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The End of Medicaid Continuous Coverage: Programmatic and Rate Setting Considerations

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Executive Summary

Medicaid enrollment grew significantly during the COVID-19 pandemic, primarily because of a moratorium on member redetermination activities required to receive enhanced federal funding. Nationally, Medicaid enrollment appears on track to exceed 94 million enrollees before member redetermination activities resume, which would represent an increase of more than 23 million enrollees relative to pre-pandemic levels. In many cases, the significant growth in Medicaid enrollment also has affected average population acuity (i.e., cost).

Medicaid enrollment levels and average population acuity are two primary contributors to state Medicaid budgets. In states that use a managed care model to operate their Medicaid program, Medicaid expenditures are largely predicated on prospective capitation rates, which rate setting actuaries who are contracted by the state develop. These rates are paid to contracted health plans, which are at risk for the relationship between actual programmatic costs and corresponding levels assumed in rate setting. Capitation rates are typically updated annually based on historical data and environmental information available when rates are developed. The uncertainty that the upcoming disenrollment will bring to both enrollment levels and population acuity has created significant additional complexities for rate setting actuaries and budget forecasts.

In our experience, rate setting actuaries employed a variety of approaches to address population acuity changes resulting from this staggering enrollment growth, ranging from specific adjustments based on prior experience, to adjusting assumptions based on the estimated impact of the pandemic, to no explicit adjustment.

While the timeline for the resumption of Medicaid member redetermination activities has remained uncertain for most of the pandemic, recent legislative action has clarified that member redetermination can resume in April 2023. Though the ultimate level of post-pandemic Medicaid enrollment remains unknown, it is likely that a significant portion of the approximately 23 million additional enrollees will be disenrolled before mid-year 2024. The timing and ultimate level of disenrollment will be influenced by each state's "unwinding" strategy, including their support to Medicaid beneficiaries and ability to curb administrative churn.[2] The expected termination of this large volume of members also has significant cost and acuity implications, which will need to be considered in the development of post-pandemic Medicaid capitation rates.

[2] Administrative churn refers to individuals who lose Medicaid coverage despite remaining eligible.

Significant Medicaid disenrollment in the coming months contributes to budgetary uncertainty for states and may result in somewhat elevated financial risk for contracted health plans. State-specific actions could mitigate this uncertainty to some extent. They will also be a determinant of upcoming population acuity changes and the ultimate new baseline enrollment level following the wave of redeterminations, which will need to be considered in capitation rate setting. Some historical examples and potential state-specific changes to eligibility rules suggest that Medicaid enrollment may not return to the pre-pandemic levels. For example, if a state's Medicaid program exhibited similar enrollment patterns to those observed in Tennessee following the 2014 suspension of that state's redetermination process, their post-pandemic Medicaid enrollment could exceed pre-pandemic levels by 10 percent or more. Further expansions in coverage from 12-month post-partum coverage to new states expanding Medicaid (i.e., North Carolina, etc.) could mean that Medicaid is a larger and different program than before the pandemic. The various rating methodologies used to address pandemic-era population acuity changes carry a range of implications for a post-April 2023 period, as discussed in this report.

Background

In response to the COVID-19 pandemic, Congress passed the Families First Coronavirus Response Act (FFCRA)[3] to support states and promote healthcare coverage stability during the public health emergency (PHE).[4] As part of the FFRCA, states received an additional 6.2 percent increase in their Medicaid Federal Medical Assistance Percentage (FMAP) during the COVID-19 PHE as long as certain criteria were met, including a maintenance of eligibility (MOE) requirement that provides continuous Medicaid coverage to members enrolled as of March 18, 2020, or anytime thereafter.[5] Consequently, Medicaid and Children's Health Insurance Program (CHIP) enrollment has grown significantly and is anticipated to increase by more than 23.3 million members between February 2020 and March 2023 (a 33% increase).[6]

Members who lapse because of redetermination are expected to exhibit lower average costs than the overall remaining population as the result of a number of contributing factors. Examples include beneficiaries gaining employment coverage and losing Medicaid eligibility or healthier enrollees disproportionally choosing not to comply with the redetermination process even if they are likely to be deemed eligible. As a result, many state Medicaid populations have experienced declining population acuity due to the continued enrollment of members who otherwise would have lapsed. Interestingly, enrollment has increased more in non-Medicaid Expansion states than

[3] 116th US Congress. Families First Coronavirus Response Act (P. L. 116-127). Government Printing Office. Available at: https://www.govinfo.gov/content/pkg/PLAW-116publ127/pdf/PLAW-116publ127.pdf

[4] The PHE was initially declared effective January 31, 2020. For more information, go to: https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx

[5] The terms MOE, continuous coverage, and continuous eligibility are used interchangeably throughout this document.

