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Medicaid MCOs Brace for COVID-Related Enrollment Surge

As the COVID-19 pandemic continues to dominate the news cycle, headlines related to rising unemployment often underscore the impact to Medicaid, suggesting that a "Record number of unemployed Americans will stress state Medicaid programs" (NBC News) and that the new coronavirus will hit Medicaid "like a punch in the mouth" (USA Today), to quote the National Association of Medicaid Directors' Matt Salo. But what about the Medicaid managed care organizations that will absorb the newly jobless and uninsured?

"I think that Medicaid MCOs are clearly in the best position to handle the influx of folks. They have the systems, they have the infrastructure and they have the experience to do this," remarks Jerry Vitti, founder and CEO of Healthcare Financial, Inc., which connects low-income elderly and disabled populations with public benefit programs. While onboarding a wave of new members may put some initial stress on plans, the real "strain" will come from covering new members who have unmet health care needs, he suggests.

Likening the current situation to the surge in new membership when states began expanding their Medicaid programs under the Affordable Care Act (ACA), Vitti says new enrollees will likely fall into one of two buckets. "One is the previously insured folks who had commercial insurance before they lost their job and have been in the health care system," he observes. This is not likely to be a "super high-demand population." But the second grouping, previously uninsured individuals who may end up enrolling as awareness goes up and barriers to enrollment go down, are likely to have "pent-up and untreated medical [needs] and substance use issues," he predicts.

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Amid Cost Unknowns, MAOs Will Get 1.66% Pay Increase

Facing a host of cost-related unknowns, Medicare Advantage organizations next year will be working with a slightly higher-than-expected pay increase, although CMS in its final MA and Part D rate notice made no adjustments to directly account for the impact of COVID-19 or the expected influx of patients diagnosed with end-stage renal disease (ESRD). However, the permanent repeal of the Affordable Care Act health insurer fee (HIF) and an adjustment to the Total Beneficiary Cost (TBC) measure may help offset some of the associated costs.

CMS in the 2021 rate notice released April 6 estimated that plans on average can expect a reimbursement increase of 1.66%. This was better than CMS's initial projection of 0.93% in February *(RMA 2/20/20, p. 1)* but lower than the healthy 2.53% pay increase plans got this year.

Although insurers might have liked to see a revenue bump to account for COVID-19, which at press time had caused nearly 31,000 deaths in the U.S., there

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was likely not enough information for CMS to make such an adjustment. "I think that's where the industry is right now; there are simply too many unknowns about COVID — unknowns about 2020, let alone 2021," says Brad Piper, a principal and consulting actuary with the Milwaukee office of Milliman, Inc.

A Wakely Consulting Group paper prepared for America's Health Insurance Plans estimated that at a high infection rate of 60%, the COVID-19 outbreak could cost U.S. insurers up to $556.1 billion in 2020 and 2021. For MA plans, costs could range from $38.8 billion to $71.5 billion for that time period assuming a 60% infection rate. At a low rate of 10%, MA plans' COVID-19 expenses could add up to between $6.5 billion and $11.9 billion.

On top of the question of how much a COVID-19 vaccine will cost — and MA plans will have to cover one when it is developed and approved — plans are facing the potential "double whammy" of increased costs associated with the deferral of certain medical procedures to calendar year 2021, combined with the challenge of gathering diagnosis information that will accurately predict next year's risk scores. "There's a concern that costs could go up in 2021 due to the deferral of services, while perhaps risk scores might go down in 2021 due to the inability to meet with beneficiaries and capture their 2020 diagnoses, and that obviously creates a challenging situation for the health plans next year," observes Piper.

One saving grace, however, could be a late-breaking adjustment to existing telehealth policy that will allow plans to use diagnoses codes from qualifying interactive video visits to count toward risk adjustment (see story, p. 3).

CMS in the rate notice had hinted at the likelihood of issuing such guidance, and did so on April 10. It also said some commenters recommended different methods for updating the CMS Hierarchical Condition Category (CMS-HCC) risk adjustment model, including the addition of risk adjustment conditions (e.g., COVID-19, Chronic Kidney Disease Stages 3A and 3B), and calibration of the model using encounter data. CMS responded that it would take commenters' concerns and suggestions regarding certain conditions such as COVID-19 "into consideration for future years."

