

Implications of the COVID-19 pandemic on health payer operations

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The COVID-19 pandemic has the potential to significantly disrupt key operational areas for health payers. It also presents opportunities for payers to deliver value for their provider partners and customers. This brief highlights some areas of impact and response strategies for payers.

The 2019 novel coronavirus (COVID-19) pandemic will have significant and long-lasting impacts on healthcare systems around the world. Health insurers, managed care organizations, and third-party administrators (payers) provide infrastructure that facilitates the flow of information and funds throughout the healthcare value chain. Payers answer benefit and coverage questions, connect patients to healthcare services, provide reimbursement for services rendered, facilitate financing, and manage relationships with purchasers.

In the current care delivery/financing paradigm, these day-to-day administrative activities are key to making the U.S. healthcare system work. However, the status quo is threatened as customers and providers experience business interruption on a massive scale due to COVID-19. This Milliman brief identifies five key payer functions likely to be affected by the COVID-19 pandemic and actions payers can take to ensure business continuity while enhancing their contributions to the value chain.

Member services

The member services function is a payer's primary front door for engaging with members. Most payers provide member services through a combination of telephone, chat, secure messaging, and, to a lesser degree, walk-in service and written correspondence. The COVID-19 pandemic has the potential to disrupt member service operations in several important ways.

INCREASED DEMAND AND REDUCED SERVICE LEVELS

The COVID-19 pandemic is expected to drive more members to [use health insurance benefits](#) related to testing and treatment of the disease. This increased utilization will likely spur member inquiries about these benefits and how to access care. Payers should prepare for surges in inquiry volumes across all channels (telephone, chat, and secure messaging) leading to service level erosion (i.e., longer hold times) and reduced call handling efficiency. Walk-in member service will likely be eliminated due to social distancing.

Contact centers may also see an increase in outbound calling projects to support other departments that need to reach members, such as care management.

REFERENCE GUIDES AND TRAINING UPDATES

Contact center reference guides will need to be updated to reflect benefit and coverage modifications implemented as a result of changes in local or national policy. Telephone scripts for COVID-19 specific information will need to be developed to ensure members receive consistent responses to common questions, especially as guidance evolves. Staff need to be trained on these changes to ensure they offer accurate responses to customer inquiries. Leadership may need to conduct daily briefings to ensure timely updates are communicated.

PROACTIVE MEMBER COMMUNICATIONS

Payers can proactively leverage member communication channels such as hold messaging, frequently asked questions (FAQ), member handbooks, and portal messaging, to communicate updates to members. In addition, they can implement a COVID-19, or general pandemic, landing page on their website where all related information can be located and more efficiently updated.

COORDINATING COMMUNICATION

Multiple departments may find it necessary to communicate with members about the pandemic. It is essential that teams coordinate their messages and outreach to members to ensure consistency and maximize the value of investment in member communications, especially traditional mail or outbound telephone calls. Payers may want to designate a single department to be responsible for coordinating communications and ensuring messaging alignment.

Provider network

Many payers view their network of contracted providers as one of their **most important assets**. These relationships are key to attracting employer groups, providing care for members, and managing unit costs and utilization.

MONITORING NETWORK CAPACITY

In times of crisis, network supply and demand can change quickly resulting in acute network inadequacies that can have serious member consequences if care is unavailable. Staffing shortages due to illness or concerns about spreading illness can lead a provider's office to unexpectedly close or cut back on available appointments. Demand for urgent and emergent services can crowd out capacity for routine services. Traditional methods of monitoring network capacity—adequacy and access—do not provide the sort of real-time information needed to enable payers to respond to supply and demand imbalances. Payers need to keep in close contact with their key providers to ensure they understand provider operational status and can execute contingency plans if warranted.

CHANGES IN PROVIDER AVAILABILITY

When there are unexpected changes in provider availability, payers can play an important role in helping providers ensure their patients' needs are met.

