Clearing the Path

Streamlining Enrollment in Covered California for Californians Transitioning from Medi-Cal

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Executive Summary

To reduce the risk that Californians will experience a coverage gap when transitioning from Medi-Cal, the state's Medicaid program, to Covered California, its health insurance marketplace, the state enacted Senate Bill 260 in 2019. The law instructs Covered California, working with the California Department of Health Care Services (DHCS), which oversees Medi-Cal, to create a streamlined pathway to insurance for people found ineligible for Medi-Cal but likely eligible for marketplace subsidies by selecting for them a subsidized health plan through Covered California. The program launched in May 2023, with initial enrollments taking effect in July 2023. By March 2024, the program had facilitated the enrollment of about 112,000 Medi-Cal transitioners into marketplace coverage.

This report describes the critical policy and operational decisions DHCS and Covered California officials made to implement SB 260 and how these choices may affect Californians' coverage transitions. It draws on a review of the relevant literature; applicable state and federal law and regulations; data and other materials from Covered California and Medi-Cal, including early data on enrollment under the program; the legislative history of SB 260; and 17 structured interviews with key informants.

Key findings include these:

- Early views of California's program
  - Although it is still early to assess the program fully, most informants believed that implementation had gone well and were optimistic that the program was reducing burdens on Californians and meaningfully increasing take-up of marketplace coverage.
  - Going forward, priority one for many informants was to collect more information on transitioners' experiences and use those data to implement improvements.
- Considerations for other states
  - Any state implementing a facilitated enrollment program will face two critical policy questions. The first is whether to enable people transitioning to opt in or opt out of the selected marketplace health plan. The second is to decide what that selected plan (the "default plan") should be.
  - In addition, states will need to conduct robust consumer education and outreach, informed by consumer testing and research, and collect, analyze, and publicly report data about the experiences of those transitioning and their coverage status. For example, Covered California stratifies and reports data based on race, language, income, and other demographic categories.
  - States will also need to engage early and often with the health plans that will provide coverage to Medicaid transitioners. This engagement includes efforts to ensure the seamless transfer of critical data, guidance on legal standards and requirements, coordination on messaging and transitioner notices, and regular testing of IT systems.
  - A facilitated enrollment program also requires extensive and ongoing coordination between a state's Medicaid agency and its marketplace. States with an integrated Medicaid-marketplace eligibility and enrollment system will have an advantage implementing a facilitated enrollment program. However, facilitated enrollment in a state without an integrated system is also feasible.

Introduction

In the United States, almost no one goes through life with just one source of health insurance. Coverage access relies on a patchwork of private and public coverage options with varying eligibility criteria. These transitions pose a challenge to continuity of coverage and may result in people becoming uninsured.[1] Among people with low incomes who lose health insurance, evidence suggests more than half go without coverage for a period of time before regaining it.[2] Once uninsured, a person is more likely to forgo care, including preventive services, and less likely to fill prescriptions.[3] Access to care is likely to be reduced even when a coverage gap is short.[4] Meanwhile, without insurance, a person's financial exposure to the cost of services they do receive is likely to increase.[5] Even a transition that does not interrupt coverage may disrupt care, due to differences between the new plan and the old (e.g., the provider network, covered benefits, and cost sharing).

To reduce the risk that Californians will experience a coverage gap when transitioning from Medi-Cal (the state's Medicaid program) to Covered California (its Affordable Care Act marketplace), the state enacted Senate Bill (SB) 260 in 2019. The law instructs Covered California to create a streamlined pathway to insurance for those determined to be ineligible for Medi-Cal but likely eligible for marketplace subsidies by selecting for them a subsidized health plan through Covered California. The program launched in May 2023, with initial enrollments taking effect in July. By March 2024, the program had facilitated the enrollment of about 112,000 Medi-Cal transitioners into marketplace coverage.[6]

This report describes the critical policy and operational decisions DHCS and Covered California officials made to implement SB 260 and how these choices may affect consumers' coverage transitions. The report aims to inform any subsequent efforts by California to build on SB 260's framework and to guide policymakers and stakeholders in other states considering whether and how to establish their own facilitated enrollment programs.

The report draws on a review of the relevant literature; applicable state and federal law and regulations; data and other materials from Covered California and Medi-Cal, including early data on enrollment under the program; the legislative history of SB 260; and 17 structured interviews with key informants. Interviews were conducted from November 2023 to February 2024 and included state legislative staff, staff from Covered California and DHCS, health plan representatives, enrollment assisters, and staff from California-based consumer advocacy organizations.

Background

Medi-Cal Eligibility and Transitions

Medi-Cal eligibility is based on various factors, such as income and membership within a specific eligibility group, and eligibility is administered at the county level.[7] California state law generally requires each county to redetermine the eligibility of its enrolled residents every 12 months or, in the case of adults, sooner if enrollees report a change.[8] Under state law that predates SB 260, if a county

A Shared Eligibility and Enrollment System

County workers perform Medi-Cal case management using one system, known as the California Statewide Automated Welfare System (CalSAWS), which interfaces with a second system, the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). CalHEERS serves as a consolidated eligibility and enrollment system and data repository for both Medi-Cal and Covered California, housing eligibility determinations for the two programs and the data on which they are based.

determines an enrollee has become ineligible for Medi-Cal, the county must transfer the enrollee's account to the marketplace to determine their eligibility for Covered California.[9] (This transfer requirement does not apply in the case of Medi-Cal disenrollment for procedural reasons rather than for a finding of ineligibility.)

Covered California staff have estimated that, before the COVID-19 pandemic, only about 20% of people determined eligible for subsidized marketplace coverage after losing Medi-Cal eligibility ultimately selected a marketplace plan.[10] According to Covered California administrative data and consumer research, younger people, those identifying as Latino/x, and Spanish speakers were less likely to select a marketplace plan than were older transitioners, those identifying as White, and people who spoke only English. Consumer research also suggested that a plurality of those who did not select a plan had become uninsured.[11]

The Legislation

SB 260 was introduced to help consumers maintain coverage when they lose eligibility for Medi-Cal but gain eligibility for Covered California.[12] The bill passed the California legislature with bipartisan support and was signed into law in July 2019. One informant with knowledge of the legislative history of SB 260 suggested that legislators from both parties had been receptive to the bill because they understood it to be a response to the kinds of life changes common to, and disruptive for, nearly everyone. At the same time, the informant said the bill's champions intended for it to play a role in improving equity: "We felt like the people that were managing to make it through the Covered California enrollment process" were English speakers with a greater familiarity with private health insurance; it was hoped SB 260 "would bring other groups, especially immigrant groups, to the table."

