GUY CARPENTER

HEALTH INSURERS AND COVID-19: ADAPTING TO A RAPIDLY CHANGING ENVIRONMENT

As COVID-19 spreads throughout the United States and the resulting economic disruption continues, medical insurance carriers are responding to the needs of their customers in a rapidly changing market landscape shaped by legislative and competitive conditions. In this article, we provide an overview of how large medical insurance carriers are adapting to the needs of their insureds and employees.

Background on the Novel Coronavirus Outbreak

At the end of the 2019 calendar year, The People's Republic of China identified a novel coronavirus (COVID-19) that had infected dozens of patients. While authorities took steps to control the epidemic, by the end of January 2020, the virus had spread across China's borders to countries around the world, including the United States. Shortly thereafter, the World Health Organization (WHO) declared the event a pandemic.

As the COVID-19 situation changes on a daily basis, legislators and market participants are trying to keep up. The health industry in particular is subject to a patchwork of laws and executive orders that include the Coronavirus Aid, Relief and Security (CARES) Act, the Consolidated Omnibus Reconciliation Act (COBRA), election deadlines and government action in all 50 states. Although the final impact on insurance markets is not yet fully known and varies significantly by state, Guy Carpenter is providing the following view of how key pieces of the industry, including COVID-19 treatments, testing, telemedicine, prescriptions and eligibility, are impacted.

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COVID-19 Timeline

January 11	Virus identified
	Cost Sharing Waivers Timeline
March 3	New York Department of Financial Services (DFS) waives COVID-19 cost sharing
March 5	California Department of Insurance (DOI) waives cost sharing
March 6	Florida requests that carriers consider waving cost sharing
March 10	Texas Department of Justice (DOJ) requests that carriers waive cost sharing
March 11	First death is reported in the United States
March 13	WHO declares the virus a pandemic
	Extension of Premium Grace Period Timeline
March 18	California extends premium grace period to 60 days
March 23	Texas requests carriers work with insureds on payment plans and extensions of coverage to avoid cancellations
March 25	Florida encourages carriers to work with insureds to avoid cancellation of policies
March 27	CARES Act passes
April 7	New York extends premium grace period to June
April 21	President Trump declares a national emergency
May 4	Department of Labor extends the COBRA enrollment deadline to 60 days following the expiration of the initial national emergency declaration
June 14	Initial expiration of national emergency declaration* - ***Order remains in place***

The Center for Disease Control (CDC) reported over 13.6 million confirmed cases and nearly 270,000 deaths in the United States as of December 2, 2020. Globally, the WHO reported over 63.7 million cases and over 1.4 million deaths as of December 3, 2020.

On March 18, 2020, Congress passed the Families First Coronavirus Response Act, which requires health insurance companies that offer individual and group health plans to waive cost-sharing charges for Food and Drug Administration (FDA)-approved COVID-19 testing. Before this law was passed, many states were already taking action in their communities by requiring carriers to waive costs for COVID-19 diagnostic tests. However, while many states' orders now overlap with the federal law, others expanded upon the federal law. For example, while some states only require testing costs to be waived at approved in-network providers according to their residents' plans, others like Arizona are requiring testing costs to be waived at all in-network or qualified out-of-network providers. Washington expanded on the federal law by not requiring prior authorization for COVID-19 testing, as well as requiring health insurers to cover out-of-network costs if they do not have enough in-network providers for COVID-19 testing.

For health insurers that provide coverage to large accounts with locations across multiple states, assuring consistent coverage for all employees and adhering to requirements in several jurisdictions is a challenge. While all states must adhere to the minimum requirements laid out in the Families First Coronavirus Response Act, they are able to institute their own requirements across topics not covered in the act, or can expand upon the requirements the act lays out. This creates a challenge for medical insurance carriers that have business in more than one state.

Below, we lay out an overall consensus on the varying state requirements over five different topics: cost-sharing, telehealth, grace periods, furloughs and COBRA.

