see big savings to Medicare — they were happy to see fewer organizations [but] with greater savings."

Ault adds that the Biden administration seems to be mindful of "the idea that history and studies have shown that, for an organization to be successful in value-based care, it takes a few years. You bring in organizations and give them the opportunity to transform the way they're delivering care. And if you make it sustainable for those organizations, then ultimately, they'll be able to be successful. And by successful, I mean providing high-quality care while reducing expenses to Medicare. Another main goal is [to address the] ongoing problem of the size of the model portfolios — how many models there are, and how they bump into each other and intersect with each other. Obviously, the more models there are, the more they overlap."

Experts Await More Specifics

Lauren Cricchi, a consultant at Avalere Health, tells AIS Health that the new approach at CMMI fits the administration's larger goals — though she emphasizes that the specifics of coming models will indicate how much success CMMI will have with the new strategy.

"It definitely was in line with what we've seen from them [the Biden administration] thus far," Cricchi says. "But it definitely was helpful to see some examples of potential actions that they might take to meet their aims over the next decade. I think we're still waiting to see concrete steps from the Innovation Center to see how they actually put this plan into action. For example, we've been waiting with bated breath to see what they do with the future of the oncology care model. And with the direct contracting model, if they'll reopen that. They're pretty tight-lipped on specific models."

CMS has said it will cancel the Next Generation ACO Model in 2022,

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

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

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

and has directed participants to apply to the Global and Professional Direct Contracting Model (GPDC) for 2022 instead. So far, the GPDC offers high levels of risk sharing — 50% or 100% — and "benefit enhancements" such as telehealth. In addition, it features a waiver of the three-day Skilled Nursing Facility rule and flexibilities not available in NextGen that are aimed at improving care coordination, reducing unnecessary utilization and generating more savings. The GPDC also features a capitated, risk-adjusted monthly payment for covered services.

Updates Are More Likely Than Overhauls

Cricchi says CMS is reviewing the model, though the agency seems to be focused on the metrics that are used to evaluate quality and effectiveness rather than the design of the model itself.

"A lot of what they put on pause was more to reassess and figure out how these models will fit into their strategy," Cricchi says. That approach is different from "not continuing to move them forward. So I think they're really reassessing and trying to improve the portfolio that they already have. We shouldn't expect to see an overhaul of what they have now, necessarily. I think that there will be, hopefully, some updates to the models that already exist to incorporate the stakeholder feedback that they're getting. Because a lot of the criticism that they've gotten is that, while these models might make a big splash [at first], when the actual evaluation comes out, they don't move the needle in terms of quality or cost. A lot of them are actually costing Medicare money... what qualifies as success is fairly limited. I think that this focus on health equity, and some of the stakeholder feedback may broaden the definition of success for some of these models."

Michael Bagel, director of public policy for the Alliance of Community Health Plans (ACHP), says that the carriers he works with are excited about the new approach.

"The fact that CMMI has come forward and said they want to do less models but be more reflective of whole-person-centered care, and that they're allowing other parties to come in participate — it's exciting," he says. "It's an opportunity for us to have more of an ability to participate than we previously did. Many of our health plans partook in models and are currently participating in models."

Plans May Get More Chances to Join In

The new approach should give even more ACHP members more opportunities to participate in models, he adds.

"One of the big challenges with CMMI, for a long time, has been that there's been very little risk perspective," Bagel says. "Providers who joined it — there was low risk, either downside or upside. The ability to make money was limited, just to secure more participation. For our members, as they work with providers that are really looking at value-based systems — how can they be more thoughtful about really getting providers incentivized to be thoughtful about whole-person care? How do they think about coordination? How are they incentivizing outcomes instead of processes, or patient experience instead of just quantitative measurement?"

Bagel says that the difficulty in measuring intangible goals like patient satisfaction also applies to equity concerns.

"One of the biggest struggles in health equity today is we don't know how to measure it," Bagel says. "We don't know how to distinguish, demographically, how things are being delivered in a comprehensive way. One of the downsides of everyone making their own efforts is that we can't know who's making the best progress, who has the best return on investment, who's making the biggest progress because we don't have a baseline measurement to compare and share these successes."

"The more CMMI can encourage that for all providers — and partner with health plans to learn and disseminate best practices — will lead everyone towards a more affordable, comprehensive, high-quality health care system," Bagel says.

