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Wisconsin's Experience with Medicaid Auto-Enrollment: Lessons for Other States

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Abstract

The Patient Protection and Affordable Care Act (ACA) relies heavily on the expansion of Medicaid eligibility to cover uninsured populations. In February 2008, Wisconsin expanded and reformed its Medicaid/CHIP program and, as part of program implementation, automatically enrolled a set of newly eligible parents and children. This process of “auto-enrollment” targeted newly eligible parents and older children whose children/siblings were already enrolled in the state’s Medicaid/CHIP program. Auto-enrollment brought over 44,000 individuals into the program, representing more than 60% of all enrollees in the first month of the reformed program. Individuals who were auto-enrolled were modestly more likely to leave the program relative to other individuals who enrolled in February 2008, unless their incomes were high enough to be required to pay premiums; these auto-enrollees were much more likely to exit relative to other enrollees subject to premium payments. The higher exit rates exhibited by non-premium paying auto-enrollees were likely due to the fact that over 40% of auto-enrollees were covered by a private insurance policy in the month of their enrollment, compared to approximately 30% for regular enrollees. A national simulation of an auto-enrollment process similar to Wisconsin’s, including the expansion of adult Medicaid eligibility to 133% of the federal poverty level under the ACA, suggests that 2.5 million of the 5.6 million newly eligible parents could be auto-enrolled, and approximately 25% of this population would be privately insured. These results suggest that auto-enrollment may be appropriate for other states, especially in their efforts to enroll eligible populations who are not subject to premium requirements.

Keywords: Medicaid; enrollment; parents; auto-enrollment

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Introduction

Enrolling eligible children and adults into Medicaid and the Children's Health Insurance Program (CHIP) has been a challenge, and many states have pursued aggressive strategies to reach and enroll those eligible for these programs (Wachino & Weiss, 2009). Some estimates suggest that Medicaid and CHIP reach only 79 percent of eligible children who lack access to private health insurance, and that as many as three-quarters of uninsured children are eligible, but not enrolled in Medicaid or CHIP (Dubay, Holahan, & Cook, 2007; Hudson & Selden, 2007; State Health Access Data Assistance Center & Urban Institute, 2005). Eligible parents can also be difficult to enroll into the program, despite most states setting parent eligibility for public coverage well below that of children. Estimates suggest that roughly 28% of uninsured parents are eligible for Medicaid/CHIP, but are not enrolled (Georgetown University Health Policy Institute, 2009; Holahan, Cook, & Dubay, 2007).

Wisconsin, in contrast to the experiences of many states, has been very successful in recent years in enrolling eligible low-income children and parents into BadgerCare Plus (BC+), its combined Medicaid and CHIP program. Wisconsin expanded eligibility for BC+ to virtually all children and to low-income parents/caretakers in February 2008. Enrollment increased rapidly, with net enrollment increasing by 51,000 in the first month alone and by 124,000 between February 2008 and November 2009—representing a 25% increase over the enrollment numbers for low-income children and parents as of December 2007. In addition to the severe economic downturn, a number of policy factors have been credited for this dramatic expansion. Examples include: clear branding, simplified application processes, reductions or eliminations of deductibles for some low-income children, easing of “anti-crowd-out” provisions, availability of a user-friendly online application, and extensive community outreach (Leininger et al., 2011). Beyond these factors, however, an important reason why Wisconsin was so successful in its enrollment efforts was that it auto-enrolled over 44,000 individuals at the time of program launch, including over 26,000 parents and 18,000 children. The auto-enrollment involved electronic database matching, which applied new program eligibility criteria to existing data already held within state databases, and immediately converted eligible persons to coverage.

The Patient Protection and Affordable Care Act (ACA) is projected to extend health insurance coverage to an additional 32 million people and relies heavily on an expansion of Medicaid to do this (Patient Protection and Affordable Care Act, 2010; Health Care and Education Reconciliation Act, 2010). It creates a new national income eligibility standard at 133% of the federal poverty level (FPL). Medicaid expansion is likely to account for about half—16 million people—of those who, by 2019, will become newly eligible for health insurance under the federal health care reform (Iglehart, 2010). Given the considerable discretion with which states operate their respective Medicaid programs, implementation of the federal health care reform efforts will rely heavily upon the engagement of states in reaching and enrolling newly eligible individuals (Holahan & Headen, 2010). We believe that Wisconsin's experience with

auto-enrollment may serve as an instructive exemplar to other states considering similar processes of enrolling those newly eligible for Medicaid under the ACA.

