

How Auto-Enrollment Can Achieve Near-Universal Coverage: Policy and Implementation Issues

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TOPLINES

Automatic health insurance enrollment could help achieve near-universal coverage, especially if paired with a public plan option

A comprehensive automatic enrollment strategy for health insurance would reduce the number of uninsured in the U.S. by 24.6 million, at a cost to the federal government of about \$140 billion in 2022

ABSTRACT

Issue: Automatic enrollment is receiving increased policy attention as a means of achieving universal coverage. Auto-enrollment also could have eliminated insurance gaps that occurred during the COVID-19 pandemic. However, it could face resistance from some Americans who would newly be expected to pay premiums. The approach also raises difficult design and implementation issues.

Goal: Explore how two auto-enrollment strategies, one affecting all legal residents and another affecting a narrower low-income population, might work.

Methods: Based on lessons learned from the Affordable Care Act and understanding of subsidized insurance programs, we explore design and implementation issues, such as how to deem enrollment, how to collect premiums, and which exemptions to permit. We also use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate coverage and cost implications of each approach.

Key Findings and Conclusions: Both the comprehensive and limited approach to auto-enrollment would require the development of new administrative systems and enhanced marketplace subsidies to improve coverage affordability. Each approach would operate more simply if accompanied by a public insurance option. We conclude that the administrative and financing challenges related to auto-enrollment can be addressed and that a balance between public costs and sufficient political support could be identified.



INTRODUCTION

The idea of using an administrative mechanism to automatically enroll people who do not actively enroll themselves in a private health insurance plan or a public coverage program is receiving increased attention recently as a way of covering Americans who remain uninsured. Depending on the design, an auto-enrollment policy can target either a narrow segment or a broad swath of the population. During the COVID-19 pandemic, when millions of people lost their jobs and their employer-based insurance, auto-enrollment strategies might have eliminated many coverage gaps.

Absent a single-payer health insurance system, a comprehensive version of auto-enrollment that is mandatory for most people who would otherwise be uninsured may be one of the most likely paths to near-universal coverage. But comprehensive auto-enrollment raises significant administrative and political challenges because it generally requires the payment of insurance premiums by at least some of the people who are auto-enrolled.¹ Given that, policymakers might also consider a narrower version of auto-enrollment, such as one limited to people who are eligible to enroll without paying a premium.

This paper explores how these two auto-enrollment variants might work and estimates their impacts on coverage and federal government costs. The first option we present is a more comprehensive approach that would lead to universal coverage for legally present U.S. residents. The second option, a less comprehensive approach, would focus on auto-enrolling the country's lowest-income residents who are eligible for comprehensive coverage without a premium contribution.

OPTION 1. MANDATORY AUTO-ENROLLMENT WITH RETROSPECTIVE INCOME-RELATED PREMIUM PAYMENTS

Policy Overview

This option would treat virtually all legal residents of the U.S. as insured 12 months per year, regardless of whether they have actively enrolled in an insurance policy. Income-related premiums would be collected at the end of the year from people who did not actively enroll in and maintain

insurance coverage. Depending on their income, enrollees would be covered by either Medicaid or an insurance plan offered through the nongroup marketplaces for any months for which they do not otherwise have public or private insurance coverage. Any premiums owed would be collected through the tax system when they filed their tax returns for the year.

To make this auto-enrollment option work, a number of other policies are required:

1. The Medicaid eligibility gap must be filled in the 14 states² that have not expanded eligibility to all those with incomes up to 138 percent of the federal poverty level (FPL). This would provide a default coverage option for a large share of the people uninsured under current law. Auto-enrolling these individuals would provide them with adequate, affordable insurance coverage.
2. Income-related marketplace subsidies for premiums and out-of-pocket costs must be more generous permanently. Without greater financial assistance, many people will still feel that the coverage available to them is unaffordable. This could make the auto-enrollment approach politically unpalatable and unsuccessful in removing financial barriers to necessary medical care.
3. Implementation of this auto-enrollment approach would be greatly facilitated if a public insurance option became available on the marketplaces nationwide. This public plan could likely charge premiums below those of many commercial insurers if the government pays providers lower rates than most insurers. Such a plan would act as the default plan in which auto-enrollees ineligible for Medicaid are enrolled. Using a default public option for auto-enrollees could address concerns related to plan assignment, plan capacity, provider networks, and reimbursement of claims.
4. The approach also requires eliminating the so-called employer-sponsored insurance firewall that prohibits people from receiving marketplace subsidies if they or one of their family members have offers of workplace insurance deemed affordable under current law. Without doing so, many people who are auto-enrolled

into marketplace coverage under this approach would find themselves ineligible for premium and cost-sharing subsidies, meaning they could be enrolled in coverage and charged premiums that they could not afford.³

5. An ongoing, well-funded education and enrollment assistance campaign is required as well. The objective is to create awareness that all Americans would be effectively insured, and those not actively choosing a plan themselves will be auto-enrolled in either Medicaid or the public insurance option. The campaign would directly explain that, depending on income, those not actively enrolling may owe premiums that will be collected through the tax system, if necessary. The idea is to aggressively encourage active enrollment in coverage over the course of each plan year, minimizing payments due at the end of the year.

