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Three Ways To Make Health Insurance Auto- Enrollment Work

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EDITOR'S NOTE

This white paper is part of the USC-Brookings Schaeffer Initiative for Health Policy, which is a partnership between the Economic Studies Program at Brookings and the USC Schaeffer Center for Health Policy & Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings.

Executive Summary

The Affordable Care Act has dramatically reduced the number of uninsured Americans, but millions of people still remain without coverage. Policies that help the uninsured gain coverage are likely to improve access to care and financial protection for those individuals, reduce uncompensated care burdens for providers, and, because the remaining uninsured are relatively younger and healthier than the population as a whole, lower overall per-capita premiums.

One attractive tool to build on the ACA and achieve coverage gains is “auto-enrollment”—that is, policies that enroll people in coverage without requiring them to actively seek out or submit an initial application. This term can include both “true” auto-enrollment, in which a consumer seamlessly and automatically obtains coverage, and approaches that take steps toward making enrollment automatic while still requiring some affirmative action from the potential enrollee.

Any auto-enrollment proposal requires policymakers to solve four distinct policy problems:

- **Obtaining eligibility information.** Currently uninsured people are eligible for different programs with different amounts of financial assistance. Policymakers must find a way to determine who is uninsured, what coverage they could be enrolled into, and at what price.
- **Collecting a premium.** Many (though certainly not all) uninsured people will owe a premium if they become enrolled in coverage. To auto-enroll such a person the policy needs a way to collect premiums.
- **Selecting an insurance plan.** If the individual would have a choice of insurance plan if they actively enrolled, auto-enrollment needs to assign them to a plan.
- **Managing false positives and false negatives.** Sometimes, auto-enrollment will get it wrong, and a person will become enrolled into coverage for which they are not eligible or remain uninsured despite having reason to believe they were covered. Policymakers need a fair approach to resolve these problems.

Under current law, each of these four problems is hard to solve. First, existing coverage programs have a patchwork of eligibility rules, and determining what program a person is eligible for requires a great deal of information—about income, family composition, and employer health plan, if any – that is not always available in government datasets. Second, premiums for many people are large, must be paid monthly, and generally must start at the end of the calendar year. Third, in the individual market, insurance carriers offer a wide variety of plans at different prices, and there is no obvious “default” option. And fourth, current rules place an especially high price on getting things wrong: individuals must themselves repay much of any financial assistance that is wrongly received, and, conversely, there is no mechanism to cover someone who was initially overlooked.

Despite these obstacles, new federal legislation to address the difficulties and move towards auto-enrollment is possible. There are a number of tools that policymakers could use. Most fundamentally, successful auto-enrollment likely requires changes to the way we determine eligibility for Medicaid and Marketplace financial assistance, to make the system easier to navigate and more generous. That is, using data to estimate eligibility is easier to achieve when eligibility criteria are designed to better fit the available data. This can include:

- Eliminating reconciliation and converting Marketplace financial assistance to a prospective award,
- Broader use of continuous eligibility, where eligibility is “locked” based on a prior point in time,
- Greater flexibility about who can conduct an eligibility determination,
- Eliminating the employer coverage firewall, and
- Improving subsidy generosity.

Policymakers can also consider retroactive approaches to enrollment, where individuals are considered “covered” during a period of uninsurance and charged a premium after the fact. The tax system can be leveraged to better facilitate enrollment, and policymakers should be realistic about what actions consumers themselves will need to take.

This paper describes three different proposals that would make some form of automatic enrollment possible. The analysis generally focuses on policies that could be enacted through new federal legislation, though some of the concepts discussed could be adapted to administrative actions or to state government.

Option 1: A Retroactive Coverage Backstop

If policymakers want to achieve “true” auto-enrollment that is seamless for the consumer, they should pursue an approach where consumers are automatically enrolled in coverage that is retroactively accounted for at tax filing. Consumers who are otherwise uninsured (and are not eligible for Medicaid) would be treated as if they were covered by a “backstop plan” for each month they did not have other coverage. If they received health care services in that time, the backstop plan would pay claims, just like other forms of insurance. At tax filing, individuals covered by the backstop would be retroactively charged a premium for the plan. This premium would be charged regardless of whether or not the individual used health care services in their months of backstop coverage, and would be income-adjusted to mirror Marketplace financial assistance.

Determining what plan will serve as the backstop is complex. One option is for the backstop coverage to be provided by a public plan in the individual market. Alternatively, a privately-operated backstop could provide temporary coverage, and then individuals would transition into traditional individual market plans. Regardless, backstop coverage would be “activated” during the year when an individual accesses care, enabling the consumer, health care providers, and the backstop plan to coordinate care delivery. The backstop should be designed and priced at the level of a bronze plan (or whatever the lowest cost individual market option is).

Coverage for Medicaid-eligible individuals would be handled outside this system, largely following current law: people would become enrolled in Medicaid when they accessed care, and Medicaid would cover their services prospectively and through the retroactive coverage period.

Such an approach could effectively create universal coverage for the eligible population, since any time an individual lacked another source of coverage, they would be covered by the backstop plan. If policymakers wanted to create a process by which individuals could opt-out of the backstop coverage, they could—but at the cost of forfeiting some of the backstop’s benefits, including its ability to ensure universal (or near-universal) coverage.

Option 2: Assessment at Tax Filing

An alternative approach would stop short of enrolling individuals into a coverage product, but would take aggressive steps to connect likely-eligible individuals to coverage and encourage enrollment. Specifically, at tax filing, individuals who have indicated on their tax return that they are uninsured would be matched to a likely source of coverage (e.g. an individual market plan or Medicaid). Targeted outreach would encourage them to enroll.

Though not strictly necessary, this approach will be more successful if combined with efforts to dramatically simplify the eligibility determination process. However, it will not represent a truly universal approach to enrollment, leaving out individuals who experience changes in coverage status or income or who fail to take the action required to begin coverage. While it could achieve some coverage gains, they are likely to be much smaller than a truly automatic system could achieve.

Option 3: Targeting Specific Populations

A third option for policymakers to consider would be to target a few specific populations at times of coverage transitions. Specifically, targeting individuals who would otherwise lose coverage when churning between Medicaid and the individual market can produce some coverage gains, especially in states where the same issuers participate in both markets. Issuers could become responsible for retaining individuals through these coverage transitions. Another potential target would be individuals claiming Unemployment Insurance (UI) benefits. UI applicants could be asked questions to determine their coverage eligibility, and if uninsured they could be directly enrolled into coverage—with premiums automatically deducted from their UI benefits. These are limited-scope activities and not a population-wide approach to enrollment, but they could still bring new people into coverage.

Contents

- Executive Summary i
- Introduction 1
- What Auto-Enrollment Requires and Why It’s Challenging..... 2
 - Obtaining Eligibility Information 2
 - Collecting a Premium 5
 - Selecting a Plan 6
 - Managing False Positives and False Negatives 6
- Towards an Auto-Enrollment Solution..... 7
 - Simplify and Expand Eligibility Rules 7
 - Establish Backwards-Looking Auto-Enrollment 10
 - Leverage the Tax System 11
 - Require Action to Begin Coverage..... 11
- Specific Auto-Enrollment Proposals 12
 - Option 1: Retroactive Coverage Backstop 12
 - Option 2: Assessment at Tax Filing..... 18
 - Option 3: Targeted Populations 21
- Conclusion..... 23

Introduction

The Affordable Care Act has dramatically reduced the number of uninsured Americans, but millions of people still remain without coverage – currently about 13 percent of nonelderly adults¹ – limiting their access to the health care system and exposing them to significant financial risk in the event of illness or injury. Further, the remaining uninsured are relatively younger and healthier than the population as a whole. Therefore, policies that help the uninsured gain coverage are likely to improve access to care and financial protection for those individuals, reduce uncompensated care burdens, and lower overall per-capita premiums.

One attractive tool to build on the ACA and achieve coverage gains is “auto-enrollment” – that is, policies that enroll people in coverage without requiring them to actively seek out coverage or submit an initial application. The behavioral economics literature consistently supports the use of defaults to encourage salutary behavior. For example, scholars have repeatedly demonstrated that if employees are automatically enrolled into retirement savings account when they begin a new job, they are much more likely to remain enrolled than if they are required to actively sign up.² Building on these insights, observers are seeking pathways to enroll otherwise-uninsured consumers into the coverage for which they are eligible with little or no active behavior required. Indeed, stakeholders across the ideological spectrum have shown enthusiasm for some type of auto-enrollment into health insurance.³ This includes support for both “true” auto-enrollment, where a consumer seamlessly and automatically obtains coverage, and exploration of approaches that make enrollment more straightforward while still requiring some affirmative action from the potential enrollee.

This piece provides a detailed examination of auto-enrollment, and is intended to inform future policymaking to fill the gaps left by the Affordable Care Act by enrolling more of the uninsured into coverage. It is not intended to make the case for *why* policymakers should be interested in these tools, but rather to provide a roadmap for *how* automatic enrollment could function. It assumes a policy environment that builds on the basic structure of the ACA, where individuals who do not have coverage from an employer are eligible for coverage in their state’s Medicaid program⁴ or for income-based financial assistance to buy coverage in a Health Insurance Marketplace selling community-rated individual market insurance products. The analysis generally focuses on policies that could be enacted through new federal legislation, though some of the concepts discussed could be adapted to administrative actions or state government.

The paper begins by examining what auto-enrollment requires and why it is challenging in the current policy environment. It then explores some of the key types of policies that could help address these issues. Finally, the piece considers three specific visions for implementing auto-enrollment.

¹ Emily P. Terlizzi, Robin A. Cohen & Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2018*, NATIONAL CENTER FOR HEALTH STATISTICS (February 2019), <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201902.pdf>

² See, e.g., James J. Choi, David Laibson & Brigitte C. Madrian, *Plan Design and 401(k) Savings Outcomes*, 57 NAT’L TAX J. 275 (2004), <https://scholar.harvard.edu/laibson/publications/plan-design-and-401k-savings-outcomes>.