Another informant said a key disparity in coverage could not be addressed by SB 260: People are now eligible for Medi-Cal regardless of immigration status, but eligibility for marketplace coverage is limited to only certain immigrant populations.

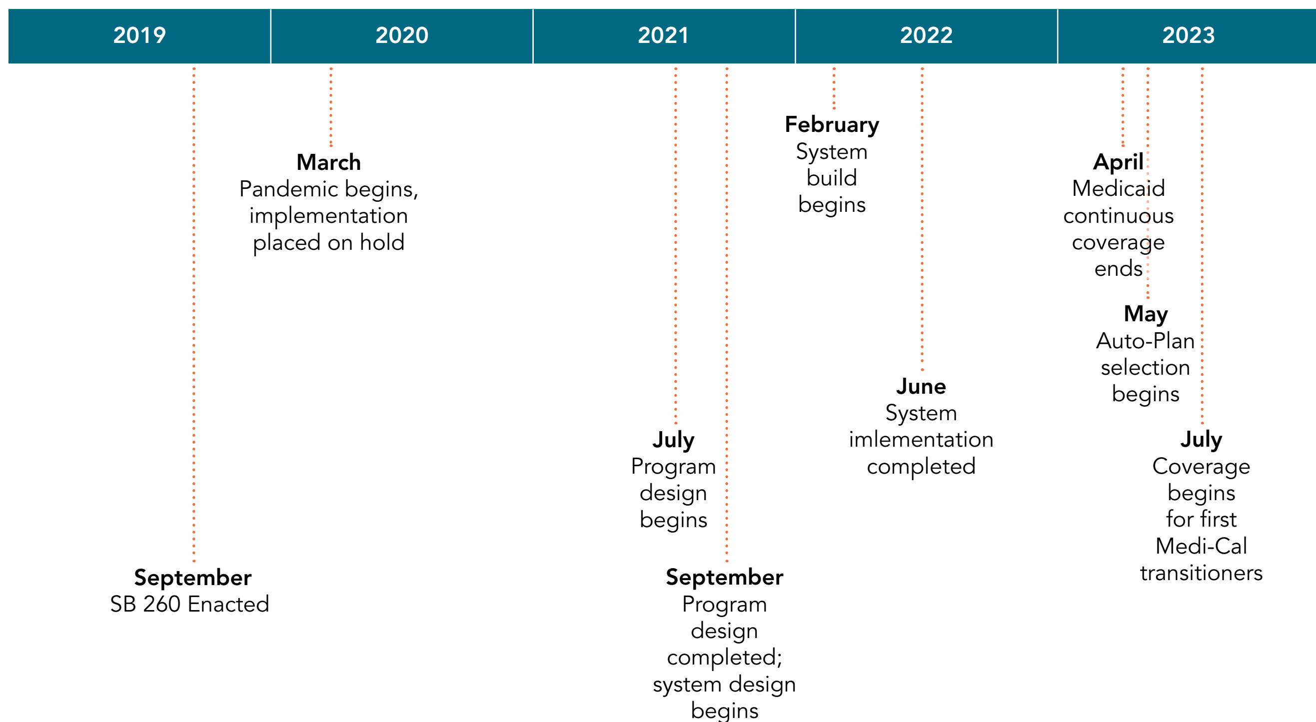
The enacted legislation requires that:

- Covered California use a transitioner's eligibility information (already shared by Medi-Cal under existing law) to enroll the person in the lowest-cost silver plan available on the marketplace.[13]
  - Enrollment must be in the lowest-cost silver plan unless Covered California has information enabling it to enroll the person in their previous managed care plan from Medi-Cal without a gap in coverage.
- Enrollment through Covered California must occur before the enrollee loses Medi-Cal coverage.
- The premium for the new marketplace plan shall be due no sooner than the last day of the first month of enrollment.
- Covered California shall provide anyone enrolled in a marketplace plan through this process with a notice that includes the following information:
  - The plan in which they are enrolled
  - Their right to select a different plan and any relevant deadlines to do so
  - How to receive assistance with selecting a plan
  - Their right not to enroll in the plan
  - Information about how to appeal the decision that they are ineligible for Medi-Cal
  - A statement that services received during the first month of marketplace coverage will be covered only if the plan premium is paid on time[14]

The Pandemic's Impact on Implementation Timing

SB 260 was enacted before the COVID-19 pandemic and specified an implementation date of July 2021. After the pandemic's onset in March 2020, Covered California put initial program development efforts on hold. Meanwhile, the federal government enacted COVID response legislation that increased the federal share of Medicaid funding on the condition that states kept people continuously enrolled in the program until the continuous coverage requirement ended.[15] As a result of this continuous enrollment policy, Medi-Cal enrollment grew while the number of people transitioning from Medi-Cal to the marketplace plummeted. Although Covered California eventually targeted June 2022 as the launch date for the SB 260 program, the persistence of the pandemic and the Medicaid continuous enrollment safeguard led that date to be pushed back even as implementation work continued. In December 2022, a new federal law established that the continuous coverage requirement would end on March 31, 2023.[16] In April 2023, California began what was expected to be a 14-month process of redetermining whether Medi-Cal's more than 15 million enrollees remained eligible for the program. The state announced that SB 260's facilitated enrollment program would launch in the spring of 2023; marketplace coverage for the first wave of Medi-Cal transitioners began July 1. (See Figure 1.)

Figure 1. The Implementation of SB 260



* Source: Authors' analysis of materials provided by Covered California.

