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Employers Seek Narrow Networks, COEs, Virtual Care Benefits

Several recent surveys on employer-sponsored health insurance have found that plan sponsors are following three major trends: expanding virtual care and telehealth benefits, narrowing provider networks and emphasizing centers of excellence in their benefit designs. Experts suggest that these trends are driven by the continuing growth in health care costs, which is reflected in growing premiums for firms and employees. Meanwhile, the COVID-19 pandemic has exposed plan sponsors to unforeseeable risk.

According to the 2020 edition of the Kaiser Family Foundation's (KFF) Employer Health Benefits Survey (see infographic, p. 7), which was published Oct. 8, this year's annual premium growth (4% for individuals and families) outstripped both wage growth (3.4%) and inflation (2.1%). That is in line with the dramatic growth in premiums in recent years, which have risen 22% in the last five years and 55% in the last 10.

Other surveys project similar results in 2021, but caution that the pandemic saddles employers with unprecedented risk and uncertainty when setting premiums. An Oct. 1 white paper from human resources consulting firm Mercer, which detailed early results from the 2020 Mercer National Survey of Employer-Sponsored Health Plans, found that businesses project health benefit costs to grow by 4.4% in 2021, but emphasized uncertainty due to the pandemic. A Sept. 29 survey of large employers by the Business Group on Health projected 5% premium growth in 2021 and also took note of pandemic-related risk.

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If Elected, Biden Could Face Tough Choices on New Waivers

With the 2020 election drawing ever closer, the Trump administration has been approving states' waiver applications at a brisk pace — greenlighting Georgia's Section 1115 Medicaid waiver on Oct. 15, and another Medicaid waiver from Nebraska on Oct. 20. Further, CMS has said that it's on the cusp of approving Georgia's unique plan to remake its individual insurance market.

Health policy experts tell AIS Health that the fate of the three waiver programs depends not only on who wins the White House on Nov. 3, but also on the outcome of a case pending before the Supreme Court. They also say that if former Vice President Joe Biden is elected, states may have to think about waivers very differently than they have under the Trump administration.

"I'm sure that the timing is not a coincidence," Allison Orris, counsel at professional services firm Manatt Health, says of the sudden spate of waiver approvals. "Waivers by their nature are always political documents," she tells AIS Health. "They give an opportunity for a state to set out their vision of how they want to pursue health reform or health coverage."

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Indeed, both the Georgia and Nebraska 1115 waivers contain elements of what has been a signature health policy priority for CMS Administrator Seema Verma: work requirements in Medicaid. And Georgia's soon-to-be approved Section 1332 waiver would take advantage of guidance issued by the Trump administration that gave states more authority to experiment with their individual insurance markets.

Georgia's Medicaid demonstration, called Pathways to Coverage, will allow working-age adults who are currently ineligible for Medicaid coverage to opt into the program "by participating in qualifying activities like work and education, as well as meeting premium and income requirements." It will only apply to people with incomes up to 100% of the federal poverty level (FPL), thus covering fewer adults than traditional Medicaid expansion.

Nebraska's demonstration, Heritage Health Adult, will apply to the full Medicaid expansion population — adults who are not medically frail or pregnant with incomes up to 138% of the FPL — but unlike other CMS-approved work requirements programs, it is voluntary. Qualifying beneficiaries who "participate in certain activities to promote health and independence," such as completing a health risk assessment, maintaining employer-sponsored coverage or regularly attending scheduled doctor appointments, will be eligible for additional benefits including vision services, adult dental services and over-the-counter medications. Beneficiaries "must also participate in community engagement activities and notify the state Medicaid agency in a timely manner of any changes that would affect eligibility for the additional benefits."

Meanwhile, in the Oct. 15 press release unveiling its approval of Georgia's Medicaid waiver, CMS noted that it "has completed its review of Georgia's 1332 waiver request and is working with the state and federal partners to finalize the terms and conditions for approval." That waiver application, which the state has revised more than once *(HPW 9/11/20, p. 3)*, would make significant changes to the state's individual insurance market — though not as significant as the state originally proposed. Most notably, it would eliminate the state's use of HealthCare.gov as a centralized enrollment platform. The state would still check consumers' eligibility for exchange coverage, but all other consumer-facing activities would be outsourced to private web brokers and insurance companies, according to a Sept. 1 report from the Brookings Institution.