Auto-enrollment has a number of potential benefits. First, it is a way of quickly extending coverage to a large number of eligible individuals and decreasing the number of uninsured individuals. Second, it may help find potentially hard-to-enroll individuals. However, as implemented in Wisconsin, the auto-enrolled or their family members had some experience being enrolled in the public insurance program in order to be in the databases, so this paper cannot speak to the promise of auto-enrollment methods in reaching the traditionally hard-to-enroll. Finally, it may capture individuals who would eventually enroll, and enroll them sooner than they would themselves, increasing their time covered and reducing their costs of enrollment. On the other hand, auto-enrollment has some disadvantages. It may enroll some individuals who do not want to be enrolled in the program and who may disenroll quickly. This may occur when they have access to coverage through other mechanisms (such as their own or their spouses' employment, COBRA, or individual purchase), or when their income places them in an eligibility category that requires premium cost sharing.

In this paper, we describe Wisconsin's experience with automatic enrollment. We use administrative data to determine whether public insurance was valuable to auto-enrollees relative to regular enrollees by comparing rates of continuous enrollment, churn rates, and percentages having private insurance at the time of enrollment. Finally, we simulate the potential impacts at the national and state levels, should an auto-enrollment process similar to that used by Wisconsin be adopted along with the expansion of Medicaid to 133% FPL under the ACA.

Auto-Enrollment: Wisconsin's Experience

Wisconsin launched BadgerCare Plus (BC+)—a health insurance reform initiative that expanded the state's Medicaid and CHIP programs—on February 1, 2008. Immediately prior to BC+ program launch, the Wisconsin Department of Health Services (DHS) carried out a one-time auto-enrollment effort that automatically enrolled more than 44,000 previously unenrolled individuals. Of these, 98 percent were siblings or parents of existing beneficiaries. This process involved applying new program eligibility criteria to previously ineligible individuals for whom there was current information in the state's administrative database of program eligibility. This included anyone who had at least one family member with an open case (already enrolled in state health programs in December 2007 or January 2008), or who had had a case closed 30 days before the BC+ implementation (i.e., in December 2007). Previously ineligible individuals could become eligible because of any one of a number of policy changes, including the elimination of income limits for children's coverage, the elimination of crowd-out restrictions for families with incomes below 150% FPL, the expansion of eligibility to parents with income levels of 185–200%, and to caretaker relatives of children with income levels of 45–200%.

Automatic Enrollment in Other Settings

Auto-enrollment is a process whereby people who meet income and categorical eligibility criteria are identified through electronic matching of various existing administrative data sets, including data culled from Medicaid and other public programs (Dorn, 2007; Dorn, 2009; Dorn & Kenney, 2006). Eligible people are automatically enrolled into coverage, with the converted beneficiaries having both the right and responsibility to opt-out of coverage. This approach contrasts with the traditional model for public benefits enrollment, which relies on the knowledge, motivation, and initiative of the potential enrollee to seek out and submit applications, to provide information demonstrating potential eligibility, and to fulfill the procedural requirements of the administrative agency. The government agency's responsibility is limited to offering subsidies or services, educating the public about available assistance, and processing applications.

Automatic enrollment lifts much of the application burden from potentially eligible individuals. Studies have consistently shown that opt-out approaches have higher rates of enrollment than opt-in policies (Remler & Glied, 2003). This finding has been extensively documented at firms where new workers establish 401(k) accounts. Only 33% of new employees enroll in a traditional 401(k) plan when they are given the choice to opt-in and are required to complete application forms, while 90% of new employees enroll when automatically placed in 401(k) accounts without declining participation by completing "opt out" forms (Choi, Laibson, Madrian, & Metrick, 2004; Choi, Laibson, Madrian, & Metrick, 2005a; Choi, Laibson, Madrian, & Metrick, 2005b; Holden & VanDerhei, 2005).

Auto-enrollment is already used for dual-eligible Medicare beneficiaries, for whom states submit their data files to the Centers for Medicare & Medicaid Services for matching. Medicare Part D subsidies were automatically extended to all Medicare beneficiaries who received Medicaid or Supplemental Security Income the prior year. The subsidy program reached 74 percent of eligible beneficiaries within six months of implementation. Medicare Part B covers more than 95 percent of eligible seniors by automatically enrolling them into the program and deducting premium payments from their Social Security checks, unless the seniors complete opt-out forms (National Council on Aging, 2006; Federman, Vladeck, & Siu, 2005).

