

August 24, 2020

VOLUME 30 | NUMBER 34

3 Firms Predict Steady Rise
in Health Costs, More
Virtual Care

4 Aetna, Cleveland Clinic to
Offer Co-Branded
Employer Plans

7 News Briefs

8 Infographic: Little Is Spent
on Treating High-Cost
Patients' Behavioral
Health Conditions

Don't miss the valuable benefits
for *HPW* subscribers at
AISHealth.com — articles,
infographics and more. Log in at
AISHealth.com. If you need
assistance, email [support@
aishealth.com](mailto:support@aishealth.com).

Managing Editor

Leslie Small
lsmall@aishealth.com

Senior Reporter

Peter Johnson

Data Reporter

Jinghong Chen

Executive Editor

Jill Brown Kettler

Appeals Court Gives Insurers a CSR Win, but Limits Payout

Health insurers that sued to recoup halted cost-sharing reduction (CSR) payments scored a key victory on Aug. 14 when a federal appeals court confirmed that the government must reimburse them for providing subsidies to low-income Affordable Care Act exchange enrollees. But that win came with a significant catch, as the three-judge panel said insurers can collect only the monetary damages that they didn't already recoup from silver loading — the process by which they raise benchmark silver-plan premiums to compensate for lost CSR payments.

Health policy experts who spoke to AIS Health say they don't expect the court's decisions will cause much to change about CSRs or silver loading, as the current setup is working well for nearly all stakeholders. Still, insurers probably won't file any more lawsuits seeking CSR reimbursement from the 2018 plan years and beyond, since they aren't likely to collect any damages.

The fight over CSR reimbursement can be traced back to 2014, when a Republican-controlled House of Representatives filed a lawsuit claiming that the subsidies — which help qualifying ACA enrollees pay deductibles, copays and other out-of-pocket health care expenses — are unconstitutional because the funds weren't appropriated by Congress. A court victory for the House in 2016 led to the Trump administration abruptly ending CSR payments to insurers in the fall of 2017. That move came in the wake of multiple unsuccessful attempts to repeal and replace the ACA by Republicans in Congress.

continued on p. 5

Health Plans Face Uphill Battle to Reach Newly Uninsured

Health insurers are conducting outreach to people who may have been left without coverage as a result of the COVID-19 crisis, but experts say they may be partially stymied in their efforts to get people enrolled in new plans by the difficulties of operating within a pandemic environment.

AmeriHealth Caritas, which is run by Independence Blue Cross in partnership with Blue Cross Blue Shield of Michigan, says it has launched a series of videos designed to help potential Medicaid enrollees learn how they can apply.

Meanwhile, Fort Worth, Texas-based Care N' Care Health Plan, which offers Medicare Advantage (MA) plans, is urging newly unemployed seniors — who already were Medicare-eligible but delayed signing up because they still had health insurance through a job — to get coverage now.

Still, reaching those who have been laid off and are suddenly in need of coverage is not an easy task, warns Jerry Vitti, founder and CEO of Healthcare Financial, Inc., a Boston-area company that connects low-income, elderly and disabled populations with public benefit programs.

“Traditionally, plans go to hospitals, community health centers, community agencies, opportunities like ethnic festivals and so forth where you have touchpoints,” or chances to interact with people who may be potential members or who might need help enrolling, Vitti tells AIS Health. With the pandemic ongoing, these in-person touchpoints are largely not available, he says.

That means insurers must reach people in other ways. AmeriHealth Caritas, which operates in 13 states and the District of Columbia and serves approximately 5 million Medicaid, Medicare and Children’s Health Insurance Program members, is promoting two videos and a one-page handout that offer enrollment assistance.

The first AmeriHealth Caritas video is “Medicaid 101,” which explains how the program works, and the second is “How to Enroll in Medicaid.” The one-page handout explains in relatively simple terms how people can get organized and apply for Medicaid coverage in their state of residence.