Coverage Expansions Might Help MCOs

From a business standpoint, both Georgia and Nebraska's Medicaid demonstrations would have a small — though still positive — impact on the managed care plans currently serving those states, Citi analyst Ralph Giacobbe wrote in recent research notes to investors. In the case of Georgia, the state estimated that about 30,000 people will enroll through its partial Medicaid expansion in the first year and about 65,000 over five years, he pointed out. That coverage gain "would be favorable, even if limited, compared to the baseline of those individuals being uninsured," for Anthem, Inc. and Centene Corp., he wrote. In Nebraska, where the state "only expects between 41,000 and 51,000 people to enroll through its Medicaid demonstration program," those coverage gains would be "favorable, even if limited," to managed Medicaid players in the state including Anthem, Centene and UnitedHealth Group, Giacobbe added.

According to The Commonwealth Fund, work requirements waivers have now been approved but not implemented in five states, blocked by federal courts in four states and halted by state officials in another two. Additionally, eight states have pending waiver applications involving Medicaid work requirements. Arkansas and the Dept.

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

of Justice have asked the Supreme Court to overturn lower court rulings that halted that state's program — a case that could ultimately decide the fate of Medicaid work requirements *(HPW 2/24/20, p. 1)*.

"Should President Trump be re-elected, I would imagine they would continue to plow forward with these kinds of approaches," says Joan Alker, a research professor and executive director of the Georgetown Center for Children and Families. "They, I believe, tailored these to be a slight variation on the theme of what is now pending at the Supreme Court," she says of the Georgia and Nebraska programs. "They obviously think that they have found a new path here, or have some legal justification in mind."

New Admin Would Have 'Thinking' to Do

But if Biden wins the presidency, it may not be solely up to the courts to decide the fate of Medicaid work requirements. Both Alker and Orris say Biden is highly likely to withdraw the federal guidance issued under Verma's watch that paved the way for such demonstrations. The new administration will then face a potentially tricky choice about how to handle the waivers approved right before the election.

"I think it will take some thinking on the part of a new administration to decide how they want to move forward with Georgia, with Nebraska," Orris says. Theoretically, it is "certainly possible if the Biden administration wanted to send a signal, they could say, 'waivers are granted at the [HHS] secretary's discretion, we're going to un-grant this waiver.' But I don't think that's how most administrations want to start their relationships with states."

It's more likely, Orris says, that the Biden administration would work "behind the scenes" with Georgia and Nebraska state officials to figure out a compromise before those states go to the trouble — and expense — of implementing a program that state and federal authorities don't equally support.

In Alker's view, a new administration would have the right to rescind those states' waivers, even if it doesn't exercise that option.

"Every administration, of both parties, uses demonstration authority to promote things they want to promote," she says. "But we have not seen such an extraordinarily broad attempt to rewrite Medicaid law and add conditions of eligibility and restrict access" until the current administration, Alker adds.

Future Waivers Could Focus On Equity

A new administration, on the other hand, would probably take a different approach to Medicaid waivers, she says, adding, "I think a Biden administration might try to think about using demonstration authority to promote coverage and to promote some other goals like health equity." For example, some states are hoping to extend postpartum coverage in Medicaid for 12 months after a woman gives birth, rather than the current 60-day limit.

"The amount of attention that has been shed on health equity as a result of COVID and other recent current events makes me think that's a space where a Biden administration could decide to send a signal early on," Orris adds.

In regard to Section 1332 waivers, Orris says she expects a new administration would follow the Trump administration's lead in approving states' reinsurance programs, as they generally receive bipartisan backing. But a Biden administration will also probably have to take "a fresh look" at the Trump-era guidance that encourages more outside-the-box demonstrations.

"Reinsurance has been a really popular use of 1332, but there haven't been many other uses, so Georgia has been sort of a novel policy, and will it be approved before the election, who knows?" Orris says. "But that also presents the Biden administration [with] a question of, 'What do we do with Georgia?'"

View CMS's press releases at https://go.cms.gov/2FWU9uw and https://go.cms.gov/3ksEFNW. Contact Orris at aorris@manatt.com and Alker at jca25@georgetown.edu. ✧

by Leslie Small

In COVID-19 Era, More Patients Appear to Fall Through Cracks

Several months into a pandemic that has fundamentally changed American life, researchers are just starting to understand the impact of COVID-19 on the U.S. health care system. During an Oct. 19 webinar hosted by the Kaiser Family Foundation, experts attempted to shed some light on that wide-ranging impact while underscoring that the effects of the crisis are still evolving.

