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Auto Casualty

COVID-19 P&C Industry Update: Regulations, Telemedicine, Access to Care and Testing

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Over the past few months, the property and casualty industry has experienced an unprecedented number of changes in a short period of time due to the COVID-19 pandemic. From a slew of regulatory updates and working remotely to fluctuations in claim frequency and severity, the industry is continuing to change and adapt every day to eventually end up at our “new normal.” COVID-19 regulatory changes, telemedicine, access to care and COVID-19 testing have been dominating the conversations on webinars, news media and internal operations for over the past few months. Let’s take a closer look at these four specific topics.

COVID-19 Regulatory Changes

The regulatory landscape went from a planned and predictable agenda to an atmosphere of executive orders, emergency bulletins and quick passage of legislation and administrative rules, all to aid in facilitating business and treating patients. At Mitchell, we have specifically tracked several categories of COVID-19 regulatory changes at the state and federal levels, including:

Claim Handling

We tracked claims handling issues from data calls and protection of healthcare workers to procedures outlined for changes concerning treating patients for opioid addiction.

Medical Coding (Billing) Additions and Changes

These changes were adopted by more than 30 states, addressing COVID-19 testing, telehealth/telemedicine billing, diagnosis coding and the nature of injury coding.

Fee Schedules

Fee schedules were updated to deal with diagnostic related groups, resident care rates and COVID-19 testing.

Legal Hearing

We also tracked legal hearing updates that waved in-person hearings in favor of remote hearings. Additionally, we looked at changes in hearing procedures during shelter-in-place orders.

Leniency

Leniency is another broad category of regulatory changes that were addressed in approximately 30 states. Leniency regulations covered everything from renewal of drivers' licenses and registrations, premium payment due dates and timelines for claim handling to general flexibility in the business of processing claims.

Pharmacy

The nationwide declarations of states-of-emergencies (some have now been lifted) and newly enacted state rules led to relaxing of days-supply and early fill rules, created formulary updates to include COVID medications, and necessitated formulary implementation delays. Additionally, the Drug Enforcement Agency (DEA) announced in January that physicians could now prescribe controlled substances to patients via telehealth without requiring an in-person visit first. To keep up with the latest by state, bookmark our pharmacy rules page for quick access to every state's workers' comp COVID website.

Policies

Policies were adopted to allow restaurant employees to utilize their own vehicles for deliveries and/or commercial purposes.

Presumptions

Presumptions will likely become one of the largest categories of change, with our current tracking showing more than 18 states addressing the issue. While several states are utilizing the legislative process to address presumptions, others are choosing to enact executive orders and emergency bulletins. Most presumption legislation, orders and bulletins address the first responder presumption, however, more recently in California there has been an expansion of presumption beyond these job classes. Read more about how presumptions may affect the industry. For a state-by-state listing of the changing presumption laws, visit NCCI.

Telehealth/Telemedicine

Rules and guidelines were implemented and changed in over 35 states. While some of the guidance about telemedicine was already underway legislatively before the pandemic (though not highly prioritized), states seemed to move quickly once the pandemic identified the need for access to care. While the above list of tracked categories is not all inclusive, it represents the majority of the areas we monitor closely to facilitate necessary changes to Mitchell's products to provide our clients with an up-to-date claim handling process. This information is maintained and updated daily on Mitchell's Compliance Connection, the regulatory portal we maintain for our customers.

The Future of Regulatory Changes

Although the COVID-19 regulatory changes have been widespread throughout the industry and implemented in a short time frame, the pace of these updates is now slowing. Many states are revisiting earlier orders and clarifying for more permanent guidance, such as telemedicine usage by providers for property and casualty claims. It is our belief at Mitchell that many of the regulatory reforms are not just temporary, with many states now prioritizing these COVID-19 regulatory changes for legislative review and actions.

Telemedicine

The property and casualty industry has used telemedicine and telehealth for many years at a minimal level. Who knew a pandemic would be the impetus to facilitating widespread usage and adoption? At the start of the crisis, many states were not prepared to implement telemedicine from a regulatory standpoint at the level needed to care for patients and provide greater and safer access to care. During the pandemic, telemedicine has shown when used effectively it can provide a safe platform for continued care, check-ins and therapeutic programs for people that have risk factors if exposed when shelter-in-place orders prohibit in-person visits. While both property and casualty and national data demonstrate nearly a 60% decline in outpatient visits overall, telemedicine has only replaced approximately 15% of that dip due to the types of treatments that are typically provided for property and casualty claims. At first glance, 15% may not seem like a lot, but it is significant in an industry where months ago this was barely on the radar. It was implemented quickly and has improved its security and efficiency in a short period of time. Prior to COVID-19, many states like Florida had been formulating bills and passing legislation that addressed, for example, prescriptions that could be issued using telemedicine, and most importantly, the process of identifying the providers that can and should use virtual visits. But, clearly, the immediate, unplanned effect allowed patients and providers the leniency to quickly shift services to telehealth and telemedicine platforms already in place. However, it should be further developed when we are not in such a crisis state—it's here to stay. Forrester reported in January of this year that only 24% of healthcare providers/facilities were even able to perform telehealth/telemedicine services. Today, telehealth/telemedicine providers are reporting they have run nearly a years' worth of services through their technologies in one month. This increase in virtual services still only partially offsets patient encounters by a small percentage. The technologies, like Zoom, are making huge strides in protecting health information while the states are attempting to become more specific in the organization and scope of the providers performing these services. Access is becoming more wide spread and affordable and is becoming accepted as a logical alternative to in-person visits that could expose patients and providers to infectious diseases. But you can't do everything through virtual visits.