By and large, very little changed from the February release of the second part of the Advance Notice. CMS factored in an effective growth rate of 4.07%, compared with 2.99% used to calculate the expected average change in revenue in February, which appeared to be the main driver of the average MA plan rate increase. "I think what's important to take from that number, though…is CMS also said there's going to be a 0.35% reduction due to the combined [impact] of rebasing and the removing of kidney acquisition costs," since health plans in 2021 will no longer be required to cover those, points out Piper.

State-Based ESRD Rates Improved

Patients who have already been diagnosed with ESRD will for the first time be able to enroll in an MA plan in 2021, thanks to the 21st Century Cures Act. Beneficiaries with ESRD typically incur higher costs than the average Medicare beneficiary, and CMS establishes separate state-based payment rates to MA plans to reflect this. Outside of the exclusion of organ acquisition costs for kidney transplants from MA ESRD rates, CMS did not change its underlying rate methodology for covering patients with ESRD. The final trend factor that will apply to the MA ESRD state-level rates, however, did improve to 4.04% from the initial growth projection of 2.8%.

Meanwhile, CMS in a separate memo from the Medicare Drug & Health Plan Contract Administration Group raised the TBC (i.e., the max-

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imum amount by which a plan may impose an increase in cost sharing or decrease in plan benefits from one year to the next) threshold from $36 in 2020 to $39 "for most plans" in 2021. CMS explicitly stated that this $3 bump will account for changes in ESRD enrollment policy and provide greater flexibility in navigating related maximum out-of-pocket (MOOP) limit changes. CMS in that memo finalized a plan to phase in the use of ESRD cost data when determining MOOP limits, starting in 2021. That's up from the $37 TBC measure that was initially proposed in a February bid memo, says Piper.

CMS also finalized a proposal to combine 75% of the risk score calculated with the 2020 CMS-HCC model (which is populated with encounter data) and 25% of the risk score calculated with the 2017 CMS-HCC model (which relies on the legacy Risk Adjustment Processing System), compared with a 50/50 blend used this year.

Analysts Viewed Increase as Favorable

"Overall, we see this improvement of 73 bps for the 2021 MA rates as a positive relative to prior investor expectations," wrote Credit Suisse analyst A.J. Rice on April 6. And the repeal of the HIF should create an additional tailwind to the tune of roughly 2% to 2.5% favorable impact, Credit Suisse estimated.

In an April 7 research note from Barclays, securities analyst Steve Valiquette also portrayed the increase as a "solid rate update." He wrote: "Importantly, the rates…do not consider the impact of favorable coding trend, which will vary by plan, but are expected to add about…3.6% on average." That combined with the "additional financial cushion" of the HIF tailwind "could add up to 6% to the headline rate," he estimated.

View the notice at https://go.cms.gov/34EBpHV and the Wakely paper at https://bit.ly/2V9D5X1.

Contact Piper at brad.piper@milliman.com, Rice at aj.rice@credit-suisse.com and Valiquette at steve.valiquette@barclays.com. ✧

Telehealth Increase Underscores Need for MA Risk Adjustment

Just days after CMS mentioned in its final 2021 Medicare Advantage and Part D rate notice that it would issue separate guidance on the topic of telehealth and risk adjustment (see story, p. 1), the Trump administration unveiled a major shift in telehealth policy by giving plans new latitude to apply diagnoses from telehealth visits for risk adjustment purposes. While this removes a longstanding barrier to MA plans' use of the technology, it remains unclear whether CMS is making a permanent policy change.

"The 2019 Coronavirus Disease (COVID-19) pandemic has resulted in an urgency to expand the use of virtual care to reduce the risk of spreading the virus," said the agency in an April 10 memo to plans. "CMS is stating that Medicare Advantage (MA) organizations and other organizations that submit diagnoses for risk adjusted payment are able to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient, or professional service, and from a face-to-face encounter."

Prior to this, CMS has required that all ICD diagnoses submitted for risk adjustment purposes must come from a face-to-face encounter with an acceptable provider type. The newly permitted use of diagnoses from virtual visits may apply when submitting codes through both the Risk Adjustment Processing System and the Encounter Data System. Such visits will count only when services are provided using an interactive audio and video telecommunications system that allows for "real-time interactive communication," added CMS.