Michael Kleinrock, a research director at the IQVIA Institute for Human Data Science, said one of the questions he's most often asked is "when are we going to start catching up" from the missed doctor visits, delayed surgeries and other types of health care utilization deferred by patients during the height of the COVID-19 lockdowns. Although utilization has bounced back from the significant drops it saw in the spring, based on IQVIA's analysis it hasn't yet completely returned to normal levels,

he pointed out, "so we're not catching up."

The volume of elective procedures, for example, is still tracking behind what it would've otherwise been, Kleinrock said. However, he also said providers appear to have harnessed telehealth to get "most of the high-management patients seen in some fashion." That's good news for patients already diagnosed with serious diseases such as cancer, but the issue of missed screenings still looms large, he said.

Missed Screenings Spark Concern

In fact, in an analysis of routine breast, colon and cervical cancer screenings, electronic health records vendor Epic has found that such screenings fell 86% to 94% below historical levels during the beginning of the public health emergency, said Christopher Mast, M.D., a physician on Epic's clinical informatics team. While screening levels gradually trended back to baseline over time, the big gap seen in the spring "created a sizeable deficit of missed screenings," he said.

More specifically, "between mid-March and mid-June, some 285,000 breast cancer screenings, 95,000 colon cancer screenings and 40,000 cervical cancer screenings that otherwise would've taken place didn't," Mast said. "And the risk there is obvious — missed diagnosis or delayed diagnosis of cancers, resulting in more advanced disease before detection and treatment."

One bright spot, however, is that IQVIA is already seeing higher rates of flu vaccinations this year compared to 2019, Kleinrock said, which will be important in order to head off the threat of a dual pandemic this winter *(HPW 8/31/20, p. 1)*.

"The system appears to be learning how to walk and chew gum — learning how to manage COVID in this environment and still deliver necessary health care for other people, which is a positive," Kleinrock said. "But there is still that lingering issue of the 'where did they go' people [for whom] we see a month or two months' worth of significant absence of normal patient flows." That phenomenon, he added, "could have longer-term impacts on chronic disease outcomes and prevention, so it's definitely worth watching."

More Consumers 'Sitting on Sidelines'

In terms of health coverage — an area seeing major shifts amid historic levels of unemployment — the issue of people falling through the proverbial cracks is also evident, according to Luke Greenwalt, vice president at IQVIA's Market Access Center of Excellence. Greenwalt has been tracking health coverage shifts among American consumers by examining their prescription activity.

"It's not just that we're observing more patients switching between payer channels, we're also observing more patients sitting on the sidelines — not showing any prescription activity," he said. "Now, that's concerning in and of itself…but when you look at this compared to 2019…you see anywhere from 20-25% more consumers sitting on the sidelines and not in the health care market than what we [saw] last year."

Part of the explanation may be that there's a considerable, predictable lag in people signing up for new coverage once they lose their employer-sponsored plans, Greenwalt said. He pointed out that in the most recent recessions, the "payer channel shift" didn't reach its height until 18 to 24 months after the peak rate of new unemployment claims. (So far in this recession, the peak was 6.9 million people per week filing new jobless claims in late March, much higher than the 685,000 peak in October 1982).

"Overall, the switching rate may not be as big as what people were anticipating, at about 7.5%, although it's growing," Greenwalt said. Consumers' likelihood of switching into Medicaid, he added, can also vary based on where they live, with people in Medicaid expansion states three times as likely to go that route than those in non-expansion states.

And when it comes to the health insurance exchanges, "while we do see some patients switching into these at about 4%, we know that there's limited options that are available, so we see more patients switching into these other channels," Greenwalt said.

View a replay of the webinar at https://bit.ly/2ThlE4W. ✧

by Leslie Small

Blues Plan Launches App-Based Care Management Programs

Blue Cross and Blue Shield of North Carolina is partnering with two vendors to offer free app-based smoking cessation and diabetes reversal programs to its individual and fully insured members. Around 500,000 members will be eligible to participate initially, the companies say.