Care N’ Care, which has both MA HMO and PPO plans, is hoping to reach newly unemployed and uninsured seniors by stressing in a public relations campaign that those people don’t need to wait until open enrollment begins later this year to choose an MA plan.

“These newly uninsured seniors comprise one of the tragic but seldom talked-about consequences of the coronavirus,” says Wendy Karsten, Care N’ Care CEO. “These seniors had coverage under their employer’s health insurance but now need to hurriedly enter the individual insurance market and shop for a Medicare plan.”

There’s evidence of a significant unmet need for consumer assistance in navigating health coverage options, including individual market coverage and Medicaid coverage, according to an analysis released Aug. 7 by the Kaiser Family Foundation.

The report, based on a survey conducted in spring 2020, found that nearly one in five consumers who looked for coverage or actively renewed their coverage received consumer as-

sistance in the past year. Most who enrolled in coverage with help said the assistance made a difference, and two out of five said it’s unlikely they would have found coverage without help, according to the report. Another 12% of target consumers tried to find help but did not get it, suggesting there is a shortage of consumer assistance.

“Most people who are uninsured or have marketplace or Medicaid coverage do not know or are unsure if the ACA has been overturned, if their state has expanded Medicaid eligibility, or time frames when they can apply,” the report said. “Consumer assistance could help people identify and navigate replacement coverage options.”

Most state Medicaid agencies have tried to make it easier for people to apply for coverage during the pandemic by offering a dedicated phone line for enrollment assistance, providing real-time eligibility decisions, and waiving interviews and other documentation requirements, according to a June 17 Health Affairs blog post. Some states also have allowed hospitals or state Medicaid agencies themselves to presume people are Medicaid-eligible and start coverage before they’ve completed the necessary paperwork.

Newly Uninsured Are Not ‘Typical’

Medicaid managed care organizations are conducting their own outreach, and “they’re really great at consumer engagement with the Medicaid population,” Vitti says. “But the folks who are newly insured are not a typical Medicaid population,” and states and plans may need different types of communications to reach people and enroll them, he says. In addition, Vitti notes, funding has been cut across the board for health care navigators who can assist prospective members in signing up for coverage.

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.

Copyright © 2020 by Managed Markets Insight & Technology, LLC. All rights reserved. On matters of fair use, you may copy or email an excerpt from an article from **HPW**. But unless you have AIS Health’s permission, it violates federal law to copy or email an entire issue, share your AISHealth.com password, or post content on any website or network. Please contact sales@aishealth.com for more information.

Health Plan Weekly is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

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

EDITORIAL ADVISORY BOARD: Michael Adelberg, Principal, Faegre Drinker Consulting; Brian Anderson, Principal, Milliman, Inc.; Pat Dunks, Principal and Consulting Actuary, Milliman, Inc.; Adam J. Fein, Ph.D., President, Pembroke Consulting, Inc.; Bruce Merlin Fried, Partner, Dentons; John Gorman, Founder and Chairman, Nightingale Partners LLC

In fact, Medicaid plans so far are not seeing as big an influx of enrollees as they might have expected in the pandemic (*HPW 8/3/20, p. 1*). Much of the Medicaid enrollment gains that publicly traded insurers have seen are related to suspended eligibility redeterminations during the public health crisis, not job losses, executives said during the companies' recent second-quarter earnings calls.

Coverage 'Falls Between the Cracks'

"People are forgoing health care, mostly preventive non-emergency visits, in favor of more pressing needs like eating and paying rent — addressing these underlying social determinants of health is primary, so health coverage kind of falls between the cracks," Vitti says. "Another reason may be that people are expecting to return to work when this is all over and are just waiting to get their old employer coverage back."

Since "at the very least I think we're looking at a protracted COVID-related recession," he says, "we should eventually see the enrollment increase they were expecting."

Still, outreach to people who might be eligible for coverage is proving challenging in this environment, Vitti says: "The plan folks we work with are extremely committed to the population, but there's a lot of financial, operational and medical strain on the system. So folks are trying the best they can in an environment that just doesn't lend itself to being able to do everything."

