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Health Plan Responses to COVID-19

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Abstract

The health insurance industry is responding to COVID-19 by paying for testing and treatment, and working with providers to assure that coverage for proper care is available. Many people are losing employment and potentially health insurance coverage, shifting the responsibility for payment among private sector and government payers. The unbudgeted costs of COVID-19 care will be substantial. At the same time, providers are postponing routine care and treatments that are not time-sensitive, reducing or deferring similarly substantial sums. The balance of payments is uncertain, though likely to favor health plans in the short run.

Keywords: COVID-19, health insurance, finance

Introduction

As other papers in the Spring 2020 issue of the *Journal of Health Care Finance* have noted, the costs to providers for testing and treating patients with COVID-19 are expected to be substantial. The American Medical Association (2020) quickly created billing codes associated with testing for COVID-19. By the time this issue is made available online, there will likely have been more than 10 million coronavirus tests processed under these new codes, at costs of $36-51 per test. While only one-in-ten or one-in-fifteen coronavirus tests will show positive results, all persons will have the expense of a test, and many of the remaining 9 million persons tested due to flu-like symptoms may require additional medical treatments. Antibody tests are also being performed, at a cost, to determine who might have had COVID-19. Under the Coronavirus Aid, Relief, and Economic Security Act, health plans are required cover coronavirus and antibody testing and related services, from March 18, 2020 until the national health emergency is ended.

In addition to testing, governmental and private sector health plans have expanded the range of services covered under usual terms or with reduced copayments. Most notably telehealth visits have increased in number and range, providing for more frequent and safer visits for both patients and providers. Payers are more commonly covering email visits, scheduled video visits and on-demand video visits, at least for the current pandemic (Wason, 2020). Expanded telehealth coverage may well extend into the future (Bashshur, et al., 2020). Health plans are also exploring

other cost-effective benefit options, perhaps advancing long-sought goals of creating more efficient benefit designs (Smith, 2010).

Estimates of the COVID-19 hospital costs per patient covered by private health insurance range from $10,000 to $20,000 (Rae, et al., 2020), with reports of costs in excess of $30,000 (Abrams, 2020). S&P Global (Banerjee et al., 2020) prepared an estimate of the total costs of the pandemic to insurance companies. With approximately half of the U.S. population covered by private insurers, a moderate scenario considered 25 million people seeking outpatient care and nearly 900 thousand people requiring hospitalization. After patient out-of-pocket expenditures, the cost to insurance companies could approach $27 billion. A severe scenario put the cost to insurance companies at over $77 billion. Estimates of the costs of treatment for COVID-19 prepared for America's Health Insurance Plans range from $56 to $556 billion over the next two years (Cohen, Whittal & Murray, 2020).

Offsetting the short-run costs of testing and treatment of COVID-19 are the loss and deferral of visits for routine care and treatments that are not time-sensitive. If providers' net revenues are reduced, it logically follows that health plans' net revenues must be increased. Medicare, the largest government payer has responded by increasing payments for all Medicare fee-for-service visits to address hospitals' finances. There have been several calls for private-sector insurance companies to do likewise (Nicholson & Asch, 2020).

An assessment of the net costs of COVID-19 to health plans requires an understanding of the cash flows for health coverage in the U.S. and an analysis of each component. In this paper, I briefly outline health care cash flows and suggest a likely net impact associated with COVID-19.

Cash Flow in U.S. Health Care System

As depicted in Figure 1, there are four parties in the U.S. health care system: consumers/patients, providers/suppliers, payers and employers/government. Consumer and patients are the first party of the health care system. The second party is the providers, which include direct patient care personnel (doctors, nurses, etc.), suppliers of facilities (hospitals, nursing homes, etc.) and suppliers of products (pharmaceuticals, medical equipment, etc.). Health plans are the third party of the health care system. Employers and the government are the fourth party.

Prior to the use of any services, consumers may purchase insurance directly form a health plan, purchase insurance through an exchange created by the Affordable Care Act, receive health insurance coverage as part of an employer-based arrangement, or receive health insurance coverage as part of a government program. This year, for approximately 200 million of the 331 million people living in the United States (60%), health insurance coverage will come from private health plans (Keehan, et al., 2020). For 153 million of the 200 million people (75%) covered by private health plans, coverage is derived from employment, leaving 47 million people (25%) purchasing insurance directly (Claxton et al., 2019). Medicare and Medicaid will cover another 137 million people (41%), with some double counting due to multiple coverages, particularly for Medicare recipients with supplemental coverage. There remain 31 million uninsured people (9%) – as estimated prior to COVID-19.

