THE BROOKINGS INSTITUTION

WEBINAR

HEALTH INSURANCE AUTO-ENROLLMENT

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P R O C E E D I N G S

MR. GINSBURG: I'm Paul Ginsburg from the Brookings Institution. I'd like to welcome you to this webinar on Auto Enrollments sponsored jointly by Brookings and the American Enterprise Institutes. To begin, a persisting of impediments are getting closer to universal coverage. It has been the reality that large numbers of people that were eligible for free, for highly subsidized coverage, are not enrolled. The Yeargan Institute is estimated with 25 percent of the uninsured are eligible for Medicaid and another 25 percent are eligible for marketplace coverage with financial assistance. Overall, it's been estimated that 35 to 40 percent of the uninsured qualified for coverage that is absolutely free.

Prospective that's been coming up, prospective that's been coming up with an approach to auto enrollment is critical to achieving universal coverage in a multiple-payor system. It's not surprising that policy thinkers on both the left and the right have been working on an approach just to using an auto enrollment processing.

This banded a good topic for Brookings and AEI to work together in sponsoring this webinar. We're privileged to have 5 panelists to speak, all of whom have been thinking and working on this issue for some time. Each of them will make remarks reflecting their perspectives on how we can practically and effectively bring more auto enrollment into health insurance. Each will comment on how their approach will navigate the political constraints that they perceive, as well as the formidable administrative constraints.

After the panelists have completed their initial remarks, I'll pose questions to the group as a whole and then turn to questions from the audience. If you have questions, send them either to events@brookings.edu or use Twitter, and it's the hashtag aut- enrollments. So, I think we'll turn to our first panelists, Christen Linke Young from The Brookings Institution.

MS. LINKE YOUNG: Hey, Everyone. Thanks so much for being here today. As Paul mentioned, we could cut the uninsured in half by enrolling those who are eligible for coverage into the program for which they are eligible, either Medicaid or subsidized coverage in the individual market. This insight is a big part of the reason that auto-enrollment is such a powerful policy concept. So, what do we mean by that term?

The word “auto-enrollment” tends to encompass 2 related ideas. The first is what I call push the button auto-enrollment, situations where the consumer becomes full enrolled into health coverage without having to take any action. The phrase “autoenrollment” without having to take any action. The phrase “auto-enrollment” is also used to refer to strategies that require some sort of affirmative action by the consumer but make enrollment far more seamless and automatic than it is today. I think you’ll hear me and other panelists today talking about auto enrollment in bulk of those type tests. So, why haven’t we done auto enrollments already?

There are 4 big challenges to auto-enrollments.

First, to auto enroll someone into coverage, we need to know who they are and then we need to have enough information to truly know what form of coverage they’re eligible for, not just have data that suggests their eligibility for a coverage program. Under current law, getting that kind of determinative information ranges from hard to basically impossible. So, getting there will require changes to our eligibility rules, generally to make eligibility more stable and predictable over a period of time.

The second big challenge is that we have to collect

a premium. Some of the underinsured can qualify for the zero premium coverage which makes some source of payment which makes true automaticity in a coverage program challenging.

Third, we need to figure out what plan we’re going to enroll someone into in an auto-enrollment program. Then, finally, we need to understand that whatever auto enrollment system we built isn’t going to be 100 percent accurate. So, we need to create something that is robust to those kinds of errors.

So, those are big challenges, but they are not insurmountable. I think there are 2 basic ways to get there, to sort of put the pieces together and enable some sort of auto enrollment system, which I’ll talk about a little bit more. The first is retroactive enrollment. The second is strategies where you target a specific group and the second is a specific moment in time in order to enroll them in coverage. So, retroactive enrollment is, in my view, the best way to get to truly population wide auto-enrollment. The idea of this type of program is that for anyone who is uninsured, we would say that they were covered by a backstop health insurance plan, that sort of operates in the background, regardless of whether the

consumer is even aware of it, much less has take any action to sign up. The backstop will pay health care claims for any person who is otherwise uninsured who needs access to a health care system. In exchange, everyone who is uninsured must retroactively pay a premium for the back-stop plan, typical when they file their taxes. The premium would be owed regardless of whether or not the person used health care services in the year. This is obviously a big change from the way we think about enrollment today, and that it effectively makes enrollment coverage mandatory, but I think it's actually less disruptive to our current system than it may sound, largely because it operates within our current patchwork health care system. Because it operates at a current population system, it's the path towards universal coverage that is in my view most feasible, but we also have other options, in this model of targeting specific populations or moments in time.

One area of particular interest is tax filing. You're going to hear more about auto enrollment at tax filing from others on the panel today, but based on some simulations we've done here at Brookings, we find that 31 percent of people who are uninsured at the time they file their taxes look like they are eligible for a zero premium option, ether the determinable Medicaid or a zero dollar marketplace plan. So, if we had a way to auto enroll that group of people at the moment, they filed their taxes, we'd reduce the number of people who were uninsured in December several months later by about 25 percent. So, a small fraction of the group we auto enrolled would be in employer coverage throughout the year. So, this is a powerful tool that can get a whole bunch of people enrolled in coverage. It's not a path to true universal coverage, but it is nonetheless a really useful step.

Another way to think about auto-enrollment targets is to think about moments when people lose coverage. For example, prior to COVID-19, more than 400,000 people every month exited employer-based coverage and became uninsured. A lot of those people interact with the unemployment insurance system. So, State UI agencies can play a role in facilitating enrollment. State unemployment insurance websites can promote health coverage insurance to consumers as they apply for and recertify benefits within the unemployment insurance workflow, or as UI agencies think about modernizing their technology, they can also consider options to integrate health coverage within the unemployment insurance application and recertification process. So, creating a really sort of truly streamlined and

unified experience for consumers. That kind of model would also work in lots of other benefit programs where you would take consumers who were interacting with a State agency interacts the health coverage application into the other process. So, these are just a couple of examples, and I look forward to our discussion on ideas like these.

So, I think, Jim, it's over to you.

MR. CAPRETTA: Here I come. Get my slides up. Okay. Can you all see my slides? I assume you can. Yes. Okay.

Thank you very much for having me on the panel today. This is a very important and good topic for us to be discussing right now, as a lot of people are about to lose their health insurance as Paul sort of hinted at in his introduction. Obviously what to do about that will dominate the conversation, I think in the coming months, and some of the ideas that were just presented and some more that are coming, I think, throughout the presentation today can be helpful as policy makers try to grapple with what I think is going to be a pretty immense challenge of a spike in the coming months. So, just to bring a slightly different prospective into how to think about this, I think the points that Christen just made were very, very good and relevant. One other framework that might come in is, of course, because of the complexity and newness of auto-enrollment, perhaps we ought to begin with initially a State option that the Federal government create a structure around which the states can explore various approaches to dealing with what is going to be a challenging and complex endeavor to start a new way of putting people into health insurance. So, working with Stan and Lanhee, two of the other panelists here today, we thought through a couple of years ago what that might look like in terms of a state option, and I think it does begin with a federal statute, that the federal government should try to put into play some kind of incentive program that brings both financial resources to bear on the question, and also new authorities and tools that the States could use to build an auto-enrollment program. Obviously, the amount of money depends exactly on what would be intended in terms of start-up funds, but I think we're talking about hundreds and millions of dollars, maybe a billion, but not that much, certainly not in the context of money that is being spent right now on the recovery program. So, in the scheme of things, this should be a fairly small investment, mainly aimed at helping the States build the systems that are necessary to do what Christen described as

sort of a point in time enrollment efforts, rather than the full retrospective approach.