Contact Ault at david.ault@faegredrinker.com, Bagel via Tricia Busch at tbusch@achp.org, Cricchi at lcricchi@avalere.com and Hempstead at khempstead@rwjf.org.

by Peter Johnson

Non-Emergent 911 Calls Offer Intervention Opportunity

Not every person who calls 911 needs to be transported to a hospital for emergency treatment. But people who make those phone calls do need some kind of health care; they just don't know how to access the services they need.

With that in mind, the health insurer CareOregon recently made a $2.5 million investment in a new Portland Fire & Rescue (PF&R) initiative to connect community members with the care they need. The Community Health Assess & Treat (CHAT) program will take a proactive approach to assessing and meeting the needs of members of Oregon Health Plan, the state's Medicaid program.

"CareOregon serves almost 400,000 people in the Oregon Health Plan in the Portland metro area...with the majority of those folks in Portland," Eric Hunter, CareOregon president and CEO, said during a recent press conference. This new program will introduce

a different way to handle 911 calls for non-emergency health issues coming from community members.

PF&R initially approached CareOregon with the idea of this community health initiative after seeing their team speak about the social determinants of health at a local event. "This topic caught the attention of PF&R who had been working toward creating a new, more proactive approach to addressing community needs," Becca Thomsen, a spokesperson for CareOregon, tells AIS Health.

The CHAT program is launching in November with a proof-of-concept phase that will last for nine months. Initially, units and vehicles will be positioned in the downtown and southeastern areas of Portland, prepared to respond to low-acuity 911 calls.

"Portland Fire, on average, responds to about 26,000 low-acuity calls per year," Tim Matthews, PF&R deputy chief, said during the press conference. Low-acuity calls are those related to minor medical issues, like a stomachache or a minor fall, which do not require emergency treatment. When first responders arrive on scene for a call that falls into the CHAT program's domain, they will not focus on transport as the first line of care. Rather, they will spend one-on-one time with the person, determining whether or not they have insurance and a primary care provider. "This gives us the opportunity to educate the individual about how to appropriately use 911 and how to access their individual health care and really make them take control of how they are navigating the health care system," Matthews said during the press conference.

The goals of the CHAT program are ambitious. Stakeholders are aiming to reduce the burden on emergency departments and to better serve the population, ultimately driving down health care costs while connecting people with the resources that they need.

"From the CareOregon perspective, there have been several recent events — ranging from severe heat this summer to the impacts of COVID-related isolation — that have impacted member health," Thomsen says.

"We believe that having a partner like PF&R on the ground in the community will help address member needs in their moment of crisis and that we'll be able to leverage additional data insights that will help us become more nimble and proactive in responding to anticipated member needs. "

Executive Compensation Data Blue Cross and Blue Shield Affiliates, 2020

Company	President/CEO	2020 Salary	2020 Bonus	2020 Stock Awards	2020 Option Awards	2020 Non-Equity Incentive Plan Comp.	2020 Other Comp.	2020 Total Comp.	Increase (Decrease) from 2019
Florida Blue	Patrick J. Geraghty	$1,350,000	$4,900,000	$-	$-	$-	$15,785,553	$22,035,553	84.19%
Anthem, Inc.	Gail K. Boudreaux	$1,400,000	$-	$9,000,196	$2,999,847	$3,270,800	$439,109	$17,109,952	10.58%
Blue Cross Blue Shield of Michigan Mutual Insurance Company	Daniel J. Loepp	$1,645,962	$8,555,765	$-	$-	$-	$1,338,607	$11,540,334	(4.66%)
Independence Hospital Indemnity Plan, Inc.	Daniel J. Hilferty	$1,298,077	$8,595,125	$-	$-	$-	$33,519	$9,926,721	73.60%
Health Care Service Corporation	Maurice Smith	$1,118,732	$4,776,726	$-	$-	$-	$9,077	$5,904,535	62.75%
Cambia Health Solutions, Inc.	Mark B. Ganz	$1,167,477	$3,821,537	$-	$-	$-	$333,352	$5,322,366	3.81%
Premera Blue Cross	Jeffrey Edward Roe	$1,232,823	$3,233,452	$-	$-	$-	$265,705	$4,731,980	17.21%
Wellmark, Inc.	John D. Forsyth	$809,792	$3,523,230	$-	$-	$-	$34,086	$4,367,108	2.86%
Blue Cross and Blue Shield of Massachusetts, Inc.	Andrew Dreyfus	$1,170,193	$3,003,240	$-	$-	$-	$74,740	$4,248,173	2.30%
Triple-S Management Corp.	Roberto Garcia-Rodriguez	$856,731	$600	$2,093,845	$-	$769,725	$9,263	$3,730,163	(11.05%)

