

U.S. Health Reform—Monitoring and Impact

# The COVID-19 Pandemic – Insurer Insights Into Challenges, Implications, and Lessons Learned

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at [www.rwjf.org](http://www.rwjf.org) and [www.healthpolicycenter.org](http://www.healthpolicycenter.org).

## INTRODUCTION

The novel coronavirus (COVID-19) pandemic has placed enormous pressure on virtually all facets of U.S. society, including the economy, family livelihoods, the health of millions of people, and the health care system. Much attention has appropriately been placed on the efforts of health care providers to deliver care to those infected with COVID-19. However, less is known about the experiences of the health insurers who reimburse the health care providers for the care they deliver, as well as insurers' insights into what the pandemic might mean for public and private insurance coverage, insurance premiums, and benefits going forward. We discussed issues related to the pandemic with representatives from 25 insurers from April 16 - June 9, 2020. Their impressions of the ongoing ramifications of the pandemic and their response to the crisis are summarized here\*:

- Insurers entered the COVID-19 crisis in a strong financial position and, as a result, have been able to assist providers and consumers financially by decreasing paperwork barriers and making it easier to access care faster.
- While the majority of insurers expect the economic downturn and rising unemployment rates to have a significant impact on their employer business, most have not yet seen a significant drop in coverage among employer clients, especially those offering large group coverage. Insurers are most concerned for their small employer clients and expect that many will drop coverage as federal support declines and the crisis persists.
- Insurers anticipate large increases in individual marketplace enrollment in the coming months, though this enrollment has been slow to materialize so far. Insurers are taking steps to prepare for members' coverage transitions and believe their companies are ready to absorb higher enrollment, if and when it comes.
- Insurers' Medicaid enrollment is increasing at a faster pace than their marketplace enrollment, though still at a slower-than-expected rate. Insurers are split on whether their states' Medicaid programs are prepared to process and serve a potential influx of enrollees.
- Insurers have taken a number of steps to assist providers who are struggling financially, including accelerating payments, offering loan assistance support, and making payments on value-based contracts, regardless of initial targets. Insurers have concerns about how the crisis might affect their longer-term relationships with providers, including whether it will trigger increased consolidation, cost shifting, and demands for higher reimbursement.
- Insurers' experience with COVID-19-related costs thus far leads them to believe that the financial impact on 2021 costs (and thus premiums) is likely to be minimal. However, insurers face a significant degree of uncertainty that could impact premiums in the long run, including whether they will be required to cover multiple COVID-19 diagnostic tests, as well as antibody tests, and how much elective and deferred care will return.

\*This report reflects federal and state policies and interview findings as of June 9, 2020. Policies and industry trends may have evolved since this date.

- Most insurers feel that the COVID-19 crisis has not prompted a need to change benefit designs to any great degree, though they believe that telehealth benefits are here to stay and the use of alternative care settings will likely expand.
- Insurers acknowledge that changes to the health care system are needed to address health disparities, especially racial and ethnic disparities, but they are unsure of where to begin, how to finance these efforts, and how to spark meaningful change.
- Though insurers have only begun to identify “lessons learned” from the early phases of the pandemic, this experience has better prepared them to some extent for what is to come.

## BACKGROUND AND APPROACH

In January 2020, the first confirmed case of coronavirus was reported in the U.S. and the World Health Organization declared the coronavirus spread to be a public health emergency of international concern.<sup>1</sup> By March, the U.S. led the world in coronavirus infections<sup>2</sup> and, as of June 2020, the disease has infected over two million individuals in the U.S. and over 115,000 have died as a result.<sup>3</sup> As the virus spread, Americans’ day-to-day lives changed dramatically. Individuals in most states were placed under stay-at-home orders, schools transitioned to online environments, and consumers’ engagements with the health care system were significantly restricted as hospitals and providers prepared to triage a surge in individuals with COVID-19 infections. As the crisis continues, it has forced the health care system to confront critical issues in operations, including a shortage of personal protective equipment (PPE) and the availability and affordability of testing for COVID-19 detection and treatment for those with and without health coverage. It has also spurred difficult economic realities, leading to historic job losses and the potential for loss of health insurance coverage.

Many experts predicted early on that large numbers of workers and their family members would lose or be required to change their health insurance coverage as they experienced job and income losses due to the pandemic.<sup>4</sup> But, a change in coverage might not mean a drop in coverage. Unlike earlier economic crises, the existence of the Affordable Care Act (ACA) could help to blunt some of the coverage losses due to COVID-19, thanks to the availability of subsidized marketplace plans and expanded Medicaid programs (in most states). As one analysis shows, the share of the unemployed who are uninsured fell dramatically (about 20 percentage points) after the ACA’s coverage reforms were implemented, predominantly through higher levels of Medicaid and nongroup insurance coverage.<sup>5</sup> As a result, it is safe to anticipate that pandemic-related decreases in employer-based insurance could lead to higher levels of Medicaid and marketplace subsidy eligibility and enrollment.<sup>6</sup>

As consumers transition between job-based and other coverage options, it is important to understand the role that the insurance industry has played in responding to the COVID-19 crisis and its experience to date. Almost immediately, many insurers took steps to ease consumers’ issues with access to care by covering and waiving cost sharing for COVID-19 testing; some did the same for the services needed to treat COVID-19.<sup>7</sup> Many also tried to make it easier for providers to focus on patient care by reducing administrative burdens.<sup>8</sup> Although many insurers took these steps voluntarily, federal and state regulators also issued benefit and coverage mandates to ensure that consumers were obtaining COVID-19 care without financial barriers.<sup>9</sup> In just a few months, the insurance industry has witnessed the profound impact of COVID-19 on the health care system, as utilization of non-COVID-19 related medical care has dropped precipitously, some providers have struggled to remain financially viable, and employers have struggled to keep their employees’ health plans intact. During this time, insurers have adjusted benefits to permit broader use of telemedicine, offered flexible financial arrangements for those unable to pay their premiums, and invested in community efforts that may help to address some of the root causes of disparate COVID-19 outcomes.

