EXECUTIVE INSIGHTS

PHE Unwinding — Impact on Medicaid Redeterminations

In January 2020, the Department of Health and Human Services (HHS) issued a public health emergency (PHE) soon after the first cases of COVID-19 were detected in the U.S. In March 2020, Congress passed the Families First Coronavirus Response Act (FFCRA), which, among other provisions, put in place controls to ensure those in need had access to care during the pandemic. These provisions included:[1]

- A temporary increase of 6.2 percentage points in the Federal Medical Assistance Percentage (FMAP) — the federal government's share of Medicaid costs — to qualifying states
- A maintenance of effort (MOE) protection, also known as "continuous coverage," which prevents states that receive the increased FMAP from terminating people's Medicaid coverage during the PHE

The PHE was renewed 12 times in 90-day increments, keeping in place the increased FMAP and MOE protections for Medicaid, before President Joe Biden announced its end date of May 11, 2023. During this same time, estimated enrollment in Medicaid and the Children's Health Insurance Program (CHIP) approached 92 million as of November 2022, an increase of over 21 million since February 2020;[2] however, on Dec. 29, 2022, President Biden signed the Consolidated Appropriations Act of 2023. This Act allows eligibility terminations to begin on April 1, 2023, permitting states to begin initiating renewals that may result in eligibility terminations as early as Feb. 1, 2023, or at the latest by April 2023, giving each state 12 months from its starting point to initiate all renewals, and 14 months from its start to complete all renewals.[3]

Additionally, the act granted a gradual phaseout of the 6.2 percentage point FMAP enhancement beginning in April 2023 and ending on Dec. 31, 2023.[4]

Now the healthcare system is preparing for the far-reaching ramifications that redeterminations will bring. In this *Executive Insights*, L.E.K. Consulting discusses the implications of upcoming Medicaid redeterminations and considerations for payers, providers and patients.

By the numbers: What Medicaid redeterminations could look like

There are three main variables defining what the impact of Medicaid redeterminations will be:

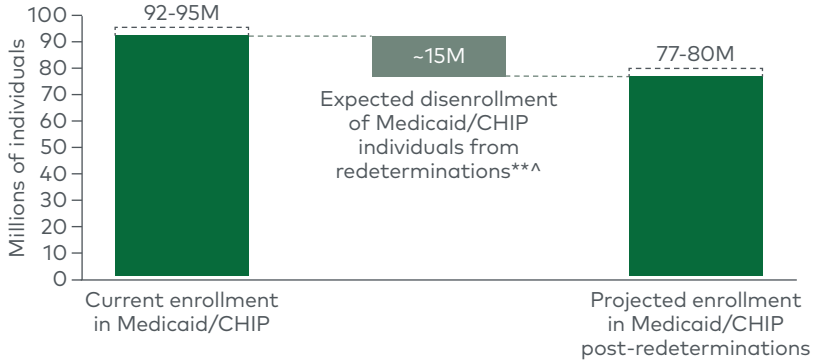
1. The number of people who will lose Medicaid coverage
2. How the disenrollments will be distributed over time
3. What type of insurance those who lose their Medicaid coverage will receive

These variables are very difficult to predict, but key indicators such as employment rates, pre-pandemic insurance coverage trends, Affordable Care Act (ACA) policies and state-published plans help shed light on a possible range of outcomes.

1. The number of people who will lose Medicaid coverage

Following the pandemic, unemployment rates have largely stabilized, indicating a return to long-term pre-pandemic trends, and Medicaid enrollment levels are expected to follow suit. A range of key reports, namely from the Urban Institute and HHS, suggest a consensus of around 15 million total Medicaid/CHIP disenrollments due to Medicaid redeterminations, with some caveats (see Figure 1).[5,6]

Figure 1
Estimate of Medicaid/CHIP enrollment based on redeterminations (November 2022-May 2024P)*