Further discussion of each of the first three companion policies is provided in a later section. We first turn to a more detailed explanation of the pathways for enrollment and then to a description of how the health care services received during the year would be reimbursed by the plan under auto-enrollment.

Paths to Health Insurance Coverage

Individuals would enroll in coverage through three pathways: active enrollment during an annual open enrollment period, midyear active enrollment, and year-end auto-enrollment. Auto-enrollment would act as a fallback and affect only the minority of people who neglect to actively enroll in an insurance option for some or all of the calendar year.

Open enrollment period. Annual open enrollment periods for private insurance would continue in the presence of this auto-enrollment option. Active enrollment in employer-sponsored coverage and private nongroup coverage during applicable open enrollment periods would be strongly encouraged, as well as supported by widely available enrollment assistance provided by trained individuals. Individuals enrolling in the nongroup market could choose from all available insurance options and pay monthly premiums related to their income, as under current policy.

Open enrollment would provide consumers with the broadest choice of insurance plan options, allowing them to enroll in the plan they anticipate will be the best fit for their needs. Over time, increased awareness of the program would lead more and more people to actively enroll.

People seeking coverage outside the open enrollment period. Active enrollment in nongroup insurance coverage would be permitted at any time, subject to some limitations. Individuals eligible for Medicaid or the Children's Health Insurance Program (CHIP) could enroll in those programs year-round, as under current rules. Midyear enrollees would remain in these programs subject to the state's eligibility redetermination processes.⁴ People covered by employer-based insurance or Medicaid for part of the year and then transitioning into nongroup insurance (due, for example, to a job loss or an increase in income) would qualify for special enrollment periods that would permit them to choose among all of available nongroup plans, as is the case today. For individuals not qualifying for a special enrollment period, midyear enrollment in nongroup insurance would be limited to the public option, as discussed below.

Those enrolling midyear in the public insurance option would be charged income-related monthly premiums for this coverage under the same terms as those who enroll during the open enrollment period. At the end of the year, they may also owe income-related premiums for any prior months in the year during which they were not actively enrolled in insurance, as described in the next section.

Auto-enrollment determined at end of a calendar year. Some people would end the calendar year with all or some months during which they were not actively enrolled in insurance coverage. Regardless, they would be considered to have been insured for those months, either through Medicaid⁵ or the public option, depending on their income and the specific eligibility rules in their state. Depending on their incomes, they would be responsible for full, partial, or \$0 premium payments for the auto-enrolled months. Cost-sharing responsibilities (e.g., deductibles, copayments, coinsurance) would also vary by income. Any unpaid premiums owed would be collected through the income tax system. As under existing rules, eligibility for financial assistance would be based on annual income

because monthly income is not reported on tax returns.⁶ If the auto-enrolled person incurred medical costs during these months, they could file claims for reimbursement with the appropriate plan, as discussed further in the next section.

Use of Services When Not Actively Enrolled in Coverage

People may seek medical care during months of the year even when they have not actively enrolled in coverage. If the need for care is urgent, the provider would be required to deliver the necessary care to the patient and accept the public option's payment rates, without balance billing.

If the need for care is not urgent, the provider would be required to inform the patient whether they are currently participating providers in Medicaid or the public option. Providers must then connect any prospective patients who are not actively enrolled to an insurance support hotline that would help them to actively enroll in Medicaid or the public option.

Providers that deliver care to a patient who has not actively enrolled would be required to submit the bill and patient contact information to the insurance support entity, which will pursue active enrollment of the patient in either Medicaid or the public option, as appropriate.

As noted above, the number of people not actively enrolling in insurance coverage should decrease appreciably over the first few years of the reform. Personal experience, educational campaigns, and knowledge disseminated via news outlets and social contacts will teach people the advantages of early active enrollment as well as the fact that income-related premiums must be paid either way. As a result, this issue should become a smaller one over time.

Exemptions from Auto-Enrollment

To maximize insurance coverage, approximating universal levels, exemptions from the auto-enrollment fallback must be kept to a minimum. The Affordable Care Act's (ACA's) original individual responsibility provision offered several exemptions that released uninsured people in particular circumstances from the coverage mandate

and its associated penalties. Both the Obama and Trump administrations used administrative actions to expand these exemptions before the penalties were eliminated entirely beginning with the 2019 plan year.⁷ Together, these actions significantly weakened the mandate. In 2017, about 4.6 million tax returns showed a penalty and nearly 12.9 million claimed exemptions.⁸ The broad availability of exemptions likely resulted in a larger number of people remaining uninsured.