The programs, run by Carrot Inc. and Virta Health, will be available beginning in November. They address two of North Carolina's "most pressing health issues," says Von Nguyen, M.D., vice president of clinical operations and innovations at the Blues insurer. Carrot will run the smoking

cessation program and Virta will run the diabetes program.

Ashraf Shehata, KPMG national sector leader for health care and life sciences, says the two deals are examples of the future of care management, particularly during the COVID-19 pandemic and its eventual aftermath.

"I think the market is going to see a big uptake of this," Shehata tells AIS Health. "From a deal advisory perspective, there is a big appetite in the market for more and more programs. Health plans are going to buy them, maybe acquire them, and maybe we are going to see private equity investments. I think we're also going to see, potentially, medical device manufacturers entering this space. This is kind of the tip of the iceberg."

Diabetes is a particularly acute problem in North Carolina, which has the 13th highest rate of type 2 diabetes in the country, Virta Health spokesperson Lauren Volkmann tells AIS Health. More than 3.7 million North Carolina residents — nearly half of the adult population — have diabetes or pre-diabetes, she says.

In addition, diabetes increases the risk for severe illness for those with COVID-19, Volkmann points out.

App Tracks Blood Sugar, Symptoms

Virta Health's program uses a virtual care model that provides enrolled patients with an app that tracks their blood sugar and symptoms. Physicians and health coaches monitor the information in what Virta calls "near real-time," and they provide individualized guidance on nutrition and behavioral change through the app.

In a clinical trial using the Virta Health program, patients eliminated 63% of diabetes-specific medications, and 94% of patients eliminated or reduced insulin usage. Patients also saw sustained improvement in their HbA1c levels, on average experiencing a 1.3 point drop at the one-year mark, according to the Virta clinical trial. Patients in the control group of the trial, who were receiving "usual care," saw no improvement in their HbA1c levels. In addition, clinical trial patients lost 30 pounds on average, or 12% of total body weight, and saw improvement in more than 20 markers of cardiovascular health, including blood pressure.

Program Uses Behavioral Science

For the smoking cessation program, meanwhile, Carrot's Pivot program uses behavioral science to help people who smoke find and develop their own motivations to quit. The program uses a carbon monoxide breath sensor coupled with in-app activities and coaching. The digital solution also includes text-based access to trained tobacco experts, nicotine therapy products and an online community.

In one clinical trial, 42% of participants successfully quit smoking over the course of the study, and seven months after the study's onset, 86% of those who quit were still smoke-free.

The North Carolina Blues plan and its two vendors will be sharing information about the programs with eligible members through emails and mailers, plus social media campaigns, through the BlueCross portal, and via in-network providers and employers, Volkmann says. She declined to provide details about the vendor-plan agreements, only calling them "long-term."

Shehata says that these types of app-based digital programs fit well within an overall care management strategy.

"The nice thing about many of these programs is, they're what I call pay per use," Shehata says. "In the old world, when you had a care management program, you had to basically build it, invest in it [and] create call center support around it. With these, you push it out directly to the consumer and the consumer engages in it. It's relatively low risk and it's low startup cost, and potentially — depending on the way the programs are designed — they might actually be very engaging to the consumers."

Still, Shehata says, insurers can't rely on these programs exclusively. "Certainly, being able to affect smoking cessation and reverse the impacts of diabetes are clearly very important and clinically relevant. By themselves, they are interesting and they're going to be helpful to certain members. But overall, the benefits of these programs from an actuarial perspective and a population health perspective need to be woven into a much broader care management and care coordination program." Insurers are doing this well, he adds.

Contact Volkmann at lauren.volkmann@virtahealth.com and Shehata via spokesperson William Borden at wborden@kpmg.com. ✧

by Jane Anderson

Employers Look to Curtail Costs

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The main cause of that uncertainty is utilization. Health insurers reported a dramatic fall in claims during the second quarter of 2020, but indications are that utilization begun to return to somewhat normal levels in the third quarter. However, the middle-term implications of that trend for employers are not easy to predict.

"There's a lot of chatter specifically about [Affordable Care Act]

marketplace insurers and about how they are experiencing fewer claims than expected, and presumably that means that they'll be doing rebates," James Gelfand, senior vice president for the ERISA Industry Committee (ERIC), tells AIS Health. "That's not what I'm hearing from member companies. They feel like they're under the same dynamic that they've been under for a decade: costs are going up, and the things they're doing to try and save money have had a very mediocre effect."