States themselves have considerable experience with data matching for a range of health care coverage purposes: income and employment verification, coordination of benefits with other insurers, Medicaid premium-assistance programs, and identification of benefits available to children from non-custodial parents. Such a process could be extended to target persons who have already sought public assistance for other social programs and who may be eligible for—but not enrolled in—Medicaid/SCHIP. For example, Massachusetts successfully employed database matching when it auto-converted former Uncompensated Care Pool enrollees into CommCare coverage (Dorn et al., 2009).

It has been argued elsewhere that tax information could provide all of the information needed to determine eligibility for Medicaid and CHIP (Dorn, 2009). Indeed, some states already use tax information and other databases to verify eligibility of program applicants. More than six out of seven uninsured individuals (86.3 percent) file federal income tax returns, and even families that are exempt from paying federal income tax may file state income tax returns when they can qualify for an earned income tax credit (Dorn, 2009).

While the promise of across-systems database matching is great, the logistics of implementing such initiatives are often daunting. Negotiating and executing data-sharing agreements across agencies can take considerable time and, depending on the specific legal environment, may be impossible. Wisconsin's experience, however, demonstrates an already accessible, feasible way for Medicaid agencies to utilize their existing Medicaid enrollment data to implement auto-enrollment—an approach that does not require participation from other agencies.

Study Data and Methods

We use data from the Wisconsin CARES eligibility and enrollment systems covering the time period from February 2008 through November 2009. Our analytic sample includes the 125,418 parents and children who enrolled during the first four months of the expanded program (from February 2008 through May 2008). We separately consider three groups: those who were automatically enrolled in February 2008, those who enrolled through regular processes in February 2008, and those who enrolled between March and May 2008. Auto-enrollment only occurred in February 2008.

For these three groups, we examine two measures of the continuity of enrollment: the probability that they remain enrolled for at least 6 months and the probability that they remain enrolled for at least 12 months. Individuals may disenroll from Medicaid because they do not want the coverage or because they have qualifying events, most notably changes in income and household composition that render them ineligible. Wisconsin requires the prompt reporting of any such changes, within 10 days for household composition changes and by the 10th of the month following an income change (Wisconsin Department of Health Services, 2008). They are disenrolled by the state if they fail to pay premiums for two months.

We also examine churning, which we define as the probability of re-enrollment within six months for those who exit by May 2009. We estimate these probabilities using probit models. Our models take the form:

$$y_i = f(X_i B + \alpha Feb_i + \gamma Auto_i + \delta P_i + \theta_1 Auto_i \times P_i + \theta_2 Feb_i \times P_i)$$

where y_i is one of the following:

an indicator variable for an enrollee remaining continuously enrolled for 6 months;

- an indicator variable for an enrollee remaining continuously enrolled for 12 months;
- or
- an indicator variable for an enrollee that exits and re-enrolls within 6 months.

The independent variables in each of these models include:

- *Auto*, an indicator for the enrollee being auto-enrolled in February 2008;
- *P*, an indicator that the enrollee is required to pay premiums;
- *Feb*, an indicator for being a February enrollee; and
- *X*, a set of demographic variables including whether the enrollee is an adult or child, includes categories for age of the youngest child in the household (age 0, age 1–5, age 6–12, age 13–18, or no enrolled children), a female indicator, number of adults in the household, number of children in the household, categories for education level (less than high school, high school, or more than high school), an indicator for whether the county of residence is urban or rural, categories for income as a percentage of FPL (under 150% FPL, 150–200% FPL, and more than 200% FPL), and county unemployment rates.

To examine whether enrollees had access to private insurance coverage at the time of enrollment, we use administrative data from three sources that are merged with the CARES enrollment data. These include the following:

- UI: Quarterly wage records from required unemployment insurance reporting;
- TPL: Wisconsin's Third Party Liability database; and
- DOL: a U.S. Department of Labor database of all self-insured firms.

The unit of observation in this dataset is an individual-month beginning in the first month that individual enrolled in BC+. We link across these different sources by using Social Security numbers (SSNs) and federal employer identification numbers (FEINs).

TPL is an individual-level database that contains all enrollees in state health insurance programs who are covered by a private, fully insured health insurance plan. We matched enrollees to the TPL database using their SSNs. This database, while an excellent resource, is limited in two ways. First, these data are available for each month in which an individual is enrolled in BC+, but do not contain information on the health insurance coverage of individuals in months prior to enrollment or following disenrollment. Second, the database does not contain individuals who are covered by health insurance provided by a self-funded employer (whose policies are not subject to state regulation). Thus, those enrollees who do not have insurance according to the TPL database either do not have private insurance or have health insurance through a self-funded employer.

