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Automatic Enrollment in Health Insurance Would Be Complex and Difficult to Administer

By Paul N. Van de Water

Some analysts suggest that enrolling uninsured people automatically in an individual health insurance plan, with a chance to opt out, would boost health coverage in a way that would be less intrusive and unpopular than the Affordable Care Act's (ACA) individual mandate. And some Republican senators have proposed adding automatic enrollment to the Senate's version of the House-passed bill to repeal the ACA. But automatic enrollment would be hard, if not impossible, to administer. As a result, it would be far less effective than the ACA's mandate at getting healthy people enrolled in coverage and keeping premiums affordable. Automatic enrollment would also require collecting much the same information as the mandate, if not more, and Americans could view it as a greater infringement on personal privacy.

Even if these challenges could be overcome, automatic enrollment would place people in coverage with limited benefits and high deductibles — coverage that could expose them to catastrophic costs if they got sick. Automatically enrolling relatively healthy people in such limited plans would also fragment the insurance risk pool and make comprehensive coverage less affordable and possibly unavailable for those who need it. Although Medicare automatically enrolls some Social Security beneficiaries, that situation is very different and doesn't provide a model for the individual health insurance market.

The ACA's Individual Mandate

The ACA reformed the individual health insurance market in three key ways. First, the ACA prohibits health insurers from denying coverage to people with pre-existing health conditions, charging them higher premiums, or excluding coverage for basic but expensive health services, such as maternity care. Second, to ensure that healthy people participate in the insurance risk pool in order to hold down premiums, the ACA requires most individuals to maintain health coverage or pay a penalty. Without this individual mandate, healthy people would be much less likely to enroll in coverage than people with expensive pre-existing conditions, knowing that they could wait until they got sick to buy coverage. Third, the ACA provides premium and cost-sharing subsidies to help low- and moderate-income families afford insurance and meet their responsibility to maintain coverage under the individual mandate.

The federal government enforces the individual mandate through the income tax system. Health insurers and employers with self-insured health plans must report to the Internal Revenue Service

(IRS) the names and Social Security numbers (or taxpayer identification numbers) of those enrolled in minimum essential health coverage during the previous year, and tax filers must report their family's coverage status on their individual income tax return. People who don't maintain coverage and don't qualify for an exemption must pay an income-related "individual shared responsibility payment" when they file their return.

The individual mandate is a fundamental building block of the ACA, but also its least popular feature.¹ In one of his first executive orders, President Trump directed federal agencies to "minimize . . . [the ACA's] regulatory burdens." In response, the IRS abandoned plans to tighten the requirements for reporting health insurance coverage on individual tax returns. Although the individual mandate remains in effect, the IRS's decision may confuse some people and lead them not to enroll or stay enrolled in health coverage, thereby weakening the risk pool and raising premiums.² The House-passed health bill would immediately repeal the penalty associated with the individual mandate, which the Congressional Budget Office (CBO) projects would raise premiums by about 20 percent for 2018.³ Insurers and regulators have cited uncertainty that the Administration and Congress have created about the individual mandate as one factor why insurers are requesting higher premiums or leaving the market.⁴

Proposals for Automatic Enrollment

Two recent proposals would allow government to automatically enroll certain uninsured individuals into health plans, and give these individuals the opportunity to opt out of coverage. One is an ACA replacement bill from Republican Senators Bill Cassidy and Susan Collins. The other is a proposal by health policy analysts Lanhee Chen of the Hoover Institution and James Capretta of the American Enterprise Institute.

The Cassidy-Collins bill would offer states three options for providing health coverage to their residents. If a state did not actively choose one of the other options, it would default to an "alternative" option, which would eliminate most ACA consumer protections and coverage provisions, including coverage of "essential health benefits" — a set of basic benefits that include, for instance, maternity care and prescription drugs. The bill would eliminate the ACA's individual mandate and reduce protections for people who don't maintain continuous coverage in order to encourage healthy people to become and stay insured. States implementing the default "alternative" would also have the option to set up a new type of health savings account on behalf of uninsured individuals, deposit a federal tax credit in their account, and use the credit to enroll them

¹ Kaiser Family Foundation, *Kaiser Health Tracking Poll: November 2016*, December 1, 2016, <http://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-november-2016/>.

