January 10, 2024

Record '24 Enrollment (20 M) in Exchange

Plans Benefit from Medicaid Reverifications

Relevant Companies

Our Take & Next Up

We are continuing to see healthy enrollment in Marketplace plans via state-based exchanges and healthcare.gov. Today CMS announced (see here for snapshot) the 20 M enrollees; this is the highest number to date of American people having health care coverage. Open enrollment ends Jan 16. The 2024 open enrollment period started Nov 1, 2023, and ends January 16, 2024, for states using the HealthCare.gov platform. Consumers can start February 1. State-based Marketplace enrollment deadlines vary. State-specific deadlines and other information are in the State-based Marketplace Open Enrollment (Fact Sheet).

Key Points

Today's CMS update represents data through December 23 for the 32 states using HealthCare.gov & the 18 states and the District of Columbia with State-based Marketplaces. See here for relevant state-based and other data and pertinent metrics.

- Total plan selections include more than 3.7 M people (18% of total) who are new to the Marketplaces for 2024 and 16.6 M people (82% of total) who had active 2023 coverage and selected a plan for 2024 coverage or were automatically re-enrolled.
- Plan selections so far represent an increase of over 8 M more people who have coverage since the start of the Administration
- 90%+ of HealthCare.gov enrollees will be able to choose from 3+ plans.
- Standardized plan options offer the same deductibles and cost-sharing for certain benefits. i.e., same out-of-pocket limits within the same health plan category, making it easier for consumers to compare and choose plans.
- Most standardized plan options offer many services pre-deductible, including (1) primary care, (2) generic drugs, (3) preferred brand drugs, (4) urgent care, (5) specialist visits, (6) mental health and substance use outpatient office visits, as well as speech, occupational, and physical therapies.

Exchange plans (UNH, ELV, CNC, CVS, others) are benefiting from Medicaid disenrollees. As a reminder, we are in the middle of the great unwinding. Medicaid redeterminations were initially scheduled to be done 1Q24 when CMS released initial guidances. Instead, states have completed <50% of the workload. The acuity of those reverified off has matched (largely) expectations from plans. In addition, states are willing to play ball on updating risk-adjusted pay rates which is helpful for Medicaid MCOs (CNC, MOH, UNH, ELV, CVS) since there are lower Medicaid volumes overall.

MEDICAID UPDATES

We have said that Medicaid redeterminations will take until the end of the year, or 6-8 months longer than anticipated by CMS (see here). The enhanced FMAP (match) ended in Jan 2024. That means that states are not receiving the COVID-era bump to pay any longer. No states appear to be asking CMS to extend the enhanced payments, despite glitches in completing the arduous process. This includes procedural disenrollments, kids getting knocked off the rolls when they may indeed qualify for CHIP, etc.

CMS is in tacit agreement that the unwinding process will take longer than the originally estimated 14 months. In a recent IFR (see below), CMS stated that the timeline for such rule-making would extend beyond the time period April 1, 2023 to June 30, 2024 (the original 14-month expected timeline). This is in line with our expectations, as we believe this process will take closer to 21 months through the end of 2024. FMAP enhanced rates end in January, only a few weeks away.

Kids are still being dropped. CMS released an interim final rule (IFR) outlining CMS enforcement of state compliance with reporting and federal Medicaid renewal requirements (here). The rule took effect December 6 with the comment period ending February 2, 2024. In addition, on December 18, the Biden Administration released new Medicaid and CHIP Renewal Data (here and here) that focuses on enrollment changes among children and youth.

The December rule from CMS could cause states to lose funding over Medicaid redeterminations. The rule outlines enforcement requirements including (1) requiring states to submit a corrective action plan (CAP), (2) requiring states to suspend disenrollments from Medicaid for procedural reasons, (3) imposing civil money penalties (CMP), and (4) applying a reduction the state-specific FMAP for failure to meet reporting requirements.

Ipsita Smolinski
Managing Director I Capitol Street
ipsita@capitol-street.com

202.250.3741 I www.capitol-street.com

900 19th St NW 6th Fl
Washington, D.C. 20006

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