SB 260: Key Implementation Decisions

Facilitated Versus Automatic Enrollment

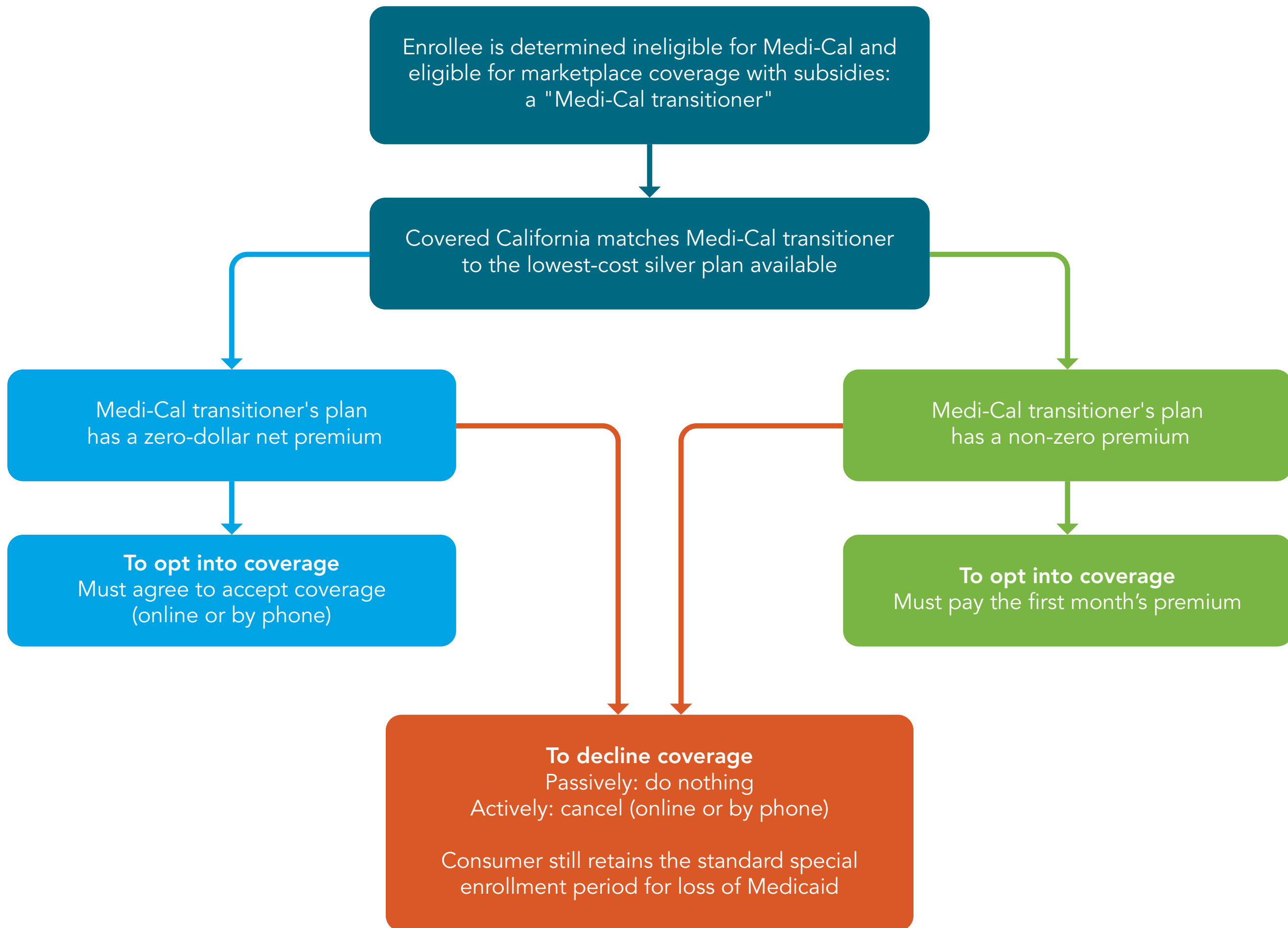
SB 260 requires Covered California to enroll eligible Medi-Cal transitioners in a marketplace plan and affirms that the new plan will not cover any health care services unless the plan's premium is paid timely. However, the statute does not otherwise specify what, if anything, a Medi-Cal transitioner must do to consent to enrollment in the new coverage.

At the time of SB 260's enactment, all marketplace health plans had a premium, even after accounting for federal subsidies. In this environment, new coverage could never be effectuated unless the would-be enrollee took action by paying for the plan. Starting in 2021 however, the situation changed. In response to the ongoing pandemic, the federal government substantially increased the generosity of marketplace premium tax credits.[17] As a result, many Covered California consumers could obtain a plan for $1 per month. Beginning in 2022, the state began applying a $1 credit toward marketplace plan premiums, thereby enabling some consumers to enroll in a plan with zero up-front cost.[18] This development was significant in the context of SB 260 because it meant some Medi-Cal transitioners would be placed into a marketplace plan that did not require any premium payment. Could the marketplace allow such coverage to take effect automatically, without requiring any action on the transitioner's part?

Covered California rejected this approach. Most informants expressed the view that SB 260 at least implicitly requires Medi-Cal transitioners to take an affirmative step to confirm enrollment. Whether or not the statute provides flexibility to automatically enroll transitioners without first obtaining their consent, marketplace officials were wary of doing so because they were concerned it could undermine trust in Covered California and expose enrollees to negative consequences. Consumer research conducted for the marketplace had found that many Californians did not like the idea of someone else making an enrollment decision for them. Informants believed pure automatic enrollment might be especially fraught because enrollment in subsidized marketplace coverage carries a risk of unexpected tax liability — if subsidies apportioned during the year based on estimated income (advance premium tax credits) exceed the amount one is eligible for, based on actual income, the overage must be paid back. Officials were reluctant to impose that risk on transitioners without their sign-off. Finally, several marketplace informants also pointed to internal survey data indicating a large share of people leaving Medi-Cal were enrolling in employer-sponsored coverage. This finding suggested it was important to be cautious about effectuating marketplace coverage based on an unconfirmed assumption it was needed.