As the CHAT program moves through its proof of concept period, stakeholders will be carefully tracking its costs and its outcomes. "There is no initial cost to the city as we run through this…proof of concept, which is what makes it innovative," Matthews explained during the press conference. The program's leaders will track quarterly key performance indicators, working with CareOregon on the future of the program beyond this initial phase.

"PF&R will keep track of the reach of the program, including the number of people they responded to and if they were able to connect them to additional resources such as care coordination," Thomsen tells AIS Health, a division of MMIT. "CareOregon will monitor emergency department utilization for non-emergent issues."

While it will take time for the program's efforts to bear fruit, CHAT's upstream, preventive model has the opportunity to reduce low-acuity 911 calls and improve health care resource utilization as more people are educated through the program. "The bulk of the people who fall into the 911 system where it is not an emergency, if we give them the right tools, we know we can change those health outcomes," Sara Boone, PF&R fire chief, said during the press conference.

Contact Becca Thomsen at thomsenb@careoregon.org.

by Carrie Pallardy

Executive Compensation Data for Blue Cross and Blue Shield Affiliates, 2020

Company	President/CEO	2020 Salary	2020 Bonus	2020 Other Compensation	2020 Total Compensation	Increase (Decrease) from 2019
BlueCross BlueShield of Tennessee, Inc.	Jason David Hickey	$867,768	$2,617,431	$211,953	$3,697,152	9.67%
Blue Cross Blue Shield of Minnesota	Craig Samitt	$1,087,915	$2,192,271	$85,266	$3,365,452	108.95%
Blue Cross Blue Shield of Arizona, Inc.	Pamela Kehaly	$928,704	$2,387,922	$21,219	$3,337,845	24.49%
Highmark Inc.	Deborah Lynn Rice-Johnson	$758,654	$2,011,034	$480,994	$3,250,682	5.28%
Excellus Health Plan, Inc.	Christopher C. Booth	$1,169,606	$1,998,489	$13,422	$3,181,517	1.96%
CareFirst, Inc.	Brian David Pieninck	$985,635	$1,718,607	$285,400	$2,989,641	13.61%
HealthNow New York Inc.	David W Anderson	$950,000	$1,789,052	$81,768	$2,820,820	7.22%
Horizon Healthcare Services, Inc.	Gary D. St. Hilaire	$1,114,423	$347,989	$265,708	$2,728,120	N/A
Blue Cross and Blue Shield of Kansas City	Erin Stucky	$957,423	$1,416,741	$30,227	$2,404,391	55.04%
Blue Cross and Blue Shield of South Carolina	David Stephen Pankau	$392,747	$1,829,122	$76,645	$2,298,514	5.85%
Blue Cross and Blue Shield of Rhode Island	Kim A. Keck	$877,185	$1,214,500	$134,811	$2,226,496	25.42%
Blue Cross and Blue Shield of Nebraska	Steve Grandfield	$826,575	$1,191,962	$47,150	$2,065,687	20.70%
Hawaii Medical Service Association	Mark M. Mugiishi	$825,558	$1,032,127	$5,500	$1,863,185	89.53%
Blue Cross and Blue Shield of North Carolina	Babatunde Sotayo Sotunde	$655,769	$-	$125,399	$1,531,168	N/A
Capital Health Plan, Inc.	John M. Hogan	$621,974	$215,515	$70,830	$908,319	(9.70%)
Blue Cross and Blue Shield of Vermont	Don George	$564,823	$134,961	$36,855	$736,639	8.15%
Blue Cross Blue Shield of North Dakota	Daniel Conrad	$418,070	$219,025	$2,931	$640,026	30.26%
Capital Blue Cross	Todd Shamash	$381,379	$249,547	$629	$631,555	10.93%