Okay. So, what can this look like? I think it should be a grant to the HHS, with funding to allow a State administered program within a federal structure, that funds would support, first of all building an IT program in programmatic infrastructure. There's going to be a need at the outset, as you will see from other conversations I think we're going to have today that to be able to do this right, we're going to have to have a lot of access to insurance registries, to be able to cross check who is enrolled in what, as well as their income to be able to get this right. When States apply for this, there should be some elements that they present to the federal government about exactly they would go about this, some sort of requirements for the application, so to speak, a little bit along the lines of when they applied for Medicaid waivers, but basically they should indicate how they would rebuild an IT infrastructure to facilitate it, how would the consumers be assigned to health plans, and what rights and options do the consumers have, both before and after assignment to a plan. I think consumers auto enrolled into insurance should be held harmless for income fluctuations during that year. One of the big complexities here is when somebody is auto enrolled into a program, what happens if their income changes sort of mid-stream. I think one of the things we have to understand about all this is we built a multi-payer insurance system that is incredibly complex, way too complicated really, on a number of levels and one element is to realize that people do have changes in circumstances, often good ones where their incomes do go up, but instead of penalizing people so repetitively and quickly, this ought to be something where if they get auto-enrolled into a program, they are held harmless for a period of time and given the assurance that you're going to be in this regardless of the next year or so, then that allows them to, I think, have some more confidence that being auto-enrolled into something isn't punitive, but it will be helpful to them.

Then a big piece of this is really around what can the federal government do to make this easier for the states to explore this kind of program. I think the first one is related to what I just said, which is to allow states to establish full year eligibility for the federal premium tax credits and Medicaid, based on prior year state tax information. So, you just say, if you are going to do auto-enrollment based on last year's income level, as you determine through your tax system, we will use that and no other conditions are necessary for the next year or so and that can become the eligibility determination for premium tax

credits for that period of time.

The second thing, I think, is to provide data sources really that allow them to handle this new responsibility better. This is actually #3 on our list here. What data can the federal government provide? Federal employee coverage data, Medicare coordination of coverage data, Health Plan ACA Section 605 data -– that's data that has to be reported by the plans -– self-insured coverage data through RISA, so you get rid of a RISA exemption for this purpose and allow States to at least find out who is in the self-insured employer plans. You can add an element of our own health insurance, which is the National Directory of New Hires, which is something you use for child support enforcement very rigorously by the States, to include a health insurance component to allow a better cross checking of who has already got insurance. I think another element here is that States ought to be allowed to enroll anyone into a catastrophic plan. Right now, the ACA limits that to people and under. Finally, and I'll stop here, encourage States to be creative about using other existing citizen touch points, unemployment insurance, DMV applications. Those seem to be 2 very good places where people are coming into contact with State government and could be reminded about options about health insurance and allowed to auto enroll into a program during that process. Thanks.

`` MR. DORN: Thanks very much. I think I'm the next person up and it's really exciting to be here today with such amazing thought partners. Can everybody see my screen? Let's see. There we go. Here we go. All right. Terrific. I'm going to talk about using a tax filing moment as an opportunity to jump start eligibility enrollment into coverage, whether automatically or in a streamlined fashion. We'll talk first about why that is a good context. Second, some early results from Maryland's experiments in this area. Third, some state and federal policy implications.

So, to begin with, why income tax filing? Let me try to make this a little better here. Why use income tax filing as a place to start enrollment? To paraphrase the phrase associated with Willie Sutton, because that's where the uninsured are. A tremendous for uninsured folks eligible for assistance file federal income tax returns, either to claim earned income tax credits or other refunds or because they're legally required to do so. There's really no other venue where you can reach as many uninsured as with tax filing and serendipitously tax filing also has all kinds of data associated with it, from which eligibility

can be determined. So, there's obviously the information on the form about income the previous year, but there's also a Social Security number from any tax filers which agencies who run health programs can use to obtain other data to establish eligibility and there are other benefits as well. There are limitations and for the purposes of this conversation, the most important limitation is that you need to have proactive opt-in mechanism for data sharing, rather than opt-out mechanisms for our revenue collection as a country and States as well, we depend on largely voluntary compliance with tax forms. People need to feel comfortable that even with illegal income generating activities or unethical ones they don't want to share with their neighbors can be put safely on the tax return, and if tax return data is scattered hither and yon, people may be less willing to come forward and share that information. We lose revenue as a result. So, unless other contexts here, it's important for people to affirmatively consent to data sharing.

Inspired by some of these insights, lawmakers in Maryland passed an easy enrollment bill in 2019. It garnered enormously bipartisan support, a unanimous State Senate vote, for example. The basic concept is when you file your State income tax return, check your box if you're uninsured and you can say, please, revenue agency, share my data with the health insurance exchange and have them see if we qualify for free or low cost health insurance. Most people file electronically, ad could potentially provide a venue where we have real time, eligibility determination, where somebody finds out right then and there. You file your tax return; you find you're eligible for Medicaid. You are automatically enrolled into Medicaid unless you opt out. We tried to push the idea of automatically enrolling people into free insurance, insurance where the premium is complexly paid by the premium tax credit, but one of the main carriers in the individual market objected. So, we're not going forward with that yet, though some of us have not given up hope of moving in that direction. The bill was signed into law in the middle of 2018. Here, less than 7 months later, State agencies were involved in implementing it. Unbelievable, unbelievable cooperation and effort on their part. It's a 3 Phase approach. Phase 1 is under way right now. State officials leveraged existing processes to enable quick implementation. So the tax agency sends dash file to the health exchange. The health exchange does a quick eligibility determination, does a mail campaign sending out notices to everyone who checked the box describing their likely eligibility for assistance. Then people who get the notices are told that they can sign up by using the standard

procedures, going out line, using the portal, or calling the 1-800 number, et cetera. That's the initial phase. Later phases are going to be more electronic, where starting with professional tech, with for profit tax prep companies and then eventually moving to everyone. People that file can get that automatic real time eligibility determination, followed by expedited or ideally automated enrollment. But that's going to be for the coming years.

For Year 1, the Phase 1 approach, we were not expecting huge numbers based on past experience. Several States had tried similar direct mail campaigns with children, based on State income tax returns, and had gotten less than a 1 percent take up rate. The Federal government did a major direct mail experiment which was incredibly important, demonstrating the mortality effects of health insurance coverage, but it increased participation. It increased coverage levels by just 1.3 percentage points. So, we were not expecting much, but what we got was really striking. Nearly $40,000 checked the box on their tax return and asked to have their information shared with the exchange to determine eligibility. Nearly 3,000 have enrolled in the coverage, really a strikingly high percentage for a direct mail campaign. It's also striking to see who has actually received coverage. So, most of the enrollees have been Medicaid folks, 71 percent. Most have been low income. Fully 26 percent are children. Most are young adults. Relatively few are in high income ranges. So, this suggests a lot of promise, if this is representative of what broader efforts may bring in the future.