*Medicaid.gov estimates ~91.8 million Medicaid/CHIP enrolled lives as of November 2022 reported enrollment data; it is expected that this number will increase by April 1, 2023
**HHS includes the elderly population in estimates and projections, while the Urban Institute appears to only include the non-elderly population
^The Urban Institute expects a total of ~18 million people will lose Medicaid coverage, ~3 million will transition from Medicaid to CHIP, resulting in ~15 million Medicaid/CHIP individuals to be disenrolled; HHS' estimate of disenrollments is outdated, as it is projected from total enrollment at the end of December 2021, is based on 2015-16 SIPP data, and projects disenrollments occurring over the course of 12 months throughout 2022.
Note: CHIP=Children's Health Insurance Program; HHS=Department of Health and Human Services; SIPP=Survey of Income and Program Participation
Source: Data.Medicaid.gov, "State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data"; Urban Institute, "The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage," December 2022; U.S. Department of Health and Human Services, "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," August 2022; L.E.K. research and analysis

Medicaid members losing coverage can be separated into two major groups: those who are no longer eligible and those who lose coverage due to administrative "churn." Those deemed ineligible will include both enrollees who have gained employer-sponsored insurance (ESI) or other insurance while maintaining their Medicaid coverage and those whose only form of insurance is Medicaid but who no longer meet the qualification thresholds.

Those who lose coverage due to administrative churn likely still qualify for Medicaid but have not completed timely paperwork needed to reassess their eligibility. There could be a variety of reasons for this, such as outdated contact information, lack of education/awareness or inability to handle the burden of paperwork. The two key reports differ in their perspectives on churn and how they account for it within the roughly 15 million estimated disenrollments: HHS includes approximately 6.8 million individuals disenrolled due to churn within its 15 million estimate. The Urban Institute estimates its results net of any churn.

2. How the disenrollments will be distributed over time

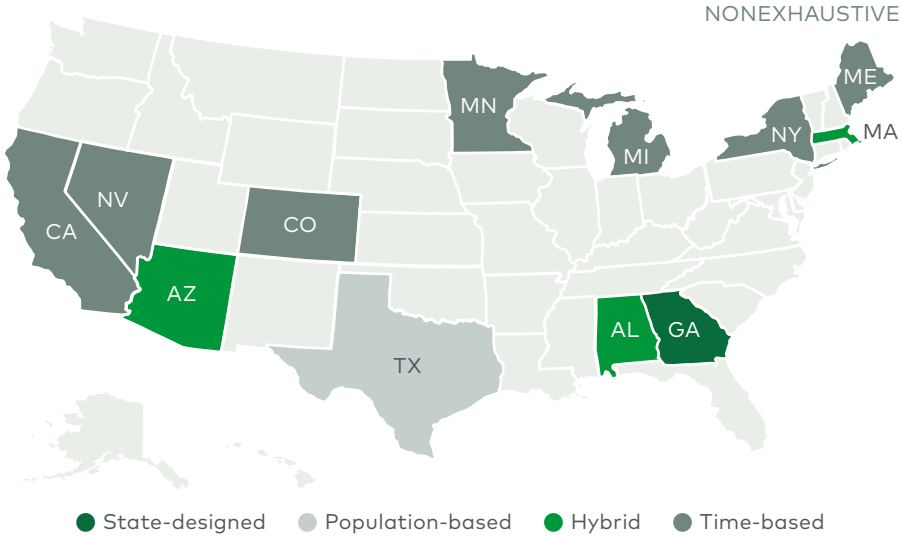
Over 40 states have published plans in varying detail as to how they will approach redeterminations and over what time frame. They fall into several different categories, as defined by the Centers for Medicare & Medicaid Services (CMS) (see Figure 2 for examples):[7]

- **Time-based approach:** Distribute renewals based on month or on amount of time since enrollee's application or prior renewal. This would tend to result in a more linear processing of disenrollments.
- **Population-based approach:** Prioritize the redeterminations most likely to result in disenrollment. This would result in the front-loading of disenrollments.
- **Hybrid approach:** Conduct specific renewals (for those with likely ineligibility) first, then apply a time-based approach for all others. This could result in a still-front-loaded but less steep curve of disenrollments.
- **Other:** Take an approach not specifically meeting one of the three CMS definitions listed above (e.g., a state-designed approach).