Cost Sharing

In the beginning of March 2020, insurers across the country immediately began requesting that barriers to providing care be removed during the pandemic to help them more efficiently test and treat COVID-19 patients. However, on March 18, 2020, Congress passed the Families First Coronavirus Response Act, which required health insurance companies that offer individual and group health plans to waive cost-sharing charges for FDA-approved COVID-19 testing. While states were already responding to requests for insurers to waive cost sharing, the passage of this act required cost sharing for COVID-19 testing to be waived in all 50 states.

However, testing is not the only area where cost sharing is being waived. Cost sharing for telehealth, office and emergency room visits and even future COVID-19 vaccines is being handled differently by each state. Some states are only requiring testing to be waived (as mandated by the Families First Coronavirus Response Act), while others have required that cost sharing be waived for

Although widespread adoption of telehealth has increased during the COVID-19 pandemic, the majority of states were already moving to enact private payer telehealth reimbursement policies before the pandemic.

actions beyond testing. Most of these requirements were put into place in the beginning of March 2020, however, a few states have since expanded on the order. These states have required carriers to provide COVID-19 treatment with no additional consumer cost sharing, provide in-network and out-of-network testing and treatment with no cost sharing and extend their initial orders longer as the coronavirus continues to spread across the country.

Telehealth

With stay-at-home orders in place across the country and elective procedures and visits cancelled, states and insurers began to encourage and promote telehealth programs. The first act many states made with regard to their telehealth programs was to ensure that carriers' programs were robust and able meet demand. Many states also requested that carriers provide coverage for telehealth services on the same basis as in-person visits.

Most states have not expanded their telehealth-related orders since March or April. Across the board, states are mainly requiring the same elements of telehealth services: no cost sharing if the visit is related to COVID-19 and coverage provided at the same rates as in-person service. However, a small number of states have instituted broader requirements for telehealth services, including the coverage of out-of-network visits and removal of prior-authorization requirements.

While the COVID-19 pandemic has imposed temporary waivers, exceptions and changes to telehealth policy across the country, in most cases, these changes are only in effect through the end of either state or national emergencies. As shown in the maps below, private payer laws for telehealth reimbursement policies have expanded greatly in the past eight years, even before the COVID-19 pandemic. For Medicaid, all 50 states and Washington D.C. reimburse for certain types of live video telehealth services, but vary on their reimbursement policies for store-and-forward and remote patient monitoring (RPM).

