THE COVID-19 CONUNDRUM FOR HEALTH CARE PAYERS

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HEALTH CARE PAYERS FACE an unexpected conundrum. On the one hand, while nearly every sector of the US economy finds itself under massive pressure from COVID-19, payers are actually doing better financially than they were before the crisis began, as demand for medical procedures plummets. On the other, the outlook for 2021 and beyond is fraught with threats, and the next 12 to 18 months could have profound structural implications for payer economics.

To be sure, payers have been doing their part to support health care providers as the COVID-19 pandemic upends much of the health care system. All payers have eliminated prior authorization and utilization management activities to enable hospitals and physicians to focus on clinical care; many have made resources available to help provide clinical care in hot spots such as New York City; and some are providing financial assistance in the form of expedited reimbursement and loans to support cash-strapped providers. As they continue these activities, however, payers need to look beyond the immediate crisis. The actions that they take—or do not take—in the next three to six months will determine their ability to compete and thrive beyond the end of this year.

Near-Term Benefits for Payers

For decades, payers have tried to address issues of rising medical costs and affordability, pursuing all kinds of solutions and achieving uneven results. It took COVID-19 less than two months to effectively reduce the volume of elective, semi-elective, and even urgent procedures to unprecedented lows, with nearly every payer enjoying significant medical cost savings—at least temporarily. Most are on track to deliver strong, if not record, financial results for the year.

Although some of the deferred care will return as providers resume scheduling patients, volume won't immediately bounce back to precrisis levels. BCG's recent COVID-19 health care survey showed a 60% decline in medical procedures in the US as

efforts to "flatten the curve" continue across the country. Approximately 80% of this drop is linked to delayed or deferred care, while 20% represents permanent cancellations.

Nearly 85% of the health care professionals we surveyed believe that, even after COVID-19 partially subsides, they will need up to a year to work through their backlog of procedures. Moreover, procedure volume is unlikely to come all the way back anytime soon. Our research indicates that government-mandated social distancing policies, the limited availability of equipment and supplies, and relevant guidance from medical organizations such as the AMA will result in procedure volume that is, on average, 30% below pre-COVID-19 levels during the next 12 to 18 months. Convincing consumers that it is safe to seek care in hospitals and physicians' offices will take time, and at least some of the volume that has shifted to lower-cost and more convenient telehealth and virtual-care formats will remain there.

Ultimately, however, private payers will not be the primary beneficiaries of lower medical costs. The Affordable Care Act (ACA) implemented strong medical-loss-ratio (MLR) floors, and few payers operate far from this range today. Assuming that no unexpected surge in medical costs occurs over the next several years, most savings will eventually have to be rebated to fully insured employers. And at most large employers—which long ago moved to self-funded, administrative-service-only (ASO) products—medical expense dollars are entirely out of play for payers. As a result, the majority of the long-term benefits will go to employers.

Shifts in Payer Membership and Profit Pools Ahead

Many experts anticipate significant disruption in the health insurance market next year. As US unemployment rates rise through levels not seen since the Great Depression, a number of analysts predict a steep drop in employer-sponsored insurance (ESI). At the same time, they project big enrollment increases in Medicaid (especially in expansion states) and in ACA plans offered through health insurance exchanges.

Although we think that these projections are directionally correct, BCG's proprietary insurance industry revenue and profit pool model suggests that payers should adopt a more nuanced understanding of the key trends at work—and the likely market shifts that they will drive.

For instance, our analyses indicate that the ESI market will shrink unevenly and less than many observers expect. Simple projections that convert unemployment numbers directly into membership losses ignore the structural reality that a plurality of workers live in dual-income households. Many unemployed workers, together with their dependent children, can switch to their spouse's (or registered domestic partner's) plan, creating a buffer against one-to-one reductions. Consequently, we believe that the average numbers of dependents on ESI plans will increase by 5% to 10% over the next year, increasing the financial pressure on employers that offer ESI. Similarly, the premise that unemployment and ESI volumes move in tandem ignores the important fact that a meaningful share of workers who lose employment did not rely on that employer for insurance in the first place. Finally, some people who lose their jobs are 65 or older and will simply switch to Medicare as their primary source of insurance.