Additional factors that will influence the distribution of disenrollments over the 14-month period are as follows:

- States may choose to begin processing renewals in February, March or April 2023. There is a lag between beginning processing and a disenrollment, meaning that while April is the first possible month for disenrollments, many states will have their first disenrollments in May or June.

Figure 2
Medicaid redetermination approaches of select states*



*Based on state plans and information available as of February 2023; although a state follows a time-based redetermination approach, there may be some select populations that are prioritized or deprioritized outside the time-based schedule.
Source: Individual state plans, as found in Georgetown University Center for Children and Families' 50-State Unwinding Tracker

- CMS recommends that states initiate no more than one-ninth of their renewals in any given month, to better balance the workload and lead to fewer inappropriate disenrollments. States will have to report their expected distribution of renewals to CMS.[8]

Given the situation's complexity, the mix of state redetermination approaches and the workforce constraints, we expect the likely distribution of disenrollments to be:

- Somewhat lower in the first two months (April and May 2023), mainly coming from states that initiated renewals in February or March 2023
- Relatively linear to slightly front-loaded in the middle 10 months (June 2023 through March 2024), since the time-based approach is more common, and states using hybrid or population-based approaches will be strongly encouraged to abide by the one-ninth maximum recommendation
- Somewhat lower in the final two months (April and May 2024), as all states that initiated renewals in February or March 2023 will have completed all renewals by this time

3. What type of insurance those who lose their Medicaid coverage will receive

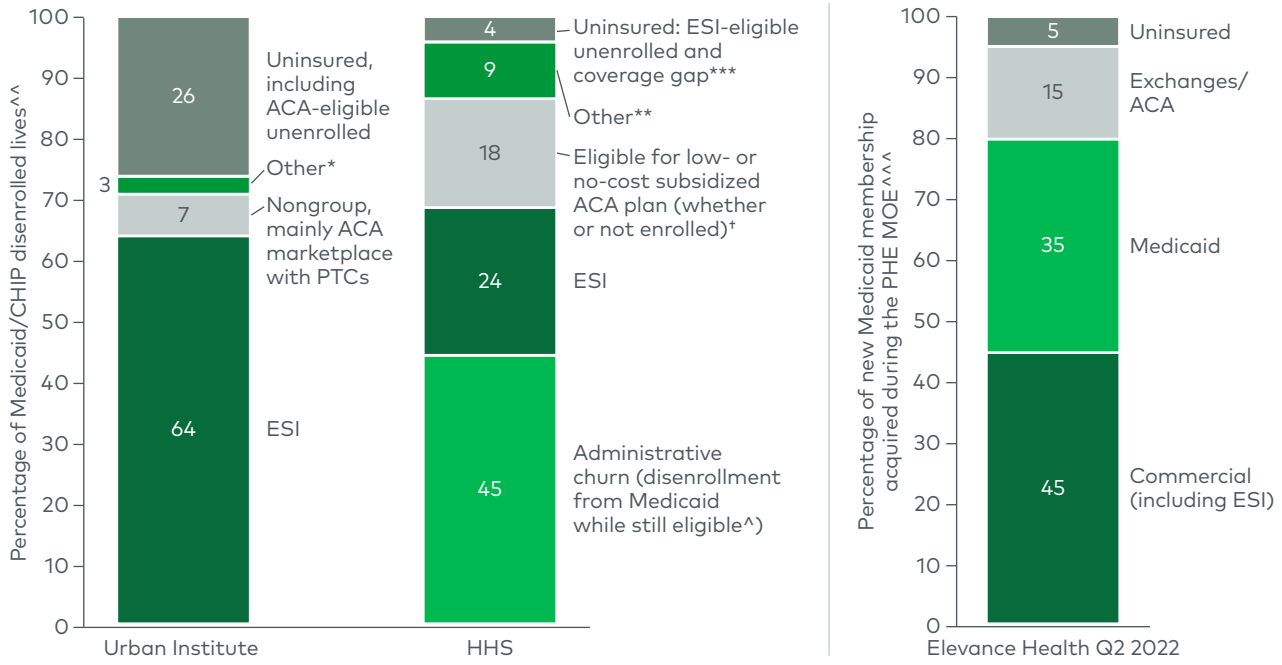
In addition to the difficulty of predicting how many Medicaid/CHIP members will be disenrolled during redeterminations, it is even more challenging to determine what portion of those individuals will remain covered under Medicaid, move to alternate sources of coverage or become

uninsured altogether. Academic, government and corporate institutions have presented a wide range of estimates (see Figure 3), but these sources share some similar overarching themes.

