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BEYOND THE NUMBERS

Wakely COVID-19 Update

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Caveats, Limitations, and Disclosures (1/2)

The purpose of this webinar and accompanying slide deck is to educate Wakely clients and other interested parties on the impact of COVID-19

The webinar is not intended to be a comprehensive summary of all potential issues related COVID-19, and does not constitute legal advice. Our comments represent our interpretations and opinions on the actuarial implications of COVID-19. Wakely does not warrant that the impacts presented will be achieved.

Depending on the slide, our comments may reflect a nationwide perspective, or be illustrative. Considerations for each health plan or other stakeholder may vary, often significantly, from the generalizations we discuss.

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Caveats, Limitations, and Disclosures (2/2)

The impacts of COVID-19 are very difficult to anticipate and estimate given many factors, including but not limited to: limitations in available data, rapid changes in government reactions and regulations, an uncertain economic environment, and significant variations in the impact of the virus from one location to another.

This document discusses many potential impacts of COVID-19, each of which could have a material impact on Health Plans. The information covered in this slide could vary materially in the future, due to changes in the following:

- Direct costs of COVID-19 testing, treatment, and prevention, including pharmaceuticals and vaccines
- Reduction in costs due to the deferral of services or
- An increase in costs due to pent up demand for services that were previously deferred
- Increases in the acuity of necessary treatment because of the deferral of medically necessary services or therapies
- Macro and micro economic changes, including changes in unemployment and personal income of the population
- The impact of changes in federal, state or local legislation, regulation, or other government actions, including benefit mandates and/or cost-sharing waivers
- Changes in the Medicare-eligible or Medicare Advantage enrolled population, including changes in the number or type of individuals covered (age, gender, morbidity, income, etc.)
- Impacts to the overall healthcare system or provider networks, including provider network coverage and reimbursement
- Impact on solvency of insurer solvency, reinsurers or providers.
- Other effects of COVID-19 not listed here

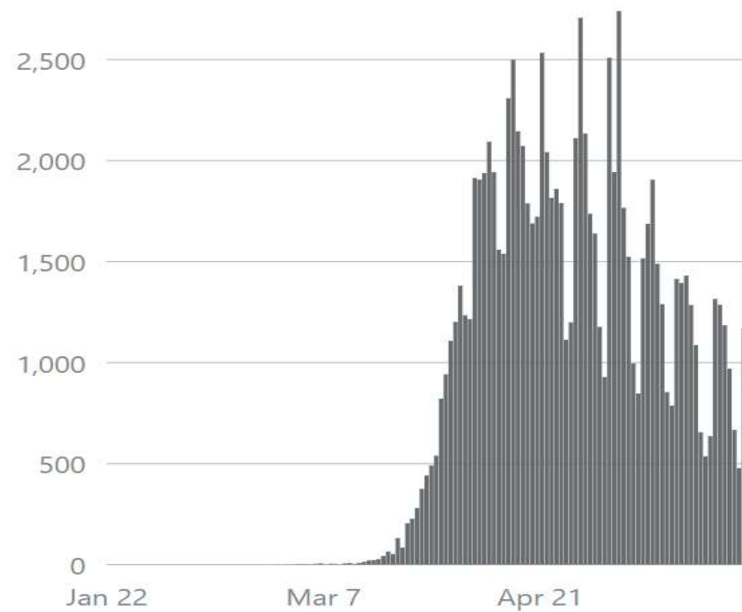
Therefore, the uncertainty inherent in the accompanying rates is larger than normal and actual experience may vary considerably from the estimates reflected herein.

COVID-19 Modeling Considerations

There are a large number of models and papers in the public domain projecting infections, deaths, with some including resource use and claim costs. The outputs are often **orders of magnitude different** from each other. When looking at impacts on pricing and reserving, consider the following:

- **When was the analysis done or updated?**
- Does the analysis include direct costs of COVID-19 do they also **include indirect impacts**, like deferred services?
- What **unit costs** are incorporated? (Medicare vs Commercial)
- What existing services are being used as a proxy for COVID-19 costs?
- What is the **timeframe** of the cost model? (2020, 2021, etc.)
- What is the **purpose** of the analysis? (e.g., Is it advocating for something?)
- Is the possibility of a **second wave** included?
- Are **resource constraints** included (e.g., personnel and equipment)
- Is new **legislation and regulation** included? (e.g., telemedicine)

