social service agencies, they may be less effective or less efficient in addressing social determinants of health than those agencies, which may have more knowledge and practical expertise in upstream drivers of health.[5] Understanding how these trade-offs inform optimal allocation of scarce societal resources will be critical to improving population health, particularly in marginalized populations. Discussions of trade-offs must recognize the fact that policymakers may assign widely varying weights to specific benefits and harms in their decision making (e.g., ongoing debates over school closures during the pandemic). Many economists would argue that the people who stand to be most affected by a given policy or health condition should be the ones to determine how to weigh various benefits and harms.

An audio interview with Dr. Green is available at NEJM.org

Public health practitioners come from a wide range of disciplines that reflects the multifaceted range of problems they must tackle. Economics meaningfully adds to these perspectives by clarifying key trade-offs and illuminating new policy options — including those that go beyond the delivery of public health services. A key contribution of economics to public health is the elucidation of complex trade-offs that may affect health-related behaviors, which include nonmonetary costs and benefits that are often ignored by policymakers. Economic models can help public health policymakers craft more equitable policies that more fully account for the lived experiences and realities of various populations.

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Automatic Insurance Policies — Important Tools for Preventing Coverage Loss

Adrianna McIntyre, Ph.D., M.P.H., M.P.P., and Mark Shepard, Ph.D.

The Affordable Care Act (ACA) is more than a decade old, but universal health care coverage in the United States remains elusive. An underappreciated fact about the roughly 28 million uninsured Americans is how many of them already qualify for subsidized coverage. It has been estimated that 57% of uninsured people in 2019 qualified for Medicaid or subsidized marketplace coverage, and 40% qualified for insurance plans with no premiums — either Medicaid or state health insurance marketplace plans (typically plans in the least-generous "bronze" tier).[1] To reduce the proportion of uninsured Americans, policymakers have focused on increasing marketplace subsidies and persuading holdout states to expand Medicaid. But policies that broaden eligibility for affordable coverage, though necessary, are unlikely to completely close the coverage gap.

Affordability-based policies do little to address the administrative burdens involved in securing and maintaining health coverage. People must navigate complicated and onerous systems to apply for, enroll in, and retain insurance. There is growing evidence that even minor hassles substantially reduce take-up. Conversely, policies that remove barriers and make it easier to stay insured can help shrink the ranks of the uninsured.

The American Rescue Plan Act (ARPA), enacted in March 2021, improved insurance affordability, at least temporarily. ARPA allowed

families with incomes below 150% of the federal poverty level (FPL) and those collecting unemployment benefits in 2021 to enroll in "benchmark" silver plans in the marketplace and pay no monthly premium (enrollees may still be charged deductibles and copayments). ARPA also increased subsidies for enrollees with higher incomes, which has made zero-premium bronze plans more widely available. As a result, nearly half the uninsured population in 2021 probably qualified for free coverage.[1]

Absent congressional action, however, these subsidy enhancements will expire at the end of 2022. States have also stopped removing people from Medicaid programs during the Covid-19 public health emergency, but eventually this "maintenance of eligibility" will end, and affected beneficiaries will need to seek other insurance. Together, these changes could instigate widespread coverage loss.

To mitigate potentially massive disenrollment, state and federal policymakers will need to take coordinated action. During key periods when people are at elevated risk for becoming uninsured — because, for example, they must switch sources of coverage — systems could employ "automatic" policies that make it easy to stay insured. The availability of zero-premium plans facilitates implementation of these policies, since it provides a free option to which people can be assigned rather than lose coverage. Recent research from Massachusetts shows sizable effects of two such policies: automatic enrollment and automatic retention.