[6] Kaiser Family Foundation. Total Monthly Medicaid & CHIP Enrollment and Pre-ACA Enrollment. Published December 2022. Available at:
https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/.

in Medicaid expansion states.[7] Unfortunately no systematic data are available to compare correlations between acuity changes in Medicaid expansion and non-expansion states.

Throughout the COVID-19 pandemic, the timing for the end of the PHE and related moratorium on Medicaid redetermination activities was unclear. While this uncertainty posed a significant budgetary and rate setting challenge, recent actions by Congress have decoupled the resumption of redetermination activities from the end of the PHE.

Legislative Action and the Resumption of Medicaid Member Redetermination

On December 23, 2022, President Biden signed the H.R.2617, the Consolidated Appropriations Act of 2023 (CAA),[8] which decouples the discontinuation of FFCRA's MOE requirements and enhanced FMAP from the end of the PHE, providing states an advance warning that they can begin redeterminations starting April 1, 2023, almost exactly three years after the MOE began. States will have 12 months following that date to initiate renewals, post-enrollment verifications, and redeterminations for members enrolled as of April 1, 2023. States are granted an additional two months to complete these processes (14 months in total).

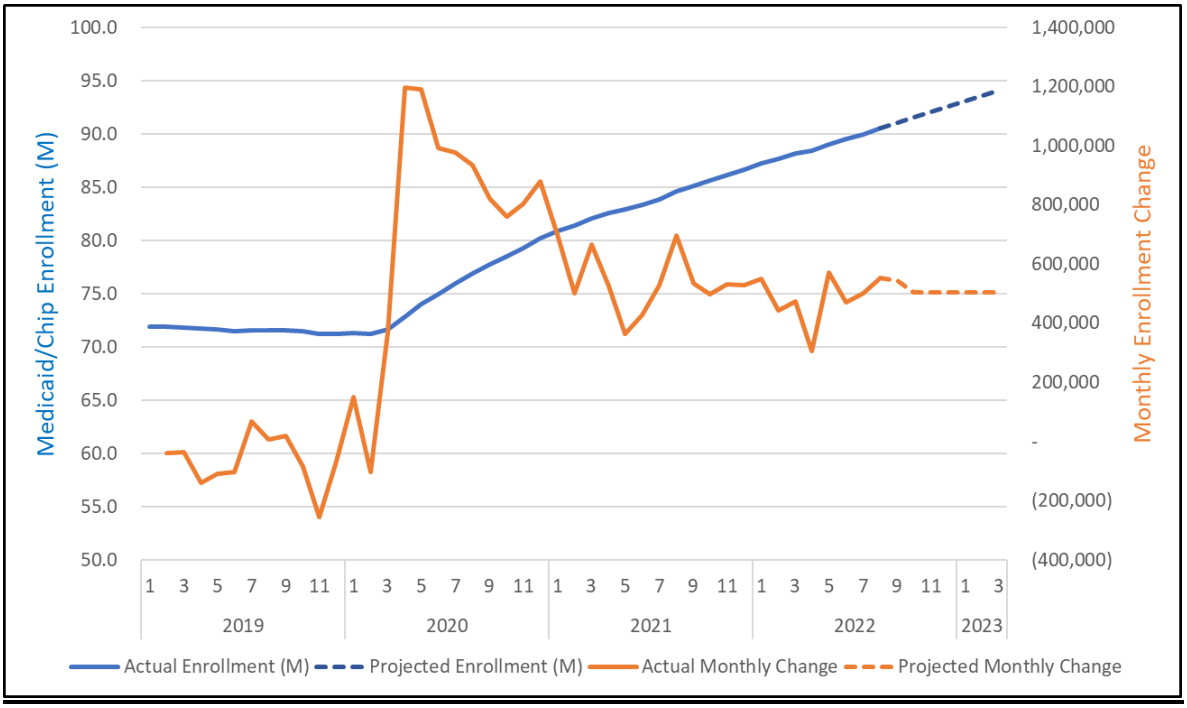
Based on Kaiser Family Foundation enrollment data, recent national Medicaid and CHIP enrollment has increased by approximately 500,000 additional members per month, suggesting that total estimated Medicaid/CHIP enrollment would reach over 94 million members in March 2023 prior to the MOE ending and redeterminations occurring (see Figure 1). This enrollment figure would represent an increase of 23.3 million enrolled members since the FFCRA passed three years ago. The enrollment growth has been most concentrated among low-income adults, who account for 63 percent of the change, including 38 percent growth among adults in the Affordable Care Act (ACA) Medicaid expansion group. Hence, these programs have exhibited the largest acuity changes and, consequently, may exhibit offsetting acuity changes upon resumption of redetermination activities.

