



January 7, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary
Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Re: Request for Comment on the Georgia Access Model

Dear Secretaries Becerra and Yellen:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on HHS' review of Part II of the Georgia waiver, as approved on November 1, 2020. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

ACS CAN supports a robust marketplace from which consumers can choose a health plan that best meets their needs. Access to health care coverage is paramount for persons with cancer and survivors. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.¹ In the United States, more than 1.9 million Americans will be diagnosed with cancer this year, including an estimated 58,060 in Georgia.² An additional 16.9 million Americans are living with a history of cancer.³ For these Americans access to affordable health insurance is a matter of life or death.

For the reasons set forth below, ACS CAN urges the Departments not to adopt the Georgia Access Model waiver.

¹ E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes, *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), <http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care>.

² American Cancer Society. *Cancer Facts & Figures: 2021*. Atlanta: American Cancer Society, 2021.

³ American Cancer Society. *Cancer Treatment & Survivorship: Facts & Figures 2019-2021*. Atlanta: American Cancer Society, 2019.



Georgia Access Model

In its waiver, Georgia proposes to eliminate healthcare.gov as an enrollment platform for Georgians and transition to an entirely new model, the Georgia Access Model, under which the private sector would provide front-end consumer shopping experiences and operations with the State validating whether an individual is eligible for subsidies and providing those subsidies to plans. Georgia would be responsible for ongoing program management and compliance of participating entities. The State believes this will help to promote competition and improve customer service. We have very serious concerns that this proposal would actually create greater confusion for consumers and potentially lead them to choose insurance plans that result in inadequate coverage were they to face a serious illness such as cancer. The Departments should not adopt the Georgia Access Model waiver for the following reasons:

Georgia Access Model fails to comply with existing statutory guardrails and Executive Orders:

On January 29, 2021, President Biden issued Executive Order 14009,⁴ which among other things required HHS to re-examine demonstrations and waivers to determine whether they may reduce coverage under the ACA or Medicaid. Subsequently HHS and IRS revised its policy imposing guardrails for the approval of 1332 waivers, requiring that states must demonstrate their waivers meet the following requirements: (1) comprehensive coverage (that the waiver will provide coverage that is at least as comprehensive as coverage offered on the exchanges), (2) affordability (the waiver will provide cost-sharing protections at least as affordable as is offered under Title I of the ACA), (3) scope of coverage (that the waiver will provide coverage to at least a comparable number of residents as would be provided under the ACA), and (4) the federal deficit requirement (that the waiver will not increase the Federal deficit).⁵

As noted in our comments to HHS and the Department of the Treasury on September 16, 2020,⁶ we believe the Georgia Access model would promote access to non-qualified health plans (thus violating the comprehensive coverage) and would suppress Medicaid enrollment (thus violating the scope of coverage requirement).

⁴ Executive Order 14009. 86 Fed. Reg. 7793 (Feb. 2, 2021).

⁵ Department of the Treasury and Department of Health and Human Services. Patient Protection and Affordable Care Act; updating payment parameters, section 1332 waiver implementing regulations, and improving health insurance markets for 2022 and beyond. Final Rule. Sept. 17, 2021, codifying 31 CFR § 33.109(f)(3)(iv)(A)-(C) and 45 CFR § 155.1308(f)(3)(iv)(A)-(C).

⁶ ACS CAN Comments to Secretary Azar and Secretary Mnuchin regarding Georgia 1332 Waiver Application. Sept. 16, 2020. Available at

https://www.fightcancer.org/sites/default/files/ACS%20CAN%20Comments%20to%20CMS%20on%20GA%201332%20waiver%2009162020_0.pdf.

Georgia Access Model would disadvantage individuals with high health care needs: The Georgia access model would allow private web-brokers to enroll consumers in a wide variety of health insurance products offered by carriers “that are licensed and in good standing with the State” – including non-Qualified Health Plans (QHPs) such as accident supplemental plans, critical illness plans, limited-benefit plans, short-term limited-duration plans, vision and dental.

For patients with cancer and cancer survivors, it is crucial to choose a health insurance plan that provides coverage for their unique needs. Cancer patients and survivors must pay particular attention to whether a plan covers the medications they need, whether their (often multiple) physicians are in-network, whether their treatment center is in-network, and the cost-sharing that will be required of them. We are concerned that allowing and encouraging access to non-QHP coverage, would result in individuals with high health care needs ending up with inadequate coverage. Further, if older and sicker individuals – who are less likely to meet the medical underwriting requirements of non-QHPs – enroll in QHPs it would result in a less healthy risk pool for QHP coverage and lead to higher premiums.

Georgia Access Model fails to meet the scope of coverage test: The Georgia Access Model would rely solely on private web-brokers. In its waiver application, the state claimed that this would increase enrollment. However, private web brokers are already permitted to sell ACA-compliant coverage in Georgia, the only change provided under the waiver would be to eliminate healthcare.gov as a viable platform for Georgians searching for health insurance. According to the waiver, in 2019, 79 percent of enrollees in Georgia's marketplace used healthcare.gov and only 21 percent were enrolled via direct enrollment or enhanced enrollment (e.g., web brokers). Thus, we fail to see how the waiver will result in enrollment growth. Eliminating healthcare.gov without creating a state-based exchange and relying only on private web brokers, increases the likelihood that healthy consumers could be steered towards non-ACA compliant plans (like short term plans) because they would meet the medical underwriting requirements associated with these plans. Older and sicker individuals – who are less likely to meet the medical underwriting requirements – would enroll in QHPs, thus resulting in a less healthy risk pool for QHP coverage which would lead to higher premiums.

Conclusion

On behalf of the American Cancer Society Cancer Action Network, we thank you for the opportunity to comment on the proposed section 1332 waiver. We have serious concerns with Part II of the Georgia Access Model and would encourage CMS to disallow this waiver to move forward. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org.

Sincerely,

A handwritten signature in black ink that reads "Lisa A. Lacasse". The signature is written in a cursive, flowing style.

Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

December 21, 2021

The Honorable Xavier Becerra
Secretary, Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20201

Janet Yellen
Secretary, Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

RE: Georgia 1332 Waiver Proposal

Dear Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure:

The American College of Obstetricians and Gynecologists (ACOG) represents more than 62,000 obstetrician-gynecologists and partners in women's health nationwide, including more than 1,200 practicing obstetrician-gynecologists in its Georgia Section. ACOG welcomes the opportunity to comment on Georgia's Section 1332 waiver proposal. As physicians dedicated to providing quality care to women, we have concerns with the state's proposal, including the elimination of the federal marketplace (HealthCare.gov) for the roughly 500,000 Georgians who enroll in private health plans or Medicaid through the federal portal. We urge the Centers for Medicare and Medicaid Services (CMS) to deny this waiver.

Georgia's Proposal Will Increase the Number of Uninsured Residents in the State

Georgia's proposal to waive certain Affordable Care Act (ACA) requirements under Section 1332 waiver authority would change where and how consumers purchase health coverage. In 2020, the vast majority (79 percent) of Georgia marketplace enrollees used HealthCare.gov to sign up for coverage, even though they already had the option to use a private broker or insurer website.¹ Georgia's waiver would eliminate the one-stop shop of HealthCare.gov and require Georgians to use private insurance companies and brokers to compare plans, apply for financial assistance, and enroll in coverage. In its application, Georgia frames its waiver proposal as a solution to the state's burgeoning uninsured rate. Conversely, this waiver proposes a fragmented system that could cause tens of thousands of Georgians

to fall through the cracks and lose coverage.ⁱⁱ If implemented, the waiver will create more barriers for a large number of Georgians to access appropriate and affordable health care.

Moreover, private brokers and insurers who operate through HealthCare.gov inconsistently alerted consumers of their potential Medicaid eligibility and have limited the plans they offer.ⁱⁱⁱ In 2020, the US Government Accountability Office (GAO) conducted a study and found that many health insurance sales representatives used potentially deceptive marketing practices with consumers seeking coverage.^{iv} Indeed, in the system Georgia is proposing, people who are eligible for Medicaid may be subject to a similar scenario found in the GAO report. The solution is continued use of HealthCare.gov.

Additionally, there are many aspects of navigation that Healthcare.gov provides, including assisting consumers with collecting the appropriate tax documents and providing consistent outreach to ensure that eligible consumers maintain enrollment. A comprehensive analysis estimate that the reality of the Georgia waiver would be a decrease in 50,000 Marketplace consumers and 10,000 Medicaid enrollees.^v

Georgia’s Proposal Will Limit Access to Essential Benefits Including Maternity Care

Georgia’s waiver proposes that substandard plans, such as short-term, limited-duration insurance (STLDI) plans, would be presented alongside comprehensive insurance. Presenting these plans in tandem with ACA-compliant coverage has the potential to increase the number of underinsured patients. ACOG opposes STLDI and other forms of substandard coverage.^{vi} STLDI plans do not have to comply with federal rules regarding coverage. As we know from before the enactment of the ACA, when only one in four health plans in the individual market provided coverage for maternity care, these benefits are particularly vulnerable to cuts.^{vii} Further, roughly half of all pregnancies in the United States are unplanned, so many women may need this coverage when they least expect it.^{viii}

A study of STLDI plans sold in Atlanta earlier this year showed that even though people would pay lower premiums up-front, they could be responsible for out-of-pocket costs several times higher for common or serious conditions, such as diabetes or a heart attack. The most popular plan in Atlanta did not cover maternity services, prescription drugs, or mental health services. In addition, this plan had pre-existing condition exclusions and had a deductible three-times as high as an ACA-compliant plan.^{ix} For these reasons, CMS should not approve Georgia’s waiver proposal that will inevitably increase enrollment in these substandard coverage options.

Georgia’s Proposal Violates Statutory Requirements of Section 1332 Waivers, Recent Legislation and Executive Orders

Because it would likely increase the number of uninsured Georgians and leave many others with worse coverage, Georgia’s 1332 waiver fails to meet the statutory “guardrails” intended to ensure that people who live in states that implement a 1332 waiver are not worse off than they would be without the waiver. Section 1332(b)(1) of the ACA requires that these waivers cover as many people, with coverage as affordable and comprehensive, as without the waiver. However, under the proposed waiver, the coverage that many Georgians would have would be less comprehensive, and more people would find themselves with less affordable coverage and more out-of-pocket costs than would be the case without the waiver. The waiver, therefore, does not meet these statutory “guardrails” under federal law and should not be approved.

Since Georgia's latest waiver proposal in July 2020, several federal policies have taken effect which the proposal does not align with, including Executive Order 14009 and the American Rescue Plan Act. The American Rescue Plan Act enhanced federal subsidies and altered qualifying eligibility, creating significant increases in health care enrollment. The Biden Administration then issued Executive Order 14009, which requires all federal agencies to review policies related to Medicaid in order to protect and strengthen the Affordable Care Act's provisions.^x Despite several requests from CMS for updated analyses about how these new policies would impact Georgia's proposal, the state did not comply. This inaction further supports ACOG's recommendation that CMS should not approve Georgia's 1332 waiver.

Thank you for the opportunity to provide comments on Georgia's waiver proposal. We hope you have found our comments useful. If you have any questions, please reach out to Rachel Thornton, Policy Associate, at rthornton@acog.org.

Sincerely,



Lisa Satterfield, MS, MPH, CAE, CPH
Senior Director, Health Economics & Practice Management

ⁱ Tara Straw, "Tens of Thousands Could Lose Coverage Under Georgia's 1332 Proposal," Center on Budget and Policy Priorities, September 1, 2020. <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>

ⁱⁱ Ibid.

ⁱⁱⁱ Tara Straw, "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm," Center on Budget and Policy Priorities, March 15, 2019, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>

^{iv} U.S. General Accountability Office. "Private Health Coverage: Results of Covert Testing for Selected Offerings Results of Covert Testing for Selected Offerings." August 2020. [Private Health Coverage: Results of Covert Testing for Selected Offerings | U.S. GAO](https://www.gao.gov/products/GAO-20-477)

^v Christen Linke Young and Jason Levitis, "REPORT: Georgia's latest 1332 proposal continues to violate the ACA", The Brookings Institution. September 2020. Available at: [Georgia's latest 1332 proposal continues to violate the ACA \(brookings.edu\)](https://www.brookings.edu/research/2020/09/01/georgia-1332-proposal-aca/)

^{vi} American College of Obstetricians and Gynecologists comments on CMS-9924-P: Short-Term, Limited-Duration Insurance. Submitted April 23, 2018. Available at: <https://www.regulations.gov/document?D=CMS-2018-0015-8434>

^{vii} Kaiser Family Foundation. Would state eliminate key benefits if AHCA waivers are enacted? June 2017. Available at: <http://files.kff.org/attachment/Issue-Brief-Would-States-Eliminate-Key-Benefits-if-AHCA-Waivers-are-Enacted>

^{viii} Guttmacher Institute, "Unintended Pregnancy in the United States". January 2019. Available at: [Unintended Pregnancy in the United States | Guttmacher Institute](https://www.guttmacher.org/unintended-pregnancy-in-the-united-states)

^{ix} Dane Hansen and Gabriela Dieguez, “The impact of short-term limited-duration policy expansion on patients and the ACA individual market,” Milliman, February 2020,

<https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>; Kelsey Waddill, “Do Short-Term Limited Duration Plans Deserve Industry Skepticism?,” HealthPayerIntelligence, March 4, 2020, <https://healthpayerintelligence.com/news/do-short-term-limited-duration-plans-deserve-industry-skepticism>.

^x Executive Order 14009 of January 28, 2021: Strengthening Medicaid and the Affordable Care Act. [2021-02252.pdf \(govinfo.gov\)](https://www.govinfo.gov/justices/eo/2021-02252.pdf)

Submitted via stateinnovationwaivers@cms.hhs.gov

Thank you for the opportunity to comment on Georgia's proposal to waive federal rules under the Affordable Care Act (ACA). I am sharing comments on behalf of the American College of Physicians Georgia Chapter to express our organization's concern about Georgia's ACA Section 1332 waiver.

The American College of Physicians is the largest medical specialty organization and the second-largest physician membership society in the United States. ACP members include 155,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The Georgia Chapter of the American College of Physicians, represents over 3700 Internal Medicine physicians and medical students across the state of Georgia.

Georgia Access Model

The Georgia Chapter of the American College of Physicians is supportive of the proposed reinsurance program. Like those approved in other states, the reinsurance portion of Georgia's proposal would reduce premiums and provide market stability. It would be a positive move forward for Georgia consumers.

However, the chapter is concerned that other aspects of the proposal could harm our patients. Instead of giving consumers more choices to enroll in comprehensive health coverage as Georgia officials claim, the Georgia Access model would eliminate consumers' option to use the one-stop-shop HealthCare.gov platform. This is likely to sharply reduce the number of Georgians with comprehensive coverage, for several reasons:

Georgians will lose coverage in the transition from HealthCare.gov to the Georgia Access system

The disruption created by the state's transition away from HealthCare.gov is likely to cause a decline in enrolment among Georgia consumers. Our state's waiver predicts a loss of about 2 percent (8,000 people) of enrollees due to the change from one system to another. However other states' experiences show this figure is unrealistic.^[1] Kentucky saw a reduction of 13 percent in its marketplace enrollment when it transitioned to the federal marketplace in 2017, compared to a 4 percent decline nationally.^[2] More recently, Nevada's 2020 marketplace enrollment dropped 7 percent after its transition to a state-based marketplace, compared to flat enrollment nationally.^[3] Similar percentage declines in Georgia

^[1] Waiver, *op. cit.*, p. 71.

^[2] Sarah Lueck, "Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges," CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

^[3] CBPP calculations from CMS public use files. See also, Nevada Health Link, "Nevada's State Based Exchange Announces Enrollment Figures for Plan Year 2020," December 23, 2019, https://d1q4hslcl8rmbx.cloudfront.net/assets/uploads/2019/12/FINAL-2020-Nevada-Exchange-Prelim-Enrollment-Release_12.23.19.pdf; Sarah Lueck, "Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges," CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

would translate into a drop of 25,000-46,000 people in marketplace enrollment.^[4] Enrollment declines of this scope would likely exceed the increases anticipated by the waiver (27,000).

Enrollment declines are especially likely given that minimal funding has been allocated for the transition — about one-third of the low amount Georgia previously estimated would be needed. This funding seems to be solely dedicated to the technological transition, but no specific funds have been allocated to help consumers understand the transition, their options for enrollment, or how to access free, unbiased enrollment assistance.

The enrollment of patients in substandard plans would threaten their health and economic well-being.

Experience with enhanced direct enrollment programs shows that some brokers and agents screen applicants before sending them down the official enrollment pathway and divert some toward substandard plans that pay higher commissions but leave enrollees with existing health needs, like (insert diagnosis, ex: diabetes or mental health conditions), exposed to catastrophic costs.^[5] Even in less egregious circumstances, these companies are allowed to show substandard plans alongside comprehensive plans, thus encouraging Georgia consumers to enroll in substandard plans.

Substandard plans are not required to cover all essential health benefits, leaving (our population) potentially without access to necessary health services unless they are able to pay out of pocket. For example, more than one-third of substandard plans do not cover [most do prescription drug benefits](#).^[6] Prescription medication coverage is most important for treatment of chronic disease patients. On top of that, substandard plans are allowed to exclude coverage for pre-existing conditions altogether and charge more for people with pre-existing conditions like diabetes. That leaves patients in Georgia vulnerable to catastrophic costs, limited access to care, and other negative consequences.

Georgia's waiver fails the ACA's tests of coverage, comprehensiveness, and affordability. There is a high chance that the waiver would cause thousands of Georgians to lose coverage and no reason to expect it would meaningfully increase coverage. It also would likely leave many Georgians with less affordable or less comprehensive coverage than they would otherwise have. Given that the Georgia 1332 waiver has the potential to harm Georgia citizens, and it is understood that the Georgia's proposal is not approvable under federal law.

Thank you in advance for your consideration of our comments on Georgia's Section 1332 waiver application. We appreciate your review of this important issue to assure affordable health care coverage providing essential health benefits to provide a pathway forward to assure good health for the citizens of Georgia.

^[4] As this calculation indicates, enrollment declines due to the Georgia Access Model would likely exceed the modest increases (about 2,000 people) Georgia projects from the reinsurance program and the total increase Georgia projects under the waiver (27,000).

^[5] Tara Straw, "'Direct Enrollment' in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm," CBPP, March 15, 2019, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

^[6] Kaiser Family Foundation, <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>

Sincerely,

A handwritten signature in black ink, reading "G. Waldon Garriss, III, MD, MS, FAAP, MACP". The signature is written in a cursive style with a large, stylized initial "G".

G. Waldon Garriss, III, MD, MS, FAAP, MACP

Governor, Georgia Chapter of the American College of Physicians

mdaniels@gaacp.org



January 7, 2022

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Comment on the Georgia Access Model

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to submit comments on the Georgia Access Model.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting state health insurance marketplaces

and the patients that they serve. We urge the Department of the Treasury and the Department of Health and Human Services (Departments) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that any changes to the healthcare system achieve coverage that is adequate, affordable and accessible for patients.¹ A strong, robust marketplace is essential for people with serious, acute and chronic health conditions to access comprehensive coverage at an affordable cost. Yet the Georgia Access Model would take this away. The state's plan would prohibit Georgians from choosing to enroll in coverage through Healthcare.gov and dictate instead that they use an insurer or broker. These options are already widely available to Georgians, who are free to choose them absent a waiver. The state's harmful decision to bar enrollment through Healthcare.gov was flawed to begin with, and its justifications have since been nullified by federal law and policy changes. Our organizations strongly urge the Departments to revoke the Georgia Access Model portion of the state's 1332 waiver.

Initial Approval of the Georgia Access Model Was Unlawful

Our organizations wrote in opposition to the version of the Georgia Access Model that was made available for federal public comment in August and September 2020. We noted that the state's plan would reduce enrollment in comprehensive coverage and jeopardize access to quality and affordable care for patients with preexisting conditions, in violation of the statutory waiver guardrails.² The Departments did not approve this plan. Rather, they approved a materially different version of the Georgia Access Model, one that was withheld from public view until the date the administration signed off on it.³ Once we, and the rest of the public, had the opportunity to review the previously undisclosed submission — again, only after a final decision had already been rendered — it was apparent that the state had not fixed the problems found in its earlier applications and that the approval was unlawful.

Federal Law and Policy Have Changed and the Georgia Access Model Does Not Comply with Statutory Protections

Assuming it was proper for the Departments to approve the Georgia Access Model in November 2020, based on the then-current federal coverage framework, subsequent events, including enactment of the American Rescue Plan Act, the COVID-19 Special Enrollment Period (SEP), and new federal investments in outreach and enrollment activities, require that the waiver's compliance with federal law be reassessed. These intervening changes materially affect and render unreliable the analyses on which the November 2020 approval was based. In light of these developments, our organizations understand there is a legal obligation to reexamine the state's waiver.⁴ We appreciate that the Departments are doing so

¹ Statement from the American Lung Association and Health Partners, "Consensus Health Reform Principles." September 20, 2021. Available at: <https://www.lung.org/getmedia/24309f63-74e9-4670-8014-d59f21104cfd/092021-ppc-healthcare-principles-42-logos-final.pdf>.

² Letter from the American Lung Association and Health Partners to Secretary Azar and Secretary Mnuchin re: Georgia 1332 Waiver Application. September 18, 2020. Available at: [https://www.lung.org/getmedia/d9b71de1-aa93-4a65-80b7-17ed3b17c001/health-partner-access-2-0-comments-\(final\).pdf](https://www.lung.org/getmedia/d9b71de1-aa93-4a65-80b7-17ed3b17c001/health-partner-access-2-0-comments-(final).pdf)

³ State of Georgia, Office of the Governor. *Georgia Section 1332 State Empowerment and Relief Waiver Application*. July 31, 2020. Available at: <https://medicaid.georgia.gov/document/document/modified-1332-waiver/download>

⁴ Tara Straw and Jason Levitis. "Georgia's Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked." Center on Budget and Policy Priorities. December 17, 2021. Available at: <https://www.cbpp.org/research/health/georgias-plan-to-exit-marketplace-will-leave-more-people-uninsured-should-be>

and that they have recognized the need for public comment as part of that process. In the comments that follow, we respectfully observe that the Georgia Access Model does not and cannot comply with federal law as it now stands and urge that it be revoked.

Impact on Coverage

Our previous comments noted numerous methodological problems with Georgia's assertion that its waiver would increase coverage, including that the state underestimated the number of individuals (8,000 people or 2% of current enrollees) who would lose coverage during the transition from Healthcare.gov. Since that time, federal policies have expanded and will likely continue to expand the number of people with coverage through Georgia's marketplace. The American Rescue Plan Act significantly expanded financial assistance for marketplace coverage. The combination of the increased subsidies and the opening of a lengthy special enrollment opportunity in response to the ongoing pandemic produced nearly 150,000 new plan selections in Georgia between February 15 and August 15 of this year.⁵ These gains, which are not reflected in Georgia's now outdated analysis, are likely to grow in the near term during an open enrollment period where more than 650,000 people have already selected a plan as of December 15 and that lasts 30 days longer than what was contemplated in the fall of 2020.⁶ What's more, this increased enrollment can be expected to be durable, even if the enhanced subsidies expire.⁷ What the enrollment boost is unlikely to withstand, however, is the implementation of the Georgia Access Model, which would abruptly fragment the market and deprive Georgians of their most commonly used pathway to individual coverage. Forced adoption of the state's plan imperils continuous coverage for the increasing number of Georgians who rely on Healthcare.gov and makes it highly likely that some of the people who purchased comprehensive marketplace coverage, including many of those who newly did so, will lose it. Coverage losses associated with the transition are thus likely to far exceed what could have been expected in November 2020 and must be newly assessed.⁸

Additionally, when the Departments originally considered Georgia's 1332 waiver, federal investments in outreach and enrollment activities were significantly lower than they are today. For example, funding for the Navigator program has increased from \$10 million when Georgia's waiver was approved to \$80 million for plan year 2022, including more than \$2.5 million for Navigator organizations in Georgia alone.⁹ This increase is in addition to significant investments in outreach and enrollment funding the

⁵ U.S. Department of Health and Human Services. *2021 Final Marketplace Special Enrollment Period Report*. 2021. Available at: <https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf>

⁶ U.S. Centers for Medicare and Medicaid Services. "Marketplace Weekly Enrollment Snapshot: Week 6." December 22, 2021. Available at: <https://www.cms.gov/newsroom/fact-sheets/marketplace-weekly-enrollment-snapshot-week-6>

⁷ Congressional Budget Office. "Reconciliation Recommendations of the House Committee on Ways and Means." February 15, 2021. Available at: <https://www.cbo.gov/publication/57005>

⁸ Tara Straw and Jason Levitis. "Georgia's Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked." Center on Budget and Policy Priorities. December 17, 2021. Available at: <https://www.cbpp.org/research/health/georgias-plan-to-exit-marketplace-will-leave-more-people-uninsured-should-be>

⁹ U.S. Department of Health and Human Services. "Biden-Harris Administration Quadruples the Number of Health Care Navigators Ahead of HealthCare.gov Open Enrollment Period." August 27, 2021. Available at: <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

Administration made during the COVID-19 SEP.¹⁰ In its waiver application, Georgia claimed that the Georgia Access Model would increase enrollment in part due to increased web-broker marketing. Yet the substantial federal investment in outreach and enrollment activities and the availability of much more generous and more broadly available federal subsidies, create a market dynamic that is entirely different than the one contemplated in the state’s application. Accordingly, Georgia’s whole theory of change — how the waiver should influence stakeholders, how that might affect coverage take-up — is no longer credible.

As the state’s projections are reconsidered in light of actual events, it is important to recognize that marketing by insurers and brokers occurs for different reasons and produces different outcomes than what we observe from publicly funded outreach and enrollment activities. Research has shown that while private marketing increases an individual insurer’s share of enrollment, it does not increase overall enrollment as government advertising does.¹¹ This strongly suggests that the promise of insurer and broker advertising relied upon by the Georgia Access Model will be insufficient to compensate for the newly expansive federally funded outreach and enrollment activities they are expected to displace.

Finally, many of the new federal investments in outreach and enrollment activities have a special focus on improving access to coverage in underserved communities. For example, the 2021 Navigator awards “focus on outreach to people who identify as racial and ethnic minorities, people in rural communities, the LGBTQ+ community, American Indians and Alaska Natives, refugee and immigrant communities, low-income families, pregnant women and new mothers, people with transportation or language barriers or lacking internet access, veterans, and small business owners.”¹² Our organizations strongly support additional outreach and enrollment investments in these communities to address longstanding disparities in coverage. Thirty million U.S. residents lacked health insurance in 2020, with most non-white groups more likely to be uninsured than whites.¹³ Of the 10.9 million people currently eligible for ACA marketplace coverage subsidies but unenrolled, 30 percent are Hispanic, 59 percent have a high school diploma or less, 42 percent are young adults, 16 percent live in rural areas, and 11 percent do not have internet access at home.¹⁴ The federal government’s new emphasis on reaching historically underserved populations is likely to be materially undermined in Georgia if the state relies solely on private entities to provide outreach and enrollment activities.¹⁵

¹⁰ U.S. Centers for Medicare and Medicaid Services. “2021 Special Enrollment Period in response to the COVID-19 Emergency.” January 28, 2021. Available at: <https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency>

¹¹ Naoki Aizawa and You Suk Kim. “Public and Private Provision of Information in Market-Based Public Programs: Evidence from Advertising in Health Insurance Marketplaces.” National Bureau of Economic Research. August 2020. Available at: <https://www.nber.org/papers/w27695>

¹² U.S. Department of Health and Human Services. “Biden-Harris Administration Quadruples the Number of Health Care Navigators Ahead of HealthCare.gov Open Enrollment Period.” August 27, 2021. Available at: <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

¹³ Kenneth Finegold et al., [Trends in the U.S. Uninsured Population, 2010-2020](#), U.S. Department of Health & Human Services’ Office of the Assistant Secretary for Planning & Evaluation (ASPE), Feb. 11, 2021.

¹⁴ Daniel McDermott and Cynthia Cox, [A Closer Look at the Uninsured Marketplace Eligible Population Following the American Rescue Plan Act](#), KFF, May 27, 2021.

¹⁵ Karen Pollitz, Jennifer Tolbert, and Kendall Orgera. “Navigator Funding Restored in Federal Marketplace States for 2022,” KFF, September 29, 2021. Available at: <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>;
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3966511.

Impact on Comprehensiveness

Today, patients who shop on Healthcare.gov can trust that they are purchasing a health insurance plan that will allow them to manage their health conditions. However, under the Georgia Access Model, issuers and brokers could sell qualified health plans alongside other types of plans that discriminate against people with pre-existing conditions and will not cover enrollees' medical expenses if they get sick.

Since the approval of Georgia's waiver, evidence of misleading marketing related to short-term and other "skippy" plans has mounted. This marketing can lead individuals to unwittingly enroll in coverage that lacks key patient protections. For example, a secret shopper study conducted by Georgetown University during the COVID-19 SEP found that just 5 of 20 sales representatives recommended a marketplace plan even when their client would have qualified for a \$0 premium plan under the American Rescue Plan Act, instead steering patients towards short-term plans, healthcare sharing ministries and other products that do not offer comprehensive coverage.¹⁶ Georgia's waiver will almost certainly create confusion for patients and lead them to purchase coverage that does not cover preventive and primary care, hospitalizations, emergency room visits, prescription medications and other treatments and services needed to maintain their health. Our organizations urge the Departments to evaluate the risks of misleading marketing that drives patients towards less comprehensive coverage as you consider the Georgia Access Model's continued compliance with the statutory guardrails.

Impact on Affordability

Georgia's claim that its waiver would bring down premiums was largely premised on the assumption that the waiver will significantly increase enrollment. As discussed above, these assumptions are now out-of-date in light of the American Rescue Plan Act, COVID-19 SEP, and outreach and enrollment funding and can no longer support the conclusion that the waiver is compliant with federal law. The market fragmentation and consumer confusion caused by the Georgia Access Model risks making the individual market risk pool sicker and more expensive. With this waiver, some individuals, including those who newly enrolled in coverage during the past year, are likely to drop comprehensive coverage and opt for a non-compliant plan or forgo coverage altogether. As non-compliant, non-comprehensive plans are less attractive — and often, because of underwriting practices, inaccessible — to people with preexisting conditions, it is likely that those who shift out of the ACA-compliant market will be disproportionately healthy. By contrast, those who remain in the individual market are likely to have more complex health conditions, causing premiums to be higher than they would be in the absence of the waiver.

Conclusion

The Georgia Access Model withholds access to quality and affordable healthcare coverage for thousands of patients with serious and chronic health conditions. We strongly urge the Departments to revoke approval of the Georgia Access Model portion of the state's 1332 waiver. Thank you for the opportunity to provide comments.

Sincerely,

¹⁶ Dania Palanker and JoAnn Volk. "Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period." Georgetown University Health Policy Institute, Center on Health Insurance Reforms. October 2021. Available at: <https://georgetown.app.box.com/s/mn7kgnhibn4kapb46tqmv6i7putry9gt>

American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Arthritis Foundation
CancerCare
Cancer Support Community
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
The Leukemia & Lymphoma Society
Mended Little Hearts
National Multiple Sclerosis Society
National Kidney Foundation
National Organization for Rare Disorders
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute



Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all.

In addition, any reform measure must support a health care system that provides affordable, accessible and adequate health care coverage and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

Health Insurance Must be Affordable – Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must be Accessible – All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must be Adequate and Understandable – All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.

Alpha-1 Foundation
ALS Association
American Cancer Society Cancer Action Network
American Diabetes Association
American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation
Autism Speaks
Cancer Support Community
CancerCare
Chronic Disease Coalition
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Immune Deficiency Foundation
Juvenile Diabetes Research Foundation

The Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes
Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Coalition for Cancer Survivorship
National Eczema Association
National Health Council
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
United Way Worldwide
Volunteers of America
WomenHeart: The National Coalition for Women with Heart Disease



September 18, 2020

Honorable Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Honorable Steve Mnuchin
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Re: Georgia 1332 Waiver Application

Dear Secretary Azar and Secretary Mnuchin:

Thank you for the opportunity to submit comments on Georgia's 1332 waiver application.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting state health insurance marketplaces and the patients that they serve. We urge the Departments to make the best use of the recommendations, knowledge and experience our organizations offer here.

While we support Georgia's plan to establish a reinsurance program, we strongly oppose the state's attempt to prohibit Georgians from choosing to enroll in coverage through Healthcare.gov, which if successful likely would reduce enrollment in comprehensive coverage and jeopardize quality and affordable healthcare coverage for patients with acute and chronic health conditions. The state's so-called "Georgia Access" Model would reduce the enrollment pathways now available to Georgians and dictate that individuals use an insurer or broker. These options, that the state hopes to make mandatory, are already widely available to Georgians, who are free to choose them absent a waiver. This proposal dramatically increases the risk of consumer confusion, creating a high likelihood that people will lose coverage and others will enroll in plans that are inadequate for their health needs. Our organizations urge the Departments not to approve the Georgia Access Model portion of this waiver.

Georgia Access Model

Georgia's application proposes to prohibit Georgians from choosing to enroll in coverage through the neutral Healthcare.gov platform and instead would require that people enroll directly through insurers or brokers. This policy will make it harder for patients to enroll in comprehensive, affordable healthcare coverage and our organizations oppose this change.

Impact on Coverage

The state's decision to fragment its market, while depriving Georgians of their most commonly used pathway to individual market coverage, makes it highly likely that some of the 450,000 Georgians who currently purchase comprehensive coverage through the marketplace will lose it. This could have a serious impact on the health of patients who are in the middle of treatment for a chronic or acute health condition and rely on regular visits with healthcare providers or daily medications to manage their conditions. Our patients cannot afford a sudden gap in care.

The state asserts that enrollment will increase, on net, by 25,000 due to "increased web-broker marketing" and the ability of individuals to shop for coverage "through multiple channels." These vague claims lack a reasonable basis and inexplicably ignore the current enrollment options available in the state's individual market. Web-brokers can and do market coverage to Georgia consumers today, and these entities can and do enroll Georgians in individual market coverage. As the application itself observes, about 20 percent of marketplace enrollees enrolled directly in 2020. Georgians do not need Georgia Access to take advantage of "multiple channels" of enrollment. All that Georgia Access does is eliminate the enrollment channel on which the majority of the state's individual market consumers have chosen to rely.

The application's attempt to explain why this reduction in choice will produce a net enrollment gain of 25,000 specifically also lacks a reasonable basis. To arrive at this figure, the state notes that the share of individual market enrollment in Georgia via private vendors has increased by about 4 percentage points a year from 2018-2020. By extending this trend to 2022, the state suggests there will be 33,000 additional private vendor enrollments, offset by an approximately 2 percent (8,000 people) decrease in marketwide enrollment during the transition. These projections suffer from fundamental defects.

First, the trend on which the state relies for its projections of total enrollment (the 4 percentage point yearly growth in private enrollments) does not describe changes in total enrollment. Rather, it describes changes in the *share* of enrollment via private vendors. There is no reason whatsoever to assume that a trend in the share of private enrollments would be predictive of changes in total enrollment in a waiver scenario, nor does the application even attempt to offer an explanation for why that might be the case.

(For example, if the state’s application is approved, the share of private enrollments will jump from approximately 20 percent to 100 percent, in the absence of Healthcare.gov. This metric fails to indicate the impact of the waiver on total coverage take-up.) This analysis is insufficient to support waiver approval.

Second, the trend on which the state is focused occurred *in the absence of the waiver*. The state does not, and presumably cannot, explain why, going forward, such growth will continue *only* if the waiver is implemented. Because the growth trend is not contingent on the waiver, it cannot be attributed to the waiver for purposes of evaluating federal law compliance.¹

Georgia’s assertion that only about 2% (8,000 enrollees) of the market will lose coverage under its proposal is also insufficient. The state claims that this projection “is based on experience seen in other states when transitioning” from the federal marketplaces. Yet recent marketplace transitions do not support this claim. For example, when Nevada transitioned from the federal marketplace to its own enrollment platform, a transition years in the making that by all accounts went smoothly, the state still saw an enrollment decline of 7%.² Georgia, for its part, seeks to initiate an unprecedented transition — likely occurring while the country continues to suffer from the pandemic — that is likely to place greater strain on state resources and current enrollees than what was experienced in these states. Under the circumstances, it is reasonable to expect enrollment declines in excess of those seen in Nevada and other states that have shifted enrollment platforms.

Patients will also lose access to features of Healthcare.gov that help to facilitate enrollment in quality and affordable healthcare coverage, further contributing to coverage losses. Currently, when Healthcare.gov screens individuals for eligibility for premium tax credits, it lets consumers know if they are eligible for Medicaid coverage and refers them to the state’s Medicaid agency. Under the Georgia Access Model, brokers and other private entities would have no incentive to provide this kind of assistance and could be instead be motivated to enroll Medicaid-eligible individuals in skimpy plans that would not provide comprehensive coverage but for which they earn a commission. Additionally, Healthcare.gov can automatically re-enroll individuals who signed up for coverage last year but do not select a new plan into coverage for the following year. However, under the Georgia Access Model, patients would lose access to the auto-enrollment function of Healthcare.gov, which automatically re-enrolled 80,000 Georgians in healthcare coverage for 2020.³ Our organizations are deeply concerned about these potential coverage losses.

Impact on Comprehensiveness

Today, patients who shop on Healthcare.gov can trust that they are purchasing a health insurance plan that will allow them to manage their health conditions. However, under the Georgia Access Model, issuers and brokers could sell QHPs alongside other types of plans that discriminate against people with pre-existing conditions and will not cover enrollees’ medical expenses if they get sick. Indeed, it is a stated objective of Georgia’s waiver for insurers to do exactly that. This will almost certainly create confusion for patients and lead them to purchase coverage that does not cover preventive and primary care, hospitalizations, emergency room visits, prescription medications and other treatments and services needed to maintain their health. There is already evidence of misleading marketing related to short-term and other skimpy plans leading individuals to unwittingly enroll in coverage that lacks key patient protections.⁴ This problem would likely worsen in Georgia under this proposal.

Healthcare.gov shows consumers all QHPs available in their area and does not favor certain plans over others. However, brokers who would be helping individuals through the enrollment process under the

Georgia Access Model would not have to show individuals all of their plan options and may receive larger commissions for certain plans over others that influence their recommendations to patients. Increasing the reliance on insurers and brokers will limit the ability of patients with chronic and acute health conditions to compare plan price and benefit design in an unbiased manner to choose the right plan for them and could ultimately result in harm to patients who become enrolled in sub-standard or inadequate insurance coverage that does not meet their needs. This failure to appropriately shield patients from risk is unacceptable.

Impact on Affordability

The state predicts that moving to enhanced direct enrollment with web brokers will bring down premiums. Unfortunately, the opposite could happen. The state's claims are premised on the assumption that the waiver will significantly increase enrollment. As discussed above, these assumptions are deeply flawed. Contrary to its analysis, the market fragmentation and consumer confusion caused by the Georgia Access Model risks making the individual market risk pool sicker and more expensive. With this waiver, some individuals are likely to drop comprehensive coverage and opt for a non-compliant plan or forgo coverage altogether. As non-compliant, non-comprehensive plans are less attractive — and often, because of underwriting practices, inaccessible — to people with preexisting conditions, it is likely that those who shift out of the ACA-compliant market will be disproportionately healthy. By contrast, those who remain in the individual market are likely to have more complex health conditions, causing premiums to be higher than they would be in the absence of the waiver.