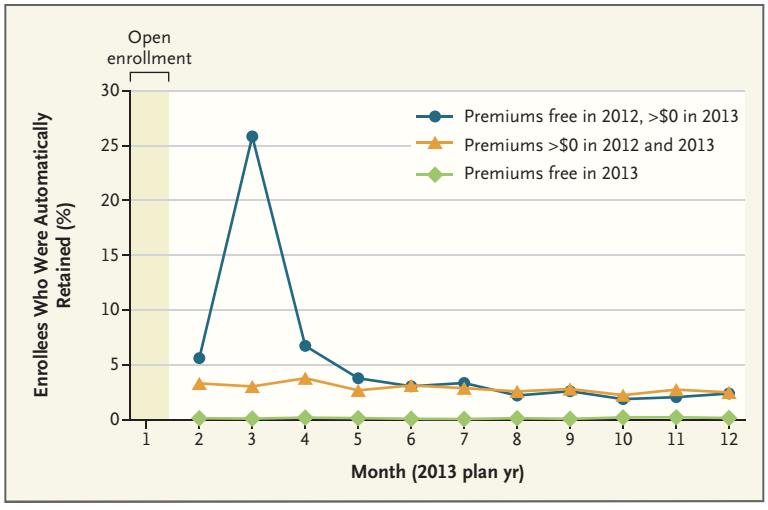
Automatic enrollment promotes take-up when people gain or lose eligibility for various types of coverage, a phenomenon known as churn. For instance, people can simultaneously lose Medicaid eligibility and qualify for marketplace subsidies because of minor changes in income or personal circumstances. Unless they successfully navigate the marketplace-enrollment process, many of them could become uninsured — and locked out of coverage until the next open-enrollment period. Evidence suggests that take-up challenges are common. One experiment found that less than 5% of people referred to California's insurance marketplace from county Medicaid programs enrolled in coverage, even after personalized reminder letters were sent to the whole group.[2]

Enrollment figures suggest that maintenance of eligibility has kept millions of people on Medicaid — many of whom could lose coverage when the Covid-19 emergency ends.

Although universal autoenrollment is probably infeasible today, a targeted autoenrollment approach could be implemented for people who have already qualified for subsidized marketplace coverage — on the basis of either an online application or information from the Medicaid eligibility-redetermination process — but who haven't completed the enrollment process. Before the ACA was implemented, Massachusetts' insurance exchange used a similar approach for applicants qualifying for zero-premium coverage. Quasi-experimental research showed that this policy increased total enrollment by 30 to 50%. People who were automatically enrolled were younger and healthier than other enrollees, with medical costs 44% below average.[3] By reducing average costs, autoenrollment policies could result in lower premiums. California intends to start automatically enrolling people churning from Medicaid to marketplace coverage in 2022.

Policies that automate enrollment can also improve retention of marketplace coverage. Many enrollees stop (or never start) paying their premiums for marketplace plans, despite maintaining eligibility for subsidies. Changes in after-subsidy premiums when rates are reset in a new plan year appear to be important — particularly when plans that have been free begin requiring a small premium. Enrollees who don't notice this change and so don't actively set up a bill-payment mechanism can easily fall behind; if they miss premiums for 3 consecutive months, their coverage can be terminated.

Automatic retention, another policy enacted in Massachusetts before implementation of the ACA, sought to address this issue. Exchange enrollees who fell behind on premium payments were automatically transitioned to a zero-premium plan if one was available, rather than losing coverage. Our research found that this



Estimated Share of Enrollees Who Were Automatically Retained in Massachusetts Health Insurance Exchange Plans in 2013.

Rates could not be estimated for the open-enrollment month. Enrollees who fell behind on premium payments were switched to an available zero-premium plan after a 2-month grace period, rather than being disenrolled (as occurs in the Affordable Care Act marketplaces). Automatic retention had an especially large effect 3 months after a plan began charging premiums between years. As expected, the policy wasn't relevant for plans that were free in 2013, since enrollees cannot lapse on a $0 premium. Data are from McIntyre et al.[4] Adapted with permission.

policy prevented coverage loss for 14% of enrollees who were eligible for zero-premium plans.[4] The graph shows the estimated share of enrollees who maintained insurance coverage because of automatic retention in each month of 2013. The largest effects occurred just after plans shifted from having a zero after-subsidy premium in 2012 to a small positive premium in the new year, with automatic retention rates exceeding 25%. The policy also kept enrolled a sizable group of people (2 to 3% per month) who missed premium payments at other times. As with autoenrollment, people who were automatically retained in plans were younger and cheaper to insure than other enrollees.

Current circumstances create new urgency surrounding these policies. Enrollment figures suggest that maintenance of eligibility has kept millions of people on Medicaid — many of whom could lose coverage when the Covid-19 emergency ends. In addition, for many enrollees, the cheapest silver-tier offerings (the ones fully subsidized under ARPA) will have changed for the new plan year; this means that enrollees who elected zero-dollar silver coverage in 2021 could face new premiums for the same plans in 2022. Absent automatic retention, these dynamics could lead to disenrollment.