Covered California therefore settled on a process best characterized as facilitated enrollment — or "automatic plan selection," as the marketplace describes it — that requires transitioners to opt in to the coverage selected for them, while clarifying they also have the option to choose a different plan or to decline marketplace coverage altogether. (See Figure 2.)

Figure 2. SB 260 Facilitated Enrollment Pathway



Source: *Medi-Cal to Covered California Enrollment Program (Senate Bill 260) Frequently Asked Questions* (PDF), Covered California, February 22, 2024.

The Default Plan

A fundamental decision facing developers of any facilitated or automatic enrollment program is how to determine which plan a person should be enrolled in by default. SB 260 provides Covered California some flexibility over the issue, requiring the marketplace to enroll Medi-Cal transitioners in the lowest-cost silver plan available to them unless: (1) their old Medi-Cal managed care plan participates in the marketplace, (2) Covered California has enough information to match them with that old plan, and (3) Covered California can match them quickly, so they are enrolled without a gap in coverage.

Informants' opinions diverged on whether it was preferable to place transitioners in a plan based solely on its low price. Many informants viewed favorably the option to match transitioners with a plan offered by the same carrier as their Medi-Cal plan, to promote continuity of care. To some, this was the ideal path, at least in theory. One informant observed that, under the alternative approach (placement in the lowest-cost silver plan regardless of carrier), some transitioners would need to find and get set up with new primary and specialty providers and would have to transfer prescriptions; it would be like "starting from square one."

At the same time, many informants (including many of the same people who saw value in an approach designed to promote continuity with a transitioner's prior plan) recognized that people are generally quite sensitive to premium affordability and noted that the "continuity plan" would sometimes be substantially more expensive than the lowest-cost silver plan. They suggested that placing transitioners in that lowest-cost silver plan by default would maximize the likelihood these transitioners — who are likely to have lower incomes — would opt into the coverage. This effect might be particularly powerful, some thought, where that lowest-cost silver plan option had no premium.

Numerous informants also cautioned that, at present, the benefits of keeping a transitioner with the same carrier might be more theoretical than real. They noted that most carriers use a different provider network for their Medi-Cal managed care plans than they do for their marketplace coverage; maintaining continuity of carrier would not guarantee continuity of care.

During implementation, operational limitations effectively rendered these policy considerations moot. Covered California's enrollment and eligibility system (CalHEERS) does not include data regarding transitioners' prior Medi-Cal carrier, and the marketplace moved forward with the lowest-cost silver plan as the default selection.[19]

Outreach, Education, and Marketing

SB 260 obligates Covered California to develop a special notice for Medi-Cal transitioners providing key information relevant to the coverage transition, including the plan they are placed in and their right to switch to a different plan or to not enroll at all. The public-facing materials Covered California developed for SB 260 were informed, in their content and format, by consumer research undertaken on behalf of the marketplace in 2021. This work included focus groups composed of, and in-depth interviews with, Medi-Cal enrollees and those who had recently transitioned from Medi-Cal. Research participants were asked, among other things, to review draft versions of Covered California's SB 260 eligibility notice, the cover letter accompanying the notice, the envelope in which these materials would be enclosed, a flyer describing the program, and several web-based resources (including Covered California's dedicated "microsite" for transitioners). Key takeaways from the research included, among other things:

- Upon learning their Medi-Cal coverage was ending and they could enroll in a plan through Covered California, many participants were stressed about losing coverage and confused about their eligibility situation.
- Participants were generally aware of Covered California but unsure about its relationship to Medi-Cal and uncertain of what the marketplace could do for them.
- The term "auto-enrollment" was not helpful; participants assumed it meant the process was fully automatic, they had already been enrolled and did not need to do anything.
- Participants wanted to feel in control and that a big decision had not been made for them — they felt better knowing they could keep the plan they were matched with, shop for a different one, or opt out entirely.

In light of these findings, Covered California sought to ensure final versions of its public-facing communications were consistent, clear, and accurate. Marketplace staff made sure the information provided to a transitioner in the notice they received matched the information they would find on Covered California's website, and that all other direct communications and marketing complemented and reinforced these resources. It was important "to make sure we're driving people to

the same website and using the same terminology." Staff were committed to this approach and generally pleased with its execution; one informant noted the state's messaging of a person's options — that they could keep the plan they were matched with, pick a different one, or choose not to enroll at all — was being delivered consistently across all messaging channels.

Covered California and DHCS officials also sought to ensure that transitioner materials helped build trust by explaining what Covered California is and making clear that the marketplace and Medi-Cal were jointly involved in the transition process. Public-facing materials and notices were co-branded, as was the dedicated microsite for transitioners (a landing page housed within the marketplace website). These efforts, staff hoped, would establish a "constant visual reminder" of the link between the programs and offer reassurance to the public about the legitimacy of the process.

Officials also voiced their commitment to ensuring that these interactions, and the transition process more generally, would work for Californians. The SB 260–required notices and some public-facing materials were translated into 14 languages and provided taglines telling people how to get assistance in their preferred language, all as required by federal language access rules. Informants generally suggested that support and investment was greatest for Spanish language access; officials tested public messaging in Spanish, conducted outbound calls to Spanish-speaking transitioners in Spanish, and created a Spanish version of the transitioner microsite before translating materials into other languages. Enrollment assister-informants appreciated these efforts and the state's larger commitment to equity. Some suggested, however, that more could be done to provide speakers of less common languages with timely access to translated resources.

Coordination with Health Plans

Informants representing health plans said they were broadly supportive of the goals of SB 260. Before and after enactment, discussions with carriers largely focused on operational considerations. Informants generally praised the level of communication and engagement between Covered California officials and the carriers throughout the implementation process and credited this collaboration with improving the program's rollout. Marketplace officials established a technical committee composed of plan representatives, separate from the regular multistakeholder plan management committee, to work through the rollout of the policy decisions and system changes needed to implement the law. Thus, for example, marketplace officials shared their public-facing materials and notices with carriers as part of the effort to ensure transitioners heard a consistent message about the program.