In addition, the application fails to account for the costs to consumers of increased broker commissions. By forcing consumers to enroll via an insurer or broker, the Georgia Access Model necessarily will drive up the share of enrollments effectuated through these pathways. In the state's view, this should result in an increase in the total volume of broker commissions. Such commissions are, of course, paid for by increases in premiums. Yet Georgia fails to account for any increase in premiums due to these foreseeable costs.

Reinsurance

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10% to 14% in its first year.⁵ A recent analysis by Avalere of seven states that have already created their own reinsurance programs through Section 1332 waivers found that these states reduced individual market premiums by an average of 19.9% in their first year.⁶

Georgia's proposal will create a reinsurance program starting for the 2022 plan year and continuing for five years. Based on the initial analysis commissioned by the state, this program is projected to reduce premiums by 10% in 2021 and increase the number of individuals obtaining health insurance through the individual market. This would help patients with pre-existing conditions obtain affordable, comprehensive coverage.

Georgia's proposal estimates that this reinsurance program will cost the state approximately \$100 million, which will come from the state's general fund. As Georgia moves forward with allocating funding for this program, it is important that the state not do so by cutting funding for other public

health and coverage programs. This would diminish health and access to care for Georgians, undermining the core goals of a reinsurance program.

Public Comment

As many of our organizations in Georgia wrote in a letter to Governor Kemp on July 17, 2020,⁷ a fifteen-day comment period is not sufficient to solicit meaningful comments on a proposal that would have such a substantial impact on access to care for patients in Georgia. A change of this significance should have been subject to a full comment period of at least 30 days to ensure that stakeholders, including the healthcare industry, patients and consumers and other interested parties, have adequate time to offer input to the state.

Since the state released the first, now outdated, version of its waiver application last year, COVID-19 has overwhelmed our healthcare system and highlighted the need for adequate and affordable health insurance coverage more than ever. If someone without health insurance contracts the COVID-19 virus, they may be forced to make the difficult decision to not be tested and treated due to fears about the cost of care. That puts all Georgians – particularly the people we represent – at risk. The state’s proposals are not directly related to COVID-19 and not slated to take effect until 2022. The Departments should require Georgia to reopen a comment period of at least 30 days to allow additional time to facilitate public review of and input on these important proposals.

Additionally, although Georgia is required to include in its application a comprehensive description of the program it will use to implement the waiver, this critical information is lacking. While the state is clear that it wants to end Georgians’ access to HealthCare.gov, the particulars of what will follow are omitted from the application. All the state offers is an outline of how it hopes to implement an unprecedented transition and promises that it “will develop” robust implementation plans in the future. This is insufficient to satisfy federal requirements and places an impermissible burden on consumers and stakeholders as they attempt to understand and provide input on this proposal.

Conclusion

Our organization believe that the Georgia Access Model withholds access to quality and affordable healthcare coverage for thousands of patients with serious and chronic health conditions. While we support Georgia’s reinsurance program, we strongly urge the Departments to reject the Georgia Access Model portion of this 1332 waiver application.

Thank you for the opportunity to provide comments.

Sincerely,

American Lung Association
Alpha-1 Foundation
American Heart Association
American Liver Foundation
Arthritis Foundation
Cancer Support Community
CancerCare

Chronic Disease Coalition
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Leukemia & Lymphoma Society
Lutheran Services in America
Mended Hearts & Mended Little Hearts
National Alliance on Mental Illness
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute

¹ Christen Linke Young and Jason Levitis, "Georgia's latest 1332 proposal continues to violate the ACA," September 1, 2020, The Brookings Institution. <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>

² Nevada health insurance marketplace: history and news of the state's exchange. Louise Norris, HealthInsurance.org. June 11, 2020. Available at: <https://www.healthinsurance.org/nevada-state-health-insurance-exchange/>

³ Christen Linke Young and Jason Levitis, "Georgia's latest 1332 proposal continues to violate the ACA," September 1, 2020, The Brookings Institution. <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>

⁴ Seeing Fraud and Misleading Marketing, States warn Consumers About Alternative Health Insurance Products. The Commonwealth Fund, Dania Palanker, JoAnn Volk, and Maanasa Kona. October 30, 2019. Available at; <https://www.commonwealthfund.org/blog/2019/seeing-fraud-and-misleading-marketing-states-warn-consumers-about-alternative-health>, and The Marketing of Short-Term Health Plans, The Robert Wood Johnson Foundation, January 31, 2019. Available at: <https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html>

⁵ American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

⁶ Avalere. *State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average*. March 2019. Retrieved from <https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-19-9-on-average>.

⁷ Letter from the American Lung Association and Health Partners to Governor Kemp re: Section 1332 Waiver Application, July 17, 2020.

December 17, 2021

Georgia's Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked

By Tara Straw and Jason Levitis¹

On November 1, 2020 the Trump Administration approved a Section 1332 State Innovation Waiver permitting Georgia to leave the federal health insurance marketplace beginning in 2023 and instead advise people to enroll directly with insurers or through online enrollment vendors or agents or brokers. The waiver proposal was flawed from the start² but is now even more clearly in violation of the statutory approval criteria, or “guardrails,” because it would result in fewer Georgians getting health coverage than would be the case without the waiver. The Biden Administration, which is currently re-examining Georgia’s waiver, should stop the state from leaving the federal marketplace by revoking federal approval to implement this harmful change.

Changes in federal law and policies have greatly increased marketplace enrollment, outstripping the estimates Georgia submitted with its waiver application. This is critical because 1332 waivers must meet a coverage guardrail, which requires the state to demonstrate that at least a comparable number of people will have health coverage under its waiver plan as would have had health coverage without the waiver. Neither the assumptions Georgia made about coverage levels absent the waiver (the baseline) nor its projections of the waiver’s coverage impacts bear any resemblance to reality. Moreover, Georgia rebuffed two requests for an updated analysis to account for these factors, adding to the ample reasons why the Biden Administration should revoke the waiver.

In its application, Georgia painted a bleak view of the future of the marketplace and claimed that the waiver was necessary to stem enrollment losses. But even before the waiver was approved, the tide turned, and the state’s baseline projections, based on the 2018 plan year, are now wildly off target. Georgia’s marketplace enrollment is more than 180,000 higher in August 2021 than in 2018

¹ Levitis is a Principal with Levitis Strategies, LLC. Levitis formerly served at the U.S. Treasury Department where he led its work on implementing the Affordable Care Act’s state innovation waivers.

² Tara Straw, “Tens of Thousands Could Lose Coverage Under Georgia’s 1332 Waiver Proposal,” CBPP, September 1, 2020, <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>, and Christen Linke Young and Jason Levitis, “Georgia’s latest 1332 proposal continues to violate the ACA,” Brookings Institution, August 28, 2020, <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>.

— a roughly 50 percent increase.³ And new federal laws, regulations, and policies in place to support enrollment have fueled, and will likely sustain, these enrollment gains.

These changes both to policy and to actual enrollment require a new analysis of Georgia’s already flawed waiver. In particular, a new analysis would find that the waiver cannot meet the statutory coverage guardrail. HealthCare.gov is positioned to maintain or grow its record enrollment through the Administration’s implementation of various laws, regulations, and policies, including renewed federal support for important functions such as marketing and enrollment assistance. In contrast, the Georgia model would forgo this expanded federal investment and abandon the success of HealthCare.gov. This would disrupt the enrollment process and lead to substantial coverage losses. Even if Georgia’s own enrollment estimates are assumed to be true, its waiver would lead to more people being uninsured than would be true absent the waiver.

The Administration can terminate the waiver not just for its violation of statutory protections but also based on administrative and procedural grounds. The state contends that the Department of Health and Human Services and Department of the Treasury (“Departments”) don’t have the authority to ask for further analysis, but this is clearly wrong under the statute, federal regulations, and the waiver approval agreement the state signed. All require ongoing compliance, including updated analyses the state must submit upon request. By not complying, Georgia has failed to meet these requirements. Both the 1332 regulations and the terms of the waiver itself expressly list termination as a possible consequence.

Georgia’s plan to eliminate HealthCare.gov always violated the 1332 guardrails, as explained further below. It would create confusion among enrollees, deny enrollment help to some people eligible for Medicaid under state law, and lead more people into low-value plans that don’t meet the Affordable Care Act’s (ACA) protections. Recent developments, which must be part of an updated analysis of the waiver, provide additional reasons the Administration should stop Georgia’s plan.

Waiver Would Upend Insurance Enrollment

On November 1, 2020 the Trump Administration approved Georgia’s Section 1332 waiver for what the state calls the Georgia Access Model.⁴ The ACA’s Section 1332 allows a state to obtain permission to waive parts of the law and design its own health coverage program as long as the proposal meets certain statutory guardrails. If the waiver reduces federal costs, the state can receive federal funds equal to those savings, known as pass-through payments. (See box, “Standards for 1332 Waivers.”)

³ In 2018, Georgia’s baseline enrollment (its starting point for enrollment over the course of the waiver) in marketplace coverage was 367,562. In August 2021, enrollment in the marketplace was 549,066. Georgia’s final application (dated October 9, 2020), approval letter, all agency correspondence, and request for public comments are at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-#please_visit_the_Georgia_waiver_section_of_this_webpage_below. Department of Health and Human Services, “Biden-Harris Administration Announces Record-Breaking 12.2 Million People Are Enrolled in Coverage Through the Health Care Marketplaces,” press release, September 15, 2021, <https://www.hhs.gov/about/news/2021/09/15/biden-harris-administration-announces-2-8-million-people-gained-affordable-health-coverage-during-2021-special-enrollment.html>.

⁴ A second portion of the waiver establishing a reinsurance program was also approved but is not open for public comment and is proceeding in 2022.

The Georgia Access Model would eliminate Georgians' access to HealthCare.gov — a centralized shopping platform that displays and allows enrollment in all marketplace health plans — without creating a comparable state substitute.⁵ Instead, beginning in 2023, Georgia would scatter marketplace functions for more than half a million enrollees among a multitude of private brokers and health insurers, akin to the insurance market prior to the ACA. The state would also rely on these private entities to conduct marketing and outreach, in place of federal investments in these activities which have proven highly effective. People could still enroll in plans that would have been available through HealthCare.gov, and access federal subsidies if they qualify, but this process would be more difficult, and many other plans that do not meet ACA standards and are not eligible for subsidies would also be on offer. The state's actuarial analysis, required for states seeking a 1332 waiver, projected the Georgia Access Model would modestly increase marketplace enrollment in 2023 and slightly lower premiums compared to a 2018 baseline.⁶ But this analysis was flawed when first released and is even more implausible now.

In letters dated June 3 and July 30 of 2021, the Departments under the Biden Administration asked the state for a revised actuarial analysis to account for changes in federal law and policy that significantly raised the baseline against which the waiver must be judged. Georgia refused to update its analysis and challenged the federal government's authority to ask for the revision. The Departments are asking for public comment on the validity of the state's data and whether the Georgia Access Model complies with the statutory guardrails, which are designed to ensure that at least as many people are covered under the waiver as would have been the case without it and that the coverage meets ACA standards for comprehensiveness and affordability and does not increase federal costs.

⁵ Straw, *op. cit.*

⁶ Marketplace enrollment was expected to increase by about 26,500 enrollees in 2023, inclusive of the state's reinsurance waiver, which is projected to have minimal impact on enrollment. Waiver, *op. cit.*, p. 60. Gross (unsubsidized) marketplace premiums would decrease by 3.6-3.7 percent, not including the significant premium decline due to a reinsurance waiver. Waiver, *op. cit.*, p. 59.

Standards for 1332 Waivers

States' 1332 waiver proposals must satisfy four statutory requirements to obtain federal approval. These guardrails are intended to ensure that state residents will be no worse off than they would be without the waiver.

The ACA requires states to demonstrate their proposals will meet the following standards.

- **Comprehensiveness:** Providing coverage at least as comprehensive as that provided through ACA marketplaces;
- **Affordability:** Providing coverage and out-of-pocket cost protections at least as affordable as those provided by the ACA;
- **Coverage:** Providing coverage to at least a comparable number of state residents as the ACA; and
- **Deficit neutrality:** Not increasing the federal deficit.

If a state's 1332 waiver reduces the federal premium tax credits, cost-sharing reductions, or small business tax credits that a state's residents and businesses qualify for, relative to what they would have received without the waiver (the baseline), the state may receive funding from the federal government up to the amount of financial assistance its residents would otherwise have received (reduced by any other costs the waiver imposes on the federal government). States can use these pass-through payments to provide financial assistance or other benefits to consumers different from those available under the ACA.

States implementing 1332 waivers must stay in compliance with all applicable federal laws, regulations, and interpretive guidance published by the Departments. In addition, approvals delineate a series of Specific Terms and Conditions agreed to by the Departments and the state, which typically state the grounds upon which a waiver can be amended, suspended, or terminated.

For further discussion of 1332 waivers, see Sarah Lueck and Jessica Schubel, "Understanding the Affordable Care Act's State Innovation ("1332") Waivers," CBPP, updated September 5, 2017, <https://www.cbpp.org/research/health/understanding-the-affordable-care-acts-state-innovation-1332-waivers>.

Georgia Cannot Match HealthCare.gov's Enrollment

Section 1332 waivers are required to cover in each year at least a comparable number of people as would be the case without the waiver. Georgia's waiver application was built around the premise that, unless the state intervened, marketplace enrollment would decline from its 2018 level, an already low enrollment count after deep cuts to marketing, outreach, and in-person assistance by the Trump Administration. But HealthCare.gov has been more effective than Georgia's baseline assumed. Enrollment rebounded in the 2019 and 2020 plan years as premiums stabilized, showing the waiver's projections were wrong before it was even approved. Then enrollment reached a historic high with the 2021 special enrollment period and Biden Administration investments.

Georgia's own goals under the waiver can't produce enrollment comparable to today's coverage numbers. The waiver's projection was that it would increase marketplace enrollment from about 366,000 in 2018 to 392,000 in 2023.⁷ Even if Georgia's waiver could generate those coverage gains over 2018, those gains would be well short of the 549,000 enrolled as of August 2021, meaning the

⁷ Waiver, *op. cit.*, p. 60.

waiver’s implementation would leave a huge coverage reduction and more people uninsured. (See Figure 1.) Any reasonable, updated analysis of the state’s waiver would also show that it can’t match, let alone surpass, today’s enrollment baseline. That’s true in part because the waiver would eliminate federal investments in the marketing, outreach, and in-person assistance that have proven to be effective in expanding coverage in the marketplace in recent years.⁸

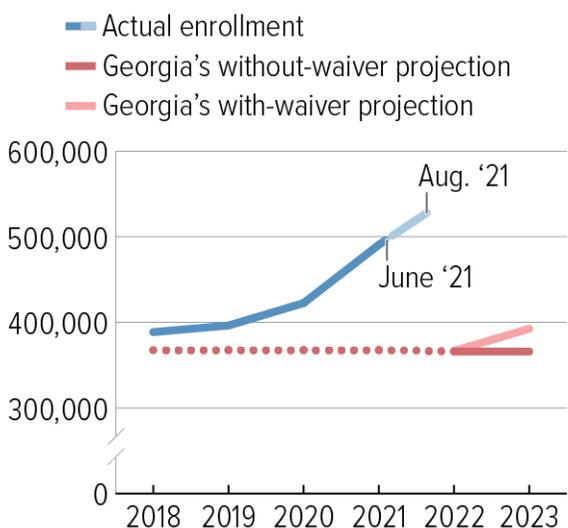
Changes in Rules and Law Boost Enrollment Beyond Georgia’s Baseline

New federal statutes and regulations have increased coverage numbers prior to implementation of the Georgia Access Model and will continue to promote strong enrollment that the state has not accounted for in its baseline. The historically high enrollment figures that must be factored into the baseline make it highly unlikely the state’s plan could meet or exceed the coverage guardrail. And if Congress passes economic-recovery legislation it is now considering, its provisions would only add to the reasons that Georgia’s waiver violates 1332 standards. (See box, “Georgia’s Waiver Clearly Deficient if Build Back Better Becomes Law.”)

FIGURE 1

Actual Marketplace Enrollment on Pace to Far Exceed Georgia’s Goal

ACA marketplace enrollment growth from 2018



Note: ACA = Affordable Care Act. Georgia's Section 1332 waiver application estimates coverage for 2018, 2022, and 2023. The with-waiver scenario assumes implementation of Georgia Access Model and reinsurance. Actual enrollment reflects total average effectuated marketplace enrollment for the first six months of each year. June 2021 enrollment = 490,539. Due to special enrollment period, number of plan selections as of August 2021 = 549,066.

Source: Department of Health and Human Services; Georgia waiver application

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New Statutes Increase Enrollment

The American Rescue Plan, enacted in 2021, boosts the premium tax credit to reduce marketplace insurance premiums across the board in 2021 and 2022 and extends eligibility to people with incomes above 400 percent of the poverty line. It lowered premiums nationwide, and by 54 percent for existing enrollees in Georgia, which was one factor that led to robust marketplace enrollment in 2021 — a trend likely to continue in 2022.⁹ While the premium tax credit enhancements are currently set to end in 2022, the Congressional Budget Office (CBO) predicts an enrollment “tail” as

⁸ CBO supports this higher enrollment baseline. In 2020 it predicted 2030 marketplace enrollment of 8 million people, but in 2021, it boosted this estimate to 10 million. Compare CBO, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT’s September 2020 Projections,” August 29, 2020, <https://www.cbo.gov/system/files/2020-10/51298-2020-09-healthinsurance.pdf> and CBO, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT’s July 2021 Projections,” July 2021, <https://www.cbo.gov/system/files/2021-08/51298-2021-07-healthinsurance.pdf>.

⁹ Department of Health and Human Services, “2021 Final Marketplace Special Enrollment Period Report,” October 20, 2021, <https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf>.

more people stay enrolled compared to the baseline without the Rescue Plan.¹⁰ HealthCare.gov’s historically strong enrollment retention could also buoy coverage levels. In the 2021 open enrollment period — prior to enactment of the Rescue Plan — 77 percent were returning enrollees.¹¹ Even if subsidies return to pre-Rescue Plan levels, most HealthCare.gov enrollees would likely be eligible for zero-premium or low-premium plans to make coverage affordable. In Georgia, 80 percent of 2021 enrollees were eligible for such plans before the Rescue Plan’s premium enhancements took effect.¹² Georgia’s analysis does not account for these enrollment increases.

In addition, the Families First Coronavirus Response Act created a Medicaid continuous coverage requirement under which states, in exchange for getting a higher federal matching percentage of Medicaid costs covered, must keep Medicaid-eligible people enrolled for the duration of the COVID-19 public health emergency. CBO anticipates that the provision will begin to unwind in July 2022. As it does, some people whose income is too high for Medicaid might qualify for a premium tax credit in the marketplace and, if the system works well, will enroll in marketplace coverage. But Georgia’s analysis does not account for it.

New Regulations Further Boost Enrollment

Several new marketplace regulations finalized in September will encourage enrollment and retention, especially among low-income people, and are not accounted for in Georgia’s baseline enrollment projections. First, the federal marketplace will extend the open enrollment period by 30 days, to January 15. Research shows that December, a time of mental and financial stress and the month when the open enrollment period ended in recent years, is the “worst time of the year to require complex enrollment decisions.”¹³ As such, giving people more time to enroll and stretching open enrollment into the early part of each year is likely to boost the number of people covered to a higher level than Georgia’s analysis has accounted for.

Another policy that could bolster enrollment during the year is the recent rule change allowing people with incomes at or below 150 percent of the poverty line to enter the marketplace in any month starting in 2022, rather than needing to have a separate life event to qualify for a special enrollment period (or SEP; this is distinct from the recent six-month, pandemic-related SEP). The enrollment effects could be significant in Georgia, where about 160,000 uninsured adults have incomes between 100 and 150 percent of poverty. This is a new avenue to enroll for people who need coverage but miss the annual open enrollment period.

¹⁰ CBO, “Reconciliation Recommendations of the House Committee on Ways and Means,” February 15, 2021, <https://www.cbo.gov/publication/57005>.

¹¹ Centers for Medicare & Medicaid Services, “2021 Federal Health Insurance Exchange Weekly Enrollment Snapshot: Final Snapshot,” January 12, 2021, <https://www.cms.gov/newsroom/fact-sheets/2021-federal-health-insurance-exchange-weekly-enrollment-snapshot-final-snapshot>.

¹² D. Keith Branham *et al.*, “Access to Marketplace Plans with Low Premiums of the Federal Platform, Part I: Availability Among Uninsured Non-Elderly Adults and HealthCare.gov Enrollees Prior to the American Rescue Plan,” Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, March 29, 2021, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//199686/low-premium-plans-issue-brief.pdf.

¹³ Katherine Swartz and John A. Graves, “Shifting The Open Enrollment Period For ACA Marketplaces Could Increase Enrollment And Improve Plan Choices,” *Health Affairs*, July 2014, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.0007>.

Georgia's Waiver Clearly Deficient if Build Back Better Becomes Law

Build Back Better (BBB),^a which is currently being considered in Congress, would extend through 2025 the American Rescue Plan's premium tax credit enhancements and provide financial help to people with income below the poverty line in states that did not expand Medicaid. If BBB becomes law, Georgia's 1332 baseline (its estimates of what would happen without the Georgia Access Model) will be even less moored to on-the-ground coverage conditions.

BBB would do many things to bolster enrollment, none of which are included in Georgia's analysis:

- It would extend the Rescue Plan's premium tax credit enhancements to 2025, lowering premiums for people with incomes between 100 and 400 percent of the poverty line and allowing people with income over 400 percent of the poverty line to claim the credit;
- It would make people who live in states that did not expand Medicaid newly eligible for a premium tax credit through the marketplace — including 275,000 uninsured Georgians, a plurality of whom, due largely to structural inequities and disparities in coverage rates, are Black;^b
- It would dedicate new funding to outreach and enrollment, including in-person assistance, for people formerly in the Medicaid coverage gap;
- It would make employer coverage more affordable for some workers, by allowing them to claim a premium tax credit when premiums cost more than 8.5 percent of income rather than 9.5 percent and by ensuring that people with income below 138 percent of poverty would not be blocked from premium tax credit eligibility due to an employer offer; and
- It would likely lead people to transition from Medicaid to the marketplace, by phasing out the financial incentives for the Medicaid continuous coverage requirement, meaning some people whose income now exceeds Medicaid eligibility levels would be eligible for a premium tax credit in the marketplace.

BBB's anticipated enrollment gains would need to be factored into the baseline to evaluate whether the waiver meets the statutory guardrails; if Georgia can't achieve enrollment at least comparable to what would occur without the waiver, its waiver would violate the coverage guardrail. At a minimum, the failure to provide new analysis to account for the effects of BBB would make it impossible for the Departments to calculate the pass-through payments Georgia would receive under the waiver. Operating under an artificially low baseline would generate a higher pass-through payment than the state would otherwise be entitled to receive.

^a Build Back Better Act, H.R. 5376, <https://www.congress.gov/bill/117th-congress/house-bill/5376>.

^b Gideon Lukens and Breanna Shearer, "Closing Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities," CBPP, June 14, 2021, <https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial>.

Georgia's Plan Jettisons Policies That Expand Marketplace Enrollment

Many people remain unaware of the financial help they can receive to purchase health insurance. This knowledge barrier indicates that more needs to be done to reach people who are eligible. The Georgia waiver would withdraw from federal initiatives to promote coverage — notably marketing and unbiased, in-person assistance — and do nothing to replace them, exacerbating the knowledge barrier and driving down enrollment.

Increased Outreach and Marketing Driving Higher Enrollment

The Biden Administration has made a historic \$100 million investment in nationwide marketing to make people aware of affordable coverage in the marketplace during the six-month emergency SEP, in contrast to the Trump Administration's \$10 million in annual funding in prior years.

Marketing is a powerful tool to drive enrollment.¹⁴ In 2016 the Centers for Medicare & Medicaid Services (CMS) determined that 1.8 million of the marketplace's 9.6 million enrollees enrolled due to advertising, and by 2017, an estimated 37 percent of enrollments were attributed to advertising.¹⁵ Covered California, a state-run marketplace, found that outreach and marketing reduced premiums for Californians and the federal government by 6 to 8 percent in 2015 and 2016. This is because marketing nudges into coverage healthier people who are less inclined to purchase insurance, lowering the marketplace's risk profile, which translates into lower premiums and higher enrollment overall.¹⁶ Kentucky's television advertising was also credited with 40 percent of the unique visitors and web-based applications in Kentucky for plan years 2014 and 2015.¹⁷

Georgia's intent to rely on insurer and broker advertising to attract enrollees — instead of federal government advertising driving traffic to one central enrollment platform — is misguided. Research has shown that government advertising is more effective than private advertising. One study found that government advertising was more likely to expand enrollment, with health plan advertising tending to reach only existing customers.¹⁸ Further, cuts to navigator programs did not increase the amount of private-sector advertising.¹⁹

Pulling out of HealthCare.gov means that Georgia will no longer benefit from this federal investment. Without government-funded advertising, Georgia can expect to have lower enrollment than would occur without the waiver, a factor that the state did not account for in its waiver application.

¹⁴ Tara Straw, "Marketplaces Poised for Further Gains as Open Enrollment Begins," CBPP, October 29, 2021, <https://www.cbpp.org/research/health/marketplaces-poised-for-further-gains-as-open-enrollment-begins>.

¹⁵ This included a combination of television, radio, direct response (text messaging, email, and autodial), internet search buys, and paid digital ads, and reflected the results of a partial open enrollment period. Centers for Medicare & Medicaid Services, "Preliminary OE4 Lessons Learned," <https://downloads.cms.gov/files/359411146-preliminary-oe4-lessons-learned.pdf>.

¹⁶ Peter V. Lee *et al.*, "Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets," Covered California, September 2017, https://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

¹⁷ Paul R. Shafer *et al.*, "Television Advertising and Health Insurance Marketplace Consumer Engagement in Kentucky: A Natural Experiment," *Journal of Medical Internet Research*, Vol. 20, No. 10, October 2018, <https://www.jmir.org/2018/10/e10872/PDF>.

¹⁸ Naoki Aizawa and You Suk Kim, "Public and Private Provision of Information in Market-Based Public Programs: Evidence from Advertising in Health Insurance Marketplaces," NBER Working Paper No. 27695, revised April 2021, <https://www.nber.org/papers/w27695>.

¹⁹ Rebecca Myerson and David M. Anderson *et al.*, "Cuts to navigator funding were not associated with changes to private sector advertising in the ACA marketplaces," pre-publication version, December 9, 2021, <https://drive.google.com/file/d/1uoQt0PepLBJNrxrtBS2OFGoGHpzYhajs/view>.

Bolstered In-Person Assistance Increasing Enrollment, Especially in Hard-to-Reach Communities

Enrolling in insurance can be complicated and many uninsured people say they need help to understand their options.²⁰ Navigators are federally funded, unbiased groups that provide this help to consumers at all stages of the coverage process, from determining eligibility to plan selection to using their coverage. In 2021, HealthCare.gov navigators received a \$70 million increase in funding. Georgia navigators saw a \$1.8 million increase, with funding rising from \$700,000 when the waiver was approved to \$2.5 million today.²¹

Unlike the brokers Georgia's plan relies on, assisters — navigators and unfunded application counselors — are knowledgeable and skilled at reaching underserved populations. They are five times more likely than agents and brokers to report that their clients were previously uninsured, according to a 2016 national survey by the Kaiser Family Foundation.²² Nine in ten assister programs helped eligible individuals enroll in Medicaid or the Children's Health Insurance Program (CHIP), compared to fewer than half of brokers. While navigators must perform public education activities on the availability of marketplace coverage and do so in a linguistically and culturally appropriate manner, brokers don't. Research shows brokers are significantly less likely to perform public education and outreach activities or to help Latino clients, people who have limited English proficiency, or people who lack internet at home. A recent study found that cuts to the navigator program in 2019 led to declines in coverage by people with incomes between 150 and 200 percent of poverty, consumers under age 45, consumers who identified as Hispanic, and consumers who spoke a language other than English at home.²³

Under its waiver, Georgia would opt out of this federal investment in in-person assistance and would fail to establish any form of impartial, unbiased help, which means that vulnerable uninsured people would be less likely to find coverage, in opposition to the intent of recent 1332 waiver regulations.²⁴ In fact, the state made it *illegal* to use state funds on navigators.²⁵

²⁰ Karen Pollitz, Jennifer Tolbert, and Ashley Semanskee, "2016 Survey of Health Insurance Marketplace Assister Programs and Brokers," Kaiser Family Foundation, June 2016, <https://files.kff.org/attachment/2016-Survey-of-Marketplace-Assister-Programs-and-Brokers>.

²¹ Karen Pollitz, Jennifer Tolbert, and Kendal Orgera, "Navigator Funding Restored in Federal Marketplace States for 2022," Kaiser Family Foundation, September 29, 2021, <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>.

²² Pollitz, Tolbert, and Semanskee, *op. cit.*

²³ Rebecca Myerson and Honglin Li, "Information Gaps and Health Insurance Enrollment: Evidence from the Affordable Care Act Navigator Programs," posted at SSRN, November 11, 2021, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3966511.

²⁴ "Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond," 86 Fed. Reg. 184, September 27, 2021, <https://www.federalregister.gov/documents/2021/09/27/2021-20509/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver>.

²⁵ GA Code § 33-1-23 (2020). "Neither the state nor any department, agency, bureau, authority, office, or other unit of the state, including the University System of Georgia and its member institutions, nor any political subdivision of the state shall establish, create, implement, or operate a navigator program or its equivalent."

Executive Orders Point to Continued Commitment to Enrollment Growth, Equity

President Biden has issued two executive orders that emphasize the Administration’s commitment to continuing federal investment in enrollment, helping the underserved, and ameliorating the effects of structural racism in health coverage rates. They both demand reconsideration of Georgia’s waiver. Executive Order 13985 asks all federal agencies to review new and existing policies to assess whether they advance equity for marginalized and historically underserved communities.²⁶ Georgia’s waiver doesn’t analyze its impact on equity, which should raise the Departments’ level of scrutiny. The preamble of recent section 1332 regulations emphasizes helping underserved communities and makes clear that a “1332 waiver would be highly unlikely to be approved by the Secretaries if it would reduce coverage for these populations, even if the waiver would provide coverage to a comparable number of residents overall.”²⁷

In practice, hard-to-reach and marginalized communities are more likely to become uninsured under the state’s plan due to cuts to in-person assistance, which disproportionately helps people with lower incomes and those who speak a language other than English in the home, as explained above. For example, among the more than 1,500 agents and brokers advertising marketplace services in one Georgia ZIP code, only 47 offer services in Spanish and many fewer in other languages.²⁸

Executive Order 14009, on strengthening Medicaid and the Affordable Care Act, calls for an immediate review of all federal agency actions with the goal of making coverage accessible and affordable to everyone.²⁹ This includes policies that undermine protections for people with pre-existing conditions; waivers that may reduce coverage under Medicaid or the ACA; policies that undermine the marketplace; policies that create unnecessary barriers to families attempting to access ACA coverage; and policies that may reduce the affordability of coverage. Georgia’s waiver violates each of these goals. Agencies are directed to “suspend, revise, or rescind” such prior agency actions, which would include having granted Georgia’s waiver.

Departments Have Authority to Review or Terminate the Waiver on Statutory, Regulatory, and Procedural Grounds

Beyond the guardrail violations discussed above, Georgia is in violation of the statutory, regulatory, and procedural requirements of 1332 waivers. In a June 3, 2021 letter, the Departments gave Georgia 30 days to provide updated actuarial and economic analysis to support its assertion that the Georgia Access Model will comply with the statutory guardrails, as well as information

²⁶ Executive Order 13095, “Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,” January 20, 2021, <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.

²⁷ “Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule,” 86 Fed. Reg. 124, July 1, 2021, <https://www.federalregister.gov/documents/2021/07/01/2021-13993/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver>.

²⁸ CBPP analysis using HealthCare.gov, ZIP code 30318.

²⁹ Executive Order 14009, “Strengthening Medicaid and the Affordable Care Act,” January 28, 2021, <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicare-and-the-affordable-care-act/>.

about the data and assumptions used in conducting this analysis.³⁰ The Departments are entitled to this information under authorities in the statute, section 1332 regulations, and Specific Terms and Conditions (STCs) of the waiver to which the state and federal government agreed. But Georgia first expressed confusion about this request³¹ and later refused to comply.³² It claimed the Departments lack authority to request this information or evaluate the waiver post-approval and prior to full implementation, and also that any evaluation was limited to the effects of changes in statute enacted by Congress. These assertions are both wrong.

Georgia's Claim That the Right to Review Applies Only Post-Implementation Is Meritless

Georgia claims the waiver terms' requirement to provide additional information for review applies only after a waiver has been fully implemented, not during the period between approval and implementation. Georgia argues that the STCs are "plainly contemplating monitoring ... once a waiver has gone into force," since there is nothing to evaluate before the waiver is effective. In coming to this conclusion, the state ignores the statute, regulations, and the terms of its waiver approval.

Under the statute, the Departments must create regulations requiring that states submit "periodic reports ... concerning the implementation of the program under the waiver" and a "process for periodic evaluation."³³ The statutory language doesn't limit when evaluations can be requested. The regulations lay out a robust regime for ongoing monitoring, in language that has stood mostly unchanged since 2012. Under these rules, "following approval" the state must comply with federal law and regulatory changes. The Departments are authorized to "examine compliance" with the terms of the waiver, and states must "fully cooperate" with the Departments in evaluating "any component" of a waiver, including "submit[ting] all requested data and information." The regulations require the state to comply with all federal policies "following the final decision"— not just following full implementation.³⁴ Similarly, the STCs provide for "oversight of an approved waiver," not merely one that has been implemented.³⁵ They use broad language requiring the state to "fully cooperate" and submit "all requested data."

³⁰ Letter from CMS Administrator Chiquita Brooks-LaSure to Governor Brian Kemp, June 3, 2021, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Request-Updated-GA-Analysis-Letter.pdf>.

³¹ See Letter from Georgia Health Strategy and Coordination Office Director Grant Thomas to Administrator Chiquita Brooks-LaSure, July 2, 2021, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Response-1332-GA-request-Updated-GA-Analysis-Letter.pdf>.

³² See Letter from CMS Administrator Chiquita Brooks-LaSure to Director Grant Thomas, July 30, 2021, <https://www.cms.gov/files/document/response-1332-ga-depts-follow-letter.pdf> and Letter from Director Grant Thomas to Administrator Chiquita Brooks-LaSure, Aug. 26, 2021, <https://www.cms.gov/files/document/1332-georgia-letter-cms-82621.pdf>.

³³ Section 1332(a)(4)(B).

³⁴ 45 CFR 155.1320(a).

³⁵ Waiver, *op. cit.*, STC 15.

The Departments may amend or terminate waivers found to be non-compliant.³⁶ The STCs themselves reiterate the state’s obligation to provide requested information and the Departments’ authority to conduct oversight³⁷ and revoke a non-compliant waiver.³⁸ And both the regulations and STCs authorize the Departments to terminate non-compliant waivers “at any time,” which they couldn’t do if prohibited from collecting information before full implementation.³⁹

The ability to collect additional information at any time is also necessary given how section 1332 waivers work in practice. Georgia claims that, pre-implementation, “there is nothing new for a state to report.” But the implementation of a 1332 waiver is an iterative process requiring close coordination and updated analysis along the way. In the normal course of administering a waiver, the Departments must update their analysis based on information from the state to annually calculate pass-through payments, as required by section 1332.⁴⁰ This function is infeasible without updated information from the state. In addition, the Georgia Access Model was approved two years in advance. It would defeat Congress’s purposes in creating the statutory guardrails if, during this window of time, a waiver could not be monitored to ensure it remains in compliance.

Waivers Are Reviewable in Many Circumstances — Not Just With a Change in Federal Statute

Changes due to federal statute — namely continued high enrollment even after the Rescue Plan’s enhanced subsidies end in 2022 — merit review of Georgia’s waiver. But even if the new statute didn’t affect the enrollment baseline, other regulations and policies do, and should be considered. Georgia’s refusal letter focuses on STC 7, which authorizes the Departments to re-examine compliance with the guardrails and potentially terminate a waiver based on a change in federal statute. The state contends that federal policy changes, like changes in regulations or increases in federal navigator and outreach funding, can’t trigger an evaluation. Georgia claims that no relevant legislation has been enacted and so STC 7 provides no grounds for review. However, the state ignores another provision, STC 17, which provides for review on much broader grounds. It authorizes the Departments to terminate a waiver “at any time” if the Departments determine that the state has materially failed to comply with the STCs or the statutory guardrails, without restriction. This is reinforced by STC 6, which requires the state to “comply with all applicable federal laws and regulations, unless a law or regulation has been specifically waived.” No federal law or regulation is specifically waived in the STCs.

The regulations include similar language, providing for ongoing review of compliance with the statutory guardrails and reserving the Departments’ right to suspend or terminate a waiver “at any time” if they determine that “a State has materially failed to comply with the terms” of the waiver.⁴¹ In short, the argument for limiting the scope of review focuses on a single ground for review and

³⁶ 45 CFR 155.1320.

³⁷ STC 15.

³⁸ STCs 7 and 17.

³⁹ 45 CFR 155.1320(d) and STC 17.

⁴⁰ See section 1332(a)(3).

⁴¹ 45 CFR 155.1320.

ignores others that authorize the Departments to look beyond statutory changes in examining a waiver's ongoing compliance.

Previous Flaws Still Exist in Violation of Guardrails

In addition to the new reasons for termination, the waiver's underlying flaws merit reconsideration of whether it complies with the guardrails. Eliminating HealthCare.gov threatens to reduce coverage due to consumer confusion, and many of the people who start their applications on HealthCare.gov but are assessed as eligible for Medicaid would likely hit an enrollment roadblock under the Georgia Access Model, as private insurers and brokers frequently lack the financial incentive to facilitate Medicaid enrollments. Further, reliance on brokers — both web brokers and individual sellers — could result in more people getting coverage that is less comprehensive than they'd otherwise have, since there are strong incentives to lure people into non-compliant coverage. This steering could also raise premiums: healthier people might be pushed to lower-benefit plans, leaving only sicker people in ACA-qualifying plans and driving up their cost.

Privatizing Marketplace Would Reduce Enrollment, Not Increase It

Georgia claims that privatizing its marketplace would increase enrollment in the individual market by about 28,000 people by giving consumers new options to shop for and enroll in plans.⁴² But even if one were to grant Georgia's unsubstantiated claim that allowing enrollment through insurers and brokers increases coverage, the premise underlying the state's coverage projection is flawed: the waiver does not add meaningful new enrollment options. Consumers already can enroll in marketplace coverage directly through insurers or brokers — including the web brokers the proposal heavily relies on. At least 17 insurers and web brokers offer these services in Georgia for the 2022 plan year.⁴³ The waiver itself notes these options are widely available. This means the waiver subtracts pathways to coverage, rather than creating net new pathways.

Meanwhile, the waiver analysis entirely ignores countervailing threats to enrollment posed by dismantling the enrollment and consumer support system that more than half of enrolled Georgians use. Abandoning HealthCare.gov would leave the majority of enrollees without their chosen enrollment platform, almost certainly reducing enrollment significantly.⁴⁴ First, fragmenting the health insurance market across brokers and insurers would make insurance-buying less accessible and more confusing for consumers. Second, people who are eligible for Medicaid could have less enrollment assistance. And last, the transition itself would inevitably cause consumers to fall through the cracks, as occurred in states moving between federal and state enrollment platforms, a transition much simpler for consumers than Georgia's proposed transition from the federal platform to a wholly fragmented enrollment system.

⁴² Waiver, *op. cit.*, p. 60.

⁴³ CBPP analysis of enrollment partners on HealthCare.gov in December 2021. The number of web brokers has not been influenced by the new business opportunities anticipated by the approval of the waiver in November 2020. In January 2020, there were already 16 web brokers in the marketplace.