So, there are a number of different state policy implications. Everybody wants to be one of the best states. Maryland's results suggested that other states could literally follow along these similar lines, including states that use the healthcare.gov portal. These states could help to use the Medicaid coverage for people who are eligible but not enrolled, including children. There are other lessons learned from the process through this thing was implemented. Unbelievable involvement through all of the State agencies in crafting legislation in stakeholders, including clans, providers, consumer groups, tax preparers have had a central role, very important to take their concerns into account. So, it has really been a marvelous process that other states could learn from. In terms of federal changes, I think Jim did a phenomenal job talking about the kinds of federal changes that could be needed, giving additional flexibility to states, to use data to determine coverage and having state pilots. They're supported by the

federal government. The federal government itself could use individual income tax filing as a launchpad, as Christen talked about. You'd have to revise eligibility criteria to record with the available data. Jim talked about that as well. You might want to think about changing the enrollment cycle, so that tax filing could be used as the time when people generally enroll in health coverage. IRS' is information technology, as have all have been recently reminded, is underinvested in. It needs modernization for his and for other purposes. You need to think about challenges to full automatic states may have concerns about their case load going up, even though it's consistent eligible. People and carriers may be concerned as well but is this the time to talk about it. We're all dominated by COVID-19. That's the topic of the day and Chumley Parker gave us the answer half a century ago. Now is the time. We have huge numbers of people who are losing employer-based coverage. Most of them are eligible for some kind of help, but we know historically, most laid off workers do not enroll in coverage for which they qualify. It's just overwhelming to be grappling with job loss. Therefore it becomes imperative to make enrollment as easy, seamless and automatic as possible. Tax time is one option, as both Jim and Kristen noticed unemployment insurance is another option. Thinking about the Pandemic now is the time when we need people to get health insurance, so that folks who come down with the illness quickly get care as soon as they start to feel sick. That's good for their health. It's good for their neighbors' and family members' health as well because it enables prompter detection of the disease, and in terms of the economy, health care losses have been enormous and if we see torrential losses in health insurance coverage, that means less revenue for hospitals, doctors and clinics. That means more job losses. So, if we want to fight both halves of the COVID crisis, health half and economic half, health insurance is critical and automatic enrollment is an important recipe to any successful approach to health insurance.

MR. CHEN: Thanks very much. Great to be with this group of people. I know all of them have worked very hard on these important ideas. So, what I thought I would do today is to share with you some thoughts about -- hopefully everyone can see this – about kind of operationalizing auto enrollment and thinking about some opportunities about deploying auto enrollment, which I think Stan did a great job of outlining at the State level how they have done that in Maryland. I just want to talk about a couple of thought experiments I have done in concern with a few others in thinking about how to use auto

enrollment. So, let me do this. I'm going to go to the presentation view. Hopefully this will work. There we go.

So, start, I think we have covered some of this, which is the challenge in operationalizing auto enrollment, is sort of multi-faceted, identifying a population, figuring out who fits in, actually enrolling them, effectuating coverage, and reconciling whatever assistance they might get at the end of the day. It does get a number of logistically challenges. So, I think it's important to start with the premise and the question of who is it that we are trying to help. What is a population group that might be sort of a useful start in thinking about this? Jim Capretta and I have talked in the past about looking at folks that might qualify, for example, at some sort of zero premium or significantly reduced premiums coverage, ideally zero premium coverage. So, I think focusing on that part of the uninsured population that falls into income categories where they would be able to look at a significant amount of assistance in effectuating coverage is a good place to start. So, in thinking about the analysis you can start by defining the problem a little bit. So, a lot of this is drawn in my presentation from 2019 data, and a lot of this comes with the assistance of the Blue Cross and Blue Shield Association.

If you look at the numbers carefully, you begin with this sort of set of 15 million people who are uninsured. This excludes those with access to offers of affordable coverage in the employer context, those with public health coverage, and those who are not lawfully present in the U.S., which is obviously 3 relatively significant groups of people, but let's just start with this group of people to begin with. These numbers obviously are going to look different with the COVID crisis. So, let's just put that caveat aside for a moment and recognize that we're looking at a group of people before the crisis hit. What you can see is there is actually a relative significantly number of people, about 4.2 million who fall into the category below 133 percent of FPL, another million in that increment between 133 and 200, 2 million in the 200 to 250, and then a relatively more sizable number over 250 percent of FPL. So, this just gives us a sense of the context we are operating in. Okay? If we look then at what percentage of the low income uninsured can access free Bronze coverage under again 2019 data. What we see if that the vast majority of rating areas, in fact almost all rating areas across the country, could offer zero dollar Bronze coverage for people in the 60 year old category and then a little bit less in the 45 and the 21 year old

category, but the basic point is that almost all of the uninsured between 133 and 200 percent of FPL could have access to free Bronze coverage, again using 2019 data, which I think is a really encouraging thing if you're trying to figure out where you start. Right? Because sometimes a thing about a problem that can be so large and so significant, but you don't necessarily know, okay, where do we get started. What I've encouraged with them is, you know, it's okay to start small, or its okay to start with a population or part of the population who could benefit from coverage or could benefit from an auto-enrollment style approach. If you look at the number of uninsured who could access free or low cost Silver, you actually see that a significant number of Silver plans could be accessed for a relatively low premium, not zero premium, although for 60 year old's, you will see on the far right, my far right that I'm looking at now, that there are a number of rating areas that the premium would be zero, even for a Silver plan. Even at that 21-year-old level, 133 percent of FPL, what you see is the vast majority of the country offers access to Silver plans for a relatively low premium. So, I do think that these last 2 charts sort of demonstrate the degree to which you might be able to gain access to either Bronze or Silver coverage across the different age strata for people who are really pretty low income and could really benefit for automatic enrollment. Another way to think about this is there some way to start with a smaller group of people, even than those people we are talking about, and that is could you auto enroll young people who are aging off their parents' plans, whose incomes fall into 133 to 200 percent of FPL level, again the goal here being for the policy makers to be able to define a population to which to pilot auto enrollment. As you will be able to see in a minute, a large percentage of this population in particular, according to an analysis that's been done, can access premium Bronze coverage with an APTC, with tax credits available through the ACA. I think the big question that we often get is how stable is this. To Stan's analysis, I really do think the State level is the key place, the key locust of activity, because that's really where is some States you could see this as being the core of the experiment but then radiates outwards, with other people, other populations potentially being included, based on the needs and the situations found in those particular States.