² Tara Straw, "IRS: ACA's Coverage Requirement Still in Effect," Center on Budget and Policy Priorities (CBPP), February 16, 2017, <http://www.cbpp.org/blog/irs-acas-coverage-requirement-still-in-effect>.

³ Congressional Budget Office (CBO), *Cost Estimate, H.R. 1628, American Health Care Act of 2017 as passed by the House of Representatives on May 4, 2017*, May 24, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf>.

⁴ CBPP, *Sabotage and Uncertainty Jeopardizing ACA Marketplaces, Insurers and Regulators Confirm*, <http://www.cbpp.org/sabotage-and-uncertainty-jeopardizing-aca-marketplaces-insurers-and-regulators-confirm>.

automatically in a high-deductible health insurance plan, with prescription drug coverage restricted to generic drugs for a limited number of chronic conditions.⁵

Determining eligibility for the health care tax credit in the Cassidy-Collins bill would not be simple. The credit would be available only to “deposit-qualifying” residents — citizens or those lawfully residing in the United States who are not eligible for Medicare and not enrolled in Medicaid or another federal health program. The amount of the credit would be adjusted for age, geographic area, and income, and reduced or eliminated for people with employer-sponsored insurance. The individual could receive the entire credit in advance and, if actual income turned out larger than estimated income, he or she would have to repay any excess advance credit.⁶

Chen and Capretta recommend that “automatically enrolling Americans eligible for tax credits into no-premium plans should be an important component” of the version of the ACA repeal bill that Senate Republicans are developing. As with the Cassidy-Collins bill, Chen and Capretta propose that states enroll tax-credit-eligible households into a default high-deductible insurance plan if they don’t choose a plan on their own. Insurers would adjust the deductibles for these health plans so that the premium charge would equal, or nearly equal, the credit amount for which the individual was eligible. The default plan would also cover some basic services, such as preventive care, generic prescriptions, and a few primary care visits.⁷

Why Automatic Enrollment Is Not Viable

Chen and Capretta acknowledge that “building an automatic enrollment system will be complex,” but some of the complexities will likely prove insurmountable. Collecting the accurate, current data needed to determine whom to enroll automatically, the amount of the tax credit for which they’re eligible, and a plan in which to enroll them would be a daunting challenge for states. Automatic enrollment would therefore be less effective than the individual mandate in encouraging healthy people to maintain coverage and in holding down premiums.

Creating such a database of the information needed to implement automatic enrollment would be as intrusive as enforcing the individual mandate or more so. Even under the best of circumstances, automatic enrollment would put people into extremely skimpy health plans that would have very high deductibles and that might not cover the medical services that the enrollee might eventually need.

No Timely Source of Data

Effective automatic enrollment would require that states assemble timely, accurate information about all the variables needed to determine who’s eligible for a premium tax credit but hasn’t used it and to assign them to an appropriate health plan. The necessary information includes health

⁵ Sarah Lueck, “Cassidy-Collins Proposal Would Weaken ACA’s Coverage and Consumer Protections,” CBPP, March 15, 2017, <http://www.cbpp.org/research/health/cassidy-collins-proposal-would-weaken-acas-coverage-and-consumer-protections>.

⁶ *S. 191, Patient Freedom Act of 2017*, January 23, 2017, <https://www.congress.gov/bill/115th-congress/senate-bill/191?>

⁷ Lanhee Chen and James Capretta, “The Senate Should Build Automatic Enrollment Into Health Reform; Here’s How,” *Health Affairs Blog*, June 5, 2017, <http://healthaffairs.org/blog/2017/06/05/the-senate-should-build-automatic-enrollment-into-health-reform-heres-how/>.

insurance coverage, income, family composition, age of family members, their citizenship status, place of residence, and possibly other items as well.

Proposals for automatic enrollment assume that the necessary data would come largely from the information that the IRS already collects to enforce the ACA's individual mandate. That means that states would assign people to a health plan for the coming year based on their income, coverage, and family status from *two years earlier*. However, that information would be out of date in a very large number of cases. People move, their incomes change, their families grow or shrink, and they lose or acquire health coverage. The individual health insurance market is characterized by very high rates of turnover.⁸ Almost 30 million people lose employer-sponsored insurance during a year due to a job loss and face a gap in coverage.⁹ And a similar number gain employer-sponsored health coverage each year.