⁴⁴ Of those enrolled in 2020, about one-fifth were through brokers or insurers. Waiver, *op. cit.*, p. 82.

Fragmentation, Loss of HealthCare.gov Would Likely Cause Coverage Losses

Under Georgia's proposal, enrollment would likely fall because buying insurance would become harder. It's well documented that having too many choices can stymie consumers.⁴⁵ For example, one study of Medicare Part D plans found that having fewer than 15 options raised enrollment, whereas having 15 to 30 options did not, and having more than 30 options actually lowered enrollment.⁴⁶ A marketplace consumer in Atlanta has 142 plan options.⁴⁷ And consumers who manage to enroll despite being overwhelmed by choice are more likely to delegate their choice to others, regret their selection, and be less confident in the choices they make.⁴⁸ Confusion could be even greater under a system that requires consumers to choose among legions of sellers before beginning the process of selecting a specific health plan, with no guarantee of a single platform on which to see and compare all plan choices on equal terms. That same Atlanta consumer has more than 1,500 individual agents and brokers to choose from, with no guarantee that any given broker they choose will sell all available marketplace plans.⁴⁹

HealthCare.gov was created to simplify this complex decision-making process. It allows people to navigate one website to get an unbiased view of all plans eligible for financial assistance and provides tools to compare plans by premium, deductible, out-of-pocket cost, in-network status of preferred providers, and prescription drug coverage, among other features. All plans are guaranteed to meet the ACA's insurance market standards, like covering the law's ten essential health benefits and having no lifetime or annual limits on benefits.

Instead of the one-stop shopping experience of the marketplace, Georgia's waiver proposes a free-for-all run largely by web brokers and insurers. This would rely on a process known as enhanced direct enrollment, under which people apply for marketplace enrollment and select a plan through websites operated by private web brokers and insurers, while eligibility for premium tax credits is determined behind the scenes by the federal government. The waiver says that Georgia will set standards for how web brokers and insurers can display plans based on standards the federal government has set for this process. But these rules leave critical gaps. For instance, insurers show only their own plans, not the full array of plans available through HealthCare.gov. Web brokers are required to show all plans (under federal rules) but can display plans that pay commissions more prominently and show scant information about other plans, even omitting the premium amount. The standards for the online enrollment process, as set by the federal government, don't extend to individual agents and brokers. And these various entities — web brokers, insurers, and individual brokers and agents — frequently sell plans that fail to meet ACA standards.⁵⁰ Indeed, displaying

⁴⁵ Consumers Union, "The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making," November 2012, https://advocacy.consumerreports.org/wp-content/uploads/2012/11/Too_Much_Choice_Nov_2012.pdf.

⁴⁶ J. Michael McWilliams *et al.*, "Complex Medicare Advantage Choices May Overwhelm Seniors — Especially Those With Impaired Decision Making," *Health Affairs*, September 2011, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.0132>.

⁴⁷ CBPP analysis using HealthCare.gov, ZIP code 30318.

⁴⁸ Consumers Union, *op. cit.*

⁴⁹ CBPP analysis using HealthCare.gov, ZIP code 30318.

⁵⁰ Web brokers can sell any type of health plan but must separate them from the ACA-qualifying health plans under federal rules; it's unclear whether Georgia would adopt those rules.

additional categories of options, including coverage that isn't comprehensive, is a stated goal of the waiver.⁵¹ This would make shopping for health insurance much more complicated — and could lead more consumers to select lower-value coverage without the ACA's protections, out of confusion rather than true preference.

Failure to successfully build a robust, reliable technology system that helps existing enrollees re-enroll under the new regime could cause consumers to lose coverage or subsidies in 2023, the first year of the new system. But even if the state mostly succeeded in launching the new system, enrollment might fall due to the transition. Georgia predicts losing only about 2 percent of otherwise-returning enrollees due to the change, but other states' experiences show this figure is unrealistic.⁵² Kentucky's marketplace enrollment fell 13 percent when it transitioned to the federal marketplace in 2017, compared to a 4 percent decline nationally; Nevada's enrollment fell 7 percent for the 2020 plan year after its transition to a state-based marketplace, compared to flat enrollment nationally.⁵³ Similar percentage declines in Georgia would translate into a drop of 38,000-71,000 people in marketplace enrollment.

Challenges during transitions away from HealthCare.gov include maintaining communication with existing enrollees, conducting strong outreach to potential new consumers, and transferring account information to facilitate automatic re-enrollment for existing enrollees. Each challenge would likely be especially pronounced in Georgia, which would lack a central system to receive consumer information transferred from HealthCare.gov. While the state claims it would engage in a “robust” transition plan with a “detailed transition strategy,” the waiver provides no details and subsequent reports to the Departments are not publicly available.

Many Georgians Would Likely Lose Medicaid Coverage

HealthCare.gov also facilitates Medicaid enrollment with a “no-wrong-door” application that routes a person to the program for which they're eligible based on their family size, income, and other factors. In many cases, this prevents someone from needing to complete multiple applications to connect with the correct program. In the open enrollment period for 2021, about 35,000 Georgians who started the process at HealthCare.gov were assessed eligible for Medicaid — more than the number of total enrollees the state projected to gain through the waiver.⁵⁴

Medicaid (including Medicaid managed care organizations) generally doesn't pay commissions. That means brokers and insurers have no incentive to provide information and assistance to consumers who turn out to be eligible for Medicaid rather than subsidized marketplace coverage, so they might not provide these consumers with any help to enroll. For example, a search on HealthCare.gov displays more than 1,500 agents and brokers that enroll people in individual or

⁵¹ Waiver, *op. cit.*, p. 4.

⁵² Waiver, *op. cit.*, p. 78.

⁵³ CBPP calculations from CMS public use files. See also Sarah Lueck, “Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges,” CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

⁵⁴ Centers for Medicare & Medicaid Services, 2021 Marketplace Open Enrollment Period Public Use Files, April 21, 2021, <https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files>. This does not include the number of Medicaid-eligible people who initially applied through the marketplace during the six-month SEP.

family coverage in one Atlanta ZIP code but *zero* agents and brokers that say they'll assist with Medicaid or CHIP enrollment.⁵⁵

Brokers and insurers could also steer low-income consumers toward private coverage, including lower-premium, limited-benefit substandard plans, without explaining that they are eligible for comprehensive coverage through Medicaid. Brokers and insurers receive commissions or make a profit as long as a few of these consumers enroll, even if most are deterred by the premiums or out-of-pocket costs and remain uninsured. Consistent with these incentives, some web brokers already neglect to identify certain children as Medicaid eligible. Consider, for example, a parent and child with household income of \$15,000, which in Georgia would qualify the child (though not the parent) for Medicaid. The web broker GoHealth fails to identify the child as likely Medicaid eligible, saying explicitly that “you may not qualify for government subsidies” and instead displays a list of full-price marketplace plans that include both the parent and Medicaid-eligible child.⁵⁶ Eliminating HealthCare.gov as an unbiased eligibility and enrollment option could significantly decrease enrollment among some of the most vulnerable Georgians.

Privatization Could Steer Healthier Consumers to Non-ACA Plans

The waiver estimates premiums would fall 3.6 to 3.7 percent due to the Georgia Access Model.⁵⁷ Not only is that estimate based on the flawed premise that the state's plan will increase enrollment, but it fails to account for the potential for greater enrollment in substandard plans, which could raise premiums for ACA-compliant coverage (and greatly increase consumers' exposure to catastrophic medical expenses) by pulling healthy people out of comprehensive coverage.

An explicit goal of the waiver is to increase access to coverage that doesn't meet ACA standards.⁵⁸ It envisions an enrollment system that promotes “the full range of health plans licensed and in good standing” in the state, including short-term, fixed indemnity, accident, and single-disease plans, which normally can't be sold alongside ACA plans through enhanced direct enrollment. Short-term plans, in particular, pose a considerable risk to consumers but have grown in popularity, especially in Georgia, since the Trump Administration expanded them in 2018.⁵⁹ One review of the most popular short-term plan in Atlanta found that although it had lower premiums, its deductible and maximum out-of-pocket costs were more than 2.5 times higher than the most popular bronze ACA plan, and it offered no coverage of prescription drugs, mental health services, or maternity care.⁶⁰

⁵⁵ CBPP analysis. HealthCare.gov search conducted on December 8, 2021, using the 30318 ZIP code.

⁵⁶ CBPP analysis as of December 10, 2021. The website also encourages people to alter their income projections to qualify for subsidies.

⁵⁷ Waiver, *op. cit.*, p. 59.

⁵⁸ Waiver, *op. cit.*, p. 4.

⁵⁹ Indemnity plans have also been found to be risky and confusing to consumers. See Christen Linke Young and Kathleen Hannick, “Fixed indemnity health coverage is a problematic form of ‘junk insurance,’” Brookings Institution, August 4, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance/>.

⁶⁰ Dane Hansen and Gabriela Dieguez, “The impact of short-term limited-duration policy expansion on patients and the ACA individual market,” Milliman, February 2020, <https://www.ills.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>. For a comprehensive report detailing problematic short-term plan practices, see Energy and Commerce Committee (Democratic Staff), U.S. House of Representatives, “Shortchanged: How the Trump

Brokers have an incentive to steer consumers toward short-term plans because they tend to pay higher commissions — the waiver notes that brokers selling short-term coverage receive average commissions that are up to 22 percent higher than those for ACA-compliant plans.⁶¹ Insurers also profit on short-term plans, which aren't required to meet the medical loss ratio standards for ACA-compliant plans: short-term plans spent only about 53 percent of premium revenue on medical care, compared to at least 80 percent for ACA plans.⁶²

Experience with enhanced direct enrollment programs shows that these incentives sometimes give rise to “steering,” in which web brokers screen applicants before sending them down the official enrollment pathway and divert some toward substandard plans that pay higher commissions but leave enrollees exposed to catastrophic costs if they get sick.⁶³ For example, some web brokers collect information that is useful in the medically underwritten market (such as height and weight) and feed the information to a broker call center, where the web broker rules prohibiting certain types of steering appear not to apply.⁶⁴ Consumers visiting web broker sites often must agree to telephone solicitation by the web broker, insurance agents, insurance companies, and partner companies, making them ripe for pressure tactics in the future. In addition to the data the consumer voluntarily submits, other information, like browser tracking data, could be gathered and sold. Based on these data, a consumer may see targeted advertisements for alternative non-ACA plans or receive phone solicitations now and in the future, including during the next open enrollment period.

Even under current law, 1 in 4 marketplace enrollees that sought help from a broker or insurer said they were offered a non-ACA-compliant policy as an alternative to marketplace coverage.⁶⁵ And consumers are often subjected to aggressive or even fraudulent marketing tactics.⁶⁶ One study, for example, showed that most brokers gave ambiguous, misleading, or demonstrably false information

Administration’s Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk,” June 2020, https://drive.google.com/file/d/1uiL3Bi9XV0mYnxpyaIMeg_Q-BJaURXX3/view. (Hereafter, House report.) Also see Sarah Lueck, “Key Flaws of Short-Term Health Plans Pose Risks to Consumers,” CBPP, September 20, 2018, <https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers>. For context on the ACA’s metal-tiering of plans, see CBPP, “Cost-Sharing Charges in Marketplace Plans, Answers to Frequently Asked Questions,” updated August 2020, <http://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-answers-to-frequently-asked-questions/>.

⁶¹ Waiver, *op. cit.*, p. 79.

⁶² National Association of Insurance Commissioners, “2020 Accident and Policy Experience Report,” July 2021, <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf>.

⁶³ Tara Straw, “‘Direct Enrollment’ in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm,” CBPP, March 15, 2019, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

⁶⁴ Sabrina Corlette *et al.*, “The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses,” Urban Institute, January 31, 2019, <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>.

⁶⁵ Karen Pollitz *et al.*, “Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need,” Kaiser Family Foundation, August 7, 2020, <https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/>.

⁶⁶ House report, *op. cit.*, p. 29; Corlette *et al.*

regarding short-term plan coverage for COVID-19-related illnesses.⁶⁷ In another recent secret shopper study, brokers recommended short-term and other non-ACA coverage in 75 percent of the marketing calls versus marketplace plans.⁶⁸ Georgia’s proposal would create many new opportunities for deceptive and aggressive marketing.

Healthier people would be more likely to opt for short-term plans, since less healthy people are less likely to qualify for a policy, face higher premiums when they do, and might be more apt to recognize absent benefits and other limitations. If healthier consumers exited the ACA-compliant market, its risk pool would become less healthy, on average, driving up premiums; in states that took advantage of the Administration’s expansion of short-term plans — like Georgia, which has few restrictions — premiums for comprehensive coverage went up by about 4 percent.⁶⁹ The waiver doesn’t account for short-term plan enrollment, its impact on ACA-compliant coverage enrollment, the risk profiles of enrollees in short-term or ACA-compliant plans, or the likelihood of premium increases in the ACA-compliant market.

Then and Now, Waiver Fails Federal Tests for Approval

The Georgia Access Model fails the statutory tests for 1332 waivers. Both prior to approval and even more so now, it does not meet the requirements that waivers cover as many people, with coverage as affordable and comprehensive as would have been covered without the waiver.⁷⁰

Coverage. Georgia’s waiver baseline doesn’t reflect the increased enrollment due to laws, regulations, and policies that have been put into place since the waiver was approved. Therefore, Georgia fails to show that its plan can achieve coverage numbers that are comparable to the enrollment otherwise expected without the waiver. In fact, the plan would likely decrease enrollment. Georgia’s claim that the waiver would increase enrollment rests on the flawed premise that it would introduce a new enrollment option; in reality, it would *eliminate* the option to compare plans and enroll in coverage through a neutral platform. In addition, as discussed above, privatizing the marketplace would make it more difficult for some consumers to enroll in coverage. Transitioning existing enrollees from HealthCare.gov to the new system could lead to additional coverage losses, and there would be no coordinated plan to get new enrollees. In all, the expected effect of the waiver is to reduce coverage, failing the statutory test.

Affordability. The Georgia Access Model would likely *increase* premiums for comprehensive coverage. That’s partly because it is very unlikely to increase marketplace enrollment, an assumption on which its projected 3.4 percent premium reduction is based. In addition, driving more healthy consumers to less comprehensive underwritten plans would likely increase marketplace premiums through adverse selection, something Georgia’s actuarial analysis doesn’t account for. And given the

⁶⁷ Christen Linke Young and Kathleen Hannick, “Misleading marketing of short-term health plans amid COVID-19,” Brookings Institution, March 24, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

⁶⁸ Dania Palanker and JoAnn Volk, “Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period,” Georgetown University Health Policy Institute, Center on Health Insurance Reforms, October 2021, <https://georgetown.app.box.com/s/mn7kgnhibn4kapb46tqmv6i7putry9gt>.

⁶⁹ Hansen and Dieguez, *op. cit.*, p. 3.

⁷⁰ Linke Young and Levitis, *op. cit.*

waiver's reliance on incentives for agents and brokers in the private market, commissions would likely increase, further raising premiums. The state's flawed, incomplete actuarial analysis makes it impossible to know whether the affordability guardrail can be met, on balance.

Comprehensiveness. Georgia's privatization proposal creates new opportunities for brokers and insurers to steer healthy people toward substandard plans that do not meet ACA requirements. Thus, it would likely result in more Georgians enrolled in non-comprehensive plans that expose them to catastrophic costs if they get sick.

2021 FINAL MARKETPLACE SPECIAL ENROLLMENT PERIOD REPORT

The Health Insurance Marketplaces 2021 Special Enrollment Period (SEP) Report summarizes health insurance enrollment activity through the individual Marketplaces during the 2021 SEP. In response to the COVID-19 Public Health Emergency, all state Marketplaces opened an SEP this year that allowed consumers without other qualifying life events to enroll outside of the annual Open Enrollment Period. This report includes SEP data for the 36 states that use the HealthCare.gov eligibility and enrollment platform for the 2021 plan year (HealthCare.gov states), where the SEP ran from February 15 through August 15, 2021, and for the 15 State-based Marketplaces (SBMs) that use their own eligibility and enrollment platforms, for which reporting dates varied.¹

During the 2021 SEP, the American Rescue Plan Act of 2021 (ARP) was signed into law and implemented in the Marketplaces. Under the ARP, more generous advance payments of premium tax credits (APTC) have become available to most consumers, further reducing premiums.² This report also includes data on the benefits of the ARP for consumers in all 50 states, plus the District of Columbia.

Key findings from this report include:

Total Marketplace Signups: Over 2.8 million Americans signed up for new health insurance coverage through HealthCare.gov and State-based Marketplaces during the 2021 Marketplace SEP.

- **HealthCare.gov Plan Selections:** In HealthCare.gov states, 2.1 million Americans signed up for new health insurance coverage using the 2021 Marketplace SEP between February 15 and August 15.
- **State-based Marketplace Plan Selections:** Across the 15 SBMs, 738,000 Americans have signed up for new health insurance coverage through the 15 State-based Marketplaces through the end of their respective reporting periods.³ California, Connecticut, DC, Nevada, New Jersey, New York and Vermont are continuing their SEP through the end of the year.

¹ New Jersey and Pennsylvania transitioned to State-based Marketplaces in 2020, and Nevada transitioned to a State-based Marketplace in 2019. Plan selections from these three states aren't included in the HealthCare.gov data in this report.

² HealthCare.gov implemented the ARP's expanded APTC eligibility and amounts for all consumers on April 1, 2021, and implemented a further APTC and cost-sharing reduction (CSR) expansion on July 1, 2021, for those consumers who received or are approved to receive unemployment compensation for any week beginning in 2021. The State-based Marketplaces implemented these ARP expansions on different schedules.

³ Due to some SBMs' corrections of previously reported new plan selection counts, SBM new plan selections through July 31 were revised to 635,000, from 723,000 reported here: <https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-4>. Total SEP new plan selections for all 50 states plus the District of Columbia through July 31, 2021 were 2.5 million.

- **Demographic Trends:** Due to the ARP expansion, HealthCare.gov consumers with a household income over 400% FPL represented a greater proportion of plan selections compared to the same period in past years, increasing from less than 2 percent in 2019 and 2020 to 7 percent in 2021. The 2021 SEP also attracted a more diverse group of consumers in HealthCare.gov states. Among consumers who attested to a race or ethnicity, 15 percent identified as African American, compared to 9 percent and 11 percent in 2019 and 2020, respectively. The percentage of consumers who self-reported as Hispanic/Latino increased to 19 percent, from 16 percent in 2019 and 2020.
- **Geographic Trends:** In several states that have not expanded Medicaid, there are counties with an average of at least 40 new plan selections per one thousand nonelderly residents--a notable contrast from HealthCare.gov states that have expanded Medicaid, where 96 percent of counties had 15 or fewer new plan selections per every one thousand nonelderly residents.

Consumer Savings: The ARP has substantially reduced enrollee premiums, as well as cost-sharing, by making richer coverage more affordable.

- **Premiums:**
 - Nationwide, existing consumers with a new or updated plan selection after ARP implementation saved an average of \$67 (or 50%) per consumer per month on premiums, totaling \$537 million per month in savings. In twenty states and the District of Columbia, existing consumers saved over \$75 per month, on average, due to the ARP APTC expansion.
 - Nearly half of HealthCare.gov consumers with a new plan selection from February 15 to August 15 had a monthly premium of \$10 or less, compared to 25 percent during the same period in 2020.
 - Across the SBMs, 33 percent of consumers with a new plan selection had a monthly premium of \$10 or less. Following implementation of ARP in the SBMs, consumers saw substantial premiums savings of approximately \$95 per month.
- **Cost-Sharing:** The median deductible for new consumers selecting plans through HealthCare.gov between February 15 and August 15 decreased by more than 90 percent, from \$750 in 2020 and 2019 to \$50 in 2021. Over 40 percent of new consumers signing up during the 2021 SEP enrolled in plans that cover 94 percent of their expected health care costs (94% actuarial value), which the ARP made available to most consumers with an income between 100% and 150% of the Federal Poverty Level (FPL) for a \$0 premium.

NEW SEP PLAN SELECTIONS THROUGH THE MARKETPLACES

Over 2.8 million consumers enrolled in a Marketplace plan during the 2021 SEP. This includes 2.1

million consumers in states using the HealthCare.gov platform (see Table 1) and 738,000 consumers in SBMs using their own platforms (see Table 2). In HealthCare.gov states, the number of new plan selections from the start of the SEP on February 15, 2021, through August 15, 2021, was nearly three times the enrollment during the same time period in 2020 and nearly four times the enrollment during the same period in 2019.

In SBM states, the number of new plan selections in this report reflects the timeframe of each SBM’s active 2021 SEP, which varied by state. Some SBMs will continue to operate their SEPs through the end of the year and reported data through August 31, 2021. The data provided is only for the SBMs’ 2021 SEPs and does not include new plan selections during SBM 2020 SEP windows, which most SBMs implemented in response to the COVID-19 Public Health Emergency.

Figure 1 shows 2021 SEP new plan selections per 1,000 nonelderly residents by county for HealthCare.gov states and by state for SBM states. While only 33 percent of the U.S nonelderly population live in states that have not expanded Medicaid, they accounted for 55 percent of enrollment during the 2021 SEP.⁴ Medicaid non-expansion states saw much higher enrollment rates than expansion states, with average enrollment per 1,000 nonelderly residents 2.5 times that of expansion states, likely due to higher baseline uninsured rates in non-expansion states.

Table 1: New SEP Plan Selections in HealthCare.gov States, February 15 – August 15

New SEP Plan Selections by HealthCare.gov State, February 15 – August 15			
State	2021	2020	2019
Total	2,069,596	751,835	554,385
Alaska	4,069	1,460	1,421
Alabama	42,094	13,084	9,243
Arkansas	19,390	6,175	6,107
Arizona	40,827	13,678	13,060
Delaware	5,882	2,583	2,036
Florida	542,067	222,588	152,295
Georgia	147,463	41,138	25,656
Hawaii	4,130	3,014	1,949
Iowa	15,246	6,644	5,875
Illinois	54,432	25,272	22,958
Indiana	27,984	11,810	11,375
Kansas	21,220	7,693	6,124

⁴ For the purposes of this report, Missouri is categorized as a non-expansion state since its expansion of Medicaid will not take effect until 10/1. Oklahoma is categorized as neither a Medicaid expansion nor non-expansion state, as its expansion took place on 7/1 in the middle of the 2021 SEP.

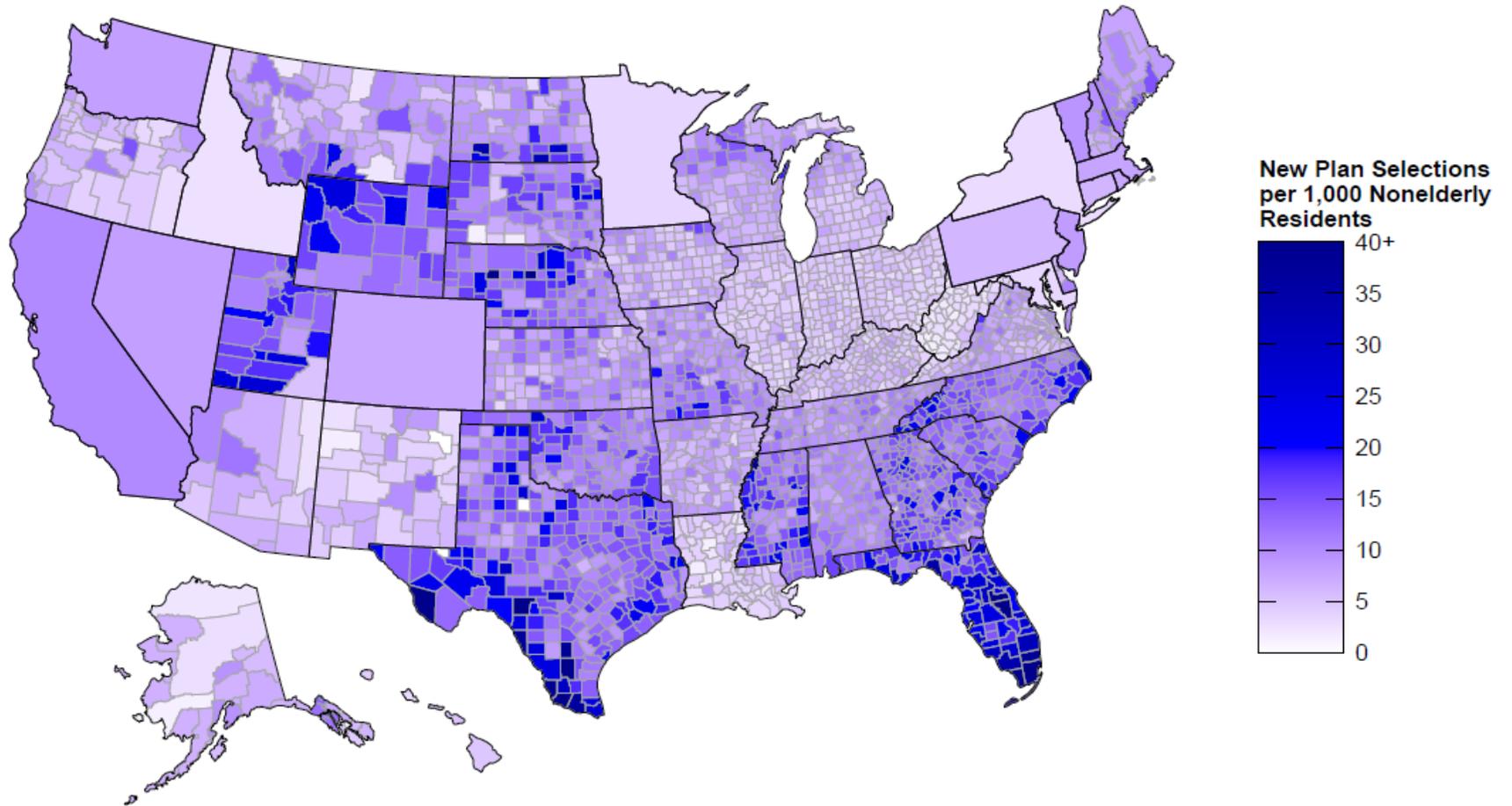
New SEP Plan Selections by HealthCare.gov State, February 15 – August 15			
State	2021	2020	2019
Kentucky	20,827	7,522	8,613
Louisiana	17,608	6,537	7,567
Maine	10,583	4,755	4,107
Michigan	47,306	22,730	20,253
Missouri	52,143	16,531	11,608
Mississippi	32,441	9,269	5,545
Montana	7,653	3,782	3,369
North Carolina	124,246	39,344	30,235
North Dakota	5,316	2,066	1,693
Nebraska	15,498	7,205	6,565
New Hampshire	9,004	4,353	3,998
New Mexico	9,203	2,961	3,062
Ohio	48,560	19,273	16,259
Oklahoma	37,259	19,258	14,251
Oregon	22,743	12,354	12,036
South Carolina	59,713	17,214	11,277
South Dakota	7,644	2,715	2,416
Tennessee	57,934	18,961	11,761
Texas	416,987	121,226	66,031
Utah	42,925	18,084	16,721
Virginia	54,518	19,876	18,577
Wisconsin	33,716	16,411	16,908
West Virginia	4,195	1,773	1,495
Wyoming	6,770	2,496	1,939

Table 2: 2021 New SEP Plan Selections in SBM States

New SEP Plan Selections by SBM State	
Total	737,922
California	338,557
Colorado	36,396
Connecticut	18,535
District of Columbia	2,433
Idaho	3,920
Maryland	17,217
Massachusetts	44,179
Minnesota	16,583
Nevada	21,450

New SEP Plan Selections by SBM State	
New Jersey	63,028
New York	47,116
Pennsylvania	64,900
Rhode Island	6,564
Vermont	4,517
Washington	52,527

Figure 1: 2021 New SEP Plan Selections per 1,000 Nonelderly Residents⁵



⁵ Data for HealthCare.gov states are at the county level, while SBM data are at the state level because county-level SBM enrollment data were not available at the time of this report. In counties with 1 to 10 plan selections, statewide median values were used in place of the county-level new plan selections per 1,000 nonelderly residents. Due to data anomalies, the value of plan selections per 1,000 nonelderly residents in Borden County, TX, was replaced with Texas' median value of new plan selections per 1,000 nonelderly residents.

CONSUMERS APPLYING FOR AND SELECTING PLANS: DETAILS

Table 3 displays metrics on the consumers in HealthCare.gov states who requested coverage on a submitted application on or after February 15 and who did not have coverage as of February 14 of each year. During the 2021 SEP, 85 percent of applicants requesting coverage through HealthCare.gov were determined eligible to make a Marketplace plan selection, compared to 79 percent in 2020 and 78 percent in 2019. While the percentage of consumers who applied for coverage and were preliminarily determined eligible for their state’s Medicaid or Children’s Health Insurance Program (CHIP) fell by 6 percentage points, to 14 percent, in comparison to 2020 and 2019, the number of consumers preliminarily determined Medicaid or CHIP eligible in 2021 increased by more than 167,000 and 233,000 from 2020 and 2019, respectively.⁶

Table 3: Application Activity and Eligibility in HealthCare.gov States, February 15 – August 15

HealthCare.gov Application Activity and Eligibility, February 15 – August 15						
	2021		2020		2019	
	Count	% of Total	Count	% of Total	Count	% of Total
New Consumers Requesting Coverage on or after February 15	3,883,935	100	1,867,381	100	1,565,918	100
Marketplace Eligible	3,291,781	85	1,470,769	79	1,225,265	78
Medicaid/CHIP Eligible	541,273	14	373,851	20	307,973	20

Table 4 shows demographic and plan characteristics among consumers with a SEP plan selection on HealthCare.gov between February 15 and August 15 of 2021, 2020, and 2019. Many of the changes in the demographic composition and plan choices of consumers in 2021 compared to prior years are due to the impacts of the ARP. For example, the percent of 2021 SEP consumers with a household income over 400% FPL increased to 7 percent from 2 percent in 2020 and 1 percent in 2019; these consumers are newly eligible for APTCs under the ARP. Relative to 2020, the percentage of consumers in all income categories between 100% to 400% FPL declined due to consumers newly eligible for APTC representing a greater share of total plan selections.⁷ During the 2021 SEP, 93 percent of consumers had their premiums reduced by APTC, compared to 89 percent in 2020 and 88 percent in 2019. The percentage of consumers who received cost-sharing

⁶ For HealthCare.gov states, individuals are generally determined eligible for either a Marketplace plan or Medicaid/CHIP, but there are cases where an individual is determined eligible for both Marketplace coverage and Medicaid/CHIP or neither. However, if a consumer is determined eligible for Medicaid/CHIP, they are typically not assessed for Marketplace eligibility.

⁷ For a family of four, a household income between 100% to 400% FPL generally corresponds to an annual household income of between \$26,200 and \$104,800 for coverage year 2021. This information can be found online at <https://aspe.hhs.gov/2020-poverty-guidelines>.

reductions (CSRs) increased to 58 percent from 54 percent and 57 percent in 2020 and 2019 respectively, and over 40 of percent of 2021 SEP enrollees are enrolled in plans that cover 94 percent of their expected health care costs (94% AV), partially due to the ARP making these plans available for zero premium for most consumers in the 100-150% FPL category.

Table 4 also provides selected data on demographics and financial assistance for consumers in SBM states. Consumers with new SEP plan selections in SBM states tend to have higher incomes compared to those in HealthCare.gov states, primarily because all SBM states have expanded Medicaid, and in New York and Minnesota, consumers with incomes below 200% of FPL who aren't Medicaid eligible are generally enrolled in the Basic Health Program. For example, in SBM states, 21 percent of new SEP plan selections were by consumers who reported income of 100-150% FPL, while 42 percent of consumers with new SEP plan selections in HealthCare.gov states fell in this income category. Similarly, 12 percent of new SEP consumers in SBM states reported income of over 400 percent of FPL, compared to 7 percent of SEP consumers in HealthCare.gov states.

Table 4: Demographic and Plan Characteristics of Consumers with New SEP Plan Selections (HealthCare.gov States Only Unless Otherwise Noted)

Demographic and Plan Characteristics of New SEP Plan Selections			
	% of Total 2021⁸	% of Total 2020⁸	% of Total 2019⁸
Age			
< 18	12	16	21
18 - 34	30	31	30
35 - 54	36	32	29
55+	22	22	20
Gender			
Female	54	55	56
Male	46	45	44
Location			
Rural	17	16	18
Non-rural	83	84	82
Race: HealthCare.gov States			
Race Known	47	49	56
African American	15	11	9
Asian	7	8	7
White	71	75	76

⁸ Totals may not sum to 100% due to rounding.

Demographic and Plan Characteristics of New SEP Plan Selections			
	% of Total 2021⁸	% of Total 2020⁸	% of Total 2019⁸
Other Race ⁹	7	7	7
Race Unknown	53	51	44
Ethnicity: HealthCare.gov States			
Ethnicity Known	60	59	64
Hispanic/Latino	19	16	16
Not Hispanic/Latino	81	84	84
Ethnicity Unknown	40	41	36
Race/Ethnicity: SBMs			
Race/Ethnicity Known ¹⁰	69	NA	NA
Hispanic/Latino	23	NA	NA
African American	7	NA	NA
Asian	16	NA	NA
White	56	NA	NA
Race/Ethnicity Unknown	31	NA	NA
Household Income: HealthCare.gov States			
< 100% FPL	3	2	2
100% – 150% FPL	42	43	38
100% – 138% FPL	33	36	30
> 150% – 250% FPL	29	30	34
> 250% – 400% FPL	16	17	18
> 400% FPL	7	2	1
Other Household Income ¹¹	3	6	6
Household Income: SBMs			
< 100% FPL	2	NA	NA
100% – 150% FPL	21	NA	NA
100% – 138% FPL	5	NA	NA
> 150% – 250% FPL	30	NA	NA
> 250% – 400% FPL	24	NA	NA
> 400% FPL	12	NA	NA

⁹ Other Race includes multi-racial, Native Hawaiian/Pacific Islander, and American Indian/Alaskan Native.

¹⁰ SBM known race/ethnicity percentages sum to greater than 100% because some states report consumers in more than one race/ethnicity category.

¹¹ Other household income includes plan selections for which consumers were not requesting financial assistance and households with unknown household income.

Demographic and Plan Characteristics of New SEP Plan Selections			
	% of Total 2021⁸	% of Total 2020⁸	% of Total 2019⁸
Other Household Income	11	NA	NA
Financial Assistance			
With APTC: All States	91	NA	NA
HealthCare.gov States	93	89	88
SBMs	84	NA	NA
With CSR	58	54	57
73% AV	4	4	6
87% AV	13	13	16
94% AV	41	36	34
American Indian / Alaskan Native	<1	<1	1
Metal Level			
Catastrophic	<1	<1	<1
Bronze	30	33	27
Silver	62	57	63
Gold	8	8	9
Platinum	<1	<1	<1
Total Plan Selections: All States	2,807,518	NA	NA
HealthCare.gov States	2,069,596	751,835	554,385
SBMs	737,922	NA	NA

CONSUMER SAVINGS THROUGH THE AMERICAN RESCUE PLAN

In March 2021, the American Rescue Plan Act of 2021 (ARP) was signed into law, establishing improvements in access to and affordability of health coverage through the Marketplace by expanding eligibility for APTC to consumers with household incomes over 400 percent of FPL and increasing the generosity of premium tax credits to consumers who were previously eligible for APTC. On April 1, 2021, HealthCare.gov implemented the expanded APTC eligibility criteria amounts, which further reduced the portion of monthly premiums paid by consumers. The SBM states implemented the ARP provisions on different timelines.

Table 5 shows the average premiums for consumers who made plan selections in HealthCare.gov states between February 15 and August 15. The average premium after APTC for new consumers fell 30 percent, from \$117 in 2020 to \$81 in 2021. Likewise, the average monthly APTC amount for new consumers increased by 12 percent, from \$418 in 2020 to \$468 in 2021, as a result of the ARP making more consumers APTC-eligible and increasing financial assistance across income

levels. In total, new consumers who enrolled during the 2021 SEP through HealthCare.gov and received APTC had their premiums reduced by nearly \$1 billion per month. As shown in Figure 2, the percent of consumers with a monthly premium \$10 or less after APTC accounted for 48% of new plan selections (990,000) during the 2021 SEP, compared to 25 percent of new plan selections (187,000) during the same period in 2020.

Table 5 also shows that existing consumers in HealthCare.gov states (those who had an active plan selection prior to April 1, 2021) benefited from an average premium reduction of \$53 per month, or 49%. HealthCare.gov automatically reduced the premiums of 2.6 million existing consumers, resulting in \$160 million of monthly savings that took effect on September 1, 2021.

Table 5 also includes the average premiums for consumers who made plan selections in SBM states following SBM implementation of the ARP’s expanded APTC eligibility criteria amounts and the new benefits available to consumers receiving unemployment compensation. It shows that existing consumers benefited from an average premium reduction of \$95 per month due to ARP. Most SBMs implemented automatic redeterminations to determine if enrollees were eligible for ARP savings, which may have included consumers with incomes over 400% FPL. Together the SBMs reduced premiums for 2.7 million consumers.