Exemptions of such breadth are not appropriate under the auto-enrollment option described here. Some exemptions may be necessary, but we believe that many of the ACA's exemptions from the mandate penalties should be eliminated and that few people would qualify for those that remained.

This is, first and foremost, because any end-of-year payments required under this approach are premium contributions, not penalties as under the ACA's individual mandate. In addition, several ACA exemptions are unnecessary under this auto-enrollment approach because the conditions they addressed would no longer exist. For example, the ACA provided an exemption for those without access to affordable coverage. Increasing the generosity of subsidies and, thereby, making coverage affordable to all legal residents eliminates the need for an affordability exemption. Similarly, the exemption for individuals ineligible for Medicaid coverage because of their state not expanding Medicaid eligibility is no longer necessary with that gap filled. The ACA exemption for those with income below the required tax filing requirement threshold is not necessary given that these individuals are exempt from any premium contribution under this design. And the ACA exemption for people uninsured for no more than three consecutive months is eliminated as the auto-enrollment strategy treats people as insured for the full year, consistent with the desire to all but eliminate uninsurance.

With that in mind, exemptions would be permitted only in the following circumstances:

- individuals ineligible for subsidized coverage (e.g., undocumented immigrants, citizens living abroad, and incarcerated individuals)

- individuals with a strongly held religious objection to receiving health care or insurance coverage (e.g., Christian Scientists and the Amish)
- members of Indian tribes (who would continue to be eligible for the Indian Health Service, for Medicaid, or for marketplace coverage under generous terms)
- in rare cases, individuals suffering hardships.⁹

Other ACA exemptions would not be adopted.

To avoid adverse selection, individuals who could enroll in Medicaid and the public option would generally need to receive an exemption in advance. For example, if the religious conscience exemption could be claimed after the fact, people could go uninsured and plan to claim the exemption but accept coverage if they get sick. On the other hand, individuals who are ineligible for subsidized coverage (e.g., undocumented individuals) could claim the exemption on the tax return, as they did under the ACA's individual mandate.¹⁰ Hardship exemptions could also be received after the fact.

Reporting of Coverage

Year-end auto-enrollment (and income-related premium collection) requires reporting to verify who lacked coverage for one or more months. The ACA's coverage reporting requirement, which was included primarily to support compliance with the individual mandate and the premium tax credit, is still in effect and should work for this purpose. The provision, in section 6055 of the Internal Revenue Code, requires providers of coverage — health insurance issuers, self-insuring employers, and government health programs — to report on the people they cover and for which months they cover them. For marketplace coverage, the reporting responsibility is satisfied by the marketplace itself. Currently this reporting is done using Form 1095-A (for most marketplace coverage), Form 1095-C (for employers that are subject to the employer mandate and self-insure), and Form 1095-B (for all other coverage).¹¹ The law requires this information to be submitted to the Internal Revenue Service (IRS), with a copy sent to covered individuals.¹² This gives the IRS a comprehensive database of which taxpayers were covered

for the year. This is precisely the information required to implement auto-enrollment with retroactive premium collection.

Collection and Enforcement

As noted above, premium payments for auto-enrolled coverage would generally be collected through the income tax system, much like individual mandate payments were collected prior to the penalties being eliminated. One concern about this approach is that it could lead to taxpayers owing unaffordable amounts at tax time. After a suitable initial period (for example, two years), deferred payments would be subject to interest under normal IRS rules to avoid a disincentive to actively enroll.

If taxpayers fail to pay their premiums at tax filing, unpaid amounts would be collected using the same methods the IRS applies to other tax debts. Individuals facing financial hardship could apply to the IRS for a payment plan to spread out the payments or to have the amounts owed reduced (in addition to the hardship exemptions discussed above). The generous contribution schedules presented above should make such cases rare, particularly over time as the number of people not actively enrolling in coverage falls with greater awareness and experience with the system.

To further incentivize active enrollment and reduce the likelihood of large year-end tax bills, a withholding mechanism could also be adopted. Employers could be required to withhold a percentage of employees' income (for example, five percent) above a certain threshold (for example, \$30,000) unless 1) the employee is enrolled in the employer's coverage, or 2) the employee attests to having other coverage. Employees who inaccurately attest to having coverage could face both interest and moderate penalties, similar to the penalties that currently apply for underwithholding and making insufficient quarterly estimated tax payments. To be sure, such an approach would imperfectly capture the ultimate premium amount given employers' incomplete information about employees' total income and family structure. But it could be better than nothing given the risks of large year-end tax debts.