The resumption of redetermination activities provides a significant inflection point in Medicaid enrollment, as most of these 23.3 million additional Medicaid members accumulated over the past three years could be disenrolled in a relatively short timeframe (see Figure 1).

[7] https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/

[8] https://www.appropriations.senate.gov/imo/media/doc/JRQ121922.PDF

Figure 1. Medicaid/CHIP Enrollment Change following Continuous Enrollment under FFCRA



Factors Affecting Medicaid Disenrollment

Though the CAA establishes an end to continuous Medicaid enrollment, it provides states with several options on the timing of redeterminations, with such activities beginning as early as February 1, 2023, to support April 2023 terminations.[9] States may initiate redeterminations in March or April 2023 for terminations beginning in May or June 2023, respectively. As mentioned earlier, states will have a total of 14 months from initiating redeterminations to complete these processes (e.g., states starting April 1, 2023, have a redetermination completion deadline of May 31, 2024). Multiple factors may affect state strategies for resuming redeterminations and the duration to complete them, including the state's budgetary situation and preparedness, (i.e., staffing levels, eligibility system capabilities, and member communication planning). Certain states may be motivated to start redeterminations earlier and process them faster than the allotted timeframe given the limited availability of enhanced FMAP funding, which will be phased out entirely in January 2024 under the CAA.[10]

[9] https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf

[10] The CAA includes the planned phase-out of the 6.2% enhanced FMAP available to states through FFCRA. States in compliance with certain new reporting requirements will receive an enhanced FMAP of 5.0% from April to June 2023, 2.5% from July to September 2023, and 1.5% from October to December 2023 before the enhanced FMAP is removed entirely in 2024.

Medicaid disenrollment in the coming months can be split into several components, including the exodus of members who are no longer eligible for Medicaid coverage, members disenrolled who are rightfully eligible (administrative churn), and various eligibility changes that have occurred since the onset of the pandemic. Each of these considerations are discussed further below.

Termination of Ineligible Members

The continuous Medicaid coverage policy under FFCRA inherently maintained enrollment for members who otherwise would have become ineligible during the pandemic. The level of disenrollment attributable to these members could vary significantly by state and would be based on state-specific Medicaid adult and children eligibility limits, which differ widely by state.[11]

The current economic environment in each state also affects the number of individuals who remain eligible. Though nationwide unemployment rates are similar to pre-pandemic levels, unemployment levels could be a contributing factor for states where unemployment rate has changed materially from pre-pandemic levels.[12]

Administrative Churn

An August 2022 report from the Assistant Secretary for Planning and Evaluation (ASPE), the principal advisor on policy development to the Secretary of the US Department of Health and Human Services,[13] found that, prior to the pandemic, 45 percent of Medicaid and CHIP beneficiary lapses represented administrative churn. This finding suggests that millions of individuals who are eligible for Medicaid could lose coverage in the coming months, including people who are no longer eligible. The extent of this administrative churn and ultimate magnitude is dependent on several factors, including:

- State-specific challenges, including budgetary pressures, staffing and training concerns (many eligibility caseworkers may not have previously processed a redetermination or renewal), and potential systems issues. Some states may attempt to process

[11] https://www.kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits/

[12] Nevada's December 2022 unemployment rate is 5.4% compared to 4.1% in 2019, an increase of 1.3%. Other states, such as Alaska, Mississippi, and New Mexico experienced significant unemployment decreases. Each of these three states saw unemployment decrease by more than 1.5% during this same timeframe (https://www.bls.gov/).

[13] https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf)

redeterminations faster than the allotted 14 months, given that enhanced federal funding is only available for nine months following the end of continuous enrollment.[14,15]

- The state's ability to improve member address and contact information, successfully outreach, and build awareness among beneficiaries. Conditions for enhanced federal funding under the CAA should promote these efforts. Examples include supporting states in maintaining up-to-date contact information and requiring them to make a good faith effort to contact beneficiaries undergoing redetermination using more than one communication method. States are prohibited from disenrolling beneficiaries solely based on returned mail.