³ See, e.g., Stan Dorn, James C. Capretta & Lanhee J. Chen, *Making Health Insurance Enrollment As Automatic as Possible (Part 1)*, HEALTH AFFAIRS BLOG, May 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180501.141197/full/>; Stan Dorn, James C. Capretta & Lanhee J. Chen, *Making Health Insurance Enrollment As Automatic as Possible (Part 2)*, HEALTH AFFAIRS BLOG, May 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180501.219130/full/>; David Anderson, *Auto-Enrollment is a Good Idea, Here’s How to Make it Even Better*, HEALTH AFFAIRS BLOG, May 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180514.705157/full/>; James C. Capretta & Lanhee J. Chen, Op-Ed, *How the GOP Could Nudge the Uninsured Toward Coverage*, WALL STREET JOURNAL, April 18, 2017, <https://www.wsj.com/articles/how-the-gop-could-nudge-the-uninsured-toward-coverage-1492555423>; Patient Freedom Act of 2017, S. 191, 105th Cong. (2017), <https://www.congress.gov/bill/115th-congress/senate-bill/191>.

⁴ The analysis presented here generally assumes that all states have expanded Medicaid, though many ideas could be adapted to a non-expansion environment.

What Auto-Enrollment Requires and Why It's Challenging

The term auto-enrollment has taken on many different meanings in conversations about expanding health insurance coverage. This paper will use the term to describe an approach by which someone will become enrolled in coverage without needing to initiate the process by submitting a health coverage application. This encompasses both “true” auto-enrollment, where a consumer seamlessly and automatically obtains coverage, and approaches that take steps toward making enrollment automatic while still requiring some affirmative action from the potential enrollee.

Making auto-enrollment work requires solving four policy problems:

- **Obtaining eligibility information.** Becoming enrolled in coverage requires information about all factors necessary to determine an individual’s eligibility for various programs. Policymakers must find a way to determine who is uninsured, what coverage they should be enrolled into, and at what price. This requires relatively current and comprehensive information regarding each eligibility criterion (or making policy changes that render that factor not relevant to eligibility).
- **Collecting a premium.** If the health coverage product for which the individual is eligible requires a premium, then the auto-enrollment approach must determine how it will collect the amount owed, such as identifying some other fund flow that can be tapped or requiring affirmative steps by the enrollee to start payment before coverage begins.
- **Selecting an insurance plan.** If the individual will become enrolled in a market segment where there are choices of carrier, provider network, or benefit structure, auto-enrollment requires rules for assigning the individual into a plan. Further, given that the population affected by auto-enrollment will likely be healthier than average, auto-enrollment where choice is available will require policymakers to pay close attention to how risk adjustment can evenly distribute that risk.
- **Managing false positives and false negatives.** In an environment where there are multiple different coverage sources and eligibility rules, any approach to auto-enrollment will generate false positives (i.e. an individual becomes enrolled into coverage for which they are not eligible) and false negatives (i.e. an individual remains uninsured despite having reason to believe they were automatically enrolled). This can result in significant financial liabilities for individuals, either in repaying “incorrectly” received financial assistance or uncovered health care costs. An auto-enrollment scheme requires an equitable approach to resolving these problems when they are identified.

All four of these problems are hard to solve under current law, as described in more detail below.

Obtaining Eligibility Information

Determining eligibility under current law requires information about characteristics that can be complex and unstable. Specifically, for enrollment in Marketplace coverage with financial assistance and many Medicaid and CHIP eligibility categories, eligibility determination requires information about five key characteristics: household income, other sources of health coverage, citizenship or immigration status, age, and county of residence.⁵ The last two factors – age and county – do not pose major issues; they are fairly stable and/or widely available in government data sources that would likely be available in an auto-enrollment context. However, collecting information on the first

⁵ A truly comprehensive view of eligibility under current law would also require information about additional factors like tobacco use, pregnancy, disability, membership in a federally recognized Indian tribe, quarters of Medicare-recognized work history, and zip code. That said, auto-enrollment will necessarily involve some simplification of eligibility and the eligibility changes reflected by these characteristics are of the sort that can likely be avoided in auto-enrollment.

three characteristics – income, other sources of health coverage, and citizenship or immigration status – creates challenges.

Income

At the center of any eligibility determination is household income, a highly volatile characteristic. For example, a recent analysis found that fully two thirds of households experienced an income gain or loss of 9 percent or more between 2014 and 2015, with a third experiencing a gain or loss of 25 percent or more.⁶ Notably, the groups most likely to be uninsured, young people and low-income households, had even higher rates of income volatility. Thus, any “backward-looking” data source (like prior year tax return information) will not present a perfectly accurate picture of current eligibility for the majority of families. And more current data sources (like state Unemployment Insurance systems, the National Database of New Hires, or private payroll data aggregators) contain only a subset of sources of income or a subset of people and still become available with at least a few month lag.⁷ Some proponents of auto-enrollment suggest combining tax data with these other more current sources,⁸ which would somewhat improve accuracy. But Marketplace enrollees are disproportionately likely to have the kinds of income that are not reflected in these wage-based datasets: one analysis found that 28 percent of workers purchasing Marketplace coverage for themselves had income that was not primarily earned from wages paid by an employer.⁹ Therefore, leveraging available income data might produce an accurate measure for some households, but given the high degree of volatility and the prevalence of alternative income sources, it will fall far short of being able to produce an income measure that is reasonably accurate across most families.

And beyond the central challenge imposed by volatility, there are several additional complicating factors. Marketplace financial assistance is calculated on a sliding scale based on income, so an auto-enrollment system needs to know a precise dollar figure (not just whether income is above or below a threshold). And the value of the tax credit is based on the household’s income for the entire calendar year, so even *if* we had perfect information about current income, it would not reflect actual eligibility since that relies on information only the household itself knows. Further, eligibility in all programs is determined at the household level based on a household’s income to poverty ratio. That means changes in household composition (marriages, divorces, birth or adoption of children, or children no longer being tax dependents) also affect eligibility and must be measured and accounted for. In addition, Medicaid eligibility and Marketplace financial assistance eligibility operate under somewhat different rules regarding household membership and current income versus projected income.

Thus, given the high degree of volatility in income, the patchwork nature of most data sources, and the nature of the relevant eligibility rules, the best policymakers can realistically achieve prospectively is a preliminary estimate of a household’s current income; they should not expect that they can accurately measure actual income for anything approaching all families.

Other Sources of Coverage

⁶ HOW INCOME VOLATILITY INTERACTS WITH AMERICAN FAMILIES’ FINANCIAL SECURITY, PEW TRUSTS (2017), <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2017/03/how-income-volatility-interacts-with-american-families-financial-security>. The analysis reflects changes in the amount of earnings for individual family members as well as changes in household composition. See also Stan Dorn, Matthew Buettgens, Habib Moody & Christopher Hildebrand, *Using Past Income Data to Verify Current Medicaid Eligibility*, URBAN INSTITUTE (October 2013), <https://www.urban.org/sites/default/files/publication/24026/412920-Using-Past-Income-Data-to-Verify-Current-Medicaid-Eligibility.PDF>.

⁷ See also Paul N. Van De Water, *Automatic Enrollment in Health Insurance Would Be Complex and Difficult to Administer*, CENTER ON BUDGET AND POLICY PRIORITIES (June 2017), <https://www.cbpp.org/research/health/automatic-enrollment-in-health-insurance-would-be-complex-and-difficult-to>.

⁸ See, e.g., Dorn et al., *supra* note 3.

⁹ Adam Looney & Kathryn Martin, *One in Five 2014 Marketplace Consumers was a Small Business Owner or Self-Employed*, U.S. DEPARTMENT OF THE TREASURY (January 2017), <https://www.treasury.gov/connect/blog/pages/one-in-five-2014-marketplace-consumers-was-a-small-business-owner-or-self-employed.aspx>.

Eligibility for financial assistance in the Marketplace turns on whether an individual has access to or is enrolled in another source of health coverage. This, too, is a highly volatile household characteristic that is not well reflected in any data sources.

There are two distinct ways in which this issue frustrates auto-enrollment policy. First, people gain and lose insurance coverage fairly frequently, so it is difficult to define who should be considered for auto-enrollment. National Health Interview Survey data indicates that about 40 percent of non-elderly adults uninsured at a given point during 2018 had been uninsured for less than a year.¹⁰ An analysis with my colleague Sobin Lee suggests that data about uninsurance status that is just 5 months old would “miss” 20 percent of the actually uninsured while 20 percent of the sample would have gained other coverage.¹¹ Further, unlike income, where at least some data sources *attempt* to capture current information from many employers, there is no source that compiles data about current enrollment in health coverage from multiple sources.¹² Indeed, this is likely part of the reason that auto-enrollment into employer health coverage is not especially common: employers do not have a reliable way of knowing whether a worker (or family member) needs their coverage.

Second, even with good evidence that the individual is uninsured, determining eligibility for Marketplace financial assistance requires knowing whether the household has a qualifying offer of coverage from an employer. Indeed, estimates suggest that 9 percent of the non-elderly uninsured in 2017 were barred from receiving a tax credit because they were eligible for qualifying employer coverage,¹³ so this is relevant for a sizable fraction of the remaining uninsured. Employers make different health coverage offers to workers of different types, so making this determination requires worker-level—not firm-level—information about the health coverage offered.¹⁴ And neither worker- nor firm-level information is available in any prospective data source.

Employers and insurers do provide information on worker-level coverage offers and enrollment to the IRS at the end of the year, but for all the reasons noted above, this prior year information is not particularly informative about an individual’s current status. Certainly, the information in these tax data sources is correlated with an individual’s current status. But it is not *determinative* of their current eligibility and cannot be treated as authoritative.