To assess whether enrollees may have access to health insurance coverage through a self-funded employer, we connect BC+ cases to their set of employers by linking CARES through SSNs to a database of quarterly earnings records from Wisconsin's unemployment insurance (UI) system. We use this match to identify workers and to obtain the federal employer

identification numbers (FEINs) of their employers. For enrollees who do not have a TPL match, we use their FEINs to link to data from the U.S. Department of Labor (DOL), in order to see if a BC+ case member's employer offers a self-funded plan. We obtained these data through a Freedom of Information Act request. The data represent the universe of employers within the United States from 2003 to 2007 that are self-insured for health, life, and disability and related insurance plans. Because we are unable to observe which members of a case with a DOL match obtain their health insurance from the self-insured firm, we impute insured status for these enrollees using data from the Current Population Survey. Details of this data matching and imputation process are available in Dague et al., (2011).

We then use the American Community Survey (ACS) to assess the potential reach and targeting of auto-enrollment in other states. Specifically, we simulate the number of parents who could potentially be auto-enrolled into Medicaid under an expansion to 133% FPL. Newly eligible parents will represent a significant proportion of newly eligible adults (35%, author calculations using the American Community Survey). We focus on this population because childless adults will not have an enrolled child and so may not be in state databases, and also because low-income parents have been a relatively higher priority adult population for some state Medicaid/CHIP programs, as substantiated by their preferential treatment in recent state-level expansions relative to low-income childless adults (Kaiser Commission on Medicaid and the Uninsured, 2009). Not only is low-income parents' public insurance eligibility of interest in its own right, but it is also an important determinant of children's public insurance take-up (Dubay & Kenney, 2003).

We use data from the 2008 ACS—the first round of the ACS to include health insurance variables—for the simulation (Davern, Quinn, Kenney, & Blewett, 2009). The ACS is a nationally representative survey fielded yearly by the U.S. Census Bureau that collects information on socio-demographic, economic, and housing characteristics of the non-institutionalized U.S. population. All estimates are weighted to reflect the complex survey design of the ACS. There are some limitations to the ACS, including a well-known Medicaid undercount and the lack of complete information on legal residency (O'Hara, 2009). Our analysis follows the "official" Census procedure of not adjusting our insurance estimates for either the Medicaid undercount or for the possibility that legal immigrants and citizen children of undocumented immigrants may be under-represented in the ACS, or that some respondents in the ACS may be undocumented immigrants. First, we estimate the total number of parents who would become newly income eligible for Medicaid under an eligibility expansion to 133% FPL using information on state-level Medicaid eligibility levels collected by the Kaiser Family Foundation (Kaiser Commission on Medicaid and the Uninsured, 2009). Some states, where income eligibility for parents already exceeds 133% of FPL, would have no newly eligible parents. We then exclude from this number those parents who appear to be newly income eligible, but report already being on public insurance (Medicaid/CHIP, Medicare, or Veteran's Administration insurance). Parents who appear to be income ineligible can report receiving

Medicaid for a variety of reasons, including a differential between the relevant time period for income reported for eligibility purposes and for the survey (monthly vs. annual), measurement error in either income or reported health insurance, and/or the absence of information in the survey needed to determine other means of eligibility (e.g., whether the parent is pregnant).

Second, we estimate the number of these newly income-eligible parents who conceivably would already be present in a state’s Medicaid data system—and potentially a candidate for auto-enrollment—because their children are already receiving public insurance. Third, we calculate the “private insurance rate,” that is, the percentage of this population that report having private health insurance in the survey.

Findings

The Impact of Wisconsin’s Auto-Enrollment

Wisconsin auto-enrolled 44,264 individuals into its BC+ program in February 2008. The auto-enrollees comprised 63% of the 69,910 new enrollees who entered into the program in February 2008 (Exhibit 1). Of these, 26,062 were parents and 18,202 were children. The vast majority of the auto-enrolled—almost 98%—had either a child or a sibling already enrolled in the program, while the remainder had recently exited the program; a few fit both characterizations.

