AHT INSURANCE – "STATE OF THE UNION" WHITEPAPER

Impact of COVID-19 Health Plan Use
Employer-Sponsored Health Plan Considerations

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AHT INSURANCE

AHT has prepared the following whitepaper to address several health plan considerations for our self-funded clients, along with additional cost impact to the healthcare system that could impact all our self-funded and insured customers. Below are some key considerations we would like to share.

Incurred But Not Reported (IBNR) Estimates – Self-Funded Plans

The IBNR looks at incurred and paid claims in recent claims months and uses past claim data to predict the IBNR liability. To the extent that the "incurred and paid" claims reduce below the norm without a corresponding reduction in enrolled headcount, you will generally see the IBNR requirement increase. For example, if your usual incurred and paid claims in a given month is $800,000, yet in the most recent month, it drops to $600,000, but your headcount has not also reduced, the model would assume the same average incurred claims and apply the $200,000 difference to your IBNR. Consider the below potential pitfalls from COVID-19 trends.

COVID-19 Health Claims trends:

1. **Low-cost services:** Swell in physician visits, primarily telemedicine, as people seek care for flu symptoms and guidance on the need for testing. There may also be a swell in prescriptions at the onset of any quarantine period or stay at home order;

2. **Moderate-cost services:** Postponement of all other non-emergent and elective services and surgeries;

3. **High-cost services:** Hospitalization for those severely impacted by COVID-19;

Plans that see items 1 and 2 but not 3 may see higher than usual IBNR liability estimates as your "incurred and paid" claims in recent months will reflect a tapering down of moderate-cost services, where the model won't account for these extenuating circumstances. For plans that have 1, 2 and 3, an increase in the IBNR requirement is appropriate in anticipation of the hospital claims that will take some time to be billed to and paid by the plan. Q1 impact of these factors will be low as lockdowns began late March and will likely escalate in Q2 and later.

Impact of Layoffs/Furloughs on IBNR Estimates – Self-funded Plans

Health plans are unlikely to see a reduction in IBNR requirement due to layoffs in the near future, as employers have taken measures to maintain coverage for displaced employees, or even without such measures, employees are more likely than ever to exercise COBRA options. As actual plan enrollment decreases over time, there are likely to be gradual reductions.

Impact of Layoffs/Furloughs on Self-Insured Plan Liability – with a Decrease in Enrollment "Potential Minimum Attachment Pitfall"

If ever there was a time where a self-insured plan could hit the aggregate attachment point, it's a time like this with multitudes of unanticipated emergency room visits, diagnostic testing, laboratory expenses, inpatient admissions and ICU utilization. If your plan has been hit hard with COVID-19 claims, and your company has had to reduce headcount, this could be a "perfect storm" environment for an aggregate stop-loss violation. This is a good time to be reminded about a rarely used stop-loss contract provision called the "Minimum Attachment Point".

Essentially, this is the minimum dollar amount of claims your plan would need to reach in paid claims before an aggregate claim could be filed. The Minimum Attachment Point is set by the number of employees covered on the plan either at the time of the quote or the first month of the plan year, whichever is higher. For example, if a contract has a 95% Minimum Attachment Point, the reinsurer will calculate your Monthly Attachment Factor (expected claims PEPM + 25%) times your January enrollment, times 12 months.

Therefore, a significant reduction in enrollment could leave a plan with much higher than the typical 25% claim liability corridor, based on the reduced headcount.

Minimum Attachment Point Example

Expected Claims: $800 PEPM

Monthly Attachment Factor (MAF): $1,000 PEPM

	Enrollment	Actual Claims	Maximum Claim Liability (MAF x Enrollment)
Jan	500	$520,000	$500,000
Feb	508	$528,320	$508,000
Mar	490	$509,600	$490,000
Apr	400	$416,000	$400,000
May	300	$312,000	$300,000
Jun	325	$338,000	$325,000
Jul	300	$312,000	$300,000
Aug	250	$260,000	$250,000
Sep	250	$260,000	$250,000
Oct	250	$260,000	$250,000
Nov	250	$260,000	$250,000
Dec	250	$260,000	$250,000
		$4,235,920	**$4,073,000**
	Minimum Attachment (MAF x Jan enrollment x 12 x 95%)		**$5,700,000**

Here, while actual claims hit $4.2m, whereas the maximum liability based on the Monthly Attachment Factor is $4.0m; no aggregate claim is payable because the "Minimum Attachment Point" is $5.7m. So the claims would have to hit $5.7m before any aggregate claim reimbursement.