Read the KFF study at <https://bit.ly/3gPyXnc> and the Health Affairs post at <https://bit.ly/3akxvXx>. Contact Vitti via Joe Reblando at joe@joereblando.com and Karsten at (817) 529-9230. ✦

by Jane Anderson

Firms Predict Steady Rise in Health Costs, More Virtual Care

While the COVID-19 pandemic has not caused employers to significantly alter their health care cost estimates for the coming year, it has unquestionably intensified their interest in embracing virtual care. Those are just a couple of the major findings from the Business Group on Health's 2021 Large Employers' Health Care Strategy and Plan Design Survey, which highlighted the variety of ways that the current public health crisis is — and isn't — affecting how self-insured companies view the health care system.

Notably, 80% of respondents said they believe virtual health will play a significant role in how care is delivered in the future, up considerably from 64% last year and 52% in 2018. Further, when asked about actions they were taking to ease the burdens of COVID-19 for employees, the largest share of respondents — 76% — said they "made changes to allow for better access to virtual care solutions."

Pay Parity Debate Isn't Settled

During an Aug. 18 press briefing to discuss the survey findings, Business Group on Health President and CEO Ellen Kelsay attributed such findings to not only telehealth's ability to offer more convenience and greater access for consumers, but also to the sheer necessity of pivoting to a different care modality amid widespread stay-at-home orders.

However, "a question that we'll be continuing to watch is, as these virtual care offerings continue to grow, what is their impact on overall quality and outcomes, how are those things measured in an increasingly virtual world, and certainly how are virtual services

paid and reimbursed in the new world going forward," Kelsay said.

During the question-and-answer portion of the briefing, Kelsay offered more details about the Business Group on Health's position regarding the controversial issue of telehealth reimbursement, which payers generally want to be lower than in-person visits but providers want to be equal (*HPW 6/22/20, p. 1*).

"There's been a lot discussed around payment parity for those types of services, and I think ultimately we are for and in support of payment flexibility," Kelsay said. In some cases that "might mean less reimbursement for telehealth, and in other instances maybe increased reimbursement for telehealth if it's a better modality for delivery, depending on the situation."



Big picture, parity laws would perpetuate the shortcomings of our current health care system by extending capitated rates at a time when employers are focused on better defining and enhancing value.

Asked by AIS Health after the press briefing when it might be appropriate to reimburse providers more for a telehealth visit, Kelsay says that while more information is needed, "previous pilot-based data for telehealth suggests there may be greater efficacy for certain mental health conditions, such as depression. That might be an example of where, as a modality, telehealth visits should be reimbursed at a higher rate," she added.

"That being said, big picture, parity laws would perpetuate the shortcomings of our current health care system by extending capitated rates at a time when employers are focused on better defining and enhancing value,"

Kelsay continued. “Evidence suggests that parity laws have contributed to compulsory adoption of delivery systems, higher costs, and overconsumption. Thus, payers should have the flexibility to set reimbursement rates

for services commensurate with the value they deliver.”

The Business Group on Health survey also highlighted employers’ growing concern over the cost of musculoskeletal conditions such as

arthritis or osteoporosis. In one finding highlighted by Kelsay, virtual care for musculoskeletal management/physical therapy is expected to see the largest growth of any other category of health services in the coming years. While

Aetna, Cleveland Clinic to Offer Co-Branded Employer Plans

CVS Health Corp.’s Aetna division — having recently rolled out two new plan designs that aim to ease customers’ cost-sharing burden — is now presenting employers with “a cost-effective offering beyond Aetna’s typical broad network plans” that requires members to receive care from a select group of Cleveland Clinic-affiliated providers.

The co-branded Aetna Whole Health – Cleveland Clinic plans will be available to fully insured and self-insured employers in 10 northeast Ohio counties this fall, according to an Aug. 19 press release. Employers could save as much as 10% in health care spending by choosing the new plan over a current Aetna broad network plan, but the catch is that members must receive care from the “Cleveland Clinic Quality Alliance network of employed and independent physicians” or at any Cleveland Clinic facility. Cleveland Clinic, meanwhile, will be rewarded for achieving quality and cost targets.