Citizenship or Immigration Status

Verifying citizenship and immigration status creates a different set of issues. It is a relatively stable characteristic, and there are some reasonably robust data sources that are available for eligibility purposes. Indeed, for immigration statuses that have a social security number (SSN), using the SSN to determine status is operationally straightforward. For other types of immigration statuses,

¹⁰ Terlizzi et al., *supra* note 1; see also “Key Facts About the Uninsured,” Kaiser Family Foundation (2018) <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/> (suggesting that about 25 percent of the uninsured had been uninsured for less than a year).

¹¹ Sobin Lee & Christen Linke Young, *Insurance Status Churn and Auto-Enrollment*, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY (June 2019), <https://www.brookings.edu/2019/06/13/insurance-status-churn-and-auto-enrollment/>.

¹² There is a standard electronic “transaction” for exchanges of information about health coverage, but this system is not well-suited to verifying uninsurance at a population level. The transactions and the underlying data are structured to avoid indicating that a person has coverage they do not in fact have, so there is reason to suspect a high degree of false positives for uninsured status. More importantly, executing the volume of transactions necessary use this approach for the population as a whole would exceed these systems’ capacity by orders of magnitude. See “HIPAA Eligibility Transaction System (HETS),” Centers for Medicare & Medicaid Services, <https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/>.

¹³ Linda J. Blumberg, John Holahan, Michael Karpman & Caroline Elmendorf, *Characteristics of the Remaining Uninsured: An Update*, URBAN INSTITUTE (2018), <https://www.urban.org/research/publication/characteristics-remaining-uninsured-update>.

¹⁴ *But see* Matthew Buettgens, Stan Dorn & Habib Moody, *Access to Employer-Sponsored Insurance and Subsidy Eligibility in Health Benefits Exchanges*, URBAN INSTITUTE (December 2012), <https://www.urban.org/sites/default/files/publication/26316/412721-Access-to-Employer-Sponsored-Insurance-and-Subsidy-Eligibility-in-Health-Benefits-Exchanges-Two-Data-Based-Approaches.PDF> (suggesting that for about three-quarters of subsidy eligible adults, “neither they nor their spouses work for a company that offers insurance to any of its employees,” so firm-level information may be sufficient in many cases).

however, determining an individual's status requires information – like document numbers of various types – that must be obtained from the household.

Further, even when it is operationally possible to determine an individual's status, doing so can pose other challenges. Across safety net programs, we generally demand that individuals give specific consent prior to a check of their immigration status. And even if authorized, federal and state tax agencies do not want to be involved in inquires about immigration status—undocumented individuals file returns and pay billions of dollars in taxes each year.¹⁵ Tax agencies are understandably concerned about discouraging these filings, and undocumented individuals are understandably concerned about being asked to disclose their status in order to file taxes. Therefore, to the extent auto-enrollment involves tax agencies, verifying citizenship and immigration status could have additional complications.

Implications

Taken together, these challenges imply that, at least in the context of existing insurance coverage programs and eligibility rules, it is not possible to use existing data sources to invisibly produce a prospective, authoritative eligibility determination that mirrors the one an individual would receive through an active enrollment. In principle, policymakers could seek to construct a new reporting infrastructure aimed at capturing the required income, coverage, and citizenship information in real time, but this would be an enormous undertaking at best and likely impossible as a practical matter.

This suggests that policymakers pursuing auto-enrollment should recognize this limitation and design around it. Rather than conceiving of auto-enrollment as something meant to approximate the prospective, binding eligibility determination of active enrollment, policymakers should recognize that they will not have the information necessary and explore ways to make auto-enrollment work without it.

Collecting a Premium

Another significant challenge for auto-enrollment is premium collection. To be sure, there are many discrete segments of the population where enrollment into health coverage does not require a premium, including most Medicaid and CHIP eligibility categories and some low-income uninsured who qualify for ACA tax credits of sufficient magnitude to purchase a plan with zero premium. (Indeed, this second category can be substantial: in 2019, a 40 year old with annual income of \$25,000 could obtain coverage at zero premium in about two thirds of counties served by HealthCare.gov.¹⁶) However, many of the uninsured will be required to pay a premium, at least at today's levels of financial assistance.

Premiums for many families are large, and therefore are likely to exceed the kinds of fund flows that can easily be tapped on a prospective basis, like tax refunds. Further, premiums must be paid monthly, and enrollees lose coverage if they fail to address a payment delinquency within three months. In addition, a household income change should also change the household's monthly premium, but this requires additional action by the enrollee.

Finally, many observers have noted that the ACA's structure requires individuals to begin premium payment at a time of year when they are most likely to be financially stressed. Because Marketplace financial assistance is anchored around a tax credit that must be "reconciled" against calendar year income, the Marketplace generally must also operate on a calendar year framework, with the first premium payment due in December. However, analyses consistently show that the end of the

¹⁵ See Lisa Christensen Gee, Matthew Gardner, Misha E. Hill & Meg Wiehe, *Undocumented Immigrants' State & Local Tax Contributions*, INSTITUTE ON TAXATION & ECONOMIC POLICY (2017), <https://itep.org/wp-content/uploads/ITEP-2017-Undocumented-Immigrants-State-and-Local-Contributions.pdf>.

¹⁶ Rachel Fehr, Rabah Kamal, Marco Ramirez & Cynthia Cox, *How ACA Marketplace Premiums Are Changing by County in 2019*, KAISER FAMILY FOUNDATION (November 2018), <https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2019>.

calendar year is when families face the most financial stress,¹⁷ making this an inopportune time to attempt to begin premium collection.

Selecting a Plan

In the ACA context, enrollment into coverage frequently requires the enrollee to make a choice among different coverage options, whether that is choosing among different Medicaid managed care organizations, or choosing an individual market plan with a specific issuer, provider network, and cost-sharing design. An auto-enrollment mechanism will generally need to assign individuals into one of the available options.

Assignment becomes more challenging as plan choice becomes more complex or less structured. For example, in Medicaid managed care, plans will differ in their provider network and customer-facing features like call center service, but benefit design is generally standardized, plans offer networks of roughly similar breadth, and there is no premium difference between options—so a random auto-assignment algorithm is fairly functional. In contrast, in the individual market plans are available at three or four different tiers of generosity, and within a tier, benefit design and network breadth differ dramatically in most states. Accordingly, premiums vary widely. Premiums for the most generous plans are roughly double the lowest cost options and even within a tier premium variation of 25 percent is typical.¹⁸ Therefore, auto-enrollment into the existing individual market will require assigning individuals into only one of many options, or alternatively enrolling people into plans with different premiums.

Further, there is no obvious default option under current law. Financial assistance is pegged to the middle silver tier of generosity, and that is the only tier where lower-income individuals can access cost-sharing reductions. However, many enrollees will prefer lower premium bronze plans and, in light of the challenges involved in collecting premiums identified above, these plans might be a more obvious target for auto-enrollment. Indeed, this is a more challenging choice environment than most other situations where auto-enrollment has been implemented.

An environment of choice among issuers also places significant pressure on risk adjustment and other risk mitigation tools, especially in the initial years of implementing an auto-enrollment policy. Auto-enrollees are likely to be healthier than those who actively enroll in coverage, and therefore can reduce average costs across a risk pool. However, bringing lower cost enrollees into the individual market can only result in lower premiums if that risk is shared across issuers—typically through risk adjustment. Because one would expect an individual who was auto-enrolled to have different spending patterns compared to an otherwise identical person who actively chose coverage it will be challenging to impute those costs in existing risk adjustment models.

Managing False Positives and False Negatives

One problem with an automatic enrollment system is the possibility of “false positives”—erroneously enrolling people who are actually insured in other coverage, or enrolling people into coverage for which they are not eligible. For individuals who are mistakenly enrolled into Medicaid, the environment is fairly forgiving. However, for those receiving Marketplace financial assistance and shopping in the individual market, the cost of erroneous enrollments will often be borne by the individual.

As noted above, financial assistance in the Marketplace is provided, in part, as an advance payment that must be recalculated and reconciled based on annual income measured at the end of the year. Individuals with annual income higher than the estimate used to calculate their advance payment, or

¹⁷ K. Steven Brown & Breno Braga, *Financial Distress Among American Families*, URBAN INSTITUTE (2019), https://www.urban.org/sites/default/files/publication/99771/financial_distress_among_american_families_o.pdf.

¹⁸ “Health Insurance Exchange Public Use Files,” Center for Consumer Information & Insurance Oversight, <https://www.cms.gov/ccio/resources/data-resources/marketplace-puf.html>.

individuals who are determined ineligible at the end of the year despite appearing eligible when they enrolled in coverage, must repay the excess financial assistance received. There are caps on repayment for many individuals, but the amounts can still be substantial—the maximum repayment is roughly 20 to 50 percent of the household’s total annual premium for the benchmark plan.¹⁹ And individuals with higher income face no caps at all. Therefore, if an auto-enrollment policy results in people receiving financial assistance greater than what they are ultimately determined eligible for at the end of the year, they will owe significant repayments. The same dynamic arises if an individual inadvertently becomes enrolled in Marketplace financial assistance as well as another coverage source, like Medicaid, Medicare, or their employer’s plan.

This repayment obligation is different from most other circumstances where auto-enrollment is successful. Put another way, becoming enrolled in Marketplace financial assistance requires people to take on risk that they will owe something back at the end of the year. But we generally expect people to meaningfully consent when taking on financial risk, making auto-enrollment into Marketplace coverage difficult to achieve.

Auto-enrollment also creates the possibility of “false negatives”: some uninsured people might be missed, leading such a system to fall short of universal coverage. Further, some missed individuals might have reason to believe they were enrolled automatically, and therefore choose to forego active enrollment. These individuals might attempt to use the coverage in which they think they are enrolled or incur significant health care costs during the year, and—to the extent the error was on the part of the auto-enrollment system—it may seem appropriate to hold them harmless. However, because coverage in the individual market is offered by multiple competing insurance companies, it is not obvious who can fairly be expected to “clean up” and pay these claims.