This next chart that I'm going to show demonstrates the percentage of 21-year old's, at 133 percent of FPL who could have free Bronze coverage after their APTC, after their premium tax credit. What you see, first of all, I will readily admit this is not that significant percentage of people. We're talking

about 50,000 individuals nationwide who are estimated to be uninsured, who are 27 years old, and who fall into this income category. So, we have taken the overall pie and we've shrunk it down to maybe an interesting thought experiment pilot group. What you see is sure enough, 95 percent of rating regions across the country, including 100 percent of many States, big States, too, like Texas. What you find is the vast majority of this sort of pilot population we're talking about could qualify for zero-dollar Bronze coverage after applying the APTC. So, there is some sense that for this population, auto-enrollment might be a good solution to get people covered, and it might be a good way of thinking about how you can take a concept, and the other speakers on the panel have really elegantly outlined, and try and put it into effect for a small group of people who could potentially really benefit for it. As you can see, for many, many people in this population, they would be able to access zero premium coverage and be enrolled into coverage that would certainly help them prevent serious calamity in the event that I don't want to have a crisis strike, such as the one that we've seen. So, I will probably end my remarks there, but I'll just briefly point out there that I know David is going to get a lot more into this. There are some political considerations to think about, namely that a lot of Republicans that I've been in contact with this have expressed the need for strong opt-out concerns. They clearly have what I would address as liberty concerns, as well as concerns about being involved in more widespread implementation of the ACA. Then I would say on the other wide, Democrats can though Democrats have generally been pretty enthusiastic, although I think the challenge there is maybe a little too enthusiastic in the sense that they have said for example, why don't we start without auto enrollment of Medicaid populations which gets many conservatives somewhat concerned. Then the last thing, which we've touched on is sort of the state versus federal issue which is how much of this belongs to the State level and how much of it belongs to the federal level. I think these are open questions. Certainly the Federal level could be involved in providing some funding, in providing some guidelines, but ultimately, I do think this is going to be a State based endeavor fundamentally and it's going to acquire that coordination from the Federal governments to the State governments together. With that, I will conclude.

MR. KENDALL: Thank you, Lanhee. That was awesome. I think my role on this panel right now is to bring back it up to the 10,000-foot level and sort of talk about the political appeal and sort

of auto enrollment. I have heard a lot of great analysis and sort of taking of the benefits and making them really visible for people. So, what I want to do is basically talk about, first of all, why I like the auto enrollment, which is simple. A lot of health care policy is complicated, and we know. Auto enrollment makes enrollment easier to get coverage for people. It creates a safe choice for consumers so they can't go too far astray when it comes to their health care coverage. If somebody forgets to enroll or gets overwhelmed by the choices, they still get coverage. Today's discussion, I think, has made it clear, that as we are grappling with auto enrollment for people who forget, we're going to make it easier for people who enroll themselves. Right now I want to cover 3 topics.

First is the appeal of auto enrolling across the political spectrum. We talked about examples of enrollment in current law. Then some of the political challenges, despite the appeal of automatic enrollment, we heard from Lanhee about that. So, first, let's look at some key pieces of legislation that include auto enrollment. The most automatic of all is the Medical for All Act, which has automatic enrollment because everybody is automatically entitled to coverage and then automatically enrolled. Medicare for America Act contains 2 kinds of auto enrollment. The first is a default for a public plan for the uninsured, and the second is automatic enrollment at birth. Then in the Patient Free Act, Senators Cassidy and Collins proposed states to do auto enrollment, as Lanhee and Tim have talked about.

Next are the various think tank proposals, we see a lot of ideological diversity. As Brookings has made it diversity clear, they are on the vanguard of making automatic proposal in retrospectives. You get automatic enrolled in retrospectively in coverage. The AEI proposal causes as much automatic enrollment as possible, doing it in another way. Then we also have the Urban Institute Plan which includes auto enrollment for the low-income individuals, as well as automatic enrollment for people receiving food stamps or welfare. Then Medicare Extra for All Plan, based on the Jaworski bill, which includes the automatic enrollment in the default public plan and automatic enrollment at birth. The Third Way proposal which includes Cost Caps and overage for all, we kind of combined the Brookings and the AEI approaches, which have as much up-front automatic enrollment as possible in a private plan. Then a retrospective proposal in a public plan for everybody who has left as a back stop. Then we all

remember fondly when Stuart Butler was at the Heritage Foundation, he proposed automatic enroll as an alternative for the individual mint.

So, the popularity of Auto-Enrollment has already become the bodies. Do you want me to give you a few examples, not a comprehensive list? Medicare Part A is automatically enrolled. It is actually kind of hard to get out of it, but you can. Medicare Part D has a low-income automatic enrollment for the subsidies for Part D drug coverage. We also have some forms of Auto-renewal in Medicare Advantage and Exchange clients. There is also this thing called Express Lane Eligibility for CHIP and Medicaid where you just have to submit one set of information for one application for multiple programs. Lastly, for employer-based plans, we saw retirement really get this whole movement started. One study showed that when you have automatic enrollment in the retirement plans, participation rates are about 86 percent compared to 46 percent. So, with automatic coverage having such strong support across the ideological divide and such strong legal presence, you might be wondering why Congress has not already enacted this. Well, you as you said, Medicare is complicated. You've heard that.

I see 3 key challenges, actually 4. The first is

what are we enrolling people in. Is this just going to be another version of an individual mandate? See, the truth is we don't have a political agreement on what the standard for default coverage is. Is it a health plan with essential benefits as defined in the ACA or a short-term plan that doesn't have ACA deductions or is it a plan that the States get to determine? That's a big plan we kind of touched on that today.

The second problem is the fiscal impact. We would be increasing coverage quite a bit. It's going to have a big impact. I know right now we are not supposed to be worrying about cost because of the COVID crisis and that's appropriate, but gosh, we're going to have to start thinking about our long-term sustainability budgets. You know, that relates to the third problem, which is as long as there is an organized group of people out there, it's going to make it hard to make a big push in Congress to get this done. I'm just making a little bit of fun in it, but there is no organized consistency for people who forget to do things or get along by their choices. They are great advocates for consumers but it's going to be hard to organize our own automatic enrollment, which Stan would love to do, but it's going to have to be coupled with a broader coverage.

The last challenge is implementation as we kind of touched on already. Some consumers would be confused about their enrollment and what they're getting. Even if they could opt out, which they should be able to, they may experience some dissidents over that, and they may be confused about how to switch to another plan if they don't like the plan, they're enrolled in. So, ultimately it comes down to doing the right thing. Elected officials are going to have to convince them that it's worth and risk and the appreciation will come later. I think that's kind of what happens with health policy. You have a lifetime Republican from Wisconsin who wrote President Obama thanking him for the Affordable Care Act which saved his life. This is what he wrote.

"To my president. I have a preexisting condition and so can never purchase health insurance. Only after the ACA came into being could I be covered. Quite simply, not to take up too much of your time, if you are in fact taking the time to read this, I would not bs alive today were it not for the access to the care I received due to your law."

The president did read that. He posted it online. I can easily imagine the next president receiving such a letter after auto enrollment is enacted and Americans find that it has given them the protection that they ended up needing. Back to you, Paul.

MR. GINGSBURG: I want to thank you all for really thoughtful presentations and I've got some questions to pose to you as the group. I think you're going to have to unmute yourselves unless the AV wants to unmute you all now. See who has something to say. First, I want to talk about doing the auto enrollments on the States or Federal level. It's not surprising that we're focusing on States today because we have always been the States for experimentation and public policy, and that's certainly happening. Of course, by doing thigs on the State level, we get away from some of the hostility and gridlock associated with the ACA. I wonder what your thoughts are if auto-enrollment really turns out to be something that works well and people support, if this something that is ultimately better as a State activity with the Federal government supporting all the States in doing it, or is this something that would work better as a Federal activity?