- State's use of temporary 1902(e)(14)(A) waivers available to them through previous CMS guidance.[16] These waivers provide administrative relief to states facing operational issues in instances involving protected beneficiaries. Examples include streamlining the renewal process based on eligibility for SNAP participants without conducting a separate modified adjusted gross income-based redetermination and performing ex parte renewals for households that have attested to zero-dollar income within the last 12 months when no financial information is received. As of February 24, 2023, CMS-approved strategies cover 163 waivers in 43 states.[17]

- Some states also have taken additional steps to mitigate churn outside of the temporary waiver authority, such as streamlined processes for eligibility autorenewal, data verification through other available sources, or prepopulated renewal forms.[18,19]

Administrative churn will affect not only the new baseline enrollment levels following the upcoming redeterminations but could also influence how long it takes enrollment to stabilize. Eligible beneficiaries who are disenrolled because of administrative churn often are unaware that their coverage has lapsed and end up re-enrolling the next time they seek services. As noted in a recent MACPAC study,[20] 37 percent of Medicaid and CHIP beneficiaries who disenrolled in 2018 re-enrolled within 12 months. This suggests that millions of members could experience gaps in

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[14] https://www.urban.org/sites/default/files/2022-03/preparing-for-the-biggest-coverage-event-since-the-affordable-care-act_0_0.pdf

[15] CAA enacted a phase-out of the 6.2% FMAP increase, which provides reductions to the enhanced federal funding through the end of 2023 (this is discussed later in this document). No additional federal funding will be provided effective January 2024.

[16] https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf

[17] https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html

[18] https://www.illinoissenatedemocrats.com/caucus-news/29-senator-ann-gillespie-news/3869-gillespie-expands-medicaid-services-cuts-red-tape-for-re-enrollment

[19] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/

[20] https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf

coverage and subsequently re-enroll in the coming months, causing further uncertainty and extending the length of time before Medicaid enrollment levels stabilize. This situation may be especially true in Medicaid expansion states, where higher income eligibility levels may reduce churn. Additionally, a higher proportion of Medicaid expansion states have adopted 12-months of continuous post-partum coverage, which could also reduce loss of coverage.[21] Finally, State-based Marketplaces, all of which have adopted Medicaid expansion, are implementing innovative policies to reduce churn. The state-specific actions listed above could mitigate this issue to some extent.

Recent Medicaid Eligibility Changes

Medicaid coverage changes also have occurred in the last three years, which could affect where enrollment lands following a full cycle of member redeterminations. For example, the American Rescue Plan Act of 2021 provided the option for states to extend Medicaid postpartum coverage to 12 months. This option was initially open for five years but was made permanent as a part of the CAA. As of December 8, 2022, 26 states and the District of Columbia have implemented this change; seven states declared their intention to make the change, and two states have proposed limited coverage extensions.[22] The CAA also requires Medicaid and CHIP programs to provide 12 months of continuous coverage for children, which could result in higher levels of child populations in certain states going forward.

Additionally, several states have approved and implemented ACA expansion coverage directly preceding or during the pandemic, resulting in a significantly higher number of Medicaid-eligible adults in these states relative to pre-pandemic levels.[23]

New Baseline Enrollment Levels Following Redetermination

Ultimate Medicaid enrollment levels following the impending wave of redeterminations are uncertain. Enrollment levels will be impacted by state-specific actions including their ability to mitigate administrative churn. Many commentators have assumed that Medicaid enrollment will return to pre-pandemic levels; however, significant enrollment changes relative to pre-pandemic baselines are possible. Recent policy changes and historical precedent point to the potential that the new “baseline” may be different than what existed prior to the pandemic.

Beyond changes in policy, there is the possibility that the intervening time has made changes to individual behavior and impacted take-up propensity. Though not an exact replica of the current environment, Tennessee’s recent experience with redetermination pauses suggests large baseline changes are possible.