FIGURE 1:TELEHEALTH SERVICES | PRIVATE PAYER LAWS IN **2012** FOR REIMBURSEMENT POLICIES

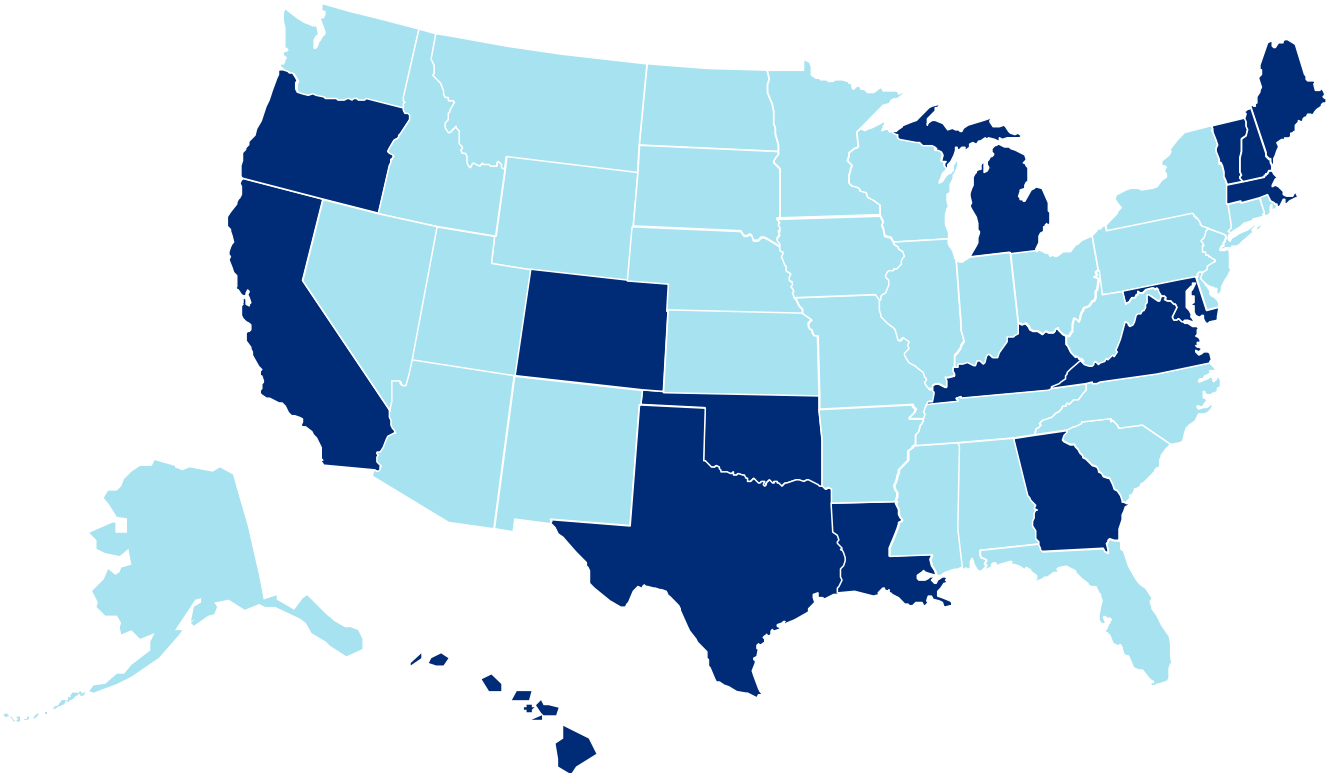
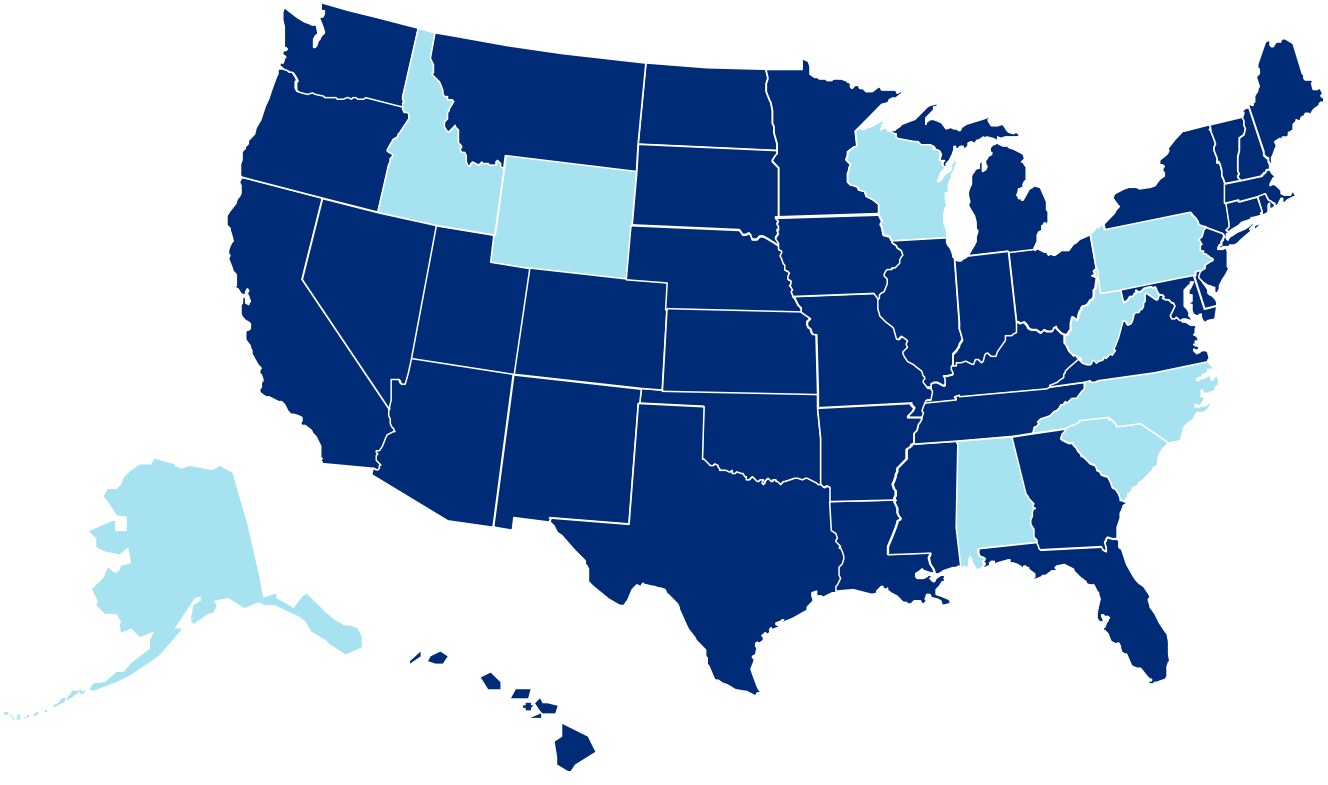