COVID: Overview



Source: www.covidtracking.com Accessed June 6

COVID-19 Related Announcements – Important Payment Provisions - MA[1]

Non-Emergency Rules	Emergency Rules	Implications
• New Vaccines are usually covered under Medicare Part D • Flu Vaccine is under Part B	CARES Act (third COVID-19 law) moves a future COVID-19 vaccine to Medicare Part B and requires it to be covered without cost sharing	• Plans need to take this account in the MA, not PD bids for 2021 and beyond • Application of a related rule means that if the COVID-19 vaccine costs more than 0.1% of AAPCC, then the Medicare FFS program will pay for it and not the MAO.
• Sequester applies until September 30, 2029 • Sequester reduces all CMS payments by 2% to both FFS providers and MA plans	• Sequester Suspended from May 1, 2020 to December 31, 2020 • Sequester extended until September 30, 2030 • Applies to both FFS and Medicare Advantage	• 2% increase in revenue for 8 months for plans and providers • Do your provider contracts obligate you to pass on the additional revenue to providers? • Can you operationalize?
IPPS Payment system applies	20% increase in Inpatient (IPPS) payments to hospitals for COVID-19 patients	• Do your provider contracts obligate you to pass on the additional revenue to providers? • Can you operationalize?
Plans can't enhance benefits mid-year	CMS is using enforcement discretion to allow plans to make cost sharing changes and/or introduce new benefits in response to COVID-19	• Many of these COVID-19 related changes were allowed to continue into 2021

1 As of June 4, 2020

COVID-19 Related Announcements – Important Payment Provisions- ACA[1]

National Requirements	State Requirements
• Require to cover COVID testing and related costs (recent guidance included antibody testing as a requirement)	• Some states have gone further to also include coverage of treatment
• Administration clarified in many cases the EHB benchmark includes COVID treatment as a required benefit	• State regulators have often clarified that interpretation
• Special Enrollment Periods (SEP) are available for individuals that lost major medical coverage	• Most SBMs have included a special COVID SEP, which makes enrollment easier
• CMS delayed the final EDGE (risk adjustment) submission and reporting deadline by about two weeks. They also delayed 2019 RADV	• Certain states have delayed filing deadlines, but, generally, DOIs have not done so • Many states are asking for very specific COVID-19 related data to justify any pricing actions relation to COVID-19 • Many states are allowing adjustments to pricing for COVID-19 after state filing deadlines

1 As of June 4, 2020

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COVID-19 Related Announcements – Current State of Legislation

Coronavirus Preparedness Bill (COVID Bill #1) – 3/6/2020

Families First Response Act (COVID Bill #2) – 3/18/2020

CARES Act (COVID Bill #3) – 3/27/2020

Future Legislation to Combat COVID Already Being Discussed (Next COVID Bill)

- Heroes Act (House Bill)

Potential Inclusions

- Risk Mitigation Program for Insurers (risk corridors)
- Additional funding for hospitals
- Funding for states
- Treatment Requirements

Perspectives on Cost

Direct COVID-19 Costs	Indirect Claim Cost Impacts

• Hospitalizations
  • Age variation
  • Geographic Variation
  • Market Segment
• Testing and Vaccine
  • Who Pays
  • Timing and availability
• Long-Term Care
• Anti-Viral and other Drugs
• How will the potential for second wave impact these costs?
	• Deferred Services
	  • How much will come back
	  • Timing and speed of recovery
	• Changes in care patterns
	  • Will people be afraid to seek care for minor illnesses in the future?
	• Changes in morbidity mix of business
	  • Economic impacts will cause shift away from employer sponsored coverage
	• Changes to Medical Management processes

Some states have publicly released 2021 requested ACA market rate increases, and we have seen wide variances from carrier to carrier even within a given state