Towards an Auto-Enrollment Solution

With that grounding in the challenges of auto-enrollment, we turn to a discussion of some of the tools available to policymakers to address them. The final section of this paper describes three specific options for implementing some form of auto-enrollment, but before addressing those options in detail, it is useful to more generally consider some of the possible policy tools. We begin by discussing eligibility simplifications that could promote auto-enrollment, explore how retroactive enrollment might be promising, and examine the role of the tax system. Finally, we consider how requiring some form of individual action—i.e. stopping short of “true” auto-enrollment—can be useful.

Simplify and Expand Eligibility Rules

Auto-enrollment will be made easier by policies that simplify and expand eligibility. As noted above, incomplete information makes estimating eligibility difficult, and potentially large repayments impose significant costs if estimates are wrong. Thus, auto-enrollment can be more successful if it does not rely on the kind of detailed, prospective eligibility determination that must be made today.

Steps to simplify eligibility would ease this burden and make auto-enrollment more feasible. For example:

- *Eliminating reconciliation:* A great deal of complexity in the current eligibility environment is driven by the fact that consumers’ final Marketplace financial assistance is computed based on their actual calendar year annual income. Most means-tested programs do not operate in this way: benefit amounts are calculated, the benefit award is given prospectively, and eligibility is reassessed at some frequency or based on a triggering event. For example,

¹⁹ Repayment caps apply in most circumstances for those below 400 percent FPL. These caps are: below 200 percent FPL, \$300 for an individual and \$600 for a family; between 200 and 300 percent FPL, \$775 for an individual and \$1550 for a family; between 300 and 400 percent FPL, \$1300 for an individual and \$2600 for a family. 26 U.S.C. § 36B.

college students are awarded year-long federal financial aid prospectively based on their family's "expected family contribution" and there is no repayment obligation if the family's income rises during the year.²⁰ SNAP benefits will decrease prospectively when a family's income rises, but families are not expected to estimate annual income or repay benefits based on a year-end reconciliation. And even within the Marketplace context, cost-sharing reduction assistance is awarded prospectively and not reconciled based on actual end-of-year income.

Converting Marketplace premium assistance into a more typical benefit award without repayment obligations would pave the way for more automatic approaches to enrollment. Families' premium assistance could be assessed annually (with an obligation to report changes in income, as in programs like Medicaid and SNAP today), and amounts could be paid to insurers not as a preliminary grant but instead as a final payment—exactly as federal student aid is paid to educational institutions today. This would come at some cost, as higher income individuals became eligible for slightly more generous financial assistance and there would be some risk of gaming, but it would foster a much simpler eligibility system.

Note that this approach would also create much more flexibility in the enrollment timeline: with benefits no longer linked to tax-year income, the entire enrollment calendar could be shifted to a different annual cycle, e.g. May-April plan years.

- *Continuous eligibility:* In means-tested programs like Medicaid or SNAP, where eligibility is not reconciled, most enrollees still have an obligation to report changes in income or other eligibility factors, which triggers a reassessment of eligibility. Enforcement of individual's compliance with this requirement varies by state, though states generally periodically assess available data sources for evidence of changes.

However, this is not a necessary feature of means-tested eligibility determinations. In Medicaid and CHIP, states do have the option to "lock" an individual's eligibility for 12 months based on information about income provided at a specific point in time.²¹ Even if a household's income rises, they remain eligible for the benefit. And in the context of federal student aid, eligibility is assessed on the basis of income information provided on a prior year's tax return, and not updated throughout the year.²²

Establishing continuous eligibility across Medicaid and for Marketplace financial assistance would make auto-enrollment more feasible by allowing past data to be used authoritatively. That is, income reported on a prior year tax return could be treated not simply as information that is *suggestive* of current eligibility, but rather as information that is on its own sufficient to *establish* eligibility for some prospective time period.

- *Presumptive eligibility:* Another eligibility tool that can be borrowed from Medicaid is presumptive eligibility, where an entity other than a state Medicaid agency is permitted to make an eligibility determination based on available information.²³ In Medicaid, hospitals generally make presumptive eligibility determinations on a temporary basis; in the context of auto-enrollment, one could imagine an entity like the state unemployment agency or an

²⁰ "Grants and Scholarships," Federal Student Aid, <https://studentaid.ed.gov/sa/types/grants-scholarships>.

²¹ For children, continuous eligibility is authorized by statute and is fairly common. For adults, continuous eligibility is possible under current law but somewhat more complex, and will likely entail a modest reduction in the state's FMAP. See, e.g., "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014," Centers for Medicare & Medicaid Services (May 2013), <https://ccf.georgetown.edu/wp-content/uploads/pdfs/SHO-13-003.pdf>.

²² Kim Reuben, Sarah Gault & Sandy Baum, *Simplifying Federal Student Aid: How do the Plans Stack Up?*, URBAN INSTITUTE (2015), https://www.urban.org/sites/default/files/publication/72826/2000507-simplifying-federal-student-aid-how-do-the-plans-stack-up_3.pdf.

²³ "Presumptive Eligibility for Medicaid and CHIP Coverage," Centers for Medicare & Medicaid Services, <https://www.medicare.gov/medicaid/outreach-and-enrollment/presumptive-eligibility/index.html>.

issuer making such a determination. This could minimize operational challenges and allow eligibility to be computed by an entity that has access to relevant information.

- *Modifying the employer coverage firewall:* Because no existing data source captures information about employer coverage offers, enforcing the employer coverage firewall through auto-enrollment is especially challenging. Eliminating the firewall would dramatically simplify the data challenges associated with auto-enrollment.

That is, individuals could be eligible for Marketplace financial assistance without regard to whether their or a family member's employer offers coverage—obviating the need to obtain information about employer coverage. Beyond making auto-enrollment more practical, it would also be a significant expansion of eligibility, especially for low-income families: it would close the “family glitch”²⁴ and also bring a much more affordable option to individuals who are today firewalled because of an employer offer of coverage that is more costly than the coverage they could obtain in the Marketplace.

Note that taking this step would not require eliminating or weakening the employer mandate. Employers could still be required to offer coverage, and still owe a penalty when their workers receive Marketplace financial assistance. (Employers could perhaps be insulated from a penalty in cases where their coverage was at least as generous as what the employee would receive in the Marketplace, though that is operationally complex for employers and may not meaningfully alter what employers would owe.) Some employers might respond by making coverage more generous for low wage workers—to discourage them from obtaining Marketplace coverage—but if they did not, the penalty payments would partially finance this expansion.

This is undoubtedly a major change. But it is not unprecedented; indeed, this is the way eligibility for Medicaid works today.²⁵ And the evidence to date tends to suggest that Medicaid expansion has not resulted in significant crowd-out of employer coverage—even in the absence of an employer mandate penalty associated with Medicaid enrollment.²⁶

- *Subsidy generosity:* Many of the challenges in auto-enrollment arise because a large monthly premium payment must be collected for many households. Beyond the steps noted above to make eligibility easier to navigate, simply making financial assistance more generous would be a useful step. Designing a subsidy expansion to maximize the number of people (or number of likely auto-enrollees) with zero premium options could facilitate auto-enrollment approaches. For example, below certain income thresholds, premium assistance could be benchmarked to the greater of the amount needed to purchase a silver plan at a specified percentage of income or a bronze plan for free. And even without a zero premium option, smaller premiums could more plausibly be collected to cover longer time periods or from sources like tax refunds or UI benefits.

More generous assistance also could make random assignment into an insurance plan somewhat more viable. If many individuals had access to many different plans with no premium owed, then a random assignment algorithm among those plans could be more equitable. Indeed, this is the basic logic of auto-assignment into Medicare Part D plans for

²⁴ Tricia Brooks, *The Family Glitch*, HEALTH AFFAIRS, November 10 2014, <https://www.healthaffairs.org/doi/10.1377/hpb20141110.62257/full/>.

²⁵ Some state Medicaid programs provide that individuals with an offer of employer coverage receive their Medicaid benefit as premium assistance and a cost-sharing and benefit wrap for their employer plan. See, “Medicaid Premium Assistance in the Employer Sponsored Insurance Market,” Medicaid and CHIP Learning Collaborative (January 2015), <https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/esi-premium-assistance.pdf>.

²⁶ See, e.g., Larisa Antonisse, Rachel Garfield, Robin Rudowitz & Samantha Artiga, *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review*, THE KAISER FAMILY FOUNDATION (2018), <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.

beneficiaries receiving the Low-Income Subsidy—the subsidy is designed so that a large group of plans are free for the consumer, and they can be randomly assigned to one of those plans if they do not make a selection.²⁷

- *Medicaid/Marketplace overlap:* Under current law, individuals with incomes near the Medicaid eligibility threshold can face a fairly complex eligibility environment. Medicaid eligibility is based on current monthly income, whereas Marketplace financial assistance is based on projected full year income. And in many states these determinations are made by different entities, who can establish slightly different verification standards. Acknowledging that there will not be a perfect seam between the two programs and allowing individuals to use either the “Medicaid” or “Marketplace” rules to determine if their income is below the Medicaid threshold would allow eligibility to be determined with less information and by a wider range of government actors.

In addition, because of incomplete or dated information about who is currently uninsured, auto-enrollment could lead to some people becoming enrolled in Marketplace coverage with financial assistance despite the fact that they were also enrolled in Medicaid during the relevant months. An auto-enrollment policy should ensure that individuals do not face liability for these situations, and generally develop some reasonable coordination rules.

These approaches—and others like them—would undoubtedly have fiscal cost. That said, their benefits would extend beyond enabling auto-enrollment, for example by reducing churn across coverage sources, making enrollment simpler, or enabling low-wage workers to access subsidized coverage in the individual market rather than costlier employer coverage. In general, legislation creating an auto-enrollment policy is likely to be paired with other changes to the ACA that make coverage more accessible; therefore, policymakers should be aware of the ways that these sorts of changes can promote more automatic enrollment.