Automatic enrollment based on two-year-old data would inevitably produce very uneven results and would be much less effective than the mandate in assuring a good mix of risks in the insurance pool. It would fail to enroll many uninsured people, and it would assign many other people to health plans they do not need or pay tax credits on their behalf for which they're not eligible. Although states would be obliged to notify people who are automatically enrolled and offer them a chance to opt out, this requirement would impose a significant and unnecessary burden on people who are mistakenly enrolled based on inaccurate or out-of-date information, and the opt-out process would not always work smoothly. Chen and Capretta suggest that states could automatically update enrollments mid-year after new tax returns are filed, but this information would still be out of date, albeit less so.

To understand the limitations imposed by this timeline, consider how automatic enrollment would work if it were in effect next year. A person who had health insurance in 2017 and lost coverage in January 2018 would not be automatically enrolled until mid-2019 at the earliest. And a person who was uninsured in 2017 but acquired employer-sponsored coverage in early 2018 would be automatically enrolled in an individual market plan in January 2019.

Chen and Capretta recognize that some people would be automatically enrolled into a health insurance plan with a premium that exceeds the amount of the credit for which they end up being eligible. In those cases, they suggest, both the individual and the insurer "should be held harmless for misestimated credit amounts." That's a fine idea, but not one that policymakers would likely adopt. Congressional Republicans have consistently opposed protecting taxpayers from errors in estimates of the ACA's premium tax credit. In 2011, they pushed an increase in the limit on any overpayment that must be repaid, and both the House-passed health bill and Cassidy-Collins bill would entirely eliminate the limit on repayments.

⁸ Gary Claxton *et al.*, *How Many People Have Nongroup Health Insurance?*, Kaiser Family Foundation, December 2013, <https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8534-how-many-people-have-nongroup-health-insurance.pdf>.

⁹ Matthew Buettgens, Stan Dorn, and Hannah Recht, *More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods*, Urban Institute, November 2015, <http://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf>.

Would Be As Intrusive As the Mandate

Tax data are highly sensitive, and taxpayers rightly expect that their information will be used for tax-related purposes. During last year's open enrollment period, as the ACA required, the IRS sent letters to about 7½ million taxpayers who either paid the penalty for not having health insurance or claimed an exemption, but appeared to be eligible for assistance based on their income. Even this modest action, intended to give taxpayers information about tax credits for which they might qualify, sparked some controversy.

House Republican leaders objected to the letters, according to the *Washington Times*, "saying that the IRS' decision to collaborate with a health care agency [the Centers for Medicare & Medicaid Services, or CMS] was an improper use of its resources and amounted to harassment of taxpayers." The IRS commissioner assured them that, "In keeping with our commitment to taxpayer confidentiality, we will send the letters directly to taxpayers; under no circumstances will we share the identities of these taxpayers or any other protected taxpayer information with CMS or with any other entity."¹⁰ Providing tax information to the states to facilitate automatic enrollment in health insurance would violate this assurance and would be much more controversial than sending an informational letter.

But automatic enrollment could require far more than the existing tax data used to enforce the individual mandate. Chen and Capretta suggest that the IRS data should form the basis of a larger "repository of information states could use to enroll persons into default insurance plans. Other parties (states, employers) should be brought into a process of maintaining and updating this database," they say. "States, for instance, can collect data on insurance enrollment through driver's license, car registration, and tax collection systems, which could then be used to verify, cross-check and update the federal database. Insurers should also be able to verify the government's data with their own." Such an extensive, widely accessible database would raise even more concerns about personal privacy and governmental intrusion than the mandate.

Furthermore, the database needed to determine who should be automatically enrolled in health insurance would have to include information on every resident of a state. In contrast, under the ACA, people seeking to obtain advance premium tax credits and enroll in marketplace coverage voluntarily provide up-to-date information as part of the application process, and others need only verify their health coverage status.