Payers and key providers can co-message to members about how to access the care system. Payers with members spread across a large geography (e.g., national or key accounts) may need to coordinate across multiple regions or with external network partners to ensure that regional considerations and challenges are understood and incorporated into messaging.

Payers can also supplement administrative capacity in short-staffed provider organizations. For example, if a provider unexpectedly closes or reduces its schedule, hundreds or thousands of appointments may need to be quickly rescheduled. Member services teams are usually well equipped to do outbound calls to individual members, and could be redeployed to assist with appointment rescheduling. Case managers and telephone nurse lines can manage demand by helping patients make informed decisions when determining whether to reschedule or delay an appointment.

IMPLEMENTING ADMINISTRATIVE PROCESS CHANGES

The COVID-19 crisis has led to several changes to administrative processes, including the introduction of new diagnosis and procedure codes and temporary modifications to benefits and coverage such as cost-sharing waivers for COVID-19 testing.

Payers must be prepared to proactively educate their network providers on these changes and their impact on administrative processes. Accurate coding will be especially important for reporting and analytics as well as risk adjustment and cost sharing waivers. Payers will need to update provider manuals, generate provider newsletters and bulletins, and hold provider briefings. The member service strategies for updating reference guides, training contact center agents, and proactive communications equally apply to provider services teams, which may experience an increase in provider inquiries.

BILLING LAGS AND CASH FLOW IMPAIRMENT

Workforce displacement and staff shortages can affect provider offices' capacity to submit claims, which can impact claim inventories and incurred but not yet reported (IBNR) projections for payers, and can negatively affect provider cash flow. Payers should monitor claim receipts at the provider level to mitigate against the risk of unexpected claim volume surges as providers catch up on their claim submissions, and to identify providers that might be suffering from cash flow issues that could lead to permanent closures. If the COVID-19 crisis goes on for a long time, payers may elect to relax timely filing requirements.

EXPANDING PROVIDER NETWORK CAPACITY

Most payers actively manage their provider networks to meet the service demands and geographic footprint of the population they serve. Expanding network coverage is very time consuming, often taking months once a prospective provider is identified. To ensure they can quickly respond to network instability and comply with social distancing, payers may consider ways to leverage telehealth and e-visits to expand network capacity.

Claim administration

Claim administration is another key payer activity that will be affected by the COVID-19 pandemic. Payers handle millions of claim transactions amounting to hundreds of billions of dollars each year in payments to healthcare providers.

The vast majority of claims are processed via auto-adjudication, where payers' transaction processing systems automatically validate the member's eligibility, provider's network status, and benefit coverage, and then calculate the reimbursement amount. These automated processes rely on standardized code sets, formats, and data elements, which are loaded and configured into claims processing systems.

The introduction of claims related to COVID-19 presents several changes to these standards including new diagnosis and treatment codes, modified benefits and coverage, and exceptions to provider network rules.

NEW CODE SETS

Recognizing COVID-19 as a new diagnosis, the U.S. [Centers for Disease Control and Prevention](#) (CDC) issued a new diagnosis code for COVID-19. Similarly, the [Centers for Medicare and Medicaid Services](#) and the [American Medical Association](#) recently issued new procedure codes for COVID-19-related testing.

To ensure they can continue to process the likely millions of COVID-19-related testing and treatment claims, payers will need to determine the capacity and timing to update their claim processing systems to accept and process claims submitted with these new codes. While these updates are pending, payers may need to establish manual processes and workarounds as a temporary measure. Depending on the volume and complexity, additional staffing may be needed to ensure these manually processed claims are handled on a timely basis.

MODIFIED BENEFITS AND COVERAGE

Additionally, many health plans have modified benefits and coverage rules for COVID-19-related [claims](#). For example, the Families First Coronavirus Response [Act](#) requires payers to waive cost sharing and prior authorization requirements for COVID-19-related testing. Some plans may expand coverage to include telemedicine and telehealth services. Implementing these exceptions to existing plan designs requires either system reconfiguration or manual processes for handling the claims. As with the new code sets, payers will need to evaluate the capacity and timing to update their claim processing systems. Reconfiguring thousands of benefit plans is a significant endeavor that will take time and resources.