Exhibit 1. Summary Statistics on BC+ Enrollment

	All	Parents	Children
New Enrollees February 2008	69,910	34,770	35,140
Number Auto-Enrolled	44,264	26,062	18,202
<i>Of which:</i>			
Premium Paying	9,625	6,389	3,236
Exited in previous 6 months	2,783	1,442	1,341
Sibling/child enrolled in Nov/Dec 07	43,239	25,390	17,849

NOTES. Subcategories are not mutually exclusive; bottom three cells should not add to total number of auto-enrollees.

SOURCE: Authors’ calculations from Wisconsin administrative data.

Relative to other new February 2008 enrollees, the auto-enrollees were slightly older and belonged to larger households (results available from the authors). Almost three-fourths of both auto-enrollees and other new enrollees had incomes that were less than 150% of the federal poverty level, and similar proportions in both groups had a required premium based on income (24% of regular enrollees and 22% of auto-enrollees, results available from the authors).

Exhibit 2. Probability of Continuous Enrollment by Enrollment and Premium Status

	All Enrollees			Parents			Kids		
	Feb. 2008	Mar.– May 2008	Non- Auto	Feb. 2008	Mar.– May 2008	Non- Auto	Feb. 2008	Mar.– May 2008	Non- Auto
At least 6 months									
No Premium	81.1%	82.9%	88.1%	78.2%	80.2%	86.0%	83.3%	85.0%	89.7%
Premium	44.1%	55.6%	77.9%	40.2%	51.6%	74.7%	47.5%	58.9%	80.3%
At least 12 months									
No Premium	60.4%	66.8%	72.2%	54.5%	61.2%	67.0%	65.1%	71.3%	76.3%
Premium	31.3%	47.0%	62.2%	26.1%	41.0%	56.3%	35.8%	52.0%	66.8%

NOTES. Probabilities are predicted from probit models with covariates other than premium status, time of enrollment, and auto-enrollment status held at their means. Means for those covariates as well as the coefficients and marginal effects from the probit models are reported in the Appendix. Sample sizes by cell are reported in Exhibit 3. All pair wise differences between February auto-enrollees and non auto-enrollees are statistically significant at the $p < 0.05$ level.

SOURCE: Authors' calculations from Wisconsin administrative data.

Exhibit 2 reports the predicted probabilities of continuous enrollment based on our estimated probit models described in the previous section. The full results of these models are reported in the Appendix. Individuals who were auto-enrolled and were not required to pay premiums were only slightly more likely to exit the program within 6 months than were regular, non-premium paying February 2008 enrollees—19% vs. 17%, respectively ($p < 0.001$). There was a modest difference in the probability of 12 months of continuous enrollment between the auto-enrollees and regular enrollees who did not pay premiums—60% vs. 67%, respectively ($p < 0.001$). Similar differences are evident for parents and for children.

By contrast, individuals who were auto-enrolled and required to pay monthly premiums exited the program at substantially higher rates than non-auto-enrolled entrants whose income was high enough to require premiums (both of whom exit at far higher rates than enrollees who do not pay premiums). Forty-four percent of premium-paying auto-enrollees remained enrolled at 6 months compared with 56% of premium-paying regular enrollees and the difference is even greater at 12 months (31% versus 47%, respectively). Premium-paying enrollees, who have relatively higher incomes, may be unwilling or unable to pay the premium cost sharing, or may be more likely to have other options for coverage.

We also calculated predicted probabilities for churning (the probability of re-entry within six months of exiting the program). As with the exit probabilities, the probability of re-entry conditional upon exit is similar for non-premium paying auto-enrollees and February 2008 regular enrollees (47% vs. 46%, $p < .217$, results available from the authors). Among the premium paying enrollees, the re-entry probability is slightly higher among those who were auto-enrolled (53% vs. 50%, $p < 0.004$, results available from the authors).

Individuals who enrolled in the expanded program in February 2008, whether automatically enrolled or enrolled through the regular application process, had higher exit rates than individuals who enrolled at any time in the subsequent three months.

Exhibit 3. Percent Privately Insured in Wisconsin for Auto vs. Non-Auto Enrollees

	Feb. 2008		Mar–May 2008
	Auto	Non-Auto	Non-Auto
All Enrollees			
No Premium	43.5%	29.8%	22.1%
	34,639	19,518	55,587
Premium	48.9%	37.2%	31.7%
	9,625	6,128	7,393
Parents			
No Premium	40.3%	29.1%	21.5%
	19,673	7,038	23,636
Premium	48.1%	38.2%	28.4%
	6,389	1,670	4,350
Children			
No Premium	47.7%	30.2%	22.5%
	14,966	12,480	33,951
Premium	50.5%	*36.9%	*36.4%
	3,236	4,458	3,043

NOTES. Calculated as the number of individuals who had third party medical insurance liability in the first month of enrollment in BadgerCare Plus. Details in text. Total number of enrollees per cell (denominators) reported below percentages. Premium status is determined by income; adults over 150% FPL are required to pay premiums and children over 200% FPL. All within-category (all, parents, children) differences between columns and rows are statistically significant at the $p < 0.05$ level or better with the exception of the two starred cells.