See a full list of director compensation for Presidents and/or CEOs of Blue Cross and Blue Shield Affiliates at https://bit.ly/3oTfcAn, compiled by AIS Health.
N/A = Not Available.
Compensation data for Mark Ganz includes payments allocated to Regence insurance operations in Washington state, Oregon and Utah but not Idaho.
SOURCE/METHODOLOGY: All data is compiled from individual health insurance companies, state insurance department documents and U.S. Securities and Exchange Commission filings.
Health plans selected based on commercial medical risk enrollment as of the beginning of 2020, per AIS's Directory of Health Plans.
NOTES: Arkansas, Alabama, Louisiana, Idaho, Mississippi, Kansas, Wyoming and South Dakota do not disclose compensation data for specific executives at health insurance companies. California and Oklahoma do not collect compensation data. Daniel J. Hilferty served as president and CEO of Independence Hospital Indemnity Plan through December 2020, and Gregory E. Deavens became president and CEO in January 2021. Maurice Smith became president and CEO of Health Care Service Corporation effective June 1, 2020. Horizon Healthcare Services, Inc.'s Kevin P. Conlin earned $5,150,144 as Chairman of the Board, President and CEO in 2020. Gary St. Hilaire became CEO and President on Apr. 6, 2020, and his sign-on payments is $1,000,000. Blue Cross and Blue Shield of Kansas City's CEO Danette K. Wilson retired in May 2019. Erin Stucky, formerly EVP for market innovation and business development, succeeded Wilson effective June 1, 2019. Mark M. Mugiishi became president and CEO of Hawaii Medical Service Association in February 2020. Babatunde Sotayo Sotunde became president and CEO of Blue Cross and Blue Shield of North Carolina effective June 1, 2020. His sign-on payment was 750,000. Todd Shamash was appointed president and CEO of Capital Blue Cross in April 2020.

Long COVID Issues Loom Large

continued from p. 1

In addition to the often-debilitating symptoms associated with long COVID, patients with this condition may face the added burden of struggling to get their treatment covered, according to an Oct. 18 blog post by the Georgetown University Center on Health Insurance Reforms.

"Some post-COVID conditions may not yet be known, and the research needed to demonstrate treatments' effectiveness for many post-COVID conditions is sparse," the post says. "This dearth of information on long COVID presents issues for patients trying to manage their condition and have their treatment covered by their health insurance plan."

Karen Davenport, the author of the post, tells AIS Health that there isn't yet any reliable data about insurance denials for long COVID care, but "there certainly have been stories about people who have been denied payment for services associated with long COVID."

For example, a July 2021 article by NPR-affiliated Michigan Radio details the case of a woman who was experiencing serious side effects 15 months after contracting COVID and as a result is facing roughly $10,000 in medical debt. The woman told the news outlet that one of the main issues is her insurance doesn't cover all of her care: There's a cap on certain doctor visits, some of her doctors are out of network and some medicines aren't covered.

Long COVID patients may receive physical, respiratory or occupational therapy to treat problems such as fatigue, shortness of breath or cognitive issues like brain fog, but many health plans restrict coverage for these therapies to a set number of visits or will only cover therapy services as long as the patient continues to improve, Davenport points out in her blog post. That can leave patients with large out-of-pocket costs.

Medical Necessity Is Often Subjective

Health plans might also determine certain services associated with treatment for long COVID aren't medically necessary and deny coverage for them, the post notes. Health plans' definitions of medical necessity are usually tied to scientific evidence and professional standards of practice, and many plans exclude coverage of unproven therapies outside of clinical trials. "Without evidence of effectiveness, such as in the case of long COVID, plans may not pay for a particular service or treatment," Davenport's post says.

"Frankly, for health plans, I think they're dealing with the same thing that physicians and physical therapists and everybody else are, which is...we don't know that much about post-COVID conditions, we don't know that much about treatment for them. There's just a lot of uncertainty," Davenport tells AIS Health, a division of MMIT.