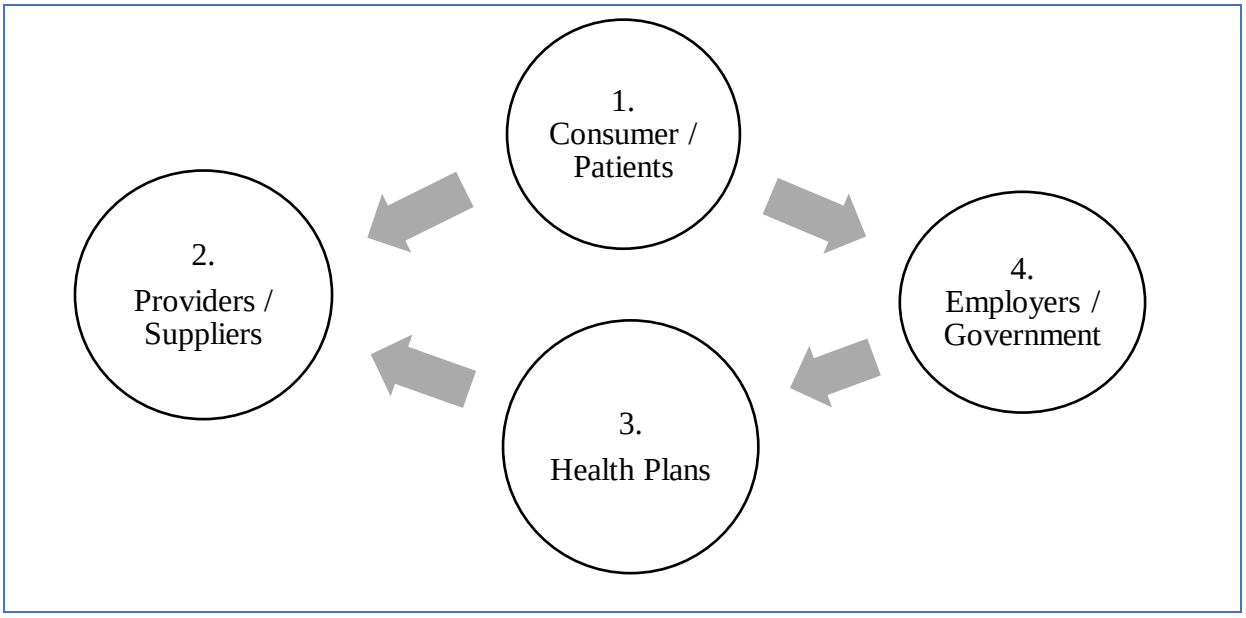

Figure 1. Cash Flow for the Four Parties in U.S. Health Care System.

Again, consumers make some payments directly to health plans (arrow missing on Figure 1). Most of the payments from consumers go to employers through wage-offsets, or to the government in the form of taxes and Medicare premiums. When consumers become patients, they make some payments directly to providers. Patients pay coinsurance percentages, copayments, deductibles and full payment for uncovered services after services are received. The bulk of the payments to providers come from health plans – at least on the surface. The last point is critical to current disruption in the flow of funds associated with COVID-19. For employers and the government, funds potentially available for the expenses of health plans arrive continuously during the year. Employees do not earn wages at the beginning of the year and pay their co-premiums all at once. Funds flow in during the year. Similarly, consumer pay taxes throughout the year. Unlike automobile insurance premiums that may be paid in an annual payment or every six months, health insurance premiums are more likely to be paid monthly.

Payments come from health plans – at least on the surface. A point not well understood by most consumers and patients, and perhaps even by persons involved in the health care marketplace, is that private health plans associated with employer-sponsored coverage are not generally at risk for payments (Levy, 2020). Large employers and coalitions generally self-fund medical expenses and use health plans for administrative services, but not risk-bearing (Goldberg, Fragala & Wohlgemuth, 2019). Health plans, in essence, pay claims for services through accounts established and managed by employers or trusts. Health plans earn fees for providing administrative services. Any disruptions in the flow of funds to employers (e.g. unemployment) or government (e.g. reductions in taxes) disrupt the available flow of funds to health plans, and through health plans to providers.