The COVID-19 situation is changing hour by hour and we recognize these observations are very fluid. The intent of this document is to provide insight into current plan considerations and how the current COVID-19 case trajectory could impact the larger healthcare and health insurer market.

Estimated Cost of COVID-19 Treatment – Insured and Self-insured Plans

From the Society of Actuaries Research Brief Impact of COVID-19, March 25, 2019

Data about the cost and utilization of treatment for individuals who are diagnosed with COVID-19 still appears to be emerging.

"On March 24, **Covered California**, an **independent** part of the California state government whose job is to make the health insurance marketplace work for California's consumers, **released a national projection of health care costs due to COVID-19.** Estimated one-year projected costs related to treatment and care of COVID-19 in the U.S. commercial health insurance market, which covers a population of approximately 170 million people, ranges from a low of **$34B to $251B or more.*** As a percent of commercial health premium, these costs could range from about **2% to over 21%** of premiums. Covered California also estimated that 2021 premium **increases could range from 4% to 40%** if carriers seek to recoup 2020 costs, price for the same level of costs for the 2021 calendar year and seek to protect their solvency"

** Society of Actuaries*

AHT Perspective

We believe the COVID-19 event will ultimately have an impact on the commercial health insurer market, however our assessment is based purely on recent published metrics that would project costs to a lesser degree. Two (2) considerations between our estimates and Covered California would be number of commercially insured and percent of annual commercial healthcare costs.

- Based on the above declaration, we used Kaiser Family Foundation number of private commercial insureds of **153M v. 170M**

- While $34B would be roughly 2% of private healthcare spend in the $1.9T commercial market, $251B is closer to **13%, not 21%**

As of April 5, 2020, there are **327,252 COVID-19 cases** and **9,536 deaths**.

If the data suggests the cases will double every 6 days, by April 26, 2020 there will be 2,665,384 cases and by May 10, 2020, there will be 10,661,536 cases. **Using current projected deaths of 75,000 to 305,150 in the US,** and a current **2.86% death rate,** the range of cases of **2.67M to 10.7M** cases could be plausible.

- Our estimates only contemplate the impact to commercial insurance, therefore our hospitalization and critical care estimates make downward adjustments for public healthcare, such as Medicare and Medicaid;

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- Consistent with the CDC, and WHO, **19-20%** of cases will be hospitalized, hospitalizations for those under 65 would be **410,469 to 1,641,877**;
- At **5%** ICU rates, **102,617 to 410,469** critical care admissions for those under 65 would be projected;
- Using estimated per COVID-19 hospitalization per case cost for private insurance as reported FAIRHealth of **$34,221**, the above estimates would range up to **$19.6B** correlated to **2.67M cases** and **$78.4B** correlated to **10.7M cases**;
- As a percent of commercial health insurance premium, these costs would range between **2% and 4%** of total annual commercial healthcare spend;
- Unless the COVID-19 crisis continues well into Q3 or Q4 of 2020 and is expected to continue into 2021, the prospective rate increases would not be nearly as impactful as some publications are suggesting. In fact, S&P Global Ratings is reporting expected COVID-19 losses up to 4% could likely be absorbed by most insurers without significantly impacting reserves;
- Unless the crisis continues far beyond the next 1-2 months, and/or hospitalizations rates are twice the current 20% rate, we would not anticipate total impact of COVID-19 to reach beyond $100B to $150B, on the high end.

Summary of AHT Impact to Employer-Sponsored Plans

- For our self-funded clients, IBNR calculations may be artificially manipulated by the change in claim utilization patterns due to the implications of COVID-19;
- For our self-funded clients, we advise there may be some aggregate reinsurance exposure if layoffs and/or furloughs impact the enrollment on the plan;
- The confluence of decreased enrollment, economic impact of COVID-19 and reinsurer calculus of "minimum attachment point" should be monitored closely;
- COVID-19 will have a significant impact on healthcare costs, however the degree of this impact will have numerous variables, such as extent of crisis, percent of hospitalizations, and degree of impact based on geographic locations;
- We have seen published predicted COVID-19 healthcare costs up to $250B or higher, with projected increases to premium of 4% to 40% in 2021, however, we take a slightly less bearish position based on current data as of April 5, 2020 and presumed flattening of the curve over the next 5-6 weeks.
- Our projections are predicated on overall cases of 2M to 10M and per case and hospitalization costs of $38,221. $19.6B to $78.4B of hospital costs could be estimated based on these cases and costs.
- If we assume the remaining 75% of non-hospital cases require nominal expense of $800 to $1,200 per case, this would take overall costs to approximately $21.5B to $85.8B for cases ranging from 2.67M to 10.7M COVID-19 cases.
- Prolonged continuance of the crisis, or greatly increased hospitalization rates, could significantly impact projected costs.