In many ways, health insurers are in a uniquely advantageous position to provide early insights into the implications of the pandemic, as they interact directly with health care providers, employers, government officials, and consumers. While company strategies vary, insurer experiences in employer, nongroup, and Medicaid markets allow them to assess how coverage is shifting across markets, how costs associated with testing and treatment are affecting overall health care spending, the extent to which different types of providers are experiencing financial distress, and how federal and state regulators and program administrators have and have not been prepared to assist. Their experiences to date can help inform policies that could improve our ability to respond to future pandemics, economic downturns, or other disruptions.

To better understand early insights into the implications of the pandemic on the health coverage system from the perspective of insurers, we conducted structured interviews with executives of 25 insurance companies collectively representing private markets of all sizes in all states and the District of Columbia. The companies included for-profit

insurers operating nationally or across multiple states; nonprofits operating regionally or locally and at least one local insurer in each of the following states: California, Colorado, Georgia, Illinois, Louisiana, New York, Virginia, and Washington. Interviews were conducted from April 16 through June 9, 2020.

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## FINDINGS

### **Insurers Are Well-Positioned Financially to Navigate the Crisis, At Least For Now**

While hospital and health systems have struggled financially during the crisis to afford the costs of providing additional care to patients and equipment to providers,<sup>10</sup> health insurers have largely not been financially burdened by COVID-19, to date. As the crisis emerged, insurers reported that they successfully transitioned the majority of their staff to work from home and collaborate through a virtual environment. Insurers explained that there were few hiccups, if any, in continuing their regular operations and sales. To prepare for a potentially high volume of COVID-19-related claims, insurers reported acting quickly to strengthen their financial footing. For example, some reported preparing for the worst by enhancing their liquidity, drawing down additional lines of credit, and taking stock of their reserves. Even before the COVID-19 crisis had fully materialized in the U.S., many for profit insurers had previously publicly reported strong revenue gains at the close of the first quarter of financial earnings for 2020.<sup>11</sup>

Insurers, therefore, went into the crisis on solid financial ground and their financial position has continued to strengthen as the crisis has continued. Most insurers we interviewed reported that as much as 30 to 40 percent of elective care has been deferred, resulting in substantially less overall spending than in a typical year. In addition to spending less overall, insurers' COVID-19-related claims have been lower than anticipated and, to date, they have not had to dip into the financial resources that they secured in March. While this trend in claims could change at any moment, no insurer we interviewed expressed concern with their current financial standing. Because of this strong positioning, insurers were able to assist providers and consumers financially by decreasing paperwork barriers, such as prior authorization requirements, and making it easier to access care faster. Some insurers used their excess cash to support their primary care providers and hospitals with advances or other support, while others redistributed their higher-than-expected revenues in the form of premium rebates to consumers. As one insurer put it: "Without being in good financial shape, we couldn't have done that."

### **Employer Business Remains Surprisingly Stable, but Concerns that Small Employer Clients will Drop Coverage Persist**

#### *Employer Business Remains Stable*

As the COVID-19 crisis evolved, the majority of insurers expected that the economic downturn and rising unemployment rates would have a significant impact on their employer business. However, despite unemployment rates reaching the highest levels since the Great Depression,<sup>12</sup> most insurers interviewed were surprised to report that they have not yet seen a significant drop in coverage among their employer clients. One insurer who expected to see "material membership reductions" instead stated being simply "shocked and not sure what to make" of their employer business remaining so stable. Another insurer described that the number of employers dropping coverage is no higher than what they would expect to see in a regular quarter. A third insurer claimed that its steady employer-based enrollment simply does not "correlate" with the rising unemployment rate.

Although insurers did not yet have data to fully understand why the employer block of business has remained largely unchanged during the crisis, many offered explanations as to why this trend might be occurring. For one, insurers were quick to point out that many of the sectors hit hardest by the crisis, including the entertainment, retail, and restaurant industries, tend not to offer health insurance benefits in the first place. Next, despite the challenging economic circumstances, insurers described a "hold-on mentality," with some of their employer clients having a "degree of optimism that the lock down will lift and there will be a return toward normalcy." Early in the crisis, some employers believed that the economic rebound would be faster than that experienced during the 2008 financial crisis. Therefore, instead of letting employees go, many employers have embraced the concept of "furloughing" staff, meaning they are no longer on payroll but are allowed to maintain benefits, including eligibility for the group health plan. As one insurer described: "There's at least an interest with some of these groups to – even if they've reduced hours – continue making premium payments for employees' health care coverage." Several insurers conveyed that many employers are "just trying to support employees as

best they can.” Further, many insurers were confident that at least some of these impacts have been stalled by a significant number of their at-risk employer clients taking advantage of the Payment Protection Program (PPP), established by the CARES Act.<sup>13</sup> One insurer stated that the PPP was “working, that the money made available to small employers has been helping, and gives them extra cash to continue paying for insurance.” Still, some interviewees cautioned that furloughs could turn into permanent layoffs and cause a meaningful change in their employer business in the coming months.