Savings or Deferred Expenses

A critical component of the calculations of net revenues for health plans are the funds associated with reducing current payment for treatments for other conditions other than COVID-19. Are these non-payments savings or merely deferred expenses? Two aspects of this question merit discussion. The first aspect is decision-making regarding provision of services. A dear friend had a knee replacement scheduled to happen in March. It was deferred until May. There was no savings for the health plan. Certainly there are many other scheduled procedures that will never occur due to alternative medications, alternative treatment options, merely foregoing the procedure, or in the worst case, death. For the most part, it appears that providers are working to reopen, reschedule and create opportunities for having the expenses (from the payer side) and revenues (from the provider side) deferred, not saved by health plans (Sax, 2020).

The second aspect is the ability of persons to retain insurance coverage, to be able to afford postponed routine care and treatments that were not time-sensitive. There are now several reports on the job loss associated with business closures due to COVID-19. One analysis predicts that 25 million people will lose current private coverage, with 6 million people finding alternative private coverage, 12 million people qualifying for Medicaid, and 7 million people becoming uninsured (Garrett & Gangopadhyaya, 2020). Another analysis estimates that there are 18 million people with some disruption in private insurance, half being direct policyholders and the other half being dependents (Golberstein, et al., 2020). Lost visits and treatments associated with loss of insurance coverage will certainly lead to lost revenues for providers, without short-run saving to health plans based on current premium dollars, but intermediate run reductions in health plan revenues.

Just as some automobile insurance companies are offering premium discounts due to less driving and lower claims costs, some health plans are offering premium discounts to consumers who pay insurance premiums. These funds are available only for fully insured consumers and small employers, not large employers that self-fund their plans. There is a limit to the duration of any discounting of premiums, as health plans that lose enrollment due to lost employer provided coverage or lost employment-afforded coverage would have no funds available to sustain providers.

Hints from the Market

"I'm sure these Wall Street investors are smart folks," (Fiscal Times Staff, 2020).

Motivated by this quote from an astute observer, financiers might assess the market reaction to all of the news and analyses for hints on the relative impacts of COVID-19 on the performance of providers and payers. There are now 40 healthcare companies among the *Fortune 500* most profitable companies in the United States. We selected nine health plans and providers to assess the balance of payments between payers and providers associated with COVID-19. The companies (with *Fortune 500* number and ticker symbol) include government focused health plans: Centene (42. CNC), Molina Health Care (193. MOH); private sector focused health plans: Anthem (29. ANTM), Cigna (13. CI), Humana (52. HUM), UnitedHealth Group (7. UNH); and hospital

systems: Community Health Systems (241. CYH), HCA Healthcare (65. HCA), Universal Health Services (281. UHS).

We created indexes of stock price change for each company using the closing price on March 2, 2020 as the base point (1.00) and the closing price for each day through April 20, 2020 divided by the closing price on March 2, 2020. The beginning of March was selected as the starting point for the analysis, as there had been very few cases earlier in the year and stock prices for health companies were quite stable during February. Results are presented in Figure 2.