In response to the pandemic that at press time caused nearly 31,000 deaths in the U.S., CMS last month said it would temporarily allow Medicare to pay for office, hospital and other visits furnished via telehealth across the country — including in patients' homes — whereas it was previously allowed only on a limited basis.

Telehealth already got a major boost in the MA program when CMS in 2019 implemented CHRONIC Care Act provisions that allowed plans in 2020 to begin offering "additional telehealth benefits" beyond what is available to Medicare fee-for-service (FFS) beneficiaries as part of the basic benefit package, thus freeing up rebate dollars to pay for richer supplemental benefits *(RMA 4/18/19, p. 1)*.

CMS Considers Additional Changes

More recently, CMS in a proposed rule for contract years 2021 and 2022 (85 Fed. Reg. 9002, Feb. 18, 2020) included some tweaks around network adequacy and telehealth. Among other telehealth-related tweaks, CMS proposed two key changes: (1) allowing MA plans to receive a 10% credit on meeting published time and distance standards when contracting with telehealth providers for five specialty types and (2) lowering the required percentage of rural beneficiaries who must reside within the maximum time and

distance standards from 90% to 85% *(RMA 2/20/20, p. 1)*.

The comment period for that 900-plus page rule touching on many other aspects of the program ended on April 6, and it generated several comments regarding telehealth and risk adjustment. In addition to asking CMS to relax certain documentation requirements for preparing bids due June 1 (see story, p. 1), Anthem, Inc. asked that CMS "during the public health emergency" allow telehealth visits to count as valid encounters for documenting diagnosis codes used in determining risk scores. "Such guidance is consistent with CMS' decision that face-to-face visits can be furnished via telehealth in FFS for payment purposes due to COVID-19 in the interim final rule, and the recommendation that older Americans remain home and avoid seeking any non-urgent healthcare," wrote Anthem Vice President for Public Policy Anthony Mader on April 6.

Plans Pushed for Risk Adjustment Change

Taking that recommendation one step further, HealthPartners in its comments to CMS recommended that the agency update the MA risk adjustment models to include diagnoses documented through telehealth/remote care "on a permanent basis." Given the expanded role of telehealth in the government's response to COVID-19 and CMS's recognition of telehealth as an "appropriate care delivery option for MA enrollees," the MA insurer said it strongly believes that "any diagnosis obtained during any kind of telehealth encounter [should] be allowed under risk adjustment."

Meanwhile, virtual care provider Doctor on Demand on March 27 wrote to CMS's Center for Medicare Principal Deputy Administrator and Director Demetrios Kouzoukas, asking that the agency recognize telehealth "as a means of diagnosis capture related to risk adjustment" and that it remove "the final regulatory barrier preventing telehealth from reaching its full potential in value-based care delivery for Medicare Advantage."

Latoya Thomas, director of policy and government affairs with Doctor on Demand, says the provider of telehealth services has been lobbying for CMS to take this final step since Congress authorized the expansion of telehealth in MA. And it's been working with its health plan partners and Faegre Drinker Consulting to encourage more advocacy on the issue.

CMS Removes Barrier to Telehealth

"There's been a lot of interest from members of Congress and the industry, both providers and telehealth providers, in terms of more adoption. And I think there's been a belief in the past decade that telehealth should not just be rural; it can be cost saving and improve outcomes and increase access in lots of different situations," says Megan Herber, a director with Faegre Drinker and a former legislative director in the office of U.S. Rep. Doris Matsui (D-Calif.). "And we were actually talking about the risk adjustment situation before COVID-19 because…it's a big barrier to telehealth adoption for the [MA] plans."

The memo, she remarks, is good news for plans and is "pretty permissive" in that it doesn't limit diagnoses used for risk adjustment to specific types of telehealth (e.g., primary care vs. specialty). "But they don't explicitly say it's only temporary during the pandemic," she points out. "Either way, we want it to be permanent, so we'll keep working on that. And if they don't put anything [additional] out, maybe they'll see that it works and keep it going."

Thomas says it's worth pointing out that the new guidance specifies video-based telehealth, which helps give a more complete picture of what signs or symptoms a patient may be exhibiting. "We rolled out a virtual primary care practice last year and we thought [video] was really important because if we're going to be held to the same standard of reporting certain quality outcomes and doing the same things in a patient's home that they would expect in an office environment, then seeing a patient and being able to assess them that way or sending out chronic care kits with peripherals — so that they can take temperature and do blood pressure monitoring and if necessary report those signs — was our ability to have a value-add to our virtual primary care practice."