BENEFIT EXCEPTIONS FOR NON-NETWORK PROVIDERS

To expand provider capacity, payers may change how benefits are applied to non-network providers for certain pandemic-related services. For example, payers may equalize member out-of-pocket amounts for COVID-19-related services across network and non-network providers. Again, system configuration or manual processes will be required to ensure these claims are correctly processed.

INVENTORY SPIKES AND PROCESSING INEFFICIENCY

As with member services, the claim administration function can be disrupted by changes in transaction volumes and processing efficiency, negatively affecting claim processing timeliness and potentially provider cash flow.

Payers typically staff for a predictable volume of claims and actively manage claim inventories to achieve a consistent throughput and turnaround time. Changes in the volume of claims requiring manual handling can reduce efficiency and

increase claim inventory. The aforementioned introduction of new code sets, modified benefits and coverage, and changes in provider network rules are all likely to result in an increase in the volume of claims requiring manual interventions and thus an increase in claim inventories and increased turnaround time.

Changes in patient volume or provider office capacity to submit claims is also likely to result in claim volume surges, which can result in significant claim inventory swings complicating staff scheduling and creating backlogs.

Delays in claim processing timeliness can expose payers to prompt payment penalties (e.g., interest) and severely affect provider cash flow, which can have a disproportionate, negative impact on smaller providers or those in rural areas.

RETURN TO NORMAL

A final consideration for claims administration is the expectation that most of these changes are temporary. Once the COVID-19 emergency passes, systems and processes will likely return to pre-pandemic protocols.

For each of these potential claim impacts, payers must decide whether to implement system changes to enable auto-adjudication or to use manual processing and workarounds. While system changes could enable auto-adjudication for managing claim inventories, some system changes would need to be reversed when the crisis is over.

Financial management

In simplistic terms, payers take in monthly premiums and then manage the distribution of those funds back to service providers for services rendered. In the fully insured health insurance market, payers take financial risk that premium revenue is sufficient to fully fund the cost of benefits (in the self-funded market, the employer takes that financial risk but delegates the financial management activity). Financial management is a key process to manage payer cash flow and reserves when the timing of premium payments is misaligned with the timing of claim payments.

UNEXPECTED ENROLLMENT SHOCKS

In the fully insured health insurance market, employers pay a monthly premium for each covered enrollment unit (e.g., employee only, employee plus spouse, employee plus children). As the roster of employees changes due to hiring and terminations, so does the roster of insureds, but enrollment is usually [stable](#) so this churn has little net impact on cash flow.

When unemployment surges, the number of insureds and thus the amount of premium collected is reduced. In the case of a crisis, unemployment can rise dramatically in a very short period. The misalignment of premium payments and claim payments puts stress on a payer's cash flow and may result in the need to access reserves to finance claim payments. Plans in the individual market can also experience enrollment surges as these newly unemployed members migrate to other coverage (this shift can be exacerbated if the government authorizes a special open enrollment period due to the crisis).

As a result of these enrollment shifts, it is essential that payers actively manage their reserves to ensure that those funds are available in the event of employment-related enrollment shocks. Payers may also change their claim payment cycles and billing runs to spread out payments over a longer time. This action will affect provider cash flow and may generate more provider service inquiries as providers contact the plan to follow up on receivables.

PREMIUM RECEIVABLE DELINQUENCIES

Payers can also expect the revenue cycle to be stressed as employers delay premium payments to conserve their own cash position. While most payers will have a policy for terminating group accounts due to non-payment, they may also have an interest in accommodating longer payment cycles for credit-worthy groups to avoid further enrollment shocks due to group terminations. This is especially true if the disruption is expected to be of limited duration. Payers may also want to implement credit review processes to avoid extending credit to employer groups at risk of financial problems.