MR. CAPRETTA: well, I guess since I did the state presentation, let me jump in here and I'm sure the others will have some thoughts too. I think this is actually something where let's imagine we

wanted to write a federal statute, I think since we did the retroactive enrollment option, sort of the big one where you just sort of placed everybody in a plan of some sort, it's not entirely clear to me that we all would agree on or even know exactly what to put in a federal statute to do auto enrollment easily at the moment. It's a pretty complex endeavor and I think there is such a differentiation across the State in terms of how they're thinking about their insurance markets, also frankly levels of capacity to engage n this, maybe that's an argument for the federal level, but I think what I'm trying to say is I'm not really sure we are even ready to write a federal statute that would make this easily done. At least I wasn't sure I would know how to do it. So, this seems to be one of those things where – also, let me just say one other thing about the framing of this. The United States, after the ACA, we got to 91, 92 percent of coverage at this point, after the pandemic, it obviously seems like the uninsured rate is going to go up, but there is a structure now in place to try to get, at least in a normal environment, at least to a 90 plus percent coverage. Let's say you ask the country at that point what do you want to do to take care of the last 10 percent. There are a lot of people proposing various programs to do that, but when you tell them, and everybody's information is indicated, the majority of people who are uninsured are actually eligible for something. I think it really changes the conversation qui9te a bit and people say why don't we try to make what we already have work better, and they get into what they are eligible for before you create another program. There I think maybe that means we're in the middle of a long slung. Let's imagine the federal government did do what I recommended, create some Federal structure, some seed money to the States. They start experimenting. I think it could take 5 to 10 years to figure it out, how to go from 90 percent coverage to 98. Maybe California would get there first. I think that's the recipe the United States might have to follow.

MR. DORN: I have a slightly different perspective. My answer is both and. That states really are where a lot of the action is right now and obviously, we're doing work in Maryland. We've done work and done conversations with people in other States to try to follow in Maryland's lead. So, that's the immediate challenge. I think Jim is completely right, that we will learn a lot, hopefully from States do and there is tradition in the country from health care innovations, beginning at the State level and eventually becoming national. That's the Children's Health Insurance Program or Medicare Part D or the ACA,

which was piloted in significant part in Massachusetts. So, hugely, I think there is definitely a role for states. I think the ideas that Jim outlined in terms of things the Federal government can do to give a boost to state governments are absolutely right on the money. On the other hand, if we do in fact see in the coming months an opportunity for a major federal coverage expansion, auto-enrollment should be a part of the design. It's not enough just to say if you build it, they will come. You need to say how exactly do they come, how do they enter and how do we make it as seamless and possible for people to get coverage. So, if we have a major federal effort in the coming months, this will be a part of the conversation. Also, if we have the existing coverage system in place, I definitely could see an opportunity for some middle level tweaks making a huge difference. So, in picking up on Christen's idea on changed eligibility criteria, and also Jim talked about this as well, and I think Lanhee did as well, saying that prior year tax records can determine current year eligibility for subsidies, that would let lots of people be allow in the coverage when they filed their income taxes whether to Medicaid or whether in still premiums marketplace coverage. So, I could see some opportunities for federal action as well. So, we're opportunistic in Families USA. Whatever opportunities we see for coverage gains, we're going to seize them and take them the best we can.

MS. YOUNG: I just want to underscore that last point that Stan made. There is absolutely a role for State experimentation here, but you do need some Federal policy infrastructure to enable that State experimentation. Every single one of us talked about what uninsured consumers are eligible for, but in fact, none of the data sources that we are using demonstrate what people are eligible for under existing law when it comes to the private insurance market. Under current law, eligibility is a calculation that is made at the end of the year, based on sort of what happened during the 12 months and consumers make a projection themselves based on their own private knowledge during the year. So, no private system can replicate eligibility the way it works under current law. So, to enable the kind of experimentation we're talking about, you do need federal changes that tweak the structure of eligibility, so that an employer who sees people turning 27 and aging out of the employer plan or whoever it is, someone can take existing information and treat that as authoritative to put them in coverage. So, that's going to be a federal policy change that's necessary for any of these ideas to move forward.

MR. CAPRETTA: Just to add one sentence on that, I think that's a very important point and ought to be considered. Our health insurance system is way too complicated. Allowing prior year tax or prior income information to determine what you're eligible for in the following calendar year is an immediately reasonable thing to do and is something that is so complicated. You don't want reasonable churn and uncertainty. Honestly they ought to just make it easier for people to stay in that coverage for some period of time and stability of coverage is important and maybe this can be part of the conversation that goes beyond auto enroll, which is what information we should be using to determine eligibility and does it really make sense for this complicated premium tax credit retroactive reconciliation process, which honestly they aren't doing that well anyway and probably missing all kinds of things they are supposedly reconciling. So, I think simplification using last year's information, making it easier to use the tax system, to put people into coverage, federal and state, Stan, I'd be willing to look at both. I think that's the way to go.

MR. DORN: Let me just add to that. You know, there are lots of other reasons for our federal policy that we use for retrospective qualifications like the student loans. All that is done on prior year taxes. So that is a good point to make as well. Let me also make an echo what the political motivation here is going to be. The biggest thing people are worried about are costs. If an elected official running for president is going to come up and say, we're going to protect everybody from some high costs, part of that has got to be coverage. You can't protect people from high costs unless they have coverage. So, I see this as fitting nicely into a federal debate about where we are going to coverage. I totally agree – and you know the states are going to be where the action takes place. So, we've really got to do both but as Christen said, it's got to be on the federal level. It should probably be at the Federal. It will have to be at the federal. Let me put it that way.

MR. CHEN: I just thought of something. So much of the work that we've done on auto has happened during a period of strong economy, economic stability. Now, the issue, the urgency of the moment is what about all this massive amount of unemployment. Are a lot of people going to lose coverage? What can the federal government do either through the states or on its own to reduce that impact? And you start thinking about prior tax data will not help fast enough to deal with something. I

almost wonder if you need to have more one approach to at least be available at our current challenge.

MS. YOUNG: I think the fact analogy that they brought up is a great one. Our student loan system which reaches high into the income spectrum. I think the analogy to cover it that way. It is not just a very low-income group. It's largely middle class as well. The fastest process is based on your families' prior year's tax return, but you also have the option of getting additional assistance if you have had a major change in circumstances. There's an additional documentation requirements if you are in this category of seeking additional assistance but we sort of start with the idea of letting the tax return do the work. People who have had significant change can get additional assistance without, as Jim mentioned, penalizing people who have had significant improvement in their circumstances. So, when I think about these kinds of policy changes, that's the model. I imagine we sort of reduce the complexity for most people and enable auto enrollment to function at that scale, whether that's in the State or a pilot program or actually function across a group of people, but you also preserve some complexity there for the people who really need it because they've had a massive change in circumstances or something like that.