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[21] https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/

[22] ibid

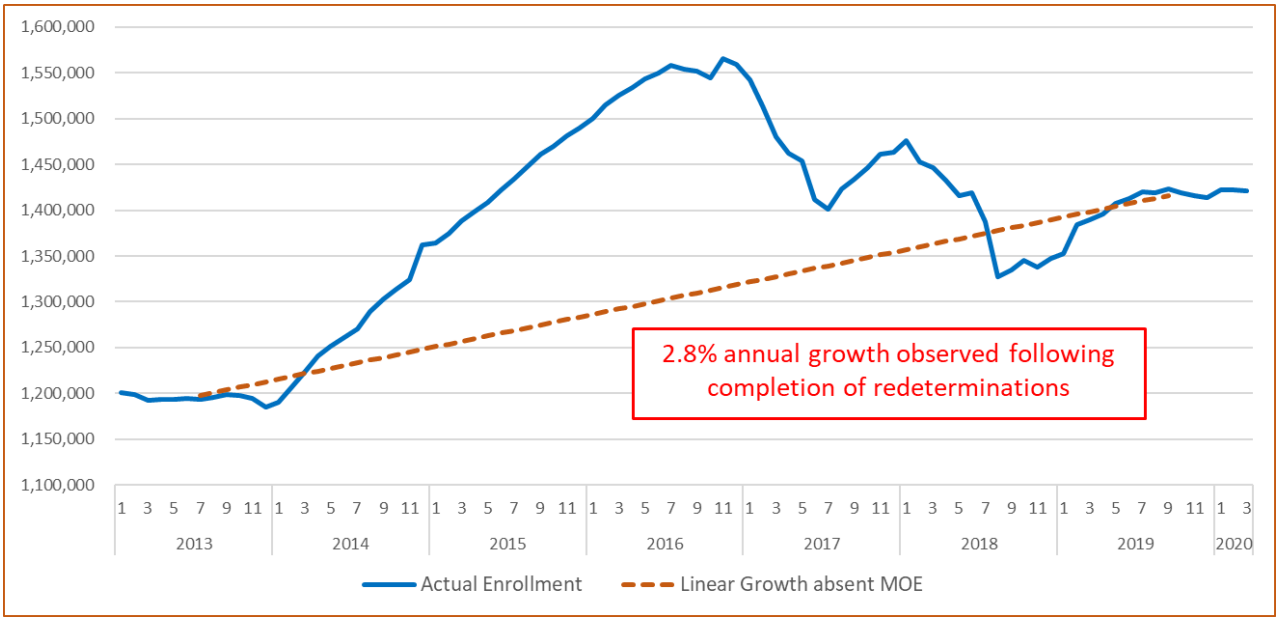
[23] https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

Tennessee Case Study

Prior to COVID-19, Tennessee Medicaid underwent a similar event to the current MOE in which redeterminations were ceased for an extended period. Specifically, the state suspended eligibility redeterminations in January 2014 as the Affordable Care Act began due to not having an online eligibility system in place. Enrollment grew by more than 380,000 members (or 32%) over the next three years[24] until the state implemented manual redeterminations in late 2016.[25] This manual redetermination process occurred in several phases and met significant administrative challenges.

Lengthy renewal packets were sent to beneficiaries, many of which reportedly were sent to the wrong address or never processed. Children also were not screened for eligibility under other Medicaid categories before being disenrolled. Most beneficiaries were found to have lost coverage due to incomplete or unreturned forms. Significant administrative churn occurred as a result. Figure 2 demonstrates the sharp rebounds in enrollment following each manual redetermination phase.

Figure 2: Tennessee Medicaid Enrollment (January 2013 – March 2020)



What happened in Tennessee provides another data point from which to estimate where Medicaid baseline enrollment will land when MOE-related redeterminations are completed. Tennessee's online eligibility system was finally implemented in March 2019, over five years after redeterminations were ceased. Figure 2 shows that stabilized enrollment following March 2019

[24] https://www.tn.gov/tenncare/information-statistics/enrollment-data.html

[25] https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf

represented 2.8 percent annual growth over 2013 enrollment levels. This moderate growth following Tennessee's redetermination event could reflect increased member interest in maintaining Medicaid coverage after being continuously enrolled for an extended period, although many other Medicaid programs exhibited enrollment increases during this period as well. It is possible this pattern may occur nationally following the upcoming disenrollments, which could result in new baseline Medicaid and CHIP enrollment levels that exceed pre-pandemic levels.

Previously, there has been some evidence of the "taste for coverage" increasing if a person is exposed to coverage. For example, in a famous Oregon Medicaid Experiment, when adults gained access to Medicaid, the number of children who were enrolled also rose despite no changes to children's eligibility standards.[26] In other words, families who have Medicaid enrollees, or a history of access to coverage, may be more inclined to encourage other family members to participate. In general, we would expect states that exhibited the largest enrollment increases during the pandemic to be most likely to maintain elevated enrollment levels post redetermination.