Our model also shows that Medicaid will grow, but much less and more slowly than predicted. One restraining factor here is the fact that it will take time for recently unemployed workers to realize incomes that are low enough to qualify for the program, muting the rate of uptake into Medicaid. More importantly, numerous states that have not expanded eligibility have incurred high job losses, and the restrictions associated with their program status will impose a lower ceiling on enrollment.

Finally, in our assessment, ACA plans will grow—but only modestly. Some share of

individuals who are currently on ACA plans will opt out as they lose their jobs and income. Some workers will lose their ESI plans but not be sufficiently motivated to sign up for ACA plans. Many workers who see unemployment as temporary may think that the benefits of enrolling in a plan are not worth the cost and effort. Even with access to the partially subsidized products available on insurance exchanges, more than 10% of non-elderly adult Americans were uninsured in the pre-COVID-19 period, and almost all of them cited the high cost of coverage as the reason, accordingly to a December 2019 report from the Kaiser Family Foundation. The percentage of people who go without insurance is likely to grow—particularly in a time when many people are avoiding seeking care and when the government, by reimbursing providers for treating uninsured COVID patients, has effectively encouraged individuals to accept the moral hazard of going uninsured. (See Exhibit 1.) According to the latest initial jobless claim data available at the time of this writing, more than 30 million Americans had lost their jobs. If these turn out to be structural losses, ESI enrollment is likely to decrease by about 21 million, or approximately 10% to 15% of nationwide ESI membership.

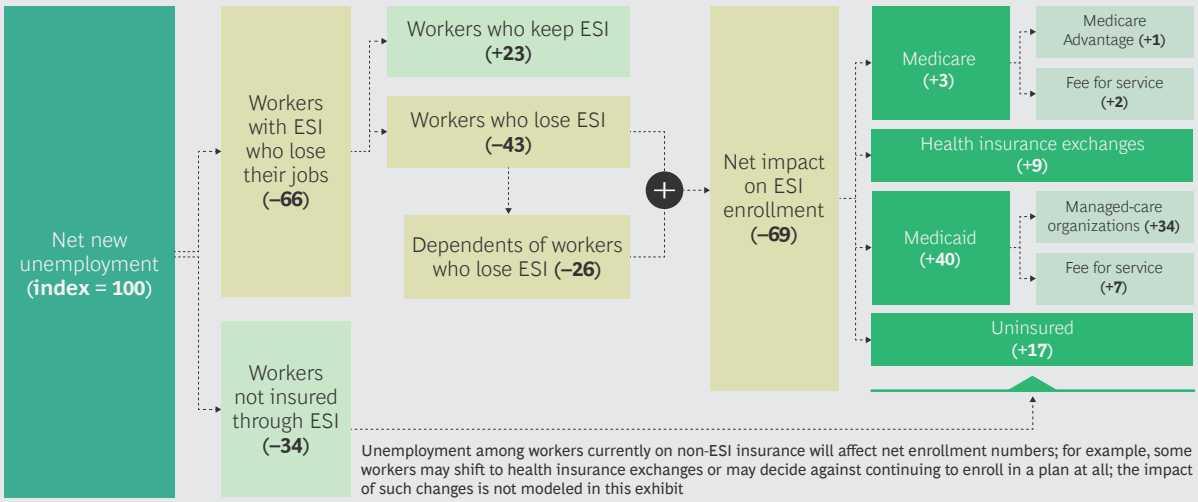
Will Government Intervention Act as a Stabilizing Force?

