From: McGlamery, Gabriel [redacted]
Sent: Monday, March 16, 2020 5:50 PM
To: O'Brien, Kelly P. (CMS/CCIIO)
Subject: FW: Demand response in pandemics
Attachments: Braithwaite_et_al-2013-Health_Services_Research.pdf; Matheny et al 2007 Financial effects.pdf

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Kelly,

If you wanted sources about medical utilization in an epidemic, the attached docs might at least suggest the financial situation for issuers and providers might not be as straight forward as claims volume growing as the epidemic grows. Both look at it from the hospital's perspective and look a little more at losses from differing elective care v. increased volume from the epidemic. When you shift to the insurer's perspective there are some other considerations:

- How will the distribution of risk across age impact issuer claims? If hospitals fill up, will Medicare push out ACA-aged enrollees?
- While the attached consider hospitals, I'd expect inpatient treatment centers would have all the negative impact, like delaying elective care or sick providers, without any of the epidemic-related admissions to offset the lost revenue.
- The impact will not be evenly distributed. I would love to have a risk adjustment conversation about this (which won't surprise Beth and Erin) and will be talking to my risk adjustment SMEs tomorrow.

Health care economics isn't easy, intuitive, or straight forward. If there are adverse selection risks, that might be mitigated through risk adjustment, but there will be time to figure that out later (next week?). From a market-wide 2021 rating perspective or from a macro-economic impact perspective, the cost of delaying action and leaving people uninsured seems higher than any adverse selection risk from a SEP. Another way of looking at it is that contagion means the risk of leaving someone

I'm happy to say the testing rate is growing very quickly (https://covidtracking.com/data/). At some point, it will reach a capacity that will loosen testing criteria, allow more proactive testing, and we might be able to mimic Korea's aggressively preventive approach that gave them their low COVID-19 growth rate and low mortality rate. But getting people to be comfortable with protective testing requires them to have insurance. So, right now, the protective benefit of insurance likely outweighs the adverse selection risk. Lots of good stuff at https://protect2.fireeye.com/url?k=d4cf5618-889b4f64-d4cf6727-0cc47adc5fa2-cc27f5fa57acc011&u=http://covid19dashboards.com/, and to illustrate why I'm pointing to Korea - check out https://protect2.fireeye.com/url?k=ba88783e-e6dc6142-ba884901-0cc47adc5fa2-f1d2748dc77cadc9&u=http://covid19dashboards.com/growth-bayes/.

- Gabe

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From: David Anderson [redacted]
Sent: Monday, March 16, 2020 4:04 PM
To: McGlamery, Gabriel [redacted]
Subject: Demand response in pandemics

Gabe –
I am attaching a few papers of relevance to your theory that non-pandemic utilization goes down in times of an epidemic.

1) Braithwaite et al 2013 looks at the financial impact of H1N1 on hospital finances and found hospitals came out ahead due to massive increase in admissions for the pandemic that outweighed lost income from postponed elective surgery. I think COVID19 will have larger magnitude but directionally similar results from this same simulation model
2) Matheny et al simulated a 1918 Flu pandemic and found healthcare costs would go down as elective surgeries postponed brought in more revenue than flu care

I think that your assumption that all other non-pandemic utilization goes down is defensible. If your claims teams could look at how many knee replacements occurred during H1N1 vs previous year and forward year, that could be helpful as well.

Dave

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Pronouns: He/Him/HIs

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