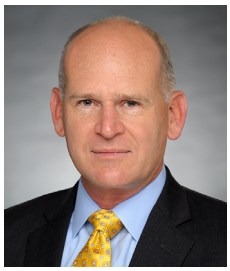
COPE HEALTH SOLUTIONS

Five Major Impacts of the Covid-19 Crisis on Health Plans



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As the Covid-19 pandemic has swept the nation, all health care stakeholders have had to make major adjustments to their business strategy and operations. Hospitals in hot spots such as New York City and New Orleans have been in the headlines, struggling to meet the surging demand while trying to keep their workforce healthy. Meanwhile hospitals with lagging or potentially overall flatter curves in states such as California are seeing massive revenue reductions from elective case cancellations and stay-at-home orders enforced in anticipation of a Covid-19 demand surge to come. In parallel, many private physicians, ambulatory surgery centers and other key network providers are under extreme financial pressure, leading some to retire, close due to cash challenges, or contend with the risk of running out of cash soon.

Another side effect of the pandemic has been the unprecedented unemployment rates across the nation. In the last two weeks of March, the United States saw a record-breaking 10 million unemployment insurance claims, peaking at 6.6 million in the final week of the month.[1] The previous weekly record was 695,000 claims in October of 1982.[2,3] This trend continued into the first two weeks of April with 6.6 million and 5.2 million, bringing total claims to over 22 million and wiping out job gains since The Great Recession. Given that the United States has an employer-based health care insurance system, this trend is intrinsically linked to the simultaneous loss of health care coverage for millions of Americans.

As we pass the mid-point of April, we can expect the continued uptick in unemployment to be complemented by a surge in applications for Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage, Medicaid benefits, and Affordable Care Act (ACA) exchange plans as people are dis-enrolled from employer plans due to layoffs. For health plans, this means a dramatic impact on their overall product portfolio, as well as implications for market share, medical loss ratio (MLR), and quality performance. Furthermore, health plans will have to begin to look forward, thinking through how today's realities will shape premiums and benefit design for 2021 and beyond.

> "Health plans will have to begin to look forward, thinking through how today's realities will shape premiums and benefit design for 2021 and beyond. Failure to take action today can have long-term business implications long after this crisis subsides."

Below are changes that health plans must adapt to in order to maintain, or improve current market position and network viability:

1. A New Competitive Landscape

As local unemployment levels rise, the demand for the various insurance products will shift, increasing demand for Medicaid, COBRA and Exchange products, with significant attrition in commercial employer and exchange SHOP products.

Commercial health plans and products in particular are vulnerable to loss in their market share as nearby competitors leverage Medicaid and exchange products to target and enroll former commercial members. The permanency of this shift will be variable, however, once these members re-enter the job market and select employer-based coverage, some percentage of these individuals may elect to remain with the new insurer on one of their commercial products rather than return to their previous health plan, if provided a choice. Likewise, employers will be shopping around for affordable plans to offer their employees, shifting the landscape.

In some instances, employer groups that have been loyal to specific health plans in the past may need to consider other options for health plan coverage for their employees with a strong emphasis on the cost. Beyond benefits, a large driver of plan selection is the ability to maintain current doctors and specialists. To prevent member loss to competitor Medicaid plans, health plans must rapidly establish network capacity for Medicaid and exchange-based products in order to absorb volumes and provide competitive access and performance. Second, they must engage in member outreach and education, informing them of the Medicaid option within their portfolio,

and create a seamless transition in coverage for existing enrollees. Both are critical to near and long-term retention.

Even with the retention and transition of commercial enrollees to Medicaid products, health plans may experience a reduction in overall revenues as commercial members shift to Medicaid and lower revenue Exchange products.

Metrics to watch: consumer engagement, market share, disenrollment rates, network adequacy, population shifts by risk level

2. Elevated Risk and Uncertainty

While there are many projections, a lack of clarity remains on important factors such as how long stay-at-home orders may be in place, whether or not the virus will be cyclical and seasonal, and when a vaccine will become available. This makes it incredibly difficult to predict the market environment for 2021. Actuarial teams are operating with more assumptions and unknowns than typical. Similarly, product teams are designing for an opaque competitive landscape.

Calculating premiums for 2021 will need to incorporate anticipated Covid-19 costs, however this is incredibly difficult to predict. Health plans will be forced to submit their proposed 2021 rates next month with very little idea of how best to set rates given the uncertainty and newness of the Covid-19 virus impacts. Since health plans are unable to build in 2020 costs and will need to forecast what they believe their 2021 costs will be, premiums are likely to increase along with employee cost sharing. In some cases, plans may elect not to offer coverage for certain products in 2021 if the profit margin were too narrow or uncertain. Plans should keep an eye on state regulations for standard Covid-19 cost assumptions for specific markets. On a national level, Congress may offer risk mitigation programs such as reinsurance or risk corridor protections, though no such programs have been officially released. Product premium decisions will need to be carefully calculated on a county specific basis.