Table 5: Average Monthly Premium before and after APTC

	Number	% of Plan Selections with ≤\$10 Premium after APTC	Average Monthly Premium Savings due to ARP	Average Monthly Premium after APTC	Average Monthly Premium before APTC	Average Monthly APTC
New SEP Plan Selections						
2021: All States	2,807,518	44%	NA	\$97	NA	NA
2021: HealthCare.gov States	2,069,596	48%	NA	\$81	\$549	\$468
2021: SBMs	737,922	33%	NA	\$142	NA	NA
2020: HealthCare.gov States	751,835	25%	NA	\$117	\$534	\$418
2019: HealthCare.gov States	554,385	28%	NA	\$116	\$535	\$419
Existing Consumers with a New or Updated Plan Selection after ARP Implementation						
All States	8,017,151	43%	-\$67	\$68	NA	NA
HealthCare.gov States	5,308,667	45%	-\$53	\$56	\$605	\$549
Actively-Returned	2,712,360	43%	-\$43	\$61	\$597	\$535
Auto-Redetermined	2,596,307	48%	-\$62	\$50	\$613	\$564
SBMs	2,708,484	39%	-\$95	\$92	NA	NA

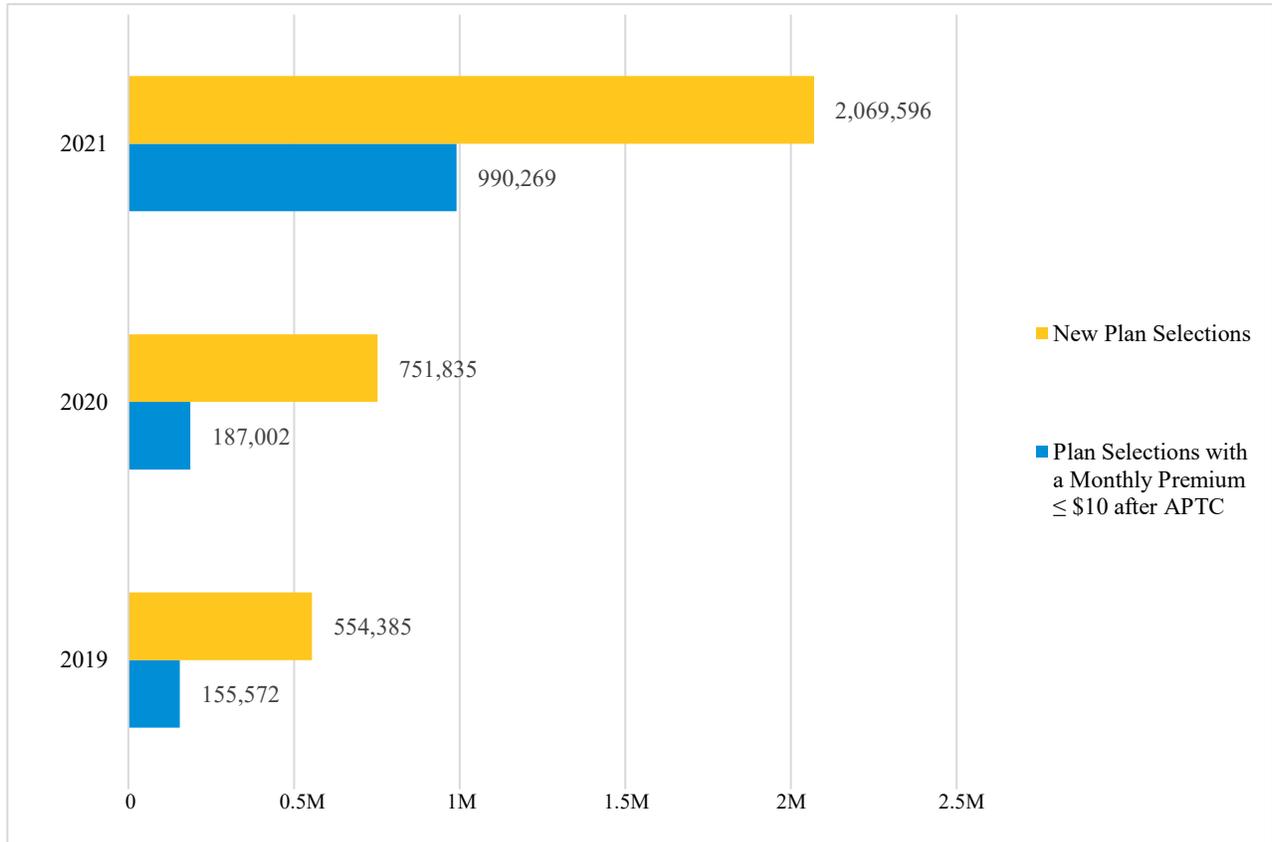
The ARP also provides additional benefits to consumers who are in a household where a tax filer receives or is approved to receive unemployment compensation (UC) for any week beginning in 2021. These consumers are eligible for enhanced APTCs and CSRs, regardless of annual income, and most of them can purchase a plan that covers an average of 94 percent of their expected health care costs for a \$0 premium after APTC.¹² Table 6 shows that after July 1, 2021, when HealthCare.gov implemented the UC provision, nearly 209,000 HealthCare.gov consumers made a plan selection or went through automatic redetermination that made them eligible for additional APTC due to the ARP’s UC provision. Out of these consumers, more than 34,000 would not have been eligible for APTC or CSRs at all without the ARP’s UC provision because they have an annual income less than 100% FPL and live in states that have not expanded Medicaid.

Table 6: Consumers Benefiting from the ARP UC Provision in HealthCare.gov States, July 1 – August 15, 2021

Consumers with a Plan Selection who are Eligible for Additional APTC due to the ARP UC Provision	208,622
New Consumers	84,246
Existing Consumers	124,376
Consumers Not Eligible for any APTC without the ARP UC Provision	34,134

¹² The ARP UC provision treats all eligible consumers as though they have an annual household income equal to 133% FPL. As a result, these consumers are eligible for an APTC amount equal to the second lowest cost silver plan’s (SLCSP’s) premium attributable to essential health benefits (EHBs). When the SLCSP covers only EHBs, the APTC covers the entire premium. Some states require plans to cover non-EHBs, which means that plan premiums in the state cannot be reduced by APTCs to zero dollars. However, due to the comprehensiveness of the Affordable Care Act’s EHBs, non-EHB portions of premiums are typically relatively small. For more details on EHBs see: <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>.

Figure 2: Total New SEP Plan Selections, and New SEP Plan Selections with a \$10 or Less Premium after APTC in HealthCare.gov States, February 15 – August 15¹³



¹³ In 2019 and 2020, SEPs were available primarily only for qualifying life events. In 2021, the Biden-Harris Administration opened a SEP for all consumers on HealthCare.gov, in response to the COVID-19 Public Health Emergency.

Figure 3 illustrates the distributions of monthly premiums after APTC for consumers in HealthCare.gov states during the 2021 Open Enrollment Period (OEP), compared to the 2021 SEP, which again highlights how ARP has made coverage more affordable for consumers. During the 2021 SEP, 37 percent of consumers selected plans with \$0 monthly premium after APTC, versus only 13 percent during the 2021 OEP, and two-thirds of SEP consumers had monthly premiums of \$50 or less, compared to 41 percent for OEP consumers. It is important to note that consumers during both enrollment periods had access to the same plan choices for 2021 coverage.

Figure 3: 2021 OEP & SEP Monthly Premium Distribution in HealthCare.gov States

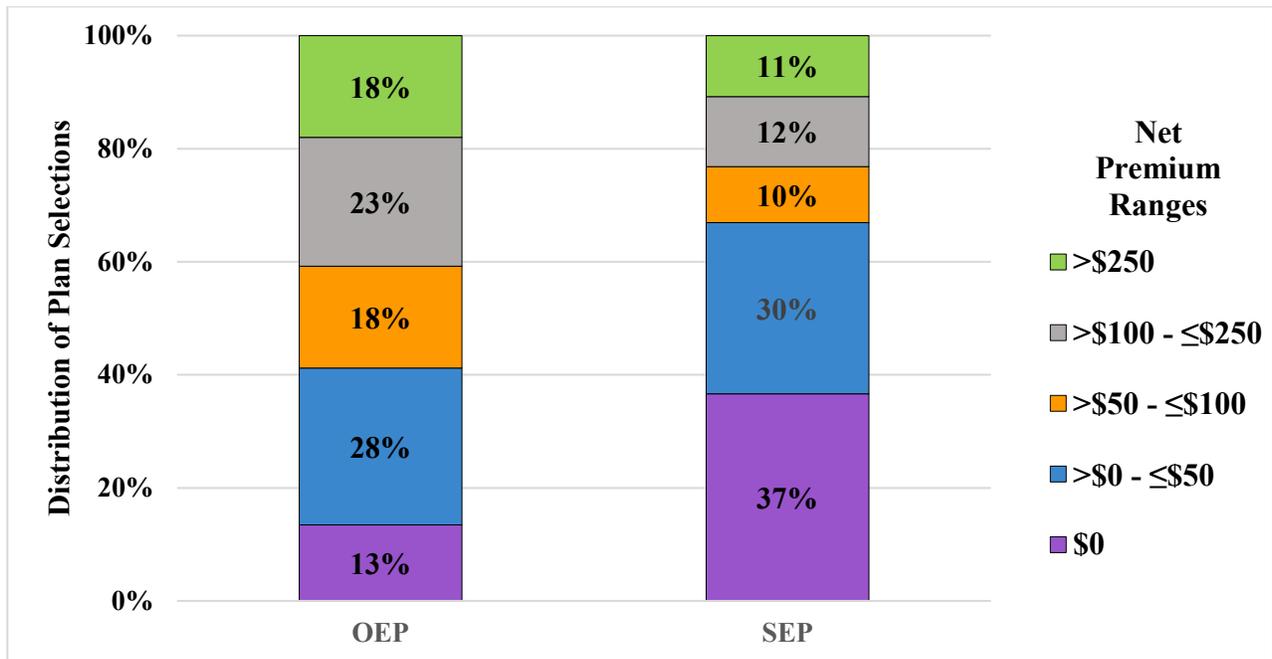


Table 7 details average monthly savings for existing consumers in all 50 states plus the District of Columbia, as well as aggregate monthly savings for consumers in each state due to the ARP. The total monthly aggregate savings for over 8 million existing consumers was \$537 million with an average premium savings of \$67 per consumer per month. Due to the ARP, most states saw substantial decreases in premiums after APTC. In 28 states, the average monthly premium reduction was 50 percent or more. In the District of Columbia and in twenty states (Arkansas, California, Connecticut, Delaware, Hawaii, Illinois, Indiana, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New York, Ohio, Oregon, Pennsylvania, Vermont, Washington, and West Virginia) existing consumers saved, on average, over \$75 per month due to the ARP expansion.

Table 7: Existing Consumer Savings through ARP

Existing Consumer Savings due to ARP				
State	Existing Consumers with a New or Updated Plan Selection after ARP Implementation	% Reduction in Average Monthly Premium after APTC due to ARP Expansion	Average Monthly Premium Savings due to ARP APTC Expansion	Total Monthly Aggregate Savings for Existing Consumers
Total	8,017,151	50%	\$67	\$537,100,000
Alaska	10,527	55%	\$67	\$700,000
Alabama	91,685	59%	\$60	\$5,500,000
Arkansas	43,176	52%	\$76	\$3,300,000
Arizona	92,336	49%	\$73	\$6,700,000
California	1,403,925	49%	\$90	\$126,400,000
Colorado	26,338	29%	\$55	\$1,400,000
Connecticut	42,588	60%	\$137	\$5,800,000
Delaware	15,349	53%	\$78	\$1,200,000
District of Columbia	1,241	27%	\$156	\$200,000
Florida	1,548,838	48%	\$40	\$62,000,000
Georgia	356,487	54%	\$49	\$17,500,000
Hawaii	11,480	55%	\$78	\$900,000
Idaho	55,648	44%	\$44	\$2,400,000
Iowa	28,959	58%	\$73	\$2,100,000
Illinois	181,823	40%	\$77	\$14,000,000
Indiana	75,059	40%	\$80	\$6,000,000
Kansas	57,857	48%	\$63	\$3,600,000
Kentucky	40,076	48%	\$75	\$3,000,000
Louisiana	50,194	46%	\$73	\$3,700,000

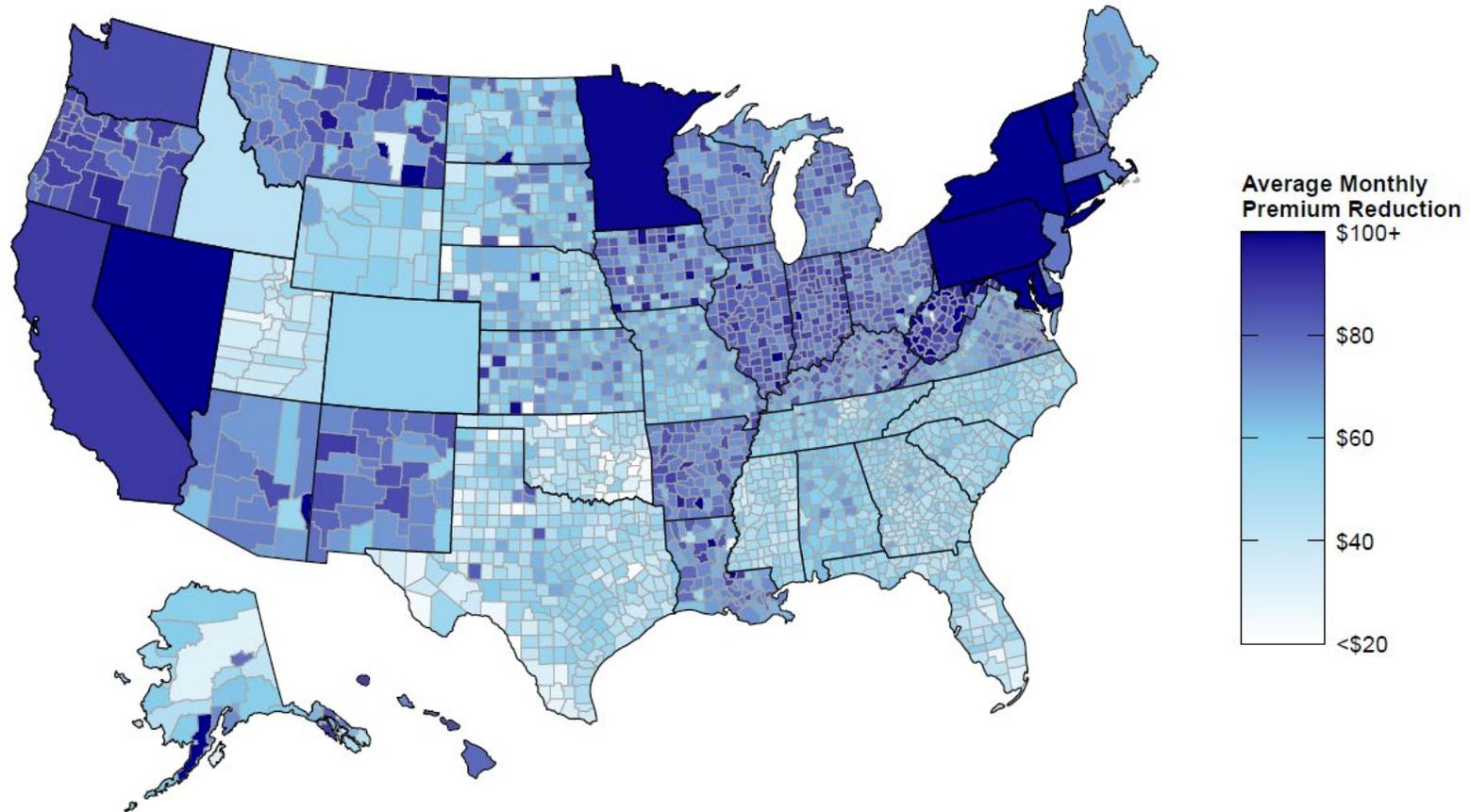
Existing Consumer Savings due to ARP				
State	Existing Consumers with a New or Updated Plan Selection after ARP Implementation	% Reduction in Average Monthly Premium after APTC due to ARP Expansion	Average Monthly Premium Savings due to ARP APTC Expansion	Total Monthly Aggregate Savings for Existing Consumers
Maine	36,757	52%	\$72	\$2,600,000
Maryland	78,837	68%	\$175	\$13,800,000
Massachusetts	225,492	43%	\$78	\$17,600,000
Michigan	167,137	45%	\$71	\$11,900,000
Minnesota	58,678	37%	\$99	\$5,800,000
Missouri	132,272	51%	\$62	\$8,200,000
Mississippi	76,200	59%	\$48	\$3,700,000
Montana	25,601	50%	\$75	\$1,900,000
North Carolina	330,341	53%	\$53	\$17,500,000
North Dakota	12,156	56%	\$60	\$700,000
Nebraska	39,254	61%	\$57	\$2,200,000
Nevada	73,121	60%	\$140	\$10,200,000
New Hampshire	24,572	48%	\$80	\$2,000,000
New Jersey ¹⁴	202,677	57%	\$77	\$15,600,000
New Mexico	21,827	51%	\$74	\$1,600,000
New York	113,953	48%	\$155	\$17,700,000
Ohio	115,924	42%	\$77	\$8,900,000
Oklahoma	86,704	56%	\$47	\$4,100,000
Oregon	72,355	46%	\$84	\$6,100,000
Pennsylvania	266,270	68%	\$100	\$26,600,000
Rhode Island	26,335	37%	\$65	\$1,700,000
South Carolina	128,681	48%	\$54	\$6,900,000
South Dakota	19,297	56%	\$61	\$1,200,000
Tennessee	125,155	51%	\$59	\$7,400,000
Texas	855,461	46%	\$42	\$35,900,000
Utah	133,763	59%	\$40	\$5,400,000
Vermont	3,446	62%	\$186	\$600,000
Virginia	159,014	55%	\$65	\$10,300,000
Washington	129,935	47%	\$86	\$11,200,000
Wisconsin	116,597	50%	\$75	\$8,700,000

¹⁴ New Jersey's premium reduction and monthly premium amount includes the application of state subsidies in addition to APTC.

Existing Consumer Savings due to ARP				
State	Existing Consumers with a New or Updated Plan Selection after ARP Implementation	% Reduction in Average Monthly Premium after APTC due to ARP Expansion	Average Monthly Premium Savings due to ARP APTC Expansion	Total Monthly Aggregate Savings for Existing Consumers
West Virginia	12,100	38%	\$91	\$1,100,000
Wyoming	13,653	65%	\$55	\$800,000

Figure 4 shows the average monthly premium savings for existing consumers due to the ARP expansion by county for HealthCare.gov states and by state for SBM states. There is a wide variation in the average savings by state due to differences in the demographic composition of consumers and automatic APTC redetermination operations in some SBMs that included previous APTC-ineligible consumers with an income over 400% FPL. States that have expanded Medicaid, have an older population, or have higher gross premiums before APTC generally have larger average savings. However, smaller average savings is also generally correlated with lower premiums after APTC. For example, for existing consumers after the ARP implementation, Florida has an average savings of \$40 per month, with a \$44 premium after APTC. On the other hand, Indiana has an average savings of \$80, with a \$119 premium after APTC.

Figure 4: Average Monthly Premium Savings due to ARP APTC Expansion by State and County¹⁵



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¹⁵ Data for HealthCare.gov states are at the county level, while SBM data are at the state level because county-level SBM enrollment data were not available at the time of this report. In HealthCare.gov counties with 1 to 10 existing consumers with a new or updated plan selection after ARP implementation, statewide median values were used in place of the county-level average monthly premium reduction values.

**APPENDIX A:
TERMS AND DEFINITIONS**

HealthCare.gov States: This report refers to the 36 states with Marketplaces that use the HealthCare.gov platform for the 2021 coverage year. The 36 states for 2021 include: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. Nevada (2019), New Jersey (2020), and Pennsylvania (2020) are not included in the 2019 and 2020 HealthCare.gov new plan selections, as they transitioned SBMs during those years.

State-based Marketplace (SBM) States: This report refers to the 14 states and the District of Columbia with Marketplaces that operate their own eligibility and enrollment platforms. The 15 SBMs for 2021 are California, Colorado, Connecticut, the District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington. Generally, the data metric definitions provided here are applicable to the SBM metrics, with some exceptions. Please contact the SBMs for additional information on their metrics. The 15 SBMs for 2021, and their SEP start, end, and reporting dates are below:

SBM	SEP Start Date (Reporting Date, if different)	SEP End Date
California	2/1	12/31
Colorado	2/8	8/15
Connecticut	2/15	10/31
District of Columbia	2/1 (2/9)	1/31
Idaho	3/1	4/30
Maryland	12/16 (2/1)	8/15
Massachusetts	1/24 (2/1)	7/23
Minnesota	2/16	7/16
Nevada	2/15	8/15
New Jersey	2/1	12/31
New York	2/1	12/31
Pennsylvania	2/15	8/15
Rhode Island	1/24 (2/15)	8/15
Vermont	2/16	10/1
Washington	2/15	8/15

New SEP Plan Selections (HealthCare.gov States): The number of unique consumers who didn't have an active enrollment as of February 14, and made a plan selection on or after February 15, that is active as of August 15. An active plan selection is one that is non-cancelled with an end date

of December 31. While this plan selection metric is net of cancellations and terminations that occur during the reporting period, it doesn't represent effectuated enrollments because reconciliation activity may continue in later periods.

New SEP Plan Selections (SBMs): The number of unique consumers who didn't have an active enrollment as of the start of the SBM's SEP, and made a plan selection during the SBM's SEP, that is active as of the end of the SEP, or August 31, 2021 if the SEP continues beyond August. Some SBMs had 2021 SEP start dates prior to 2/1 for which this data does not account. Note that this report does not fully reflect the plan selections made by consumers in the SBMs during the COVID-19 pandemic as it does not include data from the 2020 SEPs that most SBMs also implemented.

New Plan Selections per 1,000 Nonelderly Residents: The total number of new plan selections by county, from February 15 to August 15, 2021, divided by the total number of residents under age 65 by county multiplied by 1,000. Census Bureau's 2020 population estimates were utilized to determine the total number of residents under age 65 by county. These data can be found at <https://www2.census.gov/programs-surveys/popest/datasets/2010-2020/counties/asrh/CC-EST2020-ALLDATA6.csv>.

New Consumers Requesting Coverage on an Application Submitted on or after February 15: The number of unique consumers who submitted an application and are requesting coverage on or after February 15, and didn't have an active enrollment as of February 14. If determined eligible for Marketplace coverage, a consumer still needs to pick a health plan (i.e., plan selection) and pay the premium to have coverage (i.e., effectuate enrollment).

Marketplace Eligible: The number of unique new consumers requesting coverage on an application submitted on or after February 15, who are determined eligible to enroll in a Marketplace health plan, regardless of whether they applied for or are eligible for financial assistance.

Medicaid/CHIP Eligible: The number of unique new consumers requesting coverage on an application submitted on or after February 15, who are assessed or determined eligible for enrollment in Medicaid or the Children's Health Insurance Program (CHIP).

Rural/Non-Rural: The percent of consumers residing in rural locations based on ZIP code, as defined by the Health Resources and Services Administration (HRSA). This file is available at <https://www.hrsa.gov/ruralhealth/aboutus/definition/datafiles.html>.

Financial Assistance (with APTC): The percent of consumers with a plan selection that has an applied APTC amount greater than \$0.

Financial Assistance (with CSR): The percent of consumers receiving CSRs. The actuarial value

(AV), or percentage of total average costs for covered benefits that a plan covers, is higher for a plan with CSRs than a standard plan due to reduced copays, coinsurance values, deductibles, or maximum out of pocket limits. Consumers eligible for CSRs generally need to select a silver plan in order to receive these CSRs. Consumers eligible for CSRs due to their American Indian or Alaskan Native status can receive CSRs in all non-catastrophic plans.

The 73% AV silver plan variation is available to consumers who are eligible for APTC and have a household income greater than 200% FPL and less than or equal to 250% FPL. The 87% AV silver plan variation is available to APTC-eligible consumers with a household income greater than 150% FPL and less than or equal to 200% FPL. The 94% AV silver plan variation is available to APTC-eligible consumers with a household income greater than or equal to 100% and less than or equal to 150% FPL, and under the ARP, consumers who are in a tax household where someone received or was approved to receive UC for any week beginning in 2021, regardless of household income.

Average Monthly Premium before APTC: The average monthly premium per member, before the application of any APTC.

Average Monthly Premium after APTC: The average monthly enrollee share of the premium per member, after applying APTC. The average includes all consumers, including those without APTC.

Average Monthly APTC: The average monthly APTC amount per member applied to a plan selection. The average includes all consumers, including those without APTC. Consumers will receive less than the maximum APTC that they are eligible for if they don't apply the maximum APTC amount and instead claim the credit when they file taxes, or if their maximum APTC is greater than their selected plan's premium attributable to essential health benefits (EHBs). Consumers can only apply APTC towards a plan's EHB premium.

Existing Consumers with a New or Updated Plan Selection (HealthCare.gov States): The number of unique consumers who had an active enrollment as of March 31, 2021, and have a new plan selection on or after April 1, 2021, that is active as of August 15, 2021. An active plan selection is one that is non-cancelled with an end date of December 31, 2021. Consumers who actively reselected their existing plan, those who selected a new plan, and those who had their enrollee share of the premium reduced as a result of an automatic APTC redetermination are included.

- **Actively-Returned:** The number of unique existing consumers with an active enrollment as of March 31, 2021, who actively returned to the Marketplace and made a new plan selection on or after April 1, 2021.

Consumers who made an active plan selection from April 1 to June 30, 2021, did not update their application on or after July 1, 2021, and were in a tax household where a

tax filer attested to receiving UC in 2021 may have also had their enrollee share of the premium reduced as the result of an automatic APTC redetermination.

- **Automatically-Redetermined:** The number of unique existing consumers with an active enrollment as of March 31, 2021, who did not actively make a new plan selection on or after April 1, 2021, and had their enrollee share of the premium reduced as a result of an automatic APTC redetermination.

Existing Consumers with a New or Updated Plan Selection (SBMs): The number of unique consumers who had an active enrollment prior to the SBM's implementation of the new ARP provisions (expanded APTC eligibility criteria and the new benefits available to consumers receiving unemployment compensation), and have an updated plan selection after that date, that is active as of the end of the reporting period. Consumers who actively returned to the SBM to make a new plan selection and those who received an automatic eligibility redetermination that resulted in premium savings are included. Most SBMs included consumers above 400% FPL in their automatic redeterminations.

Consumers with a Plan Selection who were Eligible for Additional APTC due to the ARP UC Provision: The number of unique HealthCare.gov consumers who were in a tax household where a tax filer attested to receiving or being approved to receive UC in 2021, have a new plan selection with APTC on or after July 1, 2021, that is active as of August 15, 2021, and have a household income above 150% FPL or below 100% FPL. Without the ARP UC provision, these consumers would not have been APTC-eligible or would be eligible for less APTC. Consumers with a household income below 100% FPL who were already APTC-eligible because they were denied Medicaid or CHIP due to immigration status are excluded. Consumers who actively reselected their existing plan, those who selected a new plan, and those who had their enrollee share of the premium reduced as a result of an automatic APTC redetermination are included.

- **New Consumers:** The number of unique consumers with a plan selection who were eligible for additional APTC due to the ARP UC provision and did not have an active enrollment as of June 30, 2021.
- **Existing Consumers** The number of unique consumers with a plan selection who were eligible for additional APTC due to the ARP UC provision and had an active enrollment as of June 30, 2021.
- **Consumers Not Eligible for any APTC without the ARP UC Provision:** The number of unique consumers with a plan selection who were eligible for additional APTC due to the ARP UC provision, have a household income below 100% FPL, and would not have otherwise been APTC-eligible as a result of Medicaid or CHIP denial due to immigration status.

Average Monthly Premium Savings due to ARP / Average Monthly Premium Savings due to ARP APTC Expansion: The average monthly change in the premium per member after APTC among existing consumers with a new or updated plan selection on or after the ARP implementation (April 1, 2021, for HealthCare.gov states), when compared to their plan selection as of the day before ARP implementation (March 31, 2021, for HealthCare.gov states).

% Reduction in Average Monthly Premium after APTC due to ARP Expansion: The average monthly premium savings due to the ARP APTC expansion divided by the average monthly premium after APTC before the ARP APTC expansion.

Total Monthly Average Savings for Existing Consumers: The product of the number of existing consumers with a new or updated plan selection after ARP implementation, and the average monthly premium savings due to the ARP APTC expansion.

Fact sheet

Marketplace Weekly Enrollment Snapshot: Week 6

Dec 22, 2021 Affordable Care Act

Week 6, December 5 - December 15, 2021

In week 6 of the 2022 Open Enrollment Period, approximately 5.8 million people selected individual market plans or were automatically re-enrolled in a plan through the 33 states that use the HealthCare.gov platform. During the Open Enrollment Period, to date, approximately 9.7 million people have selected individual market plans or were automatically re-enrolled in a plan through HealthCare.gov. While past snapshots this year have measured enrollment weeks Sunday through Saturday, this week's snapshot for week six also includes the final few days prior to the deadline for January 1 coverage.

The number of plan selections associated with enrollment activity during a reporting period may change due to plan modifications or cancellations. In addition, the weekly snapshot only reports new plan selections and plan renewals and does not report the number of consumers who have paid premiums to effectuate their enrollment.

Approximately 2.8 million people newly gained access to affordable health care coverage through the [2021 Special Enrollment Period \(SEP\)](#); 2.1 million who enrolled in the HealthCare.gov states for 2021, and 738,000 who enrolled in 2021 State-based Marketplaces ahead of the 2022 Open Enrollment Period.

For 2022, three states, Kentucky, Maine and New Mexico, transitioned to State-based Marketplaces (SBMs) for the 2022 Open Enrollment Period. These factors should be considered in any year-over-year HealthCare.gov enrollment comparisons. As in past years, the final Open Enrollment numbers, including SBM numbers, will be provided after Open Enrollment ends in all states.

Definitions and details on the data are included in the glossary.

HealthCare.gov Snapshot

HealthCare.gov Snapshot	Week 6: Dec 5 – Dec 15	Cumulative: Nov 1 – Dec 15
Plan Selections	5,777,306	9,724,251
<i>New Consumers</i>	814,899	1,612,068
<i>Renewing Consumers</i>	4,962,407	8,112,183
Total Consumers on Applications Submitted	5,678,927	11,134,372
Call Center Volume	1,299,313	3,121,539
Calls with Spanish Speaking Representative	94,649	228,322
HealthCare.gov Users	6,645,197	17,224,612
CuidadoDeSalud.gov Users	233,960	627,303
Window Shopping HealthCare.gov Users	386,368	1,149,307
Window Shopping CuidadoDeSalud.gov Users	24,210	61,932

HealthCare.gov State-by-State Snapshot

The state-by-state Snapshot provides cumulative individual market plan selections for the 33 states that use the HealthCare.gov platform for the 2022 coverage year.

State	Cumulative Plan Selections Nov 1 – Dec 15
Alaska	21,818

Alabama	205,407
Arkansas	81,947
Arizona	187,651
Delaware	30,612
Florida	2,592,906
Georgia	653,990
Hawaii	21,789
Iowa	69,293
Illinois	310,489
Indiana	149,369
Kansas	102,573
Louisiana	94,635
Michigan	293,476
Missouri	241,982
Mississippi	132,432
Montana	49,413
North Carolina	638,309
North Dakota	28,849

Nebraska	97,169
New Hampshire	51,058
Ohio	247,269
Oklahoma	185,873
Oregon	142,783
South Carolina	282,882
South Dakota	39,292
Tennessee	257,778
Texas	1,711,204
Utah	245,285
Virginia	296,257
Wisconsin	205,991
West Virginia	21,435
Wyoming	33,035

Glossary

Plan Selections: The cumulative metric represents the total number of people who have submitted an application and selected a plan, net of any cancellations from a consumer or cancellations from an insurer that have occurred to date. The weekly metric represents the net change in the number of non-cancelled plan sections over the period covered by the report.

Plan selections include those consumers who are automatically re-enrolled into a plan.

To have their coverage effectuated, consumers generally need to pay their first month's health plan premium. This release does not report the number of effectuated enrollments.

New Consumers: A consumer is considered to be a new consumer if they did not have 2021 Marketplace coverage through December 31, 2021, and made a 2022 plan selection.

Renewing Consumers: A consumer is considered to be a renewing consumer if they have 2021 Marketplace coverage through December 31, 2021, and either actively select the same plan or a new plan for 2022. Renewing consumers also include those consumers who were automatically re-enrolled into a plan.

Marketplace: Generally, this report refers to 33 states that use the HealthCare.gov platform for the 2022 coverage year. These states are Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

HealthCare.gov States: The 33 states that use the HealthCare.gov platform for the 2022 coverage year, including the Federally-facilitated Marketplaces and State-based Marketplaces that use the federal platform (HealthCare.gov). For 2022, Kentucky, Maine, and New Mexico transitioned to state Marketplace platforms and are not included in the 33 states using HealthCare.gov for 2022.

Consumers on Applications Submitted: This includes a consumer who is on a completed application submitted to the Marketplace using the HealthCare.gov platform. If determined eligible for Marketplace coverage, a consumer still needs to pick a health plan (i.e., plan selection) and pay their premium to get covered (i.e., effectuated enrollment). Because families can submit a single application, this figure tallies the total number of people on a submitted application (rather than the total number of submitted applications).

Call Center Volume: The total number of calls received by the Marketplace Call Center for the 33 states that use the HealthCare.gov platform for the 2022 coverage year over the time period covered by the snapshot. Calls with Spanish speaking representatives are not included in this total.

Calls with Spanish Speaking Representative: The total number of calls received by the Marketplace Call Center for the 33 states that use the HealthCare.gov platform for the 2022 coverage year over the time period covered by the snapshot where consumers chose to speak with a Spanish-speaking representative. These calls are not included within the Call Center Volume metric.

HealthCare.gov Users or CuidadoDeSalud.gov Users: These user metrics total how many unique users viewed or interacted with [HealthCare.gov](https://www.healthcare.gov) or [CuidadoDeSalud.gov](https://www.cuidadodesalud.gov), respectively, over the course of a specific date range. For cumulative totals, a separate report is run for the entire Open Enrollment Period to minimize users being counted more than once during that longer range of time and to provide a more accurate estimate of unique users. Depending on an individual's browser settings and browsing habits, a visitor may be counted as a unique user more than once.

Window Shopping HealthCare.gov Users or CuidadoDeSalud.gov Users: These user metrics total how many unique users interacted with the window-shopping tool at [HealthCare.gov](https://www.healthcare.gov) or [CuidadoDeSalud.gov](https://www.cuidadodesalud.gov), respectively, over the course of a specific date range. For cumulative totals, a separate report is run for the entire Open Enrollment Period to minimize users being counted more than once during that longer range of time and to provide a more accurate estimate of unique users. Depending on an individual's browser settings and browsing habits, a visitor may be counted as a unique user more than once. Users who window-shopped are also included in the total [HealthCare.gov](https://www.healthcare.gov) or [CuidadoDeSalud.gov](https://www.cuidadodesalud.gov) user total.

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At a Glance
Reconciliation Recommendations of the House Committee on Ways and Means

As ordered reported on February 10 and 11, 2021

By Fiscal Year, Millions of Dollars	2021	2021-2030	2021-2031
Direct Spending (Outlays)	655,183	877,761	878,022
Revenues	-33,809	-49,588	-45,638
Increase or Decrease (-) in the Deficit	688,992	927,349	923,660

Statutory pay-as-you-go procedures apply?	Yes	Mandate Effects	
Increases on-budget deficits in any year after 2030?	No	Contains intergovernmental mandate?	No
		Contains private-sector mandate?	Yes, Over Threshold

CBO has not reviewed the legislation for effects on spending subject to appropriation.

The legislation would

- Extend until August 29, 2021, many of the enhanced unemployment compensation benefits created under the CARES Act and the Families First Coronavirus Relief Act
- Increase and expand the subsidies for health insurance coverage through the marketplaces for calendar years 2021 and 2022, increase marketplace subsidies for people receiving unemployment benefits in 2021, and subsidize COBRA premiums at 85 percent for people through September 2021
- Provide additional recovery rebates to eligible people, expand the child tax credit, Earned Income Tax Credit, and the child and dependent care credit in 2021, and extend and modify tax credits for paid sick and family leave and for employee retention
- Provide additional assistance to some multiemployer defined benefit pension plans that are financially troubled and reduce funding requirements for single-employer pension plans
- Impose private sector mandates by requiring COBRA notifications and amending the Internal Revenue Code

Estimated budgetary effects would mainly stem from

- An increase in spending on unemployment benefits
- An increase in premium tax credits for health insurance purchased through the marketplaces and federal subsidies for COBRA premiums
- Additional recovery rebates and expanded tax credits
- Increased assistance to private pension plans

Areas of significant uncertainty include

- General economic conditions that would affect the number of people eligible for and receiving benefits like unemployment insurance and expanded tax credits

Detailed estimate begins on the next page.

Legislation Summary

S. Con. Res. 5, the Concurrent Resolution on the Budget for Fiscal Year 2021, instructed several committees of the House of Representatives to recommend legislative changes that would increase deficits up to a specified amount over the 2021-2030 period. As part of this reconciliation process, the House Committee on Ways and Means approved legislation on February 10 and 11, 2021, with a number of provisions that would increase deficits.

The legislation would extend unemployment benefits, establish a pandemic emergency fund, increase subsidies for health insurance, provide cash payments to eligible people, expand several tax credits, and modify rules for pensions, among other provisions designed to mitigate the impact of the COVID-19 pandemic caused by the coronavirus.

Estimated Federal Cost

CBO and the staff of the Joint Committee on Taxation (JCT) estimate that the reconciliation recommendations of the Committee on Ways and Means would increase deficits by \$927 billion over the 2021-2030 period. The estimated budgetary effects of the legislation are shown in Table 1. The changes in outlays from the legislation fall within budget functions 500 (education, training, employment, and social services), 550 (health), 570 (Medicare), 600 (income security), 800 (general government), and 900 (net interest).

Basis of Estimate

For this estimate, CBO and JCT assume that the legislation will be enacted by the end of March 2021.

Subtitle A. Crisis Support for Unemployed Workers

Subtitle A would expand and extend until August 29, 2021, many of the enhanced unemployment compensation benefits created under the CARES Act and the Families First Coronavirus Relief Act (FFCRA), including pandemic unemployment assistance (PUA), pandemic emergency unemployment compensation (PEUC), and federal pandemic unemployment compensation (FPUC). In total, added support for the unemployed would increase the deficit by \$246 billion.

The expansion and extension of unemployment insurance benefits could increase the unemployment rate as well as decrease labor force participation throughout the period for which those benefits would be in place. The estimated costs incorporate some behavioral changes from FPUC and the PUA but do not incorporate any behavioral effects on the unemployment or labor force participation rates primarily because CBO has not estimated those effects.

Federal Pandemic Unemployment Compensation. Under this legislation, people who receive regular or extended unemployment compensation benefits, trade readjustment allowances, short-time compensation, PUA benefits, or PEUC from March 15, 2021, through August 29, 2021, would receive their regular weekly benefits plus an additional \$400 each week. Under current law, people in these programs are receiving \$300 each week for weeks of unemployment from December 27, 2020, through March 14, 2021. Additionally, people who received at least \$5,000 in self-employment income in the most recent tax year and receive an unemployment benefit other than PUA receive an additional \$100 each week; this legislation would extend that add-on through August 29, 2021. Enacting this provision would increase direct spending by a total of \$163 billion in 2021 and 2022.

Pandemic Unemployment Assistance. This legislation would extend the time in which people can apply for PUA and increase the duration of benefits from 50 to 74 weeks. PUA provides weekly cash benefits to people who are unemployed, partially unemployed, or otherwise unable to work because of the coronavirus, but who are not eligible for regular unemployment compensation, extended unemployment benefits, or the PEUC program. CBO estimates that the extension would increase direct spending by \$44 billion in 2021 and 2022.

Pandemic Emergency Unemployment Compensation. The PEUC program provides additional weeks of benefits for people who have exhausted regular state unemployment compensation benefits. The legislation would extend the time period in which people can receive PEUC benefits, and increase the duration of benefits from 24 to 48 weeks. CBO estimates that PEUC benefits would increase direct spending by \$35 billion in 2021 and 2022.

Regular Unemployment Compensation. The extension of FPUC and the PUA program would increase the costs of regular unemployment compensation relative to CBO's baseline. Although not every eligible person claims benefits, CBO expects that more people would apply for and receive regular unemployment compensation benefits because weekly benefit amounts would temporarily increase under FPUC. However, CBO also expects that fewer people would challenge their denial of regular unemployment benefit payments, because they could apply and receive benefits more quickly through the PUA program (a person cannot collect benefits from both programs). Some people who are initially denied regular benefits later receive those benefits after they appeal to their state workforce agency, so that decrease in appeals would decrease regular unemployment compensation relative to CBO's baseline. CBO estimates the net effect would be to increase regular unemployment insurance outlays by \$0.4 billion in 2021.

Extended Unemployment Compensation. This legislation would extend the temporary full federal financing of extended unemployment benefits through August 29, 2021. States are normally required to pay half the cost of those benefits. However, because this legislation

also would extend the number of weeks available under the PEUC program, CBO expects that most people who would have received extended benefits in 2021 would receive PEUC benefits instead. CBO estimates the net effect would be to decrease extended unemployment compensation outlays by \$3 billion in 2021.

Other Unemployment Provisions. Subtitle A contains additional unemployment insurance provisions that would increase outlays by about \$3 billion over the 2021-2030 period. These provisions would:

- Extend increased federal funding for short-time compensation programs (\$0.3 billion);
- Temporarily waive the accrual of interest on federal loans to state unemployment trust funds (\$0.7 billion);
- Allow the Department of Labor (DOL) to continue providing funds to states for administration of FPUC and the PUA and PEUC programs (\$0.1 billion); and
- Directly appropriate funds to DOL for administrative and program integrity activities associated with unemployment compensation programs (\$2 billion).