Some of the country's top scientists and clinicians are striving to understand

MCO Stock Performance, October 2021

	Closing Stock Price on 10/29/2021	October Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2021 EPS*
COMMERCIAL				
Cigna Corp.	$213.61	6.7%	2.6%	$20.29
UnitedHealth Group	$460.47	17.8%	31.3%	$18.83
Anthem, Inc.	$435.13	16.7%	35.5%	$25.95
Oscar Health Inc.	$17.28			($2.51)
Bright Health Group	$8.75			($0.72)
Commercial Mean		**13.8%**	**23.1%**	
MEDICARE				
Humana Inc.	$463.16	19.0%	12.9%	$21.54
Alignment Healthcare, Inc.	$19.86			($0.67)
Clover Health	$7.50	1.5%		($1.24)
Medicare Mean		**19.0%**	**12.9%**	
MEDICAID				
Centene Corp.	$71.24	14.3%	18.7%	$5.11
Molina Healthcare, Inc.	$295.72	9.0%	39.0%	$13.25
Medicaid Mean		**11.7%**	**28.9%**	
Industry Mean		**12.2%**		
Industry Mean ex-new MCOs		**13.9%**	**23.3%**	

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

SOURCE: Bank of America Merrill Lynch.

the biological basis for the problems experienced by people with long COVID, according to Walter Koroshetz, M.D., director of the National Institute of Neurological Disorders and Stroke at the National Institutes of Health (NIH). The challenge is that there are so many moving pieces because COVID affects so many different organ systems in the body, he said during the NIHCM webinar.

> **The good news is we really have an army of people working on this problem now.**

So far, "we don't really have the data to try to inform how to take care" of long COVID patients, Koroshetz said. The United Kingdom has issued some guidelines, but they're basically just management of symptoms. To try to close those gaps, Congress has set aside $1.5 billion for an NIH-led program, called the RECOVER initiative, aimed at studying patients who have contracted COVID — particularly those with lingering symptoms. The government agency is also creating a large electronic health record-based system that will look at long-term effects of COVID infections on health, such as how it affects patients' likelihood of developing certain disorders down the road.

The next steps after that, according to Koroshetz, will hopefully be to conduct clinical trials on potential treatments for long COVID. "The good news is we really have an army of people working on this problem now," he added.

Another ongoing effort to address long COVID is the COVID Patient Recovery Alliance, Giroir said during the webinar. The alliance is a multisector collaboration started by Leavitt Partners, and its goal is to examine both gaps and opportunities for public and private sectors related to COVID recovery.

As part of that effort, the alliance hopes to collect information about how COVID patients are covered — whether by private plans, Medicare or Medicaid — and how to fill coverage gaps if patients fall in them, according to Giroir. Creating a sources-of-coverage survey is among a spate of recommendations included in an interim report that the alliance recently presented to Congress, which also outlines potential models of care and payment systems to address COVID treatment.

One idea floated by the alliance is to allow long COVID patients to be included in Medicare Advantage Chronic Condition Special Needs Plans (C-SNPs), Giroir said.

The alliance has been pleased to learn that the creation of a sources-of-coverage survey, as well as four other suggested policies, were included in the recently proposed CURES 2.0 legislation, Giroir added.

Blues Plan Sets Up Resource Site

On the health plan side, Florida Blue has created a long-COVID-focused resource site for its members, according to a slide deck from Kelli Tice Wells, M.D., senior medical director, medical affairs at the insurer. Wells was slated to present during the webinar but was unable to because of technical difficulties. The resource site includes information about in-network providers/specialists, evidence-based educational materials, care pathways and protocols, behavioral health support, community health resources and support, financial assistance resources and more, according to Wells' slides.

Still, "a comprehensive plan is needed to alleviate the burden of long-term complications and treatment of COVID-19," Wells' presentation states. Payers themselves should evaluate their policies regarding access to physical therapy, mental health services for those at increased risk of depression, anxiety or PTSD, and timely access to treatment, she suggested.

New Billing Code May Smooth Processes

One step that can help is the availability of a new ICD-10 code that clinicians and insurers can use for long COVID, Davenport points out in her blog post. "Providers can also use this code to indicate the relationship of a previous COVID infection to the current diagnosis, which may simplify some payment disputes — some payers, such as Medicare, will assess both procedure and diagnosis codes when determining whether to pay a claim," she writes.

When asked what else private payers could do, Davenport says one critical step is simply to be "aware that these claims are coming through and that some of their regular systems might automatically deny them."

"When they're evaluating medical necessity, it obviously comes down to individual judgment anyway; they have clinicians who work for the plans who are part of making those decisions, and I think that having a predisposition to cover at this point — as we're learning more — might be an unusual practice for them but one that might be appropriate in this case."