CMS at press time did not respond to an inquiry from AIS Health about the permanence of the change.

Read the comments on the proposed rule at https://www.regulations.gov/document?D=CMS-2020-0010-0481. Contact Herber at megan.herber@faegredrinker.com and Thomas at lthomas@doctorondemand.com. ✧

While MAOs Embrace 'Flex Benefits,' SSBCI Uptake Is Slow

After a relatively modest first year, the number of condition-specific supplemental benefits offered by Medicare Advantage plans more than doubled from approximately 820 in 2019 to 1,850 this year, according to a new report from Faegre Drinker Consulting. And, in the first analysis of new Special Supplemental Benefits for the Chronically Ill (SSBCI) for 2020, Faegre

Drinker found that only 245 plans out of approximately 6,000 MA plans total offered them. But the firm observed that adoption of the new "flexible benefits" permitted by CMS may improve as plans see what works and what doesn't and explore their potential to increase enrollment, improve outcomes and generate net cost savings.

"We see a big increase in condition-specific benefits in 2020, but the SSBCI uptake was pretty small," remarks Michael Adelberg, a principal with Faegre Drinker and a former CMS MA official. Nevertheless, the industry is only at the start of a multiyear process to embrace flexible benefits, he points out.

CMS in April 2018 finalized and issued guidance on a broader definition of "primarily health related" supplemental benefits that may be included in plan benefit packages. At the same time, it offered a new interpretation of its MA benefit uniformity rule that permitted plans to tie benefits to certain conditions for "similarly situated" beneficiaries. And for 2020, plans for the first time were permitted to offer SSBCI, a new category of "non-primarily health related" items and services that may be extended to certain beneficiaries.

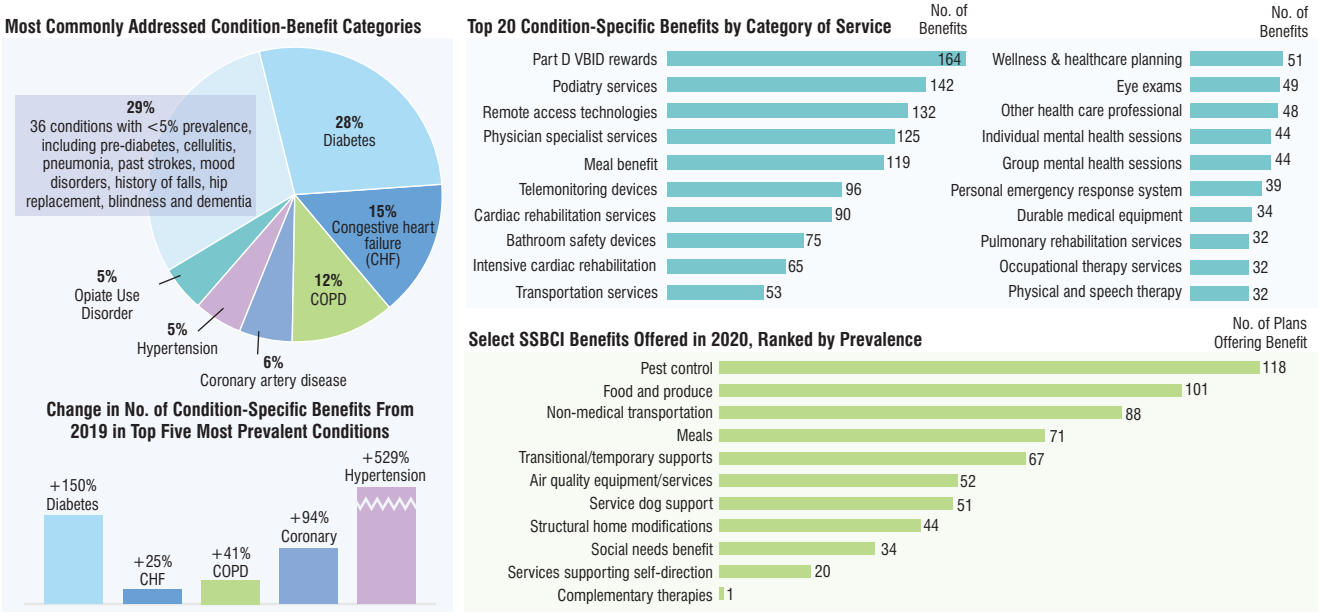
Analyzing condition-specific benefit and SSBCI data from CMS, Faegre Drinker observed that diabetes (offered by 28% of plans with condition-specific benefits) topped the list of condition-benefit categories and saw a 150% increase in benefits related to that condition (see infographic). Hypertension had the greatest increase (529%) but is still tied to only 5% of targeted benefit offerings.