“Given the current economic climate, employers are looking for a cost-effective, high quality insurance plan that also provides access for their employees to coordinated care and advanced medical expertise,” Steven C. Glass, chief financial officer of Cleveland Clinic, said in the

release. Added Angie Meoli, Aetna’s senior vice president of network strategy and provider experience: “Cleveland Clinic is renowned for delivering exceptional health care, and our new collaboration will enable our members to receive the personalized and coordinated care they need to get and stay healthy.”

Dan Mendelson, founder of consulting firm Avalere Health, says the new plans fit in nicely with Aetna’s other new offerings for the employer market. In recent weeks, the insurer rolled out the Aetna Flexible Five Plan and Aetna Up-front Advantage, which respectively offer up to five no-cost, in-network selected services before members hit their deductible and a customizable dollar amount of coverage pre-deductible (*HPW 8/10/20, p. 1*).

“They appear to be really committed to having a diversity of products in the marketplace,” Mendelson says of Aetna. “This [offering] is interesting because it leverages the knowledge base and the care management they have at Cleveland Clinic,” he adds. “Cleveland Clinic for over a decade has been developing insights and algorithms and ways to control costs while still providing a high level of quality; they’ve been very committed to that.”

Aetna and Cleveland Clinic are also offering a new program that provides Aetna members nationwide with “streamlined scheduling for specialty services and access to health-plan directed, virtual second opinion services at Cleveland Clinic through a dedicated specialty referral line.” As part of the program, Aetna care managers will work with members to create personalized care plans and address their specific health needs.

For Cleveland Clinic, the team-up with Aetna will be the second foray into the health insurance space. Starting in 2018, the health system joined startup insurer Oscar Health to offer co-branded individual market plans in five northeast Ohio counties, and the companies expanded to three more counties in 2020.

Mendelson says Cleveland Clinic’s partnership with Aetna has more potential for future expansion than the Oscar collaboration, given the larger insurer’s diversified portfolio of plan offerings. “If they prove this out in one market, it is definitely the kind of thing that can be leveraged over into other markets as well.”

View the release at <https://bit.ly/2Y1Zj98> and contact Mendelson at dmendelson@avalere.com.

by Leslie Small

29% of survey respondents said they would offer musculoskeletal management virtually next year, another 39% are considering adding it by 2023.

“We know that many people out there struggle with joint issues, [and] there are very effective modalities of treatment that can be delivered via a virtual environment. Those often stave off unnecessary surgical interventions,” Kelsay said during the press briefing. “And now that we have a workforce that for many months has been working at home and probably not in the most ideal of ergonomic situations, we expect to see musculoskeletal [conditions] continue to worsen.”

COVID-19 Isn't Seen as Big Cost Driver

In addition — as they did in 2019 — survey respondents highlighted musculoskeletal conditions as the biggest cost driver for employer health plans, followed by cancer and cardiovascular conditions. COVID-19, the disease caused by the novel coronavirus that has killed more than 170,000 people in the U.S., was not among the top cost drivers cited by employers when the survey was conducted.

In fact, Kelsay emphasized that there are still more questions than answers about how the pandemic will affect health care costs for companies and their workers. For 2021, the Business Group on Health is projecting the total cost of health benefits will rise by 5.3% — slightly higher than the 5% trend it predicted in the past few years despite the massive amount of deferred care that has boosted publicly traded health insurers' second-quarter earnings (*HPW 8/17/20, p. 1*).

“There is a lot of uncertainty around what is actually going to manifest itself in terms of costs, both this year and next year. Many employers are having a really hard time from a

budgeting and actuarial perspective working with their health plan and consulting partners, to really get a good handle of what that means,” Kelsay said. While the care-deferral phenomenon is real, some of that utilization will likely resume in the year ahead, and “perhaps some chronic conditions that have gone unmanaged might balloon and become bigger issues in the coming year because people forewent preventive screenings,” she observed. “And we also just don't quite know what the long-term impact of COVID will be on health status.”