For most insurers, if a significant number of employer clients drop coverage, the loss of revenue would have a greater impact than other crisis-related factors. Insurers, anticipating “dire losses” in their employer business at the start of the crisis, have offered employers mid-year open enrollment periods, more flexible payment arrangements, and longer premium “grace periods” than those required under state law. Among the insurers that have extended their grace periods, most report that an increasing number of employers are taking advantage of the flexibility. Some insurers have quietly implemented a company policy to not terminate employer clients for lack of payments during the first few months of the crisis. As one insurer put it: “We’ve been clear that our top goal is to keep [] employees in the group sector . . . because we would prefer they stay in the group market than chance them going to the individual market and never coming back.” However, insurers expressed concern that as federal PPP funding dries up, “customers’ ability to pay premium[s] might get harder.” For example, one insurer worried whether “companies will be able to sustain [their plans through] June and July.”

#### *Small Employer versus Large Employer Book of Business*

Overall, insurers expressed far more concerns about the future of their small employer clients – defined, in most states, as those with 50 or fewer employees – than their large employer clients. For the most part, the insurers reported that their large employer clients have maintained their plans and interviewees expressed little concern about upcoming coverage losses. Still, some characterized large employers’ experience thus far as a bit of a mixed bag, with one insurer depicting a “tale of two cities.” This insurer noted that some sectors, such as technology firms, have actually been “growing by tens of thousands” during the crisis, while other large employer clients, like school districts, were “shrinking slightly.” A number of insurers explained that if their large employer clients were experiencing financial difficulties, they were more likely to seek modifications to their policies (e.g., reducing benefits, increasing cost-sharing) than to drop coverage altogether. As noted above, many insurers indicated that it

was in their best interest to accommodate these modification requests, when possible.

Insurers also raised few solvency concerns about their self-funded clients. One insurer noted that while self-funded plans are “not completely immune to economic stresses,” it has seen some actually expand coverage of services, like telehealth, during the outbreak. Another insurer posited that self-funded employers might stand to gain during the crisis “to the extent that their claims savings are bigger than any of the direct COVID[-19] costs.”

On the other hand, insurers expressed numerous concerns with their small employer clients. As one insurer described: “Small businesses are cash business[es], they’re month to month, and, even in a good economy, they go bankrupt.” While most insurers did not have a confident estimate of the number of small employers that are likely to drop coverage, early indications suggest that a wave of disruption is on the way. First, many insurers reported that a higher number of small employer clients than usual are already in payment delinquency, in one case, double the number than in a typical year. Second, a few insurers reported an abnormal increase in calls from their small employer clients. For example, one insurer that predominantly sells to small businesses said: “We didn’t have a huge disruption initially but we are [now] having a lot of [small] employer groups calling and saying, ‘What kind of payment plan can I do?’” Some insurers have already started to see their small employer numbers decline. Most insurers expect these declines to continue as clients exhaust their PPP benefits and reach the end of their grace periods.

#### **Increased Enrollment in the Individual Market is Expected, But Large Increases Have Not Yet Materialized**

While many insurers we spoke with anticipate large increases in individual marketplace enrollment in the coming months, this additional enrollment has been slow to materialize. Voicing a common observation, one insurer explained that despite offering a special enrollment period for individual market coverage: “We haven’t seen many [new enrollees]. The unemployment rate went up significantly, but we haven’t seen people yet migrating . . . we expect that to change over the next few months.” Insurers expressed similar sentiments about the individual market as they did with the employer market, noting that the use of PPP funds and furloughing has likely created a lag in coverage transitions.

For those insurers who *are* beginning to see coverage changes, some are taking steps to ensure a smooth transition. For example, they have deployed agents or brokers to give departing employees information on marketplace policies as they disenroll from employer plans. Others are offering

websites that allow people to directly enroll in marketplace coverage. As one insurer explained, “We built a cross-channel opportunity and website communication tools to help group customers and people being laid off, furloughed, or let go from group insurance understand what’s available in the individual market, commercial market, and Medicaid.” This insurer felt that it is “a big part” of their role to help customers understand what their options are (and presumably to encourage them to remain with the insurer through its marketplace offerings). Another insurer described working with the business community to make sure they are aware that the marketplace remains an option for employees losing employer-based coverage. Many insurers also applauded the outreach efforts made by state-based marketplaces that have been promoting special enrollment period opportunities for uninsured individuals and lamented the absence of such efforts on the part of the federally facilitated marketplace (FFM). Interviewees were concerned that the FFM had not led an outreach campaign during the crisis to inform individuals who have lost jobs that they are likely to be eligible for financial help, have access to numerous coverage options, and need to act within a 60-day special enrollment window to obtain marketplace coverage.

At least two insurers with whom we spoke sell short-term plans as well as marketplace coverage, and were directing employees to both types of plans. Short-term plans are not guaranteed issue and set premiums based on an applicant’s health status. They may appear low cost for the young and healthy compared to more comprehensive coverage, but they do not cover the ACA’s essential health benefit requirements and often come with substantial limits and exclusions on benefits. Enrollees in these plans are also not eligible for the premium tax credits that are offered for marketplace plans.

