Five Recommendations To Make Renewal a Success

Enrolling over 12 million consumers in coverage during the first open enrollment period was a landmark achievement. Partners from the public and private sectors came together and overcame formidable challenges to reach — and exceed — initial enrollment projections. Looking ahead to the next open enrollment period, stakeholders must not only continue to identify, educate, and enroll more of the remaining uninsured, they must also ensure that those who enrolled initially keep their coverage. Coverage gaps lead to delayed care and poorer health outcomes for consumers, as well as administrative inefficiencies for federal or state agencies administering health coverage programs and for health plan issuers.

Unfortunately, history suggests that coverage loss at renewal is all too common in public health coverage programs like Medicaid and the Children's Health Insurance Program (CHIP).[1] This fall, some 8 million consumers will experience the marketplace renewal process for the first time, and millions more will need to recertify their Medicaid eligibility. Marketplaces and Medicaid and CHIP agencies will need to stand up new systems to handle renewals, and consumers and assisters will need to learn how these new processes work.

The law and federal regulations envision a process in which marketplaces can automatically renew an enrollee's coverage on an annual basis. Similarly, Medicaid and CHIP renewals are intended to be data-driven and only require a consumer to take action if their information has changed.[2] But as the first open enrollment period demonstrated, the process of turning the

1. Set clear expectations and communicate these early. Consumers, assisters, and organizations doing education and outreach need clear and consistent information about how the process will work.

2. Do not require action for those without changes. Automating renewal as much as possible increases the likelihood that consumers will stay enrolled.

3. Minimize action necessary for those with changes. Pre-populate renewal notices and do not require enrollees to repeat steps of the application process that are not needed to make a new eligibility determination.

4. Send a clear message about the December 15 deadline, to reduce potential coverage gaps. Deadlines are powerful motivators, and consumers who take action early stand the best chance at keeping continuous coverage.

5. Ensure a streamlined process for transitions between the marketplace and Medicaid. Earlier problems with file transfers must be resolved, so that consumers can apply for — and renew — coverage without delay and without having to provide duplicate information to multiple agencies.

vision of simplified enrollment and renewal into reality is gradual. When renewal policies and systems are rolled out for the first time this fall, they will not be perfect. Enroll America offers the following recommendations for the Department of Health and Human Services (HHS) and state policymakers to consider as they institute marketplace and new Medicaid renewal policies for the first time this fall.

Discussion

1. Set clear expectations and communicate these early.

Consumer research conducted at the conclusion of the first open enrollment period identified large knowledge gaps among consumers, including both the uninsured and those who enrolled during the first open enrollment period.[3] Consumers are confused about when the next open enrollment period begins, whether they received financial help, and what they may need to do to keep coverage. Expectation-setting is an important part of a positive user experience; consumers must be primed for what they may hear from their marketplace, Medicaid agency, and health plan issuer and any action steps they may need to take to keep coverage or change health plans.[4] HHS, state-based marketplaces, and Medicaid and CHIP agencies are uniquely positioned to begin communicating with consumers about renewals, since they have email addresses or other contact information for all enrollees.

Likewise, it is of utmost importance that HHS and state policymakers provide organizations conducting outreach, assisters, and call center staff with timely, consistent information about how the renewal process will work. These entities are well-positioned to educate and prepare consumers for the renewal process, but they currently lack the information needed to help in this way. This information should be conveyed clearly and consistently as soon as possible so that organizations can plan accordingly and ensure that consumers are empowered with the information they need to make timely, informed decisions when it is time to renew or change coverage. At the latest, this information needs to be available by early September when new federal Navigator grantees are announced, so that Navigators can learn about renewals as part of their training and certification/recertification. Similarly, state-based marketplaces should include renewal information in their training and certification/recertification for assisters for the second open enrollment period.

2. Do not require action for those without changes.

Consumers enrolled in marketplace coverage who expect their income and household composition to be the same in 2015 and want to keep the same plan, should be able to keep coverage without taking action. The default action should be that enrollees' coverage is renewed for the 2015 coverage year. As with the application process, HHS should build a renewal system that can accommodate enrollees whose situations are uncomplicated, to ensure that these cases can be processed easily and quickly. Federal regulations and guidance to issuers envision that this will be possible, as long as the enrollee has given consent for the marketplace to use existing government databases to assess ongoing eligibility, but it is crucial that this be true in reality, as well.