In the self-funded market where the employer is at risk for benefit expenses but the financial management function is performed by a TPA (or health plan providing administrative services only), it is still important to monitor employer financial solvency. While a TPA may not necessarily be held responsible for claim liabilities due to a lack of funding by an employer, these failures can still generate significant disruption for members and providers. Well-capitalized payers may explore offering temporary financing for self-funded employer claim expenses.

ENROLLMENT CONSERVATION

In the individual market, where retail customers purchase insurance coverage directly or through a health benefits exchange, financial stresses can result in early terminations. Payers may want to invest in proactive policy conservation to help retain at-risk enrollees (while offering COBRA is required by law, payers may also offer individual products to group health plan members who lose coverage). To the extent allowed by law, payers may offer premium payment plans or premium financing to avoid temporary disenrollments and risk losing the member to a competitor when the financial situation improves.

Business development

In a period of uncertainty, market-facing roles like sales and account management are certain to be inundated with questions from employers, brokers, government entities, and other stakeholders representing current and prospective customers. This customer engagement can offer payers an opportunity to emerge as solution-oriented partners.

COMMUNICATION AND OUTREACH PLAN

A cohesive communication and outreach plan is an important component of most payers' existing business continuity planning. Despite advance planning, however, it is unlikely that existing communication plans sufficiently address the current worldwide pandemic and potential widespread and prolonged business interruption. Proactive outreach to check in with group customers and offer assistance can significantly strengthen relationships and customers' perception of value.

Payers may develop communication and engagement plans by customer segment. For example a payer may send email communications to all small group customers but hold telephone or virtual meetings for mid-market customers. For their key accounts, large group, and government purchasers, payers may deploy senior account executives to make personal calls accompanied by a medical director who can speak to the particulars of the situation and answer questions.

PROACTIVE CUSTOMER SUPPORT

Many of the proactive strategies described above can be competitive differentiators. For example, employers may be overwhelmed with questions from their employees about benefits, coverage, testing, treatment, and how to access services. Many employers are scrambling to execute their own business continuity plans and thus ill equipped to answer these questions. Payers that can help these employees on behalf of the employer, and proactively assist in accessing healthcare services, may find themselves viewed more favorably by their employer clients at renewal time.

IMPACT ON GROWTH PLANS AND STRATEGIES

Payers need to consider implications for their own business development initiatives, most notably the impact of the pandemic on pipeline and sales/revenue forecasts. Group purchasers will generally be reluctant to switch payers during a crisis. Thus sales and new revenue sources may slow while revenue from inforce clients may diminish as a result of workforce reductions.

In markets where distribution relies heavily on in-person sales, particularly the individual and senior markets, payers will need to explore alternative ways of engaging with customers who are social distancing such as online self-service, plan recommendation engines, and telesales.

Payers will need to adjust their sales objectives for individuals and teams to reflect the new normal, especially if distribution channels are reworked. They may also need to restructure sales compensation programs to focus on profitable business segments/markets or new production expectations.

IMPACT ON PRODUCT DEVELOPMENT

Although expected or intended to be temporary, some of the changes brought on by the COVID-19 pandemic will result in long-term changes in the health insurance market. For example, it is likely that use of telehealth services will grow during the period of social distancing and as consumers become

accustomed to use of telehealth, higher demand for these services may continue long after the crisis ends. This may lead to market expectations that products include telehealth benefits in the future. Given the length of the product development cycle, payers may be well served to consider post-pandemic product design and whether new and differentiated products could create competitive advantages in the future.

Conclusion

While the world readjusts to a new normal, leadership in the payer community can use this time to proactively address potential operational challenges, plan for recovery, and return to standard operations, all in an effort to fortify relationships with members, providers, and customers as a valued and collaborative partner.



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