Most insurers felt that the state-based marketplaces and their own companies are prepared to handle a large influx of individual market applicants, if and when demand materializes. Some pointed to the IT preparedness and regular testing conducted by their state-based marketplaces, while others praised the executive staff at these marketplaces, saying they are easy to communicate with and anxious to address any technical problems that arise. Many likened the potential influx of applicants to the heavier enrollment they experience towards the end of the annual open enrollment period. Multiple insurers raised concerns for their members living in FFM states. As one explained, “The FFM, of course, has downgraded its call center and its system is on life support. And so I think that, if they had a big surge, it might be a little more difficult.” Another commented that the Centers for Medicare and Medicaid Services (CMS) had asked them to keep volume off the FFM, explaining, “They’re not ramped up.”

Overall, insurers were confident about the ability of their plans to absorb higher enrollment. In fact, some national insurers had already been planning to expand their footprint in the marketplaces, and the pandemic has not altered those plans. A few insurers noted that the summer months are also the time in which they typically begin to hire seasonal staff to prepare for the fall open enrollment period. One explained that they “ramp up starting in August for open enrollment . . . [and] bring in hundreds of temporary staff” to assist with the process. This year, these “ramp ups” will coincide with potentially new COVID-19-related applicants; staff will likely need to manage this volume in a work-from-home environment.

### **Medicaid Enrollment Is On The Rise, But Even Larger Increases Are Expected**

In some states, insurers reported that Medicaid enrollment is increasing at a faster pace than marketplace enrollment, though still at a slower-than-expected rate. Insurers universally felt that Medicaid enrollment increases will ultimately far outpace marketplace increases in the states that have expanded Medicaid, given the reduced incomes resulting from widespread job losses, Medicaid’s greater affordability and comprehensiveness, and the fact that the program does not have a limited enrollment period. However, insurers reported that enrolling in Medicaid may be taking a back seat to consumers’ other needs, such as unemployment compensation and food stamps. Another suggested that, given shelter in place orders, people were not enrolling in Medicaid unless and until they were sick. Some insurers also indicated that there is still confusion among employees as to whether they and their family members are even eligible for Medicaid, especially since some unemployment checks provide higher payments than some employees’ typical salaries. They suggested that more education was needed to explain what income did and did not count for purposes of determining program eligibility.

When asked whether states’ Medicaid programs were prepared to process and serve a potential influx of enrollees, insurers had mixed reactions. Insurers in states that had expanded Medicaid after the start of the 2014 reforms felt that the systems and marketplaces were particularly well prepared for a large influx of applicants. One insurer stated that all the Medicaid plans in their state would eagerly take on additional enrollment. There was also little concern about insurers’ networks being able to manage large numbers of new Medicaid enrollees. However, some acknowledged that providers would likely not be happy about so many individuals shifting from private coverage to Medicaid, due to the latter’s lower reimbursement rates. A small number of insurers expressed some apprehension about whether their

states' old Medicaid IT platforms and enrollment systems would be able to efficiently handle high demand. And many insurers acknowledged the financial toll that COVID-19 is likely to have on state budgets, including the impact an explosion of new Medicaid enrollees could have on already-strained finances.

### **Some Providers Are In Financial Trouble And There Are Concerns about Further Consolidation**

The COVID-19 crisis has had a significant negative financial impact on physicians and hospitals. As office visits and elective procedures were halted during the stay-at-home orders, many providers saw their revenue fall dramatically. This has affected both hospitals and physicians, though the impacts have not been felt equally. Physician practices who are not providing direct COVID-19 treatment or testing and who have been largely restricted by law from providing non-essential care have seen significant reductions in revenue. This has been particularly true of primary care physicians and obstetrician-gynecologists. Smaller independent physician practices of all specialties have also been hard-hit as the CARES Act's Provider Relief Fund dollars were mostly targeted at supporting major hospital systems. One insurer noted, "When the CARES Act got put together, the medical societies . . . got shut out behind the hospitals." Federal lawmakers have reported that some providers treating vulnerable populations, such as federally qualified health centers (FQHCs), and other safety net providers have not yet received money from the CARES Act, though the Department of Health and Human Services recently announced plans to allocate additional funds to these providers in future rounds of federal relief.<sup>14</sup>

Beyond the lack of stimulus funding, physician practices have also had to grapple with other operational issues. For instance, many providers quickly switched to providing telehealth services for patients in part because it allowed them to maintain some source of income. However, some providers were reluctant or unable to make the full transition to telemedicine. Insurers mentioned several reasons why some providers did not take up telehealth, including that some did not have the technology and systems in place to make this transition swiftly or easily. Others providers feel that in-person visits are crucial to achieving a positive outcome.

In order to aid providers, many insurers have taken or are considering taking a number of actions. In addition to providing advanced payments and reducing administrative burdens, as mentioned earlier, insurers have worked to process claims faster to ensure that reimbursements flow to providers as quickly as possible. Some insurers mentioned that they were making payments on value-based contracts, regardless of whether the quality or cost-savings targets had

been met. For instance, one insurer described paying up-front the rate consistent with practices' previous year's metrics, instead of setting payments to be made in 2021 based on 2020 performance, as originally planned. If a provider ends up exceeding its prior year's targets it will receive additional payments, and if they end up not performing as well, they still get to keep the initial payment. The same insurer noted that their providers using capitated payments were faring substantially better since the capitated payments were being made on schedule and were not dependent on the utilization of services. As a result of the crisis, several insurers said that in future negotiations they would encourage more of their network providers to move to capitated rates because it would both help to contain costs in typical years and provide support in the event of future crises or a second wave of COVID-19. Some insurers reported that providers themselves have expressed growing interest during the pandemic in moving to capitated payments.

