

FAQs on COVID-19 and Its Effects on Health Spending and Health Insurance

The novel coronavirus has caused a worldwide pandemic, with COVID-19 outbreaks across the globe. The United States is still coming to terms with what this pandemic will ultimately mean—for the health care system, for the economy, and for individuals. The American Academy of Actuaries Health Practice Council has developed some frequently asked questions (FAQs) to share insights on COVID-19's potential effects on health care spending and the health insurance system.

There is tremendous uncertainty regarding the potential effects of this pandemic; these FAQs will be updated periodically as new information becomes available.

How can we expect the COVID-19 pandemic to affect health care spending in 2020? In 2021?

The ultimate effects on 2020 health spending are unknown and depend on many factors including: how many people contract COVID-19 and of those the share with severe symptoms requiring hospitalization; whether new treatments are found; whether health system supply constraints (e.g., the number of available hospital beds, availability of personal protective equipment) limit access to treatment; and the extent to which elective visits, treatments, and procedures are deferred or canceled. These factors could vary by insurance market (e.g., based on enrollee demographics) and geographic area (e.g., based on hospital capacity, rural vs. urban, population composition).

Although social distancing measures are being adopted, the number of COVID-19 cases in the United States is growing and will likely continue to grow.¹ This increase will likely lead to more hospitalizations and higher hospital spending. Such increases could be offset in part by reductions in elective services and procedures, especially following a Centers for Medicare and Medicaid Services (CMS) recommendation to delay all elective surgeries and nonessential medical, surgical, and dental procedures during the COVID-19 outbreak.² Hospitals have already started to delay surgeries to free up space for COVID-19 patients.³ At the same time, CMS⁴ as well as private insurers⁵ are expanding coverage to make telehealth more available. Telehealth can be used in place of in-person office visits.⁶

1 [Coronavirus COVID-19 Global Cases](#) by the Center for Systems Science and Engineering at Johns Hopkins University.

2 Centers for Medicare and Medicaid Services (CMS), "[CMS Adult Elective Surgery and Procedure Recommendations](#)," March 15, 2020.

3 Melanie Evans and Anne Wilde Mathews, "[Hospitals Push Off Surgeries to Make Room for Coronavirus Patients](#)," *The Wall Street Journal*, March 16, 2020.

4 CMS, "[Medicare Telemedicine Health Care Provider Fact Sheet](#)," March 17, 2020.

5 Blue Cross Blue Shield Association, "[Media Statement: Blue Cross and Blue Shield Companies Announce Full Coverage of Telehealth Services for Members](#)," March 19, 2020.

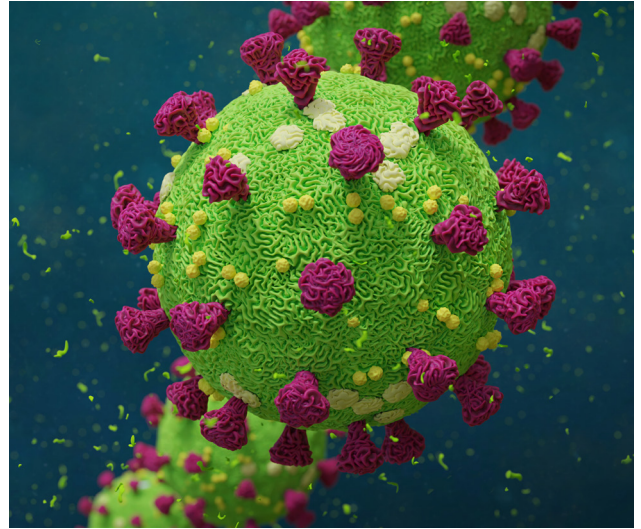
6 See an issue brief from the American Academy of Actuaries, [Telehealth—A Digital Communication Approach to Improving Care](#), and related [briefing presentation](#) regarding telehealth issues, including what it is, how it is paid for, how different rules apply to different coverage types, and barriers to further adoption. Some of the barriers to further adoption have been addressed through the increased flexibility provided by CMS.



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If the incidence of COVID-19 takes place mainly in 2020, much of any higher spending could be concentrated in 2020. Deferrals of nonessential services during the height of the outbreak could lead to higher spending for those services either later in 2020 (which would limit the extent to which higher COVID-19 spending is offset by reductions in other spending) or higher spending for those services in 2021; presumably some nonessential services will be canceled altogether. However, the incidence of COVID-19 could continue into 2021,⁷ directly affecting spending beyond 2020. In addition, spending for a COVID-19 vaccine, if one becomes available, could begin in 2021. In the longer term, any continuing effects of COVID-19 will likely be included with other virus (e.g., flu) spending projections.



Although cost-sharing for COVID-19 testing and related provider visits will be waived,⁸ there is still the potential for patients to receive surprise bills for related treatment, especially among enrollees in narrow-network plans.⁹

Will COVID-19-related outlays result in solvency issues for private health insurers?