Establish Backwards-Looking Auto-Enrollment

One promising policy—and a potential alternative to a dramatic overhaul of eligibility rules—is to establish a backwards-looking approach to eligibility determination and premium collection. Individuals can be considered covered throughout the year, and then retroactively charged a premium (whether or not they use medical care) at a time when their eligibility can be fully known and the premium collected.

While such an approach may not be what stakeholders typically imagine when they conceive of automatic enrollment into health coverage, it is already a feature of our current policy landscape. Specifically, this is the basic logic behind the retroactive coverage period in Medicaid. When an individual who is Medicaid-eligible but not enrolled seeks care and then subsequently becomes enrolled in Medicaid, Medicaid will typically cover services received in the three months prior to their application for coverage.²⁸ As a result, even when an eligible individual is not affirmatively enrolled into Medicaid, they are effectively covered for care that they might receive.

Similarly, backwards-looking enrollment into individual market coverage can be accomplished. Individuals who had no other coverage for a period during the year could be charged a premium (e.g. through the tax system) for the months they would have otherwise been uninsured—and that premium, net of financial assistance, could be accurately computed based on backwards-looking data sources. And when an otherwise-uninsured individual received medical care during the year, providers could be paid and cost-sharing charged as if the individual had affirmatively enrolled—as is the case for Medicaid’s retroactive coverage period.

²⁷ See “An Overview of the Medicare Part D Prescription Drug Benefit,” The Kaiser Family Foundation (October 2018), <https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/>.

²⁸ “Eligibility,” Centers for Medicare & Medicaid Services, <https://www.medicaid.gov/medicaid/eligibility/index.html>.

There is significant operational complexity in establishing such a system, but it is a powerful tool for ameliorating the challenges associated with determining eligibility, collecting a premium, and managing inaccuracies. Indeed, such an approach has surfaced in other discussions around expanding access to health coverage, including proposals from the Center for American Progress²⁹ and my colleague Matthew Fiedler,³⁰ and as Fiedler, other colleagues, and I recently outlined.³¹

Leverage the Tax System

The tax system can interact with enrollment policy in a number of ways. At tax filing, we generate a complete annual account of the primary factors (other than citizenship or immigration status) necessary for eligibility determinations: we have information on household composition, final annual income, and other coverage offered to or received by the individual. That information is backwards-looking, and therefore not generalizable to current eligibility under current law for the reasons noted above, but it is nonetheless a snapshot of a particular point in time.

Further, tax filing also creates an opportunity to ask questions of the individual or ask for their consent to take particular actions. The tax system also, of course, involves the collection of money from a household, so it can potentially be used to collect premiums owed for coverage.

However, there are limits to how much can be accomplished through tax processes. As noted above, tax agencies are wary of interacting with information about an individual's immigration status. The timing of tax filing is not well aligned with the current calendar for health coverage. Finally, while tax filing can be used to collect some additional information from individuals, lengthy additions to the tax process are likely undesirable.

Require Action to Begin Coverage

Another “tool” at policymakers’ disposal in designing an auto-enrollment system is to be realistic about what can feasibly be accomplished automatically and what will require action from the consumer. That is, there is a spectrum from truly seamless and automatic policies that get consumers enrolled with no action, to policies that require consumers to make a decision to opt in or out, to policies that remove barriers to enrollment but still require action by the consumer to initiate coverage. A policy that estimated eligibility and matched people to an insurance product—but still required the to verify their eligibility and make a premium payment if applicable—would be a significant improvement over the status quo. Further, if individuals were assigned to a particular insurance plan, the issuer would be likely to perform targeted outreach that may be far more intensive and cost-effective than population-level activities.

There is precedent for this approach. Beginning in 2016, the federal Health Insurance Marketplace began “auto-enrolling” existing consumers into coverage with a new health insurance issuer when their prior issuer exited the Marketplace.³² Individuals are required to make a premium payment to begin this new coverage. Data are not available on the rate at which consumers have paid these premiums; however, the fact that the practice continues suggest that stakeholders view the policy as helpful in maintaining enrollment. Of course, using a similar approach to target the uninsured would be less effective than targeting consumers who had previously decided to enroll in Marketplace coverage, but the precedent is still illustrative.

²⁹ *Medicare Extra for All*, CENTER FOR AMERICAN PROGRESS (2018),

<https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/>.

³⁰ Matthew Fiedler, “Conference on Universal Health Care,” Massachusetts Medical Society (October 2018),

http://www.massmed.org/uhc2018/#.XGQqd_mPJhE.

³¹ Matthew Fiedler, Henry J. Aaron, Loren Adler, Paul Ginsburg, Christen L. Young, *Building on the ACA to Achieve Universal Coverage*, 380 NEW ENG. J. MED. 1685 (2019), <https://www.nejm.org/doi/full/10.1056/NEJMp1901532>.

³² HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12203 (March 8, 2016),

<https://www.federalregister.gov/documents/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017>.

Specific Auto-Enrollment Proposals

This section now turns to three specific auto-enrollment proposals. The first is a retroactive coverage backstop that represents a completely seamless, population-level enrollment process on a retroactive basis. The second proposal leverages tax data and simplifies eligibility rules to make enrollment more straightforward prospectively. Finally, a third proposal describes steps that would reach target populations at coverage transitions.

Option I: Retroactive Coverage Backstop

For all of the reasons noted above, “true” auto-enrollment—where eligibility is determined, premiums are paid, and coverage is selected without requiring affirmative steps by the consumer—is likely not feasible on a prospective basis without a total overhaul of eligibility rules. However, a backward-looking approach to enrollment administered through the tax system can achieve this goal. With my colleague Matthew Fiedler and other coauthors, we have previously outlined a version of this proposal:

“[Uninsured people not eligible for Medicaid would be] enrolled in a ‘backstop’ insurance plan, which could be either public or private. Health care providers would submit claims to the backstop plan whenever people in this group used health care services. On each year’s income tax return, people who lacked coverage other than the backstop plan for at least 1 month during the year would pay a premium for the backstop plan for each month they lacked other coverage, whether or not they actually used the backstop coverage. The premium would be reduced by the amount of any tax credit for which they were eligible.”³³

Of course, creating this coverage backstop is complex. The general principle is that for each month a person (not eligible for Medicaid) does not have other coverage: they would be considered to be enrolled in a backstop plan, they would owe an income-adjusted premium for that plan, the premium would be calculated and collected at the end of the year through the tax filing process, and the backstop plan would pay claims for health care services received.

Calculating and Collecting the Income-Adjusted Premium

The retroactive backstop approach allows for a highly accurate assessment of eligibility and the collection of premiums through the tax filing process. The backstop plan itself will be defined further below, but first it is useful to focus on how an individual’s premium charge for the plan would be determined and collected.

The backstop plan would be considered part of the individual market, and so it should have a gross premium that is equivalent to the lowest cost plan available to the consumer in the individual market single risk pool. Under current law, this would be the regional lowest cost bronze plan for the individual or family.³⁴ (Note that while the backstop plan is *priced* at the level of the lowest cost bronze plan otherwise available to the individual, the backstop coverage would actually be *provided* by a specific backstop entity, described in more detail below).

At tax filing, a household would indicate on its tax return each month during which each household member did not have another source of coverage; that is, each month during which a household member would be covered by the backstop plan. At the time a federal tax return is filed, the tax agency can access all information needed to determine coverage eligibility: the return indicates the

³³ Fiedler et al., *supra* note 31.

³⁴ Linking backstop premiums to an existing plan ensures that an individual is not be able to get a “better deal” through auto-enrollment than they would be able to achieve by actively choosing coverage, and seamlessly accounts for regional variation in health care costs.

household's composition and actual annual income, and from 2014 until 2018 the return also indicated all months during which an individual did not have other sources of coverage.³⁵

The tax agency would use this information to calculate the gross premium for the lowest cost plan and the amount of financial assistance that would have been received had the individual actively enrolled in Marketplace coverage. The premium assistance amount would be applied towards the premium for the backstop coverage, and the backstop premium net of financial assistance would be collected as additional tax. Backstop premiums (including amounts collected and financial assistance amounts) would be transferred to the backstop plan, and would flow to the individual market as a whole through risk mitigation tools.

While alternative methods of income-adjusting the premium could be applied, symmetry with Marketplace financial assistance ensures that there are no groups who are better or worse off under the backstop compared to an active enrollment. However, implementation of the backstop plan should be paired with policies that improve the generosity of Marketplace financial assistance for all enrollees— some modest, some significant:

- Because premiums are collected through tax filing, financial assistance should be structured so that any household that does not have a tax filing requirement does not owe a premium for the backstop plan, which should come at trivial cost.
- Under existing law, premiums vary by tobacco-use, and that factor is not reflected in financial assistance (or, obviously, on tax returns). Eliminating tobacco-based premium variation would simplify backstop premium collection. Given that issuers generally use fairly small tobacco rating factors,³⁶ this should also impose limited costs.
- Of dramatically greater significance, the employer coverage firewall should be eliminated. As noted above, under current law about 9 percent of the uninsured are ineligible for a premium tax credit because of coverage offered by an employer, and if they are considered covered by the backstop plan they will owe the full premium. Further, this group is indistinguishable from other uninsured until tax filing. Therefore, the backstop plan will function most successfully if the employer coverage firewall is repealed.
- Finally, many proposals to build upon the ACA include significant additional financial assistance across the income spectrum. Pairing the backstop with investments in broad subsidy enhancements will improve the functioning and political appeal of a backstop approach and minimize the premium liability that must be collected at tax filing.

Even with these enhancements, we should consider the impact of collecting premiums through tax filing. For modest income households, assuming historical withholding patterns, the amount that otherwise would have been received as a tax refund will often be sufficient to cover most or all of the premium owed. Detailed analysis is beyond the scope of this paper, but as an illustrative example: in 2016 85 percent of households earning between \$25,000 and \$50,000 received a refund, and the average refund for those households was just over \$2,600.³⁷ A married couple with income at 200 percent FPL (or about \$33,000 annually) will owe \$2,200 for 12 months in the benchmark *silver* plan at current subsidy levels. Buying down to bronze coverage, enhanced financial assistance, and the fact that many people face shorter periods of uninsurance should reduce those liabilities significantly in typical circumstances.