Though insurers are making these funding sources and loan assistance support available to independent practices in their networks, many interviewees were surprised that provider take-up of such support has not been higher. Only a few insurers we spoke with indicated that the demand from their providers for these resources was high, while the majority of insurers said that it was not. While our respondents could not identify the reasons for varied demand, many suspected that providers were taking advantage of either the PPP or the Provider Relief Fund, preferring to take federal bailout dollars over money from insurance companies.

Many of the insurers we spoke with expressed concerns about how the crisis could affect their longer-term relationships with providers. There was widespread worry that this pandemic would exacerbate existing problems, in particular that it would lead to more consolidation among providers. With large numbers of independent practices currently under financial strain, more could be open to offers to merge with large hospital systems. Virtually all insurers indicated that, based on experience, this consolidation would translate into demands for higher reimbursement rates as larger practices and health systems gain greater negotiating leverage. However, at least one factor has the potential to mitigate such an outcome. One insurer reported that private equity groups – who, in recent years, have been buying up physician practices and emergency department services – have also been struggling with the economic fallout of COVID-19. Large hospital systems that might want to acquire more physician practices have also been affected. This means there are fewer entities with the financial capital to buy smaller independent practices. Still, the financial incentives are strong

for independent practices to band together or to join larger health systems in order to weather this and future crises.

A number of insurers also said they were worried about cost shifting, even though some studies have shown that payment rate reductions in public programs do not lead to higher prices in private insurance.<sup>15</sup> However, assuming large job losses lead to a substantial shift from enrollment in employer-based plans to Medicaid and marketplace coverage (both of which tend to pay providers at lower rates than commercial insurers in the employer market), insurers worry that hospitals and providers may make up lost revenue by increasing the prices charged to commercial insurers. One large national insurer reported that they have already been asked by providers to renegotiate rates mid-contract to increase payment rates. Providers may feel that they have increased leverage right now to negotiate, since insurers are largely unable to terminate a relationship with a hospital in the middle of the pandemic. Indeed, some insurers and hospitals that have been publicly engaged in contract disputes since before the outbreak have put these disputes on hold so that consumers can continue to receive in-network care during the emergency.<sup>16</sup>

A handful of insurers we spoke with stated that labs have started to increase their billing rates for COVID-19 testing, another way they have been able to make money since federal law requires insurers cover and waive cost-sharing for COVID-19 testing and related services.<sup>17</sup> Finally, one insurer predicted that if provider practices fail, there could be provider supply shortages among at least some specialties and primary care. Although this viewpoint was not widespread, it is important to consider the potential effects this could have on access to care during the pandemic as well as in the future.

### **Cost of COVID-19-Related Care Thus Far Has Been Lower Than Initially Feared, Implying Low Premium Increases For 2021**

#### *In The Short Term, The Financial Impact of COVID-19 on Insurers is Likely to Be Minimal*

The general consensus from insurers is that overall claims are currently down substantially as non-urgent medical care and COVID-19-related costs are less than expected. First, care utilization dropped dramatically in the early phase of the crisis. While some insurers anticipate that claims for elective procedures will rise by the end of 2020, they still expect claims for elective care to be down 20-30 percent for the year. Most agreed that deferred and elective care will not come back “one-for-one” in 2020, and that services like dental cleanings and rehabilitation appointments might be skipped altogether. In some cases, treatment may no longer be needed, such

as for a minor back injury that has since healed. Second, while the treatment of COVID-19 cases has led to some new costs for insurers, most indicated that these costs have not been as high as originally expected. There is considerable geographic variation in COVID-19-related costs, with testing and treatment costs in New York, for example, being much greater than in other states. Even in New York, costs upstate have been low compared to the costs highly concentrated in New York City. However, since many people diagnosed with COVID-19 have been instructed to stay at home and quarantine, most patients have imposed very little costs on insurers. For those that are hospitalized, insurers report that treatment costs tend to range from \$50,000 to \$100,000 per episode. For example, one insurer described having a high volume of members being hospitalized and requiring ventilators early on in the crisis and said that those costs were much greater than for an average case of pneumonia. But the insurer noted that over time, the treatments for COVID-19 have become more standardized and care more efficient, leading to a reduced need for ventilators and more predictable costs. Overall, respondents generally indicated that the costs of hospitalizations have been manageable and that the financial impact in 2020 has been “minimal” to date.

#### *Factors That Might Influence Premiums in the Long Run*

Still, insurers emphasized that they continue to face a significant degree of uncertainty, such as: When, and how severe, will a second wave of COVID-19 be? When will consumers feel safe seeking non-COVID-19 related care again? How many employers will drop coverage? Will they be required to cover testing costs for millions of asymptomatic people?