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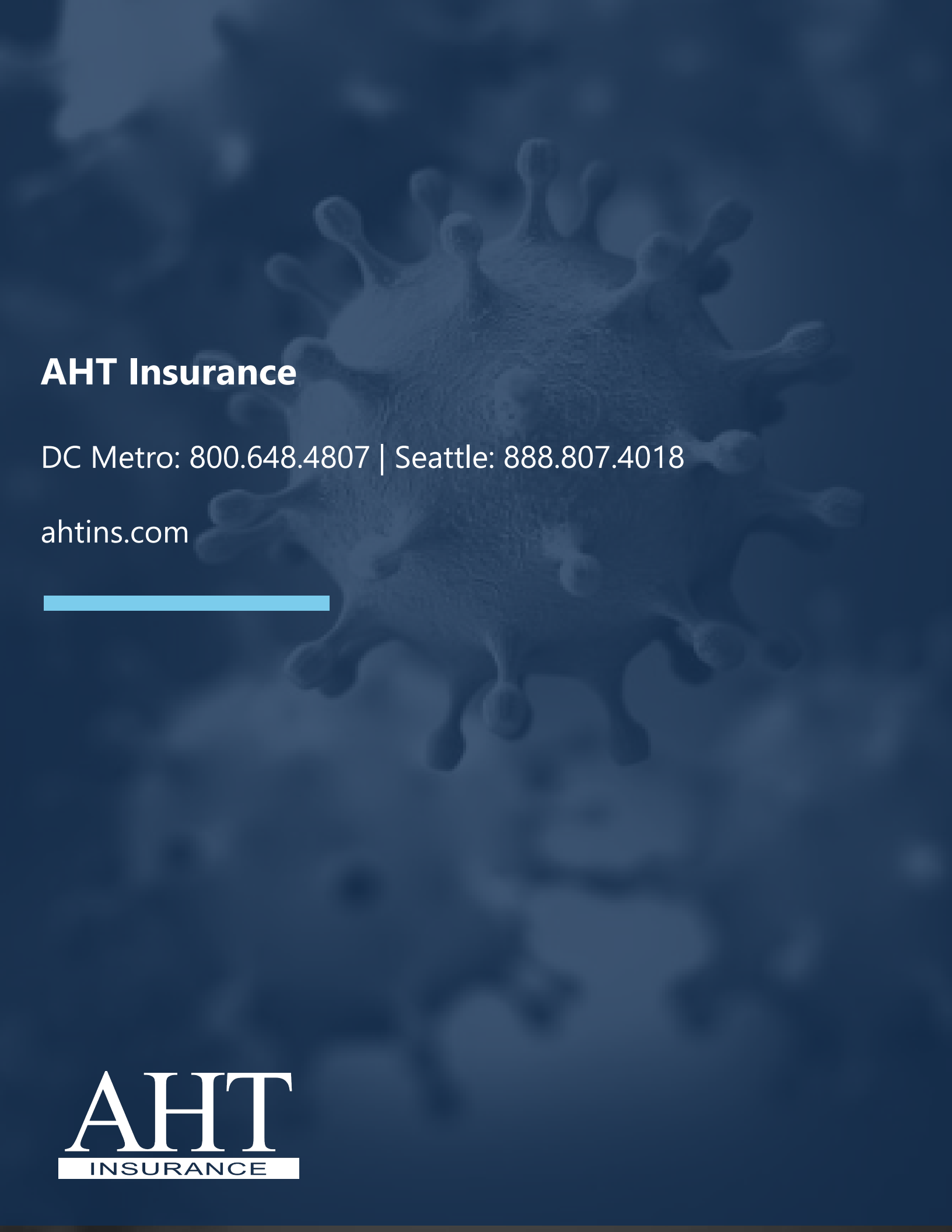

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