That tension has led to the emerging trend of narrower networks. Lowering costs and reducing unnecessary utilization is a key goal of narrowing provider networks, along with emphasizing quality and return on investment. According to an Oct. 16 survey published by insurance brokerage and actuarial firm Willis Towers Watson, "cost savings are the key consideration in adopting a more restrictive, narrow network. To consider adopting a narrow network with less than 25% of providers, half of respondents indicated that costs would need to decline to a great extent, and a third indicated that quality would need to improve to a great extent."

Firms Use Data to Steer Members

The survey adds that "a quarter of employers use data on provider quality and costs to steer members toward higher-value providers; this figure may rise to 59% by 2023." The KFF survey found that "Only 22% of [employers offering health benefits]…report being 'very satisfied' while 39% report being 'satisfied' with the cost of provider networks available. Small firms are more likely than large firms to be 'very dissatisfied' with the cost of the provider networks available." However, despite the dissatisfaction of small firms with network choices, the KFF survey found that "firms with 5,000 or more workers were more likely to offer a narrow network plan than smaller firms."

Drew Hodgson, the national practice leader for health care delivery at Willis Towers Watson, points out that providers might be more amenable to adopting the changes that narrow provider networks are meant to produce. Hodgson observes that narrower networks are a response to the incentives for providers in fee-for-service reimbursement models to maximize visits and procedures, which drives premium growth. He says providers in capitated models have fared better in the pandemic than fee-for-service providers, which saw their revenue crater in the second quarter.

> **Unfortunately, most health plans equate 'high performance' with lower prices.**

"It gets to the whole ultimate goal here, which is population health and value-based care," Hodgson tells AIS Health. "This is something that a lot of providers out here are realizing: the ones that did not embrace value-based care before the pandemic and continued on fee-for-service — they're the ones that are really struggling. They are wishing they had capitated arrangements right now. I think this potentially could push more [providers] into that avenue. If you start to capitate more, and you start to have more risk-based arrangements and emphasize population health, then I'm not concerned necessarily about the overutilization, because they are managing to a cost."

However, channeling patients to a narrow network of providers does not always mean better outcomes if quality is not a consideration.

"Unfortunately, most health plans equate 'high performance' with lower prices. While these are by no means mutually exclusive, the two are not the same," Joe Paduda, founder of consultancy Health Strategy Associates, tells AIS Health. "Relatively few employers — and far too few members — base their healthcare provider decisions on meaningful quality metrics."

Quality metrics are the driver behind employer plans' increased emphasis on centers of excellence, which are specialized providers with a demonstrably high level of quality in treating specific conditions while offering competitive prices. The Business Group on Health survey found that 81% of employers will have at least one condition-specific center of excellence in place in 2021.

"I would say that a lot of employers are looking at [centers of excellence] more than they ever did," Hodgson says. "Mainly because of the fear of the rising costs right now, and they think they can control costs."

COEs Can Offer Long-Term Benefits

Paduda says that centers of excellence don't necessarily create up-front savings, but they are usually worth the investment.

"While it can be difficult to document and account for savings, improvements in outcomes, fewer complications and lower incidence of adverse health effects of treatments will mean lower medical costs overall. The key here is for plan sponsors to work closely with their health plan and perhaps outside experts to implement a meaningful evaluation process and metrics," Paduda says.

However, Hodgson points out that the pandemic will likely stall the center of excellence strategy, which often requires patients to travel to other states to access care: few patients, particularly ones with acute health conditions, are

up for taking a flight. According to Steve Wojcik, the vice president for public policy at the Business Group on Health, that specific challenge has led plan sponsors to take a look at localized centers of excellence.