The Urban Institute, HHS and Elevance Health all expect the majority of disenrolled individuals either already have moved or will move to commercial (mainly ESI) coverage, as national unemployment — a driver of Medicaid enrollment — has returned to pre-pandemic levels. Following transitions to commercial coverage, sources expect ACA marketplace plans to act as another lever to reduce the magnitude of uninsured individuals nationally.

Where sources differ, however, is in how they expect the remainder of disenrolled members to churn and presumably reenroll in Medicaid versus move to alternate coverage or remain uninsured. Sources are also discrepant as to how many disenrolled individuals will become uninsured; the Urban Institute says there could be approximately 3.8 million uninsured individuals following the redeterminations.

Figure 3
Projections of disenrolled Medicaid/CHIP individuals, by insurance status, by source



*Urban Institute's "Other" category includes other public or non-ACA-compliant coverage
**HHS' "Other" category refers to those who "Changed to Non-Marketplace Coverage that Precludes Advanced Premium Tax Credits"
***HHS' "Coverage gap" category refers to the Medicaid coverage gap in Medicaid nonexpansion states
††This represents eligible individuals, whereas the ESI and Other categories represent projected enrollment; not all who are eligible would enroll in the ACA plans
^The period over which a "churn" individual would be placed back onto Medicaid coverage is not specified by HHS
^^Specifically referring to nonelderly individuals
^^^In the Q2 2022 earnings call, Elevance Health stated, "Over the past year, we've added more than 2.7 million net new members, including over 1.5 million net new government members and nearly 1.2 million net new commercial members."
Note: CHIP=Children's Health Insurance Program; ACA=Affordable Care Act; PTCs=premium tax credits; ESI=employer-sponsored insurance; PHE=public health emergency; MOE=maintenance of effort; HHS=Department of Health and Human Services
Source: Urban Institute, "The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage," December 2022; U.S. Department of Health and Human Services, "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," August 2022; Elevance Health Q2 2022 earnings call transcript and Form 10-Q

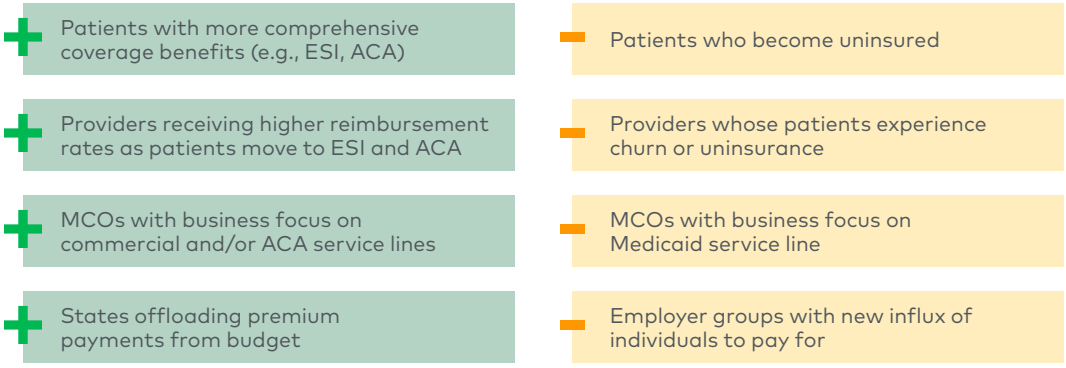
Implications across the healthcare ecosystem

The impact of Medicaid redeterminations will be felt across the healthcare ecosystem — from managed care organizations (MCOs) to providers and patients.