Provides Limited Coverage

Even if states could surmount the administrative challenges of automatic enrollment, the health plans in which people would be enrolled would provide extremely skimpy benefits. In the Cassidy-Collins and Chen-Capretta proposals, states would automatically enroll people in a high-deductible health plan that could be purchased with their premium tax credit alone. Both the Cassidy-Collins bill and the House bill, however, would provide far less help for low-income and older people than the ACA does.

¹⁰ Tom Howell, Jr., "IRS targeting those not on Obamacare," *Washington Times*, November 27, 2016, <http://www.washingtontimes.com/news/2016/nov/27/irs-assures-no-privacy-violated-as-it-lures-new-cu/>.

CBO estimates that the House bill would provide a 64-year-old individual with a tax credit that would cover only about a quarter of the average premium for a comprehensive health insurance plan in a state that does not request a waiver of the ACA's market regulations. Even for a 21-year-old, the credit would pay for only about three-fifths of the average cost.¹¹ The fraction of health care costs covered by plans that could be purchased with the House bill's credits (that is, the plans' actuarial value) would be even smaller than these numbers, and the plans would have far higher deductibles than are typical today.

What might these zero-premium plans look like? An analysis based on the tax credits in a bill introduced by former Rep. Tom Price, now Secretary of Health and Human Services, finds that only the youngest adults could purchase a policy covering all essential health benefits, and even they would face a deductible of \$4,500 for a single person. Most people would be able to purchase only plans excluding brand-name drugs, treatment for mental health and substance use disorders, and physical and occupational therapy, and deductibles would range from \$6,850 to \$25,000 for an individual, depending on his or her age.¹²

Automatically enrolling relatively healthy people in high-deductible health plans with limited benefits would further fragment the insurance risk pool and make comprehensive coverage less affordable and possibly unavailable for those who are not automatically enrolled. Even if the ACA's risk adjustment were not repealed (as Cassidy-Collins would do), it would become very difficult to implement effectively when plans varied substantially in benefits and actuarial value. At the very least, insurers would price their comprehensive plans on the assumption that they would attract enrollees with higher-than-average expected costs. At worst, comprehensive policies might become unaffordable, or insurers might stop offering them at all.¹³

Medicare Is Not a Model

Advocates of automatic enrollment in non-group health insurance plans sometimes point to Medicare as a precedent. People who are receiving Social Security retirement benefits, which can start as early as age 62, are automatically enrolled in Medicare's Parts A and B when they reach age 65. Automatic enrollment in Medicare, however, is a far simpler matter than enrolling people in individual health insurance coverage.

First, everyone who is receiving Social Security retirement benefits and has reached age 65 is also eligible for premium-free Medicare Part A (Hospital Insurance). The Social Security Administration can easily identify these people in its administrative records without collecting any additional information, and eligible beneficiaries have little reason not to participate.

Second, the vast majority of Social Security and Medicare beneficiaries choose to participate in Medicare Part B (Supplementary Medical Insurance) and to have their Part B premiums deducted from their monthly Social Security benefits. Part B benefits are financed three-quarters by general

¹¹ CBO, *Cost Estimate, H.R. 1628, American Health Care Act of 2017*, Table 5.

¹² Linda J. Blumberg, *What Can Consumers Purchase with the Age-Related Tax Credits in the Empowering Patients First Bill?*, Urban Institute, March 2017, http://www.urban.org/sites/default/files/publication/88566/2001169-what-can-consumers-purchase-with-the-age-related-tax-credits-in-the-empowering-patients-first-bill_0.pdf.

¹³ Blumberg, p. 2.

revenues and only one-quarter by beneficiary premiums, giving beneficiaries a great financial incentive to participate. In most cases the premium is less than the amount of the Social Security benefit, so the premium is easy to collect.

Third, once retirees enroll in Medicare, almost all of them continue to participate in the program for the rest of their lives. As a result, unlike the individual insurance market, Medicare has very little turnover in coverage.

Under these favorable circumstances, automatic enrollment of Social Security beneficiaries in Medicare has worked smoothly. Automatic enrollment of employees in employer-sponsored retirement plans has also proved successful in encouraging retirement saving. But automatically enrolling people who may be uninsured in high-deductible health insurance plans would face formidable administrative challenges and could make comprehensive coverage less rather than more affordable.