Employers Will Probably Be Conservative

Given all those variables, employers probably won't be changing their premium rates significantly next year, and some might even decrease them, Kelsay predicted. But she cautioned that firms probably are going to be hesitant to immediately pass on any health care cost savings to their employees.

“I think what you're also going to see is some employers hedging because they're not really sure what the future's going to look like in 2021, and the worst thing they could do is to reduce premiums this year and then to snap back with some significant jump next year,” she said.

On the issue of benefit design, the survey found that employers are continuing to move away from offering consumer-directed health plans (CDHP) — also known as high-deductible health plans — as the only plan type available to employees. Just 22% of firms said they will have a “full replacement” approach in 2021, down from a high of 39% in 2018. Yet the percentage of companies that offer a CDHP as an option rose slightly, from 64% in 2020 to 67% in 2021.

Meanwhile, 97% of survey respondents said they would pair their

CDHPs with health savings accounts (HSAs) next year, while just 22% will offer them with a health reimbursement arrangement. Yet employers also would like to allow health plan enrollees to access certain health services before they hit their deductible — something they currently can't do if a plan is to be HSA-eligible, Kelsay said in response to a question from AIS Health during the briefing.

Therefore, “we are certainly advocating for increased flexibility there, to have more services of a preventive nature or for management of chronic diseases to be covered before the deductible, and to remove barriers for services,” she said. “So [it's] certainly something we are seeing increased traction [on] and are keeping a watchful eye on as well.”

View the survey results at <https://bit.ly/32akKvg>. Contact Kelsay via Ed Emerman at eemerma@eaglepr.com. ♦

by Leslie Small

Insurers Notch Limited CSR Win

continued from p. 1

In a cascading series of lawsuits, insurers — which still had to keep providing CSR subsidies to enrollees — sued the government to claw back their losses. Some of those cases are class-action suits. Others are very recent, including one filed by Humana Inc. earlier this month (*HPW 8/17/20, p. 1*) after the Supreme Court sided with health insurers in a similar case seeking to recoup unpaid funds from the ACA's temporary risk corridors program.

Meanwhile, starting in 2018, insurers worked with state regulators to set up the process of silver loading, which compensated them for lost CSR reimbursement by raising the premiums of silver-level benchmark plans.

Because advance premium tax credit levels are tied to the rates set for benchmark plans, silver loading caused more federal subsidy money to flow into the individual insurance market, shielding most consumers from the premium hikes. In fact, an August 2017 report from the Congressional Budget Office estimated that halting CSR payments and subsequent silver loading will come at a net cost of approximately \$194 billion for the federal government through 2026.

Firms Seek Damages From 2017, Beyond

In the various court battles over CSR payments, insurers pointed out that they had no way to recoup their losses for the last few months of 2017, as they are not allowed to alter premiums midyear. And in cases involving claims for 2018 and beyond, insurers claimed the ACA still dictates that they're owed CSR payments, even if they found a way to mitigate their losses. The federal government, in general terms, argued that because silver loading made insurers whole, there is no further obligation to compensate them.

In a pair of decisions issued Aug. 14, the Court of Appeals for the Federal Circuit essentially split the difference. In *Sanford Health Plan v. United States* — a case involving two insurers that sued for 2017 CSR payments — the three-judge panel agreed with a lower court ruling that the federal government owes the health plans about \$1.6 million combined. But in *Community Health Choice v. United States*, which addressed two suits from insurers seeking 2017 and 2018 payments, the panel said the insurers can only be compensated for losses incurred in 2018 that weren't already mitigated by silver loading. The appeals court remanded *Community Health Choice* back to the lower courts to grapple

with the complex question of how to calculate those damages.