Companion Policies Required for Implementation of Comprehensive Auto-Enrollment

Medicaid gap considerations. As of May 2021, 14 states have not expanded Medicaid to all those with incomes up to 138 percent of the FPL, as provided by the ACA. The drafters of the ACA had anticipated all states expanding, and the law was written to limit premium tax credit eligibility to those with incomes between 100 percent and 400 percent of poverty. As a result of this language, combined with the Supreme Court decision that expansion was voluntary for states, millions of adults experiencing poverty are ineligible for any financial assistance for health coverage. This eligibility gap makes comprehensive auto-enrollment (and universal coverage) impossible.

We and others have suggested several federal policy approaches to filling in this gap.¹³ For purposes of Option 1, we assume elimination of the 100 percent of poverty threshold for marketplace subsidy eligibility (thereby covering everyone in the Medicaid gap), while simultaneously eliminating the 10 percent state financing share of Medicaid expansion costs for states that have expanded eligibility under the ACA.¹⁴

Affordability/household financial burdens. Under current law, marketplace subsidies decline on a sliding scale as income rises. Specifically, the long-run structure of the premium subsidy schedule put in place for 2021 (i.e., prior to the temporary two-year enhancements introduced in the American Rescue Plan Act) was set so individuals with incomes at 100 percent of FPL would have an expected contribution of 2.07 percent of income to purchase a benchmark silver plan, rising to 9.83 percent of income for those with incomes between 300 percent and 400 percent of FPL.

Separately, cost-sharing subsidies increase the actuarial value of a silver plan (normally 70 percent) to 94 percent at incomes below 150 percent of FPL. These cost-sharing subsidies decrease as income rises and phase out for incomes above 250 percent of FPL.

In previous work done by two of us and our Urban Institute colleagues,¹⁵ we provided two possible alternate subsidy schedules, both more generous than current law and the second more generous than the first. Recently introduced legislation, the “Improving Health Insurance Affordability Act of 2021,” includes a schedule that falls between the two we analyzed and is presented in Exhibit 1.¹⁶

Exhibit 1. Enhanced Premium Tax Credit and Cost-Sharing Reduction Schedules

Income (% of FPL)	Premium tax credit schedule: household premium as percentage of income		Cost-sharing reduction schedule: actuarial value of plan provided to eligible enrollees (%)	
	2021 pre-ARPA schedule: pegged to silver (70% AV) premium, indexed	Alternative schedule: pegged to gold (80% AV) premium, not indexed	2021 pre-ARPA schedule: coverage provided for silver plan enrollee	Alternative schedule: coverage provided for gold plan enrollee
100-138	2.07	0.0	94	95
138-150	3.10-4.14	0.0	94	95
150-200	4.14-6.52	0.0-2.0	87	95
200-250	6.52-8.33	2.0-4.0	73	90
250-300	8.33-9.83	4.0-6.0	70	90
300-400	9.83	6.0-8.5	70	85
400-500	NA	8.5	70	80
500-600	NA	8.5	70	80
600+	NA	8.5	70	80

Notes: AV = actuarial value; ARPA is the American Rescue Plan Act; FPL = federal poverty level; NA = not applicable. The Pre-American Rescue Plan Act schedule reflects the long-run policy under current law, as opposed to the temporary increase in premium tax credit generosity provided by the Rescue Plan.

Since most people have insurance coverage already and, thus, would not be auto-enrolled in coverage, those affected by the auto-enrollment policy are primarily those who would otherwise be uninsured.¹⁷ According to our calculations, the alternative subsidy schedule could provide zero-premium coverage in benchmark plans for 42 percent of the currently uninsured. Another 15 percent of the currently uninsured would have an expected premium contribution of no more than 4 percent of income, which is a large discount off the full premium price, yet still a potential source of resistance from some who would prefer to be uninsured.

This schedule would also improve affordability for millions of Americans already enrolled in marketplace coverage or employer-based insurance requiring large household premium contributions relative to income. In general, making financial assistance more generous would increase the cost to the federal government while reducing the costs to households along with the expected resistance to auto-enrollment.

Public option considerations. Option 1 assumes a nationwide public option, allowing all auto-enrollment to be directed into either Medicaid or the public option. The public option would be a plan administered by the federal government or a federal government contractor. The plan would provide benefits consistent with the requirements of a marketplace qualified health plan, and it would be included in the risk-adjustment system. The public option would be available in the marketplace and would be eligible for the premium tax credit and cost-sharing reductions under rules similar to those for other marketplace plans.

A public option is an important component of Option 1 for several reasons:

- A public option would eliminate the need for the marketplace to assign enrollees to a particular plan. It is frequently not clear which plan is “best” for a given enrollee. Any assignment algorithm — lowest-cost plans, random assignment, etc. — would create winners and losers among both enrollees and plans. A public option accepting all non-Medicaid auto-enrollment would avoid these issues. This also highlights the importance that auto-enrollees be fully

risk-adjusted with the rest of the nongroup insurance market.