³⁵ Notably, the IRS also receives third-party information returns about income and enrollment in other coverage so information can be verified without any new requirements.

³⁶ See Abigail S. Friedman, William L. Schpero & Susan H. Busch, *Evidence Suggests that the ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation*, 35 HEALTH AFFAIRS 1176 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5589079/>.

³⁷ See "SOI Tax Stats-Historic Table 2," Internal Revenue Service, <https://www.irs.gov/statistics/soi-tax-stats-historic-table-2>.

That said, some households of limited means will face a large liability at tax time. Further, the lump-sum burden for many higher-income households, even under a more generous subsidy structure, would be significant. Indeed, at all income levels paying a full year of monthly premiums in a single payment will be challenging in cases where it is not offset by refunds.³⁸ And reducing refunds would diminish a source of financial stability for many families (though the protection from unexpected medical bills would have the opposite effect). However, this is a largely unavoidable cost of “true” auto-enrollment for populations that owe a premium – there simply are not monthly fund-flows that can be leveraged for these purposes.

How the Backstop Operates

A backstop plan with premiums collected retroactively at tax filing makes it possible to determine eligibility and collect a premium—two of the hardest problems to address in any prospective approach to auto-enrollment. However, policymakers need to define what the backstop actually is and how this coverage is administered.

A key feature of the proposal is that individuals are considered covered by the backstop plan in the months that they do not have another source of health insurance, which means the backstop needs to function as health insurance—paying claims for incurred medical services, computing cost-sharing, and exercising some degree of care coordination and utilization management—for a population that is not prospectively enrolled.

To operationalize this, an otherwise-uninsured individual would have their backstop coverage “activated” when they use medical care. For example, imagine an otherwise-uninsured, backstop-covered individual who seeks care from a Community Health Center for abdominal pain, or who arrives at the emergency

department of a hospital with injuries resulting from a car accident. The provider would screen for Medicaid eligibility; if the individual did not appear to be Medicaid-eligible, it would seek the individual’s permission to activate the backstop plan. The provider would then notify the backstop plan, and the backstop would create an enrollment for the individual—just as any payer would do for a new customer—allowing the backstop and providers to communicate regarding coverage and payment for the services received. Further, the backstop could then prospectively provide care and utilization management for the individual and provide the customer service necessary to help them navigate additional treatment, such as finding in-network providers for follow-on care.

The backstop plan could also, at the point coverage is activated, attempt to prospectively enroll the individual (into the same plan) and begin monthly premium collection. The backstop will be paid its

The Backstop Plan

- Premium is equivalent to regional lowest-cost bronze plan.
- Premium is collected on tax returns, net of financial assistance.
- When a patient with no other coverage seeks care from a provider, the provider will:
 - Screen for Medicaid eligibility; if not Medicaid eligible, treat the individual as backstop-enrolled.
 - Communicate with the consumer and the backstop plan to “activate” coverage.
 - After coverage is activated, communicate with the backstop plan, as it would with any other payer, regarding delivered services in real-time (for example, regarding cost-sharing charged and prior authorization).
 - Bill the backstop plan in real time.
- Once coverage is activated, the backstop plan will treat the individual as enrolled.
- Premium is owed for all months without other coverage, regardless of whether the backstop is activated.
- Risk mitigation tools average the cost of the backstop-covered population into the rest of the individual market risk pool.

³⁸ Tax filers facing large liabilities in these circumstances could be given special rights to establish a payment plan with the tax agency.

premium for all months of coverage, regardless, but prospective enrollment would increase the likelihood that the individual stays prospectively enrolled into the future, smooth premium payments and minimize potential household liability at tax time, and reduce the burden on providers to navigate the “activation” process for a future episode of care. Backstop-covered individuals could also be permitted to activate their own coverage to better access care and begin monthly premium payment.

Under this structure, the backstop plan could theoretically function with any cost-sharing design. However, a simple cost-sharing structure will enhance administrability, so the backstop could be designed to mimic a “catastrophic” plan design: high-value preventive and primary care services covered with low or no cost-sharing, and all other services subject to a relatively high deductible and equivalent out-of-pocket limit. The plan’s actuarial value should be consistent with the minimum level that is available in the individual market, consistent with the fact that it is priced at that level of generosity. Depending on what other enhancements to Marketplace financial assistance are part of a package that includes the backstop, it may also be desirable to income-adjust the cost-sharing in the backstop plan. Implementing such a policy will introduce an additional level of operational complexity, and would be simplest if linked to an individual switching into prospective coverage (with an associated eligibility determination) once their coverage was activated.

Who Operates the Backstop

Policymakers must also define what entity will operate the backstop plan. As described above, backstop coverage will be activated by consumers seeking care from a provider, therefore it is important that the backstop plan be able to establish an in-network payment relationship with all providers where an otherwise-uninsured individual is likely to initiate an episode of care. Further, it should generally be obvious to providers and consumers who the backstop is so that they can navigate the system.

If auto-enrollment is implemented in concert with a public plan offering coverage in the individual market, the backstop could be operated by the public plan. It will have strong relationships with the sorts of safety net providers likely to be an initial point of care, and the network and legislatively-established provider payment rates for the public plan as a whole will easily flow through to backstop coverage.

This would operate smoothly if the public plan was the lowest cost plan available in all (or nearly all) markets: the backstop premium is most naturally benchmarked to the lowest-cost plan available, which is also the “actual” premium for the coverage being provided. However, if the public plan is more expensive than some private plans, it is more challenging. Backstop enrollees could all be charged the higher public plan premium, but there could be significant regional variation and it may be unpalatable to charge backstop enrollees *more* than they could pay through active enrollment. But, conversely, it is also problematic to charge backstop enrollees *less* for public plan coverage than active enrollees pay for the same plan. Benchmarking financial assistance to the public plan—for active and backstop enrollees alike—could potentially smooth over these challenges.

Alternatively, the backstop could function as a temporary source of coverage. For example, the backstop could pay claims for, e.g., 30 days after it was initially triggered, and consumers would have a special enrollment period to switch into a traditional individual market plan.

During the temporary period of backstop coverage, the backstop would be operated by a private contractor. It would pay claims—and would need a mechanism to ensure it was able to establish a payment rate with all providers. For example, providers could be required to accept a specific rate. The backstop plan should also perform some limited care coordination and utilization management. This role is analogous to the functions of the state Medicaid agency in some states with Medicaid managed care: the state agency pays claims on a fee-for-service basis for a 30 to 60 day period before a newly-eligible individual becomes enrolled in a managed care plan.

Individuals would need substantial consumer assistance to help navigate the transition to an individual market plan during their special enrollment period. Consumers should be permitted to bring their “accumulators” (i.e. amounts paid towards the deductible and out-of-pocket limit) from the backstop plan into new coverage. This population will obviously be significantly adversely selected. However, because premiums will be paid for all months—before and after activation, and for individuals that do not activate coverage—carefully designed risk mitigation tools should prevent this selection from negatively impacting any carrier. That said, it would be appropriate to prevent consumers from electing a higher actuarial value of coverage during the transition.

Risk Mitigation

A backstop plan will cover a population that is on average healthier than the remainder of the individual market. It will include a large number of low-risk individuals who do not use care at all, as well as a small number of high-cost enrollees who activate their coverage when in need of significant medical care. Distributing this relatively good risk from the backstop plan into the rest of the market will require careful attention. There are a number of reasons for this—some of which are associated with limited information during a transition period while others are permanent features of the backstop plan:

- The population that will be covered by the backstop plan is large compared to the size of today’s individual market, and so implementing the backstop will cause a discontinuous change in the risk pool.
- As noted above, it is difficult to predict how backstop-covered individuals will use health care services compared to otherwise-similar individuals who choose to enroll.
- The existence of backstop coverage is likely to lead to some amount of adverse selection against the actively-enrolled segment of the market. For example, individuals who would have actively enrolled in coverage solely for the financial security it would provide in the event of a major medical issue (e.g. those needing coverage for a short time between jobs) would now have a limited incentive to enroll. It is difficult to predict the extent of this change, and it could accelerate over time.
- Similarly, if the backstop plan coverage is at the lowest actuarial value level, it will likely lead to some number of individuals who might have otherwise opted for coverage at a higher level paying lower premiums.
- The backstop plan will cover some number of “missing” people who are not actually known—and so will not perfectly collect premiums. Specifically, individuals who do not have a tax filing requirement and those who might fail to file a return will be covered if they have an activating event, but will remain invisible if they do not activate their coverage. This premium revenue must be estimated and paid to the backstop plan, or the loss must be accounted for as a unique cost faced by the backstop plan in any risk adjustment methodology.

Therefore, the backstop should be implemented with focused risk mitigation tools. At the very least, risk adjustment should separately model the backstop-covered population. Given the magnitude of the information gaps, it may be prudent to couple implementation of a backstop plan with other more predictable tools for spreading risk that sit alongside risk adjustment. An aggressive (and funded) risk corridor program for a 3-4 year period would allow the market to acclimate and allow the necessary information collection to model the backstop population. Risk could also be shifted to the backstop plan by creating a reinsurance program for non-backstop plans, funded by an assessment against the backstop (which operates before risk adjustment). In an environment of perfect risk adjustment, this reinsurance program would not be necessary, but in the years before adequate data are available and before stakeholders have confidence in the risk adjustment model, this could help more smoothly spread risk.

While different risk mitigation tools can be used, under the system described above it is generally important that all premium revenue for backstop coverage is kept within the individual market (rather than, e.g., some portion of tax credits “owed” to the backstop plan intentionally not being paid). Specifically, the premium for the backstop plan is pegged to the lowest cost non-backstop plan available—which will reflect the cost of the entire individual market risk pool (backstop and non-backstop covered alike) only if all backstop revenue stays within the individual market.