"I imagine that there's quite a few actuaries at this point trying to come up with a ballpark estimate as to incremental damages that might be out there for the insurers that silver loaded," David Anderson, a research associate at the Duke-Margolis Center for Health Policy, tells AIS Health. "My opinion is, for insurers that silver loaded in 2018 to present, there probably will not be much net damages that could be applied for federal reimbursement," he adds.

However, silver loading has not been adopted everywhere. In 2018, insurance commissioners in the District of Columbia, North Dakota and Vermont all decided against silver loading for various reasons. As of the 2020 plan year, 47 states and D.C. have gotten on board with silver loading, with Indiana, Mississippi and West Virginia the outliers, Anderson says. Those three states instead opted for "broad loading," where the cost of unpaid CSRs is compensated by raising the premiums of all plan types — not just silver.

There is evidence that such a strategy led to ACA enrollees in those states having access to less-generous subsidies, and thus, lower exchange enrollment, Anderson points out. For insurers in non-silver-loading states, "there might be damages that are worthwhile to pursue" tied to the 2018 plan years and beyond, "but that's going to be a fairly complex calculation," he adds.

Is Silver Loading Here to Stay?

Going forward, "there's no strong incentive for any insurer to get out of silver loading" as long as state and federal regulators permit them to do so, according to Anderson. The Trump administration has suggested at various

points that it might consider banning the practice in future rulemaking (*HPW 4/23/18, p. 1*), but such a provision was never formally proposed. A spending bill passed in late 2019 explicitly permitted the practice through 2021, and "the policy implication is that it's probably going to be a constant going forward," Anderson says.

In an Aug. 17 Health Affairs blog post about the recent CSR decisions, attorney Katie Keith argued that all parties involved with CSRs and silver loading are likely to maintain the status quo. The Trump administration probably won't resume making CSR payments, both for political reasons and because it may not have the legal authority to do so, she wrote. And even if Democrats win control of Congress, lawmakers probably won't appropriate funding for CSRs because that would cause consumers to lose the more generous premium tax credits that resulted from silver loading, potentially depressing ACA enrollment.

Status Quo May Be Better for Consumers

For health insurers, meanwhile, "there's no incentive to not silver load and then go to court to try to get the CSRs that you were owed," Keith tells AIS Health. That's because it would make little sense to give up the security of being able to bake CSR costs into premiums every year in the hopes of collecting damages through a lengthy legal process, she explained in her post.

"And I think there's a lot of people who think that's a better outcome for consumers, too," given that "silver loading means more generous premium tax credits for low-income consumers," Keith tells AIS Health.

With the appeals court decisions now made in *Sanford Health Plan* and *Community Health Choice*, Keith says she anticipates there will be some effort

at the district-court level to uniformly calculate what insurers are owed. “The chief judge of the [federal] court of claims has a bunch of these cases, including the two class actions, so my money would be on watching her to see how she wants to approach doing

these damage calculations,” she tells AIS Health. And because the *Community Health Choice* ruling significantly restricted what insurers can recoup for 2018 and beyond, it’s unlikely that any more insurers will file claims related to those plan years, Keith adds.

View the court decisions at <https://bit.ly/2ClpbV9> and <https://bit.ly/3iWlrPq>. Contact Keith at kmk82@georgetown.edu and Anderson at david.m.anderson@duke.edu. ✦

by Leslie Small

News Briefs

◆ ***The Supreme Court will hear oral arguments on Nov. 10 in a case seeking to dissolve the Affordable Care Act.*** Many health care policy watchers noted the timing of the arguments, as they are scheduled one week after the presidential election is set to take place. In *California v. Texas*, previously known as *Texas v. United States*, a coalition of Republican-led states is arguing that the ACA’s individual mandate is unconstitutional now that the tax penalty has been repealed. Thus, they contend, the entire law should be thrown out. Visit <https://bit.ly/3aJdvy6>.

◆ ***Anthem, Inc. and Quest Diagnostics said on Aug. 17 that they’re entering a new “strategic relationship.”*** The insurer and lab company plan to leverage “a broad range of tools and programs to drive operational improvements, create pricing transparency, and enhance health care consumer engagement and outcomes.” Visit <https://prn.to/32aaa7d> to learn more.