- A public option would simplify provider network questions that are likely to arise. When initiating or considering medical services, both patients and providers want to know as quickly as feasible which providers are included in the patient’s insurance network. This would be challenging if a patient might later be auto-enrolled into any number of insurance plans. A public option would avoid this pitfall by making clear which plan applies to people seeking care who are not already actively enrolled in coverage.¹⁸
- Since many midyear auto-enrollees would be identified when they use medical services, private insurers might resist a system of auto-enrolling people in private coverage because of concerns that the auto-enrollees are likely to incur above-average health care costs.¹⁹
- A public option would avert complications related to plan capacity. Currently marketplace plans are permitted to cap their enrollment based on network capacity. The public option could be designed to provide flexible capacity as with existing public programs.

Making auto-enrolled coverage affordable requires subsidies sufficient to make the public option premium affordable. The alternative (higher-generosity) premium tax credit schedule is tied to the second lowest-priced gold plan premium available to the enrollee (the benchmark premium) and would eliminate the indexing of the percentage of income caps that occurs under current law. In some circumstances, the public option would be the benchmark plan or priced even lower; this is particularly likely in noncompetitive markets with high commercial insurance premiums. However, the public option premium could exceed the benchmark premium in some areas, particularly in markets that are already highly competitive.²⁰ In that case we assume the premium tax credit for public option enrollees (actively enrolled or auto-enrolled) would be tied to the public option instead of the second lowest premium plan.

OPTION 2. AUTO-ENROLLMENT FOR INDIVIDUALS IDENTIFIED AS ELIGIBLE FOR FREE COVERAGE

While Option 1 would likely achieve near-universal coverage, one of its central planks may be controversial: It requires individuals to pay for coverage whether they want insurance or not. Although premiums, not penalties would be collected from people otherwise uninsured, some people would compare these premium payments to an individual mandate penalty. At some income levels, the premium contributions would exceed the ACA's original individual mandate penalties. Option 2 would avoid these concerns by auto-enrolling only a segment of low-income people for whom coverage would be free.

Policy Overview

This auto-enrollment system would apply to a narrow segment of the population: low-income people who are eligible for comprehensive \$0 premium coverage and who can be identified through their participation in other public assistance programs, such as Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). By focusing on those people enrolled in TANF and/or SNAP, auto-enrollment could take place during the annual open enrollment period and when people enroll in one of these programs midyear.

As with Option 1, a number of complementary policies would be implemented in conjunction with Option 2 to make it workable, fair, and effective:

1. The employer-sponsored insurance firewall would be eliminated because auto-enrollees cannot fairly be penalized for the government acting unilaterally to enroll them in coverage.
2. Reconciliation of the premium tax credit would be eliminated for people enrolled in SNAP or TANF, including those auto-enrolled under this option. This ensures that auto-enrolled people receiving upfront premium subsidies are not at risk of having to pay them back at the end of the year.
3. The Medicaid eligibility gap would be filled in states that have not expanded eligibility to all those with incomes up to 138 percent of poverty. Without doing

so, auto-enrollment would largely be limited to Medicaid expansion states.²¹

4. Income-related marketplace subsidies would be made more generous to increase the number of low-income people eligible for comprehensive \$0 premium coverage beyond those eligible for Medicaid.

Given that auto-enrollment Option 2 would affect a much smaller number of people than would Option 1, and since most of those affected would be auto-enrolled into Medicaid, development of a public option is probably not necessary, although it would be helpful. It is likely feasible for people auto-enrolled into marketplace coverage to be enrolled in the two lowest premium gold marketplace plans in their residential areas.

Implementation Issues

This more limited approach to auto-enrollment could be implemented in several different contexts:

- a component of Option 1 to strengthen its impact
- a stand-alone policy to increase coverage beyond current law but not reach universal coverage
- a first step or phase-in policy to which Option 1 would be added at a later date.

Under any of these contexts, the marketplace or a similar entity would obtain data, including income information, on active SNAP and TANF enrollees from state government agencies. People who are not already enrolled in Medicaid or marketplace coverage and who are eligible for no-premium coverage would be prospectively auto-enrolled into Medicaid or marketplace coverage, depending on their eligibility. Auto-enrollees would be notified of their coverage and given a time window for declining the coverage or opting for a different plan. This opt-out opportunity, combined with limiting auto-enrollment to free coverage, obviates the need for a formal system of exemptions.²²

Comparison to Current Law

Under current law, many states' Medicaid and CHIP programs reimburse providers (or enrollees, if they paid directly) for the costs of care provided to patients during a short period preceding enrollment in these programs.