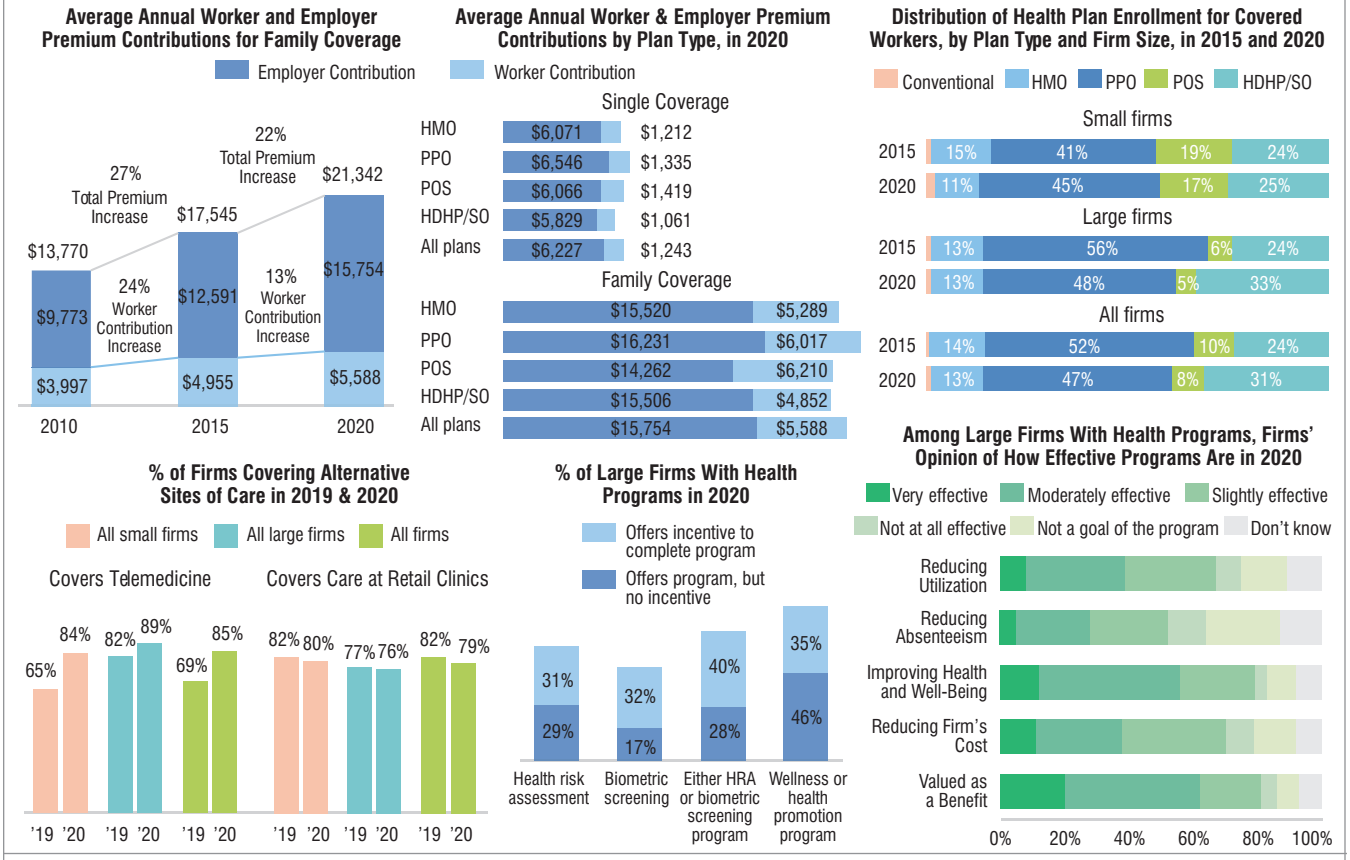
"One thing that we're seeing more is a focus on regional centers, rather than a national center, so that there are more options available locally, with less travel involved for the employee or their family member," Wojcik tells AIS Health. However, he suspects that the regional trend might be durable. Wojcik notes that, with a post-pandemic focus on regional centers, employers wouldn't need to pay for as much in travel costs, and patients with acute conditions would avoid the discomfort that comes with long flights.

Similarly, concerns about COVID-19 exposure have caused a boom in virtual care and telehealth utilization, as patients have avoided in-person clinical visits. The Willis Towers Watson survey found that 90% of employers "report that their focus on telemedicine/virtual medicine increased during the pandemic," while 52% think telemedicine and virtual

Average Employer-Sponsored Plan Premium Rose 4% in 2020

by Jinghong Chen

The average annual premium for employer-sponsored health insurance rose 4% to $7,470 for single coverage and $21,342 for family coverage this year, according to the Kaiser Family Foundation 2020 Employer Health Benefits Survey. The survey found that among firms with 50 or more workers, 85% offered telemedicine coverage in their largest health plan, up from 69% last year. The majority of large firms offered health and wellness programs, including health risk assessments and biometric screenings. The survey was conducted from January to July 2020, and may not reflect the full impact of the COVID-19 pandemic.