As a result of the provisions in subtitle A, CBO estimates that revenues would decrease, on net, by about \$3.4 billion over the 2021-2030 period, mostly in 2021. The unemployment insurance system is a federal-and-state partnership: unemployment compensation benefits paid by states are recorded as federal outlays and the taxes levied by states to pay for certain benefits are recorded as federal revenues. CBO expects that any change in outlays would be partially offset by a change in revenues so that state unemployment insurance trust funds remained in balance. The legislation contains several provisions that would shift the funding of certain unemployment benefits from the states to the federal government. As a result, states' unemployment taxes would be lower and federal revenues would decline.

Specifically, the legislation would shift funding from the states to the federal government for a portion of the regular unemployment compensation benefits paid between March 15, 2021, and August 29, 2021, for people who worked for public-sector entities and nonprofit organizations. That provision would decrease revenues by a total of \$1.8 billion in 2021 and 2022. Under the legislation, if states waive the current one-week waiting period, the federal government would fully reimburse them for the first week of regular unemployment benefits through August 29, 2021. This provision would decrease revenue by about \$2.0 billion over 2021 and 2022.

CBO estimates that those decreases in federal revenues would be partially offset by a \$0.3 billion increase over the 2021-2030 period as states respond to smaller balances in their

unemployment trust fund accounts by increasing their future collections of unemployment taxes.

Subtitle B. Emergency Assistance to Families through Home Visiting Programs

Section 9101 would appropriate an additional \$150 million through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and establish rules for use of that funding. To be eligible for funding, entities must meet specified criteria, including maintenance of staffing levels and coordination with local diaper banks. Entities may use the funding to serve additional families; to cover ongoing staffing, training, and administrative costs (including the costs associated with conducting virtual home visits); and to pay for emergency supplies. CBO estimates that subtitle B would increase direct spending by \$149 million over the 2021-2030 period.

Subtitle C. Emergency Assistance to Children and Families

Section 9201 would appropriate \$1 billion for a newly established fund, the Pandemic Emergency Fund. Through grants to states and tribes, this fund would provide nonrecurring short-term benefits, like cash and vouchers, to eligible families with low incomes. CBO expects that the fund would increase direct spending by \$1 billion over the 2021-2030 period.

Subtitle D. Elder Justice and Support Guarantee

Section 9301 would provide additional funding for programs authorized by the Elder Justice Act, including long-term care ombudsman programs, elder abuse forensic centers, and grants to states for adult protective services. CBO estimates that subtitle D would increase direct spending by \$276 million over the 2021-2030 period.

Subtitle E. Support to Skilled Nursing Facilities in Response to COVID-19

Section 9401 would appropriate \$200 million to support COVID-19 infection control in skilled nursing facilities (SNFs). The funding would be used to develop and disseminate COVID-19 prevention protocols through contracted quality improvement organizations (QIOs). Based on historical spending patterns, CBO estimates that this section would increase direct spending by \$200 million over the 2021-2030 period.

Section 9402 would appropriate funding to create strike teams in SNFs. Under this section, \$250 million would be provided to states, including the District of Columbia and U.S. territories, to establish strike teams in SNFs with suspected or diagnosed cases of COVID-19. The strike teams would assist SNFs with clinical care, infection control, or staffing for the duration of the pandemic public health emergency. Based on historical spending patterns, CBO estimates that this section would increase direct spending by \$250 million over the 2021-2030 period.

Subtitle F. Preserving Health Benefits for Workers

Under current law, people who lose their job or experience another qualifying event that results in a termination of their employment-based health insurance are eligible to continue health insurance coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA). If an individual chooses to enroll in COBRA coverage, he or she may be required to pay up to 102 percent of the total premium and can maintain the coverage for 18 months. Under section 9501, qualifying COBRA enrollees would be required to pay 15 percent of the total COBRA premium from the first of the month following the date of enactment through September 30, 2021. The federal government would provide a subsidy on behalf of the individual for the remainder. People would be eligible for premiums to be paid on their behalf if they are enrolled in, or are eligible to enroll in, COBRA coverage because of an involuntary termination or reduction of hours at the time of enactment. Section 9501 would permit eligible people who did not previously elect COBRA coverage and eligible people who discontinued COBRA coverage prior to enactment to enroll within 60 days of being notified about the availability of these subsidies.

CBO and JCT estimate that enacting section 9501 would increase federal deficits by \$7.8 billion over the 2021-2030 period, after accounting for interactions with sections 9661 and 9663 in subtitle G. That increase in deficits would consist of a decrease in direct spending of \$6.5 billion and a decrease in revenues of \$14.3 billion over the period. Those effects would primarily stem from federal subsidies for COBRA premiums, partially offset by a reduction in federal subsidies for other sources of health insurance coverage.

Under current law, after adjusting for the effects of sections 9661 and 9663 (described below), CBO and JCT project that about 800,000 people would be enrolled in COBRA coverage on a full year equivalent basis (FYE), representing less than 10 percent of the eligible population. The estimated take-up of COBRA coverage is low because premiums are not typically subsidized by employers as they are when people are actively employed. The remaining estimated 12 million eligible people who do not enroll in COBRA coverage would enroll in another form of insurance coverage or be uninsured.

In response to the availability of those subsidies, CBO and JCT estimate that an additional 2.2 million people, on a FYE basis, would enroll in COBRA coverage, resulting in a total of about 3 million FYE COBRA enrollees in 2021. In total, the agencies estimate that subsidies for COBRA—for existing and new enrollees—would increase deficits by \$14.8 billion over the 2021-2030 period.

CBO and JCT estimate there would be offsetting effects as people who would newly enroll in COBRA coverage would no longer enroll in other sources of health insurance coverage that are subsidized by the federal government. Of the 2.2 million FYEs that CBO and JCT estimate would newly enroll in COBRA coverage, an estimated 1.1 million would have

otherwise been enrolled in Medicaid or CHIP and about 600,000 would have forgone insurance coverage and been uninsured. About 300,000 FYEs would otherwise have enrolled in subsidized nongroup coverage, and the remainder, about 200,000, would have been enrolled in employment-based coverage. CBO and JCT estimate that those changes in health insurance coverage would offset the cost of the new COBRA subsidy by \$7 billion over the 2021-2030 period. On net, the COBRA provisions in the legislation would increase deficits by \$7.8 billion over the 2021-2030 period.

Subtitle G. Promoting Economic Security

Subtitle G includes provisions that would modify or extend various tax rules. Those changes include the provision of an additional round of direct payments to people (“recovery rebates”) and changes to the child tax credit, Earned Income Tax Credit (EITC), child and dependent care tax credit, credits for paid sick and family leave, the employee retention credit, and the premium tax credit (or marketplace subsidies).

2021 Recovery Rebates for Individuals. For tax year 2021, section 9601 would create a refundable tax credit of \$1,400 (\$2,800 for joint filers) plus \$1,400 per dependent.¹ The credit would phase out for taxpayers with adjusted gross income (AGI) between \$75,000 and \$100,000 (between \$150,000 and \$200,000 for joint filers; between \$112,500 and \$150,000 for head-of-household filers).² A similar benefit would be available to residents of U.S. possessions. Advance payments of the credit would be made “as rapidly as possible.”

Eligibility for the advance payments would be based on information reported on 2019 or 2020 (if available) tax returns. Tax year 2020 returns are due to the Internal Revenue Service (IRS) by April 15, 2021. If a 2019 or 2020 return has not been filed by the date of determination of eligibility, other information available to the Treasury could be used to determine eligibility.

Any taxpayers eligible for a larger credit based on tax year 2021 information could claim the additional amount when they file a 2021 tax return, most likely in the spring of 2022. Taxpayers who are eligible for tax year 2021 credits that are less than their advance payments would not be required to repay the difference. Dependent filers would not be eligible, and a Social Security number would be required for eligibility for filers and their

1. Refundable tax credits reduce a taxpayer’s overall income tax liability; if those credits exceed other tax liabilities, the taxpayer may receive the excess in a refund. Such refunds are classified as outlays in the federal budget.

2. AGI refers to total income for the tax year that is not specifically excluded by the tax code minus certain deductions, including contributions to individual retirement accounts, alimony paid, and student loan interest.

dependents. JCT estimates that the provision would increase outlays by \$413.6 billion and reduce revenues by \$8.7 billion over the 2021-2022 period.³

Child Tax Credit. Section 9611 would expand the child tax credit for 2021 and allow taxpayers to receive the credit in advance of filing tax returns. The credit amount would increase from \$2,000 to \$3,000 for each qualifying child aged 6 and older (or \$3,600 for each child under the age of 6), 17-year-old children would be eligible, and the credit would be fully refundable. The expanded portion of the credit would start to phase out when a taxpayer's income exceeds \$150,000 for joint filers (\$112,500 for head of household filers and \$75,000 for other filers). The phase out reduces the expanded portion of the credit by \$50 for each additional \$1,000 in income. The Secretary of the Treasury would be directed, as feasible, to issue monthly advance payments of the credit based on information from 2019 or 2020 tax returns beginning in July 2021.

Section 9612 would provide for payments to U.S. territories for the cost of the expanded child tax credit, although the advance payments would not apply. For tax years after 2021, residents of Puerto Rico would be able to claim the refundable portion of the child tax credit. JCT estimates that, together, the changes to the child tax credit would increase outlays by \$88 billion and reduce revenues by \$21 billion over the 2021-2030 period.

Earned Income Tax Credit (EITC). Sections 9621 through 9626 would expand the EITC in several ways. Some of those changes would apply only to tax year 2021, while others would be permanent.

For tax year 2021, the amount of the credit would be increased for taxpayers with no qualifying children and eligibility for the credit would be expanded to higher-income taxpayers and to certain childless taxpayers who are younger than 25 or older than 65. Taxpayers would also be allowed to use their 2019 earned income to calculate their credit for taxable year 2021, if their earned income in 2021 is less than it was in 2019.

For tax year 2021 and all future years, taxpayers whose children fail to meet certain identification requirements could still claim the EITC for taxpayers with no qualifying children. Separated spouses would also be allowed to claim the EITC, and the amount of investment income that would disqualify a taxpayer from receiving the EITC would increase. In addition, the Secretary of the Treasury would make payments to certain U.S. territories related to the cost of each territory's respective earned income tax credit. JCT estimates that

3. Joint Committee on Taxation, Estimated Budgetary Effects of the Revenue Provisions of the Budget Reconciliation Legislative Recommendations, as Passed by the House Committee on Ways and Means on February 11, 2021, JCX-10-21 (February 15, 2021), <https://www.jct.gov/publications/2021/jcx-10-21/>.

those changes to the EITC would reduce revenues by \$4 billion and increase outlays by \$21 billion over the 2021-2030 period.

Dependent Care Assistance. Section 9631 would expand the child and dependent care tax credit available to taxpayers for tax year 2021. The legislation would make the credit refundable, increase the amount of eligible expenses that may be used to calculate the credit, increase the credit rate from 35 to 50 percent, and increase the income levels at which taxpayers' eligibility for the credit begins to phase out. The credit would also be made available to taxpayers who were previously ineligible because they reside outside of the United States, provided they maintain a principal residence in the United States.

Section 9632 would also expand the exclusion for employer-provided assistance for dependent care, increasing the maximum amount of excludable earnings from \$5,000 to \$10,500 for a married couple filing jointly. JCT estimates those provisions would increase outlays by \$4 billion and reduce revenues by \$4 billion over for the 2021-2022 period.

Credits for Paid Sick and Family Leave. The Families First Coronavirus Response Act (FFCRA) established fully refundable credits against payroll taxes to compensate employers and self-employed people for coronavirus-related paid sick leave and family and medical leave, which were extended through March 31, 2021, by the Consolidated Appropriations Act, 2021. Section 9641 would extend these credits through September 30, 2021. Sections 9642-9650 would modify the credits for sick or family leave taken after March 31, 2021, (December 31, 2020, for self-employed people) in several ways, including:

- The maximum amount of wages or self-employment income that can be used to calculate the credit would be increased.
- The maximum number of sick days for which an employer may claim the credit would be reset after March 31, 2021.
- The credit would be allowed for leave related to COVID vaccination.
- State and local governments and certain other governmental employers would be allowed to claim the credit.
- The credit would be restructured after March 31, 2021, as a credit against Hospital Insurance (HI) taxes rather than the Old-Age, Survivors, and Disability Insurance (OASDI) taxes.

JCT estimates those changes would increase outlays by \$3.8 billion and reduce revenues by \$1.5 billion over the 2021-2022 period.

Employee Retention Credit. The CARES Act, as subsequently modified by the Consolidated Appropriations Act, 2021, allows qualified employers to claim a refundable credit against the employment taxes due from them. Qualified employers are typically those adversely affected by the COVID-19 pandemic, and the amount of credit is equal to

70 percent of up to \$10,000 in qualified wages paid to the eligible employees in any calendar quarter before July 1, 2021, in which the employers were adversely affected. Section 9651 would extend the availability of those employment retention credits by two calendar quarters through December 31, 2021. In addition, after June 30, 2021, the credit would apply against the employer's share of HI taxes rather than OASDI taxes. The credit would continue to be refundable for employers with insufficient tax liability.⁴ JCT estimates those changes would increase outlays by \$2 billion and reduce revenues by \$7 billion over the 2021-2022 period.

Premium tax credit. Under current law, subsidies for health insurance through the marketplaces established under the Affordable Care Act are primarily provided through premium tax credits, which are available to people with modified adjusted gross income between 100 percent and 400 percent of the federal poverty level (FPL) who are lawfully present in the United States, are not eligible for public coverage (such as Medicaid or the Children's Health Insurance Program (CHIP)), and do not have an affordable offer of employment-based coverage. Eligible people can use those tax credits to lower the out-of-pocket cost of their monthly premiums. The amount of a person's premium tax credit is calculated as the difference between the benchmark premium (that is, the premium for the second-lowest-cost silver plan available in the marketplace in the area of residence) and a specified maximum contribution expressed as a percentage of income. That specified percentage of income varies according to household income.⁵

Expanding premium assistance for consumers. Section 9661 would increase premium tax credits for most currently eligible people and expand eligibility to people with incomes greater than 400 percent of the FPL through the end of 2022. For 2021, the legislation would modify the subsidy structure under current law, as detailed in Exhibit 1.

CBO and JCT estimate that section 9661 would increase federal deficits by \$34.2 billion over the 2021-2030 period: an increase in direct spending of \$22.0 billion and a reduction in revenues of \$12.2 billion. Those effects reflect a \$35.5 billion increase in premium tax credits for health insurance purchased through the marketplaces established under the Affordable Care Act, partially offset by other small effects.

Section 9661 would have a twofold effect on people with health insurance coverage through the marketplaces. First, most marketplace enrollees with subsidies under current law would gain access to enhanced subsidies, lowering their out-of-pocket premium costs. Second, marketplace enrollees who are currently ineligible for subsidies because their income is greater than 400 percent of the FPL could gain eligibility for subsidies under the enhanced

4. See pages 58-71 of JCX-3-21 <https://www.jct.gov/publications/2021/jcx-3-21/> for a detailed description of the Employee Retention Credit provisions of the CARES Act, the Consolidated Appropriations Act, and the budget reconciliation recommendations of the Committee on Ways and Means.

5. A silver plan covers about 70 percent of the costs of covered benefits for most people. Cost-sharing reductions have the effect of increasing that share for people between 100 and 249 percent of the federal poverty level.

subsidy structure. In addition to reducing the costs of marketplace coverage for those currently enrolled, CBO and JCT project that the enhanced subsidies would also attract enrollees who are new to the marketplaces, particularly people who are uninsured under current law. CBO and JCT estimate that new marketplace enrollees would account for \$13.0 billion of the estimated increase in premium tax credits and existing marketplace enrollees would account for the remaining \$22.5 billion.

Exhibit 1. Maximum Income Contribution Percentage by Household Income for Premium Tax Credits in 2021

Income Range (Percent of FPL)	Range of Maximum Income Contribution (Percent of Income)	
	Under Current Law ^a	Under Section 9661
100 – 133	2.07	0
133 – 150	3.10 – 4.14	0
150 – 200	4.14 – 6.52	0 – 2.0
200 – 250	6.52 – 8.33	2.0 – 4.0
250 – 300	8.33 – 9.83	4.0 – 6.0
300 – 400	9.83	6.0 – 8.5
400+	--	8.5

Source: Congressional Budget Office.

FPL = federal poverty level.

a. [irs.gov/pub/irs-drop/rp-20-36.pdf](https://www.irs.gov/pub/irs-drop/rp-20-36.pdf)

In general, the enhanced tax credits under the legislation would be larger than the premium tax credits under current law. In an illustrative example, CBO and JCT estimate that a 21-year-old with income at 150 percent of the FPL in 2021 would be eligible for a premium tax credit of about \$3,500 under current law; the tax credit would increase to about \$4,300 under the legislation (see Exhibit 2). CBO and JCT expect that people with incomes just over 400 percent of the FPL who are older or enrolled in family policies or in insurance rating areas with especially high premiums would experience the greatest reduction in net premiums.

Exhibit 2: Illustrative Example of Premium Tax Credits under Current Law and under Section 9661 in 2021

	Benchmark Premium ^a	Premium Tax Credit ^b	Net Premium Paid
Single individual with income of \$19,300 in 2021 (150% FPL)^c			
Current Law			
21 years old	\$4,300	\$3,500	\$800
45 years old	\$6,200	\$5,400	\$800
64 years old	\$12,900	\$12,100	\$800
Under Section 9661			
21 years old	\$4,300	\$4,300	\$0
45 years old	\$6,200	\$6,200	\$0
64 years old	\$12,900	\$12,900	\$0
Single individual with income of \$58,000 in 2021 (450% FPL)^c			
Current Law			
21 years old	\$4,300	\$0	\$4,300
45 years old	\$6,200	\$0	\$6,200
64 years old	\$12,900	\$0	\$12,900
Under Section 9661			
21 years old	\$4,300	\$0	\$4,300
45 years old	\$6,200	\$1,250	\$4,950
64 years old	\$12,900	\$7,950	\$4,950

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

All dollar figures have been rounded to the nearest \$50; FPL = federal poverty level.

a. For this illustration, the Congressional Budget Office estimated, for a 21-year-old, national average premiums for nongroup health insurance in 2021 under current law and under section 9961. On the basis of that amount, CBO calculated premiums for a 45-year-old and a 64-year-old, assuming that the person lives in a state that uses the federal default age-rating methodology. Variation of premiums by age is limited to 3-to-1 for adults under current law and under section 9961.

b. Under current law, premium tax credits are calculated as the difference between the benchmark premium and a specified percentage of income for a person with income at a given percentage of the FPL.

c. Income level refers to modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers.

In 2022, the year for which the provision would be in effect for the entire calendar year, CBO and JCT estimate that enacting the provision would increase the number of people with

coverage through the marketplaces by 1.7 million. The agencies project that roughly 40 percent of the additional marketplace enrollees would be people ineligible for premium tax credits under current law because their income exceeds 400 percent of the FPL.

The estimated increase in marketplace enrollment would consist of 1.3 million fewer uninsured people, 300,000 fewer people with nongroup coverage purchased outside of the marketplaces, and 100,000 fewer people with employment-based coverage. The estimated effect on the number of people with employment-based coverage is limited because CBO and JCT do not anticipate that many employers would change their decision to offer health insurance given the temporary nature of the enhanced subsidy.

CBO and JCT estimate that enacting section 9661 would affect health insurance coverage to a much more limited extent in 2021 and 2023. The effect on health insurance coverage in 2021 would be constrained because the enhanced subsidy structure would take effect midway through the plan year. For 2023, CBO and JCT anticipate that some of the estimated increase in enrollment would persist beyond 2022, when the enhanced subsidy structure prescribed by this legislation would expire, and would gradually return to current law levels by 2024.

Modification of limits on reconciliation of tax credits. Under current law, people are entitled to advance payments of their subsidies, which are based on income estimated from tax returns for prior years. If people's circumstances change to the extent that their advanced subsidies exceed the actual subsidies to which they are entitled, they may be required to repay some or all of the credits. Section 9662 would remove this requirement for purposes of plan year 2020.

Section 9662 also would eliminate the requirement that people must repay any overpayments of health insurance subsidies received for plan year 2020. JCT estimates that section 9662 would increase the federal deficit by \$6.3 billion over the 2021-2030 period after accounting for interactions with sections 9661 and 9663 as well as section 9501 in subtitle F. This increase would come from a decrease in revenues.

Application of premium tax credit for people receiving unemployment compensation in 2021. Under current law, eligible people may receive a premium tax credit for health insurance through the marketplaces that equals the difference between the benchmark premium and a maximum contribution specified as a percentage of household income. Exhibit 1 shows the maximum income contribution percentages for 2021 under section 9661. (CBO and JCT estimated the effects of section 9663 relative to section 9661, which would increase premium tax credits for all currently eligible income levels and expand eligibility to people with incomes greater than 400 percent of the FPL through the end of 2022.)

Section 9663 would increase the amount of the premium tax credit for people receiving unemployment benefits for any length of time in 2021. People with household incomes greater than 100 percent of the FPL after excluding unemployment benefits—who are otherwise eligible for premium tax credits—would receive a premium tax credit as if their income were 133 percent of the FPL in 2021.

After accounting for the effects of section 9661, CBO and JCT estimate that section 9663 would increase federal deficits by \$4.5 billion over the 2021-2030 period, which would consist of an increase in outlays of \$2.4 billion and a decrease in revenues of \$2.1 billion. Those effects would stem primarily from an increase in premium tax credits for health insurance purchased through the marketplaces.

In 2021, CBO and JCT estimate that about 900,000 people enrolled in subsidized coverage through the marketplaces under current law and after incorporating the effects of section 9661 would receive unemployment benefits and an increased subsidy under section 9663. The average incremental subsidy people would receive is estimated to be \$1,040. An additional 500,000 people, who would otherwise obtain health insurance through COBRA or be uninsured, would newly enroll in coverage through the health insurance marketplaces and newly receive on average a premium tax credit of \$7,040.

Overall, the agencies estimate a total of about 1.4 million people receiving unemployment benefits would be enrolled in subsidized coverage through the marketplaces and receive a premium tax credit. The mid-year enactment of the policy would limit the provision's effect on health insurance coverage. CBO and JCT expect that most of the people newly enrolling in coverage through the marketplaces because of the increased premium tax credit are those who would begin receiving unemployment benefits following enactment of the legislation and would have otherwise enrolled in another form of coverage, such as a spouse's employment-based insurance plan or COBRA continuation coverage. The provision would not affect the incentives of most recipients to take a new job because they would be considering job offers from employers that would not provide them with an offer of health insurance coverage that would disqualify them from receiving the subsidy in 2021. For recipients considering job offers that would disqualify them from receiving the subsidy because the job included an affordable offer of employment-based health insurance, the effect of the provision on the disincentive to take the job would depend on the extent of the subsidy for health insurance provided by the employer.

For 2022, CBO and JCT anticipate that some of the estimated increase in enrollment would persist beyond 2021, when the increase in premium tax credits in this provision would expire, and would return to current law levels by 2023.

Miscellaneous tax provisions. Section 9671 would repeal the option for taxpayers to elect to allocate interest expenses on a worldwide basis, effective for tax years beginning after December 31, 2020. Under current law, for the first taxable year beginning after December 31, 2020, U.S. corporations with worldwide operations can make a one-time, irrevocable election to treat the interest expenses of their foreign and domestic affiliates as if they were a single group, instead of being required to consider domestic and foreign affiliates separately in allocating and apportioning interest expense. For some corporations, making that election would result in increased foreign-source income, which would allow them to claim additional foreign tax credits when calculating their U.S. tax liability. Section 9671 would repeal this provision, eliminating the ability of U.S.-based corporations to elect worldwide allocation of interest expense in calculating their foreign-source income for the purposes of determining allowable foreign tax credits. JCT estimates the repeal would increase revenues by \$20 billion over the 2021-2030 period.

Subtitle G also would appropriate funding to the IRS to implement provisions in the legislation. Sec 9601 would appropriate about \$1.5 billion for activities related to Recovery Rebates and taxpayer assistance, and to modernize and secure IRS systems. Sec 9611 would appropriate about \$0.4 billion to facilitate advance payments of child tax credits to taxpayers.

Subtitle H. Pensions

Subtitle H, the Butch Lewis Emergency Pension Plan Relief Act of 2021, would provide additional assistance to certain multiemployer defined benefit pension plans, reduce funding requirements for single-employer pension plans, with a specific provision for community newspapers, and freeze the cost-of-living indexation of the limits on contributions to pension plans.

Multiemployer pension plans. Under current law, the Pension Benefit Guaranty Corporation (PBGC) guarantees the payment of benefits for about 10 million participants in multiemployer pension plans by providing financial assistance to plans that become insolvent. As a condition of receiving assistance, those plans must reduce participants' benefits to a maximum guaranteed amount.

Multiemployer plans are categorized according to how well-funded they are and how long they are projected to remain solvent. Plans have various status categories: not in distress (green zone), endangered (yellow zone), seriously endangered (orange zone), or critical (red zone). As of 2017, more than 300 plans were classified as critical and more than 100 of those were classified as critical and declining. In addition, to avert insolvency, the Multiemployer Pension Reform Act of 2014 (MPRA) allows the most financially troubled of the critical plans—the critical and declining plans—to reduce benefits (referred to as benefit suspension) if the Department of the Treasury approves. Currently, 18 plans have been approved to suspend benefits under MPRA.

Assistance is currently paid from PBGC’s multiemployer revolving fund, which is supported by premiums that the plans pay and by interest credited on the fund’s balance. CBO projects that under current law the revolving fund will be exhausted in 2027. PBGC will then be required to reduce current-law assistance to amounts that can be supported with premium income; that level of funding will reduce participants’ benefit payments substantially below the guaranteed amounts.

Under the legislation, PBGC would provide eligible multiemployer plans with grants, which the legislation calls “special financial assistance.” Those grants would come from Treasury’s general fund rather than from the existing multiemployer revolving fund. Money would be transferred from the general fund to a new fund within PBGC and then disbursed to plans.

PBGC would be required to publish requirements for the grant applications within 120 days of the date of enactment, and applications would have to be submitted by December 31, 2025. During the first two years after enactment, PBGC could give priority to plans with large expected assistance and plans expected to face insolvency within five years. To qualify for a grant, a plan would have to meet one of the following criteria:

- In any plan year beginning in 2020 through 2022, be in critical and declining status or have an approved suspension of benefits;
- In any plan year beginning in 2020 through 2022, be in critical status, be funded at less than 40 percent, based on current liability measures, and have a ratio of active to inactive participants of less than 2:3;
- Have become insolvent after December 16, 2014, but not yet be terminated; or
- Have had a suspension of benefits approved as of the date of enactment.

Plans would be eligible for a grant projected to be sufficient to pay benefits through 2051 and would not be required to repay the grants.

In general, projections would be based on assumptions used in a plan’s most recent status determination filing from before January 1, 2021, unless PBGC determined that an assumption was “clearly erroneous.”

A special rule applies to the assumed interest rate: Plans could use the lower of the rate used in its status determination and a measure approximately equal to 2 percentage points above the third segment rate (a rate used in determining funding requirements in the single-employer program under current law). CBO expects that rate to be about 5.5 percent, which is lower than the rate used by most plans. However, Central States, Southeast & Southwest Areas Pension Plan, the largest plan projected to be eligible for a grant, uses a lower rate. (The lower the assumed interest rate, the higher the grant amount.)

Grants would be paid in a lump sum and could be used to make benefit payments and pay plan expenses. Special financial assistance would be required to be invested separately from other plan assets, in investment grade bonds or other investments permitted by PBGC, which CBO assumed would have the same returns as investment grade bonds. However, plans could choose when to spend from the grant account and when from their traditional asset account. CBO expects that plans would spend down the grant account first. PBGC could place additional limits on plans receiving grants, including rules about benefit increases, contribution reductions, and investments. Plans would remain in critical status through 2051. Upon insolvency, current law assistance rules would apply.

The legislation also would increase premium rates for multiemployer pension. Under current law, the rate is \$31 per participant for plan year 2021 and will grow with average economy-wide wages in future years; CBO projects the rate would be \$44 for plan year 2031. Under the legislation, the rates would be \$52 for plan year 2031 and would grow with wages thereafter.

To estimate the effects of the multiemployer provisions of the legislation, CBO used a model that simulates projections of the financial condition of multiemployer pension plans, including benefit amounts, employers' contributions, plan assets and liabilities, and financial assistance claims paid by PBGC. The model's inputs include information from public filings of IRS Forms 5500, primarily for plan year 2018. CBO generated a probability distribution of firms' potential financial outcomes by running 500 simulations in which many factors (such as returns on assets, the 30-year Treasury rate, inflation, and the liability discount rate) were varied, and CBO then used the average of those simulations to produce this estimate.

CBO projects that grants would total \$86 billion; of that, \$82 billion would be spent in 2022, \$2 billion in 2023, and \$0.6 billion in 2024. In CBO's projections, 336 plans would receive grants in at least one of the 500 simulations; on average, about 185 plans would receive grants.

CBO estimates that PBGC will make \$7 billion in assistance payments under current law to multiemployer pension plans that are projected to become insolvent over the 2021-2030 period. CBO also projects that the multiemployer revolving fund will be exhausted in 2027, at which point PBGC will reduce financial assistance to amounts that can be supported with premium income. Consequently, spending under current law will not cover the full guaranty payment of benefits for retirees receiving payments from PBGC. Under the legislation, CBO estimates, fewer plans would draw from the revolving fund because the new grants would allow them to remain solvent for longer, reducing spending on current-law assistance by \$2 billion over the 2021-2030 period. As a result, CBO expects that the multiemployer revolving fund would remain solvent until the mid-2040s.

Under the legislation, PBGC would issue rules for the program, review grant applications, and disburse grants. Under the legislation, such activities would be paid from the general fund. CBO estimates that those administrative costs would total \$0.1 billion over the 2021-2030 period.

The multiemployer pension provisions would increase revenues because retirees would receive retirement benefits under the legislation that they would not receive under current law if the pension plans become insolvent. CBO and JCT estimate that those provisions would increase revenues by \$1.7 billion over the 2021-2030 period.

Single-employer pension plans. Current law specifies minimum funding requirements for single-employer private pension plans. In general, employers must contribute an amount that is at least equal to the present value of future benefits expected to be accrued that year (called the normal cost) plus a portion of the plan's funding shortfall.⁶ The funding shortfall is the difference between the plan's assets and the funding target—a measure of the present value of future benefits—which generally must be funded over a seven-year period. The funding target and the normal cost are computed using a complex discounting formula in which different interest rates—currently below 5 percent—are used for benefits that are expected to be paid out over different future periods.

The legislation includes three provisions that would affect single-employer plans.

- First, the legislation would set all previous plan funding shortfalls to zero, thereby permitting a fresh calculation of plan funding deficiencies. These newly calculated shortfalls and all future funding shortfalls would be paid off over a period of fifteen years, rather than the current-law period of seven years.
- Second, the interest rate used for calculating minimum plan funding requirements would increase. A higher interest rate reduces the present value of future liabilities, reducing the amount of current funding required. The interest rate would be based on a specified percentage of the corporate bond yields for the segment over the prior 25-year period, known as the 25-year corridor. The Bipartisan Budget Act of 2015 increased those percentages through 2021; the legislation would extend that adjustment through 2026. Additionally, the legislation would institute a 5 percent interest rate floor, so the rate used would be the higher of the formula rate or 5 percent.
- Third, the legislation would allow community newspapers to reduce the amounts they contribute to their pension plans by choosing a higher interest rate of 8 percent. The legislation also would allow plans to fund the shortfall over a period of 30 years.

6. A present value expresses a flow of future payments as a single amount at a specific time. The value depends on the rate of interest, known as the discount rate, used to translate future cash flows into current dollars

All three provisions would reduce required employer contributions, which would increase the degree to which some plans are underfunded and would over the next decade increase both federal revenue and income from PBGC premiums.

Employers can deduct their pension fund contributions from taxable income, and JCT estimates that the reduction in contributions would result in \$12.6 billion in increased revenues from corporate income tax collections over the 2021-2030 period.

Most single-employer pension plans are underfunded and pay variable-rate premiums to PBGC that are based on the amount by which the plans are underfunded. For 2021, the premium rate is 4.6 percent of a plan's funding shortfall. Smaller contributions would result in greater shortfalls and higher variable-rate premiums. (Variable-rate premiums would be based on the funding shortfall computed using current-law interest rates, not the higher rates that would be used to compute minimum contributions.)

CBO estimates that receipts from variable-rate premiums would increase by \$7.2 billion over the 2021-2030 period because of the increase in underfunding.

Freeze Cost-of-Living Indexation for Pension Contributions. Under current law, there are limits on the contributions that people can make to defined contribution retirement plans and on amounts paid by defined benefit pension plans, and those limits are adjusted annually for cost-of-living (COLA) increases. The legislation would stop those COLA adjustments for overall contributions to defined contribution plans and for the maximum annual benefit under a defined benefit plan, freezing those amounts, effective for calendar years beginning after December 31, 2030. The freeze also would apply to the limit on the annual compensation of an employee that may be taken into account under a qualified plan. This measure excludes individual retirement accounts (IRAs), certain deferred compensation plans maintained by state and local governments and tax-exempt organizations (457(b) plans), simplified employee pension (SEP) plans, and union plans; indexation would continue to apply to those programs. JCT estimates that the provision would reduce revenues by \$29 million over the 2021-2030 period.

Subtitle I. Child Care for Workers

Section 9801 would amend title IV of the Social Security Act to permanently increase total funding for the Child Care Entitlement Program to \$3.55 billion. That program, which provides assistance to low-income families who need child care because of work and work-related activities, is currently authorized through September 30, 2021, at an annualized rate of \$2.92 billion. CBO's baseline projections include the assumption that the program will continue at that level of funding, consistent with the rules specified in section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985. Thus, relative to CBO's

baseline, Section 9801 would increase budget authority for the program by \$0.63 billion annually.

Net Effects on Health Insurance Coverage

CBO and JCT estimate that the legislation would reduce the number of people under age 65 in the United States without health insurance coverage by about 800,000 in 2021, 1.3 million in 2022, and 400,000 in 2023. Most of the effect in 2021 would stem from section 9501, as people would enroll in COBRA rather than forgoing insurance coverage. Overall, the greatest reduction in the number of uninsured people would stem from section 9661.

Enacting that section, which would increase premium tax credits for all currently eligible income levels and expand eligibility to people with incomes greater than 400 percent of the FPL, would decrease the number of people without health insurance by 1.3 million in 2022.

Uncertainty

The continuing effects of COVID-19 on the labor markets, an important component of much of this estimate, are difficult to predict. In addition, the interaction between expanded unemployment benefits, the unemployment rate and labor force participation, and the consequent effects on the budget are difficult to estimate. It is also difficult to forecast eligibility for and responses to new subsidies for health insurance. With respect to Subtitle H, there is uncertainty about both the number of pension plans that would qualify for grants and about the amount that each plan would receive.

The revenue estimates provided here are uncertain because they rely on underlying projections and other estimates that are uncertain. Specifically, they are based in part on CBO's economic projections for the next decade under current law, and on estimates of changes in taxpayers' behavior in response to changes in tax rules.

Pay-As-You-Go Considerations

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays and revenues that are subject to those pay-as-you-go procedures are shown in Table 1.

Increases On-Budget Deficits in any Year after 2030

Several provisions would have budgetary effects after 2030, but CBO, in consultation with JCT, projects that on net, the legislation would not increase on-budget deficits in any year after 2030.

Mandates

CBO and JCT have determined that the legislation would impose private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). Using information from JCT, CBO

estimates that the aggregate cost of the mandates imposed by the legislation would exceed the annual private-sector threshold established in UMRA (\$170 million in 2021, adjusted annually for inflation).

Specifically, the tax provisions of the bill would impose two private-sector mandates by repealing worldwide interest allocation and extending the amortization period for single employer pension plans.

The nontax provisions of the legislation would impose private sector mandates by requiring group health plans to include additional information about COBRA eligibility and premium assistance in notifications made to beneficiaries. Because group health plans routinely provide information to beneficiaries, CBO estimates that the additional cost of those mandates would be small.

CBO and JCT have determined that the legislation would not impose intergovernmental mandates as defined in UMRA.

Previous Estimate

This version replaces the estimate that was transmitted on February 15, 2021. For the provisions “Administrative Funding for the Department of Labor” and “Elder Justice and Support Guarantee,” the previous table showed budget authority in fiscal year 2022 that should instead be shown in 2021. This version corrects those errors; as a result, in 2021 budget authority increased by about \$2.2 billion (and decreased by the same amount in 2022) and estimated spending and deficit effects increased in 2021 by about \$600 million. This version also corrects the provision “Freeze Cost-of-Living Indexation for Pension Contributions.” The previous table included an incorrect sum for the 2021-2030 period for that provision. The estimated total spending, revenue, and deficit effects over the 2021-2030 period were not affected and are the same for both estimates. In addition, Exhibits 1 and 2 were revised to reflect that no indexing adjustments would be applied to the maximum income contribution percentages for premium tax credits under section 9661.

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Table 1.