Faegre Drinker also identified 22 common condition-specific benefits by category of service, with Part D value-based incentive design rewards and incentives, podiatry services, remote access technologies, physician specialist

New Analysis Shows Medicare Advantage Condition-Specific Benefit Offerings Soar in 2020

by Carina Belles

The number of condition-specific benefits offered by Medicare Advantage organizations more than doubled in the 2020 plan year, according to a recent analysis of CMS data from Faegre Drinker Consulting. As in 2019, diabetes, congestive heart failure and chronic obstructive pulmonary disease (COPD) remained the most targeted illnesses, though researchers noted rapid growth in hypertension and coronary artery disease offerings. This plan year also marked the first time MAOs were able to offer Special Supplemental Benefits for the Chronically Ill (SSBCI), non-medical benefits that aim to help members limit and prevent complications from serious conditions, though uptake of these benefits was modest compared to the growth in condition-specific offerings. The graphics below highlight the most commonly offered condition-specific benefits, plus the diseases they target, as well as an overview of SSBCI uptake, ranked by the number of plans offering each benefit type.



SOURCE: 2020 Vision: New Information on 2020 Medicare Advantage Benefits, Part II, Faegre Drinker analysis of CMS data, March 27, 2020. Visit https://bit.ly/34toEQv.

services and meal benefits at the top of the list.

While some plans chose to attach certain prerequisites (e.g., participation in a wellness or care management program, which was offered by 34% of MA plans) to condition-specific benefits, 60% had no such requirement.

The report also found that there was significant variation regarding which of these benefits were offered by MA organizations. While many MAOs are not yet using condition-specific benefits, 10 MAOs with significant MA membership have more than 50% of beneficiaries in plans featuring these benefits.

Early Adopters Included Regional Plans

"The conventional wisdom is that the national plans are way out in front, but the data tells a more nuanced story," Adelberg tells AIS Health. "A handful of regional plans are ahead of the nationals on benefit innovations."

In offering SSBCI, plans for 2020 were given a list of 15 conditions for which they could offer benefits that aren't primarily health related so long as there is a "reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee." CMS in an April 2019 memo told MA plan sponsors they have "broad discretion in determining what may be considered a reasonable expectation," and in a recent proposed rule (85 Fed. Reg. 9002, Feb. 18, 2020) suggested that plans should have greater leeway to determine what qualifies as a chronic condition for SSBCI.

The April 2019 memo also contained a detailed list of permissible benefits. Explaining that the list was not meant to be exhaustive, CMS at the time identified 11 examples with clarifications for each. For instance, CMS suggested that food and produce to help chronically ill enrollees meet nutritional needs may include frozen foods and canned goods but stated that tobacco and alcohol are not allowed. And home modifications, which have the potential to prevent falls and other injuries, may include the widening of hallways or doorways, permanent mobility ramps and "easy use" doorknobs and faucets.

But uptake of those benefits by insurers was modest, with only 245 plans out of 6,000 MA plans overall (including employer-only plans) offering SSBCI. Of the 11 categories outlined by CMS, pest control was the most common, featured by 118 plans in the Faegre Drinker analysis. Only one plan included complementary therapies, while just 20 chose to include services supporting self-direction (e.g., services to assist in establishing health-related "decision-making authority" such as power of attorney).

"In the long run, we'll see plans with outcome-improving, actuarially solid condition-specific benefits throughout the MA landscape," predicts Adelberg. "But it's going to take a while."

View the full report at https://bit.ly/2UMoQal. Contact Adelberg at michael.adelberg@faegredrinker.com. ✧

Medicaid MCOs Brace for Surge

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In the meantime, plans' medical loss ratios (MLRs) are improving as members delay certain medical procedures to the second half of the year or 2021, reports Jeff Myers, senior vice president, reimbursement strategy and market access with Catalyst Health Care Consulting. "I'm hearing from plans I've worked with that on both the MA and the Medicaid side…their MLRs have dropped substantially," he tells AIS Health. "And though I think their net income is certainly looking up, that means they're busy strengthening their capital position for what they expect to be the next phase, which is a big enrollment spike on both the [ACA] marketplace and Medicaid programs. And so I think they're gearing up for a run not of the same size as when they expanded Medicaid under the ACA, but I think they see significant opportunity for additional lives."