MR. CHEN: Sorry, Stan. I would just add that the current economic condition where we know a lot of people are probably going to be displaced from employer coverage to the extent that, for example, they worked at a smaller business, and smaller business offered coverage, which is more limited to start with, I recognize, but this would seem to be one of those scenarios that would be ideally suited to auto-enrollment. Now, having spent a little bit of time over the last 2 weeks kind of thinking about how you would operationalize it, it is a challenge. There are any nu8mber of different challenges, but you could imagine some States trying to take up the mantle here, and figuring okay, we've got a group of people that is no longer on employer coverage. Could they easily be bridged in a marketplace plan that would offer similar or substantially similar coverage that would also be available at a cost point to them that is similar to what their premium contributions may have been under an employer sponsored plan. So, that's just the theoretical framework you apply. It's obviously much more difficult in these situations because people are churning between jobs. Potentially hopefully when the economy begins to recover, they might get an offer of coverage again. There are issues involved there, but certainly for this period of time, I do think it bears thinking about whether in fact there is some way of continuing people

from their employer coverage into an affordable marketplace plan. Certainly that would be a more affordable route than subsidizing Cobra continuation coverage, which maybe the best available option out of very few options at this point, but still, I would think auto enrollment would be an interesting and attractive alternative.

MR. GINSBURG: But Lanhee, do you think it's feasible that this could actually show up at a federal COVID relief bill and the sense be one more example of responding to the Pandemic was changing policy more dramatically in areas than we would have the right to envision otherwise?

MR. CHEN: I would say, Paul, just in the conversations I've had, I think it's only going to be feasible if you can identify a group of people to start with. It can't just be everybody who has lot employer sponsored coverage in the last 3 months, although we would want in an ideal world to help those folks transition to marketplace coverage. I think it's got to be narrower than that. So, this is why I've been kind of wracking my brain trying to figure out is there a subset of people whose been economically displaced and displaced from coverage who could find their way to a good marketplace plan. I mean, one sort of basis for inspiration for this is there are actually a few carriers in a few States as I understand it, anecdotally, who have offered to essentially transfer the deductible in a spending, an employer plan, to a marketplace plan. So in other words, if you have spent $200 out of your $500 deductible, you would get credit out for that spend against your deductible in a marketplace plan as if it were your employer plan. This is not happening widely. I've just heard that it's happened in a few cases in a few States. That's the kind of thing that would make a transition into marketplace coverage much more seamless during a time when people could use it. I think what we have to start thinking creatively, and by we, I mean everyone on this call and everyone who is listening, about are there specific target populations that we might be able to propose as a demo, for example. That very well could make it into some kind of relief package later this year.

MS. GINSBURG: Thank you. Stan, I think you were waiting.

MR. DORN: No, that's okay.

MS. GINSBURG: Okay. Good. Let me go on to another question. How do other advanced economies or countries with multi-payer systems, for example, Germany, Switzerland,

Netherlands, how do they use auto-enrollments to achieve universal coverage?

MR. CAPRETTA: I think I'll jump in here because actually, Paul and I talked about this in advance, but I'm sure others might have some information in here as well. It's interesting to look at these countries, particularly the Netherlands because they do have multi-payer systems, private insurance, and all of them have an individual mandate. It's actually much more rigorously enforced than anything we were thinking about doing before the tax penalty was repealed in this country and they're pretty tough about it. The auto enrollment feature is really tied to their systems of tracking down people who are not insured. Then going through a series of hoops with them, trying to get them into a plan and then the ultimate step is just to put them into a plan and then trying to make sure that they pay for it. So, for instance, in the Netherlands, a few years ago they set up a special data registry to try to kind of collect the same kind of thing we're trying to do on the State level through that legislative structure I was proposing earlier, is to give essentially, they set up a matching system of registries to try to figure out who was registered in their country, using the insurance plans that are regulated by the country and the State. If someone is sort of recalcitrant and not signing up, they actually then displace them in the competing plan in the country on a proportional basis based on market share. Then they assign the premiums that are owed to that person and have a number of collection authorities that they can then implement over time to try to extract the money out of the person. So, in some sense, our task should be a lot easier than it is in the Netherlands because what we're trying to say essentially is hey, we're already giving you the money to pay for a premium, as Lanhee said, so we'll sign you up for a plan. The amount of coercion of trying to extract some money out of the folks will be a lot less, I think, in our auto enrollment system than they even are in these other countries, than they are in an enforcement of an individual mandate. Switzerland has a cantonal system where the cantons force their mandate and it varies a little bit across them. Basically, at the end of the day, they always start with a number of other things where a person voluntarily signs ups, but if a person does not sign up, they assign them to a plan and again they go through a collection process to get the premiums.

Germany has a very small private insurance plan to the sickness funds and I can't quite tell, but I don't think they have that much auto enrollment in the plan. There's much more of an

enforcement of an individual man.

MR. GINSBURG: Any other comments on this question or should I go on? I'm going to go on. What have we learned from initiatives from employers who use auto enrollment for retirement plans? Are any employers using such an approach for their health benefit plans?

MR. CAPRETTA: I know a little bit about the employer retirement system. I've got to say I don't know for sure if there are any doing employee health, but on the employee retirements, which is obviously a lot easier, the basic story there is that it has boosted enrollment into 401K's quite substantially. There is some question about whether or not – because they are putting them in a certain tier of contributes whether or not the person did it on their own, they would have contributed more, but in general, I think the body of evidence would indicate that this has worked fairly well to boost coverage, but the really important point is once people are in, they don't ever opt out again. They are given plenty of opportunity to get out if they want or to change the selection. As Lanhee indicated earlier, there is a lot of inertia that drives non-enrollment and I think some Americans think or on the conservative side of the political spectrum, there may be some point of view that sort of says well, you know, we ought to give people the option to not participate because that's their constitutional right. Maybe perhaps, so, but honestly most people aren't invoking a constitutional right not to sign up with health insurance. What they're doing is, they're just busy with other things in life and they're not signing up. So, I think the reaction would be, like it has been in 401K's, if we did a lot more auto enroll, even through employers, I think most of the response that get auto enroll would be golly, thank you; I'm glad I got this. It's one last thing I have to worry about now, rather than you've violated my rights.

MS. YOUNG: Do you think there are -- I think there are 2 dynamics that make auto enrollment into health insurance different in the employer context than into a retirement benefit. The first is when an employer enrolls you into a 401K, the employer is largely spending your money. Sometimes there is a matching contribution, but they are primarily spending your money by enrolling in a 401K. When they are enrolling you into a health insurance plan, they're primarily spending their own money because of course, employer sponsored health insurance pay between 70 and 85 percent of the premium. The sort of financial side of the employer is a little bit different. The other, I think, important

dynamic here is that it is affecting employer's eligibility for premium assistance in the individual market. So, of course, under current law, people who are offered employer coverage but for whom that coverage is very expensive, are able to receive a premium tax credit if they decide to forego their employer coverage and opt for marketplace coverage instead. So, there is some concern that employers, by auto enrolling employees may be firewalling individuals from some sort of better, more affordable coverage for their low wage workers in the marketplace. So, I think that has been sometimes a concern. I think that has been overblown at times. On the other hand, the employer has manipulated its own liability under the employer responsibility requirement potentially in this way which could be a cause for concern. So, employers generally tread lightly here. One thing that has come up, and Stan uses this word a lot, is employers so more commonly use a more forced choice. In a lot of employer health plans, it's not possible to just answer the question. Your HR office is going to keep hounding you until you tell them yes or no to the health coverage that they're offering. You are allowed to opt out but they will keep hounding you until you tell them yes or no, which is not quite the same as auto enrollment but may achieve some of the same benefits.