Rate Setting Considerations during the COVID-19 Pandemic

State-specific actions will affect the magnitude and timing of redeterminations in coming months, which, in turn, could directly influence the amount of budgetary uncertainty and level of financial risk to contracted health plans as these changes are considered in capitation rate setting. Rate setting actuaries will need to consider the many influences affecting redeterminations in their respective states, including state-specific actions, similar to how previous rating periods accounted for enrollment increases arising from continuous Medicaid eligibility.

The absence of Medicaid redetermination activities during the COVID-19 pandemic led to significant enrollment increases for many programs and population groups, fundamentally altering their risk profile.[27] Specifically, populations that experienced significantly increased enrollment have often also exhibited corresponding reductions in morbidity (e.g., average claim cost levels).

Rate setting actuaries have used a variety of approaches to address population acuity changes during the COVID-19 pandemic. Evaluating potential changes in population acuity has been a common challenge in rate setting and one that has evolved during various stages of the pandemic. Initially, rate setting actuaries faced the challenge of accounting for acuity differences between pre-pandemic base data and pandemic-era rating periods, such as using calendar year (CY) 2019 base data to develop CY 2021 capitation rates. Over time, this dynamic has evolved, as some

[26] https://jamanetwork.com/journals/jamapediatrics/fullarticle/2086457

[27] Changes in the volume of new members joining the program may have contributed to enrollment increases for some Medicaid programs/populations. In our experience, the impact of altered new member enrollment patterns has varied by program and population and is generally a smaller contributor to Medicaid enrollment increases than the lack of member redetermination activities during the public health emergency.

recent capitation rate methodologies are developed using pandemic era data as a starting point (i.e., CY 2021 base data used to develop CY 2023 capitation rates). Though the differences in enrollment levels and acuity may have moderated somewhat with the use of pandemic-era data, the evaluation of population risk differences remains a fundamental challenge for rate setting actuaries.

In our experience, Medicaid rate setting actuaries commonly have used one of the following approaches to account for changes in population acuity and utilization patterns during the pandemic.[28] The approaches described are listed in roughly descending order of actuarial complexity. Certain approaches may be more actuarially complex, but this does not necessarily mean their application resulted in more accurate acuity estimates. The accuracy of state-specific acuity assumptions is dependent on a range of factors and should be retrospectively reviewed for accuracy and to consider future implications upon the resumption of redetermination activities.

Develop acuity adjustments based on historical claim cost and/or risk score differentials

These approaches attempt to quantify the acuity difference between members who would have disenrolled (theoretical lapsers) under normal circumstances compared with the overall (baseline) population. As noted earlier, theoretical lapsers prior to the pandemic tended to be lower acuity than the baseline population, so their accumulation on Medicaid rolls has the potential to decrease average population costs. We observed a variety of approaches that were employed to assess the potential acuity impact of retaining theoretical lapsers. In general, these approaches compare either historical claim costs or historical risk scores for pre-pandemic lapsers to their corresponding baseline populations.

This methodology also requires an estimate of the volume of theoretical lapsers who will remain enrolled per month. These estimates generally increase on a month-over-month basis due to the absence of members disenrolling during to redetermination. In our experience, rate setting actuaries have generally based the enrollment increase estimates on pre-pandemic lapse rates and/or emerging month-to-month changes in enrollment levels (with an increased reliance on the latter during more recent stages of the pandemic).

[28] This list summarizes common approaches used to quantify population acuity changes during the PHE and likely does not include every approach the country's various Medicaid programs have used. Some rating methodologies incorporate components from multiple items on this list.

Quantify risk differences between the base and rating periods based on concurrent risk score differentials Some rate setting methodologies attempt to quantify the difference between base and rating periods by comparing composite population risk scores from each period (i.e., if a rate group's average score decreased from 1.00 to 0.99, it was assumed that the overall population acuity similarly declined by 1%).

Given that the pandemic resulted in the suppression of various types of medical services, unadjusted pandemic-era risk scores may not accurately reflect population acuity differences from pre-pandemic periods. In our experience, rate setting actuaries using this approach may attempt to quantify this potential understatement of risk scores due to pandemic-era suppression in an attempt to ensure risk scores are comparable between pre-pandemic and pandemic-era experience periods.

These methodologies tend to have a long adjudication tail, as claims experience must be collected for the rating period (inclusive of a sufficient level of claims runout) to determine the final risk scores for the period. As a result, contracted health plans will not know their final revenue levels until a given rating period has ended.