Estimated Budget Effects of Reconciliation Recommendations

As Reported by the House Committee on Ways & Means on February 10 and 11, 2021

	By Fiscal Year, Millions of Dollars											2021-	2021-
	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2030	2031
Increases or Decreases (-) in Direct Spending Outlays													
Subtitle A – Crisis Support for Unemployed Workers^a													
Federal Pandemic Unemployment Compensation													
<i>Estimated Budget Authority</i>	154,920	8,130	0	0	0	0	0	0	0	0	0	163,050	163,050
<i>Estimated Outlays</i>	154,920	8,130	0	0	0	0	0	0	0	0	0	163,050	163,050
Pandemic Unemployment Assistance													
<i>Estimated Budget Authority</i>	42,030	2,210	0	0	0	0	0	0	0	0	0	44,240	44,240
<i>Estimated Outlays</i>	42,030	2,210	0	0	0	0	0	0	0	0	0	44,240	44,240
Pandemic Emergency Unemployment Compensation													
<i>Budget Authority</i>	33,030	1,560	0	0	0	0	0	0	0	0	0	34,590	34,590
<i>Estimated Outlays</i>	33,030	1,560	0	0	0	0	0	0	0	0	0	34,590	34,590
Regular Unemployment Compensation													
<i>Estimated Budget Authority</i>	385	0	0	0	0	0	0	0	0	0	0	385	385
<i>Estimated Outlays</i>	385	0	0	0	0	0	0	0	0	0	0	385	385
Extended Unemployment Compensation													
<i>Estimated Budget Authority</i>	-3,030	0	0	0	0	0	0	0	0	0	0	-3,030	-3,030
<i>Estimated Outlays</i>	-3,030	0	0	0	0	0	0	0	0	0	0	-3,030	-3,030
Short-Time Compensation Programs													
<i>Estimated Budget Authority</i>	295	15	0	0	0	0	0	0	0	0	0	310	310
<i>Estimated Outlays</i>	295	15	0	0	0	0	0	0	0	0	0	310	310
Interest on Advances to State Unemployment Trust Funds													
<i>Estimated Budget Authority</i>	0	291	117	143	157	0	0	0	0	0	0	708	708
<i>Estimated Outlays</i>	0	291	117	143	157	0	0	0	0	0	0	708	708
Administrative Funding for States													
<i>Estimated Budget Authority</i>	140	0	0	0	0	0	0	0	0	0	0	140	140
<i>Estimated Outlays</i>	140	0	0	0	0	0	0	0	0	0	0	140	140
Administrative Funding for the Department of Labor													
<i>Budget Authority</i>	2,008	0	0	0	0	0	0	0	0	0	0	2,008	2,008
<i>Estimated Outlays</i>	602	1,004	201	201	0	0	0	0	0	0	0	2,008	2,008
Subtitle A, Total													
<i>Estimated Budget Authority</i>	229,778	12,206	117	143	157	0	0	0	0	0	0	242,401	242,401
<i>Estimated Outlays</i>	228,372	13,210	318	344	157	0	0	0	0	0	0	242,401	242,401
Subtitle B – Emergency Assistance to Families through Home Visiting Programs													
Sec. 9101. Home Visiting Programs													
<i>Budget Authority</i>	150	0	0	0	0	0	0	0	0	0	0	150	150
<i>Estimated Outlays</i>	5	48	60	36	0	0	0	0	0	0	0	149	149
Subtitle C – Emergency Assistance to Children and Families													
Sec. 9201. Pandemic Emergency Fund													
<i>Budget Authority</i>	1,000	0	0	0	0	0	0	0	0	0	0	1,000	1,000
<i>Estimated Outlays</i>	375	535	50	40	0	0	0	0	0	0	0	1,000	1,000
Subtitle D – Elder Justice and Support Guarantee													
Sec. 9301. Additional Funding for Aging and Disability Services Programs													
<i>Estimated Budget Authority</i>	276	0	0	0	0	0	0	0	0	0	0	276	276
<i>Estimated Outlays</i>	40	120	88	28	0	0	0	0	0	0	0	276	276
Subtitle E – Support to Skilled Nursing Facilities in Response to COVID-19													
Sec. 9401. Infection Control Support Through Quality Improvement Organizations													
<i>Budget Authority</i>	200	0	0	0	0	0	0	0	0	0	0	200	200
<i>Estimated Outlays</i>	22	128	50	0	0	0	0	0	0	0	0	200	200
Sec. 9402. Funding for Strike Teams for Resident and Employee Safety													
<i>Budget Authority</i>	250	0	0	0	0	0	0	0	0	0	0	250	250
<i>Estimated Outlays</i>	50	175	25	0	0	0	0	0	0	0	0	250	250
Subtitle E, Total													
<i>Estimated Budget Authority</i>	450	0	0	0	0	0	0	0	0	0	0	450	450
<i>Estimated Outlays</i>	72	303	75	0	0	0	0	0	0	0	0	450	450

continued

Table 1. Estimated Budget Effects of Reconciliation Recommendations by the House Committee on Ways & Means on February 10 and 11, 2021
continued

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2021- 2030	2021- 2031
Subtitle F – Preserving Health Benefits for Workers^{a,b}													
Sec. 9501. Preserving Health Benefits for Workers													
<i>Estimated Budget Authority</i>	-6,018	-374	-74	0	0	0	0	0	0	0	0	-6,466	-6,466
<i>Estimated Outlays</i>	-6,021	-371	-74	0	0	0	0	0	0	0	0	-6,466	-6,466
Subtitle G – Promoting Economic Security													
Part 1 - 2021 Recovery Rebates to Individuals^a													
Sec. 9601 Recovery Rebates for Individuals													
<i>Estimated Budget Authority</i>	404,937	8,700	0	0	0	0	0	0	0	0	0	413,637	413,637
<i>Estimated Outlays</i>	404,937	8,700	0	0	0	0	0	0	0	0	0	413,637	413,637
Internal Revenue Service													
<i>Budget Authority</i>	1,465	0	0	0	0	0	0	0	0	0	0	1,465	1,465
<i>Estimated Outlays</i>	483	499	483	0	0	0	0	0	0	0	0	1,465	1,465
Fiscal Service													
<i>Budget Authority</i>	7	0	0	0	0	0	0	0	0	0	0	7	7
<i>Estimated Outlays</i>	3	4	0	0	0	0	0	0	0	0	0	7	7
Treasury Inspector General for Tax Administration													
<i>Budget Authority</i>	8	0	0	0	0	0	0	0	0	0	0	8	8
<i>Estimated Outlays</i>	2	3	3	0	0	0	0	0	0	0	0	8	8
Part 2 - Child Tax Credit^a													
Sec. 9611 Child Tax Credit Improvements for 2021 ^c													
<i>Estimated Budget Authority</i>	18,169	66,185	710	721	725	721	307	311	316	320	323	88,485	88,808
<i>Estimated Outlays</i>	18,169	66,185	710	721	725	721	307	311	316	320	323	88,485	88,808
Internal Revenue Service													
<i>Budget Authority</i>	397	0	0	0	0	0	0	0	0	0	0	397	397
<i>Estimated Outlays</i>	199	198	0	0	0	0	0	0	0	0	0	397	397
Fiscal Service													
<i>Budget Authority</i>	16	0	0	0	0	0	0	0	0	0	0	16	16
<i>Estimated Outlays</i>	8	8	0	0	0	0	0	0	0	0	0	16	16
Part 3 - Earned Income Tax Credit													
Sec. 9621. Strengthen the EITC for Individuals With No Qualifying													
<i>Estimated Budget Authority</i>	0	9,278	0	0	0	0	0	0	0	0	0	9,278	9,278
<i>Estimated Outlays</i>	0	9,278	0	0	0	0	0	0	0	0	0	9,278	9,278
Sec. 9622. Eligibility With Qualifying Children Who Fail to Meet Certain Identification Requirements ^a													
<i>Estimated Budget Authority</i>	0	11	2	1	1	1	2	2	2	2	2	24	26
<i>Estimated Outlays</i>	0	11	2	1	1	1	2	2	2	2	2	24	26
Sec. 9623. Credit Allowed in Case of Certain Separated Spouses													
<i>Estimated Budget Authority</i>	0	18	18	19	20	21	21	22	23	24	24	186	210
<i>Estimated Outlays</i>	0	18	18	19	20	21	21	22	23	24	24	186	210
Sec. 9624. Modification of Disqualified Investments Income Test ^a													
<i>Estimated Budget Authority</i>	0	224	141	143	165	164	162	159	159	165	173	1,482	1,655
<i>Estimated Outlays</i>	0	224	141	143	165	164	162	159	159	165	173	1,482	1,655
Sec. 9625. Application of the EITC in													
<i>Estimated Budget Authority</i>	0	738	746	764	781	798	814	831	849	867	885	7,188	8,073
<i>Estimated Outlays</i>	0	738	746	764	781	798	814	831	849	867	885	7,188	8,073
Sec. 9626. Temporary Special Rule for Determining Earned Income for the EITC ^a													
<i>Estimated Budget Authority</i>	0	2,866	0	0	0	0	0	0	0	0	0	2,866	2,866
<i>Estimated Outlays</i>	0	2,866	0	0	0	0	0	0	0	0	0	2,866	2,866
Part 4 - Dependent Care Assistance^a													
<i>Estimated Budget Authority</i>	0	3,752	0	0	0	0	0	0	0	0	0	3,752	3,752
<i>Estimated Outlays</i>	0	3,752	0	0	0	0	0	0	0	0	0	3,752	3,752
Part 5 - Credits for Paid Sick and Family Leave^a													
<i>Estimated Budget Authority</i>	3,323	431	0	0	0	0	0	0	0	0	0	3,754	3,754
<i>Estimated Outlays</i>	3,323	431	0	0	0	0	0	0	0	0	0	3,754	3,754

continued

Table 1. Estimated Budget Effects of Reconciliation Recommendations by the House Committee on Ways & Means on February 10 and 11, 2021
continued

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2021- 2030	2021- 2031
Part 6 - Employee Retention Credit													
<i>Estimated Budget Authority</i>	1,090	878	0	0	0	0	0	0	0	0	0	1,968	1,968
<i>Estimated Outlays</i>	1,090	878	0	0	0	0	0	0	0	0	0	1,968	1,968
Part 7 - Premium Tax Credit													
Sec. 9661. Expanding Premium Assistance for Consumers ^{a,b}													
<i>Estimated Budget Authority</i>	2,731	13,945	4,942	404	0	0	0	0	0	0	0	22,022	22,022
<i>Estimated Outlays</i>	2,731	13,945	4,942	404	0	0	0	0	0	0	0	22,022	22,022
Sec. 9663. Application of the Premium Tax Credit for Individuals Receiving Unemployment Compensation in 2021 ^a													
<i>Estimated Budget Authority</i>	1,351	926	149	0	0	0	0	0	0	0	0	2,426	2,426
<i>Estimated Outlays</i>	1,351	926	149	0	0	0	0	0	0	0	0	2,426	2,426
Subtitle G, Total													
<i>Estimated Budget Authority</i>	433,494	107,952	6,708	2,052	1,692	1,705	1,306	1,325	1,349	1,378	1,407	558,961	560,368
<i>Estimated Outlays</i>	432,296	108,664	7,194	2,052	1,692	1,705	1,306	1,325	1,349	1,378	1,407	558,961	560,368
Subtitle H - The Butch Lewis Emergency Pension Plan Relief Act of 2021													
Sec. 9704. Multiemployer Pension Plans ^{a,d}													
<i>Estimated Budget Authority</i>	13	82,468	2,496	651	25	13	0	0	0	0	0	85,666	85,666
<i>Estimated Outlays</i>	12	82,452	2,379	497	-341	-1,206	-839	102	91	81	75	83,229	83,304
Sec. 9705. Single-Employer Pension Plans ^{a,e}													
<i>Budget Authority</i>	0	0	0	0	0	0	0	0	0	0	0	0	0
<i>Estimated Outlays</i>	-107	-144	-232	-353	-1,124	-93	-917	-1,156	-1,419	-1,643	-1,819	-7,188	-9,007
Sec. 9707. Modification of Special Rules for Minimum Funding Standards for Community Newspaper Plans ^a													
<i>Budget Authority</i>	0	0	0	0	0	0	0	0	0	0	0	0	0
<i>Estimated Outlays</i>	-7	-7	-11	-15	-18	-21	-24	-27	-30	-32	-35	-192	-227
Subtitle H, Total													
<i>Estimated Budget Authority</i>	13	82,468	2,496	651	25	13	0	0	0	0	0	85,666	85,666
<i>Estimated Outlays</i>	-102	82,301	2,136	129	-1,483	-1,320	-1,780	-1,081	-1,358	-1,594	-1,779	75,849	74,070
Subtitle I - Childcare for Workers													
Sec. 9801. Child Care Assistance Programs													
<i>Budget Authority</i>	633	633	633	633	633	633	633	633	633	633	633	6,330	6,963
<i>Estimated Outlays</i>	146	317	456	519	570	601	633	633	633	633	633	5,141	5,774
Total Increase in Direct Spending													
<i>Estimated Budget Authority</i>	659,776	202,885	9,880	3,479	2,507	2,351	1,939	1,958	1,982	2,011	2,040	888,768	890,808
<i>Estimated Outlays</i>	655,183	205,127	10,303	3,148	936	986	159	877	624	417	261	877,761	878,022
Increases or Decreases (-) in Revenues													
Subtitle A – Crisis Support for Unemployed Workers^a													
<i>On-budget</i>	-3,380	-349	83	83	65	31	25	4	0	0	0	-3,438	-3,438
Subtitle F – Preserving Health Benefits for Workers^{a,b}													
<i>On-budget</i>	-10,832	-3,488	55	0	0	0	0	0	0	0	0	-14,265	-14,265
<i>Off-budget</i>	4	-32	-13	0	0	0	0	0	0	0	0	-41	-41
<i>Total</i>	-10,828	-3,520	42	0	0	0	0	0	0	0	0	-14,306	-14,306
Subtitle G – Promoting Economic Security													
Part 1 - 2021 Recovery Rebates to Individuals^a													
Sec. 9601. Recovery Rebates for													
<i>On-budget</i>	0	-8,700	0	0	0	0	0	0	0	0	0	-8,700	-8,700
Part 2 - Child Tax Credit^a													
Sec. 9611. Child Tax Credit Improvements for 2021 ^c													
<i>On-budget</i>	-7,657	-13,063	0	0	0	0	0	0	0	0	0	-20,720	-20,720
Part 3 - Earned Income Tax Credit													
Sec. 9621. Strengthen the EITC for Individuals With No Qualifying Children ^a													
<i>On-budget</i>	-521	-2,083	0	0	0	0	0	0	0	0	0	-2,604	-2,604
Sec. 9622. Eligibility With Qualifying Children Who Fail to Meet Certain Identification Requirements ^a													
<i>On-budget</i>	*	-1	0	0	0	0	0	0	0	0	0	0	0

continued

Table 1. Estimated Budget Effects of Reconciliation Recommendations by the House Committee on Ways & Means on February 10 and 11, 2021

continued

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2021-2030	2021-2031
Sec. 9623. Credit Allowed in Case of Certain Separated Spouses ^a													
<i>On-budget</i>	-1	-2	-3	-3	-3	-4	-4	-5	-5	-6	-7	-36	-42
Sec. 9624. Modification of Disqualified Investments Income Test ^a													
<i>On-budget</i>	-24	-106	-57	-57	-60	-65	-76	-74	-72	-75	-78	-666	-744
Sec. 9626. Temporary Special Rule for Determining Earned Income for the EITC ^a													
<i>On-budget</i>	0	-319	0	0	0	0	0	0	0	0	0	-319	-319
Part 4 - Dependent Care Assistance^a													
Sec. 9631. Refundability and Enhancement of the Child and Dependent Care Tax Credit													
<i>On-budget</i>	-2,127	-2,085	0	0	0	0	0	0	0	0	0	-4,212	-4,212
Sec. 9632. Increase in Exclusion for Employer Provided Dependent Care Assistance													
<i>On-budget</i>	-27	-14	0	0	0	0	0	0	0	0	0	-41	-41
<i>Off-budget</i>	-51	-25	0	0	0	0	0	0	0	0	0	-76	-76
<i>Total</i>	-78	-39	0	0	0	0	0	0	0	0	0	-117	-117
Part 5 - Credits for Paid Sick and Family Leave^a													
<i>On-budget</i>	-731	-723	0	0	0	0	0	0	0	0	0	-1,454	-1,454
Part 6 - Employee Retention Credit													
<i>On-budget</i>	-1,701	-5,115	0	0	0	0	0	0	0	0	0	-6,816	-6,816
Part 7 - Premium Tax Credit													
Sec. 9661. Expanding Premium Assistance for Consumers ^{ab}													
<i>On-budget</i>	-1,419	-8,004	-2,813	-97	23	0	0	0	0	0	0	-12,310	-12,310
<i>Off-budget</i>	7	76	52	10	0	0	0	0	0	0	0	145	145
<i>Total</i>	-1,412	-7,928	-2,761	-87	23	0	0	0	0	0	0	-12,165	-12,165
Sec. 9662. Modification of Limits on Reconciliation of Tax Credits													
<i>On-budget</i>	-4,696	-1,565	0	0	0	0	0	0	0	0	0	-6,261	-6,261
Sec. 9663. Application of the Premium Tax Credit for Individuals Receiving Unemployment Compensation in 2021 ^a													
<i>On-budget</i>	-1,379	-841	-108	0	0	0	0	0	0	0	0	-2,328	-2,328
<i>Off-budget</i>	107	107	25	0	0	0	0	0	0	0	0	239	239
<i>Total</i>	-1,272	-734	-83	0	0	0	0	0	0	0	0	-2,089	-2,089
Part 8 - Miscellaneous Provisions													
Sec. 9671. Repeal of Election to Allocate Interest on a Worldwide Basis													
<i>On-budget</i>	335	1,277	2,023	2,284	2,383	2,334	2,358	2,385	2,343	2,283	2,327	20,005	22,331
Subtitle G, Total													
<i>On-budget</i>	-19,948	-41,344	-958	2,127	2,343	2,265	2,278	2,306	2,266	2,202	2,242	-46,463	-44,221
<i>Off-budget</i>	63	158	77	10	0	0	0	0	0	0	0	308	308
<i>Total</i>	-19,885	-41,186	-881	2,137	2,343	2,265	2,278	2,306	2,266	2,202	2,242	-46,155	-43,913
Subtitle H - The Butch Lewis Emergency Pension Plan Relief Act of 2021													
Sec. 9704. Multiemployer Pension Plans ^{ad}													
<i>On-budget</i>	12	15	17	25	120	214	257	292	334	377	406	1,663	2,069
Sec. 9705. Single-Employer Pension Plans ^{ae}													
<i>On-budget</i>	229	311	499	688	973	1,273	1,522	1,644	1,611	1,329	976	10,079	11,053
<i>Off-budget</i>	25	53	95	150	238	312	380	434	447	374	273	2,508	2,781
<i>Total</i>	254	364	594	838	1,211	1,585	1,902	2,078	2,058	1,703	1,249	12,587	13,834
Sec. 9707. Modification of Special Rules for Minimum Funding Standards for Community Newspaper Plans ^a													
<i>On-budget</i>	16	10	10	9	7	7	6	4	1	-3	-5	67	63
<i>Off-budget</i>	2	2	3	3	3	3	3	2	1	1	*	23	21
<i>Total</i>	18	12	13	12	10	10	9	6	2	-2	-5	90	85
Sec. 9708. Freeze Cost-of-Living Indexation for Pension Contributions													
<i>On-budget</i>	0	0	0	0	0	0	0	-2	-7	-13	38	-22	16
<i>Off-budget</i>	0	0	0	0	0	0	0	-1	-2	-4	20	-7	13
<i>Total</i>	0	0	0	0	0	0	0	-3	-9	-17	58	-29	29

continued

Table 1. Estimated Budget Effects of Reconciliation Recommendations by the House Committee on Ways & Means on February 10 and 11, 2021
continued

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2021- 2030	2021- 2031
Subtitle H, Total													
<i>On-budget</i>	257	336	526	722	1,100	1,494	1,785	1,938	1,939	1,690	1,415	11,787	13,202
<i>Off-budget</i>	27	55	98	153	241	315	383	435	446	371	293	2,524	2,817
Total	284	391	624	875	1,341	1,809	2,168	2,373	2,385	2,061	1,708	14,311	16,019
Total Changes in Revenues													
<i>On-budget</i>	-33,903	-44,845	-294	2,932	3,508	3,790	4,088	4,248	4,205	3,892	3,657	-52,379	-48,722
<i>Off-budget</i>	94	181	162	163	241	315	383	435	446	371	293	2,791	3,084
Total	-33,809	-44,664	-132	3,095	3,749	4,105	4,471	4,683	4,651	4,263	3,950	-49,588	-45,638
Net Increase or Decrease (-) in the Deficit From Changes in Direct Spending and Revenues													
Estimated Effect on the Deficit	688,992	249,791	10,435	53	-2,813	-3,119	-4,312	-3,806	-4,027	-3,846	-3,689	927,349	923,660
<i>Estimated Change in On-Budget Deficit</i>	689,086	249,972	10,597	216	-2,572	-2,804	-3,929	-3,371	-3,581	-3,475	-3,396	930,140	926,744
<i>Off-Budget Deficit</i>	-94	-181	-162	-163	-241	-315	-383	-435	-446	-371	-293	-2,791	-3,084

Components may not sum to totals because of rounding.

CHIP = Children's Health Insurance Program; EITC = earned income tax credit; * = between zero and \$500 million.

- a. Section would affect direct spending and revenues, which are shown separately.
- b. The estimated budgetary effects differ from estimates published by the staff of the Joint Committee on Taxation (JCT). This estimate includes \$10 million in funding for implementing section 9501 and for changes in outlays under sections 9501 and 9661 for Medicare, Medicaid, and CHIP, whereas JCT's estimates do not. (See Staff of the Joint Committee on Taxation, Estimated Budgetary Effects of the Revenue Provisions of the Budget Reconciliation Legislative Recommendations, as Passed by the House Committee on Ways and Means on February 11, 2021, JCX-10-21 (February 15, 2021), <https://www.jct.gov/publications/2021/jcx-10-21/>.)
- c. Includes the budgetary effects of section 9612.
- d. Includes the budgetary effects of sections 9701, 9702, and 9703.
- e. Includes the budgetary effects of section 9706.

Starting January 1, 2022, there are new patient protections against surprise medical bills. Learn more at [cms.gov/nosurprises](https://www.cms.gov/nosurprises).

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U.S. Department of Health & Human Services

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FOR IMMEDIATE RELEASE

August 27, 2021

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Biden-Harris Administration Quadruples the Number of Health Care Navigators Ahead of HealthCare.gov Open Enrollment Period

In largest-ever investment in the program, CMS is awarding \$80 million to support Navigators in ensuring health coverage access to underserved populations

The Biden-Harris Administration is expanding the number of Navigator organizations to help people enroll in coverage through the Marketplace, Medicaid, or the Children’s Health Insurance Program (CHIP) in 30 states with a Federally-Facilitated Marketplace. Through \$80 million in grant awards for the 2022 plan year, 60 Navigator awardee organizations will be able to train and certify more than 1,500 Navigators to help uninsured consumers find affordable and comprehensive health coverage.

The Navigator awardees include community and consumer-focused non-profits, faith-based organizations, hospitals, trade and professional associations, and tribes or tribal organizations. Navigators help families and other underserved communities gain access to health coverage options through the Marketplace, Medicaid, or CHIP. They can assist with enrollment applications and help consumers receive financial assistance through HealthCare.gov. With the additional funding, more Navigator organizations can provide assistance to people with limited English proficiency in multiple languages. They can also provide more assistance to rural areas and communities of color.

“Our local partners are crucial in helping people get covered. By expanding our pool of Navigators, we will reach more underserved communities, and grow our network of trusted experts who can help people across the country navigate their health care options,” said U.S. Department of Health and Human

Services (HHS) Secretary Xavier Becerra. “Thanks to President Biden, health care is more affordable than ever on HealthCare.gov – and with this historic investment, we’ll be making it even easier for people to enroll in coverage through the Marketplace, Medicaid, and the Children’s Health Insurance Program.”

“Local health coverage experts have worked hard to build relationships and trust in the communities in which they serve. These Navigators consistently help consumers understand their options, helping with potential language and other barriers, so they can find health coverage that best fits their needs,” said CMS Administrator Chiquita Brooks-LaSure. “With this additional grant funding, even more Navigators will be able to provide comprehensive assistance through customized educational and outreach activities, especially to underserved communities.”

The 2021 Navigator awardees will focus on outreach to particularly underserved communities. Awardees will focus on outreach to people who identify as racial and ethnic minorities, people in rural communities, the LGBTQ+ community, American Indians and Alaska Natives, refugee and immigrant communities, low-income families, pregnant women and new mothers, people with transportation or language barriers or lacking internet access, veterans, and small business owners.

The 2021 Navigator awards are for a 36-month period of performance, funded in 12-month increments known as budget periods. This multi-year funding structure is designed to provide greater consistency for Navigator awardee organizations, reducing yearly start-up time and allowing more efficient use of grant funds.

Navigator grant applicants were asked to detail their outreach and enrollment efforts to the underserved or vulnerable population(s), while still assisting other consumers. The 2021 Navigator awardees must comply with the terms and conditions of the award, including submission of regular reports to CMS documenting their progress and activities. CMS will work closely with the awardees to ensure they are meeting these goals.

[View the list of 2021 CMS Navigator Awardees. - PDF](https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf) (<https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf>)

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Note: All HHS press releases, fact sheets and other news materials are available at [https://www.hhs.gov/news \(/news\)](https://www.hhs.gov/news (/news)).

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Fact sheet

2021 Special Enrollment Period in response to the COVID-19 Emergency

Jan 28, 2021 Affordable Care Act

The coronavirus disease 2019 (COVID-19) national emergency has presented unprecedented challenges for the American public. Millions of Americans are facing uncertainty and millions of Americans are experiencing new health problems during the pandemic. Due to the exceptional circumstances and rapidly changing Public Health Emergency (PHE) impacting millions of people throughout the US every day, many Americans remain uninsured or underinsured and still need affordable health coverage. In accordance with the Executive Order issued today by President Biden, the Centers for Medicare & Medicaid Services (CMS) determined that the COVID-19 emergency presents exceptional circumstances for consumers in accessing health insurance and will provide a Special Enrollment Period (SEP) for individuals and families to apply and enroll in the coverage they need. This SEP will be available to consumers in the 36 states served by Marketplaces that use the HealthCare.gov platform, and CMS will conduct outreach activities to encourage those who are eligible to enroll in health coverage. CMS strongly encourages states operating their own Marketplace platforms to make a similar enrollment opportunity available to consumers in their states.

Starting on February 15, 2021 and continuing through May 15, 2021, Marketplaces using the HealthCare.gov platform will operationalize functionality to make a SEP available to all Marketplace-eligible consumers who are submitting a new application or updating an existing application. These consumers will newly be able to access the SEP through a variety of channels: through HealthCare.gov directly, the Marketplace call center, or direct enrollment channels. Additionally, consumers can work with a network of over 50,000 agents and brokers who are registered with the Marketplace, along with over 8,000 trained assisters, ready to assist consumers with their application for coverage.

To promote the SEP and ensure that a broad and diverse range of consumers are aware of this implementation, CMS will conduct an outreach campaign in cooperation with community and stakeholder organizations, focused on education and awareness of this

new opportunity to enroll in English, Spanish and other languages. CMS outreach efforts will use a mix of paid advertising and direct outreach to consumers. Outreach efforts will include considerable awareness building efforts to encourage the uninsured and those who come to HealthCare.gov to explore coverage to continue the process and enroll. CMS plans to spend \$50 million on outreach and education, on a mix of tactics to increase awareness, including advertisements on broadcast, digital, and an earned media.

Some consumers may already be eligible for other existing SEPs, Medicaid, or the Children's Health Insurance Program (CHIP) – they can visit [HealthCare.gov](https://www.healthcare.gov) now to find out if they can enroll even before this new SEP. Starting February 15, consumers seeking to take advantage of this SEP can find out if they are eligible by visiting [HealthCare.gov](https://www.healthcare.gov), and are no longer limited to calling the Marketplace call center to access this SEP. Consumers who are eligible and enroll under this SEP will be able to select a plan with coverage that starts prospectively the first of the month after plan selection. Consumers will have 30 days after they submit their application to choose a plan. Current enrollees will be able to change to any available plan in their area without restriction to the same level of coverage as their current plan. In order to use this SEP, current enrollees will need to step through their application and make any changes if needed to their current information and submit their application in order to receive an updated eligibility result that provides the SEP before continuing on to enrollment. This SEP opportunity will not involve any new application questions, or require consumers or enrollment partners to provide any new information not otherwise required to determine eligibility and enroll in coverage. In addition, consumers won't need to provide any documentation of a qualifying event (e.g., loss of a job or birth of a child), which is typically required for SEP eligibility.

As always, consumers found eligible for Medicaid or CHIP will be transferred to their state Medicaid and CHIP agencies for enrollment in those programs.

To read the **executive order**, visit: <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/>

To read the HHS **press release**, visit: <https://www.hhs.gov/about/news/2021/01/28/hhs-announces-marketplace-special-enrollment-period-for-covid-19-public-health-emergency.html>

For more information about the Health Insurance Marketplace^{®[1]}, visit: <https://www.healthcare.gov/quick-guide/getting-marketplace-health-insurance/>

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[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services.

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NBER WORKING PAPER SERIES

PUBLIC AND PRIVATE PROVISION OF INFORMATION IN MARKET-BASED PUBLIC PROGRAMS:
EVIDENCE FROM ADVERTISING IN HEALTH INSURANCE MARKETPLACES

Naoki Aizawa
You Suk Kim

Working Paper 27695
<http://www.nber.org/papers/w27695>

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Public and Private Provision of Information in Market-Based Public Programs: Evidence from Advertising in Health Insurance Marketplaces

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ABSTRACT

This paper studies the effect of provision of information by the government and private firms through marketing activities in the Affordable Care Act health insurance marketplace. Using detailed TV advertising data, we present evidence that government advertising and private advertising target different geographical areas and provide different messaging content. We estimate the impacts of both types of advertising on consumer demand. We find that government advertising increases overall enrollment and enhances welfare; however, it does not induce consumers to select a particular insurer. Private advertising, in contrast, increases demand for specific insurers, and insurers spending more on advertising tend to offer plans associated with higher consumer utility. However, private advertising alone does not induce consumers to select insurers with better plans very efficiently because it tends to be excessive due to rent-seeking competition.

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1 Introduction

Incomplete take-up is prevalent in many public programs. A common explanation for incomplete take-up is choice frictions such as a lack of information about eligibility or transaction costs associated with enrollment (Currie, 2006). To address this problem, the government often conducts marketing and outreach for public programs. Recent studies (e.g., Aizer, 2007 and Finkelstein and Notowidigdo, 2019) find that providing information through public outreach is an important policy lever for the government to mitigate these choice frictions in *traditional* public programs—such as Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and the Supplemental Security Income Program—where the government directly provides the benefit to enrollees.

A growing number of studies document that choice frictions are also prevalent in *market-based* public programs, which have become increasingly common in various settings, such as markets for health insurance, education, mortgages, and electricity.^{1,2} In such programs, differentiated benefits are provided by private firms in a regulated market. Importantly, unlike in traditional programs, both the government and private firms conduct significant marketing activities, suggesting that choice frictions might be addressed by both public and private provision of information.³ Then, a natural question is: what are the appropriate interventions for the government in market-based programs in the presence of provision of information by private firms?

To answer this question, one must understand how the incentives of providing information differ for the government and private firms and how information provided by each type of entity affects market outcomes and welfare. If the government and private firms have different objectives in conducting marketing activities, they may target different populations and provide different information, which may lead to differential impacts on consumer’s choice frictions. For example, while government marketing may reduce extensive-margin choice frictions about signing up for the program, private marketing may reduce intensive-margin information frictions about the quality of the firm’s specific products. Moreover, the welfare impact of private marketing depends on marketing competition between firms. For example, private marketing may have a positive spillover effect or simply serve to steal consumers from other firms. Although these issues are central in designing market-based public programs to efficiently mitigate choice frictions, none of previous

¹Market-based health insurance programs include the Affordable Care Act marketplace, Medicare Advantage, and Medicare Part D. An example of education benefits is a charter school. Residential electricity is also often provided in a regulated market. In the mortgage market, the Making Home Affordable Program (MHAP) was set up in 2009 to help underwater homeowners modify or refinance their mortgages through private lenders. In response to the Covid-19 pandemic, moreover, the CARES Act provides forbearance for mortgage borrowers through private lenders.

²For the evidence of choice frictions, see Polyakova (2016) and Handel et al. (2020) for health insurance, Andrabi et al. (2017) and Allende et al. (2019) for education, Johnson et al. (2018) for mortgages, and Hortaçsu et al. (2017) and Ito et al. (2017) for electricity.

³For example, the federal government spent more than \$125 million on marketing MHAP (makinghomeaffordable.gov/press-release/Pages/pr_09242014.aspx), where mortgage lenders also conducted significant marketing activities.

studies have examined them so far to the best of our knowledge.

This paper studies the effects of provision of information by the government (both federal and state) and private insurers through marketing activities in the Affordable Care Act (ACA) health insurance marketplace. Among possible marketing tools, we focus on TV advertising, which is commonly used by both the government and private insurers.⁴ How much the government should advertise the ACA marketplace has been discussed in many policy debates, and the Biden administration has proposed increasing government advertising to expand the ACA marketplace.⁵ However, its effectiveness and specific role relative to private advertising has not been well understood. Moreover, because advertising is less regulated than are private plans in the ACA marketplace, it may be an important tool for private firms to increase their enrollment. In this paper, we first document how the government and private insurers target their advertising and which information is provided in their advertising. Then, we estimate the impact of government and private advertising on consumer demand. Finally, we study the normative implications of government and private advertising.

We use detailed TV advertising data from Kantar Media, which allows us to identify the sponsor of each advertisement and to observe advertising content through a video file of each advertisement. This information enables us to classify advertisements into different categories, including whether the advertisement provides specific information about the ACA marketplace—for example, the end date of the open enrollment period and the availability of financial assistance—as well as about an insurer’s specific plans or brand.

Observing advertising content and geographical targeting allows us to make inferences about the different objectives of the government and private insurers. While both public and private advertisements often discuss general features of the ACA marketplace, over 60% of private advertisements focus solely on promoting a private insurer’s brand. This suggests that private advertising is meant to provide firm-specific information affecting consumer selection across insurers. Then, we find that private advertising is geographically targeted to markets with higher potential profitability. In contrast, advertising by both federal and state governments is targeted to a broader set of markets, suggesting that the government’s objective is likely to increase overall enrollment by reaching out to a broad population, including those who live in markets where private insurers find it unprofitable to advertise.

We then study the effectiveness of advertising by estimating a consumer demand model for ACA health plans using insurer-level enrollment data. In our model, we allow advertising by

⁴The Department of Health and Human Services, responsible for health programs, typically spends more on advertising than other departments except for the Department of Defense (Kosar (2014)).

⁵Before 2018, the federal government spent \$100 million annually on marketing for the marketplace, comparable to advertising spending by private insurers based on our data in this paper. In 2018, the federal government drastically cut its spending to \$10 million, which spurred many discussions about their negative impacts on the marketplace. The Biden administration is considering to increase the advertising spending up to \$50 million.

federal and state governments and by private insurers to have different effects on the decision to purchase health insurance. To address the potential endogeneity concern that advertising may be targeted to certain markets based on unobserved characteristics, we exploit discontinuity in advertising spending along the borders of local TV markets. We estimate not only the average effect of advertising by different sponsors but also how the effect of advertising differs depending on its contents.

We find that government advertising, especially by the federal government, has a market-expansion (*extensive-margin*) effect, increasing overall enrollment for the marketplace. The estimated demand elasticity with respect to federal advertising is about 0.05, which is at a higher end of recent estimates for advertising in private markets (Shapiro et al., 2021). Also, it is as effective as other government outreach activities—for example, letters that the Internal Revenue Service sent to the uninsured population who paid a tax penalty (Goldin et al., 2021). However, government advertising has little differential effects on demand for insurers providing different plan characteristics, suggesting that it has little *intensive-margin* effects.

In contrast, private advertising increases an insurer’s own enrollment, but its extensive-margin effect is not greater—statistically smaller in some specifications—than that of federal advertising. We find no positive spillover of private advertising. In fact, private advertising has a modest business-stealing effect. The lack of positive spillover, together with the fact that not all insurers advertise, implies that private advertising has both intensive-margin and modest extensive-margin effects. Further, the marginal return from private advertising appears relatively invariant to the level of government advertising, suggesting limited crowding-out or -in of private advertising by government advertising.

To uncover mechanisms behind our estimates, we exploit a unique feature of our data: advertising content. We find that federal advertising that provides information about the open enrollment period and financial assistance under the ACA is very effective. However, private advertising with specific ACA-related information does not contribute to increasing enrollment, suggesting that who provides which information matters. In contrast, private advertising intended to affect a consumer’s choice in the intensive margin—for example, emphasizing an insurer’s brand or plan quality—increases insurer-level enrollment, consistent with our finding that private advertising lacks positive spillover.

The results from our demand estimates and targeting analysis suggest that government and private advertising play different roles in addressing consumer choice frictions. In markets where private insurers do not find it very profitable to advertise, government advertising may be necessary to mitigate choice frictions for a broad population.⁶ In markets with both types of advertising,

⁶In addition, reducing the number of uninsured population increases social welfare by decreasing the negative externality from the uncompensated care for the uninsured (Finkelstein et al., 2019)

information provided by the government affects different choice frictions than that provided by private firms. Therefore, if advertising can be delivered efficiently, the provision of information by both entity types of entities likely increases welfare.

We then explore the normative implications of advertising by the government and private insurers. We evaluate the welfare impact of government advertising using a framework similar to Finkelstein and Notowidigdo (2019). Based on our demand estimates, we find that federal advertising enhances welfare at least up to its observed level of spending by inducing more individuals to purchase health insurance.

While federal advertising reduces extensive-margin choice frictions, it does not affect consumer choices in the intensive margin. We explore whether private advertising can mitigate intensive-margin choice frictions. We first document how an insurer's advertising spending is related to consumer utility and its plan characteristics. We find that insurers spending more on advertising tend to provide higher consumer utility overall (net of the utility effect from advertising) estimated from the demand model. They also tend to offer health plans that are attractive to consumers, e.g., plans with broader hospital networks and more varieties, but with similar premiums. Thus, private advertising can increase social welfare if the benefit for consumers selecting these product characteristics outweighs potential social costs associated with the characteristics (e.g., possible excess health care spending from the broader access of hospital networks). However, despite these potential welfare benefits, it is not obvious that the equilibrium level of private advertising is efficient. Because of the estimated business-stealing effect, rent-seeking competition may lead to excessive advertising spending. By simulating the effect of shutting down advertising, we assess how much the effect of advertising depends on rivals' equilibrium responses. We find that the effect of private advertising on an insurer's own enrollment is considerably lower (up to 15%) if we take into account rivals' equilibrium responses. Thus, private advertising spending is excessive to some degree, suggesting that private advertising alone may not efficiently mitigate intensive-margin choice frictions. Our findings imply that potential welfare-improving policies for the government are to supplement the private provision of information with a well-designed plan quality disclosure system or to implement plan standardization, instead of subsidizing private advertising.

Although our findings are specific to the context of the ACA marketplaces, they have broad implications in evaluating the design of other market-based public programs. A common rationale for government outreach and marketing is to mitigate consumer choice frictions in program participation. In a market-based program, an additional issue is that firms participating in the program often provide program benefits with different quality. This issue is absent in traditional public programs because the government is the only provider of benefits. Our finding suggests that government and private marketing address choice frictions to some extent. However, we also find potential inefficiency in private marketing, suggesting that other policies facilitating more efficient insurer

choices are also necessary.

This paper contributes to the literature studying the design of health insurance markets. This literature has extensively focused on pricing/product regulations and subsidy designs/risk adjustment—e.g., Hackmann et al. (2015) and Handel et al. (2015) for pricing regulations; Shepard (2016) and Ho and Lee (2019) for provider network provider regulations; Brown et al. (2014) for risk adjustment; and Cabral et al. (2018), Curto et al. (2021), Duggan et al. (2016), Tebaldi (2017), and Polyakova and Ryan (2019) for capitation payments or subsidy designs. Recently, Aizawa and Kim, (2018) show that private insurers use advertising to achieve risk selection in Medicare Advantage, and the recent health policy literature (Karaca-Mandic et al., 2017; Gollust et al., 2018; and Shafer et al., 2020) document how advertising is *correlated* with aggregate enrollment in Medicaid and the marketplace. Our paper is also closely related to recent studies that emphasize choice frictions as the key source of inefficiency in health insurance markets (e.g., Handel, 2013, Polyakova (2016) and Handel et al., 2020), which argue that the government should design the market to efficiently mitigate choice frictions. However, an open question is *who* should address choice frictions. By estimating *causal* impacts of advertising and exploiting detailed data on advertising content, we show that the answer depends on whether choice frictions affect the extensive or intensive margin of consumer decision making in the context of information provision through advertising.

More broadly, this paper contributes to the active literature on government interventions that increase the take-up of public programs. Most studies evaluate marketing and outreach activities for traditional public programs, such as Medicaid (Aizer, 2007) and SNAP (Finkelstein and Notowidigdo, 2019).⁷ Recently, Domurat et al. (2020) and Goldin et al. (2021) study randomized experiments of direct mailings with information on the ACA marketplace that the government sent to specific populations.⁸ Relative to these studies, we study the appropriate roles for the government and private firms in providing information about a market-based program. Our finding that the government and private firms have different roles suggests that both types of information provision should be considered to address choice frictions in a market-based public program.

Finally, this study is related to the extensive literature on the effect of provision of information on market outcomes. In the literature on market-based public programs, Hastings et al. (2017) show that private advertising may distort consumer choices by making them less price sensitive. Ericson and Starc (2016) find that plan standardization mitigates choice frictions in the intensive margin of health insurance choices. Moreover, there is the literature evaluating the effect of providing information about the quality of products. For example, Jin and Leslie (2003) and Jin and Sorensen (2006) show that publicizing product ratings results in better consumer choices.

