Institute for Responsive Government

Automatic Enrollment in Health Coverage Programs

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Publicly funded or supported health programs in the United States have a varied history in terms of the ease of enrollment for eligible persons. The Affordable Care Act (ACA) included a number of steps to make enrolling in health coverage easier, but the true innovation came when states identified opportunities to automate the enrollment process. By leveraging real-time data connections and modern eligibility rules engines, states have created processes to automatically enroll and retain eligible persons in health coverage.

History of Enrollment Processes

Prior to the ACA, there were two main coverage programs for Americans (outside of employer sponsored insurance), Medicare and Medicaid. Medicare is the main health coverage source for people aged 65 and older and people with disabilities with a significant work history and is fully managed by the federal government. Medicaid covers persons with certain special health needs (certain disabilities and long-term care needs) and persons that meet certain low-income thresholds. Medicaid operations, including eligibility limits and enrollment processing, are run by states.

Enrollment in Medicare has a number of steps and options for enrollees. Medicare has four parts: Part A (Hospital Coverage), Part B (Physician and Outpatient Coverage), Part D (Prescription Drug Coverage) and Part C (Medicare Advantage, which is an alternative bundled plan for Parts A, B, and D). If a person elected to enroll in Social Security early, whether due to disability or retirement, they are automatically enrolled in Medicare Parts A & B. They then have an opportunity to choose their desired Part D coverage or enroll in a Part C plan. However, if a person is not receiving Social Security prior to their 65th birthday, they must enroll on their own.[1]

Historically, Medicaid has been a program that has required someone to complete an enrollment process in order to obtain benefits. The only population that did not need to take steps to enroll were children in the foster system. Such children, eligible for Medicaid because they are in the foster system, are enrolled through an intergovernmental process – a collaboration between Medicaid and the child welfare agency in a state or county. Changes brought about by federal legislation in 2009 and system modernization efforts have opened the door to increased opportunities to leverage data sharing to create automatic enrollment pathways.

Express Lane Eligibility

Federal safety net programs like Medicaid, the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF), are income-based benefits. That is, an applicant needs to attest to, and sometimes prove, a certain income in order to qualify for the program. Advocates frequently criticized the burden that was placed on families when these programs required separate applications and often multiple copies of the same information to enroll in each program. The CHIP Reauthorization Act of 2009 created an opportunity to ease this burden by creating the Express Lane Eligibility option for states. Through Express Lane Eligibility, the state Medicaid or CHIP agency can accept information from a set of approved "Express Lane agencies" to support the completion of an application and in some cases, automatically enroll eligible children.[2]

Eight states took up the Express Lane option when it was first offered, and South Carolina represents an important use case. Prior to Express Lane, South Carolina estimated that 64% of the children that left Medicaid because they did not complete the renewal process returned within one year, many within just one month. By moving to Express Lane, the number of children leaving Medicaid because they did not complete the process dropped, as did the percentage of returns. The state also used Express Lane to enroll 92,000 children in new coverage in less than a year.[3]

Ex Parte Renewals

In a similar policy effort, the Medicaid program issued rules that require states to first conduct renewals automatically. The so-called "ex parte renewal process" directs states to use data from available sources to conduct an analysis of an individual's income to determine if their Medicaid enrollment can be renewed

automatically. To conduct ex parte renewals, state Medicaid agencies develop data use agreements with a set of federal and state agencies in order to query for datapoints that can help Medicaid determine whether a person remains eligible.

Medicaid eligibility can depend on a number of factors, but generally, income is a core component and represents the key question for renewal – *Does your income still make you eligible for Medicaid?* As such, the most common datapoints that ex parte renewal needs are income, both earned and unearned. States will connect to data sources including the IRS, the state wage information collection agency, the Social Security Administration, state unemployment agencies, and SNAP and TANF program agencies. Nine states currently complete more than 75% of their Medicaid renewals through ex parte processing.[4]

Note: During the COVID-19 public health emergency (PHE), states are required to provide continuous enrollment in Medicaid, so the renewal process has been suspended until the PHE ends.

California's Automatic Health Insurance Enrollment

If a person's income exceeds Medicaid's limits, but is below the marketplace income threshold, they then qualify for coverage through the Marketplace (if they do not qualify for Medicare or are offered affordable coverage from their employer). Until recently, there has been no way for states to seamlessly and automatically move from Medicaid to marketplace coverage. If a person ends their Medicaid coverage, their information might be forwarded to the marketplace, which might reach out to the consumer. However, this outreach did not always happen and many were left to find coverage on their own. Legislation passed in California in 2019 required the state to develop a pathway for automatic enrollment in marketplace coverage if a person is no longer Medicaid eligible.[5]

Covered CA, the state's health insurance marketplace will accept information from Medi-Cal, the state's Medicaid agency, for persons transitioning off Medicaid. Covered CA will then automatically enroll that person in the lowest-cost sliver-level plan to maximize federal subsidy availability. The consumer will be notified of their enrollment and must either pay the premium due to remain enrolled, or, if no premium is due, accept terms and conditions. Consumers also have the ability to opt-out of the automatic enrollment and select the plan of their choice.[6]

Future opportunities

The California model is a test case in true automatic enrollment. Some states use information from state tax filings to support a streamlined enrollment and if California is successful, those states may to an automatic enrollment. As state systems that support health care eligibility continue to be updated, the capacity to support automatic enrollment will grow.

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[1] https://www.medicare.gov/Pubs/pdf/11036-Enrolling-Medicare-Part-A-Part-B.pdf
[2] https://www.medicaid.gov/federal-policy-guidance/downloads/SHO10003.PDF
[3] https://www.healthmanagement.com/wp-content/uploads/Final-South-Carolina-ELE-Case-Study-ASPE-03062014.pdf
[4] https://www.cbpp.org/research/health/streamlining-medicaid-renewals-through-the-ex-parte-process
[5] https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB260
[6] https://hbex.coveredca.com/data-research/library/CoveredCA-Medicaid-to-Marketplace-AutoenrollmentStrategy-FactSheet-v1.pdf