Eligible people may generally enroll in these programs during or just after an episode of care (for example, when admitted to a hospital) and be covered for that care. Consequently, some analysts and policymakers consider people eligible for Medicaid but not enrolled as being effectively insured. Under that assumption, auto-enrollment for people already eligible for Medicaid but not enrolled, as proposed here, would have little to no effect on the new enrollees. If that were true, the primary effect of Option 2 would be to auto-enroll people in nonexpansion states into marketplace coverage with enhanced subsidies.

However, there is good reason *not* to consider people who are eligible for but not enrolled in Medicaid as having coverage. Research indicates that people in this circumstance do not use medical care at the levels they would if they were actively insured. For example, Davidoff et al. found that Medicaid-eligible but uninsured adults are significantly less likely to have a usual source of care; more likely to have unmet medical, dental, and prescription drug needs; more likely to delay care because of cost; and less likely to have a healthcare provider visit in the past year.²⁵ These findings control for an array of individual characteristics, including health status.

Consequently, notifying low-income people identified through their participation in SNAP or TANF at the beginning of the year that they have been auto-enrolled in Medicaid can be expected to have a significant effect on their use of medical care and well-being. These auto-enrollees will tend to use more medical care and be significantly less likely to delay their use of necessary care. Consequently, the benefits of Option 2 should accrue to people in both expansion and nonexpansion states.

ESTIMATED COVERAGE EFFECTS OF TWO AUTO-ENROLLMENT OPTIONS

We used the Health Insurance Policy Simulation Model (HIPSM)²⁴ to provide estimates of the impact of the two auto-enrollment approaches presented on the number of people uninsured and on federal government spending for the year 2022 (Exhibit 2). To measure the specific implications of each auto-enrollment strategy, we assumed that the following four reforms had been fully implemented whether Option 1 or Option 2 were enacted:

- Significantly more generous subsidies would be offered on the marketplaces than provided in the long-run ACA schedule. We assume that the alternative subsidy schedule (Exhibit 1) is in place. A less generous subsidy schedule could also be used at lower federal cost, while a more generous schedule could be used to help overcome political resistance to the more aggressive Option 1 approach. Consistent with current law, the subsidies provided under the reforms are assumed to be limited to people legally present in the U.S.
- A public option would be made available.
- The employer-sponsored insurance firewall would be eliminated.
- Eligibility for marketplace subsidies would be expanded to people in the Medicaid coverage gap.

We also looked at the effect of adopting these four reforms under current law prior to the American Rescue Plan Act *without* enacting any type of auto-enrollment.

Exhibit 2. Estimated Impact of Auto-Enrollment Options, 2022

	Number of uninsured (millions)			Federal spending (\$ billions)		
	Pre-ARPA law	Reform	Difference	Pre-ARPA law	Reform	Difference
Reforms without auto-enrollment	30.8	21.9	-8.8	467.1	546.7	79.6
Reforms with limited auto-enrollment (Option 2)	30.8	18.3	-12.5	467.1	580.5	113.4
Reforms with strong auto-enrollment (Option 1)	30.8	6.2	-24.6	467.1	606.6	139.5

Data: Health Insurance Policy Simulation Model, Urban Institute, 2021.

Notes: ARPA = the American Rescue Plan Act. To produce estimates akin to steady-state effects, we do not include temporary reforms to health insurance premium subsidies enacted as part of the American Rescue Plan Act.

Compared to current law (prior to the American Rescue Plan Act), the set of complementary reforms described above (enhanced subsidies and extension to Medicaid gap population, public option, elimination of the firewall) without any auto-enrollment strategies would reduce the number of uninsured Americans by 8.8 million people at a cost to the federal government of \$79.6 billion in 2022.

Adding the limited auto-enrollment features under Option 2 would reduce the uninsured by 12.5 million people compared to current law at a cost to the federal government of \$113.4 billion in 2022.

Finally, our comprehensive auto-enrollment strategy, or Option 1, would reduce the number of uninsured by 24.6 million people compared to current law prior to the American Rescue Act, leaving only 6.2 million people residing in the U.S. without legal documentation as uninsured. The additional cost to the federal government of Option 1 combined with the other reforms would be \$139.5 billion in 2022. Importantly, our estimates show that the stronger the auto-enrollment approach, the lower the government cost associated with each additional covered life, since stronger auto-enrollment brings in healthier enrollees on average.

CONCLUSION

Even with very generous subsidies available, a purely voluntary system will never reach universal coverage. To the extent that insuring the entire population or almost the entire population is an objective, some type of automatic enrollment will be necessary, whether into a single-payer system or built onto our current multifaceted health insurance system. Here, we present two possible approaches to auto-enrollment built on our current system: One has the potential to approximate universal coverage for the legally present U.S. population, and the other would expand coverage among those eligible for fully subsidized (free) coverage significantly beyond voluntary measures. Both would require the development of new administrative systems as well as improving coverage affordability for many Americans. Ideally, each approach would also include implementation of a public insurance option.