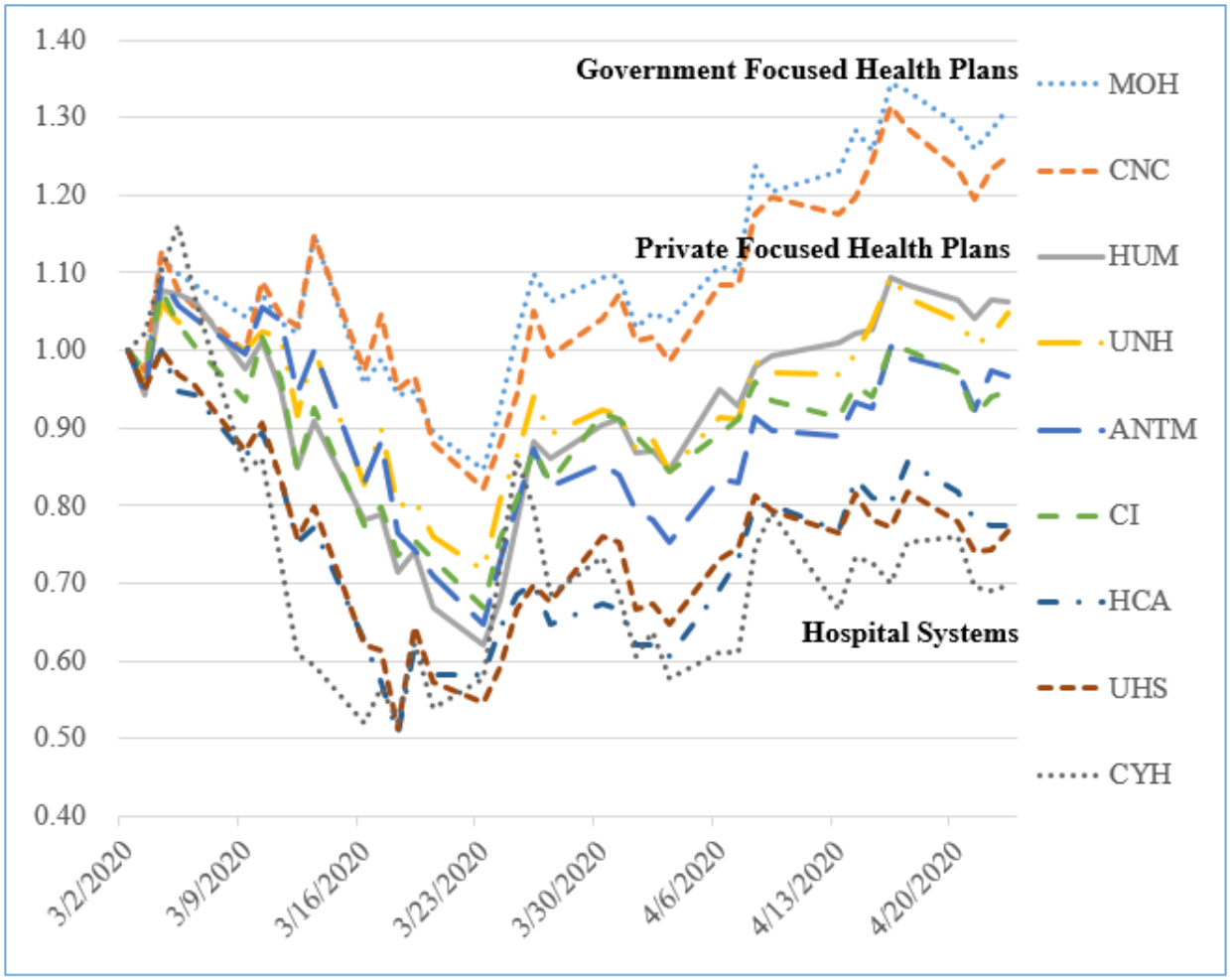

Figure 2. Indexes of Stock Price for Selected Health Companies. Base 1.00 on March 2, 2020 – April 20, 2020.

With the expected variation among companies within each line of business, the patterns of the short-run assessment of the impact of COVID-19 on the balance of payments is clear. Government focused health plans are expected to benefit from the changing flow of funds associated with COVID-19. After the depression in all stock prices in the first two weeks of the market reaction to the health crisis, stock prices of government focused health plans had increased 25 percent after

the first two months of the pandemic. Government focused health plans are likely to have increasing enrollment, particularly for Medicaid focused plans, as people lose employer based insurance and qualify for Medicaid in States that adopted Medicaid expansion through the Affordable Care Act. Further, some savings may accrue from savings of payments for services that are either not provided or deferred.

Private sector focused health plans are expected to neither benefit nor lose much associated with the changing flow of funds. Again, after the immediate decline in the market, private focused health plans achieved break-even, plus or minus 5 percent. There will likely be reduced enrollment associated with loss of employment and little net revenue change per enrollee. Health plans that support employer-funded health insurance through provision of administrative services neither gain nor lose much net revenue associated with savings or deferring of medical services.

The market clearly anticipates financial losses for hospital systems. Prices for hospital systems recovered little after the initial market decline and ended the first two months down 25 percent, mirroring the gains of government focused health plans. The expense of treating COVID-19 patients, the loss or deferral of medical services and the anticipation of an increasing share of government focused health plans, which result in lower prices for services than are paid by private focused health plans, all suggest reductions in net revenues.

Conclusions

The health insurance industry is responding to COVID-19 by paying for testing and treatment, and perhaps saving money in the short-run as providers are postponing routine care and treatments that are not time-sensitive. The flow of funds is changing with seemingly greater flows into government focused health plans and less into hospital systems. For faculty who teach and conduct research in the area of health care finance, a greater focus on the operations of health plans and health plan operations may be warranted. In addition to managing the flow of funds for health plans, financial management of hospital systems and other parts of the health systems would benefit from understanding the financing of health plans (Smith, 1991). Research on financial management of health plans and hospital systems is an area of continuing need (Smith, 2015), with new opportunities created on the hospital and health plan sides associated with the natural experiment of COVID-19.

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