FIGURE 2: TELEHEALTH SERVICES | PRIVATE PAYER LAWS IN **2020** FOR REIMBURSEMENT POLICIES



Source: Center for Connected Health Policy

Grace Period

On top of the complications surrounding care delivery, roughly 49 percent of the U.S. population is covered by employer-sponsored health plans (2018 figures from the Census Bureau's American Community Survey 2008-2018 sponsored by the Kaiser Family Foundation). Health insurers are partnering with their insureds to navigate issues around employers' and employees' ability to pay premiums for coverage, eligibility to participate in the plan and impacts on future pricing.

Prior to March 2020, policy grace periods were typically 30 days, but many states are requesting or mandating extensions, and individual state actions range in their scope. For example, an executive order was issued in New Jersey on April 9 to extend the grace period to 60 days, with the provision that premiums can be paid on an installment basis over a 12-month period. Alternatively, insurance commissioners in Arizona and Florida are requesting that carriers work with their insureds on extending grace periods, maintaining claims payments during this extension and waiving late fees or interest.

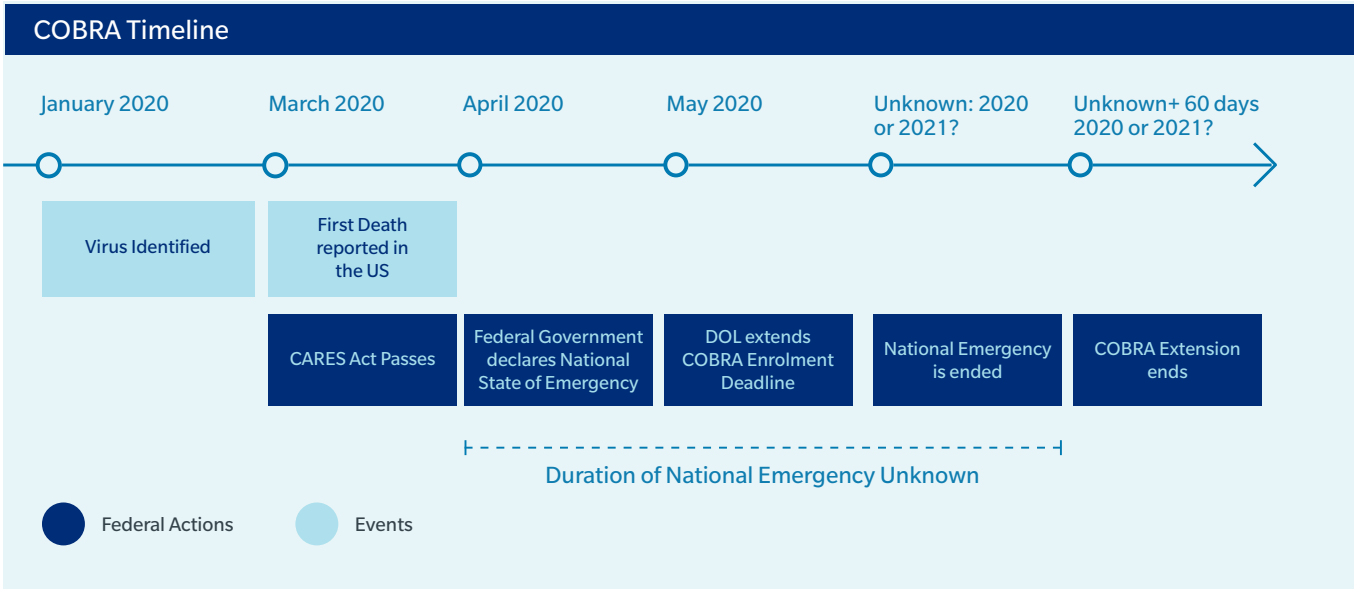
Carriers are not commenting on anticipated rate renewal changes, but are instead opting to defer mid-term rate changes due to participation changes and other developments related to the renewal. As carriers move through their renewal cycles, the market consensus will likely become clearer.

Furloughs

As employers try to manage through the economic uncertainty, many have chosen to furlough workers or reduce employee hours to manage payroll expenses instead of closing facilities or laying people off. Prior to the COVID-19 outbreak, terms and conditions around eligibility remained fairly consistent in the market, with minimum work hours in place to define actively at work and COBRA in place in the event of layoffs. The current environment has prompted many carriers to temporarily amend these provisions. The duration of these provisions varies significantly from carrier to carrier, but all carriers agree that the option must be offered to all employees on a non-discriminatory basis. Larger employer groups under administrative services only (ASO) contracts have the flexibility to amend these conditions for their plan. Although many states are issuing regulations on copayments, grace periods and other policy terms, regulation on how to treat furloughed employees is less explicit. Regulations can vary significantly from state to state, with some encouraging carriers to be flexible and others setting requirements for policy cancellation, though the recent federal COBRA regulation provides a backstop for furloughed employees.

COBRA

On May 4, the U.S. Labor and Treasury Departments temporarily extended the period during which an individual may select COBRA coverage. New regulations allow employees to select COBRA up to 60 days after the end of the declared disaster period. The current outbreak period is defined as March 1, 2020, to 60 days after the end of the declared national emergency or on another date in the future as determined by the Labor Department. Since COBRA is retroactive to the date of the qualifying event, insurers will also experience some enrollment uncertainty during this time. The Kaiser Family Foundation 2019 Employee Benefit Survey estimated that COBRA coverage is five times more expensive than typical payroll deductions, so COBRA would likely not be the first option. Employees could also access healthcare options by enrolling in coverage provided by the Affordable Care Act (ACA) or applying for Medicaid. The popularity of health savings accounts (HSAs) with high deductible plans and the amount of deductible exhausted will likely impact employee decisions on continuing coverage.



Future Impacts

End of National Emergency: Although sources have floated the possibility of ending the national emergency, no definitive timeline has been announced. The recent uptick in cases will likely delay this decision.

Impact of Future Regulatory Changes in Specific States: As states grapple with increasing case counts, additional DOIs may decide to amend or extend their current regulations and guidelines.