The paper proceeds as follows. Section 2 provides institutional background on the marketplace.

⁷See also Hastings and Weinstein (2008), who study the importance of outreach in public schools.

⁸Domurat et al. (2020) consider individuals who had accounts in marketplaces but did not sign up.

Section 3 introduces our main data and provides descriptive evidence. Section 4 presents our demand model and its estimates. Section 5 discusses our supply-side model and counterfactual simulation results. Finally, Section 6 concludes.

2 Background on the Health Insurance Marketplace

The health insurance marketplace is a federal/state-based health insurance program for the non-elderly (people younger than 65) in the United States. It was established in 2014 as part of the ACA. The marketplace is designed to provide health insurance for non-elderly uninsured individuals, which was close to 20% of the population before the ACA. In the marketplace, private insurers offer health plans, and the federal government offers premium and cost-sharing subsidies to low-income enrollees. Individuals can decide to purchase health plans during the open enrollment period, typically starting at the beginning of October of the preceding year when the new coverage begins. Each plan is an annual contract, and individuals need to re-enroll every year.

Regulations on Health Insurance Plans. There are many regulations on plans sold in the marketplace. First, each plan must meet a minimum quality defined over the generosity and coverage of health care. Each plan is categorized based on a “metal” ranking, indicating different generosity levels: Bronze, Silver, Gold, and Platinum. Bronze plans are the least generous, which still cover health care costs of about 60% of actuarially fair value. These plans must cover essential benefits, including at least ten different types of specified health services.

The premium is also subject to many regulations. First, it is subject to a modified community rating regulation within each rating region. Each state is divided into geographical rating regions, and a rating region consists of multiple counties or zip codes. Within each rating region, insurers are not allowed to explicitly discriminate their pricing and product offerings based on the consumer’s health status.⁹ Second, the medical loss ratio regulation requires an insurer to maintain a loss ratio—i.e., the ratio of total claim costs over the total premium revenues—of at least 80% at the state level. This regulation directly limits the markup that insurers can charge. Third, an insurer’s request for a premium increase of more than 10% is subject to state- or federal-based rate reviews and must publicly disclose the proposed premium increase and the justification of the increase.

These numerous regulations on pricing and plan benefits make it more difficult for private insurers to compete with competitors via product designs only. Moreover, the ACA did not impose any extra regulations on marketing activities in the marketplace. Thus, marketing activities are a

⁹Insurers can still charge different premiums based on an individual’s age and smoking status under a pre-specified rule. The maximum premium ratio between the oldest (age 64) and the youngest (age 18) must be equal to a factor of 3, and the smoker’s insurance premium is 1.5 times as high as that for non-smokers.

potentially important way for insurers to enroll more consumers.

Consumer Subsidies. Consumers are offered income-based premium subsidies from the federal government. A household with a lower income receives a more generous subsidy. Moreover, the subsidy depends on whether the state government expanded Medicaid. If Medicaid is expanded, subsidies are given to households with incomes between 138% and 400% of the federal poverty level (FPL); households with incomes below 138% of the FPL qualify for Medicaid. Without Medicaid expansion, subsidies are given to households with incomes between 100% and 400% of the FPL; households with incomes below 100% of the FPL can still purchase a plan from the marketplace without subsidies.¹⁰ Consumers purchasing Silver plans also receive income-dependent cost-sharing subsidies. Overall, the government spends close to \$40 billion per year on premium and cost-sharing subsidies.

Marketplace Administration and Marketing. State governments have three options to administer marketplaces. First, they can participate in the federally facilitated marketplace, operated by the Department of Health and Human Services (HHS). Second, they can create own marketplaces (state marketplaces). Third, they can partner with the federal marketplace (partnership marketplaces). Each of these three options provides state governments with different levels of freedom in designing their marketplaces. In particular, different models allow more or less control in tailoring consumer outreach and assistance to state populations. Under the state marketplace model, states assume full responsibility for operating consumer assistance, including marketing through TV advertising. In the federally facilitated marketplace, however, the federal government is responsible for conducting these activities. In the partnership marketplace, enrollment is conducted through the central website for the federally facilitated marketplace (HealthCare.gov), but the state retains the outreach function.

3 Data and Descriptive Evidence

3.1 Data Sources

Advertising Data Our advertising data are from the Campaign Media Analysis Group at Kantar Media. The data provide detailed characteristics of advertising related to health insurance, particularly the ACA health insurance marketplace, at the occurrence level. There are two unique aspects of the data that make it suitable for our research. First, the data allow us to identify which entity

¹⁰The ACA also imposes the tax penalty on the uninsured, known as the individual mandate. Households with income less than 100% of the FPL will be exempt from the individual mandate if the state government does not expand Medicaid.

(the federal government, state governments, or private insurers) sponsored a given advertisement. Moreover, the data contain information about ACA-related political advertising and advertising by insurance navigators, who help consumers with enrolling in the marketplace. Second, we can access a video file of each advertisement in the data, which allows us to characterize each advertisement's message content and see how content varies across sponsors.

The main measure of our analysis is each sponsor's per-capita advertising spending in a local TV market (usually called a designated market area (DMA)), which typically consists of a major city and surrounding counties.¹¹ We create this measure by combining spending on advertisements on local DMA-level TV channels and spending on advertising on national network TV.¹²

Identifying Advertisement Relevant for the Marketplace We exploit detailed information in the database to identify which advertisements are relevant for marketplaces. Using Amazon Web Services, we transcribed each advertisement and examined its content based on keywords. As a result, we can identify whether an advertisement (i) is related to the marketplace, (ii) merely promotes a private insurer's brand, or (iii) is related to health insurance but not about the marketplaces (i.e., Medicare). In our analyses, we consider types (i) and (ii) and exclude type (iii). Depending on advertisement sponsors, we use a slightly different algorithm to classify each advertisement into type (i), (ii), or (iii). We provide details in Appendix B.

Firm- and Market-Level Data Our analysis combines enrollment data of federally facilitated and partnership marketplaces and the two largest state marketplaces from California (CA) and New York (NY). Each year, the Centers for Medicare and Medicaid Services (CMS) releases enrollment data for 38 states in federally facilitated or partnership marketplaces. The data provide information on enrollment at the insurer-county level for each year from 2014 to 2018 and its breakdown by a few demographic groups (e.g., age and household income). In addition, we also obtain enrollment data from state marketplaces in CA and NY. These data provide total enrollments for each insurer-county-year but do not include totals by demographic group.

To construct market shares for each insurer in a county, we obtain the county-level market size from the American Community Survey. Following Tebaldi (2017) and Polyakova and Ryan (2019), we define the county-level market size as the number of uninsured individuals and indi-

¹¹We also observe gross rating points (GRP), which is often used in other research on advertising. However, we believe that per-capita advertising spending is more suitable for this paper. We observe GRPs only for a subset of advertisements. Further, GRPs measure the share of the general population exposed to a particular advertisement. Because the ACA marketplace is mainly relevant for a very particular population, GRPs may misrepresent how much of the population is exposed to an advertisement.

¹²Specifically, we sum two ratios: (i) the ratio of a sponsor's total spending in local TV channels in a DMA to the DMA-level market size and (ii) the ratio of a sponsor's national network TV spending to the national market size. The way we construct the per-capita spending is similar to Sinkinson and Starc (2018).

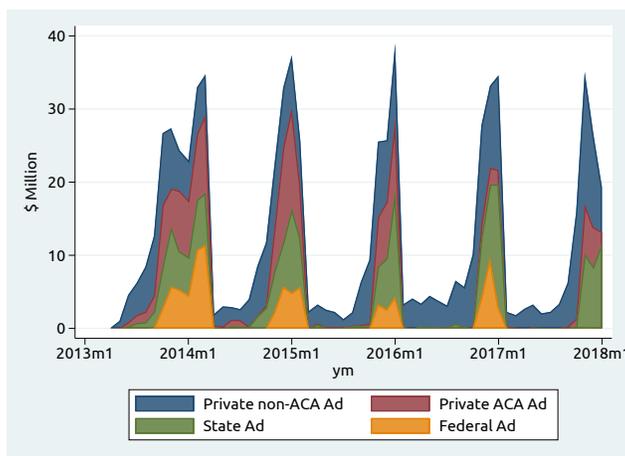
viduals who individually purchased health insurance instead of obtaining it from their employers. This measures the number of potential marketplace enrollees. We also obtain county-level health characteristics, such as the fraction of populations with poor or fair self-reported health from the County Health Rankings by the Robert Wood Johnson Foundation (CHR).

Moreover, we obtain data about plan characteristics (premium, the generosity of insurance plans, and the hospital network structure) for each insurer from the CMS. This information is used to characterize how the effect of advertising varies with plan characteristics and how advertising affects a plan that the consumer obtains.

3.2 Summary Statistics

First, we document the volume of advertising relevant to the marketplace by each sponsor type. Figure 1 reports monthly time-series patterns of advertising spending by governments and insurers. Private ACA-related advertising is somewhat larger than advertising by state and federal governments. However, total government advertising (federal and state combined) is still sizable, generally more than \$100 million per year. This amount is comparable to total private advertising for health insurance (ACA and non-ACA advertisements combined). All sponsors place advertisements around the marketplace’s open enrollment periods.

Figure 1: Time Series of Advertising Spending

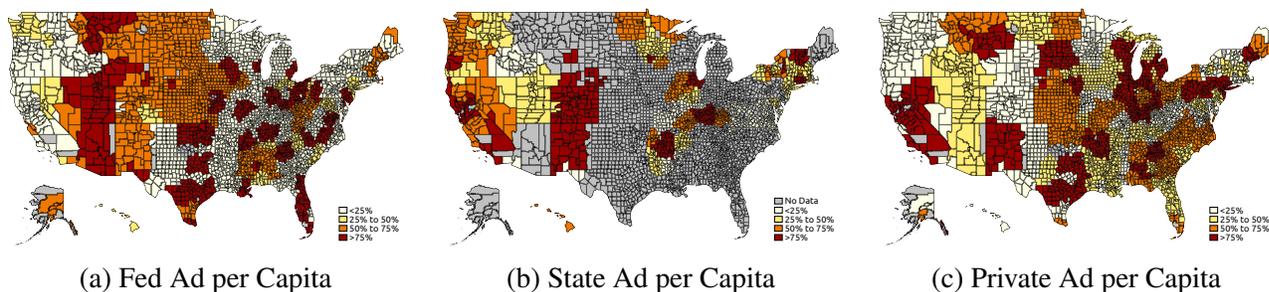


Note: This figure plots monthly expenditures in millions for TV advertisements by the federal and state governments and private insurers’ ACA-related and non-ACA-related advertisements. The four different advertisement types are stacked in this figure. Data source: Kantar Media.

In 2017, the federal government decided to cut its total marketing budget for 2018 to only \$10 million. As seen in Figure 1, TV advertising in 2018 by the federal government is reduced to almost zero. At the same time, both ACA and non-ACA private advertising increased, resulting in the total advertising volume roughly unchanged from 2017. Because there are many other changes

that may increase private advertising in 2018, we do not interpret this relationship as causal. We examine this issue in detail in 4.3.2.

Figure 2: Geographical Patterns of Government and Private Advertising



Note: This figure plots geographical patterns of advertisements by the federal and state governments (Panels (a) and (b)) and private insurers (Panel (c)). In each panel, a DMA is highlighted in different colors depending on relative advertising spending. The larger the total spending in a DMA is, the darker its color is. DMAs for which state governments are not responsible for marketing are highlighted in grey and denoted as "No Data" in Panel (b). Data source: Kantar Media.

Figure 2 shows DMAs in which different sponsors advertised for the 2014 open enrollment period. The figure shows that federal and state governments advertised in very different DMAs—state governments advertised mainly in DMAs with state or partnership marketplaces, while the federal government advertised mainly in DMAs with federally facilitated marketplaces. The same figure also shows that the distribution of government and private advertising spending differs significantly across DMAs. For example, compared with private insurers, the federal government advertises extensively in Arizona and Florida.

Table 1 presents summary statistics on characteristics of markets, split by the intensity of federal, state, and private advertising spending. For columns regarding state advertising ((3) and (4)), we restricted the sample to DMAs that include counties from states responsible for marketing the marketplace. The table shows that government and private advertising spending are not perfectly correlated. Comparing Columns (1) and (2), it is apparent that private advertising spending is lower in DMAs with above-median federal advertising spending. The table also shows that almost all DMAs where state governments directly advertised the marketplace have expanded Medicaid (comparing Columns (3) and (4) with other columns).¹³ Private advertising is also larger in those DMAs. Moreover, although advertising by both governments and private insurers tends to be larger in DMAs with greater market size, private advertising is especially larger in these markets. Lastly, demographic characteristics considered for this table do not seem highly correlated with any types of advertising. However, this result does not rule out the possibility that advertising is still targeted based on these demographic variables if these demographic variables are correlated with other fac-

¹³Every state with positive advertisement spending also expanded Medicaid. The Medicaid dummy is not equal to one in Columns (3) or (4) because some DMAs include counties from states with and without expanded Medicaid.

Table 1: Summary Statistics at DMA-Year Level

	By Fed Ad Spend		By State Ad Spend		By Priv Ad Spend	
	(1) Below Median	(2) Above Median	(3) Below Median	(4) Above Median	(5) Below Median	(6) Above Median
Fed Ad per Capita (\$)	0.14	0.50	0.27	0.17	0.25	0.35
State Ad per Capita (\$)	0.41	0.22	0.19	1.88	0.26	0.40
Priv Ad per Capita (\$)	1.16	0.94	0.76	1.53	0.11	2.02
Medicaid Expanded	0.66	0.64	0.94	0.98	0.61	0.69
Market Size (100,000)	1.99	2.95	2.00	3.62	1.26	3.57
No. of Insurers	3.55	3.37	3.46	3.79	2.89	4.06
Share: Income \leq 138% of FPL	0.23	0.23	0.23	0.19	0.23	0.23
Share: Age \geq 55	0.18	0.18	0.18	0.19	0.18	0.18
Share: Poor or Fair Health	0.17	0.17	0.17	0.16	0.18	0.17
N. Obs.	434	350	124	124	392	392

Note: This table reports summary statistics of market characteristics depending on federal, state, and private advertising spending. Odd (even)-numbered columns present characteristics of DMAs below (above) the medians of the three types of advertising. We restricted the sample year up to 2017 for this table because there is no federal advertising in 2018, although our demand estimation in Section 4 uses the sample up to 2018. For Columns (3) and (4), we restricted the sample to DMAs that include counties from states responsible for marketing the marketplace. The number of observations is not balanced for Columns (1) and (2) because there are DMAs with zero local federal advertising. "Medicaid Expanded" is the fraction of markets where Medicaid was expanded under the ACA. "Share: Income \leq 138% of FPL" is the share of individuals with incomes below or equal to 138% of FPL. "Share: Age \geq 55" is the share of individuals aged 55 or above. "Share: Poor or Fair Health" is the share of individuals with poor or fair self-reported health. Data source: Kantar Media.

tors that are also taken into account for targeting. In Section 3.3, we use DMA-level regressions to study more systemically how advertising is targeted.

Table 2: Ad Contents

	(1)	(2)	(3)
	Private	Federal	State
Share: Any ACA-related	0.37	1.00	1.00
Share: Open Enrollment	0.24	0.22	0.24
Share: Financial Assistance	0.22	0.31	0.42
Share: Open Enrollment and Financial Assistance	0.14	0.20	0.16
Share: Healthcare Reform	0.14	0.18	0.02
Share: Uninsured	0.02	0.03	0.10
Share: Penalty	0.09	0.00	0.02
N. Obs.	998,017	249,215	508,275

Note: This table reports summary statistics of messages in advertisements by private insurers and the federal and state governments for 2014–2018. The unit of observation is each advertisement occurrence, and reported numbers are averages weighted by each advertisement's dollar cost. Numbers in each column do not necessarily sum up to one because each advertisement can have multiple messages. Data source: Kantar Media.

Advertising Content. Table 2 shows summary statistics of advertisement content depending on sponsor types (federal and state governments as well as private insurers). With transcripts of advertisements in our sample, we first consider the following types of advertising content: whether an advertisement mentions the open enrollment period, financial assistance under the ACA, health-

care reform, being uninsured, or the financial penalty of not having health insurance. Details on how these variables are constructed are in Appendix G. We then tabulate the proportion of advertisements that mention keywords related to each topic by sponsor type.¹⁴

There are certain similarities among advertisements by different sponsors. For example, all sponsor types commonly discuss the open enrollment period and financial assistance in their advertisements. These two types of content are the most common in ACA-related advertisements for all sponsors. Moreover, these two types of content are often discussed together in the same advertisement by all sponsor types. The fourth row of Table 2 shows that there are more advertisements that discuss both the open enrollment period and financial assistance than advertisements that discuss contents other than the open enrollment period or financial assistance.

However, there are also significant differences in content between government and private advertisements. Government advertisements tend to provide general information about enrolling in the marketplace. Even when federal or state advertisements do not mention the ACA specific content defined above, they still inform consumers of the presence of marketplaces, always showing the web addresses of the federal and state marketplaces, as in Figure 3 in the Online Appendix. In contrast, private advertisements always provide sponsor-specific information such as insurer names and their web addresses, as in Figure 3 in the Online Appendix. Moreover, about 60% of private advertisements do not mention any of the keywords related to the marketplace that we considered. These private advertisements without ACA-related content usually promote an insurer's brands, quality, and various insurance options provided by its plans.¹⁵

This difference in content between government and private advertisements reflects their different objectives. Our evidence is consistent with the hypothesis that the government's objective is to expand total enrollment in the marketplace by reducing choice frictions through provision of the ACA specific information. In contrast, the large fraction of private advertisements not providing specific information related to the ACA marketplace reflects that private advertising may be used to increase an insurer's own enrollment and to maximize its profit. We will further examine differences in the objectives by looking at how advertisements are targeted in the next section.

Moreover, the difference in content suggests that government advertising and private advertising potentially have different effects on consumer enrollment. The general information provided by the government likely influences overall enrollment, potentially increasing demand for even

¹⁴The set of content we consider in Table 2 is not necessarily exhaustive. For example, one could also look at whether the federal government tried to use advertising as a tool of political persuasion or whether an advertisement conveys misinformation about the marketplace. We focus on the types of content in the table because they are identified in a relatively objective way. Moreover, we believe that the misinformation channel is less relevant in our context because of regulations that ban marketing providing misinformation about health insurance markets (e.g., see CMS Managed Care Manual for regulations of marketing activities).

¹⁵We also checked a random sample of private advertisements visually to see whether they show the web address of the marketplace (e.g., Healthcare.gov), but none of them, including even ACA-related ones, do. In contrast, federal and state advertisements always show the web address of their marketplaces.

insurers without any advertisements. Insurer-specific information provided by private advertisements likely influences demand for insurers sponsoring the advertisements. We will examine these potential differential effects more closely in our demand analysis in Section 4.

3.3 Suggestive Evidence for Geographical Targeting of Advertising

We now carry out preliminary analyses to explore how advertising, both by governments and private insurers, is geographically targeted. We investigate how advertisement spending is correlated with DMA characteristics by estimating the following regression:

$$\ln(1 + ad_{mt}^k) = X_{mt}\gamma + \xi_t + \varepsilon_{mt}. \quad (1)$$

The dependent variable ad_{mt}^k represents advertising spending per capita by sponsor type $k \in \{f, s, p\}$, which is the federal government (f), state government (s), or private insurer (p). Explanatory variables X_{mt} include various DMA-level characteristics considered in Table 1. ξ_t refers to a year fixed effect. Although we are reluctant to view our estimates as causal, we aim to learn which market characteristics are associated with greater advertising spending by sponsor type.

Table 3: Targeting of Advertising: Aggregate Results

	(1) Federal	(2) State	(3) Private (All)	(4) Private (ACA)
Share: Income \leq 138% of FPL (%)	-0.008 (0.012)	-0.209*** (0.050)	0.096* (0.050)	0.046** (0.020)
Medicaid Expanded=1	-0.099* (0.057)		0.563** (0.226)	0.196* (0.101)
Medicaid Expanded=1 \times Share: Income \leq 138% of FPL (%)	0.017 (0.015)		-0.113** (0.057)	-0.032 (0.029)
Share: Age from 35 to 64	-0.004 (0.006)	-0.105** (0.043)	0.041* (0.024)	0.003 (0.010)
Share: Poor or Fair Health (%)	0.007 (0.009)	0.061 (0.040)	-0.045 (0.029)	-0.011 (0.018)
No. of Insurers	0.017*** (0.006)	0.116*** (0.025)	0.061*** (0.015)	0.020*** (0.007)
Log of Market Size	0.027*** (0.008)	0.002 (0.047)	0.130*** (0.023)	0.070*** (0.012)
Year FE	Y	Y	Y	Y
N. Obs.	784	332	983	983
Adj. R^2	0.148	0.259	0.207	0.209

Note: This table reports estimates of the coefficients in Equation (1). Because there is no federal advertising spending in 2018, we restricted our sample years to 2014–2017 for Column (1). For Column (2), we restricted the sample to DMAs that include counties from states for which states are responsible for marketing the marketplace. For the same column, we do not include the dummy variable for Medicaid expansion because every state with positive advertisement spending expanded Medicaid. Standard errors are in parentheses and clustered at the DMA level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 3 presents estimates of the regression in Equation (1). Columns (1) and (2) report results

for federal and state advertising, respectively. Column (3) presents results for all private advertising, and Column (4) restricts private advertising to ACA-related content. We find that both governments and private insurers do more advertising in markets with more private insurers. However, government advertising is not particularly targeted based on DMA-level demographic characteristics. In contrast, private advertising varies much more with demographic characteristics and health care policies. For example, private advertising is significantly larger in markets with more potential enrollees. Moreover, Medicaid expansion is associated with 76% ($\simeq 100 * (\exp(0.563) - 1)$) additional total private advertising. We also examine targeting based on the share of the population reporting poor or fair health across DMAs, but we do not find statistically significant correlations with advertising by any sponsor.^{16,17} These findings are consistent with the profit-maximizing motives of private insurers. First, larger markets typically include more urban areas, where many insurers have their established networks with hospitals. Such markets also tend to have more providers, which usually keep health care costs lower. Second, markets in states with Medicaid expansion can be more profitable because Medicaid will improve the risk pool of the marketplace by absorbing low-income populations, who are more likely to be high-risk.¹⁸

3.4 Discussion: Government’s Objectives

Our finding of advertising contents and geographical targeting provides suggestive evidence about what the government’s objectives are in our context and how they are different from those of private insurers. First, our finding is consistent with the view that the federal government advertises to reduce consumer choice frictions, especially those associated with the extensive margin of enrollment, by providing information such as the open enrollment period and the availability of subsidies. This likely reflects the government’s interests in increasing total program enrollment.

Second, government advertising is less responsive to measures related to potential profitability than private insurers, such as the market size and the Medicaid expansion status. This suggests that the government’s advertising decision is based on factors that private insurers do not take into account. The government may want to promote equity and reach out to a broad population. Moreover, it may also internalize negative externality of being uninsured. For example, health care spending of the uninsured is often covered by the uncompensated care, leading to higher tax for the insured (Finkelstein et al., 2019). Government advertising can potentially mitigate such inefficiency, which private insurers unlikely take into account.

¹⁶We also examined other health measures such as health care costs and the fraction of obesity and diabetes but found similar patterns. These results are available upon request.

¹⁷In Appendix H, using the list of message content from Table 2, we investigate how per-capita advertisement spending for each type of content and sponsor is targeted to different DMAs. We also find differences in the targeting of advertising that provide specific content by different sponsors.

¹⁸See Sen and DeLeire (2018) for evidence that Medicaid expansion improves the risk pool of the marketplaces.

Lastly, our finding that government advertising does not appear to be targeted toward certain demographic groups perhaps reflects conflicting objectives of the government. On the one hand, the government may want to target to the younger and thus healthier population to improve the risk pool in the marketplace, lowering the average cost and thus the premium. On the other hand, the government may want to target older and unhealthy populations because they would typically benefit more from health insurance.

Thus, these empirical patterns suggest that the government's objective inferred by its advertising targeting is to increase total program enrollment from diverse demographic groups. However, it is not obvious a priori whether the government's advertising has the intended effects. In the next section, we estimate the demand effects of advertising.

4 The Impact of Advertising on Consumer Demand

4.1 Market-level Analysis

To examine the effect of government and private advertising on consumer demand, we first estimate its impact on market-level enrollment in the marketplace. The primary objective of this analysis is to understand whether advertising has any meaningful effect on the market expansion. Although advertising could have an impact on Medicaid enrollment, we exclude such an analysis from this paper because we find limited effects on Medicaid enrollment in our preliminary analysis.¹⁹

4.1.1 Identification: Border Strategy

In estimating the effects of advertising, the endogeneity of advertising is a threat to credible identification. Private insurers may choose to advertise more in markets with higher profits from advertising because of unobserved heterogeneity in consumer demand. For example, some insurers may have better brand images in certain markets and thus concentrate their advertising campaigns in such markets. In contrast, it is not clear whether the government implements a sophisticated targeting strategy. Even if the government is sophisticated, it is not obvious whether it targets a market with high or low demand for insurance. Depending on how advertising and demand for insurance are correlated, a naive regression of county-level enrollment on advertising may lead to under- or over-estimation of the effects of advertising.

To address the endogeneity of advertising, we implement a border identification strategy by building on recent studies of advertising (e.g., Shapiro, 2018, Spenkuch and Toniatti, 2018, Aizawa

¹⁹This result is available upon request.

and Kim, 2018, Tuchman, 2019, and Moshary, 2020).²⁰ The border strategy exploits a discontinuity of advertising expenditures across a border between DMAs. This discontinuity arises because the Federal Communications Commission regulations grant media companies local broadcast rights at the DMA level. A DMA typically contains a major city and surrounding counties. Thus, there are “border counties” in an outer part of a DMA located adjacent to at least one county in a different DMA. The border strategy relies on the regulation-induced discontinuities in exposure to advertising across neighboring border counties in the same state but different DMAs.²¹ An advertising decision is likely based on characteristics of the entire DMA, not a specific border county. Differences in DMA-level characteristics between two neighboring DMAs can result in discontinuities of advertising exposures to two neighboring border counties in different DMAs although the two border counties likely have similar unobserved heterogeneity in demand.

To implement the border strategy, we first identify pairs of adjacent border counties in the same state that belong to two different DMAs, which we refer to as border pairs. With fixed effects for border pair-by-year, we control for unobserved heterogeneity in demand common within each border pair and year. Using the panel structure of our data, we also include county fixed effects to control for time-invariant county-level unobserved heterogeneity in demand. With the two sets of fixed effects, remaining unobserved heterogeneity is at the level of county and year within a border pair. Our identifying assumption is that the remaining unobserved heterogeneity is uncorrelated with advertising. In other words, we assume that growth in advertising spending in a DMA is uncorrelated with changes in county-level unobserved heterogeneity in demand over time.

One important advantage of the border strategy is that it teases out separate exogenous variations in advertising by different sponsors. It is possible that advertising spending of private firms and the government are jointly determined in equilibrium in each DMA. However, what matters for the identification is that unobserved heterogeneity in consumer demand in border counties is uncorrelated with growth in advertising by different sponsors, which are determined at the DMA level. As long as our identification assumption is met, all we need to separately identify sponsor-specific effects of advertising is variation in the difference of advertising spending by different sponsors across border pairs.

The border strategy also allows us to identify the effect of advertising separately from other ways in which the government or insurers can increase enrollment. First, insurers are typically allowed to choose premium or product characteristics for multiple neighboring counties. Thus, consumers in neighboring border counties are more likely to face similar product characteristics. Moreover, other marketing activities are unlikely to bias our estimates. Such activities will violate

²⁰The main idea behind this type of border strategy is already presented in the seminal work by Holmes (1998) and Black (1999). See Li et al. (2020) for the relationship between the border strategy and the Waldfoegel instrument (Waldfoegel, 2003), which is commonly used in the industrial organization literature.

²¹We only compare border counties in the same state because marketplaces in different states can be very different.

the identifying assumption only if geographical targeting of these activities systemically depends on growth in TV advertising across the DMA border *and* if these activities are effective. For example, the state government may conduct outreach activities besides TV advertising, such as sending reminders to specific enrollees (e.g., Domurat et al., 2020). These activities often target specific individuals as opposed to a county as a whole. Other outreach activities, such as in-person assistance programs, may vary across counties. Private insurers may engage in other marketing activities, such as digital advertising. They are typically designed to target at the individual level and therefore are unlikely to discretely change across DMA borders in a way that is correlated with growth in TV advertising.

We provide evidence that at least some outreach activities by the state government are not correlated with its TV advertising. In Online Appendix A, we show that TV advertising for California (CA)’s own marketplace (Covered California) is uncorrelated with the zipcode-level number of agents or entities that assist consumers signing up for the marketplace. Moreover, the numbers of agents and entities are very similar across border counties in CA.

The identifying assumption for the border strategy will be more plausible if county characteristics are indeed balanced between border counties in the cross section. Having balanced county characteristics is not a necessary condition of our identification assumption because we use the panel structure of the data. However, one might expect that counties with similar characteristics are likely to have similar trends for unobserved heterogeneity. Indeed, we find that those market characteristics are also almost identical between pairs of border counties with different advertising, as discussed in detail in Appendix A.

An important caveat to the border strategy is that the estimated effect is only local to potential marketplace enrollees in border counties. Thus one must be cautious in generalizing the estimated effect to non-border counties. In Appendix A, we show a considerable amount of overlapping support in observables between the border and non-border counties. This result suggests that the estimated effect of advertising could be generalizable to even non-border counties. Another caveat is that its reliance on many fixed effects could result in limited remaining variation in advertising. In Appendix A, we report that we have enough advertising variation within border pairs.

4.1.2 Effects of Advertising on Market-level Enrollments

We estimate the following county-level regression:

$$\ln(s_{bct}) = \sum_{k \in K} \ln(1 + ad_{bm(c)t}^k) \beta_k + x_{bct} \gamma + \xi_{bt} + \xi_c + \xi_{r(c)t} + \varepsilon_{bct}. \quad (2)$$

The dependent variable refers to the log of the share of individuals that enrolled in the marketplace plans in border pair b , county c , and year t . On the right-hand side, $ad_{bm(c)t}^k$ refers to the advertising

expenditure of category k per potential marketplace enrollee in border pair b , DMA $m(c)$ to which county c belongs, and year t .²² Advertising of category k refer to advertising by different sponsors. In the main specification, $K = \{f, s, mp\}$. $ad_{bm(c)t}^f$ and $ad_{bm(c)t}^s$ denote advertising by federal and state governments, respectively, and $ad_{bm(c)t}^{mp}$ is *market-level* private advertising, defined as the sum of advertising expenditures by all insurers in each DMA and year. In some specifications, we include advertising of other categories to control for additional variables that also vary discretely across DMA borders: insurance navigators (nv) and political advertising on the ACA by Democrats (dem) and Republicans (rep).²³ Note that TV advertising decisions are typically made based on a DMA, which contains several counties. Thus, we assume individuals in different counties but in the same DMA are exposed to the same advertising level. We add one to the advertising variables before taking the logarithm because there are markets with zero advertising spending by the government or private insurers. Because both dependent and independent variables are in logarithms, the coefficient β_k is the elasticity of county-level demand for marketplace plans with respect to advertising by a sponsor k .

Next, x_{bct} refers to a set of time-varying characteristics for each county-year pair (ct). We include the number of insurers and the market size. To control for unobserved heterogeneity in demand, we include fixed effects for a border pair-by-year (ξ_{bt}), county (ξ_c), and rating area-by-year ($\xi_{r(c)t}$). As discussed above, the border strategy relies on the first two fixed effects. The first fixed effect controls for time-varying unobserved heterogeneity across border pairs, and the second one controls for time-invariant unobservables that vary within border pairs at the county level. In addition, a rating area is a collection of counties within which an insurer sets characteristics for its plans. Thus, $\xi_{r(c)t}$ controls for effects of plan characteristics on enrollments, although we do not explicitly include specific plan characteristics in the regression models. An alternative way to control for differences in plan characteristics across rating areas and years is to further restrict the sample to border pairs that are included in the same rating area. We present estimates from the alternative sample in Section 4.4 for robustness checks.

An important question is whether we should look at advertising effects by advertising sponsors or by the content of advertising. One can argue that we should classify advertising solely based on the type of information that it contains because the sponsor does not matter but the information matters. In our view, there are several reasons why we should distinguish advertising by their

²²Throughout the paper, we measure advertising spending as a flow, as opposed to stock. A stock measure of advertising spending is more appropriate for markets where consumers make purchasing decisions at a relatively high frequency, such as weekly or monthly. For example, see Shapiro (2018), Sinkinson and Starc (2018), Dubois et al. (2018), and Tuchman (2019), who study consumer purchases of pharmaceuticals, e-cigarettes, and junk food, respectively. We view that a flow measure is more appropriate for our context because advertising is concentrated around the open enrollment each year and because health insurance purchasing decision is only made once in a year during the open enrollment period.

²³The classification of political advertising is based on information on the political party affiliation of advertising sponsors in the data.

sponsors. First, the amount of advertising is chosen by each advertising sponsor. Second, it is plausible to hypothesize that the effectiveness of advertising can be different depending on advertising sponsors, even if the advertising contains similar information. For these reasons, we explicitly distinguish advertising by its sponsors. In Section 4.2.4, we explicitly look at how the effect of advertising providing similar information contents differs depending on advertising sponsors.

4.1.3 Estimation Results

Table 4: The Effects of Advertising on Market-level Enrollments

	(1)	(2)	(3)	(4)
Fed Spend	0.041 (0.028)	0.041*** (0.015)	0.050** (0.021)	0.050** (0.021)
State Spend	-0.028 (0.035)	0.019 (0.027)	-0.011 (0.034)	-0.008 (0.034)
Priv Spend	0.006 (0.016)	0.011 (0.012)	0.023 (0.018)	0.024 (0.017)
Navi Spend				-0.055 (0.122)
Dem Spend				0.049*** (0.016)
Rep Spend				-0.015* (0.008)
No. of Insurers	0.046*** (0.011)	0.012* (0.007)	0.012 (0.008)	0.013 (0.008)
Market Size	0.000 (0.000)	-0.009** (0.004)	-0.026*** (0.006)	-0.026*** (0.006)
BorderYear FE	Y	Y	Y	Y
County FE		Y	Y	Y
RatingYear FE			Y	Y
N. Obs.	18,862	18,840	18,182	18,182
Adj. R^2	0.707	0.913	0.919	0.919

Note: This table reports the estimates of the coefficients in Equation (2). Different columns have different combinations of the fixed effects. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA \times Year and the County level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 4 presents regression results from various specifications. Standard errors in all specifications are two-way clustered at the level of DMA-by-year and county. In almost all specifications, the coefficient estimates for advertising by the federal government are positive and statistically significant, and their magnitudes are largely invariant across the specifications. Based on the estimates in Column (3), we find that a 1% increase in federal advertising leads to a 0.05% increase in the share of individuals enrolled in the marketplace. Extrapolating the coefficient to larger changes, if the federal government doubles advertising spending, then the market-level share will increase by 1 percentage point (pp) given the unconditional average of the market-level take-up rate of 0.2. Another way to interpret the coefficient is that eliminating federal advertising (conditional on advertising by other sponsors) will decrease enrollment by 5%. This estimate is around the upper end

of the estimates of the effectiveness of private advertising in other markets. For example, Shapiro et al. (2021) document the median elasticity is 0.01 among 288 private goods markets.

One can also compare the effectiveness of federal advertising with that of other government outreach. We find that it is quite comparable to that of a direct mail reminder to enroll in the marketplace that the Internal Revenue Service sent to taxpayers, which is studied by Goldin et al. (2021). We provide a more detailed comparison in Online Appendix F.

In contrast, the coefficient estimates for advertising by state governments are very small and almost close to zero. This small average effect could mask heterogeneous effects of advertising by different states. In marketplaces for which state governments are responsible for marketing instead of the federal government, each state government organizes its marketing activities. It is reasonable to expect that some states have more resources to design more effective marketing activities than others. To explore this possibility, in Section 4.5.2, we examine how effective state advertising is in CA relative to other states, where the state government spent a lot of resources for marketing its marketplace.²⁴ We find a large and positive effect of state advertising in CA, which indicates heterogeneous effects of advertising by different state governments.

Next, we find that market-level private advertising is not more effective than government advertising in increasing market-level enrollment in any specifications. The point estimates for the effect of private advertising are smaller than those for federal advertising and statistically insignificant in all specifications. Based on these estimates, we robustly reject that private advertising is more effective in expanding total enrollment than federal advertising.

Our main specifications do not reject the possibility that federal advertising is equally as effective as market-level private advertising. However, we can make a slightly sharper comparison of the effects of federal and private advertising in an alternative specification where the advertising variables enter the regression in levels instead of logs (see Table 21 in Online Appendix). In this specification, federal advertising is more effective than private advertising at the 10% significance level. Table 21 also shows that with an alternative sample that is restricted to border pairs in the same rating area, we reach the same conclusion at the 5% significance level.

However, it is still difficult to clearly distinguish statistically the effectiveness of advertising by different sponsors except for a few specifications, partly due to relatively large standard errors of the estimates. Nevertheless, in Table 19 in the Online Appendix, we still find that the effect of federal advertising is statistically larger than the combined effect of non-federal advertising in the marketplace. Thus, federal advertising is more effective in increasing total enrollment than typical advertising by sponsors other than the federal government.

There are two possibilities behind limited effect of private advertising. First, as recent research on advertising documents, private firms may not necessarily be very good at using advertisements

²⁴See Lee et al. (2017) for the summary of the marketing campaign of CA marketplace programs.

to increase demand.²⁵ Second, even if private advertising is very effective in increasing demand for insurers that conduct advertising, it does so, at least in part, by stealing consumers from other insurers. In this case, private advertising may reallocate consumers among insurers to some extent and thus result in a smaller market-level effect. In the next section, we will estimate the effect of advertising on individual insurer demand to further investigate this issue.

In Column (4) of Table 4, we include additional categories of advertising to control for other factors that also vary discretely across DMA borders. Including the additional variables does not change very much the coefficient estimates for the three main advertising variables. Interestingly, the estimated effects of political advertising are consistent with how each party views the ACA. Democratic advertising increases market-level enrollment, and its effect is comparable to federal advertising. The point estimate for Republican advertising is negative.

4.2 Demand Model

We now analyze the impact of advertising on enrollment at the insurer level. This analysis will help us understand whether private insurer advertising is effective in increasing enrollment for the advertising insurer as well as its impact on other insurers.

4.2.1 Utility Specification

Consider individual i who lives in market ct , which is defined as a county-year pair. The number of marketplace insurers available in each market is denoted by J_{ct} . Because the outside option—for example, being uninsured—is always available, a consumer has a total of $J_{ct} + 1$ options. The consumer optimally chooses the insurer that maximizes his utility.²⁶ We assume that the consumer obtains indirect utility u_{ijct} from insurer $j > 0$ as follows:

$$u_{ijct} = \sum_{k \in K} \ln(1 + ad_{jm(c)t}^k) \beta_k + \xi_{jct} + \varepsilon_{ijct} \quad (3)$$

An individual's insurer choice is affected by advertising in various categories $ad_{jm(c)t}^k$, where each category is defined over advertisement sponsor and content. It is also affected by the non-advertising utility from an insurer (ξ_{jct}).