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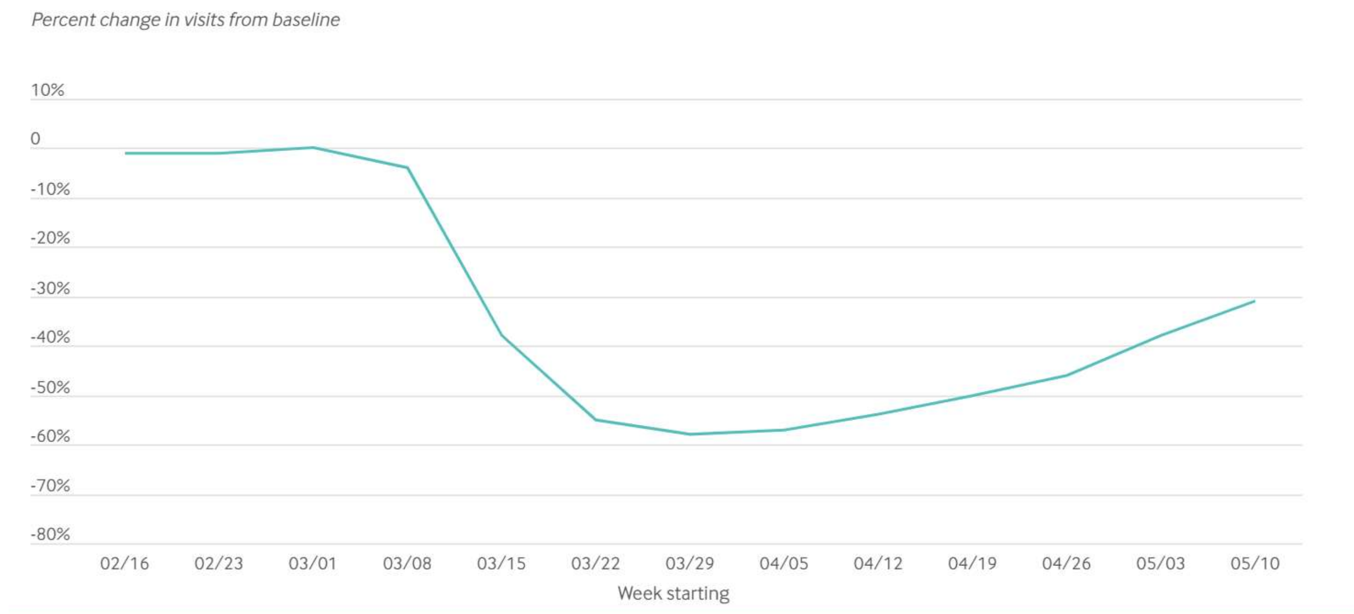
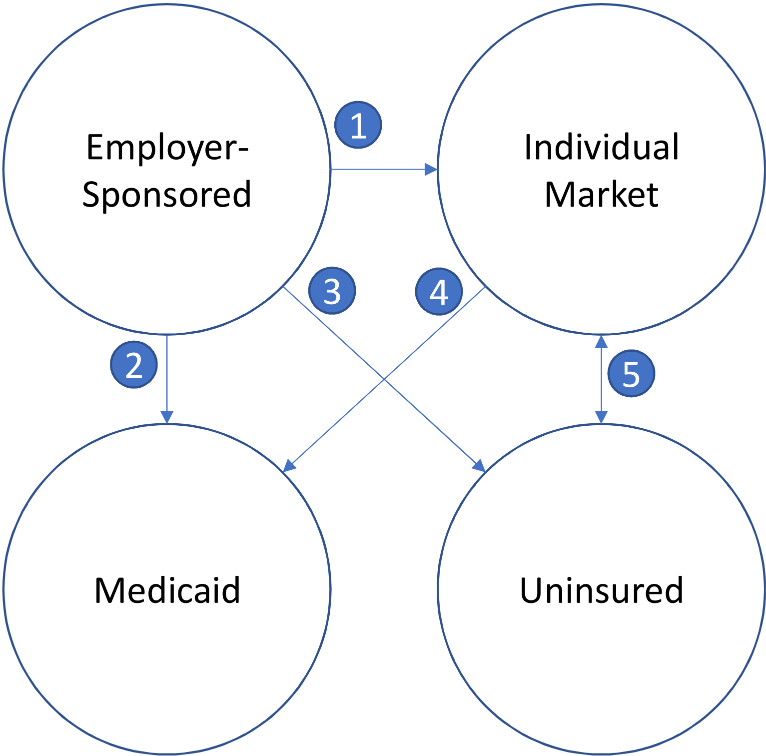
Outpatient Spending

Declined but then rebounded



Source: Ateev Mehrotra et al., "The Impact of the COVID-19 Pandemic on Outpatient Visits: A Rebound Emerges," *To the Point* (blog), Commonwealth Fund, May 19, 2020. https://doi.org/10.26099/ds9e-jm36

COVID-19 Market Shifts will Substantially Increase Medicaid Enrollment



1. Employees lose employer-sponsored coverage, but still maintain projected annual income over 100/138% of FPL[1]
2. Employees who lose employer-sponsored coverage and income drops below Medicaid eligibility threshold
3. Employees who lose employer-sponsored coverage and do not to buy coverage
4. Individual market members lose income and fall below income threshold
5. Special COVID-19 Enrollment period[2] will allow uninsured to take-up coverage, while Individual market members who can no longer afford to be in the market and are ineligible for Medicaid (or don't want to sign up)

1 CARES Act Paycheck Protection Loans from Small Business may partially mitigate this movement
2 Most State-Based Exchanges have offered a special enrollment period (SEP) to the uninsured. The Federal Facilitated Exchanges are not having a COVID-19 SEP

Estimates of Market Migration

Urban Institute

- For unemployment of 15%-25%
  - ESI decrease 17 to 33 million
  - Individual market increase 4 to 8 million
  - Medicaid 8 to 15 (about 50% of those losing ESI eligible for Medicaid)

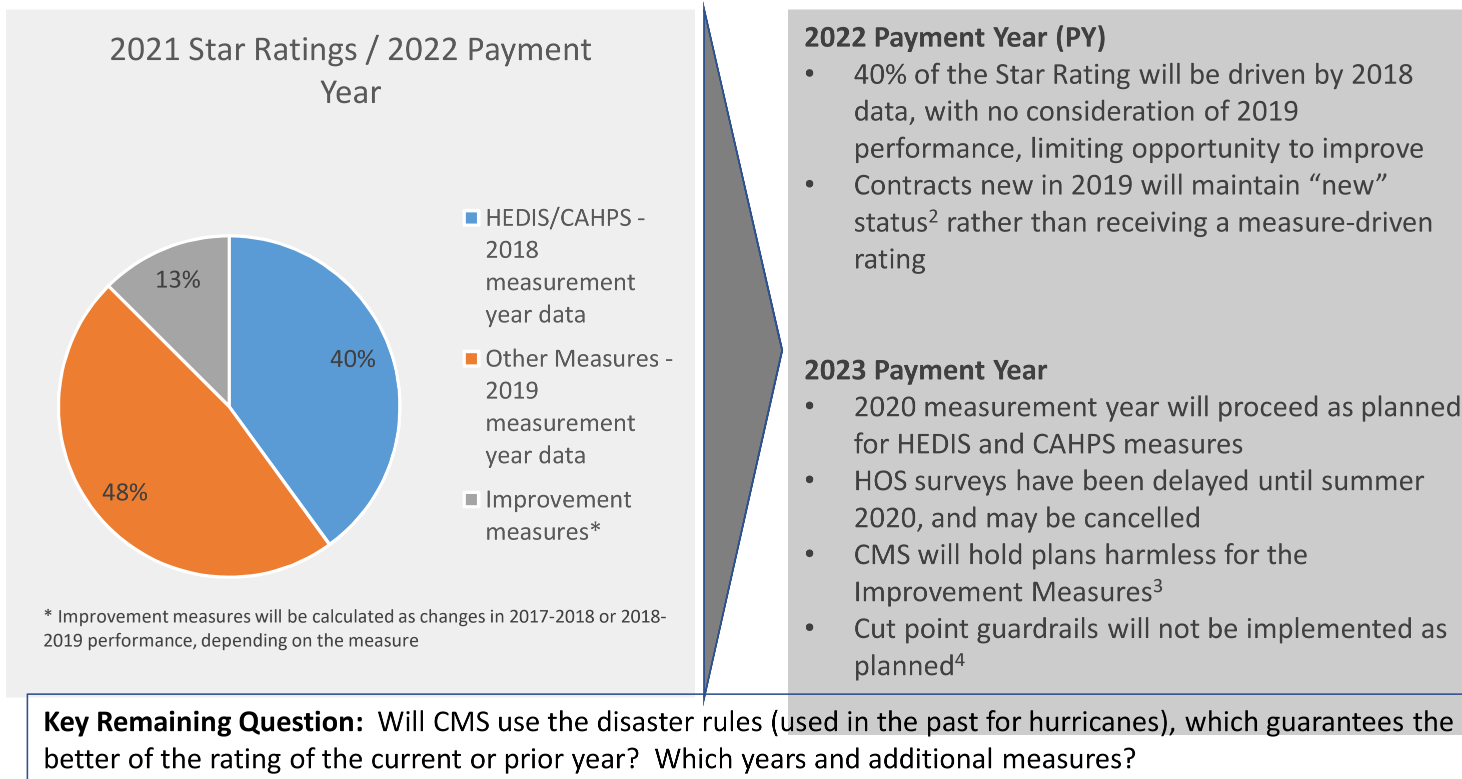
Kaiser Family Foundation

- As many as 27 million could have lost ESI (as of 5/2/2020)
- 8.3 million eligible for subsidized coverage with UI
  - 6.2 eligible for subsidized coverage without UI
- 2.7 Million eligible for Medicaid
  - 16.8 million eligible for Medicaid without UI