Price Transparency Regulation: Although the Healthcare Price Transparency order was issued on November 1, 2019, a lawsuit brought by the American Hospital Association and a consortium of hospitals challenging the order has been working its way through the court system. The U.S. District Court in Washington, D.C. dismissed the lawsuit on June 24, 2020, but plaintiffs are appealing the decision. The regulations are scheduled to take effect on January 1, 2021. The order requires price transparency on 300 services. Centers for Medicare and Medicaid Services (CMS) will choose 70 services that require the publication of pricing, and hospitals will chose the remaining 230. Senators Chuck Grassley (R - Iowa) and Mike Braun (R - Indiana) introduced the Healthcare Price Transparency Act on June 30. There has also been discussion of adding price transparency provisions to the next CARES Act. The deadline for implementation is less than six months away.

ACA Lawsuit – Maine Community Health Options v. United States: This case revolves around the reimbursements for the risk corridors under the ACA. This decision stems from a consolidation of three cases brought by four insurers over whether insurers are entitled to almost USD 12 billion in unpaid risk corridor payments due between 2014 and 2016. The court voted eight to one that the government is obligated to reimburse the carriers. The court remanded the cases to the Court of Federal Claims for adjudication under the Tucker Act. The Court of Federal Claims will issue a judgment for each carrier against the Department of Health & Human Services (HHS) and HHS will then have to approach the Financial Management Service department within the DOJ to certify payment. There are many more cases pending, including a class-action lawsuit. The process of reimbursement will be lengthy due to the number of cases and COVID-19.

ACA Lawsuit - Texas v. United States: The ACA is headed for another review by the Supreme Court during the upcoming fall session. The original case, Texas v. United States, was filed by the Republican Attorney General's (AG) office in Texas and 20 other states, now 18. When the DOJ declined to defend the ACA, California and a coalition of 21 Democratic AGs intervened to defend it. Texas, the DOJ and the two original plaintiffs filed opening briefs with the court on June 25, 2020. The briefs argue that the individual mandate is unconstitutional, that the mandate is an inextricable part of the ACA and that the entire ACA should thus be declared unconstitutional. Oral arguments were presented on November 10, 2020. A decision will likely be issued in spring 2021. The hearings and ultimate Supreme Court decision in spring 2021 will be final regardless of the outcome of the election – however, it will still be up to Congress to act on the decision and make any changes. If and how that happens will depend on the results of the Congressional races.

Election Results: Even though the presidential race has been decided, the future of Healthcare and specifically the Affordable Care Act still remain uncertain. Both Georgia senate seats are entering a run-off race in January 2021, and the results could potentially impact the balance of power in the Senate and therefore the legislative agenda.However, regardless of the results of the two congressional run-off races, healthcare in the United States will likely change. How it changes and any impacts to the Affordable Care Act will vary widely depending on the results. The varying degrees to which the Affordable Care Act could change range from a complete end and subsequent replacement, to minimal adjustments. Democrats generally argue for government involvement in healthcare insurance, while Republicans tend to believe the government should play a smaller role in healthcare insurance.

In Conclusion

As the COVID-19 pandemic and concerns surrounding a second wave of infections continue through autumn, public health remains a top priority for people both in and outside the healthcare industry and Guy Carpenter is actively working with healthcare executives on how to mitigate the impacts of the virus on the sector. Virtual healthcare options are becoming increasingly commonplace, and the growing use of telemedicine and capacity constraints within our healthcare system will potentially dull utilization increases. Though the ultimate impact of the COVID-19 crisis on the (re)insurance industry is still unknown, it is already clear that the exposures are immense and beyond the financial capabilities of the industry alone. The (re)insurance industry, policyholders and the public sector must come together on an approach that offers relief to those who need it now and develop a plan to implement mitigation strategies and a response mechanism for future pandemic events.

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