What is Auto-Enrollment?

Auto-enrollment policies seek to reduce barriers that often deter people eligible for coverage from enrolling, in the same way employers sometimes automatically enroll employees into retirement savings plans to increase participation in a program that benefits employees.

Auto-Enrollment Principles

Continued lack of health insurance is not a sustainable status quo for the millions of Americans affected. Enabling millions of uninsured Americans to be enrolled in health coverage for which they are already eligible is an efficient and effective strategy that will help improve the health of those Americans, their communities, and our health care system. More streamlined, automated, efficient, and effective enrollment processes would help millions of these Americans gain coverage that meets their needs.

Crafting effective auto-enrollment policies requires protecting enrollees, ensuring fair treatment of participating health plans, and maintaining program integrity. The following principles are specific to auto-enrollment of eligible but uninsured individuals into Medicaid, CHIP, Basic Health Plans (BHPs) or Exchange plans with zero net premium.

<u>Enrollee Protections</u>: Auto-Enrollment policies should protect enrollees and respect affirmative choices they have made. These protections include:

- Avoiding disruption to existing care relationships, which can lead to delayed care and worse health outcomes;
- Helping enrollees understand their potential out-of-pocket costs, coverage, and appropriate contacts for common needs and questions;
- Maintaining affirmative consumer choices, including primary care provider selection, until or unless changed by the consumer and not overriding consumer choices with automatic assignments;
- Communicating with enrollees effectively, employing a series of notifications using multiple forms of communication (mail, email, phone call, text message) about opportunities to select and review plans; adequate time for the enrollee to review auto-enrollment selection and opt out; and an appeals process; and
- Ensuring adequate network capacity for enrollees.

<u>Fair treatment of health plans</u>: Auto-enrollment policies should take care to avoid inadvertent disruption to or penalization of participating health plans, including:

- Holding health plans harmless from enrollee concerns that are not the fault of the plan, such as which plan the enrollee is assigned to; and
- Ensuring fairness to participating plans when assigning members.

Program Integrity: Program integrity helps ensure the sustainability of programs like Medicaid and CHIP and is a requirement of good stewardship of taxpayer funds.

State Flexibility

- It should be easier for states to use prior calendar year income for the purpose of making coverage decisions for Medicaid, CHIP, BHPs, and financial assistance for Exchange coverage in order to maintain their commitment to reducing avoidable churn, dis-enrollment for procedural reasons, and administrative burden.
    - This would include opportunities for beneficiaries to seek additional help based on changes in circumstances like loss of job or qualifying non-financial criteria in the current year.
    - Using prior calendar year income for coverage decisions would be in keeping with income eligibility requirements for certain other federally funded programs and could facilitate more efficient referrals and transitions between Medicaid, CHIP, and individual insurance marketplaces.
- Federal policy should support States that choose to make coverage decisions using prior calendar year income for **Medicaid**, **CHIP** and **Exchange coverage**, without a beneficiary request for coverage, but with notification to the beneficiary and ability to opt out.
- CMS should provide additional technical assistance to states interested in leveraging these flexibilities and streamline processes and approval wherever possible.

Enhanced Data and Systems

- CMS should support states that wish to invest in the design and development of state eligibility-determination systems by re-issuing a previous exception to the cost allocation requirements set forth in the Office of Management and Budget (OMB) Circular A-87 and extending it to CHIP and Exchanges. This would allow states to leverage investments in eligibility and enrollment systems across multiple programs
- CMS should provide technical assistance to states in implementing strategies included in the March 3, 2022, guidance related to syncing **Medicaid** and **CHIP** redeterminations with recertifications for human service programs including SNAP and TANF and establishing linkages to the U.S. Postal Service's National Change of Address database.
- The National Directory of New Hires (NDNH) should be updated to include information about employer-based coverage and made available to HHS for use in the verification of employer-sponsored coverage and financial eligibility for **Exchange** assistance. It should also be available to **Medicaid** and **CHIP** programs. This would improve accuracy and reduce administrative burden to consumers for the income verification step during the eligibility process. Access to the NDNH would also provide users visibility to information for cross-state employment situations.

Access to Federal Funding

- Federal grants and technical assistance should be provided to states that want to pilot policies for auto-enrollment in order to facilitate continuous coverage and access to care. In exchange for financial and technical assistance, states should be required to collect and publish outcomes to inform future policy.

Program Integrity

- HHS should confirm that the more recent and specific ACA §1413(c)(1) prevails over the Social Security Act §1137 in that states may opt to and will not be penalized for electronically verifying directly against the SSA citizenship database in lieu of completion of a mere attestation (via the SAVE form). This would enhance program integrity and facilitate automatic enrollment into Medicaid.