SOURCE: Authors' calculations from Wisconsin administrative data.

In Exhibit 3, we provide estimates of the proportion of new enrollees that were covered by private insurance policies at the time of their enrollment. Individuals who were auto-enrolled were much more likely to be covered by these private policies—44% of non-premium payers and 49% of premium payers—than those who enrolled through the regular application process (30% of non-premium payers and 37% of premium payers, respectively). The rates of private insurance coverage were lower among those who enrolled in March through May 2008 than for those who enrolled in February 2008.

These findings, overall, suggest that an appreciable proportion of those enrolled into BC+ via the auto-enrollment process either did not want to be on the program or had a qualifying event precluding the continuation of BC+ coverage within a year of enrollment, and that others already had private insurance coverage and therefore may not have needed public coverage. Both phenomena are especially true among the higher income groups that were required to pay premiums.

Simulation of Parental Auto-Enrollment under the ACA's Medicaid Expansion

Our estimates suggest that 5.6 million parents would become income eligible for Medicaid should the eligibility threshold be increased to 133% FPL (Exhibit 4). Many eligible parents—2.5 million or 44% of them—have children who are already enrolled in Medicaid/CHIP. These parents comprise the group that could most easily be auto-enrolled into public coverage. Of these almost 1.9 million report being uninsured and the remainder—0.6 million—report being privately insured. Thus, nationwide, the private insurance rate among those with the potential to be auto-enrolled is 25%. This evidence suggests that, on average, populations that could potentially be auto-enrolled are likely to have considerably lower rates of private coverage relative to Wisconsin auto-enrollees. Of course, these estimates are more dependent upon the characteristics of the expansion population considered in the policy simulation rather than the fact that they are targeted for auto-enrollment. A policy to auto-enroll a much lower income population likely would yield even lower estimates of the private insurance rate.

Exhibit 4. State-Level Estimates of Potential Number of Auto-Enrolled Parents

State	Parents	Newly Eligible Parents	With Children on Medicaid/CHIP	Uninsured	Privately Insured	Percent Privately Insured
U.S.	74,700,000	5,580,969	2,476,798	1,865,178	611,620	25%
Alabama	1,067,192	191,525	88,881	61,828	27,053	30%
Alaska	177,717	10,451	*	*	*	*
Arizona	1,553,725	—	—	—	—	—
Arkansas	650,261	142,173	89,056	64,786	24,270	27%
California	9,888,105	521,013	202,763	149,100	53,663	26%
Colorado	1,210,316	118,429	40,355	31,163	9,192	23%
Connecticut	870,134	—	—	—	—	—
Delaware	202,359	2,581	*	*	*	*
District of Columbia	95,912	—	—	—	—	—
Florida	4,033,518	554,196	185,558	142,583	42,975	23%
Georgia	2,412,300	330,353	153,836	114,855	38,981	25%
Hawaii	319,332	—	—	—	—	—
Idaho	391,444	70,051	36,791	27,105	9,686	26%
Illinois	3,284,227	—	—	—	—	—
Indiana	1,549,137	—	—	—	—	—
Iowa	691,626	—	—	—	—	—
Kansas	670,648	92,832	40,203	26,230	13,973	35%
Kentucky	1,014,106	145,305	67,306	51,329	15,977	24%
Louisiana	1,031,309	190,001	99,509	76,730	22,779	23%
Maine	289,673	—	—	—	—	—
Maryland	1,390,053	23,815	*	*	*	*