Expanded coverage would, therefore, come with additional public costs and may also come with some political resistance from households required to contribute to the costs of their insurance who would prefer to remain uninsured. However, we believe that the administrative and financing challenges are feasible to address, and that a balance between public costs and sufficient political support can be identified.

NOTES

1. Any program that aims to achieve universal coverage, including single-payer, would require some people to make payments into a system (either via premiums or taxes) that they would prefer not to make, leading to some significant political resistance.
2. Oklahoma is set to begin enrolling people eligible under their new expansion on June 1, 2021, with coverage beginning on July 1, 2021, but we continue to count it as a nonexpansion state until the expansion is actually in place. At the same time as Oklahoma, Missouri passed a ballot initiative to expand eligibility, but there continues to be uncertainty around Missouri's plans to implement its expansion.
3. Relatedly, the employer mandate would be eliminated since its operation is tied to the employee firewall (and it is currently expected to collect very little revenue). To encourage active enrollment and reduce the likelihood of large year-end payments, this approach could be combined with some sort of income withholding for employees not enrolled in the employer's coverage and not attesting to other coverage.
4. As under current Medicaid rules in many states, coverage would be retroactively effective for a short period (perhaps one to three months) to provide immediate reimbursement for ongoing episodes of care.
5. When auto-enrollment in Medicaid is determined at year end or tax time, enrollment would be done through the state's fee-for-service system to avoid complexities around retrospectively assigning people to managed care plans. Importantly, this approach avoids the necessity of making per capita payments to Medicaid managed care plans on behalf of auto-enrollees who never use medical care during the year.
6. Under current law, Medicaid eligibility is typically determined using monthly income at the time of enrollment. However, using income information provided at the time of tax filing requires eligibility for Medicaid for auto-enrollment purposes to be determined using annual income. Under this approach, people could still actively enroll in Medicaid based on monthly income through traditional enrollment systems.
7. See, for example, Timothy S. Jost, "Implementing Health Reform: Exemptions from The Individual Mandate," *Health Affairs Blog*, June 27, 2013; and Katie Keith, "New Guidance on Exemptions from Individual Mandate," *Health Affairs Blog*, Apr. 10, 2018.
8. Internal Revenue Service, *Statistics of Income — 2017 Individual Income Tax Returns Line Item Estimates* (IRS, 2017). For both counts, each return may represent more than one uninsured person. Also, the exemption figure is an undercount since it leaves out tax units that are exempt because of income below the filing threshold.
9. The individual mandate allowed hardship exemptions for those who experienced a hardship that interfered with their ability to maintain coverage. Regulations from the Centers for Medicare and Medicaid Services designated specific personal and financial circumstances that qualified as a hardship, including homelessness; eviction from a home; having a utility shut off; medical debt; unexpected increases in expenses for caring for an ill, disabled, or aging relatives; experiencing a natural disaster that resulted in significant property damage; experiencing domestic violence; or experiencing the death of a close family member. Given the additional generosity of subsidies, most individuals facing the designated circumstance are likely to be able to afford coverage, many with no premium contribution required. Thus, we assume that hardship exemptions would be relatively rare and would be available only by applying to the marketplace on a case-by-case basis.
10. To avoid the need for undocumented individuals to assert that status on the tax return, the individual mandate exemption form ([IRS Form 8965](#)) allowed individuals to use a single code to indicate either being undocumented or other grounds for an exemption. A similar approach would be adopted here.
11. Employers that are subject to the employer mandate (generally those with 50 or more full-time-equivalent employees) and that self-insure report using Form 1095-C because that form also includes the information needed to enforce the employer mandate. Specifically, in addition to coverage reporting under Code section 6055, the ACA added Code section 6056, which requires employers subject