Opting Out

This framework effectively creates mandatory enrollment for the eligible population— either an individual is covered by another insurance plan, or they are considered enrolled and charged a premium for the backstop plan. This is obviously the most effective way to bring low-risk individuals into the individual market and such an approach is necessary if the basic ACA framework is going to be used to achieve near universal coverage. However, if policymakers want to avoid mandatory enrollment, then an opt-out opportunity could be added to the backstop approach.

If an opt-out is pursued, individuals could be given a narrow window of time in which to make an opt-out election, such as within 15 days of when the period of uninsurance begins. Opting out would relieve the individual of paying backstop premiums for the period of uninsurance, and would make them ineligible for coverage. Allowing people to opt-out would have clear downsides: it would keep the automatic enrollment system from achieving universal coverage and increase premiums for the backstop and other individual market plans.

These concerns are inherent in allowing opt-out, but there may be ways to mitigate them. The opt-out should exclude the person from both the backstop and the rest of the individual market and should be binding for some period of time—longer time periods could more effectively discourage individuals from opting out, though may also lead to individuals making decisions that poorly serve their long-term interests. Further, the opt-out process could be made fairly cumbersome, such that only those individuals who were extremely motivated would take advantage of the process.

Excluded Populations

Finally, there are a handful of issues related to excluded populations—and the false negatives and false positives that can arise—that must be addressed. As noted above, the backstop policy would apply to otherwise uninsured individuals who are not eligible for Medicaid. In general, for Medicaid eligible individuals who present in need of health care services, they can become enrolled into public coverage that will pay for the services needed, including through the retroactive coverage period.³⁹ However, administering this distinction introduces some complexity. Providers will need to screen for Medicaid versus backstop eligibility, and they will not always make an accurate assessment. While an inaccurate assessment of Medicaid eligibility can be uncovered in close to real time, an inaccurate assessment of backstop eligibility will not be known until tax filing. Providers may also face incentives to favor backstop coverage because of higher payment rates.

In addition, an individual might appear to be backstop eligible at the time they receive care, but actually be covered by another source of insurance (like an employer plan). To some extent, existing coordination of benefits rules might enable the payers and providers to “unwind” paid claims and assign them to the right coverage, but that may not always be feasible.

In these cases, a detailed set of gap filling rules will be needed. For example, there will be individuals who at tax filing have year-end incomes in the Medicaid eligibility range, but were assessed at the time of activation as backstop-eligible—perhaps in error, or perhaps because their monthly income at the time was much higher, and it will often not be clear at tax filing which explanation is more likely. In this situation, it is likely desirable to pay the backstop plan the full owed premium as if the

³⁹ Under current law, CHIP does not have a retroactive coverage period. Retroactive coverage should be extended to CHIP in concert with implementation of the backstop.

individual was eligible for financial assistance covering their full premium. Further, we will need rules about how to treat that consumer's incurred cost-sharing (including any outstanding amounts not yet paid to providers). But in general, it should be possible to shield individuals from unfair liabilities. As long as the system maintains a fairly high degree of accuracy, the backstop plan and Medicaid programs can be expected to bear the burden of paying claims and/or foregoing premiums when these issues arise.

Another set of complications arises if undocumented individuals are excluded from financial assistance and the backstop plan. Given that a provider activates coverage with the patient's consent, the coverage activation process could include consent for verification of citizenship or immigration status. Indeed, this is similar to the way Medicaid enrollment works today. (One could also imagine the backstop plan offering providers payment for emergency services received by undocumented but otherwise backstop eligible individuals, much as emergency Medicaid functions today.) The undocumented population also needs to be excluded from premium payment for the backstop plan without being asked to disclose their status to the tax agency. This could be operationalized in the same way as the exclusion from the ACA's individual mandate—the tax agency would offer an exclusion process available to the undocumented population as well as other groups of tax filers.⁴⁰

Summary

Creating the retroactive coverage backstop is complex, but it can successfully address all four of the policy challenges that auto-enrollment must navigate. The tax filing process allows for a highly accurate, backwards-looking eligibility determination, and enables the collection of the premium an individual owes for any months of backstop coverage. A special backstop plan can be “activated” by individuals accessing care and function as health coverage. And this backstop plan can be counted on to smooth over challenges associated with inaccurate assignment into or away from the backstop plan.

Option 2: Assessment at Tax Filing

The retroactive coverage backstop is a powerful tool to achieve universal or near-universal coverage. However, it may be a more aggressive option than policymakers wish to pursue. An alternative approach would stop short of enrolling individuals into a coverage product but would take significant steps to connect potentially-eligible individuals to coverage and facilitate enrollment. This type of approach would likely achieve much smaller coverage gains than the retroactive coverage backstop, but might still be an improvement relative to the status quo.

The basic framework is that information on the tax return would be used to conduct an assessment of potential eligibility. Individuals would be referred to the programs for which they appear eligible, coupled with aggressive outreach. The coverage source would facilitate a complete eligibility determination and enrollment, and eligibility enhancements could reduce friction.

Assessment Process

First, tax return information would be used to conduct an assessment of potential eligibility at the time of tax filing, based on information available for the prior calendar year. This information would generally come from submissions required under current law, from both the individual's return and from information returns submitted by third parties. This assessment may be most naturally completed by the tax agency itself, though the information could also be provided to another government entity (like the Marketplace) for the assessment process.

Specifically, the assessment could determine who was uninsured in December of the prior year based on information returns submitted by coverage providers. For those individuals, it would examine annual income from the 1040 and the coverage available from employers as reflected on information

⁴⁰ See “2018 Instructions for Form 8965,” Internal Revenue Services, <https://www.irs.gov/pub/irs-pdf/i8965.pdf>.

returns, and then use that information to assess the individual’s potential eligibility for Medicaid, individual market coverage, or coverage offered by an employer. This assessment would assume their current income is the same as the prior year and they and their family members continue with the same employers with the same coverage offerings—and, for all the reasons noted above, it is only suggestive of their potential eligibility. After making the assessment, the information would be shared with the state Medicaid agency or Marketplace or individual market issuer, as discussed further below.

Minor additions to the tax return would be necessary. Most importantly, individuals would need to give consent to have their information shared and potentially processed as an application for coverage (including expressly consenting to verification of immigration status). Individuals could also be asked a very basic question that allowed them to indicate whether they expected a major change in income or household composition in the coming year – which could facilitate processing by the source of coverage.

Referral to Source of Coverage

After receiving the potential eligibility assessment, the source of coverage would process the information and go as far as possible toward enrolling the individual.

In Medicaid, eligibility generally does not depend on access to employer coverage, so the return information could automatically be treated as an application for Medicaid coverage and the Medicaid agency could attempt to verify income and citizenship status. This automatic processing could be limited to those who had indicated on their tax return that they did not expect a major change in income.⁴¹

If the Medicaid agency was able to verify the information from the tax return, it could treat the individual as provisionally enrolled. These individuals could be sent Medicaid insurance cards, and the enrollment would be activated if the coverage was used. Louisiana used exactly this approach of sending Medicaid cards based on its own determination of eligibility to enroll 30,000 children in CHIP in 2010.⁴² Further, this activation should limit the extent to which individuals become dually enrolled in Medicaid and Marketplace financial assistance, though attention to this issue is important and is discussed further below. It may result in some individuals becoming enrolled in Medicaid despite (unexpected) increases in income or changes in family composition that render them ineligible, but this is likely a small cost to the Medicaid program and there is no penalty for the individuals themselves.

Assessment at Tax Filing

- Preliminary eligibility assessment based on tax information is conducted.
- Appear Medicaid eligible:
 - Information on potentially Medicaid eligible individuals is sent to Medicaid agency for verification.
 - If information can be verified, individuals are enrolled.
 - If not, outreach is conducted to facilitate enrollment into Medicaid or individual market.
- Appear individual market eligible:
 - Individuals have SEP to enroll in coverage.
 - Individuals are matched to low-cost individual market plan.
 - Outreach is conducted by Marketplace or by matched insurance plan to encourage submission of application and enrollment.
- Appear employer coverage eligible:
 - Tax agency or Marketplace conducts outreach to individual.

⁴¹ See Dorn et al., *supra* note 6 (arguing that an attestation of income in Medicaid-eligible range can be considered verified when consistent with prior year tax data). Automatic processing could also be limited to those with social security numbers since other immigration statuses will be difficult to verify without additional information provided by the individual.

⁴² See Stan Dorn, Margaret Wilkinson & Sarah Benetar, *CHIPRA Express Lane Eligibility Evaluation*, URBAN INSTITUTE (2014), <https://www.urban.org/sites/default/files/publication/33691/413272-CHIPRA-Express-Lane-Eligibility-Evaluation-Case-Study-of-Louisiana-s-Express-Lane-Eligibility.PDF>.

For individuals that could not be enrolled—because they indicated an expected change in income, or because their tax return information could not be verified—the Medicaid agency would provide a notice and conduct other outreach to help them become enrolled in Medicaid or other coverage.

For those assessed as potentially eligible for the individual market, the process would be more challenging, but could still result in coverage gains. First, individuals would need to be given a special enrollment period (SEP) to enroll in coverage based on the tax agency’s assessment of likely eligibility. Stakeholders will undoubtedly raise concerns about adverse selection associated with this SEP: individuals without immediate health care needs could forego enrollment in the early months of the year, knowing that they could wait to become enrolled based on this tax eligibility assessment SEP. While that is certainly possible, it seems likely that these concerns have been overstated given the limited information that most individuals have about their eligibility. Indeed, in Massachusetts, individuals with incomes below 300 percent FPL can enroll in coverage for the first time at any time, and even those with higher incomes can apply for an SEP if they did not “intentionally forego enrollment”⁴³—and the Massachusetts individual market remains one of the strongest in the country. This suggests that the enrollment gains among healthier, low-information individuals associated with this SEP could more than offset any potential gaming.