State	Parents	With Children			Percent	
		Newly Eligible Parents	Medicaid/CHIP	Uninsured	Privately Insured	Privately Insured
Massachusetts	1,583,152	—	—	—	—	—
Michigan	2,431,344	265,665	98,054	66,968	31,086	32%
Minnesota	1,312,042	—	—	—	—	—
Mississippi	690,934	141,624	67,318	42,115	25,203	37%
Missouri	1,404,865	233,112	111,593	84,138	27,455	25%
Montana	212,975	21,120	*	*	*	*
Nebraska	433,843	40,462	16,781	10,745	6,036	36%
Nevada	638,250	43,868	*	*	*	*
New Hampshire	331,639	18,327	*	*	*	*
New Jersey	2,289,829	—	—	—	—	—
New Mexico	466,218	73,728	32,030	22,283	9,747	30%
New York	4,761,878	—	—	—	—	—
North Carolina	2,194,468	314,574	149,596	109,994	39,602	26%
North Dakota	150,227	16,021	*	*	*	*
Ohio	2,702,566	174,970	45,992	27,652	18,340	40%
Oklahoma	861,809	141,752	65,736	46,298	19,438	30%
Oregon	888,266	43,852	15,249	10,362	4,887	32%
Pennsylvania	2,878,281	—	—	—	—	—
Rhode Island	245,752	—	—	—	—	—
South Carolina	1,021,770	85,609	33,780	23,219	10,561	31%
South Dakota	189,363	21,596	*	*	*	*
Tennessee	1,441,600	—	—	—	—	—
Texas	6,465,897	1,259,966	665,222	550,151	115,071	17%
Utah	755,150	—	—	—	—	—
Vermont	148,555	—	—	—	—	—
Virginia	1,917,554	207,342	84,053	61,295	22,758	27%
Washington	1,602,692	—	—	—	—	—
West Virginia	386,533	72,306	36,431	31,221	5,210	14%
Wisconsin	1,339,429	—	—	—	—	—
Wyoming	128,024	12,350	*	*	*	*

NOTES. An em dash (—) indicates that a state has already expanded eligibility past 133% FPL. An asterisk (*) indicates that although a state would have potential auto-enrollees, ACS sample sizes are too small for reliable calculations (weighted from <100 respondents). National estimates are not equal to the sum of state estimates due to the exclusion of individual estimates for the (*) states.

SOURCE: Authors' calculations from 2008 American Community Survey.

Exhibit 4 also reports the state-by-state estimates of the number of parents who would become newly eligible for Medicaid under the ACA, the number that could be potentially auto-enrolled, and the private insurance rate. Estimates of the number of newly eligible parents vary widely by state because of variation in existing eligibility rules. For example, Arizona currently covers parents up to 200% FPL while Texas covers parents up to 27% FPL (Kaiser Commission on Medicaid and the Uninsured, 2009). As a result, in Arizona no parents would become newly

eligible while all parents between 27% and 133% FPL in Texas (roughly 1.3 million individuals) would become newly eligible. States also vary somewhat in the number and percentage of newly eligible parents who potentially could be auto-enrolled, as this number depends on eligibility levels of children relative to parents and in the private insurance rate among this population.

Discussion and Conclusions

Wisconsin's auto-enrollment process was an effective route to reaching eligible individuals already connected to public insurance either through past enrollment or through the enrollment of a family member. Auto-enrollment reached a large number of previously ineligible siblings and parents. This group had already demonstrated some proclivity toward participation in public benefits, and thus may be less likely to opt-out than might persons captured through a broader match with state income tax or unemployment insurance data, for example. Deploying the relatively low-cost method of auto-enrollment would allow states to target more resource-intensive outreach efforts on those groups that may not be well-represented in existing state databases, who may be eligible for other forms of subsidized coverage, or who may be less amenable to default coverage.

Our results show a mixed picture as to whether the use of automated database matching is a reasonably efficient way to enroll uninsured individuals and individuals who would want to participate in the public program. On the one hand, among those who were not subject to premium payments, exit rates among those who were auto-enrolled were only modestly higher than those for individuals who enrolled through the regular application procedure. On the other hand, a much higher percentage of auto-enrollees were privately insured at the time of enrollment than were regular enrollees. One important and unambiguous lesson learned from the Wisconsin experience is that auto-enrollment appears to be an ineffective and poorly targeted strategy for Medicaid-eligible populations who are subject to premium payments.

The national simulations suggest that up to 2.5 million parents nationwide could immediately and automatically be enrolled in coverage upon an expansion of Medicaid eligibility to 133% FPL and that, in a departure from the Wisconsin case, more than 75% of these potential auto-enrollees are uninsured. These results suggest that the use of auto-enrollment in other states could be an effective means of enrolling uninsured populations—and as the Wisconsin case demonstrates, the greatest success will likely be achieved by using auto-enrollment for eligible populations not subject to premium payments.