Other areas of coordination were more technical. Marketplaces generate an electronic enrollment file (an "834 transaction") whenever someone enrolls in coverage and transmit this file to the enrollee's carrier. In consultation with the carriers, Covered California incorporated a new code into the 834 that enables carriers to see whether the new enrollee is a Medi-Cal transitioner. Armed with that information, carriers have been able to tailor their communications to transitioners and perform additional outreach usually in the preferred language of the transitioner through snail mail, email, text, or direct calls. For example, one insurer noted they send out welcome letters specifically tailored to transitioners and then follow up directly with those that haven't yet effectuated coverage. Once enrolled, another insurer offers "special handling" processes in support of transitioners, including direct phone calls from enrollment specialists specifically trained to help those leaving Medi-Cal understand how to secure services under a commercial plan. "Having the unique identifier is a game changer," said one plan representative. "It's at the top of the list of great decisions."

SB 260: Preliminary Enrollment Data and Next Steps

By March 2024, about 335,000 Medi-Cal transitioners had been determined eligible for subsidized marketplace coverage and automatically placed into a subsidized plan through the SB 260 program.[20] Roughly 112,000 of these transitioners opted into coverage, an effectuation rate of 33%.[21] Most of those who opted in (69%) stayed with the default plan; those who switched were more likely to choose a different carrier but keep a silver tier plan (though some changed both carrier and tier).[22]

When asked to evaluate the performance of the facilitated enrollment program so far and to consider what actions California might take to improve the process, most informants prefaced their views with words of caution. They noted that because the program had launched only a few months earlier — interviews began in November 2023 and concluded in February 2024 — enrollment numbers were preliminary, and consumer research (consisting of surveys and interviews) was ongoing. Accordingly, priority one for many informants was to collect more information on enrollees' experiences.

Still, most informants said implementation had gone well and were optimistic the program was reducing burdens on the public and meaningfully increasing take-up of marketplace coverage. One informant noted that the early enrollment data showed an effectuation rate for Medi-Cal transitioners that was much higher (33% by March 2024) than it had been before the pandemic and SB 260 (when the rate had been about 20%), a promising indicator of initial impact.

Going forward, informants suggested there was more to do to improve education and outreach, particularly for residents of historically underserved communities. Several informants said the marketplace's practice of calling transitioners to encourage them to sign up has paid dividends. These informants aimed to increase outbound outreach and to better tailor it to the public's needs and preferences in the future — for example, attempting to reach someone by text to schedule a call at a convenient time. Informants with DHCS and Covered California also looked forward to learning much more about the effectiveness of their messaging and to hone their communications based on enrollee feedback.

Most informants, regardless of background, indicated it would be fruitful to continue exploring ways to improve how the default plan is selected. As a starting point, informants hoped the state would be able to overcome the data and systems limitations that currently inhibit Covered California from timely identifying a transitioner's Medi-Cal carrier. With that information in hand, the marketplace could examine network overlap between an enrollees' Medi-Cal plan and that carrier's Covered California offering. That sort of analysis could shed light on the extent to which coverage continuity translated to continuity of care and potentially enable development of more nuanced plan selection. Regardless of whether a transitioner's Medi-Cal carrier can be identified and timely communicated to Covered California, one informant suggested marketplace officials could do more to educate enrollees on their right to maintain access to their providers.[23]

Considerations for Other States

California is not alone in seeking to ease coverage transitions for its residents. During the Medicaid unwinding, Maryland and Rhode Island also launched Medicaid-to-marketplace facilitated enrollment programs.[24] Other states are exploring whether and how to do so. As state policymakers consider their options for facilitated enrollment, California's experience with SB 260 can provide some important lessons for policy development, program implementation, and ongoing operations.

Policy Development

Any state implementing a facilitated enrollment program will face two critical policy questions. The first is whether to enable people transitioning to opt in or opt out of the selected marketplace health plan. The second is to decide what that selected plan (the "default plan") should be.

Opt In Versus Opt Out

An "opt-out" approach informs the transitioner they are being enrolled in a marketplace plan and effectuates the enrollment unless the transitioner takes an affirmative step to decline the coverage. An "opt-in" approach does not finalize the transitioner's enrollment unless they have affirmatively informed the marketplace that they want the coverage.

The opt-out approach reduces the number of administrative actions people must make, which can boost enrollment and reduce the risk of unintended coverage loss, helping to overcome the disparities in uninsurance rates. At the same time, it holds the risk that some people will be enrolled in coverage they do not want or faced with an unexpected tax bill (because they are required to pay back advance premium tax credits, or APTCs, for which they are not eligible). Rhode Island chose an opt-out approach for its facilitated enrollment program.[25]

An opt-in approach, which California chose, helps protect against the risk of an unintended tax liability, but could result in more people having gaps in coverage or going uninsured because they did not have the information or support they needed to confirm their marketplace enrollment.

Both approaches involve trade-offs. Given this, states choosing the opt-in approach will need to ensure transitioners receive clear and consistent messaging about the value of remaining insured and the tax implications of receiving APTCs if they are not eligible or are eligible for less than they receive. If a state chooses an opt-out approach, it will be critical to craft notices and other communications that ensure enrollees contact the marketplace right away to disenroll if they have another form of insurance (such as Medicare or an employer-based plan) or if their circumstances have changed.

States should also consider collecting and analyzing data, including through surveys, to assess the effectiveness of their approach and the public's understanding of their options. States that choose the opt-in approach may want to assess who declines to enroll and why, and to analyze whether there are meaningful differences in the enrollment experience for certain underserved populations. Such information can help identify whether those populations need any additional or different supports. States that choose the opt-out approach may want to use data to determine whether transitioners are aware they have been enrolled in a plan and whether they adequately understand their right to opt out and how to do so, as well as the tax implications of remaining enrolled.

Choice of Default Plan

States implementing a facilitated enrollment program will need to decide what the default marketplace plan for people transitioning should be. Covered California chose the lowest-cost silver plan

as its default option. The decision was informed by data that showed that, before SB 260, 60% of Medi-Cal transitioners enrolled in a silver plan, with 60% of those enrolling in the lowest-cost silver plan option.[26] However, states could incorporate other considerations into their selection method, such as provider network overlap and quality ratings.