Impact on MCO Rates Is Uncertain

"All of them are concerned about state budgets," continues Myers, pointing out that this is usually the time when managed care rate negotiations would begin with states. "I think the challenge for the few state folks I've talked to is modeling out, in states with extensive managed care programs, what that influx of people is going to look like given what the unemployment rate may look like, and also given whether they've expanded [Medicaid] or not," he adds.

An estimated 54 million individuals (out of nearly 74 million total Medicaid recipients, including Children's Health Insurance Program enrollees) are currently in managed care plans, according to AIS's Directory of Health Plans. A recent report from A2 Strategy Group suggested that under a 30% unemployment scenario, Medicaid enrollment could exceed 104 million if all states were to expand eligibility. And if additional states didn't expand Medicaid, "10 million-plus Americans could be newly uninsured, with Medicaid still substantially growing to 91 million," estimated the report published in March.

As a result of these potential changes in coverage, A2 Strategy

Group suggested that plans make the following considerations:

✦ ***Medicaid and individual health plans must be ready to onboard unprecedented numbers of new enrollees*** and scale operations to support a significantly larger membership base.

✦ ***Plans must "maintain flexibility in administrative expansion*** as some economic scenarios show an equally precipitous decline in unemployment from peak levels."

✦ ***Plans must "be mindful of capital and financial considerations — maintaining appropriate statutory capital to support new membership*** and the potential for significant claims experience arising from COVID, but also the potential for substantial financial gains should new membership be temporary and not utilize care. Especially under the latter scenario, Medicaid and Individual plans should use the opportunity to create durable customer relationships, which can lead to customer preference in future years or as individuals become eligible for Medicare coverage."

For states whose budgets have been stretched thin by COVID-19 testing and presumptive eligibility determinations to guarantee payments to hospitals, the pandemic could be the driving factor in expanding Medicaid where a legislature has historically blocked it. Or it may result in states seeking to expand federal Medicaid funding rather than limit it through block grants, suggests Myers.

"It would not surprise me at all if six to eight months from now, right in the middle of a presidential election cycle, you had serious talks about another ACA-type design to expand either the [federal matching assistance percentage] or some other mechanism to get money into the states' hands to pay for this growth in the Medicaid program," he adds.

Meanwhile, plans may experience swings in their per-member per-month (PMPM) administrative expenses as a result of short-term membership growth or declines, suggests a new analysis from Sherlock Company. In the April report, "Short-Term Economies of Scale: Growth in Membership and Health Plan Administrative Costs," Sherlock analyzed the impact of membership changes on the administrative costs of 25 health plans between 2017 and 2018 and found that, in the short term, certain investments remain relatively fixed regardless of membership swings.

For example, the Sherlock analysis found that a 10% increase in membership would lead to a 6.7% reduction in corporate services costs on a PMPM basis. That includes the CEO's salary and other related expenses, board expenses, strategic planning, the chief financial officer's salary/benefits and other financial activities, legal, human resources and other similar activities, explains Douglas Sherlock, president of Sherlock Company. Account and membership administration, which includes customer service, would be less affected by membership changes. And while plans cannot bake into their annual staffing projections unexpected factors such as COVID-19, in some cases they can move expenses around to accommodate changes in claims processing and certain other activities, he suggests.

"Health plans' inability to adjust for actual versus estimated volumes can mean that costs that are variable over the intermediate term can behave like fixed costs in the short term. A short duration time-series analysis, such as the subject of this analysis, can measure short-term scale," observed the report, which was based on available data from provider-sponsored and Blue Cross and Blue Shield plans and not specific to one product type.