Adjust trend development assumptions or methodologies to account for impact of the pandemic Some rate setting actuaries did not directly attempt to quantify MOE-related changes in population acuity and instead adjusted prospective trend assumptions to reflect emerging utilization and cost patterns. This approach is relatively simple to apply if credible recent data are available, although it likely captures a combination of population acuity changes and changes in member behaviors (i.e., suppressed utilization, pent-up demand, etc.) that occurred during the various stages of the pandemic. Because member behavior patterns changed materially during the course of the pandemic, emerging trends have not always been reliable indicators of prospective trend levels.

No explicit acuity adjustment Some rate setting actuaries did not apply explicit acuity adjustments in pandemic-era rate development. Though many states fell into this category during rating periods that encompassed the initial months of the pandemic (i.e., rating periods effective July 2019, January 2020, etc.), fewer states maintained this approach during subsequent rating years when the material effects of the pandemic became clearer.

In addition to the approaches above, many Medicaid programs implemented risk mitigation strategies such as risk corridors to account for the increased claim cost uncertainties that the COVID-19 pandemic created. Some states have maintained these risk mitigation strategies during recent rating periods, while many others have removed them as pandemic-related uncertainty declines.

In general, rate setting actuaries set rate setting methodologies with consideration of state feedback. While the method is important, what is equally important to the ultimate impact is the associated assumptions that accompany the adjustment design.

Post-April 2023 Programmatic and Rate Setting Considerations

Many of the same rate setting considerations needed during the pandemic also will apply when membership declines occur once redetermination activities resume beginning in April 2023. However, while earlier pandemic-era rating periods frequently were expected to have higher enrollment (and lower acuity) than their corresponding base data, the post-April 2023 environment is expected to reverse this trend.

A variety of factors will affect how individual programs/populations and associated capitation rates are impacted by the resumption of redetermination activities. Such considerations include, but may not be limited to:

Rating period timing. Medicaid rates are generally effective for 12-month periods. However, timing of rating period cycles varies considerably by program. Many programs develop capitation rates on a calendar year basis, but others may be implemented during other months of the year. The April 2023 resumption of redetermination activities will have varying implications depending on rating period timing. For example, a program that develops capitation rates on a calendar year basis may need to reconsider previously developed CY 2023 population acuity rating assumptions, whereas a program that implements rates each April may be able to seamlessly address the resumption of redetermination activities in the April 2023 rates.

In many cases the April 2023 resumption of redetermination activities may not align with prior rating assumptions, which may necessitate retroactive adjustments to previously developed rates. The nature of such adjustments will depend on the initial rating assumptions, as rating actuaries may have assumed redetermination activities would resume either before or after April 2023.

Selected base data. Capitation rates effective during the earlier phases of the pandemic tended to rely on pre-pandemic base data (i.e., CY 2019 base data used to develop CY 2021 rates). We have observed that some programs have shifted to using pandemic-era base data to develop recent capitation rates whereas other programs have continued to use pre-pandemic data.

Because pandemic-era enrollment levels increased materially for many programs and populations, the use of base data from this period may reflect higher enrollment and lower acuity than earlier periods. Rating actuaries will need to consider the relative enrollment acuity levels between the base and rating periods, which may differ materially depending on whether pre-pandemic or pandemic-era base data are used.

Expected post-pandemic enrollment levels. Many programs and populations have experienced significant enrollment increases during the pandemic. Though the suspension of member redetermination activities is likely the primary driver of these increases, a number of factors could affect the level of enrollment a program might ultimately experience after all members have undergone redetermination (as discussed earlier in this document).

These factors will determine how post-pandemic Medicaid enrollment levels will compare with those observed prior to March 2020. It is possible that some programs and populations will exhibit lower levels of enrollment post-pandemic, whereas others may experience the opposite scenario. Furthermore, these and other factors will determine how a population's future acuity will compare with pre-pandemic levels. Consider a scenario where a population grew by 50,000 members during the pandemic, and these members are believed to have 8 percent lower acuity than the baseline population. If 40,000 of the 50,000 surplus members ultimately lapse post-pandemic, it is possible their acuity may differ from the 8 percent differential observed for the larger population. How, and in what direction their acuity differs may have significant implications for future population cost levels and corresponding implications for rate adequacy.

Administrative cost rate setting assumptions. Many rate setting actuaries adjusted per-member-per-month administrative funding during the pandemic to account for increased MCO membership. In these cases, these assumptions presumably will be unwound to align membership declines expected to occur beginning April 2023.