- to the employer mandate to report on their full-time employees and the coverage that is offered to them (whether or not they enroll). If the employer mandate and employee firewall were repealed, there would be a strong case to repeal section 6056, which is used primarily to enforce those two provisions. In that case, the IRS could straightforwardly shift these employers to doing their coverage reporting on Form 1095-B, which is a shorter and simpler form.
12. Following the repeal of the individual mandate penalty, the IRS released guidance permitting issuers to refrain from sending Forms 1095-B for 2019 and 2020 to covered individuals unless they request it. This relief does not apply to 2021 and later years.
 13. Timothy S. Jost and Harold Pollack, *Key Proposals to Strengthen the Affordable Care Act* (Century Foundation, Nov. 23, 2015); and Linda J. Blumberg et al., *The Healthy America Program, An Update and Additional Options* (Robert Wood Johnson Foundation and Urban Institute, Sept. 2019).
 14. This approach was described in Linda J. Blumberg et al., *From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs* (Urban Institute and Commonwealth Fund, Oct. 2019). We assume that the federal government would take over the 10 percent contribution that states currently make toward the costs of their Medicaid expansion populations in order to not financially disadvantage expansion states compared to nonexpansion states. A financially equivalent strategy could be used that would increase the federal Medicaid match rates in each expansion state to a level that would approximate 10 percent of costs associated with their expansion populations.
 15. Blumberg, *From Incremental to Comprehensive*, 2019.
 16. The proposed premium tax credit schedule shown in Exhibit 1 is also used in the American Rescue Plan Act, which provides enhanced marketplace premium subsidies for 2021 and 2022. However, in addition to being temporary, the American Rescue Plan Act continues to tie premium subsidies to silver-level premiums (consistent with current law) and does not increase cost-sharing subsidies beyond those in current law. In contrast, the Improving Health Insurance Affordability Act of 2021 ties premium tax credits to gold-level premiums and enhances cost-sharing subsidies further for those with incomes up to 400 percent of FPL.
 17. Linda J. Blumberg et al., *Characteristics of the Remaining Uninsured: An Update* (Robert Wood Johnson Foundation and Urban Institute, July 2018). According to this report, 57 percent of the uninsured had incomes below 200 percent of FPL, 26 percent had incomes between 200 percent and 400 percent FPL, and 17 percent had incomes above 400 percent of FPL in 2017.
 18. There is a trade-off between the level of provider payment rates and voluntary participation of providers in the public option's network. The higher provider payment rates are set, the higher voluntary provider participation. However, higher provider payments also mean higher premiums associated with the public option and higher federal government subsidy costs. The federal government also could consider requiring provider participation as a condition of participation in the Medicare and Medicaid programs as a way to increase the breadth of the public option's provider network, if necessary.
 19. A counterpoint to this perspective is that, without a public option, private issuers would not only receive auto-enrollees seeking health care midyear but would also be assigned people who have never actively enrolled in coverage and have used few or no health care services. A strong risk-adjustment system could mitigate at least some of the remaining concerns about the distribution of risk of auto-enrollees. In any case, private issuers' objections to a public option might swamp any such concerns about risk.
 20. Since premiums are strongly associated with the level of payments a plan agrees to pay health care providers, the full premium for a public option will be correlated with the payment rates it uses. Paying providers something like Medicare rates would lead to lower premiums than paying them at the levels typical of commercial insurers. Consequently, the policy decision of which provider payment rates will be used by the public option will have important implications for whether its premium is at or below the benchmark.

21. Without filling the Medicaid eligibility gap, some people in nonexpansion states who are eligible by traditional Medicaid rules would be auto-enrolled. However, the impact on the number of people uninsured would be far smaller in these states. One also could envision auto-enrolling people eligible for \$0 premium marketplace bronze coverage where available; however, we oppose such a policy. The large out-of-pocket cost requirements for these plans would make coverage in them of little value to this low-income population, although the full premium cost paid by the federal government on behalf of all of the auto-enrollees would be significant.
22. Others have suggested a different approach to prospective auto-enrollment of those eligible for free coverage: identifying eligible people through income tax returns. See Christen Linke Young and Sobin Lee, *How Well Could Tax-Based Auto-Enrollment Work?* (Brookings Institution, Apr. 2020). While the impact of this option would be limited by the lack of a filing requirement at very low incomes, many people with incomes below the filing threshold choose to file a return — often either to claim tax benefits like the earned income tax credit or to receive a refund of excess income tax withholding. This approach would require larger accompanying changes, such as shifting the marketplace plan year and more broadly eliminating reconciliation. Such an approach could be combined with ours or implemented separately. However, combining the two could be complex given that our approach relies on current-year income while this other approach relies on past-year income.
23. Amy Davidoff, Bowen Garrett, and Alshadye Yemane, *Medicaid-Eligible Adults Who Are Not Enrolled: Who Are They and Do They Get the Care They Need?* (Urban Institute, Oct. 2001).
24. Matthew Buettgens and Jessica Banthin, *The Health Insurance Policy Simulation Model for 2020: Current-Law Baseline and Methodology* (Urban Institute, Dec. 2020).

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ACKNOWLEDGMENTS

The authors are grateful for the funding for this report from the Commonwealth Fund. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban Institute experts. Further information on the Urban Institute's funding principles is available at urban.org/funding-principles.

The authors are grateful for analytical contributions to this work from Michael Simpson, who estimated the effects of auto-enrollment strategies using the Health Insurance Policy Simulation Model (HIPSM). In addition to Simpson, Matthew Buettgens, Clare Pan, and Robin Wang comprise the HIPSM technical team. As such, work by all of them contributes to each analysis that uses HIPSM.

Editorial support was provided by Maggie Van Dyke.

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