

Automatic Health Insurance Policies and Coverage Outcomes: Evidence from Massachusetts and Implications for ACA Reforms

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How much do small hassles in health insurance enrollment processes affect insurance take-up and coverage outcomes? Can policies that make it easier to get and stay insured have a meaningful impact?

We provide evidence on these questions by studying “**automatic health insurance**” policies used by Massachusetts in its pre-ACA health insurance exchange. The policies’ basic insight is to focus on moments of transition when people face a risk of becoming uninsured unless they complete a minor administrative step. In practice, many people fail to take action at these key moments. Under the policies we study, individuals are automatically assigned to a \$0 health plan if one is available, rather than being allowed to passively slide into uninsurance.

Specifically, we study two policies:

- 1) **Automatic Enrollment (at initial eligibility):** Many individuals apply and are determined eligible for coverage but do not respond when asked to finish enrollment by choosing a health plan – even if they qualify for free coverage. This is of particular concern when people are transitioned *off* of Medicaid due to an increase in income. Massachusetts ensured that these individuals did not become uninsured by *auto-enrolling* them in a \$0 plan if available.
- 2) **Automatic Retention (at premium non-payment):** Individuals who miss premium payments often lose their insurance coverage – even when the monthly premiums are small and they qualify for another plan that is free. Massachusetts *auto-retained* these people by switching them into a \$0 plan, rather than disenrolling them from coverage.

We use administrative data from the Massachusetts insurance exchange from 2007-2013 and quasi-experimental variation in use of these policies to infer their causal effect on coverage outcomes (see discussion below). Our analysis finds three key implications of these policies:

- **Higher insurance enrollment:** We find substantially higher enrollment when automatic insurance policies are in place. Auto-enrollment leads to 30-50% higher total enrollment into the exchange, while auto-retention keeps 14% of people from losing coverage. More than 95% of auto-enrolled/auto-retained individuals lack another form of coverage so would have become uninsured without the policies.
- **Lower-cost insurance market risk pools:** The policies differentially enroll/retain young, healthy, and low-cost people – notably healthy 19-34-year-olds, a group sometimes called “young invincibles” who are especially likely to be uninsured today. By including them in the market, the policies lowered the cost of the market risk pools. Auto-enrollees had 44% lower monthly medical spending; including them meant that the market had 14% lower average costs.

- **More equitable enrollment in insurance:** Auto-enrollees who gained coverage were more likely to have lower incomes and live in economically disadvantaged areas. These groups are both more likely to be uninsured today and to be enrolled by automatic policies.
- **Cost-effective ways to expand coverage:** By increasing enrollment in subsidized health insurance, total public spending rises – this is the central tradeoff of the ACA. However, the coverage vs. spending trade-off involved with automatic insurance is relatively favorable. In addition to enrolling relatively young and healthy (and therefore low-cost) people, auto-enrollment does not require spending more on higher subsidies for *existing* enrollees. As a result, the government cost per new enrollees (or cost-effectiveness) is at least 25% lower with auto-enrollment relative to subsidy expansions.

Policy Implications

These findings are important in light of continued high uninsurance in the U.S. Most of the 28 million uninsured already qualify for subsidized coverage, and about 40% qualify for free health insurance via Medicaid or ACA Marketplace plans. For these groups, *non-price barriers*, like the complexities and hassles of enrollment processes, are the key barriers to insurance coverage.

Auto-enrollment and auto-retention work best when individuals are eligible for at least one \$0 premium plan – as was the case when they were used in Massachusetts. Increasingly, this is also true in ACA marketplaces. The American Rescue Plan Act (ARPA) expanded access to zero-premium offerings by allowing households with incomes below 150% of the federal poverty line (FPL) to qualify for at least two zero-premium plans in the silver tier. Additionally, the subsidy enhancement means that zero-premium plans in the bronze tier are available for a wider range of enrollees.

Two features of the current policy landscape create urgency for implementing automatic health insurance policies:

- End of Medicaid “maintenance of effort” (MOE): As part of expanded Medicaid funding during the COVID-19 public health emergency, states must comply with an MOE requirement; they cannot terminate enrollees’ Medicaid coverage, even if their eligibility changes. When the MOE requirement ends, millions of Medicaid enrollees will be disenrolled. Auto-enrollment could help smooth transitions to marketplace coverage by automatically shifting qualifying enrollees into \$0 premium marketplace plans, rather than letting them become uninsured.
- Marketplace volatility in \$0 premium status: Each year, carriers submit new premium bids and subsidies are re-calculated using the second-lowest cost silver plan (also called the “benchmark plan”). As a result, some plans that were zero-premium when a consumer enrolled might take on positive premiums in the new year. To maintain coverage, their enrollees need to initiate premium payment, but we found that many enrollees fail to do so and instead have their coverage terminated. Automatic retention can prevent this inadvertent disenrollment from

occurring. This volatility is a particular concern for people below 150% FPL, who (because of subsidy design) have access to only two zero-premium silver plans.

Source of Evidence and Additional Details

Our evidence comes from studying Massachusetts' pre-ACA subsidized health insurance exchange, a program known as Commonwealth Care (or "CommCare"). Established in the state's 2006 health care reform, CommCare offered heavily-subsidized private plans to non-elderly adults below 300% of poverty without access to insurance through an employer or another public program.

A model market for the ACA Marketplaces, CommCare also implemented a variety of creative policies that did not make it into the ACA's policies. These include the auto-enrollment and auto-retention policies we study.