Visit https://a2strategy.com/ or contact Myers and Vitti via Joe Reblando at joe@joereblando.com and Sherlock at sherlock@sherlockco.com. ✧

News Briefs

✦ ***UnitedHealth Group on April 15 reported first-quarter 2020 adjusted earnings per share of $3.72, in line with the same period last year, and maintained its full year EPS outlook in the range of $16.25 to $16.55.*** These results reflected "minimal impact from the progression" of COVID-19 across the U.S., given that it emerged late in the quarter, according to a press release. Revenues for the quarter ending March 31 rose 6.8% to $64.4 billion, "reflecting broad-based revenue growth across Optum and UnitedHealthcare," and UHC's medical loss ratio dropped from 82.0% in the year-ago quarter to 81.0% in the recent quarter, largely as a result of the Affordable Care Act health insurer fee returning and partly offset by additional calendar days. UHC's first-quarter revenues increased by 4.4% to $51.1 billion, primarily due to enrollment growth in Medicare Advantage and Dual Eligible Special Needs Plans; revenues in the Medicare & Retirement seg-

News Briefs *(continued)*

ment climbed 9.7% to $23.2 billion in the recent quarter, as the business grew to serve 5.6 million MA enrollees — a year-over-year increase of 410,000. The company added that UnitedHealth Group President and Optum CEO Andrew Witty is taking a leave of absence to help lead the World Health Organization's new initiative for COVID-19 vaccine development. View the release at https://bit.ly/3co3qGC.

✦ ***Medicare Advantage has experienced year-to-date (YTD) enrollment growth of 6.4%, and added nearly 78,000 members from March to April, according to a Credit Suisse analysis of the latest enrollment figures from CMS.*** YTD enrollment this year is "above the pace of the prior two years," which was 4.8% in 2019 and 5.2% in 2018, and "runs counter to conventional wisdom which says the return of the HIF [health insurer fee] should dampen the Y/Y growth rate," wrote Credit Suisse analyst A.J. Rice on April 15. UnitedHealth Group and Humana Inc. were YTD growth leaders, as UnitedHealth added an industry-leading 355,900 members and Humana grew by 337,300 enrollees, Credit Suisse estimated. The five major MCOs (including CVS Health Corp.'s Aetna), which account for roughly 61.6% of total MA enrollments, have cumulatively grown 8.1% YTD, compared with 3.7% YTD growth for the remaining MA plans, added Rice. View the monthly enrollment report at https://go.cms.gov/3cln7P7 or contact Rice at aj.rice@credit-suisse.com.

✦ ***Just days after Sen. Bernie Sanders (I-Vt.) suspended his presidential campaign, effectively clearing the way for Joe Biden to become the presumptive Democratic nominee, Biden introduced a plan to expand health care coverage that included lowering the Medicare eligibility age from 65 to 60.*** Under the Biden plan, Medicare would be available as an option to people who turn 60 and "retire before they turn 65, or who would prefer to leave their employer plans" or other coverage. Biden said a "Medicare-like public option," as well as other subsidized private plans available through the Affordable Care Act, would remain available. Medicare Advantage organizations such as UnitedHealthcare, Humana and Aetna would benefit most from the plan, predicted securities analyst A.J. Rice in a research note from Credit Suisse. "While the current MA penetration rate stands at 36%, the individuals that are currently aging in to Medicare are selecting Medicare Advantage at a higher rate (50%)," he wrote. Contact Rice at aj.rice@credit-suisse.com. View the Biden proposal at https://bit.ly/2w-znlDa.

✦ ***Molina Healthcare, Inc. is ditching its previously announced plan to acquire all the capital stock of Illinois insurer NextLevel Health Partners, Inc. for $50 million.*** According to an April 14 filing with the U.S. Securities and Exchange Commission, Molina terminated the deal "due to the seller's stated unwillingness to close pursuant to the terms of the acquisition agreement." The transaction, which was unveiled in January, would have given Molina about 50,000 Medicaid and long-term services and supports enrollees in Illinois' Cook County *(RMA 1/16/20, p. 8)*. Visit https://molina-healthcare.gcs-web.com.

✦ ***Cigna Corp. on April 13 said it is launching a pilot to increase social connectivity among its MA members during the COVID-19 pandemic.*** The effort will involve reaching out to seniors to monitor their health, well-being and daily needs such as food, housing and transportation. Those customers can then opt in to get follow-up calls from the same Cigna representative, "to help cultivate meaningful connections." The pilot — which will also involve "additional proactive outreach measures" for higher risk MA members — will include 24,000 Cigna customers initially, and the company said it plans to expand the initiative rapidly. Read more at https://bit.ly/3abVjeL.

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