Metrics to watch: Covid-19 PMPM expenditure by risk group, MLR, Covid-19 related utilization costs

3. Shifting Utilization Patterns

Outpatient utilization has to date experienced a 40 to 60 percent[4] drop as people postpone their visits for non-urgent and non-essential services, only partially offset by virtual visits. Inpatient and emergency utilization is up in Covid-19 hotspots and anticipated to peak at 270 percent of capacity, with local differences ranging from about 100 percent to more than 500 percent[5] at peak surge. However, this utilization is largely driven by Covid-19 emergent care, as elective procedures have been postponed. These utilization shifts can have unpredictable impacts on MLR. Many of those individuals receiving emergent care may otherwise be low risk members, leading to low risk adjusted payments for high cost utilization. UnitedHealth[6], for example, reported an earnings increase this past quarter, seeing Covid-19 costs offset by postponement of high cost, elective procedures across the nation. However, patients who postpone elective surgeries and visits in 2020 due to the pandemic may instead choose to have these surgeries in 2021, potentially reducing medical spend this year and increasing next year. Depending on local realities, product portfolio and population demographics, health plans may experience drastic changes, positive or negative, in their MLR.

Metrics to watch: MLR, risk adjustment, outpatient vs. inpatient utilization trends, e-visits

4. Erratic Network Performance

Downstream provider contracts and delegations often have provisions that include payment for specific performance metrics and, in some cases, risk pools and bonus pools tied to individual or collective provider performance. Both numerators and denominators for these metrics are disrupted by this crisis.

To reduce the reporting and data collection burden on providers, the Centers for Medicare and Medicaid (CMS)[7] has granted exceptions to reporting requirements for Q4 of 2019 through Q2 of 2020. CMS will also omit data from January – June 2020 from Medicare quality programs. It is likely that states will take similar action for Medicaid quality programs. For commercial products, health plans may consider implementing similar exceptions. Specifically, health plans with value-based payment (VBP) agreements in place may want to consider suspending the reporting requirements and explore new means for holding providers accountable for at least a six month period after June 2020. In the immediate term, health plans may choose to continue to pay providers for their participation in quality programs regardless of their 2020 performance.

Metrics to watch: performance-based risk pool payments, plan performance bonus payments

5. Evolving Consumer Expectations

Many of the changes in care delivery occurring during this period are designed to drive data sharing and bring care into the home. A potential side effect of the growth in telemedicine is the reluctance to return to the status quo. Once members realize they can receive their care on their phones and in their homes, they may expect their insurance to cover this option more often. Providers losing volumes to the pandemic will want to indulge more in teleservices and will expect reimbursement. This consumer-centrism has been a trend for some time now and is present even beyond telehealth. Benefits such as mail-order and 90-day prescriptions are also likely to stay beyond the crisis. Providers have also increased provision of support resolving social determinant of health (SDOH) issues, such as food insecurity, during this crisis. Moving forward, patients will expect the care management function to provide holistic support, deepening the need for non-clinical networks and contracting strategy. Health plans must be able to accommodate both member and network expectations should these changes become permanent.

Metrics to watch: Regulatory trends, telehealth penetration by population

While the current scenario presents in an enormous challenge to health plans, it is also an opportunity to re-position their business for success in the future. There is no question that the market landscape as we know it will be forever changed by current events. To be successful, health plans will have to evolve and adapt, despite uncertainty. Today, circumstances are rapidly evolving and the window of time to act is narrow. Failure to take action today can have long-term business implications long after this crisis subsides.

For more information on how plans can navigate the current crisis, please contact Carla D'Angelo, Vice President, cdangelo@copehealthsolutions.com or 213-514-4823 or Allen Miller, Principal & CEO, at amiller@copehealthsolutions.com or 310-386-5812.

Endnotes

[1] https://www.nytimes.com/interactive/2020/04/01/upshot/coronavirus-jobless-claims-forecast-predictions.html

[2] https://finance.yahoo.com/news/coronavirus-covid-weekly-initial-jobless-claims-march-28-165758189.html

[3] https://www.businessinsider.com/us-weekly-jobless-claims-labor-market-unemployment-filings-recession-coronavirus-2020-4

[4] https://www.modernhealthcare.com/physicians/independent-physicians-push-expedited-covid-19-aid?utm_medium=social&utm_source=linkedin&utm_term=modern%20healthcare&utm_content=cedd0c9f-4c8a-4838-8cb6-a23f82582673

[5] https://www.healthaffairs.org/do/10.1377/hblog20200317.457910/full/

[6] https://khn.org/morning-breakout/for-unitedhealth-coronavirus-costs-have-been-offset-by-the-cancellations-of-routine-medical-appointments/

[7] https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting