Health Insurance Profitability During the COVID-19 Pandemic

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Due to the surge of COVID-19 cases during the Spring of 2020, many hospitals across the US were mandated by state executive orders to cancel elective surgery to generate hospital capacity. Not only did this result in postponed medical and surgical care for patients, but also an estimated \$323 billion financial loss for US hospitals in 2020 and a rash of closures disproportionately affecting safety-net hospitals.¹ Although patients, physicians, and hospitals all suffered financially during the pandemic, this loss resulted in one of the few financial boons—record second quarter earnings for US commercial insurers.

Second quarter earnings reports from major commercial health insurance companies tell a consistent story: increased operating income from decreased care utilization. UnitedHealth Group, CVS Health Care Benefits Segment, Anthem, and Humana all saw operating earnings over 200% of their 2019 Q2 amounts, much of which has been attributed to delays in routine care^{2–5} (Fig. 1). A fall in medical loss ratios (MLRs) supports this finding. MLR decreased between 6.9% to 13.7% across the 4 major payers.

In routine times, we consent to the practice of health insurance companies making a profit from premiums in excess of what is claimed in care. In the unprecedented crisis represented by the pandemic that confronts the healthcare system as a whole, those earnings may need to be viewed in a different light. The record profits for insurance companies represent reduced utilization, and we are only starting to understand the consequences of this profound shock to the health care system. Early data suggest increased non-COVID mortality during the first wave of the pandemic.⁶ The increased morbidity and mortality of delaying routine care (eg, cancer screenings) will likely take years to fully appreciate. Similarly, progression of surgical disease over the Spring 2020 operative shutdown has no precedent for changes to risk profiles, ranging from operable cancers to failing cardiac valves. Such a delay will likely be born out through disease progression, increased operative difficulty, and increased overall morbidity and mortality for surgical patients. Surgeons attempted to bridge this extraordinary delay in surgical care with neoadjuvant or extended neoadjuvant treatment while waiting for operating rooms to re-open for elective procedures. These on-the-fly treatment methodologies were largely crafted without clinical trials or the rigorous evidence of formalized guidelines surgeons are accustomed to using to guide treatment decisions.

Under the Affordable Care Act, health insurance issuers are required to report the proportion of their premium revenues spent on clinical services or quality improvement.⁷ The proportion is the MLR, and insurers are required to issue rebates if their MLR drops below 80% to 85%. In recognition that widespread unemployment and the financial downturn will make premium payments difficult for many, Centers for Medicare and Medicaid Services (CMS) issued guidance allowing insurers in the individual and small group markets to offer temporary premium reductions in August 2020.⁸ In effect, these temporary premium credits will function as an advance on MLR rebates. Measures like this are a necessary component of COVID relief, particularly in the setting of forestalled congressional negotiations on additional relief bills. Ensuring that those who have paid premiums pre-COVID are able to continue health insurance coverage during a pandemic is an obligation of the insurers who find themselves with unexpectedly large profits from premiums intended to cover care that was never received.

Insurers have a responsibility to the healthcare system from which they benefit and on which they rely to provide and deliver care. The fulfillment of this obligation should take three forms: (1) support of individual beneficiaries, (2) support to surgical and physician practices, and (3) support to hospitals and healthcare systems.

Support required by individual surgical patients is arguably the most urgent and complex of these responsibilities. As patients often wait until the end of the year to pursue elective operations after deductibles have been met, we may not understand the full scope of delayed or foregone surgical care until well into 2021. When combined with the personal financial strain facing many patients, the amount of canceled elective surgical care in the final quarters of 2020 could be tremendous. Compounding this is the loss of employer-sponsored insurance for millions of people who are newly unemployed, especially for those in states who have not adopted Medicaid expansion. The ability to seek coverage through Affordable Care Act (ACA) marketplaces is essential, as the cost of Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage is prohibitive for many. This insurance churn complicates the implementation of beneficiary rebates, but they could potentially take the form of a collective fund or rebates to those who paid but did not utilize premiums pre-COVID, regardless of their current insurer.

Insurers can follow the lead of CMS, who expanded their current Accelerated and Advance Payment Program for the duration of the COVID-19 pandemic. These payments are “intended to provide necessary funds where there is a disruption in claims submission and/or claims processing.” Many practices operate on margins unable to reliably sustain disruptions in payment amid the effects of the financial crisis, delayed or canceled appointments and procedures, and the increased operating demands of the pandemic. All of these factors directly impact surgical departments. The majority of system “flex” capacity during the height of the COVID pandemic’s first wave was derived from the cancellation of elective procedures and, in some cases, transformation of surgical wards into overflow for COVID patients. Some surgical practices suddenly facing lower earnings from this decreased volume alongside increased operating costs will face bankruptcy without temporary support. Recognition that these surgeons are not merely businesses

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FIGURE 1. Q2/Q3 earnings results and medical loss ratios for the 4 major US commercial health insurers, 2019 versus 2020. A, Q2/Q3 earnings from operations 2019 to 2020. B, Q2/Q3 medical loss ratio 2019 to 2020.

that should be allowed to sink or swim, but an essential part of the healthcare system worth supporting by ensuring or advancing payments, providing higher reimbursement rates to meet higher operating costs, and capitated payments to practices should be the shared obligation of CMS along with private insurers.

The crisis facing surgical practices is also facing hospitals and health systems, in no small part because the delayed and canceled surgical care represents such a large portion of healthcare revenue. Rural hospitals and hospitals in urban areas serving largely poor, non-White patients are disproportionately affected by this crisis. Hundreds of hospitals are in danger of bankruptcy, with the financial strain placed upon them by the COVID pandemic and recession far from over. The closures of these hospitals, in many cases, would leave a healthcare desert in their wake, further complicating the ability of rural and poor, urban patients to receive timely and quality

surgical care. Without places to seek and receive healthcare, being insured matters little.

Spending in Q3, while more alike the historical 2019 trend than Q2 spending, has not rebounded to equalize the Q2 boon. With potential impending lockdowns and the threat of exceeding hospital capacity as COVID numbers crest in Q4, the final quarter of 2020 will potentially look more like Q2 than its 2019 counterpart. The longer elective healthcare is foregone as the pandemic compromises routine hospital workflow, the less likely care skipped in Q2 is to be made up in later quarters. The April 2020 mammogram rescheduled for April 2021 does not constitute a delay in care; it represents care that was prepaid for in insurance premiums but will never be collected by the patient. Establishing the obligations of insurers to the surgical system in its time of need will continue to be relevant until the time that surgical care returns to full, unthreatened capacity.

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