Medicaid redeterminations will benefit some participants in the healthcare value chain more than others (see Figure 4):

- **Patients:** Redeterminations will not impact all disenrolled members negatively; many have transitioned to ESI coverage while regaining employment and are utilizing more comprehensive care benefits. However, millions are still at risk of losing insurance.
- **Providers:** Some may experience the net benefit of higher reimbursement rates for patients who transitioned from Medicaid to ESI or ACA. Others who serve communities with higher unemployment and/or poverty may be adversely impacted if more of their patients experience churn or uninsurance.
- **Health plans:** MCOs with a high proportion of Medicaid members will face headwinds as ineligible members are disenrolled and associated premiums disappear. Those with a focus on commercial and other government service lines will benefit from shifts to ESI and ACA exchange plans.

Figure 4
Shifts in the value chain across healthcare stakeholders as a result of Medicaid redeterminations



Note: ESI=employer-sponsored insurance; ACA=Affordable Care Act; MCO=managed care organization
Source: L.E.K. research and analysis

Following Medicaid redeterminations, the five largest Medicaid MCOs all have significant revenue losses at stake. Centene and Molina are at greatest risk, as Medicaid is the largest business segment for both companies. Centene expects around $9 billion in run-rate revenue giveback after redeterminations resume.[9] Molina anticipates the potential loss of 300,000 or more Medicaid members when redeterminations commence.[10] This presents these plans with

a large incentive to act in the short term and utilize these opportunities for the long term as well. Thus, MCOs should:[11,12]

- **Proactively assist state Medicaid agencies** in all ways possible. This will allow MCOs to gather beneficiary renewal information that will help individuals avoid disenrollment and/or help those who are ineligible transition to ACA marketplace coverage.
- **Maximize retention of eligible members** to reduce churn and preserve continuity of benefits.
- **Expand their geographic presence in ACA marketplace offerings**, beginning in states where the MCO has Medicaid presence.
- **Diversify their ACA exchange product offerings** by designing more plans with various price points and choices of benefits to attract more consumers, especially those who have been disenrolled. Centene, for example introduced new marketplace product designs in 2022.[13]

The nation's largest health plans could offset potential losses, or even create new revenue streams, by channeling their integration of Medicaid Managed Care and exchanges within states. HHS recently reported a record-high 16.3 million people selecting ACA marketplace plans during the 2022-23 open enrollment period, including 3.6 million new-to-marketplace enrollees, up 21% relative to the prior year.[14] This achievement signals the promise of greater public awareness of and access to marketplace coverage.

Given the Inflation Reduction Act extension of premium subsidies (i.e., premium tax credits) until 2025, MCOs have supporting incentives to persuade beneficiaries to transition. However, MCOs will have to overcome their greatest and most well-known barriers, as follows:[15,16,17]

- **Gaining timely information from state agencies** to target ineligible Medicaid individuals to share with marketplace colleagues
- **Building awareness among current Medicaid beneficiaries** of the upcoming redetermination process and of alternate coverage options — and, when within state regulations, assisting members with completing the redetermination process
- **Informing disenrolled individuals of how, when and where to enroll in other coverage options**, such as CMS' temporary special enrollment period for disenrolled individuals to enroll in ACA marketplace coverage from March 31, 2023, through July 31, 2024[18]
- **Maintaining compliance with complex Federal Communications Commission regulations** regarding outreach to members

Health plans will have to continue prompting and collaborating with states as best they can to bridge the coverage transition gap that could otherwise lead to losses in both dollars and insured members.

Conclusion

In Q1 2022, the national uninsured rate reached an all-time low of 8%.[19] Now, 2023 will be a pivotal year in preserving health insurance coverage for as many individuals as possible, even as Medicaid redeterminations begin in the spring. L.E.K.'s Healthcare Services practice continues to perform work across this space to help clients navigate uncertainties. With our knowledge and expertise, we can help develop strategic solutions that fit your needs for commercial excellence but also for growth in the years ahead.

For more information, please contact healthcare@lekinsights.com.

Endnotes

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