MR. CHEN: The other big difference with health coverage in the employer context is you might be turning down the employer plan because you're covered by your spouse's plan. For auto enrollment to work, you need to know that the benefit that you're enrolling people in is going to be something that folks by and large value and if you have a large per centage of people who don't because they're enrolled in their spouses' plan, that's a problem. It's a challenge, but I want to underscore the point that Jim made which is the success of auto enrollment of the employers' retirement savings accounts really shows that it can offer enormous potential with health coverage too. I'm thinking about when in Louisiana when they did the closest thing, we've come in Medicaid to automatic enrollment with an express eligibility program where they essentially mailed a family's cards, mailed Medicaid cards to families where they said your child is eligible for Medicaid based on Snap. You can enroll by using the card. By the end of the year, 80 percent of the families had used the card. We did some focus group studies when I was at the Urban Institute and we talked to these families and they loved it. People who had not used the cards said it is just such a source of piece of mine to know that if anything happens to

my child, I can go to the doctor and it's going to be covered. It was not the kind of pushback we were concerned about. People just loved it. So, I think Jim is right. If we design it right, people will like it a lot. One of the reasons that the one carrier in Maryland pushed back against automatic enrollment was a lot of people who were enrolled, they won't like it, they're going to call us up, they're going to complain. I'm hopeful to at least see our way towards testing it, towards pilot testing it in part of the state. My hope would be that the carrier would be that in fact, people re happy to be enrolled in coverage that doesn't cost them anything, that provides them with some access to coverage and care. So, I think Jim makes a really good point there, as usual.

MR. GINSBURG: I would ask that I take almost a profound change in thinking in economics, as come in the last couple of decades, as far as behavioral economics, as far as people can sometimes make better decisions with help. The notice that (inaudible) was that there was a nudge, that maybe some of the auto-enrollment basics was a failure, that most people would actually be very pleased that this happened to them, that we ought to help them, but with a gentle enough nudge, that we're not taking their freedom away. Let me go to another question. I can't think. You've done a good job on that one. Any comments on the political needs to avoid what turn out to be overpayments and underpayments in subsidizing coverage.

MS. YOUNG: I can't start on this one. I think an overpayment and an underpayment is what the law defines as an overpayment or an underpayment. So, in my view, the way we should be approaching this, is to define eligibility in a way that makes overpayments and underpayments not the same problem that they are today, rather than considering it an overpayment if last year's tax return said your income was 178 percent of poverty, but now your income is 201 percent of poverty, that's an overpayment. We can just say last year's tax return was just sort of good enough for us. I think we do have to acknowledge, and I said this at the beginning, we'll put people in Medicaid when they should have been in the private market or vice versa. We just need to build a system that doesn't treat those things as an error or a failure but rather as the inevitable impact of running something across a large population. Cost is important, and I would want to avoid the thing with underpayments and overpayments because an overpayment is what you define in overpayment.

MR. CAPRETTA: I want to raise one issue which is related to all of this and very much agree with that point. If you did a state based experimentation program, I could imagine a State like Maryland or another state saying wouldn't it make sense for us to use prior tax information to do all of this, but also to shift regular enrollment for the exchange process at the end of this spring and not to have it in the fall. Maybe the federal structure should allow this as sort of a waiver idea and to go from July 1 to July 1 and so everybody's income from the prior year will count for eligibility for Medicaid and premium tax credits July 1 going to the following July 1, based on the prior calendar year tax information and honestly, you'd just make it a lot easier for everyone if you would just do it that way. I can see the State coming to that conclusion, once the Federal structure put all this in place, gave them the information, gave them the authority to do it, and we can see what happened. I think it might actually work a little bit better than the process we have now where we are trying to put them into eligibility based on everybody trying to guess what their income is going to be in the following calendar year.

MR. GINSBURG: I see 2 panelists nodding heads and would like to give you the opportunity to follow up on what Jim said.

MR. DORN: I agree.

MR. KENDALL: But, Stan, don't you have a problem with July 1st? Don't you want to do it a little earlier in the year?

MR. DORN: Those are small details. The point is I agree.

MR. KENDALL: I just want to make sure that the States have time to process all that tax data.

MR. GINSBURG: Good point. Some questions have come in. The 2 ways I mentioned, remember, that's at Brookings@edu.twitter, auto enrollments. They keep coming in, so I moved my screen. Several States don't have broad based income tax. How would auto enrollments work in those states? From Chris Farrell.

MR. CHEN: Stan, do you want to take that one?

MR. DORN: Sure. A couple of possibilities. One is particularly in the current environment, state work force agencies with unemployment insurance programs, I think are a critically

important place to look. As I mentioned earlier, we've tried many times in the country's history, Cobra subsidies in 2009, now the ACA, we've generally failed to reach this population because people are just overwhelmed and struggling with the challenges of the emotionally and practically, I've lost my job. Who am I as a person? How do I get unemployment insurance? People do not have the banlieue to deal with health coverage. So, this is a very important opportunity to figure out how can we make it as light a lift as possible for people. So, what we're suggesting to folks is even unemployment agencies themselves are overloaded right now. They don't have much space to do huge innovations. One possibility would be the state health agencies in an exchange in a state based marketplace state where the Medicaid agency sends an email so all its UI applicants seems to me to be the lowest hanging fruit. Let the unemployment recipient of the applicant click the link, go to a web page maintained by the agency and just provide contact information and Social Security number and say please reach out to me in the following way, email, text, cell phone call, and sign me up for coverage and walk me through the process. That would require the health agency to invest resources in doing the individualized follow-up, but that's the kind of thing that would actually get the people involved in coverage. That's one option. The other place to look, it seems to me, is drivers' license, now that we're doing real ID, good, bad or indifferent. No matter how you feel about real ID, that means that states have a lot of data about us in important ways and that may be a useful place to go in states that don't have their own income tax systems.

MS. GINSBURG: And Dave?

MR. KENDALL: Yeah, just let me add that a state that doesn't have its income tax. That is a really good question because it shows the employee and state policy at the same time, that State without a state income tax is going to have access to the Federal income tax data. When I filled out the student loan applications for my kids for college, there was an automatic download that I agreed to from the IRS to my FASFAC application. We can do the same thing for states that don't have income tax.

MR. GINSBURG: Very good points. Anyone could speak to, besides Maryland, which States have been active in pursuing auto-enrollment experiments?

MR. KENDALL: Well, Massachusetts has done some interesting things. They've got a lot of great academics who have been working with exchange there and figuring out what kinds of nudges

work most effectively with people and what sort of auto enrollment strategies work. We've gotten inquiries from states like Colorado, New Mexico, Virginia, Maine, Pennsylvania, but a lot of that interest went away when COVID hit. That's very much front of mind for people, although this is important. There are other topics that understandably have limited with the short legislative decision makers that have come to the fore. We had some interest early on in this session. We still have some interest in a number of states. I don't know how many states are going to be following Maryland's lead this year.