NOTES: Small firms have 3-199 workers and large firms have 200 or more workers. HMO is a health maintenance organization. PPO is a preferred provider organization. POS is a point-of-service plan. HDHP/SO is a high-deductible health plan with a savings option.

SOURCE: Kaiser Family Foundation Employer Health Benefits Survey. Visit https://bit.ly/3kw9sJm.

medicine will be an important priority within their organization's health care activities in the period following the pandemic. Hodgson emphasized the importance of making a distinction between virtual care and telehealth.

"When I think about telehealth versus virtual care, I like to think about it as two separate things," Hodgson explains. He says telehealth is an existing, pre-pandemic trend, citing the example of virtual-only, start-up providers like Teladoc Health, Inc., which have been launching with increasing frequency and growing ambition over the last several years. Hodgson says virtual care is something new.

"Virtual care to me, which is what we've seen this huge spike in, is the actual doctor's office providing virtual care direct to their patients," Hodgson says. He adds that plan sponsors and insurers need to determine how virtual visits will fit into benefit designs going forward. For most of the pandemic, plans have reimbursed virtual visits with traditional providers at parity with in-person visits. Hodgson says he has discussed the question with carriers including UnitedHealthcare and CVS Health Corp.'s Aetna, which he says are "trying to figure out how to reimburse" virtual visits going forward.

"My concern with virtual care is it adds cost to the system if it's left unchecked," Hodgson says. He observes that providers may take advantage of the efficiencies of virtual care to increase their volume of visits, which would have a dramatic cost impact if visits are reimbursed at parity.

Telehealth, on the other hand, almost always saves plan sponsors money, according to Gelfand.

"The telehealth benefit is cheaper, period," Gelfand says. "We know that the doctors who have chosen to participate in the telehealth benefit are accepting more moderate rates."

Find the Business Group on Health survey at https://bit.ly/37xl8Iv, the KFF survey at https://bit.ly/35pPvxz, the Mercer survey at https://bit.ly/37wZZ0X and the Willis Towers Watson survey at https://bit.ly/3mefPBS. Contact Gelfand via Kelly Broadway at kbroadway@eric.org, Hodgson and Wojcik via Ed Emerman at eemerman@eaglepr.com and Paduda at jpaduda@healthstrategyassoc.com. ✧

by Peter Johnson

News Briefs

✦ ***On Oct. 19, CMS released a report that found premiums for plans sold on HealthCare.gov have dropped for the third consecutive year, and insurer participation has increased.*** The average premium for 2021 benchmark silver plans dropped by 2% year over year, while benchmark plan premiums have dropped by 8% since 2018. In a press release, the agency said Iowa, Maine, New Hampshire and Wyoming will see "double-digit decreases in the average benchmark plan premiums for 27-year-olds." The report also found that the number of HealthCare.gov enrollees with access to a single insurer has dropped from 29% in 2018 to 4% in 2021. However, premiums have grown substantially since the start of the Trump administration in 2017, with 27% net growth in benchmark premiums for 27-year-olds between that year and 2021. Read more at https://go.cms.gov/3jiOEUB.

✦ ***The Commonwealth Fund found in an Oct. 15 study that outpatient care visits per week have "fully rebounded" after dropping off earlier this year due to the COVID-19 pandemic.*** "In total, weekly visit counts now slightly exceed pre-pandemic levels," the study found, though "there is considerable variation by patient age, geographic area, clinical specialty, and insurance coverage." Outpatient care utilization dropped dramatically during the early days of the pandemic: according to the report, the lowest point in utilization was a 58% reduction in visits on March 29. Read more at https://bit.ly/3dNwjh2.

✦ ***Cancer screenings, diagnoses and treatment in the Medicare population all dropped a "considerable" degree because of the COVID-19 pandemic.*** That's according to an Oct. 21 analysis prepared by Avalere Health and the Community Oncology Alliance and published in the Journal of Clinical Oncology, which found biopsies for breast, colon and lung cancer all dropped year over year compared to 2019, as did procedures including mastectomies, colectomies and prostatectomies. Chemotherapy treatment also dropped. The findings bolster widespread concerns that the dramatic fall in care utilization during the second quarter could lead to dangerous health outcomes (see story, p. 3). Read more at https://bit.ly/35t51c4.