#### *Coverage of Testing*

Insurers consistently voiced concerns that as COVID-19 testing ramps up and if individuals begin receiving multiple diagnostic tests as well as antibody tests, testing costs could skyrocket, particularly if they must continue to waive cost-sharing. While the cost of each test is relatively low, the potential utilization is enormous. For example, one smaller insurer explained that while it has spent only \$5 million on COVID-19-related costs to date, “If every one of [its] members gets tested this year, it’s going to be about \$140 million. A totally different scale.” The cost per test may also increase. CMS is reimbursing approximately \$100 per laboratory test administered to Medicare enrollees,<sup>18</sup> and the largest labs are charging cash prices for those receiving tests that range from \$50 to \$200.<sup>19</sup> As noted above, some providers are charging commercial insurers many times those prices. A number of insurers mentioned that employers could begin testing workers daily as a condition of re-opening, and that demand for antibody tests could soar as well. One insurer explained:

"A big unknown for us and all blocks of business is how much utilization there is going to be on antibody tests. That could be a significant cost that nobody planned for." While the majority of insurers support "paying for testing in clinical situations when it's needed and ordered by the practitioner to diagnose and treat individuals," they argued that regular and widespread testing for surveillance purposes should be considered a public health expenditure.

### *Elective and Deferred Care*

While many elective procedures postponed during the crisis are generally expected to be provided in the future, the timing is unclear. Some providers are informing insurers they will perform elective surgeries on weekends to "catch up" once the demand returns. In some geographic areas, that has already happened. One insurer reported, "We are seeing a rapid return of non-COVID-19 services, so I don't know where we will land. We doubt that the amount of care will come back to 100 percent, but we do see it coming back rapidly." There is also some concern that individuals who delayed care for chronic conditions during the pandemic could end up being sicker, adding to aggregate costs.

### *Actuarial Uncertainties*

Insurers broadly expect 2021 premium increases to be modest or even zero, although many reported that their actuaries are modeling a wide range of possibilities. Insurers' general consensus is that COVID-19 infections could decrease in the latter half of the year, but then re-surge in 2021. But, if this is the case, insurers expect that social distancing measures would be implemented much more widely and quickly than in 2020. To the extent that COVID-19 cases increase significantly in 2021, insurers predict that non-COVID-19 care would fall off again as it did in 2020. One respondent stated, "In 2020, non-urgent care costs decreased faster than COVID-19 costs were increasing. But we need to set 2021 premiums based on expected 2021 claims. In general, we do not expect a repeat of 2020."

Because of such projections, while 2021 premiums had not yet been set at the time of our discussions, our sources anticipated that any premium increases in 2021 would be small. Some insurers did, however, articulate a worst-case scenario in which the number of COVID-19 cases could be much higher if people became less committed to social distancing, that testing for both infections and antibodies could greatly expand, and that it would not be as feasible to defer as much non-COVID-19 care compared to the experience thus far. If this situation materialized, costs in both late 2020 and 2021 could be much higher than generally expected. When asked what 2021 expenses would look like, one insurer summarized: "We are doing a ton of scenario

planning. If anybody's going to be honest, they are going to say, 'I don't know; there are so many variables.'" Due to these uncertainties, some insurers have worked with state regulators to ensure that they are able to revise their 2021 proposed premium rates, if a major resurgence of COVID-19 occurs over the summer or there are policy changes requiring them to expand coverage (e.g., mandates to cover asymptomatic testing).

### **Telehealth Is Here to Stay And the Use of Alternative Care Settings May Expand**

#### *Benefit Designs*

Hardly any insurers felt that the COVID-19 crisis has prompted a need to change their benefit designs to any great degree. Beyond waiving cost sharing for COVID-19 testing and treatment and temporarily reducing the use of utilization management tools like prior authorizations, the majority of insurers reported that their benefit designs are comprehensive and have worked well during this period. At the beginning of the crisis, a few insurers expressed a willingness to adapt their designs, if needed, as one insurer described: "We'll see what COVID[-19] demands." But, ultimately, only a few insurers saw the need to make immediate changes, such as more clearly stating when prior authorization applies in consumers' policy documents and allowing early pharmacy refills for policyholders needing to self-quarantine.

At the same time, the pandemic has caused some insurers to question how much of the health care services delivered today are "really needed." For example, one insurer noted: "If we see a 40-50 percent drop in claims costs [for] deferred care, what does that really say about what is core health care?" Another insurer characterized the COVID-19 crisis as "a big experiment in rationing," since most consumers have only been able to access care if it is an emergency or COVID-19-related. While not yet clear whether the deferral of services is leading to worse health outcomes or whether some of this deferred care is needed – just not right now, some insurers suspect that at least some of these services are not truly medically necessary. A few insurers plan to analyze utilization patterns during the pandemic to better understand what services are or are not needed, and hope that this experience will drive a conversation about over-consumption in the health care system today.

Once the COVID-19 crisis lessens and the temporary regulatory changes made to benefit designs are lifted, one insurer also noted that there will be a need to re-educate consumers on their benefits. For example, this insurer worried that there may be "lots of complaints and confusion and appeals" once cost sharing is imposed again, and that

“resetting customer’s expectations is going to be really tough.” While consumer-friendly tools like flexible spending accounts were adopted for some during the outbreak and economic downturn, many of these policies will not be carried into 2021. The insurer expects that it will be hard to message to consumers why their benefits are reverting to pre-crisis levels.

### *Telehealth*

Though aspects of insurers’ emergency response, like cost-sharing waivers, will likely be rolled back as the crisis subsides, insurers were united in stating that telehealth benefits are here to stay. For years, telehealth services have been promoted as an avenue to improve access to care, particularly in rural areas where meeting with a health professional in-person can be challenging. However, providers and consumers alike have been slow to adapt to and use these services.<sup>20</sup> Insurers echoed this sentiment, saying that while they have offered generous telehealth policies before, the take up has been minimal and when it came to adoption “providers were not there.” Now, telehealth is being used like never before. As the COVID-19 crisis emerged, some health systems reported that their use of telehealth escalated from 700 video visits a month to 70,000 a week and that the number of providers engaged grew from 50 to 7,000.<sup>21</sup> Across the board, insurers explained that most once-reluctant providers quickly moved to telehealth as the virus spread and office visits were restricted. One insurer quantified, “We did more telehealth in April than all of 2019.”