If the eligibility rules resemble those in place today, to actually achieve an enrollment through this SEP individuals would need to submit additional information, beyond what is indicated on the prior tax return and used for the initial eligibility assessment. So, an entity receiving information about the individual could conduct intensive outreach to these consumers.

This outreach could come from the Marketplace itself. Alternatively, to make the process closer to actual automatic enrollment and to leverage additional outreach resources, one could imagine involving issuers in the process. As part of the preliminary eligibility assessment, an individual could be matched to a particular insurance plan in the individual market. For example, individuals could be randomly assigned to a standardized group of low cost plans at the silver or bronze metal level, if offered by an issuer that agrees to certain guardrails regarding outreach. Individuals would still need to submit additional information to the Marketplace (potentially through the issuer) and would have the option to select another plan, but such an approach could make the process more seamless.

Finally, for those that appear to be potentially eligible for coverage from an employer, the tax agency or Marketplace could conduct outreach directly to the consumer to inform them and provide guidance on obtaining employer or other coverage.

Eligibility Changes

If lawmakers were willing to pursue a redesign of Marketplace financial assistance eligibility rules, then the tax-time eligibility assessment could come closer to automatic enrollment. Converting to a prospective award of financial assistance (that is not subject to reconciliation) and eliminating the employer coverage firewall—such that eligibility for Marketplace financial assistance was structured in much the same way as Medicaid—would allow the assessment to much more closely match actual eligibility. In that environment, individuals could be invited to confirm that the information used by the tax agency in their eligibility assessment was still accurate and that they had not obtained coverage. This would also make it more straightforward for an entity other than the Marketplace, like an issuer, to obtain the necessary confirmation and proceed to enrollment. These changes would, as noted above, come at significant cost, but they would also make the entire process easier to navigate and could result in large coverage gains.

⁴³ “Request an Open Enrollment Waiver,” Massachusetts Health Connector, <https://www.mass.gov/request-an-open-enrollment-waiver>. See also Sarah Lueck, *Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage*, CENTER ON BUDGET AND POLICY PRIORITIES (June 2019), <https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve>.

Even without dramatic changes, smaller eligibility changes could streamline the ability to become enrolled after a tax time assessment. In particular, changes to eligibility such that people would not be penalized if they inadvertently become jointly enrolled in Medicaid and Marketplace financial assistance would be necessary.⁴⁴ And requiring the Marketplace and the state Medicaid agency to accept as verified the income used for the tax agency’s assessment would minimize the amount of additional effort needed to become enrolled if the individual believed the tax assessment was based on accurate assumptions.

Limitations

This approach is, of course, not “true” auto-enrollment—some Medicaid-eligible individuals could potentially be enrolled, but for other populations it represents targeted outreach. Many potentially eligible individuals would not become enrolled in coverage under this system, including the newly uninsured and anyone who declines to take the necessary action. It would be a major operational endeavor for the tax agency, state Medicaid agencies, and the Marketplace and/or issuers, and it is difficult to predict the magnitude of the coverage gains.

That said, this kind of system it is likely the closest one can get to automatic enrollment without adopting either a retroactive approach or an overhaul of eligibility rules. Notably, advocates of auto-enrollment have recently succeeded in enacting an approach along these lines in Maryland. Maryland legislators had initially considered a more aggressive auto-enrollment policy with the goal of actually enrolling people into the individual market,⁴⁵ but such an approach was not successful. Instead, lawmakers are moving forward with eligibility assessment based on tax data to help facilitate enrollment, scheduled to begin in 2020.⁴⁶

Option 3: Targeted Populations

A third option for policymakers to consider is to target a few specific populations at times of coverage transitions. Specifically, targeting individuals as their eligibility moves between Medicaid and the individual market and targeting individuals applying for Unemployment Insurance benefits could potentially bring eligible individuals who might otherwise not seek out enrollment into coverage.

Moving Between Medicaid and the Individual Market

Some currently uninsured individuals who are eligible for coverage entered their spell of uninsurance after having previously been enrolled in either Medicaid or the individual market, but lost coverage when they could have transitioned into the other program. This includes situations like: an individual’s income changes above or below the Medicaid threshold, young people age out of Medicaid, and women lose Medicaid after the birth of a child. In many states, some of the same companies offer Medicaid managed care products and individual market insurance. Thus, individuals could stay enrolled with the same issuer (with similar provider networks and care management supports) if they were able to avoid the gap in coverage at the time of transition.

However, today it is difficult for issuers to help support consumers through these transitions. Medicaid agencies generally frown upon managed care organizations using their prior Medicaid

⁴⁴ Today, an individual who is receiving APTC when they are enrolled in Medicaid (even if not aware of the Medicaid enrollment) will have to repay the APTC received, subject to the applicable repayment cap. For example, a married couple with a projected income at 140 percent FPL would have been paying individual market premiums totaling roughly \$800 over 12 months for the benchmark plan. If during that year they were also enrolled in Medicaid for 2 months or longer, they will owe an additional \$600 in excess PTC at tax filing. Thus, becoming enrolled in Medicaid after a tax-based assessment can inadvertently impose significant costs on a household absent changes to eligibility rules.

⁴⁵ See Stan Dorn, *Health Insurance Down Payments: The Maryland Plan*, FAMILIES USA (February 2018), <https://familiesusa.org/product/health-insurance-down-payments-maryland-plan>.

⁴⁶ Stan Dorn, *Maryland’s Easy Enrollment Health Insurance Program: An Innovative Approach to Covering the Eligible Uninsured*, FAMILIES USA (May 2019), <https://familiesusa.org/blog/2019/05/maryland%E2%80%99s-easy-enrollment-health-insurance-program-innovative-approach-covering>.

relationship with a consumer to market other products like individual market offerings, and managed care organizations are also usually prohibited from assisting with enrollment into Medicaid (to prevent them from influencing a consumer's choice of managed care plan). Replacing these policies with new rules that expressly allow issuers who offer products in both markets to cross-promote and facilitate enrollment, with appropriate safeguards, would be an important first step.

Policymakers could go further by requiring issuers to take certain outreach actions when a consumer is losing coverage, or even providing bonus awards to issuers that have a lower percentage of consumers exit their coverage into uninsurance. Issuers could also be given basic authority to collect eligibility information and provide a temporary period of coverage (like hospitals' existing presumptive eligibility authority in Medicaid) while eligibility is being verified through the state Medicaid agency or the Marketplace. This could include beginning premium collection in the individual market.

One could even imagine designing a special "post-Medicaid" product for the individual market, with an identical cost-sharing design and premium across all carriers. This would make it more equitable for carriers to be directly involved in keeping a consumer enrolled across the threshold, since consumers would have the same costs regardless of which issuer they started with.

Regardless, directing issuers to support consumers in this way would require rules and oversight to ensure that issuers were providing consumers with the information they needed to understand their eligibility and not discriminating among different potential enrollees in their efforts (such as by avoiding outreach to those with health conditions). Further, consumers would need to be informed of the opportunity to pursue a broader range of coverage options by using a different enrollment pathway. And in all of these variations, consumers will still need to provide *some* information to become enrolled, though the process could be streamlined as noted in the previous section. But they will be supported by an entity with whom they have an existing relationship (and who will have a direct financial interest in keeping them connected to coverage). Such an approach could lead to significant coverage gains by making the process more seamless for affected consumers.

Unemployment Insurance Claims

A very different opportunity to facilitate more seamless enrollment into coverage arises when consumers file Unemployment Insurance claims. The loss of a job is a major driver of uninsurance, so many consumers seeking UI benefits are newly eligible for coverage programs. State UI benefit applications could be modified to ask consumers for additional information necessary to determine their eligibility for Medicaid coverage or Marketplace financial assistance. The additional information is substantial—it would include their household composition and insurance status, the household's projected annual income from sources other than UI benefits, household members' offers of health insurance from an employer, and potentially tobacco use and pregnancy status—but it could be integrated into the existing application and the information treated as an application for coverage with an eligibility determination granted.

Those eligible for Medicaid could be enrolled by the state agency. For those eligible to buy coverage in the individual market, consumers would need to select a plan. Ideally, the system would be set up to default to a plan selection with Marketplace financial assistance applied, with the consumer given the option or change plans or forego enrollment.

Critically, because the individual will be receiving UI benefits, if the individual elects to enroll the premium can be deducted from their UI benefits and directed to the issuer they have selected. The precise magnitude of the UI benefit compared to the premium will obviously depend on the specific household and how much of the year is reflected in the period of unemployment, but for typical scenarios where families are eligible for financial assistance the premium will be far smaller than the benefit. However, the fairly short duration of UI benefits in some states would make this approach less effective.

Finally, this system could be facilitated by delegating certain eligibility-related functions to the state UI agency. Specifically, the UI agency's electronic verifications could be used for Medicaid and Marketplace purposes, and the UI agency staff could perform functions that would otherwise be performed by social services staff or by document submission and review through the Marketplace. For example, the citizenship and immigration status verification could be addressed through the UI process (rather than a separate Medicaid or Marketplace verification). Certain patterns of information on household income could be automatically considered verified if they matched the UI record for the individual. And UI staff could review documents that would otherwise be submitted to another agency. This should increase the number of people that could be directly enrolled as part of their UI application.

Conclusion

Auto-enrollment has been embraced by health policy experts across the political spectrum, but it is fraught with policy and operational challenges. That said, there are three promising pathways that policymakers can explore. The first is a backstop plans that treats the otherwise-uninsured as if they were covered and retroactively collects premiums at the end of the year through tax-filing, a powerful tool to achieve universal coverage. The second is referrals to coverage—stopping short of true auto-enrollment—based on prior year tax information. A policy along these lines has recently been enacted in Maryland and will take effect in the coming years, though this kind of approach will likely result in far smaller coverage gains than a backstop approach. Finally, policymakers may wish to explore targeted interventions at times of coverage transitions, which will not be population-wide automatic enrollment but could still bring new people into coverage.

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