Given the large and sudden rise in unemployment, several industry stakeholders have urged Congress to take bold actions to mitigate the resulting shifts in enrollment. In a recent open letter, payers, providers, and a number of industry associations asked the government to manage the costs associated with private insurance for both employers and workers. Examples of suggested initiatives includes subsidies for employers' health insurance costs, subsidies for workers to cover COBRA, and incentives to increase participation in health insurance marketplaces by expanding the eligibility criteria for federal subsidies.

Such measures might reduce or delay the large-scale enrollment shifts that we would otherwise expect to see. They would provide financial benefits not only to employers and workers, but also to providers, by increasing the share of the population covered by insurance that carries more attractive rates.

In the bigger picture, however, the extent to which such measures reduce the shift from ESI will depend on how quickly employment returns to pre-COVID-19 levels. If

EXHIBIT 1 | The Impact of Rising Unemployment on ESI



Sources: Kaiser Family Foundation; US Bureau of Labor Statistics; US Census; BCG payer profit pool model.
Note: ESI = employer-sponsored insurance.

the bounce back is slow and gradual, government action is likely to delay, rather than reduce, health care market shifts, since any government stimulus is unlikely to continue indefinitely. In fact, these measures, together with other unemployment benefits currently offered, might unintentionally slow the country's return to fuller employment, especially if the health benefits under the government's program exceed those offered by employers with open positions.

Payers Must Begin Restructuring Now

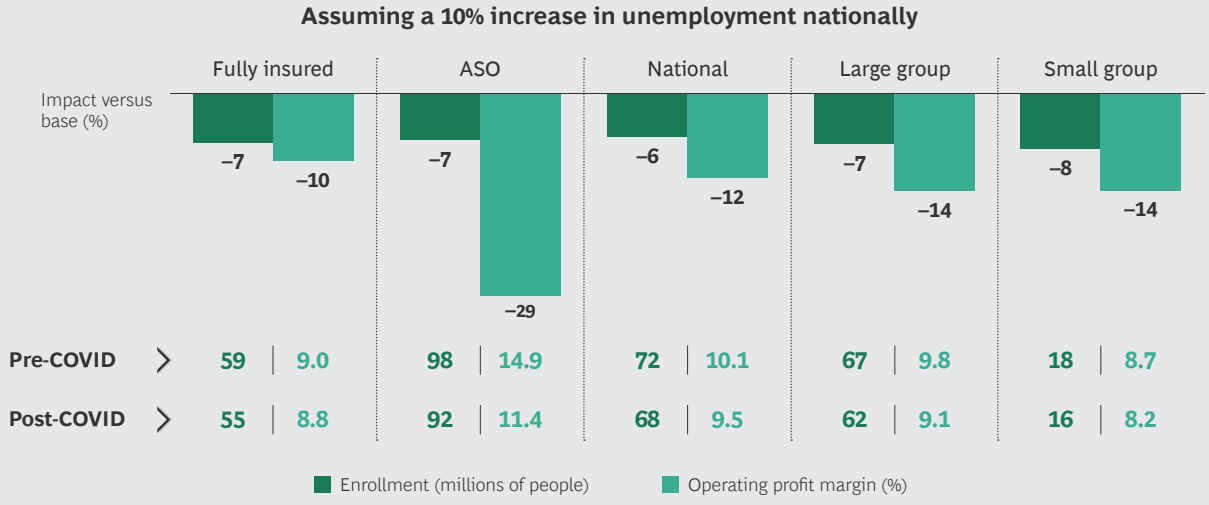
The prospect of administrative pressure in a year marked by massive medical cost reductions might seem counterintuitive, but this is the likely reality in the absence of significant government intervention aimed at stabilizing ESI enrollment. As aggregate ESI enrollment drops—and with medical loss ratios capped—most payers will have to spread their fixed-cost base over fewer members and in lines of business that have less headroom (such as managed Medicaid and individual ACA plans). As a result, paradoxically, payers that do not take quickly action to reduce costs could find themselves in the red.