We use quasi-experimental variation in use of these policies across income groups and over time to infer their causal effect on coverage outcomes. Specifically, our sources of evidence are:

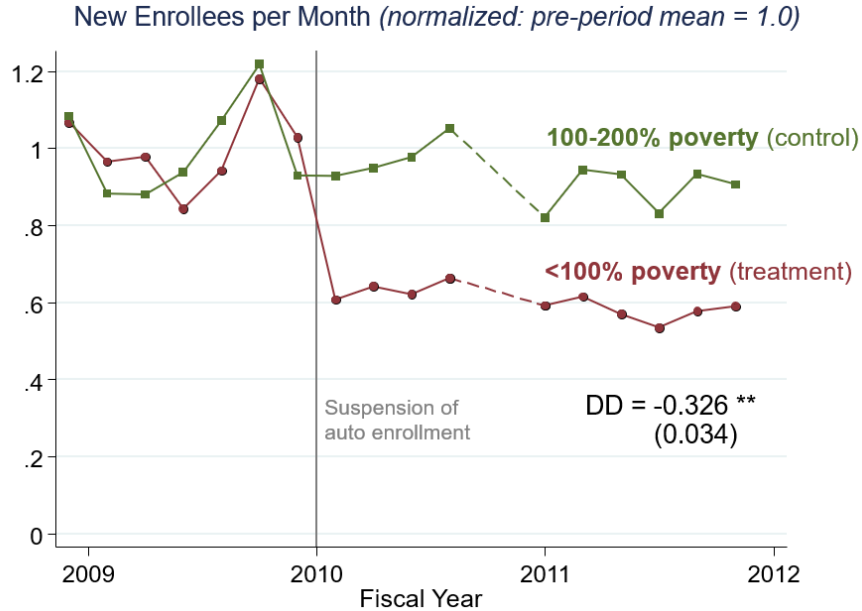
- **Auto-enrollment:** We use a 2010 policy change in which auto-enrollment was suspended because of a budget crunch following the Great Recession. We compare enrollment among the lowest-income enrollees (below 100% of poverty) for whom auto-enrollment was in place from 2007-09 versus a comparison group of slightly higher-income enrollees (100-200% of poverty) not subject to auto-enrollment throughout. We estimate that new enrollment declined by 33% because of the policy change (**Figure 1**) and show that the people who stopped getting auto-enrolled were younger, healthier, and more economically disadvantaged ([see paper](#), Table 2).
- **Auto-retention:** We measure auto-retention from rates of "mid-year" plan switching (outside of open enrollment), which is not typically allowed but that occurs when enrollees are auto-retained rather than being disenrolled. We use the fact that the policy applied only to enrollees in the 100-150% of poverty group (who had access to a \$0 plan) but not to higher income enrollees (150-200% of poverty). **Figure 2** shows rates of auto-retention in 2010-2012, breaking down rates by a plan's premium in the prior and current year. The spike in month four comes from plans that *transition from a \$0 to positive premium* at the start of the year. Almost one-fifth of their enrollees do not start paying premiums, and the auto-retention policy prevents them from being disenrolled.

Works Cited

McIntyre, A., Shepard, M., & Wagner, M. (2021, May). Can Automatic Retention Improve Health Insurance Market Outcomes? In *AEA Papers and Proceedings* (Vol. 111, pp. 560-66). ([link](#))

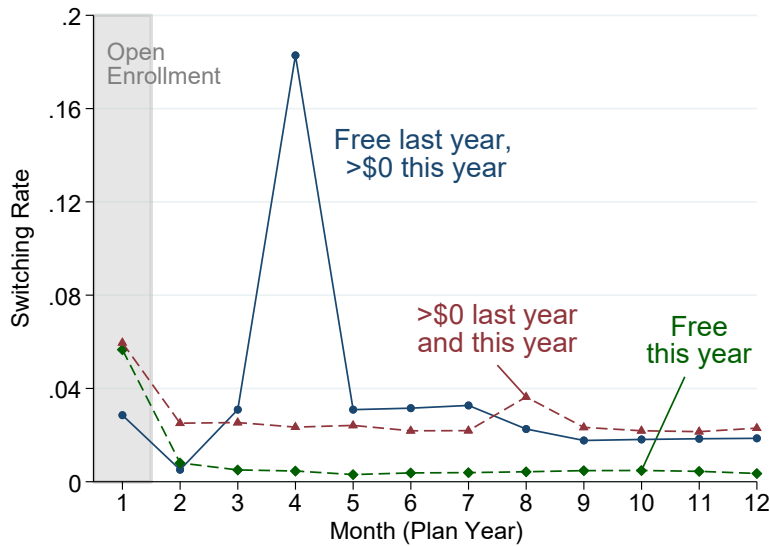
Shepard, M., & Wagner, M. (2021). Reducing Ordeals through Automatic Enrollment: Evidence from a Subsidized Health Insurance Exchange. Working paper, Harvard University. ([link](#))

Figure 1: Effect of Suspension of Auto-Enrollment in 2010 on Exchange Enrollment



Note: Figure 1 shows the 33% fall in new enrollment in Massachusetts exchange when auto-enrollment was suspended at the start of 2010 for enrollees with incomes below 100% of poverty (treatment group), relative to a control group (100-200% of poverty) for whom auto-enrollment was not used.

Figure 2: Rates of Automatic Retention (2010-12), by Origin Plan’s Premium



Note: Figure 2 shows automatic retention rates for enrollees in the Massachusetts health insurance exchange, by plan premium status. About 14% of enrollees were auto-retained each year, rather than being disenrolled. The most common situation occurs when plans transition from zero- to positive-premium (blue series), after which about 18% of their enrollees do not initiate premium payment and are auto-switched rather than being disenrolled.