Behavioral economics research has shown that automatically enrolling an individual in a program, with the option to opt out (opposed to opt in), increases participation in voluntary programs.[5] A number of public benefit programs have increased enrollment by setting the "default" in favor of participation.[6] As envisioned by the law, these principles should guide the policies that govern renewal of marketplace, Medicaid, and CHIP coverage.

Of course, even consumers without eligibility changes may choose to change plans during the second open enrollment period, or their issuer may decide to change plan details or exit the marketplace. In order to give these enrollees adequate time to consider their options, marketplaces should post plans and premiums for 2015 as early as possible; consumers may wish to change plans if rates or plan details change significantly.

3. Minimize action necessary for those with changes.

Research suggests that more than 40 percent of adults likely to enroll in Medicaid or marketplace coverage (with financial help) will experience a change in eligibility during a 12-month period.[7] These individuals will need to report these changes and navigate the process of transitioning from one form of coverage to another (some of which will occur at annual renewal, and some of which will occur throughout the year as enrollees report changes).

Processes must be in place to minimize the loss of coverage during the year and at the time of renewal. Enrollees experiencing changes should not be required to complete a full application again, or resubmit information that has not changed. They should also not be asked to supply information that has already been verified, like identity and citizenship. Marketplaces and Medicaid and CHIP agencies should allow consumers to make simple "account updates" online and by phone for changes of address, income, and adding or subtracting a household member.

4. Send a clear message about the December 15 deadline, to reduce potential coverage gaps.

Just as during the initial open enrollment period, a person must enroll in or renew coverage by the 15th of the month in order for his or her coverage to begin on the first of the following month. Consequently, consumers who renew after December 15 may experience a lapse in coverage, since their 2014 coverage ends on December 31, and their 2015 coverage will not take effect until February 1 at the earliest. Automatic renewals as discussed above would mitigate this risk, but there is still potential for disruptions in coverage or services as an individual changes plans (see table below).

Date of Enrollment/ Renewal	Effective Date of Coverage
November 15, 2014 – December 15, 2014	January 1, 2015
December 16, 2014 – January 15, 2015	February 1, 2015
January 16, 2015 – February 15, 2015	March 1, 2015

Enrollment deadlines are already a source of confusion for consumers, and the new and unfamiliar renewal process will pose additional public awareness challenges.[8]

Experience during the first open enrollment period suggests that deadlines are motivating.[9] However, if the February 15 deadline is the one that is emphasized, many consumers may wait until then to take action, potentially resulting in coverage gaps or "coverage confusion" for the first two months of the year (January-February 2015). In order to ensure that as many consumers as possible maintain continuous coverage, federal and state policymakers, as well as organizations engaged in public education and outreach, should emphasize the importance of renewing coverage during the first month of the second open enrollment period (November 15 – December 15).

Using contact information collected in the HealthCare.gov application process to proactively inform consumers of the renewal deadline would help to maximize the number of consumers that maintain continuous coverage. Research on consumer engagement during the first open enrollment period indicates that contacting consumers multiple times and through multiple mediums (e.g. by email and by phone) can yield significantly better results than limited outreach via a single medium.[10]

5. Ensure a streamlined process for transitions between the marketplace and Medicaid.

Medicaid and CHIP renewals may be more complicated in 2014, as states transition to new Affordable Care Act (ACA) requirements. Consumers will need to return a renewal form to ensure the state has all the necessary information to make a redetermination based on new income-counting rules. The current model form for these renewals is nine pages long (not including supplemental forms that some consumers may need to complete).[11]

States should be encouraged to adopt a shorter form, should test these forms with consumers before they are used widely, and should pre-populate online and paper renewal forms before consumers receive them.

Account transfers between marketplaces and Medicaid agencies (and vice versa) have been challenging. Although these processes are improving, the vision for a truly streamlined single application has not yet become a reality in most states. This situation could become even more complicated as annual renewals begin. As mentioned above, a significant proportion of enrollees may experience a change in eligibility from Medicaid to marketplace (and vice versa), so it is even more important during the second open enrollment period that marketplaces and Medicaid agencies be able to transfer accounts.

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Endnotes

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