Key Assumptions

- Economy
- Unemployment Insurance
- Implementation

COVID-19 Related Announcements – Stars Provisions[1]



2022 Payment Year (PY)

- 40% of the Star Rating will be driven by 2018 data, with no consideration of 2019 performance, limiting opportunity to improve
- Contracts new in 2019 will maintain "new" status[2] rather than receiving a measure-driven rating

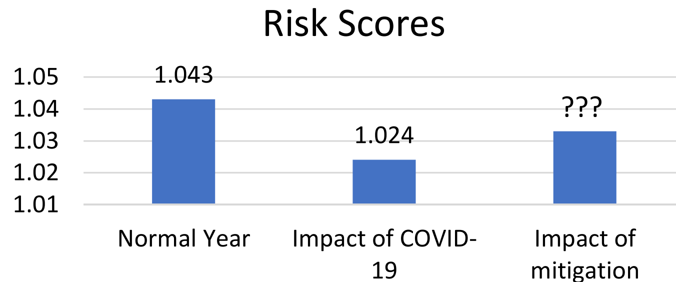
2023 Payment Year

- 2020 measurement year will proceed as planned for HEDIS and CAHPS measures
- HOS surveys have been delayed until summer 2020, and may be cancelled
- CMS will hold plans harmless for the Improvement Measures[3]
- Cut point guardrails will not be implemented as planned[4]

Key Remaining Question: Will CMS use the disaster rules (used in the past for hurricanes), which guarantees the better of the rating of the current or prior year? Which years and additional measures?

1 Based on CMS Final Call published on April 6, 2020
2 If parent organization has other contracts, the contract will receive the average Star Rating of the parent organization. Otherwise, the contract will continue to receive "new" status, with 3.5% Quality Bonus Payment
3 Similar to current practice for 4+ star plans, CMS will use the better of the two Star Ratings, one calculated with and one without the improvement measures
4 Cut Point Guardrails would have prevented cut points to move more than 5% from year-to-year. Due to the expectation that measure raw scores could get significantly worse due to COVID-19, CMS is delaying implementation of this previously announced provision

COVID-19 Related Announcements – Risk Adjustment Impact[1]



Key Takeaways

Impact of COVID-19[2]

- Due to COVID-19, continuing enrollee risk scores for 2021 Payment Year could drop by as much as 1.8%
- Effective risk coding accuracy programs will mitigate some or all of this reduction
- COVID-19 patients could also get credit for certain HCC's around respiratory issues[3]

Mitigation efforts possible

- Identify and engage chronic members (potentially through telemedicine) with suspected HCC diagnoses early who may have their visits deferred (you can't chase a chart if a visit doesn't take place)
- Right now, focus coding accuracy efforts on providers that are seeing fewer patients now (Note that some providers may be treating COVID-19 outside of their geographic or primary practice area)
- Focus on auditing EMR's that can be accessed directly to avoid bothering providers directly
- Monitor HCC Prevalence rates to see if there are particular conditions that have been affected

CMS Guidance

- It is unlikely that risk adjustment models will be changed
- CMS made no adjustment to the risk adjustment normalization factor in the Final Call on April 6
- Telemedicine will count for risk adjustment in both EDS and RAPS[4]
  - Ensure your EDS and RAPS submission process considers telemedicine visits
  - Use telemedicine to supplement accurate diagnosis coding, including health risk assessments

1 Normal Year is based on continuing enrollee non-dual risk scores for Medicare Limited Dataset (5% Sample) for 2018
2 Assumes no diagnosis codes are captured for half of the claims incurred from 3/15 to 6/30. This would be an extreme scenario.
3 HCC"s 82-84 (Respiratory Dependence, Respiratory Arrest, Cardio-Respiratory Failure) and HCC 114-115 (Pneumonias)
4 Conditional upon all other criteria for an acceptable claim/encounter is met

Questions?

To get a copy of this presentation or to discuss any of this material, please contact any of the presenters today:

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