Premiums for most 2020 private health insurance plans have already been finalized and cannot be changed during the year. Health spending for insurers could be higher than expected when they developed those premiums, both due to increased costs for COVID-related hospitalizations and other services as well as from waiving cost-sharing for COVID testing and related provider visits, especially if those higher costs are not offset by reductions in other health spending, for instance by reductions in nonessential services. Moreover, insurers could receive lower revenues if individuals and groups can no longer pay premiums, yet maintain coverage during grace periods. Both factors could lead to insurers experiencing financial losses in 2020.

Well-capitalized insurers should have sufficient reserves to cover COVID-19-related 2020 losses. Insurers build up reserves specifically to be prepared for unexpected events. Some insurers, especially those already at risk of insolvency, could face increased solvency risk due to higher costs during the outbreak. State regulators monitor insurer solvency and can take action if necessary to protect consumers.

⁷ Imperial College COVID-19 Response Team, [Impact of non-pharmaceutical interventions \(NPIs\) to reduce COVID-19 mortality and healthcare demand](#), March 16, 2020.

⁸ The Families First Coronavirus Response Act, enacted on March 18, 2020, requires COVID-19 testing and related provider services to be available without cost to consumers, regardless of insurance coverage. Some states are requiring or are considering requiring coverage of other tests, such as for flu and strep throat, with no cost-sharing, as these tests are often given to rule out other conditions before testing for COVID-19.

⁹ See the American Academy of Actuaries issue brief [Surprise Medical Bills: An Overview of the Problem and Approaches to Address It](#) (September 2019) for more information regarding surprise bills.

Many employers self-insure, and they don't always have as much reserved for unexpected events as an insurer would. Some employers could be experiencing revenue losses and a depletion of investments at the same time they are experiencing higher medical claims. Although some have stop-loss coverage, the majority of COVID-19 claims will fall below the large claim threshold.

Enrollees in Medicare and Medicaid can be particularly at risk from COVID-19, due to being older, medically frail, or having underlying health conditions. Therefore, Medicare Advantage and Medicaid managed care plans could be more at risk for having 2020 health spending higher than expected.

What can individuals expect in terms of 2021 health insurance premiums?

Insurers are currently developing premiums for 2021. If insurers expect that most COVID-19-related costs will be incurred in 2020, 2021 premiums might be affected only minimally, for instance due to any expected uptick in nonessential services that were deferred from 2020 and to any expected vaccination spending that would not begin until 2021. However, as noted above, the incidence of COVID-19 could continue in 2021. In addition, if insurers expect to rely on existing surplus to offset 2020 financial losses, margins in 2021 may need to increase in order to rebuild surplus over the next few years. With even a short amount of 2020 experience being taken into account, there could be a tendency for insurers to reflect some of that experience into 2021 rates. Aside from considering the effects of the outbreak on health spending generally, insurers will also need to consider any related economic effects, such as job losses, that could affect enrollment and morbidity in the individual and small group markets. Such effects are also uncertain and could make it difficult to set rates appropriately.

Insurance regulators will likely scrutinize any 2021 premium filings to ensure that any medical trends or other load factors that assume higher 2021 costs due to the outbreak's effects on health spending or its effects on the risk pool provide sufficient support for those assumptions. That said, there is much uncertainty regarding how health spending in 2021 will be affected by the outbreak, which could lead to more conservative assumptions in general.

Initial rate filings for Affordable Care Act (ACA) marketplace plans as well as Medicare Advantage and Part D plans are due in the spring. States and the federal government could consider revising rate filing deadlines or allowing insurers to revise their rate filings as new information on COVID-19 incidence, seasonality, and spending continues to emerge.

How will special enrollment periods under the Affordable Care Act (ACA) affect insurance plans?

The ACA requires that individuals who experience changes in circumstances, including a job loss or a change in eligibility for ACA premium subsidies, have access to a special enrollment period (SEP). In addition, many state-based insurance exchanges have reopened the ACA annual enrollment period to allow uninsured individuals to enroll in ACA individual market plans; the federal government is considering doing the same for states using the federal exchange. These provisions provide an important opportunity for uninsured individuals and those who may no longer have access to employer coverage¹⁰ to get insured and could increase enrollment in the ACA individual market. However, these provisions can also increase the risk of adverse selection—that is, people who expect they will have high health costs might be the ones most likely to take advantage of such enrollment opportunities. On the other hand, the availability of premium subsidies for those who are newly eligible for premium subsidies could help encourage enrollment and reduce adverse selection. The adverse selection risk would be even greater if SEPs were opened up solely for those who test positive for COVID-19.

If plans experience adverse selection, it could increase their claims expenditures relative to their premium revenue and put them at greater risk of losses in 2020. If insurers expect that such adverse selection will continue into next year, 2021 premiums could increase as a result.

¹⁰ Workers losing their jobs and their health insurance as a result could have access to COBRA coverage. However, access to that coverage depends on the employer continuing to offer coverage to its active workers. In addition, premiums for COBRA coverage reflect the full costs of coverage, rather than just the employee share.

Academy Offers Resource Page on Coronavirus Pandemic Information

The Academy has created a [webpage with resources for the ongoing coronavirus \(COVID-19\) pandemic](#). The page includes resources such as links to the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO), the Centers for Medicare & Medicaid Services (CMS) regulatory activity and other legislative and regulatory actions, pertinent articles, and more. The Academy will continue to add resources to this freely available webpage as more information becomes available.

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