Predictions for the Future of Telemedicine

Many of the emergency adoptions, legislative changes and guidance for telemedicine and telehealth were in the works prior to this pandemic but were not prioritized as highly as other items on states' agendas for property and casualty lines of insurance. The pandemic quickly moved this mode of a visit to the top of the priority list, leaving everyone wondering why this had not happened sooner. Practitioners are coming to understand the value of this technology and patients are enjoying the convenience. Telemedicine and telehealth are here to stay and will grow to see even greater volume as we move forward.

Access to Care in the Time of COVID-19

Most of the shelter-in-place orders put into place across the country only allowed certain providers to practice with strict constraints around which patients they can see, with many prohibiting elective surgeries. It's important to note that elective surgeries encompass a broad scope of procedures, (not just facelifts or other cosmetic related procedures) elective surgeries include time-sensitive biopsies, removal and replacement of orthopedic devices and hardware and even something as simple as cast replacement—surgical units were effectively shut down to prioritize emergency care and provide care to COVID-19 patients and limit additional exposure. Wellness visits were not happening, even though the main purpose of wellness visits is to be preventative and hopefully catch medical issues before they require significant remediation. As the limitations are lifted, the effects may be akin to when the Affordable Care Act was implemented. At that time, many people who were uninsured previously had delayed seeking medical care and by the time they received care under the ACA their condition was much worse. The expense of caring for these folks was much greater and needed care to be more aggressive overall. One of the many concerns is that the injuries that are typically sustained in property casualty claims, for example soft tissue injuries, heal with time, and patients would typically receive a regime of palliative care for a specified duration. The pandemic has created a gap in care for these treatments, leaving many to wonder—will there be other methods to help care for those patients, such as telemedicine to ensure the patient is getting the proper treatment? Will this gap in care extend the length and cost of the care and potentially the return to work process? This situation is unprecedented but should be monitored moving forward due to the volume of this case mix.

Reopening Trends and Predictions Related to Access to Care

As states begin to allow for elective surgeries, how will they be triaged? On April 17, 2020, the American College of Surgeons (ACOS) released "Local Resumption of Elective Surgery Guidance," which provides guidance for facilities in ramping up to perform elective surgeries that were postponed. The ACOS has broken down its guidance into four sections:

- Awareness of COVID-19
- Preparedness
- Patient Issues
- Delivery of Safe High-Quality Care

The triaging guidance provided involves objective scoring of patients for prioritization with numerous considerations specific to the facility itself. It is our impression that the P&C patient will be prioritized along with everyone who has had elective surgeries delayed and may cause extended claims and lost time from work.

COVID-19 Testing

Interestingly enough, we are seeing COVID-19 testing not only in workers' compensation claims, but also for auto accident claims. Its not surprising to find COVID-19 testing within workers' compensation claims, as many patients have been exposed as first responders and in other essential jobs. Interestingly, for auto claims, claimants have been tested for COVID-19 after potential exposure in the emergency room following an auto accident or while in a facility being treated for an auto-related injury. In Mitchell's auto casualty data, we encountered nearly 2,000 COVID-19 test bills on claims in 16 states since the pandemic started. In workers' compensation, nearly 10,000 COVID-19 tests in 27 states were captured in our bill review applications. The ICD-10-CM diagnosis code for Coronavirus was not made available until April 1, 2020 (U07.1 COVID-19), so although the testing has been available and codified early, the specific diagnosis was not immediately available. Further research is needed to identify early claims. Prior to the implementation of the new diagnosis code, general guidance was to code Pneumonia as J12.89 (viral pneumonia) and B97.29 (other coronavirus) as the

cause of diseases classified elsewhere. In addition, other conditions such as Acute Bronchitis, Lower Respiratory Infection, Acute Respiratory Distress Syndrome (ARDS) and exposure to COVID-19 have coding guidance provided before the new codes were made available.

Conclusion

We have encountered rapid change to the property and casualty regulatory world within a short period of time during this pandemic. The swift implementation of new technology to accommodate these changes has been agile and demonstrated flexibility in one of the most rule-based and rigid systems of healthcare—workers' compensation and auto claims. Managing individual rules and legislation from 50 states on top of federal government guidance has created a quagmire of rules and welcomed changes. The pandemic has demonstrated that the property and casualty industry can move quickly to care for patients when we need to, which should be remembered and used in the future as a banner for implementing needed change.

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