In part, this shift was driven by many insurers reimbursing telehealth visits near or on par with office visits, otherwise referred to as “paying at parity.” The majority of insurers we interviewed reported that telehealth payment parity was one of the first things providers asked for as the crisis set in. These payments have helped providers who have struggled financially. A number of insurers pointed to the speed at which mental health visits in particular transitioned to telehealth platforms. For instance, while some forms of elective care are down as much as 50 percent, one insurer commented that their mental health claims are down just 10 percent. This insurer described that “mental health providers flipped over to telehealth so quickly that they were able to keep assisting members and keep their doors open.” In addition to providing a steady stream of revenue for providers, several insurers commented that their members have largely enjoyed using telehealth. Many insurers pointed to the convenience that telehealth offers and the potential that it can help providers to reach consumers who otherwise might delay or forgo a needed consultation. While insurers acknowledge that telehealth will not completely replace office visits, they agreed that the COVID-19 crisis has moved the platform forward in a significant way. Despite the medical

field operating on a “fairly traditional model,” one insurer best summarized: “I think this is probably the event that forced a change. I think a lot of people won’t go back.”

Still, insurers’ praises of telehealth were not without reservation. Insurers raised a number of questions and concerns about the expanded use of telehealth, including whether the services will be subject to fraud and abuse, how to promote quality, how to protect patients’ privacy, and how telehealth regulations that were relaxed during the emergency will be reinstated after the crisis wanes. Some contemplated the challenges of making telehealth available in areas where consumers do not have access to high speed internet and whether this discrepancy further exacerbates health care inequities in the system. Also chief among these concerns is whether insurers will continue to be required to reimburse telehealth near or at parity. Some insurers argued that a phone call consultation should not be reimbursed at the same rate as an office visit. Several insurers said that while payment parity makes sense during a public health emergency, reimbursements should ultimately reflect services rendered, and services delivered over the phone and computer versus in-person can be significantly different. Finally, many insurers commented that there is a risk that telehealth drives up costs and further contributes to overutilization. For example, one insurer described that telehealth should not be “additive,” saying that the company has already seen instances of providers calling consumers to schedule telehealth visits when only laboratory testing was needed. Insurers shared the perspective that telehealth visits should follow medical necessity guidelines.

### *Alternative Care Settings*

The crisis has also highlighted the opportunity to treat patients in alternative care settings that are often less costly and more convenient than receiving care in a hospital. When the crisis began, there were concerns that hospitals might be overrun with patients needing COVID-19 care. To make space and preserve resources, insurers and providers worked together to move patients who were not infectious out of the hospital. For example, one insurer noted easing administrative requirements so that patients could more readily be transferred out of hospital inpatient beds and into post-acute care settings, when appropriate. These efforts helped to keep patients without COVID-19 symptoms safe, while freeing up beds in hospitals for those who needed COVID-19-related care.

Insurers reported that similar efforts have continued in recent months, with much care now being delivered in alternative care settings, including patient’s homes, sub-acute facilities like skilled nursing facilities, long-term acute care hospitals, and rehab centers. As one insurer described: “You don’t always

have to go into a medical clinic to get your service.” This insurer explained that it is now providing more home health services including patient monitoring, so that its members can avoid inpatient care. Another insurer pointed to the availability of “corner stores” that offer diagnostic testing and vaccinations. One insurer even argued that providers’ rates for rendering home care “should be increased,” saying: “We want to move the needle, keep people in the community, keep people in their home, so we’re going to have to pay those providers, those support systems, to do that.”

### **Insurers Acknowledge: Changes to the Health Care System Are Needed to Address Health Disparities, but Unsure Where to Begin**

The United States’ health care system is plagued with health disparities, in which individuals’ health, access to care, and care experiences can differ based on their race/ethnicity, socioeconomic status, gender, sexual orientation, age, and/or disability status.<sup>22</sup> The COVID-19 crisis has, once again, exposed these glaring health disparities, especially racial and ethnic disparities, as Black individuals have suffered a disproportionate share of COVID-19 illnesses and deaths.<sup>23</sup>

The insurers we interviewed reported that they are aware of the racial and ethnic disparities in the health care system, and some are taking steps, albeit limited ones, to address these shortcomings. Some insurers highlighted their efforts to reach out to members facing higher risk of poor health outcomes and use data to determine where disparities exist to better target their initiatives. For instance, one insurer described using data to drive where it implements its pregnancy and chronic disease management initiatives. Another insurer, reflecting on their Black, Latino, and Pacific Islander populations being hardest hit by COVID-19, said that “a big lesson” learned during this crisis is the need to reach out to consumers in those populations with multiple chronic conditions “a lot sooner” to ensure they have access to needed care. One insurer emphasized the work they have done to form a diverse network of providers so that patients of minority groups feel comfortable seeking care. One insurer felt that they had already made meaningful strides in reducing inequities, saying: “We have multi-lingual and disciplinary staff, we do translation, we welcome people into the system with[out] documentation or insurance already.”

