Qral Group
Adaptive Transformation

US Healthcare Burden

Qral Group
Together we advance

Published May 22, 2020

US HEALTHCARE BURDEN

Vasilis Moisiadis, Vandana Rangnekar, Firhan Malik, Shirley Wuu, Chih-Kao Hu

REACTIONARY RESPONSE

"It's really about getting people the access they need"

As COVID-19 and stay at home orders spread across the country, health insurers quickly responded by removing barriers to accessing care. They allocated additional resources to promote telemedicine (now reimbursed at rates equal to face-to-face visits) as a safe option for patients seeking medical advice, helping to ensure continuity of care while diverting patients from emergency rooms and urgent care centers. The use of telemedicine has exploded, particularly among patients with chronic conditions, and is expected to continue growing even in a post-COVID world. Payers acknowledge that physicians may not have all of their patients' information and that telemedicine is not possible for everyone. Therefore, prior authorizations (tools for managing the use of procedures and medications) have been relaxed or extended for at least six months, early fill restrictions removed, and patients can automatically access 90 days prescriptions all in the name of improving access. Note: essential medications (e.g. albuterol and azithromycin) are not subject to these relaxed rules. People who contract COVID do not face copays or prior authorizations for diagnostic testing or treatment.

"Home delivery from retail pharmacies went up 1000% in the first quarter"

With limited access to offices and hospitals, more patients are using homecare services such as mail order or home delivery of prescriptions, and home infusions of specialty medications. At the same time, physicians are looking to switch patients from medications that require an infusion (e.g. drugs for cancer, many rare diseases) and onto more convenient methods of treatment, such as oral or self-injectable medications.

CALCULATING LOSS

"The long-term consequence are going to be harder to adjust to. How many members are going to be lost as a result of being furloughed or unemployed? How will employers pay premiums?"

The rate of COVID infections appear to be slowing and the country beginning to loosen stay-at-home restrictions. Now, the broader impact of COVID on the economics of healthcare is becoming apparent. Hospitals and physicians' offices lost much of their primary revenue sources: outpatient visits, elective procedures, and even routine care visits (e.g. wellness checkups) as patients defer care out of fear over COVID and/or loss of insurance coverage. At the same time, institutions face greater demand for cost- and labor-intensive inpatient services due to the surge in COVID-19 patients. Even with higher rates of reimbursement for COVID claims (due to the need for more intensive care and resources, e.g. large numbers of PPEs), our healthcare system faces large budget shortfalls.

"We're anticipating that outpatient will open under different circumstances. We're looking at some type of new normal with reduced volume, schedules that allow distancing, cleaning. At 50% capacity, how much are we going to recoup? We may break even at best"

No one expects a quick return to pre-COVID levels of patient volume. The general public will need time and scientific data to feel comfortable reentering their doctor's office. Sites of care will need to adopt new practices to ensure the safety of their staff and patients: increased staff and resources to screen patients, social distancing and designated waiting areas, scheduling fewer patients throughout the day, increased time between patients for disinfection protocols. Furloughs, layoffs, and permanent closures should be expected unless federal and local governments step in with support. Institutions that survive face the additional challenge of determining how to prepare for projected subsequent waves of infections in the fall and winter. How much space, resources, and staff should be allocated back to 'normal' care work? How will budgets and supply lines be able to meet the needs for PPE? How do we ramp up delivery of care when our supply (staff and institutions) will have declined?

A DISTANT TOMORROW

"All vaccines for prevention are $0 copay, and will be available without any barriers from the plan. It's a question of ample supply at pharmacies and offices"

Multiple vaccines are in development and existing treatments are under evaluation, but it is not clear when a safe and effective solution will become available. Furthermore, we lack guidance from the government on how any potential vaccine or treatment will be rolled out. At the very least, health insurers feel confident any vaccine or treatment will be made readily available to the general public. They are prepared for an expedited review of any new product for COVID-19, and expect coverage and rollout to be modeled on existing vaccines, such as for the seasonal flu. Payers' stated goal is to ensure broad access to a vaccine with no or low ($20) copay through local channels, such as doctor's offices, pharmacies, grocery stores, and other centers of the community.

"Once approved and available, we want broad access to be on the pharmacy and medical benefit. Like the flu or pneumococcal vaccine"

Before any treatment or other solution can be discussed, there are still an enormous number of details to address. Will a treatment or vaccine be approved with sufficient efficacy and safety data? How many doses would a COVID vaccine or treatment require? Will there be prioritization of people to get access? If so, how will that be determined? How will manufacturers provide an adequate supply? Will manufacturers set an accessible price? Who will share the cost?

RESEARCH METHODOLOGY: Direct telephone interviews with medical and pharmacy directors from state, regional, and national healthcare plans covering a total of 143 million lives.

DISCLAIMER: Please check with city and state public health departments to coordinate local response; call your doctor if symptoms appear.