Our analysis suggests that payers might have to endure an operating margin compression of as much as 10% to 25%, assuming a jump of 10 to 20 percentage points in unemployment from pre-COVID-19 levels. This impact is likely to be disproportionately heavy among payers with high ASO exposure. In the absence of a meaningful reduction in fixed costs, ASO could see a dramatic compression of 30% to 60%, compared with the already high compression of 10% to 20% for fully insured plans. In addition, local and regional plans are likely to suffer a larger share of the volume loss than national or large-group plans. (See Exhibit 2.)

The Urgency of Joining the Public Dialogue

Owing to the preceding factors, payers will soon find themselves caught between a rock and a hard place with respect to public perception. On the one hand, they recognize the financial hardships that are coming and must take action to shed costs rapidly and to reposition their capabilities to ensure that health care remains affordable and accessible. On the other hand, the public will find it difficult to look past the industry's record quarterly profits at a time

EXHIBIT 2 | The Impact of Reduced Enrollment on ESI Profitability



Sources: Analyst reports; annual reports; BCG analysis.
Note: Figures for operating margin and operating profit exclude state premium taxes and HMO tax, but include selling, general, and administrative expenses and commissions. Calculations assume that 42% to 58% of nonmedical-cost-related costs are fixed, depending on insurance model (fully insured/ASO) and size (national, large, or small). Enrollment numbers represent million of lives covered, and operating profit margin is expressed as a percentage of premium. ASO = administrative services only.

when hospitals are under strain and many people have lost their jobs. Even if current profits are fleeting and only on paper, a public not steeped in the complexities of insurance regulation is likely to interpret the situation as evidence of payers putting profits over people.

Payers are inherently conservative organizations, and many have adopted a wait-and-see attitude. It is therefore all the more critical for payers to move out front and be seen as driving the conversation on what to do with potential rebate dollars. Just as financial insurers have already done, payers could return some premium dollars to employers on their own initiative or even help shore up health systems that are in greatest need. In light of payers' deep understanding of the cost of health care in their communities, it would be natural for them to start and lead the dialogue about where these dollars should go.

What Happens Next

Given these new pressures, we believe that payers must take the following actions now:

- **Conduct a detailed membership and economic simulation to understand the likely impact of market shifts at both the aggregate level and the line-of-business level.** The effect of market changes will be different for each payer, depending on business mix, exposure to ASO plans, and geography. A general understanding won't suffice to properly inform the required decision making.

- **Prepare now for a leaner cost base.** It will take time to adapt to a lower membership base, and payers that wait will find that they cannot make changes fast enough to protect themselves. As a potential recession looms, it becomes critical to take steps to preserve cash and keep the balance sheet healthy from a position of strength.

- **Leapfrog to medical management and telemedicine capabilities.** COVID-19 presents payers with a once-in-a-lifetime opportunity. The next six months will effectively give them a free pass to shut down unsatisfactory programs, build new ones, and experiment with fresh capabilities. Now is the perfect time to make a clean break from old and ineffective programs, such as telephonic care management and disease management, and rapidly usher in the next generation of technology and capabilities.

- **Get ahead of the conversation on rebates and medical surplus.** Payers that are not seen as actively guiding unused medical spending back into the hands of employers, members, or even providers are at high risk of incurring a public backlash.

- **Renegotiate provider contracts with an eye toward long-term value.** Because many providers need cash in the near term, this is a good time to strike deals that disincentivize volume-driven medicine and better align incentives for the future.

- **Aggressively acquire and integrate.** For payers that are currently in a strong position—in particular, larger regionals, integrated payer-providers, and national plans—there may never be a better time to acquire care delivery assets, as providers are in great need of financial assistance.

As payers experience brisk fiscal tailwinds this year, they may be tempted not to take these much-needed actions. But in light of how quickly the winds are likely change as a result of enrollment shifts and cost pressure from employers and government programs, it is essential not to give in to inertia. Companies that take early and aggressive action will put themselves in a much better position to thrive in the aftermath of COVID-19.

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