Yet insurers acknowledged they need to do more, but few had a clear vision of where to start. Some insurers pointed to their recent investments in social determinants of health (SDOH) – factors like economic stability, education, food, housing, transportation, and health coverage – which contribute to disparities.<sup>24</sup> Still, for commercial insurers these investments are largely done through insurers’ philanthropic arms, and

not reflected in benefit design or payment policies.<sup>25</sup> For many insurers, the COVID-19 crisis has underlined the need for continued investment in these areas. For example, one insurer lamented: “[T]elling people to shelter at home is great unless you’re homeless or unless you live in a congregated living situation.” For this insurer, the crisis has “reinforced” the connection between health and socioeconomic status and has made the company question how it can better integrate social factors into its approach, such as through food and housing investments. Another insurer reported that one out of three of its members has pre-diabetes, so nutrition is a “huge aspect” they hope to address.

However, it is not always clear how to finance and ramp up these initiatives. As one insurer put it: “We’ve been talking about social determinants of health for a long time, but no one has quite figured out how to pay for addressing them.” At least one insurer questioned the potential for real change. As a health plan with just four million members, it asked: “Can we pull this off on our own? Can we accomplish this by ourselves?” Candidly, one insurer explained that their company is “still at a definitional phase” of determining what their work to address equality and disparities will look like.

### **Insurers Are Starting to Consider Early Lessons Learned**

Insurers commonly maintain risk management programs, a key component of which is the assessment of their business continuity and financial solvency in the event of a pandemic. However, it is unlikely any such programs could have anticipated the multitude of business and financial decisions that insurers had to make in response to COVID-19. Many insurers voluntarily took action to expand coverage and reduce other barriers to care before being required to by federal or state law. However, the subsequent federal and state legislative and regulatory response to the pandemic has left some insurers concerned.

First, without a coordinated and comprehensive federal response to coverage issues, insurers that operate in multiple states were faced with trying to navigate different state emergency orders and state insurance department requirements. The diverse approaches across states created challenges for some of these multi-state insurers that were trying to quickly develop uniform policies for all of their members. For example, two insurers noted that some states required insurers to file amendments to their policies and provider contracts in order to waive cost-sharing, expand telehealth availability, or pay telehealth at parity. While these insurers respected the need for regulatory oversight of benefits, they commented that the administrative hurdle of re-filing ultimately served to “hamstring” the insurers from acting faster. In an emergency setting, these insurers

questioned how regulators could adapt these processes to more quickly “get the people care they need or providers the payments that they need.”

Second, many insurers recognized that in a crisis, regulators and legislators need to make decisions quickly, but one insurer argued that this does not always lead to “good policy.” This insurer pointed to state mandates that dropped cost sharing for certain services which “feel good and sound good” in the moment, but are not necessarily helpful in the long-term. They explained that “when [policy makers] say no cost sharing, it doesn’t mean that the share goes away, it means the insurer has to pay for it.” Ultimately, these costs are passed onto consumers in the form of higher rates.

Finally, in some states, insurers suggested that they were left out initially of emergency response discussions, some even months into the crisis. Though insurers acknowledged a need for the medical and scientific community to act first and get a handle on the outbreak, one insurer reported that they continued to be left out of policy discussions that informed that state’s response to coverage and payment issues. This insurer felt “sidelined” and argued that their state took a less than ideal approach, especially since the payment of health care services is critical to consumers feeling comfortable

seeking critical COVID-19 testing and treatment services. “We really had to push our way into a conversation,” one insurer said. In another state, insurers continued to be frustrated with the “lack of dialogue” between state officials and insurers. For some insurers, the lack of engagement and outreach from officials has been perplexing and a missed opportunity, since insurers maintain critical information on their members. This information could have helped states in their emergency responses by aiding in contact tracing, providing a clearer understanding of health needs in the community, and better identifying at-risk individuals.

Looking forward, insurers have just begun to consider “lessons learned” from the early phases of the pandemic. One insurer volunteered that “we’re all feeling our way through” and that no insurer was “as prepared as it could [have been] because no one thought [a pandemic] would happen to this degree.” Another noted, from a policy perspective, “it feels like we should have all of this ready to go [for the next pandemic].” In fact, some insurers were already discussing how to best prepare for the next wave of COVID-19, such as by documenting all of the company’s action to date to inform the development of a “pandemic response plan.”

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## CONCLUSION

The COVID-19 outbreak has had a profound impact on day-to-day life, with repercussions that are likely to be felt for some time. Amidst this crisis, the health care system and its providers and insurers have stepped up in an immediate and substantial way. Insurers are and can continue to play a meaningful role supporting providers on the front lines and ensuring that consumers can access affordable and necessary health care services. Most insurers entered the crisis in a strong financial position, which allowed them to reduce cost barriers to care and offer financial support to providers. Despite early predictions that COVID-19 would drive massive losses in employer-based coverage, it appears that many employers have kept workers enrolled in benefits

longer than anticipated. However, as the crisis goes on and federal stimulus funding dries up, many in the insurance industry believe that significant coverage disruptions are inevitable. Beyond coverage implications, COVID-19 has sparked important conversations within insurance companies about the consumption of health care in the United States, the use of technology to deliver services, and the critical need to acknowledge and address the racial and ethnic disparities that plague the health care system. Though no one can predict how the COVID-19 crisis will evolve, lessons learned from insurers’ early experience have already better prepared them to some extent for what is to come.

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