MR. GINSBURG: Question on Medicare enrollments which may not be relevant. Let me just read it. Medicare enrollment process is extremely confusing and complicated, especially compared to Medicaid or the marketplace. How does Medicare enrollment fit into the conversation? This is somewhat of a broad neck, which I think I know the answer. IF anyone would like to take a crack.

MR. DORN: Well, you're automatically enrolled into both Part A and Part B at age 65 unless you essentially opt out if you have started applying for Social Security benefits at that point. If you have not applied for Social Security by that point, then you have to find a way of paying your Part B premiums. You can, of course, elect to take Medicare Advantage, as opposed to fees for service of A and B coverage. That requires an over opt in. You have to go through the Medicare managed portal for looking at your option and deciding which coverage you would like. You also have to do similarly for Part D for prescription drugs. It's sort of a mix. In addition to all that, if you go into a Medicare fee for service, which many people do, about half of the new enrollees are going to the fee for service, half to Medicare Advantage, those who go into the fee for service, also at that time have to figure out if they want supplemental coverage, that is a different service, through a different portal. I would agree with the questioner in the sense that this whole process needs to be reorganized to be a little bit clearer to people and what the implications of them are, but that's a big topic that goes way beyond what we're talking about today.

MS. GINSBURG: Actually to me, the Medicare auto enrollments, we had a system, but then as people started working longer, beyond 65 and not needing Medicare, Part B, we kind of created a new problem of people who don't enroll, because Medicare has a very call in mandates where if you don't enroll in Part B when you're supposed to, your premium is higher for life and it goes up based on the

number of years, but I think that is a very specific Medicare issue that is probably outside what we have been discussing. That's one of the questions here. What protections have been put in place to ensure personal data privacy? This is from Michelle (inaudible) cultural distance.

MS. YOUNG: So, data privacy is really important here. So, obviously whatever city or state agency is handling this information handle it with care, and it is subject to strict agreements about how the information is used. Certainly we need to assure the consumer's personal information is not being exposed by State agencies, subject to strict agreements about how the information is used. Certainly we need to assure the consumer's personal information is not being exposed by State agencies that are assisting in health insurance enrollment or anything else. I don't think auto enrollment poses sort of new or different challenges on data privacy issues than the underlying systems that exist, State Medicaid agencies, tax agencies, their Federal equivalent to a large amount of information that needs to be protected. So, I agree that those protections are critical. I don't think the questions here are different in kind from what we are already dealing with and the data privacy structure is set up to protect. In certain ways, I think our long-standing sensitivity about how and where tax data in particular gets shared have really hampered auto enrollment activities. Our attitude towards Federal tax data in particular is that it can't go anywhere for any purpose, absent an express statutory nuance that we don't need to get into here. So, that really makes it difficult to do something like the Maryland experiment as well as it could be done. If there was more robust access to Federal tax data, if we opened up the situation in which State agencies could use federal and state tax data, we would. We would be able to layer on the necessary privacy protections and really do a lot of good. I think we also are similarly, the national database of new hire which is used for child support enforcement today and very few other things but is a similarly potentially really powerful in facilitating enrollment and again, the types of privacy protections we would need are the kind that exist under current law. So, opening up those data bases for this kind of project and could be done in a way that is absolutely respectful of consumer privacy.

MR. DORN: I agree. One point that is sort of interesting is the data architecture is the data services hub which is the way that lots of different data sources have been made in private as well in exchanges and in state Medicaid agencies. It doesn't operate as a Federal depository of data. It's a

Federal doorway in which you can ping the underlying data sources maintained by separate agencies. That's an important element of the architecture that reduces the risks of privacy losses.

MR. GINSBURG: We're nearing the end of our time. I'd like to give each of the panelists the opportunity to state any final thoughts they have reflecting on our conversation.

MS. YOUNG: I'll start. I have really enjoyed this discussion. One of the things that is most striking for me on this and others that I've had privately with you all and others is that anybody who has been seriously about operationalizing auto-enrolment at any meaningful scale is thinking about changing our eligibility rules. It's not possible to tackle this policy problem without reimagining the way we do eligibility to make it more stable and more predictable over time and that's coming from the left and from the right. It is a prerequisite to efforts in auto enrollment and so, I think that's one of my main takeaways from this conversation, that there are lots of different ways to tackle this problem. They are the reimagining ability we do, for health care coverage programs.

MR. CAPRETTA: I would just add that I think it speaks volumes about the promise in the politic solutions that we've all talked about that you see the kind of ideological diversity that's represented here, as well as the kind of really what I think is technocratic. I mean that in the kindness sense of the word, a sort of technocratic approach to try and figure out how we can facilitate enrollment in this way. I do think it speaks to one of those rare opportunities when right and left might work together to make something happen in a really meaningful way.

MR. DORN: I completely agree. It's just such a joy to see at a time of tremendous partisan strive to figure out a way to solve problems that help people's every day lives. In terms of technocracy and simplification and all that, a Dave's point about making it simple, I think about it in terms of – the things we're talking about are complicated. I think about a car. I have no idea about what happens under the hood of my car. I know there's a carburetor. It's run by a computer. All I know is I push one thing and I go. I push another thing and I stop. I turn the wheel and I stop and it stops for me. A lot of complicated engineering under the hood makes it possible for me as a person to make it a really easy driving experience. That's what we want to do for health coverage. It may take a lot of engineering and work behind the hood and we may have to get out hands greasy and Lord knows what we're going to

have to do, but the goal is to make it really simple. It's a complicated system we have now and whatever we have to do to make it simpler for people, we're going to get a lot more health coverage and that will be good for the country.

MR. CHEN: I think carburetors went out of cars a couple of decades ago.

MR. DORN: Shows you what I know.

MR.CHEN: I echo what has been said. I think if the United States is gong to have a multi payer system, which we probably will have, in the absence of other things happening, I think we probably will have a multi payer system for some time. There is only one way to move forward, which is to try to make tht mutipayer system is to get people into what they are supposed to be in, based on their current life circumstances. Given the ACA and what is set up, attached to the employer system, attached to Medicaid, attached to Medicare program, how do we make all that work a little bit better with each other and as people move around and there are changes to their life circumstances, I think auto enrollment could be a very big part of that. I very much agree and complicated engineering out of sight. Simplicity for the consumer. Getting general bipartisan agreement about what happens when and what are the options for people in what point in time. Getting the employer community to participate in all this. I think all that could go a long way toward being in a better place 5 years from now.

MR. GINSBURG: Dave, if you would like, you have the last word.

MR. KENDALL: Sure, just real quick. The tremendous thoughts and ideas we've head today are good signs for the future health policy, even if we end up having a fight over health policies, which we seem to have inevitable. There will be a lot that girds the efforts. It's just a matter. Regardless of the politics, no matter how cynical you are about the policies, this discussion is going to be 3essential about moving forward with people covered and protected from high costs.

MR. GINSBURG: Thanks a lot. You know my long experience in health policies is we consort health care policy issues and there is somewhere that partisan differences don't come in. It doesn't mean that they're easy. The state called differences that limit what we can do, but anyway, that's very encouraging that auto-enrollment might be contacted and multi data systems might be in that non-partisan category. I want to thank all of you. Your presentations and your discussion comments were all

very, very valuable. We can be glad that we got together on Zoom to do this. I look forward to seeing you at least virtually again soon.

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CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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