◆ ***The American Hospital Association on Aug. 14 sent a letter to United-Healthcare urging it to scrap a forthcoming change in how it covers lab services.*** The insurer said recently that it will require a laboratory-specific, unique code to process claims for the majority of lab testing

services, in addition to the standard Current Procedural Terminology codes, according to the letter. “This new reporting policy could negatively impact the accessibility of care, as well as create unnecessary burdens on both patients and providers at the same time that such providers are expected to still be managing the COVID-19 public health emergency,” the provider trade group wrote. See <https://bit.ly/3hhj6hs>.

◆ ***A federal judge on Aug. 17 issued a preliminary injunction blocking an HHS rule that rolled back regulations protecting LGBTQ+ patients from discrimination in health care.*** HHS had finalized that rule just a few days before the Supreme Court issued a decision in *Bostock v. Clayton County*, ruling that discriminating against LGBTQ+ people in the workplace violates the federal Civil Rights Act. In his opinion, Judge Frederic Block of the Eastern District of New York wrote that the HHS rule is contrary to the Supreme Court’s decision in *Bostock* and that the department “did act arbitrarily and capriciously in enacting” the regulations. View the opinion at <https://bit.ly/34kjsR4>.

◆ ***Blue Shield of California said on Aug. 6 that it’s teaming up with a company called Cricket Health to offer an “innovative, personalized***

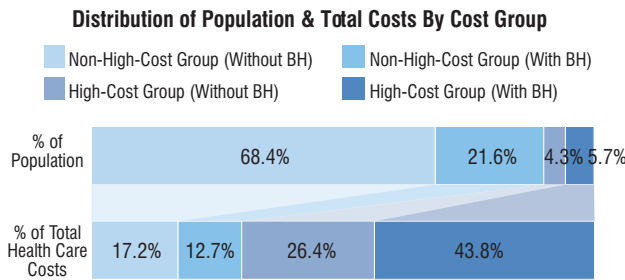
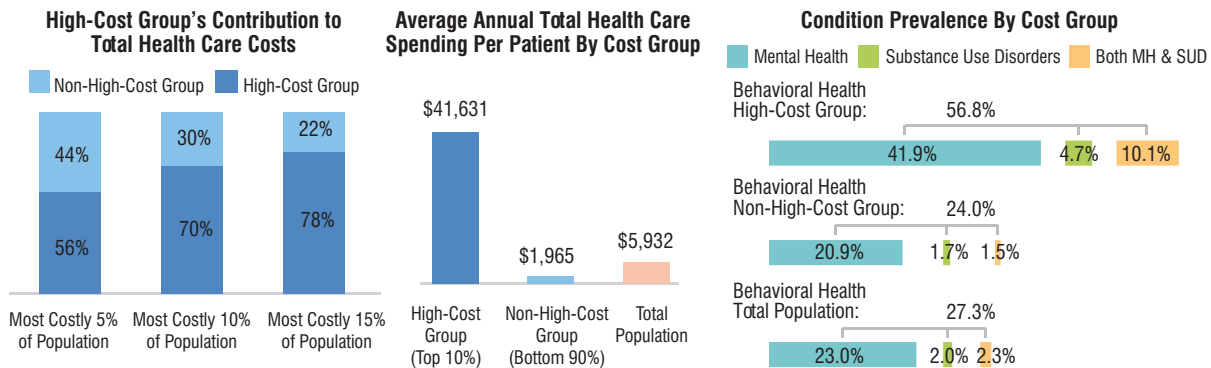
and comprehensive care coordination program for members who have late-stage chronic kidney disease or end-stage renal disease.” As part of the program, Cricket Health will deploy a care team and virtual programs that aim to slow the progression of kidney disease, reduce complications and avoid emergency department visits or hospitalizations. Read more at <https://bit.ly/3fVavQa>.