Automatic insurance policies pose several challenges. Some require federal action — at a minimum, guidance is needed on what states can do under existing rules or with a Section 1332 innovation waiver.

Currently, subsidies for marketplace plans are calculated using estimated annual household income; discrepancies between estimated and actual income are later "reconciled" through taxes. Automatic insurance policies could therefore create unexpected tax liabilities for some enrollees. Federal policymakers could establish safe harbors for people who are autoenrolled or autoretained in marketplace plans so that any unexpected tax liabilities are forgiven. Alternatively, they could harmonize the marketplace's income rules with Medicaid's system of using real-time monthly income to determine eligibility.

Another concern is automatic enrollment of people who are ineligible for subsidized insurance (e.g., because they have employer-sponsored insurance). Evidence from Massachusetts, however, suggests that duplicative-enrollment rates were generally less than 5%.[3,4] State regulators could work with carriers to minimize this issue.

To address potential enrollee dissatisfaction, policymakers could add automated coverage assignments to the list of qualifying life events that trigger special-enrollment periods — windows in which plan changes are permitted. Under a new regulation finalized in September 2021, states may also permit enrollees with incomes below 150% of the FPL who qualify for zero-premium silver-tier coverage to change marketplace plans throughout the year.[5]

Challenges could be further mitigated with improved eligibility and enrollment systems. States' health information–technology infrastructure varies widely: some states, such as Massachusetts, have integrated Medicaid and marketplace eligibility systems, but most have not. When people churn off Medicaid, the timing and content of data sent

to state marketplaces varies. Inconsistent administrative capabilities create uneven opportunities, which suggests that sustained federal investments in states' data infrastructure could be valuable.

Achieving universal health care coverage in the United States will require more than making insurance affordable; policymakers also need to make it easier to stay insured than to fall through the cracks of the country's complicated insurance system. In combination with expanded eligibility and outreach, we believe automatic enrollment policies should be central to strategies for reducing the proportion of uninsured people in the United States.

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The Care I Needed

Jessica Gregg, M.D., Ph.D.

One afternoon last winter, I caught myself massaging aches in my wrists and hands, aches that hadn't been there the day before. A few hours later, I was rolling away pain in my shoulders, then in my neck. The next morning, my knees hurt too, and my stiff paws fumbled as I tried to turn the doorknob.

I was worried, but not terrified; I've been healthy my whole life, and I have excellent insurance through a large HMO. Also, I'm a doctor; I would get the care I needed. I scheduled an urgent telehealth visit for the following day through my HMO's elegant app. So easy! Then I took extra-strength Tylenol, chased it with ibuprofen, and went to work.

I had a new patient to see, an older guy, with stubble and jowls. Though I'm trained in internal medicine, I mostly treat addiction now, mostly among people without housing, steady incomes, or loved ones to catch them when they fall. My new patient told me about his slide into addiction, his terrible luck and lousy choices. He told me opioids numbed his pains, and cannabis and methamphetamines helped him forget — but now he worried that the forgetting was becoming permanent: he was having trouble remembering basic things, like a friend's address or which bus lines went where. Maybe, he said, it came from too many drugs and too much hard living. Or maybe, he shrugged and smiled, he was just getting old.

"Aren't we all?" I replied, rolling and popping my creaky neck.

He laughed. "You got that right."

He spoke to me as if I were a friend, and I forgot my own hurts and remembered to slow my speech and check for understanding. I prescribed medication to reduce opioid cravings and said I wanted to see him again in a week. He thanked me, blessed me, and said he'd try to remember.

The following morning, I shuffled and groaned myself to the coffee maker and a cup whose handle I couldn't quite grip, before settling in front of my computer as if it were Christmas morning and Santa was bringing me telehealth. I imagined unburdening myself to a white-coated colleague, someone about my age, maybe a little older. She would lean forward, asking concerned questions. Did I have any rashes? What about fevers? Did it feel safe to drive? Then she would think aloud about possible causes of my symptoms while reassuring me that we'd get to the root of it all. My imaginary doctor was unrushed, had no other thoughts but of my problems, and sort of loved me.