Disclaimer

The views expressed in this paper are those of the authors and should not be interpreted as those of the Congressional Budget Office or the Robert Wood Johnson Foundation.

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Appendix

Exhibit 1. Probit Models for Results in Exhibit 2

Variable	Mean	P(12 Months Continuous Enrollment)		P(6 Months Continuous Enrollment)	
		Coef.	Marginal Effect	Coef.	Marginal Effect
February enrollee	0.5305	-0.155 <i>0.0119</i>	-0.072 <i>0.0040</i>	-0.229 <i>0.0139</i>	-0.078 <i>0.0032</i>
Premium required	0.1740	-0.280 <i>0.0218</i>	-0.187 <i>0.0069</i>	-0.412 <i>0.0240</i>	-0.217 <i>0.0068</i>
Auto-enrollee	0.3381	-0.171 <i>0.0124</i>	-0.080 <i>0.0042</i>	-0.069 <i>0.0143</i>	-0.029 <i>0.0034</i>
February enrollee X premium required		-0.231 <i>0.0260</i>		-0.397 <i>0.0274</i>	
Auto-enrollee X premium required		-0.241 <i>0.0262</i>		-0.220 <i>0.0264</i>	
Child enrollee	0.5454	0.277 <i>0.0091</i>	0.103 <i>0.0034</i>	0.186 <i>0.0107</i>	0.049 <i>0.0029</i>
Youngest HH member 0 years old	0.2014	-0.001 <i>0.0249</i>	0.000 <i>0.0093</i>	-0.361 <i>0.0314</i>	-0.095 <i>0.0082</i>
Youngest HH member 1–5 years old	0.4022	0.007 <i>0.0241</i>	0.003 <i>0.0090</i>	-0.231 <i>0.0307</i>	-0.061 <i>0.0081</i>
Youngest HH member 6–12 years old	0.2489	0.069 <i>0.0244</i>	0.026 <i>0.0091</i>	-0.202 <i>0.0310</i>	-0.053 <i>0.0081</i>
Youngest HH member 13–18 years old	0.1184	-0.088 <i>0.0250</i>	-0.033 <i>0.0093</i>	-0.224 <i>0.0317</i>	-0.059 <i>0.0083</i>
Female	0.5681	0.051 <i>0.0078</i>	0.019 <i>0.0029</i>	0.068 <i>0.0088</i>	0.018 <i>0.0023</i>
Number of adults in household	1.6326	-0.018 <i>0.0063</i>	-0.007 <i>0.0023</i>	-0.022 <i>0.0072</i>	-0.006 <i>0.0019</i>
Number of children in household	2.3287	0.030 <i>0.0031</i>	0.011 <i>0.0011</i>	0.025 <i>0.0035</i>	0.007 <i>0.0009</i>

Exhibit 1 (cont.)					
Variable	Mean	P(12 Months Continuous Enrollment)		P(6 Months Continuous Enrollment)	
		Coef.	Marginal Effect	Coef.	Marginal Effect
High school graduate	0.5779	-0.012 <i>0.0093</i>	-0.004 <i>0.0035</i>	-0.062 <i>0.0108</i>	-0.016 <i>0.0028</i>
More than high school	0.1924	-0.035 <i>0.0117</i>	-0.013 <i>0.0044</i>	-0.077 <i>0.0133</i>	-0.020 <i>0.0035</i>
Rural county	0.3642	-0.016 <i>0.0082</i>	-0.006 <i>0.0031</i>	0.007 <i>0.0093</i>	0.002 <i>0.0025</i>
HH income under 150% FPL	0.7316	0.333 <i>0.0228</i>	0.124 <i>0.0085</i>	0.211 <i>0.0251</i>	0.056 <i>0.0066</i>
HH income between 150 and 200% FPL	0.1814	0.046 <i>0.0188</i>	0.017 <i>0.0070</i>	-0.037 <i>0.0196</i>	-0.010 <i>0.0052</i>
County unemployment rate	5.0826	0.035 <i>0.0039</i>	0.013 <i>0.0015</i>	0.034 <i>0.0044</i>	0.009 <i>0.0012</i>
Constant		-0.053 <i>0.0388</i>		0.987 <i>0.0457</i>	
Log likelihood		-75947.4		-55920.2	
Observations		125418		125418	

NOTES. Standard errors in italics. Marginal effects measured as (dydx) at mean; for factor variables, as change from 0 to 1. Covariates measured at beginning of spell.

SOURCE: Authors' calculations from Wisconsin administrative data.

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