◆ ***CVS Health Corp.’s health insurance division on Aug. 3 unveiled a new initiative as part of the Aetna Maternity Program that aims to reduce the incidence of preeclampsia.*** The condition, marked by dangerously high blood pressure in pregnant women, “is the leading cause of maternal and infant illness and death,” a press release noted, and the U.S. Preventive Services Task Force has recommended a regimen of low-dose aspirin for women at high risk for developing preeclampsia. As part of its program, Aetna will mail high-risk members a personalized prenatal care kit containing educational materials and an 81-mg bottle of low-dose aspirin. They will also receive “an appointment reminder card encouraging them to speak with their pregnancy care provider about the potential benefits of low-dose aspirin and whether it is right for them,” the release stated. Visit <https://bit.ly/32oef8f> to learn more.

Little Is Spent on Treating High-Cost Patients' Behavioral Health Conditions

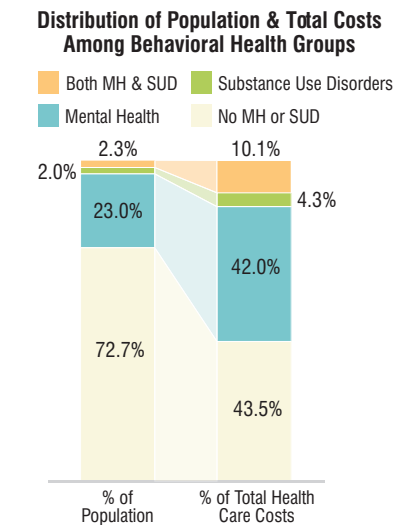
by Jinghong Chen

While a small proportion of people who have behavioral health conditions in addition to physical conditions account for 44% of all health care spending, most of that spending is on physical rather than behavioral treatment, according to a new study by Milliman, Inc., commissioned by The Path Forward for Mental Health and Substance Use. In fact, 50% of all patients with behavioral health conditions had less than \$68 of total annual spending for behavioral health treatment, and another 25% had very limited spending on behavioral treatment — between \$68 and \$502 per year. “While the Milliman report did not study the effect of COVID-19 on mental health, its analysis of 2017 claims data provides a baseline for estimating the potential subsequent impact of the pandemic on the treatment of behavioral conditions and medical spending,” Andy Keller, Ph.D., president and CEO of Meadows Mental Health Policy Institute, said in a press release about the findings.



Average Annual Health Care Costs Per Individual

Cost Subgroup	Average Total Costs	Average BH Treatment Costs	Average Medical/Surgical Treatment Costs
Non-High-Cost Group (Without BH)	\$1,488		\$1,488
Non-High-Cost Group (With BH)	\$3,475	\$531	\$2,944
High-Cost Group (Without BH)	\$36,183		\$36,183
High-Cost Group (With BH)	\$45,782	\$2,620	\$43,162
Total Population	\$5,932	\$263	\$5,669



Average Annual Health Care Treatment Costs Per Individual by Behavioral Health Category

Behavioral Health Category	Number of Individuals	% of Total Population	Average Total Costs	Average BH Treatment Costs	Average Medical/Surgical Treatment Costs
No BH	15.3M	73%	\$3,552		\$3,552
MH and/or SUD	5.7M	27%	\$12,272	\$965	\$11,307
Any MH	5.3M	25%	\$12,221	\$1,017	\$11,204
MH Without SUD	4.8M	23%	\$10,855	\$772	\$10,083
Any SUD	0.9M	4%	\$19,796	\$1,989	\$17,807
SUD Without MH	0.4M	2%	\$12,923	\$303	\$12,619
Both MH and SUD	0.5M	2%	\$25,602	\$3,413	\$22,189
Total Population	21.0M	100%	\$5,932	\$263	\$5,669

SOURCE: “How Do Individuals With Behavioral Health Conditions Contribute to Physical and Total Healthcare Spending?” Milliman, Inc. Visit <https://bit.ly/321gDBu>.