A default plan other than the lowest-priced option, such as a plan that has a similar provider network to the enrollee's prior Medicaid plan, would require the state Medicaid agency to be capable of timely sharing with the marketplace any relevant plan and network data. Further, research on plan preferences in California and other states finds that, for the vast majority of the public, premium affordability is the primary concern. If the default plan is something other than the lowest-priced option, many may opt out of coverage altogether due to cost. Indeed, even very modest premiums, as low as $1 per month, have been shown to cause people to forgo coverage.[27] At the same time, switching people to the lowest-cost plan available may result in disruptions to their access to services as they navigate different provider networks and benefit designs.

In Covered California's case, the decision to use the lowest-cost silver plan was a relatively easy one, as there was no existing system functionality to convey the transitioner's prior Medicaid plan. But even if a marketplace had access to those data, keeping transitioners in a marketplace plan offered by the same issuer as their Medicaid plan would not necessarily translate into network or coverage continuity. In many states, the Medicaid and marketplace plan networks are different even when offered by the same insurer.

Regardless of whether a state chooses the lowest-cost silver plan or the transitioner's prior Medicaid plan as their default option, it may want to consider complementary policies that will help ensure that anyone transitioning between Medicaid and the marketplace can continue to access services with minimal barriers. These include policies such as the following:

- **Ensuring provider access.** States could enact or amend existing continuity of care laws to require health plans ensure that transitioning enrollees with significant health care needs can maintain access to their treating providers and face only in-network cost sharing.[28]
- **Reducing paperwork barriers to care.** States could ensure that marketplace plans honor the decisions of an enrollee's prior Medicaid plan to approve coverage of services that require prior authorization or drugs that require step therapy.
- **Reducing cost-sharing barriers.** States could require marketplace plans to prorate deductibles and plan maximum out-of-pocket caps based on the enrollment month. With average annual deductibles for a marketplace silver plan over $5,000 in 2024, prorating deductibles can help lower financial barriers to care for former Medicaid enrollees who transition in the later months of the plan year.[29]

Implementation

As states build out the staffing and infrastructure necessary to stand up a facilitated enrollment program, they'll need to make multiple critical decisions relating to the user experience with the eligibility and enrollment system, public education and outreach, and coordination with key partners such as Medicaid and marketplace insurers. In its rollout, California officials flagged several important decision points.

Medicaid Procedural Disenrollments During Unwinding: Need for States to Prioritize Reenrollment of Eligible People

Evidence from the Medicaid unwinding experience demonstrates that large numbers of people were disenrolled from Medicaid not because they were determined to be ineligible but because of missing paperwork or other procedural reasons. To date, 69% of Medicaid disenrollments during unwinding were procedural terminations. In California, 83% of Medi-Cal enrollees were procedurally disenrolled.[30] These former enrollees, many of whom likely remain eligible for Medicaid, should not be directed to the marketplaces, but rather need to be the focus of a targeted outreach campaign and provided as simple and streamlined a process as possible to reenroll in Medicaid. Those seeking marketplace coverage should be appropriately screened and referred back to state Medicaid agencies for reenrollment.

User Awareness

The theory behind programs such as the one created by SB 260 is that minimizing a transitioner's obligation to interact with a complex and burdensome eligibility and enrollment system will increase the likelihood they will obtain new coverage without a gap. Even so, most informants expressed that these programs have an obligation to ensure that people engage enough with the system to fully understand (1) that they are being disenrolled from Medicaid coverage because they have been determined to be ineligible, (2) what their options are (i.e., keep the default plan, choose a different one, or not enroll at all), and (3) what steps they must take.

Aligning Program Enrollment Timelines

One issue California officials wrestled with, and never quite perfected, was timing, particularly the coordination of marketplace plan start dates with Medicaid rules. State officials wanted to ensure that people transitioning had sufficient time to exhaust any reconsideration of Medicaid eligibility and appeals processes but not so much time that they would experience an unwelcome gap in insurance coverage. Enrollees might face different scenarios depending on the date of the month they receive a notice of Medicaid discontinuance. "The timing dynamics are really complicated," state officials observed.

Marketplace officials building a facilitated enrollment program will need to fully understand how Medicaid eligibility determinations and renewals work. Similarly, state Medicaid officials will need to educate themselves about the eligibility and enrollment process on the marketplace side. Both coverage programs will also need to devote sufficient time and resources to properly train their frontline eligibility and call center workers on how the facilitated enrollment program will work and how to resolve the challenges transitioners could face.

Consumer Education and Outreach

Consumer education and outreach was a top priority for California's implementation of SB 260. State officials flagged several important tactics that helped build public awareness about the upcoming coverage transition. In particular, they noted it is important for outreach and education efforts to start early, before Medicaid coverage has been terminated. This is particularly important for those who may still be eligible for Medicaid and need to provide proof of eligibility to remain enrolled.

State officials also noted the importance of collaboration between Medicaid and the marketplace on outreach and marketing initiatives. For example, early in the implementation process, it will be critical to assess each entity's budget for, and strengths and weaknesses of, its outreach and marketing. In California, officials identified opportunities to supplement Medi-Cal's outreach and marketing and used the marketplace's marketing

resources to help fill gaps. This helped avoid duplication of effort and the inefficient deployment of marketing dollars.

Covered California's consumer research found that many Medicaid transitioners are unfamiliar with the marketplace. Placing the logos of both the state Medicaid agency and the marketplace on public notices can help to establish trust in the marketplace as a legitimate and viable coverage option. Further, state officials will need to coordinate within their own agencies, and across agencies, to ensure the language in those notices matches, or is at least consistent with, language on state websites, call center scripts, and communications from health plans and consumer assisters.