For prospective rating periods, we anticipate that many rating actuaries will attempt to estimate post-April 2023 population acuity using approaches that align with the earlier methodologies used within the corresponding program. Post-April 2023 use of the approaches described above have somewhat different implications for future rating periods, as described below.

Develop acuity adjustments based on historical claim cost and/or risk score differentials. As noted previously, these approaches tend to estimate a) the relative acuity of theoretical lapsers in relation to the corresponding baseline population and b) the number of these members who are likely to be enrolled during each period.

During pandemic-era rating periods, these assumptions have frequently assumed increased enrollment and decreased acuity. For post-April 2023 rating periods, this dynamic is expected to reverse.[29] In many cases, the claim cost or risk score methodologies employed by rate setting actuaries may be leveraged to estimate the corresponding expected declines in acuity. The relative acuity of post-April 2023 lapsers, and whether these lapsers exhibit acuity consistent with the overall theoretical lapser population is a potentially significant variable that should be considered in prospective rate setting.

Quantify risk differences between the base and rating periods based on concurrent risk score differentials. These types of approaches are generally designed so that the methodology is well defined in advance of the rating period, creating little process uncertainty; however, these methodologies require the availability of rating period enrollment and claims data to adjudicate.

[29] A variety of factors will affect whether prospective enrollment levels will be higher or lower than the base period. Such factors include the months included in rating period (i.e., a rating period of CY 2023 will likely have different considerations than July 2023 through June 2024), the base period chosen to develop prospective rates, the state's approach to member redetermination and associated timeline, etc.

For example, member risk scores for a rating period beginning April 2023 cannot be calculated until the 12-month period ends in March 2024. Some level of claims runout is likely desired to ensure that risk scores for this period are not understated. Ultimately, final concurrent risk scores for this period may not be available until late 2024.

Adjust trend development assumptions or methodologies to account for impact of the pandemic. This approach is relatively simple to apply from a technical standpoint. However, development of post-MOE trend assumptions is a nuanced and complex process given the consistently evolving conditions that have occurred since the beginning of the pandemic. While "past performance is no guarantee of future results" certainly applies to Medicaid trends during normal times, this statement is particularly true since the onset of the pandemic.

Medicaid trends observed during the pandemic have varied considerably over time and across states as a result of stay-at-home orders, changes in population acuity, claims suppression, pent-up demand, etc. As a result, recent trends are unlikely to be highly predictive without significant actuarial analysis and adjustments to reflect the expected future environment. Similarly, pre-pandemic trends may not be good predictors given expected prospective changes in population acuity, return of deferred services, etc. As a result, rate setting actuaries who previously used this approach may need to consider how to separate changes in acuity from other factors affecting recent and future trends.

No explicit acuity adjustment. This approach is similar to the prior one, with the exception that rating setting actuaries using this methodology would not attempt to explicitly adjust PHE-era trend assumptions to account for pandemic-related effects. Actuaries using this approach likely will not be able to rely heavily on recent trend experience without significant consideration of any necessary actuarial adjustments. They additionally may want to consider separately evaluating population acuity changes and programmatic trends. Without specific adjustments for changing population acuity and lessened claims suppression, it is likely that rates using this approach that are based on pandemic-era base data may result in the underfunding of future rating periods due to expected increases in population acuity.

Conclusion

State-specific actions will directly influence the magnitude and timing of Medicaid enrollment declines following the resumption of redetermination activities. These enrollment changes may significantly affect population acuity levels, which will need to be addressed in capitation rate setting. While the impending changes result in increased uncertainty, actuaries have a variety of tools at their disposal to prospectively estimate the potential impact with consideration of specific state, program, population, economic, and environmental factors that will impact experience. Careful monitoring of emerging enrollment levels and claims experience will provide significant insight into the accuracy of prospective rating assumptions and offer guidance as to whether retrospective adjustments may be appropriate.

Appendix A: Disclosures and Limitations

Responsible Actuary. Taylor Pruisner and Sam Rickert are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Risks and Uncertainties. Users of the results should be qualified to use them and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. It is the responsibility of the those receiving this analysis to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, the responsible actuary is financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent from the Robert Wood Johnson Foundation.

Data and Reliance. We have relied on information from public data sources in the analysis. We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events. Material changes in state or federal laws regarding Medicaid or the US health care system were not addressed in our analysis but could have a material impact on its the results. The potential future impact of COVID-19 may also influence results and is an uncertainty. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document constitutes the entirety of actuarial report and supersedes any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality, ASOP No. 41, Actuarial Communications, ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification, ASOP No. 56, Modeling