On the regulatory front, Davenport says policymakers could look into requiring payers to cover patients' out-of-pocket costs for certain services. And she suggests that self-funded employers could encourage insurers to set up dedicated networks around post-COVID care.

Contact Davenport at karenfdavenport@gmail.com.

by Leslie Small

News Briefs

✦ ***HHS Sec. Xavier Becerra is defending No Surprises Act-related regulations from growing criticism by providers and members of Congress, citing an HHS report on the cost and prevalence of surprise bills.*** Becerra said on Nov. 22 that providers who overcharge for services will simply have to change: "I don't think when someone is overcharging, that it's going to hurt the overcharger to now have to [accept] a fair price," he told Kaiser Health News. "Those who are overcharging either have to tighten their belt and do it better, or they don't last in the business. It's not fair to say that we have to let someone gouge us in order for them to be in business." The HHS report found that "surprise medical bills are relatively common among privately insured patients and can average more than $1,200 for services provided by anesthesiologists, $2,600 for surgical assistants, and $750 for childbirth-related care." More than 150 members of Congress from both parties, many of them physicians, sent a letter to Becerra earlier this month protesting the latest rulemaking on the No Surprises Act. In addition, Texas' largest provider organization filed suit to block the latest interim final rule.

✦ ***CareSource, a Medicaid-focused Ohio carrier, will acquire the Columbus Organization, a provider of services for individuals with intellectual/developmental disabilities (IDD).*** According to a press release, the Columbus Organization serves 100,000 people across 13 states with care coordination, clinical staffing and quality improvement services. The organization has also assisted over 140 local agencies in 40 states and the District of Columbia. The Columbus Organization was previously owned by HeatlhEdge Investment Partners, a Tampa private equity firm. Terms of the deal were not disclosed.

✦ ***The ERISA Industry Committee (ERIC) joined other plan sponsor groups in lobbying Congress to allow high-deductible plan members to use telehealth without meeting a deductible*** and remove limits on telehealth patients' use of health savings accounts. In a letter to Reps. Susie Lee (D-Nev.) and Michelle Steel (D-Calif.), ERIC endorsed the Telehealth Expansion Act of 2021 (H.R. 5981), which would allow first-dollar coverage of telehealth services for employees enrolled in high-deductible plans.

✦ ***AHIP, ERIC, the Blue Cross Blue Shield Association, and American Benefits Council all signed a letter calling on Congress*** to remove language in the Build Back Better Act that allows "Department of Labor to assess significant civil monetary penalties on group health plan sponsors, issuers, and administrators" that do not comply with mental health parity laws. The signees called on Congress to "amend the language to ensure adequate due process and ensure robust compliance assistance and opportunities to rectify identified issues before fines are imposed."

✦ ***In the third week of the annual open enrollment period for Affordable Care Act marketplace plans, approximately 810,00 people selected plans on HealthCare.gov.*** To date, about 2,435,000 people have enrolled in plans on the federal exchange, which is used by 33 states. The open enrollment period started on Nov. 1 and is set to run through Jan. 15. Signup data from states that run their own enrollment platforms typically is released at the end of open enrollment. Three new states — Kentucky, Maine and New Mexico — moved to state-based marketplaces for 2022.

✦ ***A white paper from the Robert Wood Johnson Foundation and Urban Institute found that "if Medicare were to cover vision and hearing services, it would primarily benefit lower income enrollee groups who likely have considerable unmet needs for these services*** and the increase in overall Medicare spending would be relatively small." The white paper found that, of the $8.4 billion spent by Medicare enrollees on vision services in 2020, $5.4 billion was paid out-of-pocket; for the $5.7 billion spent by Medicare enrollees on hearing, $4.7 billion was paid out-of-pocket. Unsurprisingly, given that dependence on out-of-pocket funds, "utilization of and expenditures on vision and hearing services both increased markedly with income."

✦ ***An investigation published by Kaiser Permanente in JAMA Network Open found that telehealth visits do not cause excess utilization.*** The researchers wrote that "adjusted rates of prescribing and nonmedication orders were significantly lower for telemedicine visits than for clinic visits, with slightly higher rates of follow-up office visits after telemedicine visits but no significant difference in rates of 7-day emergency visits or hospitalizations." The researchers studied data gathered from 2016 to 2018, well before the telehealth surge brought on by the COVID-19 pandemic.