Another critical challenge for state officials will be crafting public communications that provide accurate, sufficient information, at a cadence that will prompt transitioners to take the desired actions, without being overwhelming. Achieving the optimal balance will benefit from market research (i.e., focus groups and interviews), message testing, and readability analyses both before and throughout the implementation process. Well after launching their facilitated enrollment program, California officials noted they continue to subject their direct marketing efforts to testing, analysis, and revisions to continually improve their impact. For example, data collected on Covered California's outbound call program found it to be quite successful, prompting them to make further investments to improve their collection of transitioners' contact information and expand their outbound call capabilities.

States will also need to ensure their messaging to transitioners is accessible to those with limited English proficiency and is tailored appropriately to the needs of different populations. In addition to providing translated materials informed by testing and access to real-time translators via call centers, states will also want to leverage their navigator and broker assisters. For example, California officials are relying heavily on brokers "deep into demographic communities, who do multi-lingual outreach," to guide people through the process. Navigators are being tapped to address "harder to serve" communities.

Coordination with Health Plan Partners

States will need to engage early and often with the health plans that will be providing coverage to Medicaid transitioners. This engagement includes efforts to ensure the seamless transfer of critical data, guidance on legal standards and requirements, coordination on messaging and public notices, and regular testing of IT systems.

Health plans that receive transitioners need to engage with them in different ways from a typical person who actively selects a plan. State officials need to ensure participating issuers receive consistent and clear information about legal restrictions or standards for sharing data about and communicating with people transitioning, before and after they have been enrolled in a plan. In California's case, marketplace officials worked closely with insurers to answer questions and provide technical assistance relating to data privacy and allowable forms of public communications. Officials also noted the importance of collaborating with insurers on language for the notices and messages they are sending to people transitioning. Last, both health plans and state officials emphasized the critical need to engage in "several rounds" of testing the electronic enrollment files (the 834 transactions) and IT required to support a smooth transition.

Building Equity into Data Collection and Reporting Efforts

States will need to collect, analyze, and publicly report data about the experiences of transitioners and their coverage status. For example, Covered California stratifies and reports data based on race, language, income, and other demographic

categories. Thinking about, and building the capabilities for, data collection and reporting that appropriately captures the experience of underserved populations such as people of color and those with limited English proficiency is best done well before launching a facilitated enrollment program. This includes identifying and prioritizing performance measures that center health equity, determining the measures to be publicly reported, and considering how best to contextualize the information for stakeholders and the public.[31]

Operations

California officials and stakeholders identified several key factors that contribute to the successful operation and maintenance of a facilitated enrollment program. In California's case, these include executive branch leadership, cross-agency coordination, and a "rapid response" infrastructure that can identify and respond to the inevitable system glitches or enrollee challenges that arise.

Cross-Agency Coordination and Executive Branch Leadership

A facilitated enrollment program requires extensive and ongoing coordination between a state's Medicaid agency and its marketplace. In California's case, Medi-Cal and Covered California had long experience working together to improve eligibility and enrollment processes, well before enactment of SB 260. In states without this history of collaboration, or without a clear infrastructure for cross-agency engagement, implementing a facilitated enrollment program will likely work best when senior levels of a state's executive branch, such as the governor or other key leadership, have bought into the initiative and are committed to its success.

States with an integrated Medicaid-marketplace eligibility and enrollment system will have an advantage implementing a facilitated enrollment program. For example, California has had a number of transitioners that returned to Medicaid. Officials noted that their ability to identify these transitioners and ensure they enrolled in the correct coverage program was helped by the officials' ability to access updated data from the Medi-Cal program. However, facilitated enrollment in a state without an integrated system is also feasible. California stakeholders noted that their consolidated eligibility and enrollment system is not fully integrated because there is also a separate county-based Medi-Cal case management system with limited data sharing capabilities. The investment of senior agency leadership in the state helped ensure the staff tasked with building and maintaining the necessary infrastructure for the program was also invested in its success.

A Rapid Response Team

California officials also emphasized the importance of maintaining a "rapid response" interagency group that holds regular meetings and has a clear process for tracking the program's progress, identifying glitches or problems, responding as needed, and implementing necessary fixes. "There are always surprises," said one official. "Not assuming that everything is going to be perfect from the first release is important."

Conclusion

The administrative burdens associated with applying for and enrolling in public coverage programs fall disproportionately on certain populations, such as people of color and those with limited English proficiency. States seeking to reduce uninsurance, improve health equity, and reduce disparities in health coverage and outcomes can do so by establishing a facilitated enrollment program. Such programs cannot remove all the frictions people experience navigating from one coverage program to another. In particular, the temporary expansion of marketplace premium subsidies that made possible zero-dollar premiums for marketplace enrollees with the lowest income helped alleviate a significant barrier.[32]

Beyond affordability barriers, Covered California's early experience with facilitated enrollment suggests that a combination of committed leadership, cross-agency coordination, and investment in enrollee education and assistance can go a long way toward simplifying the process of applying for and enrolling in public coverage. The state's continued efforts to collect and assess data will be important in understanding how policy decisions and implementation have impacted the effectiveness of the program in helping Californians avoid gaps in coverage.

Endnotes

1. Administrative burdens imposed by often complex eligibility and enrollment rules and processes are a significant barrier to take-up of public programs, including Medicaid. These burdens are experienced disproportionately by members of historically underserved populations, exacerbating inequity. See, e.g., Pamela Herd and Donald Moynihan, "**How Administrative Burdens Can Harm Health**," *Health Affairs*, October 2, 2020; Suzanne Wikle et al., "**States Can Reduce Medicaid's Administrative Burdens to Advance Health and Racial Equity**," Center on Budget and Policy Priorities, July 19, 2022; and ***Study to Identify Methods to Assess Equity: Report to the President*** (PDF), Office of Management and Budget, July 2021.
2. Benjamin D. Sommers et al., "**Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many**," *Health Affairs* 35, no. 10 (Oct. 2016), 1816–24.
3. See, e.g., Sara R. Collins, Shreya Roy, and Relebohile Masitha, "**Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer — Findings from the Commonwealth Fund 2023 Health Care Affordability Survey**," Commonwealth Fund, October 26, 2023; and Ritesh Banerjee, Jeanette Y. Ziegenfuss, and Nilay D. Shah, "**Impact of Discontinuity in Health Insurance on Resource Utilization**," *BMC Health Services Research* 10, art. 195 (July 2010).
4. Salam Abdus, "**Part-Year Coverage and Access to Care for Nonelderly Adults**," *Medical Care* 52, no. 8 (Aug. 2014): 709–14.
5. See, e.g., Julia Foutz et al., ***The Uninsured: A Primer — Key Facts About Health Insurance and the Uninsured Under the Affordable Care Act*** (PDF), KFF, December 2017.
6. ***Medi-Cal Transitioner Profiles: 2024 March Profile***, Covered California, April 16, 2024.
7. Miranda Dietz et al., ***California's Biggest Coverage Expansion Since the ACA: Extending Medi-Cal to All Low-Income Adults***, UC Berkeley Labor Center, April 14, 2022. Medi-Cal covers adults with incomes up to 138% of the federal poverty level, with other categories of people with low incomes covered at higher incomes (like children and people who are pregnant) and some at the same level (like seniors and people with disabilities). Over time, California gradually has expanded access to full-scope Medi-Cal benefits to residents regardless of immigration status. Using state funds only, the state extended eligibility first to undocumented children under age 19 (2016); then young adults under age 26 (2020), low-income adults age 50 and over (2022), and low-income adults age 26 to 49 (2024).
8. **California Welf. & Inst. § 14005.37**. Although children now receive 12 months of continuous eligibility, for other eligibility groups, a county will redetermine eligibility sooner if enrollees report a change in circumstances that may affect Medi-Cal eligibility or if, for example, enrollees can be renewed based on a successful renewal (that involved updated income information) for another public program.
9. California Welf. & Inst. § 14005.37.
10. "**Plan Management Advisory Group**" (PDF) (Covered California webinar, Mar. 2, 2023).
11. Internal data from Covered California, on file with the authors.
12. Teri Boughton, "**SB 260**," Senate Rules Committee, Office of Senate Floor Analyses, September 10, 2019.
13. For more information on Affordable Care Act marketplaces, see Congressional Research Service, ***Overview of Health Insurance Exchanges*** (PDF), last updated March 17, 2023.
14. **SB 260** (Cal. 2019). The enacted legislation contains additional provisions that require insurers to provide notice to enrollees in specified circumstances regarding Medicare and marketplace coverage and to share specified enrollee information with Covered California if the enrollee's existing coverage terminates (subject to the enrollee's right to opt out of this information transfer). These provisions are not addressed in this brief.
15. **Families First Coronavirus Response Act** (PDF), Pub. L. No. 116-127, § 6008, 134 Stat. 208 (2020).
16. **Consolidated Appropriations Act, 2023** (PDF), Pub. L. No. 117-328, § 5131, 136 Stat. 5949 (2022).
17. **American Rescue Plan Act of 2021** (PDF), Pub. L. No. 117-2, § 9661, 135 Stat. 182 (2021).
18. California Government Code § 100503.5. See Rachel Schwab, Justin Giovannelli, and Kevin Lucia, "**California's Marketplace Tries New Tactics to Reduce the Number of Uninsured and Underinsured**," *To the Point* (blog), Commonwealth Fund, March 31, 2022.
19. "**Medi-Cal to Covered California Enrollment Program (Senate Bill 260) Frequently Asked Questions**" (PDF), Covered California, February 22, 2024. If a dependent is determined ineligible for Medi-Cal and determined to be eligible for Covered California and there is only one existing family enrollment, the dependent will be added to the existing Covered California plan.
20. *March 2024 Medi-Cal Transitioner Profile*.
21. *March 2024 Profile*, Covered California.
22. *March 2024 Profile*, Covered California.

23. California requires most marketplace plans to offer continuity of care protections to enrollees with specified health conditions who have involuntarily lost Medicaid. See Sabrina Corlette and Maanasa Kona, "**The State of State Protections: Maintaining Access to Services After Transitioning from Medicaid**," *To the Point* (blog), Commonwealth Fund, February 6, 2023.

24. Jason Levitis and Claire O'Brien, "**State Facilitated Enrollment Resources**," State Health and Value Strategies, December 12, 2023.

25. Rachel Swindle and Sabrina Corlette, "**What States Are Doing to Keep People Covered as Medicaid Continuous Enrollment Unwinds**," *To the Point* (blog), Commonwealth Fund, December 6, 2023.

26. See "Plan Management Advisory Group," Covered California.

27. See, e.g., Keith Marzilli Ericson et al., ***Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment***, Natl. Bureau of Economic Research, January 2023; Adrianna McIntyre, Mark Shepard, and Myles Wagner, "**Can Automatic Retention Improve Health Insurance Market Outcomes?**," *AEA Papers and Proceedings* 111 (May 2021): 560–66; Adrianna McIntyre, Mark Shepard, and Timothy J. Layton, "**Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016–17**," *Health Affairs* 43, vol. 1 (Jan. 2024): 80–90.

28. Most states do not currently provide enrollees with continuity of care protections when they must leave one plan and enroll in another. Recent research found that only 12 states and the District of Columbia extend their continuity of care laws to people transitioning from Medicaid to a commercial market plan, and then only for certain high-need patients. See Corlette and Kona, "The State of State Protections."

29. "**Deductibles in ACA Marketplace Plans, 2014-2024**," KFF, December 22, 2023.

30. "**What Is Happening with Medicaid Renewals in Each State?**," Georgetown Univ., accessed May 29, 2024.

31. Elizabeth Lukanen and Emily Zylla, "**Best Practices for Publicly Reporting State Unwinding Data**," State Health and Value Strategies, June 30, 2023.

32. People may be eligible for tax credits to lower their premiums for marketplace plans, depending on household income and the availability of other coverage. Congress increased the value of the premium tax credits with passage of the American Rescue Plan Act in March 2021, and extended the enhanced subsidies with enactment of the Inflation Reduction Act of 2022. The enhanced subsidies are set to expire at the end of 2025. For more information on the enhanced subsidies, see Jessica Banthin et al., ***Who Benefits from Enhanced Premium Tax Credits in the Marketplace?***, Urban Institute, June 17, 2024.