The set of advertising categories we consider in the main specification is a collection of the per-capita spending by different advertising sponsors: $K = \{f, s, p, r, nv, dem, rep\}$, where an important change from the market-level analysis is our treatment of private advertising. We let $ad_{jm(c)t}^p$ denote

²⁵For example, see Blake et al. (2015) and Lewis and Rao (2015).

²⁶Although plan-level enrollment data are available, the data only provide total enrollment for each plan aggregated across multiple counties. Moreover, because the effects of advertising on the market- and insurer-level demand are the first order channels, we leave incorporating a plan choice for future work.

advertising by insurer j . In the insurer-level analysis, we consider this insurer-specific advertising measure instead of market-level private advertising ($ad_{m(c)t}^{mp}$).

Note that with our framework, an insurer j 's advertising will inherently have some business-stealing effects. In other words, its advertising will increase own market share at the expense of rivals' market shares as well as the outside option. Thus, the effect on total enrollment can be smaller even if private advertising is as effective as government advertising in increasing demand for an individual insurer. To allow for a more flexible substitution pattern among insurers with respect to private advertising, we include advertising by an insurer's rivals (r) in some specifications such that $ad_{jm(c)t}^r = \sum_{h \neq j} ad_{hm(c)t}^p$.²⁷ The coefficient for $ad_{jm(c)t}^r$ will determine whether private advertising has positive spillover to rivals or steals business from rivals. If the coefficient, β_r , is positive and large relative to the coefficient on own advertising (β_p), then private advertising has a positive spillover effect: that is, private advertising increases not only the insurer's own demand but also rivals' demand, thereby leading to market expansion. To the extent that some private advertising provides general information about the marketplace—for example, the open enrollment period—it could potentially have positive spillover to rivals. Otherwise, private advertising increases own enrollment from the outside option and steal consumers from other insurers. In other words, if the coefficient β_r is positive but small or even negative, private advertising will have at least some business stealing effect.

As in the market-level analysis, we include federal (f), state (s), navigators (nv), Democrats (dem), and Republicans (rep) advertising. Note that each advertising has the j subscript; however, it does not change across insurers within the same DMA and year. Thus, if advertising by governments increases an insurer's market shares, it will increase all other insurers' market shares in the same way, thereby expanding the total enrollment in marketplace plans.

Non-advertising utility (ξ_{jct}) denotes utility from characteristics of an insurer's plans or the insurer itself such as premiums, generosity of coverage, provider networks, and its brand image. For the purpose of this paper, it is not crucial to estimate how much utility depends on specific plan characteristics. Thus, we do not explicitly model how each plan characteristic affects utility.

A consumer's outside option ($j = 0$) is to stay uninsured or purchase an off-marketplace plan, from which a consumer receives utility of u_{i0ct} :

$$u_{i0ct} = \varepsilon_{i0ct}. \quad (4)$$

The deterministic portion of u_{i0ct} is normalized to 0 for all ct because only the relative utilities can be identified in a discrete choice model. Lastly, ε_{ijct} is an individual i 's preference shock for each plan. We assume that ε_{ijct} is independently and identically distributed according to a Type I

²⁷We also experimented with an alternative specification, where we define rivals' advertising as the average per-capita spending by rivals. This variable definition does not affect our results.

extreme-value distribution.²⁸

Also, variables in the utility function do not include the subscript for border pair (b) for now because we will first write a general consumer demand model. When we estimate the model, we will also employ the border strategy, where we will add the subscript for border areas (b) to appropriate variables when discussing identification.

There are a few remarks in order. First, our choice model does not allow interaction between advertising and private advertising or plan characteristics. For example, private advertising could be more or less effective depending on government advertising. Further, private advertising could make consumers less sensitive to the premium, a channel studied in other markets (Hastings et al., 2017). We relax this assumption in Section 4.3.1 and 4.3.2.

Second, we *purposefully* specify that advertising only affects consumer's indirect utility, without assuming how it affects consumer's choice. For example, as Hastings et al. (2017) shows, our indirect utility function encompasses a pure consideration set model (e.g., Goeree, 2008), in which the role of advertising is to increase the probability that a consumer will consider the plan j . In this case, advertising will be welfare-enhancing by mitigating information friction. Although this approach is common in many studies in marketing, this may make underlying mechanisms behind the advertising effect less clear. Our objective is to take advantage of rich information of advertising content to *empirically* infer a relevant mechanism that drives the effectiveness of advertising in Section 4.2.4. An advantage of this approach is that it allows us to discuss a welfare channel without taking any stances before estimating the model.

4.2.2 Identification and Estimation

To estimate the model, we exploit the one-to-one mapping between each insurer's market share and the deterministic part of u_{ijct} given in Equation (3) as in Berry (1994). Define $\delta_{jct} \equiv u_{ijct} - \varepsilon_{ijct}$. Then it is easy to show, based on the assumption on ε_{ijct} , that

$$\delta_{jct} = \ln(s_{jct}) - \ln(s_{0ct}),$$

where s_{jct} denotes insurer j 's empirical market share. We will denote the empirical counterpart of δ_{jct} by $\hat{\delta}_{jct}$. Then the estimating equation is given by

$$\hat{\delta}_{jct} = \sum_{k \in K} \ln(1 + ad_{jm(c)t}^k) \beta_k + \xi_{jct}. \quad (5)$$

²⁸One could assume a nested logit error term to allow for additional flexibility in substitution patterns. For example, we can have all inside options in a single nest. However, we would need an instrument to estimate the nesting parameter because we only have aggregate data on market shares. We find it challenging to come up with a reasonable instrument because we include an extensive set of fixed effects due to the border identification strategy. Thus, we do not consider a nested logit model.

Notice that estimating coefficients in Equation (5) simply requires running a linear regression. However, estimating the coefficients with an ordinary least square regression is likely to result in biases in our advertising coefficients (β_k) because of the endogeneity of advertising, as discussed earlier in Section 4.1.1. Thus, we employ the border strategy to estimate the coefficients.

Border Strategy at the Insurer Level Consider an insurer j in county c in border pair b . With the border strategy, we assume that the insurer’s non-advertising utility is

$$\xi_{jbct} = \xi_{jbt} + \xi_{jc} + \xi_{jr(c)t} + \Delta\xi_{jbct}. \quad (6)$$

First, ξ_{jbt} refers to fixed effects for insurer j , border pair b , and year t . They capture any common factor that affects demand for insurer j in both counties in border pair b in year t . Second, ξ_{jc} refers to insurer \times county fixed effects, which capture any time-invariant factor that commonly affects demand for an insurer in a county. Second, $\xi_{jr(c)t}$ denotes fixed effects for insurer j , rating area $r(c)$, and year t . An insurer is restricted to offer the same price for a given plan within a rating area and a year. Thus, we indirectly control an insurer’s plan characteristics with $\xi_{jr(c)t}$. Alternatively, we control for this heterogeneity by further restricting our sample to border pairs in the same rating area. We show results with this alternative sample in Section 4.4 for robustness checks. Lastly, $\Delta\xi_{jbct}$ denotes the remaining component in ξ_{jbct} .

Combining Equations (5) and (6), we have the following estimating equation with the border strategy:

$$\hat{\delta}_{jbct} = \sum_{k \in K} \ln(1 + ad_{jbm(c)t}^k) \beta_k + \xi_{jbt} + \xi_{jc} + \xi_{jr(c)t} + \Delta\xi_{jbct} \quad (7)$$

The identifying assumption is that none of the advertising variables are correlated with the structural error term $\Delta\xi_{jbct}$ —i.e., unobserved heterogeneity in demand for an insurer that varies at the level of county and year within a border pair.

4.2.3 Estimation Results

Table 5 presents coefficient estimates in the utility function described in Equation (3) with different specifications. Standard errors for all specifications are two-way clustered at the level of DMA-by-year and insurer-by-county. The table shows that, in all specifications, an insurer’s own private advertising is effective in increasing demand for an insurer. Based on the estimate from Column (6), which contains the most extensive set of fixed effects, the average elasticity of insurers’ demand with respect to advertising is 0.03 among insurers that had positive advertising spending.²⁹

²⁹Because the elasticity becomes zero for insurers with zero advertising spending, we only calculated the number among insurers with positive advertising.

Table 5: Estimated Coefficients in Insurer-Level Demand Model

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fed Spend	-0.009 (0.059)	0.079* (0.043)	0.131*** (0.048)	0.125** (0.053)	0.123** (0.053)	0.129** (0.054)	0.127** (0.054)
State Spend	0.012 (0.054)	-0.050 (0.052)	-0.033 (0.059)	-0.033 (0.070)	-0.031 (0.070)	-0.028 (0.069)	-0.025 (0.069)
Priv Spend	0.217*** (0.042)	0.309*** (0.056)	0.149*** (0.043)	0.093* (0.048)		0.090* (0.047)	
Priv ACA Spend					0.048 (0.054)		0.042 (0.054)
Priv non-ACA Spend					0.121** (0.056)		0.121** (0.055)
Rival Spend						-0.043 (0.047)	-0.044 (0.046)
Navi Spend						-0.390 (0.240)	-0.391 (0.240)
Dem Spend						0.049 (0.037)	0.047 (0.037)
Rep Spend						0.017 (0.018)	0.018 (0.018)
No. of Insurers	-0.190*** (0.020)	-0.203*** (0.019)	-0.189*** (0.023)	-0.091*** (0.024)	-0.091*** (0.024)	-0.087*** (0.024)	-0.087*** (0.024)
Market Size	0.001*** (0.000)	-0.012*** (0.003)	-0.022*** (0.006)	-0.021*** (0.005)	-0.021*** (0.005)	-0.022*** (0.006)	-0.022*** (0.006)
FirmBorderYear FE	Y	Y	Y	Y	Y	Y	Y
County FE		Y	Y				
FirmCounty FE				Y	Y	Y	Y
FirmRatingYear FE			Y	Y	Y	Y	Y
N. Obs.	39,782	39,770	38,316	36,558	36,558	36,558	36,558
Adj. R^2	0.791	0.824	0.897	0.938	0.938	0.938	0.938

Note: This table reports the estimates of the coefficients in Equation (7). Different columns have different combinations of the fixed effects and different combinations of the advertising variables. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA \times Year level and the Firm \times County level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

The magnitude of this estimated impact of private advertising is largely consistent with typical findings in the marketing literature estimating the elasticity of demand with respect to advertising (see Shapiro et al. (2021)). In Columns (5) and (7), we include private advertising that does and does not provide content about the marketplace instead of the total private advertising spending. We find that private advertising without marketplace-related content is statistically significant.

We also find that the estimates for rivals' advertising in Columns (6) and (7) are small and negative, and they are not statistically significant. This finding suggests that private advertising does not have positive spillovers to rivals and that it has a business-stealing effect to some degree. In Table 20 in the Online Appendix, we provide more direct evidence of the business-stealing effect of private advertising. The table reports a reduced-form model regression of the log of the enrollment size (not the mean utility, as shown here) on the advertising variables along with the usual fixed effects and controls. We find that rivals' advertising has a negative effect in markets with a smaller number of rivals conducting advertising. Therefore, both our demand model and reduced-form

model estimates suggest that private advertising increases enrollment from the outside option and from other insurers and does not have positive spillovers to rivals.

The estimates for advertising by federal and state governments are consistent with our finding with the market-level regression. Federal advertising is effective in increasing demands for all insurers, whereas advertising by state governments has limited effects. We can use the estimate to evaluate the effect of shutting down federal advertising. We find that it decreases the average county-level take-up rate from 19% to 18.6%. However, the effect varies significantly across counties depending on the baseline federal advertising level. We find that in markets with with top 10% of federal advertising spending in the benchmark, the enrollment decreases from 17.9% to 16.7%. These findings suggest that increasing federal advertising from zero—a policy being considered by the Biden administration—could increase enrollment to some extent, as long as the effectiveness of federal advertising remains largely unchanged from the sample period (See also Section 4.5.1).

4.2.4 Advertising Content

Our demand estimates so far confirm that both federal and private advertising are effective in increasing enrollment. We now utilize information on advertisement content to provide suggestive evidence about plausible mechanisms behind the results. Specifically, we estimate a model that allows for advertising with different content to have different impacts on demand. We consider separate effects only for the two most common content types: the open enrollment period (OE) and financial assistance (FA). We do not allow for the separate effect for each of the types of content we considered in Section 3 because it will be difficult to precisely estimate effects for content types that are infrequently provided in advertisements.

Table 6 shows key coefficient estimates. We summarize the main findings here and discuss details of the specifications and the entire estimates in Online Appendix B. First, we find that the coefficient of federal advertising providing content about *both* OE and FA is very large and statistically significant. Moreover, it is larger than the rest of federal advertising, suggesting complementarity between the two content categories for consumers. In contrast, the coefficient of private advertising providing content about *both* OE and FA is very small and not statistically significant. Further, it is statistically smaller than the coefficient of federal advertising providing the same content type. However, the coefficient of private advertising not providing specific information about the marketplace is positive and statistically significant, consistent with Table 5.

This result suggests that government advertising and private advertising alleviate different kinds of choice frictions and have different effects on consumer choices at the extensive and intensive margins. Government advertising primarily mitigates choice frictions to participate in ACA marketplaces by providing general information about the marketplace. However, private advertising is effective when it provides plan or brand quality information, which may help consumers to

Table 6: Selected Estimates of Effect of Advertising Contents

	(1)	(2)
Fed Spend:		
Open Enrollment and Financial	0.316** (0.135)	0.325** (0.141)
Fed Spend:		
Not Both Open Enrollment And Financial	0.089 (0.060)	
Fed Spend:		
Either Open Enrollment or Financial (not both)		-0.056 (0.237)
Fed Spend:		
Other ACA-related		0.102 (0.068)
Priv Spend:		
Open Enrollment and Financial	0.058 (0.064)	0.076 (0.069)
Priv Spend:		
Not Both Open Enrollment And Financial	0.096** (0.048)	
Priv Spend:		
Either Open Enrollment or Financial (not both)		0.072 (0.072)
Priv Spend:		
Other ACA-related		-0.062 (0.063)
Priv non-ACA Spend		0.121** (0.055)
FirmBorderYear FE	Y	Y
FirmCounty FE	Y	Y
FirmRatingYear FE	Y	Y
N. Obs.	36,558	36,558
Adj. R^2	0.938	0.938

Note: This table reports the estimates of the selected coefficients in the specifications that include advertising content types. The regressions also include the same content types for state advertising as well as the number of insurers and the market size. The entire coefficient estimates are reported in Table 24 in the Online Appendix. The set of advertising content types considered in Column (1) is: (i) advertisements that provide information about the open enrollment period and financial assistance and (ii) the rest of advertisements. The set of advertising content considered in Column (2) is: (i) advertisements that provide information about the open enrollment period and financial assistance, (ii) advertisements that provide content about the open enrollment period or financial assistance, but not both, (iii) the rest of ACA-related advertisements, and (iv) non-ACA related advertisements. The non-ACA related advertisements only exist for private insurers because advertisements by the federal or state governments are ACA-related by definition. All specifications include Firm×Border×Year fixed effects, Firm×County fixed effects, and Firm×Rating Area×Year fixed effects. Standard errors are in parentheses and two-way clustered at the DMA×Year level and the Firm×County level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

choose better plans or insurers. These findings may justify the presence of both forms of advertising in the same market. Moreover, the result on advertising contents is also informative about why private advertising does not have positive spillovers. If private advertising were very effective in providing general information about the marketplace, such as OE or FA, it would have positive spillovers to rivals' enrollments and have greater impacts on market-level enrollments.^{30,31}

³⁰For example, Shapiro (2018) and Sinkinson and Starc (2018) find spillovers of advertising for prescription drugs.

³¹It is not very clear, without further information, why the information provided from private advertising is not as

We do not take a stance on whether or not non-ACA private advertising provides valuable information that can improve consumer welfare. However, even brand advertising can generate welfare gains by signaling the advertising insurer’s quality (Milgrom and Roberts (1986)). For example, insurers who do more advertising may provide better plans than others. In this case, brand advertising can improve consumer welfare by inducing consumers to choose better plans.

Finally, this result also suggests that differential effects of government and private advertising are not entirely due to differences in advertising contents. Even for the same content type, advertising effectiveness is different for the government and private insurers. This result supports our demand model specification that allows for the different effects of advertising by sponsor types.

4.3 Impact of Government Advertising on Insurer Choice

4.3.1 Interaction between Advertising and Plan Characteristics

Government advertising in our demand model is assumed to have only the extensive-margin impact. In other words, it has the same impact on demand for all insurers in a market. This is a reasonable assumption because government advertising does not contain specific insurer’s information, unlike private advertising (Section 3.2). As discussed in Section 4.2.4, federal advertising increases enrollment by providing general information about financial assistance and the open enrollment period, which does not favor certain insurers. Now we explore more systematically the possibility of whether government advertising have larger or smaller impacts on certain insurers.

Specifically, we estimate a demand model that allows for interactions between advertising and average metal-tier level product characteristics offered by each insurer.³² In Section C in the Online Appendix, we discuss how we construct insurer-level plan characteristics. Here, we summarize the main finding from our analysis with the silver plan characteristics. Table 7 show that the coefficient estimates of the interaction terms between advertising and various salient plan characteristics, such as the network structure, premium, and financial generosity (all among the silver plans). We normalized that each plan characteristic by subtracting its mean and standard deviation. Thus, the estimates of the interaction terms measure how much the advertising coefficients change with a standard deviation change in each plan characteristic. The table shows that the point estimates for the interaction terms are mostly small for federal and state advertising. None of them are statistically significant. We also find qualitatively similar results with bronze and gold plan characteristics in Tables 31 and 32 in the Appendix.

effective. It could be due to consumers’ mistrust of information from private firms. In the context of the mortgage market, Johnson et al. (2018) find that many consumers did not act on the information provided by banks on the federal refinancing program because of their suspicion of banks’ motives.

³²Because we include the extensive list of insurer-level fixed effects, we expect that there is little room for the potential endogeneity with respect to this interaction term.

This result suggests that government advertising has limited impacts on consumer choices of insurers within the marketplace and is unlikely to mitigate choice frictions in the intensive margin.³³ However, this does not apply to private advertising. Even if there is little interaction of advertising and product characteristics, private advertising can still induce consumers to switch to different insurers because the amount of advertising is substantially different among private insurers, and it lacks the positive spillover. We discuss the role of private advertising in consumer welfare in detail later in Section 5.

Table 7: Coefficient Estimates: Plan Characteristics (Silver)

	(1) Characteristic = Num of plans	(2) Characteristic = Share of PPO plans	(3) Characteristic = Out-of-country cov.	(4) Characteristic = Premium	(5) Characteristic = Fin. Generosity	(6) Characteristic = Deductible	(7) Characteristic = Out-of-pocket max	(8) Characteristic = Coinsurance
Fed Spend	0.134** (0.053)	0.135** (0.061)	0.137** (0.061)	0.109* (0.059)	0.109* (0.060)	0.122** (0.057)	0.129* (0.072)	0.141*** (0.050)
Characteristic × Fed Spend	-0.028 (0.044)	-0.009 (0.059)	-0.003 (0.081)	-0.081 (0.062)	0.027 (0.059)	-0.028 (0.052)	0.004 (0.060)	-0.009 (0.035)
State Spend	-0.090 (0.073)	-0.095 (0.079)	-0.066 (0.075)	-0.060 (0.076)	-0.064 (0.076)	-0.096 (0.073)	-0.067 (0.075)	-0.108 (0.075)
Characteristic × State Spend	-0.062 (0.057)	0.046 (0.064)	-0.035 (0.055)	0.018 (0.066)	-0.034 (0.037)	0.029 (0.066)	0.093* (0.052)	0.132 (0.103)
Priv Spend	0.115** (0.055)	0.123** (0.061)	0.064 (0.051)	0.129** (0.054)	0.106** (0.052)	0.040 (0.059)	0.121** (0.053)	0.074 (0.056)
Characteristic × Priv Spend	-0.091** (0.042)	-0.044 (0.046)	0.109** (0.049)	0.049 (0.034)	-0.022 (0.023)	-0.057 (0.036)	0.059* (0.031)	0.102** (0.047)
FirmBorderYear FE	Y	Y	Y	Y	Y	Y	Y	Y
FirmCounty FE	Y	Y	Y	Y	Y	Y	Y	Y
FirmRatingYear FE	Y	Y	Y	Y	Y	Y	Y	Y
N. Obs.	33,484	33,480	33,480	33,480	33,480	25,546	33,228	25,622
Adj. R ²	0.937	0.937	0.937	0.938	0.937	0.944	0.936	0.944

Note: This table reports the estimates of the coefficients in specifications that include interactions between advertising and the average characteristics of silver plans offered by each insurer. We normalized that each plan characteristic by subtracting its mean and standard deviation. All specifications include the number of insurers, the market size, and Firm×Border×Year fixed effects, Firm×County fixed effects, and Firm×Rating Area×Year fixed effects. Standard errors are in parentheses and two-way clustered at the DMA×Year level and the Firm×County level. The stars indicate: *** for p<0.01, ** for p<0.05 and * for p<0.1. Results for other metal tier plans are reported in the Online Appendix.

4.3.2 Interaction between Government and Private Advertising

Government advertising could also affect an insurer choice if the effective of private advertising depends on the government advertising. Such dependence may also matter in understanding whether government and private advertising are complements or substitutes from an insurer’s perspective.

We now extend the baseline specification in Equation (3) to allow an interaction term between federal and private advertising in the demand model. In Table 30 in the Online Appendix, we present results for separate interaction models using both logs and levels of advertising spending

³³Due to the substitution pattern implied by the logistic error term, federal advertising has mechanically larger impacts on demand for insurers with larger market shares. However, the lack of dependence of the advertising effects on many salient product characteristics suggests that government advertising does not induce a welfare-enhancing consumer switching across insurers.

as explanatory variables. Although the estimate of the interaction term in the log specification has a large standard error, it is more precisely estimated in the level specification. Both estimates are statistically insignificant, and the point estimates are close to zero.

Thus, we find that the interaction between government and private advertising on the consumer demand is very limited. Moreover, we show in Section 4.5.2 that government advertising has limited heterogeneous effects on enrollment of consumers with different characteristics related to their health risk, suggesting that it is unlikely to affect the risk pool of private insurers. An important implication is that the marginal return from private advertising does not vary much with the level of government advertising. Thus, as long as private insurers correctly know these demand effects, private insurers may not adjust their advertising in response to government advertising, suggesting that government advertising has a limited crowding-out or crowding-in effects on private advertising.

4.4 Robustness Checks

In our main specifications in Equations (2) and (3), we used a log-transformation of advertising variables ($\ln(1 + ad)$). Although this specification is common in many studies on TV advertising, one may wonder whether our results hold only with this specific functional form. Moreover, there are some DMAs with no federal or state advertising, and some insurers did not advertise at all in certain DMAs in certain years. Thus, the estimated effects of advertising could just reflect the effect of any positive advertising compared to not advertising at all, instead of the effect of varying positive advertising levels. Another question is whether our results are robust to an alternative way to control for unobserved heterogeneity that varies across rating areas. Instead of the fixed effects for rating area-by-year or insurer-by-rating area-by-year, we could just restrict the sample to border pairs in the same rating area.

We estimate our models with alternative specifications. First, we estimate the model with the *level* of advertising instead of the *log* specification. Second, we specify a more flexible functional form by including dummy variables for positive advertising spending in the demand model. Third, we estimate the same regressions with the restricted border sample. As reported in Tables 21 and 22 in the Online Appendix, our results are robust to these alternative specifications. Even with the level of advertising in the estimating equations, our main results remain qualitatively unchanged. Including the dummy variables for positive advertising change our main coefficient estimates very little. Lastly, the estimates remain largely similar even with the restricted border sample.

4.5 Heterogeneous Effects

Our main results show that advertising by the federal government and private insurers is effective, on average, in increasing enrollments. Here, we investigate whether advertising is more effective for certain markets and for certain consumers.

4.5.1 Effects of Advertising in New vs. Mature Markets

The true effects of advertising could vary with the length of time the marketplace has been active, but our baseline estimates are simply the average effects over time. On the one hand, because many advertisements in our sample provide information about the marketplace to some degree, this information provision may have a larger market-expansion effect in the early years of the marketplace. On the other hand, advertisements providing information about the open enrollment period could be effective even in the later years of the marketplace. Moreover, if there is a steady influx of new customers to the marketplace each year, then advertising may still be effective even when the marketplace is mature. We examine different specifications that interact advertising with time effects. Table 23 in the Online Appendix show that the effectiveness of advertising had been stable at least for the first five years.

4.5.2 Selection Effects

Because this paper studies an insurance market, a natural question is whether advertising has differential effects for consumers with different health risks. Here, we briefly summarize the main findings and relegate details to Online Appendix D.2. We find that heterogeneous effects of both government advertising and private advertising across consumers of different health status, based on several proxy variables (age, income, and market-level health variables), tend to be very small and statistically insignificant. These results suggest that advertising has at most limited effects on the risk pool or the degree of adverse selection in the marketplace.

These estimates are consistent with our finding that advertising is not very targeted based on these demographic characteristics (Section 3.3). As discussed in Section 3.4, the government may want to enroll a broad population.³⁴ Further, private insurer's risk selection incentive may be muted in part due to many risk adjustment policies implemented in this market.³⁵

³⁴Moreover, findings from recent studies suggest that selection effects of government outreach are context-specific. Goldin et al. (2021) find that older individuals are more responsive to federal direct-mail outreach, while Domurat et al. (2020) find that younger and healthier individuals are more responsive to outreach by the CA government.

³⁵The lack of heterogeneous demand effect is not inconsistent with our finding that private advertising is targeted to certain markets (e.g., based on the market size). As long as profitability is different across markets, insurers will want to target certain markets, even if the effectiveness of advertising is similar across consumers.

4.5.3 Heterogeneity across States

We also examine whether advertising effectiveness depends on the state government’s choice of other healthcare policies. We report the detail in Online Appendix D.1 and D.3. First, we find some interaction effects between each state’s Medicaid expansion status and advertising. Moreover, we find that there is meaningful heterogeneity in the effects of advertising by different state governments. In particular, state advertising in California (CA) has a large positive effect on enrollment. Although it is beyond the scope of this paper to examine why state advertising in CA is so effective, we conjecture that it could be due to large marketing resources available for the CA marketplace (Lee et al. (2017)).

5 Normative Implications of Advertising

The demand model estimates show that both government and private advertising increase insurer-level enrollment. We explore welfare implications of government and private advertising.

5.1 Welfare Implications of Federal Advertising

Our finding suggests that federal advertising mitigates consumer frictions by providing informational messages to consumers. We develop a welfare framework motivated by Finkelstein and Notowidigdo (2019), who study welfare impacts of the government’s information provision to potential public program enrollees who face choice frictions. Motivated by our finding that federal advertising mainly increases total program enrollment, we focus on its welfare effect through the extensive margin of consumer choices.

We define the total social welfare given federal advertising spending as $TSW = \int_h SS_h q_h(ad^f) dF(h) - ad^f$. SS_h denotes the social surplus (the sum of consumer and producer surplus net of the government expenditure associated with enrollment) from enrolling a consumer of demographic type h , whose distribution is denoted by F . $q_h(ad^f)$ denotes total program enrollment given federal advertising spending ad^f , and this demand function embeds an individual’s optimal decision to enroll in the marketplace subject to choice frictions such as being unaware of the marketplace. Federal advertising can reduce these choice frictions and increase take-up.³⁶ We assume away the possibility that federal advertising affects the social value of health plans, which implies that welfare gains

³⁶Although there are various models with choice frictions that rationalize $q_h(ad^f)$, one plausible framework is a consideration set model, where federal advertising affects an individual’s awareness of marketplaces (See Online Appendix E for details). This is a reasonable description of an individual’s decision process given the evidence in Section 4.2.4 that federal advertising providing specific information about marketplaces, such as the end date of the open enrollment period and financial assistance, is effective.

from federal advertising calculated in our framework is likely a lower bound. Moreover, we assume that the supply side does not respond to federal advertising, because government advertising does not affect the risk pool of private insurers and has limited interactions with private advertising and plan characteristics in terms of their enrollment effects (as discussed in Section 4.3).

In this framework, federal advertising increases the total social welfare if $\int_h SS_h q'_h(ad^f) dF(h) > 1$. In Online Appendix E, we show, based on our demand estimates, that if $\int_h SS_h dF(h) > \$32$, then federal advertising enhances welfare. We only need to consider the *average* social welfare because government advertising has little selection effects and thus reduces choice frictions across consumers similarly. It is very difficult to credibly estimate the social value of health insurance. However, existing studies suggest that \overline{SS} is likely to be much bigger than \$32 after taking into account government spending for uncompensated care for uninsured individuals, as discussed in Online Appendix E. This result suggests that federal advertising likely enhances welfare.

5.2 Role of Private Advertising

Table 8: Correlation between Private Advertising and Mean utility and between Private Advertising and Plan Characteristics for Silver Plans

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Utility	0.114*** (0.015)							
Number of Plans		0.088*** (0.018)						0.075*** (0.016)
Share of PPO Plans			0.074*** (0.022)					0.070*** (0.020)
Share of Plans with Out-of-Country Coverage				0.046** (0.019)				0.033** (0.016)
Premium					-0.022 (0.023)			-0.033 (0.029)
Financial Generosity						0.065*** (0.017)		0.047*** (0.015)
Out-of-Pocket Max							-0.035 (0.024)	0.003 (0.021)
County X Year FE	Y	Y	Y	Y	Y	Y	Y	Y
N. Obs.	30,812	27,849	27,847	27,847	27,847	27,847	27,547	27,547
Adj. R^2	0.152	0.113	0.087	0.063	0.044	0.073	0.044	0.176

Note: Each column reports the estimated coefficient of insurer-level characteristics on insurer's advertising, controlling for county×year fixed effects. Column (1) reports the coefficient of the mean utility net of utility effects from any types of advertising. Column (2) to (8) report the coefficient of plan characteristics of Silver plans. The regressors are normalized by dividing the original variables by their standard deviations. The coefficient estimate measures how a standard-deviation change of a regressor is correlated with advertising. Standard errors are clustered at the insurer level and the county×year level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$. Results for other metal tier plans are reported in the Online Appendix.

The previous result establishes the welfare benefit of government advertising through market expansion. However, in market-based public programs, welfare also depends on from which insurer-

ers consumers purchase health insurance plans because each insurer offers differentiated products. As discussed in Handel (2013) and Handel et al. (2020), choice frictions may prevent consumers from choosing better plans. In the context of ACA marketplaces, Pollitz et al. (2016) document that a majority of consumers do not have a basic understanding of health insurance and face difficulties in selecting plans. Importantly, our demand estimates show that federal advertising has little intensive-margin demand effects, suggesting that alternative tools are necessary to mitigate these choice frictions in the intensive margin.

Given our finding that private advertising increases an insurer's own enrollment, a natural question is whether it also mitigates intensive-margin choice frictions by inducing consumers to select better plans. Because not all insurers advertise equally, private advertising can impact the allocation of consumers to insurers. To fully investigate the welfare impact of consumer switching by private advertising, one must know whether insurers spending more on advertising provide better plans.

We examine this question in two ways. First, we find that consumers tend to receive higher utility from insurers spending more on advertising in the context of our demand model even after subtracting the contribution of advertising to utility, as shown in Column (1) of Table 8. The regression the county \times Year fixed effect, so we are comparing utilities from insurers within the same market. However, a drawback of this approach is that the utility backed out from our model includes the cost of choice frictions, and we cannot distinguish between the true utility from each insurer and the cost of choice frictions.

Our second approach is to examine the relationship between an insurer's advertising and some of welfare-relevant plan characteristics, instead of calculating the consumer welfare from the model. Table 8 shows that an insurer's advertising spending is positively correlated with the number of plans offered and the network size (whether a plan is PPO) and the access of hospital outside the county (whether it covers out-of-county health care) within the Silver metal tier and within the same market. It is not correlated with the premium, suggesting that these benefits do not translate into higher premiums. We also find qualitatively similar results with Bronze and Gold plans, which are reported in Tables 33 and 34 in the Online Appendix.

These results suggest a possible welfare gain through private advertising. Through private advertising, consumers may end up choosing insurers that provide more options; moreover, the broader hospital network size through the PPO may increase the consumer welfare and health relative to the narrow hospital network via HMO.³⁷ The latter is especially relevant in the ACA marketplace, where the network size in HMO plans is very limited (Shepard, 2016). Moreover, premiums of plans offered by insurers with more advertising are not higher, suggesting that con-

³⁷Abaluck et al. (2020) find that characteristics of plans that lower the consumer's mortality rate are correlated with the plan's network.

sumers likely benefit from those additional coverage.

It is important to point out that the ultimate effect on social welfare depends on many features that are hard to assess. For example, PPO plans may induce excess health care spending. Further, the welfare impact on hospital networks depends on many equilibrium features in health care markets as well (Ho and Lee, 2019). Moreover, consumers may instead benefit from having a smaller number of plans if it is costly for them to compare multiple plans or if insurers may strategically increase the number of plans to get attentions from consumers and charge higher premium (Brown and Jeon, 2020). However, as long as the welfare gain mentioned above outweighs the social cost, this private advertising can be a tool with which to induce an efficient allocation in the marketplace.

5.3 Equilibrium Effects

Although private advertising may reduce intensive-margin choice frictions, an important question is whether it can be done efficiently. There are at least two relevant issues. First, one should consider whether the presence of government advertising crowds out private advertising. As discussed in Section 4.3.2, the marginal return of private advertising does not vary very much with government advertising, suggesting that crowding out is likely limited.³⁸ Second, private advertising has some business-stealing effects, leading to excessive spending in equilibrium. In this case, private advertising will be a costly way to induce a more efficient allocation.³⁹

We further examine how quantitatively important the second issue is. We quantify how much the effect of private advertising is reduced when taking into rivals' equilibrium response. Specifically, we simulate the effect of shutting down private advertising on insurer demand in two scenarios: the first one is the partial equilibrium case where we shut down advertising for an insurer and calculate its effect on the insurer demand while holding other insurers advertising levels fixed; and the second one is the full equilibrium case where we shut down advertising by all insurers and calculate its effect on the insurer demand. The main difference between these two scenarios is whether changes in an insurer's enrollment are affected by changes in rivals' advertising.⁴⁰

³⁸ This argument rests on the assumption that private insurers choose advertising to maximize their profits by correctly accounting for the effect of government advertising on the consumer demand. Motivated by Figure 1, we examined the crowding-out effect by exploiting changes in private advertising in response to the cut of federal advertising in 2018. Because federal advertising was distributed unevenly across regions, one can potentially estimate the response by private insurers with a difference-in-differences (DID) regression. However, we found that the common trend assumption in DID is not met. We found that private advertisement spending was not parallel between neighboring DMAs with larger and smaller pre-2018 federal advertisement spending, possibly because the marketplace was evolving differently across markets in its first few years. When we estimated the DID regression despite the violation of its identifying assumption, we found that estimate impacts of the 2018 cut are statistically insignificant.

³⁹ Furthermore, if private insurers do not understand the true effect of their advertising, it can be difficult to induce an efficient allocation through private advertising. In fact, recent papers on advertising find that private firms may not advertise to maximize their profits (Blake et al. (2015), Lewis and Rao (2015) and Shapiro et al. (2021)).

⁴⁰ An advantage of this approach is that we calculate equilibrium advertising competition without imposing strong

Table 9 reports the insurer’s enrollment elasticity with respect to advertising both in the partial and equilibrium settings, depending on the number of insurers with positive baseline advertising. By construction, the partial and full equilibrium elasticity is the same in the market where there is only one insurer with positive baseline advertising. We find that the full equilibrium elasticity is much smaller than the partial equilibrium elasticity by about 10–15% in markets with multiple insurers with positive baseline advertising. This result is due to the fact that rivals’ equilibrium responses reduce the effect of own advertising on enrollment. Thus, private advertising is excessive in that some of those spending may not really impact equilibrium allocation.

Table 9: Elasticities of Insurer Enrollment with Respect to Private Advertising

Number of insurers with positive baseline ads	Baseline private advertising (\$)	Partial equilibrium elasticity	Full equilibrium elasticity
1	0.817	0.040	0.040
2	0.726	0.036	0.032
3	0.771	0.039	0.033
4+	0.593	0.033	0.028

Note: This table presents elasticities of insurer’s enrollment with respect to advertising both in partial equilibrium and full equilibrium for insurers with positive baseline advertising spending, depending on the number of such insurers in a market. We calculate those elasticities by shutting down advertising. Column (1) reports the average advertising spending. Column (2) reports the partial equilibrium elasticity of insurer enrollment with respect to advertising, holding other insurers’ advertising fixed at the baseline level. Column (3) the equilibrium elasticity of insurer enrollment with respect to advertising where rivals’ advertising are also shut down.

Our findings suggest that it is likely difficult to achieve an efficient allocation through private advertising alone. Thus, the government should supplement private advertising by implementing other welfare-improving policies, instead of subsidizing private advertising. Such policies can also mitigate inefficiency from the rent-seeking competition. For example, providing information about plan quality can also facilitate a more efficient allocation in the intensive margin. The literature finds that providing product quality information generally leads to better outcomes (e.g., Jin and Leslie, 2003). In the context of health plan choices, Jin and Sorensen (2006) find that plan quality information induces consumers to enroll in better plans. While the ACA marketplace introduced the star rating program, consumers are often unaware of this information.⁴¹ Moreover, the rating may not reflect some of the beneficial aspects on health outcomes.⁴² Thus, a well-designed information disclosure policy would be important. In addition, as explored by Ericson and Starc (2016), better designs of choice architecture or plan standardization may make the comparison of plans or insurers less costly for consumers.

assumptions on insurers’ objective functions. A downside of this approach is that it does not allow us to examine other counterfactuals, such as the effect of subsidizing insurers.

⁴¹Charbi (2020) reports that 80 % of the population does not know the star rating system in Medicare Advantage .

⁴²Abaluck et al. (2020) show that characteristics of plans that lower the consumer’s mortality rate are uncorrelated with the plan rating in Medicare Advantage.

6 Conclusion

In this paper, we study the impact of public and private provision of information in publicly designed private markets in the context of health insurance marketplaces. We first show suggestive evidence that advertisements by the government (both federal and state) and private insurers are targeted to different geographical areas and provide different messaging content. Then, we estimate the impact of government and private advertising on consumer demand. Our empirical design exploits discontinuities in advertising along the borders of local TV advertising markets to address the endogeneity of advertising.

We find that government advertising is a welfare-enhancing tool to lead more consumers to sign up for health plans. However, it does not induce consumers to select specific insurers. In contrast, private advertising plays a different role by inducing consumers to select plans from certain insurers, which are likely to increase consumer welfare. However, private advertising alone unlikely efficiently leads consumers to select insurers with better plans because rent-seeking competition may lead to excessive private advertising spending. Thus, additional policy interventions are necessary to supplement the private provision of information.

A broader implication of our finding is that the difficulty in addressing intensive-margin choice frictions must be considered when the policy makers assess the benefit and cost between market-based and traditional programs. Moreover, investigating these issues in other contexts, such as education, electricity, and mortgage, is therefore an important next step. Another interesting avenue to explore is the effectiveness and efficiency of other marketing and outreach activities beyond TV advertising.

References

- Abaluck, Jason, Mauricio M. Caceres Bravo, Peter Hull, and Amanda Starc**, “Mortality Effects and Choice Across Private Health Insurance Plans,” Working Paper 27578, National Bureau of Economic Research July 2020.
- Aizawa, Naoki**, “Labor market sorting and health insurance system design,” *Quantitative Economics*, 2019, 10 (4), 1401–1451.
- **and You Suk Kim**, “Advertising and Risk Selection in Health Insurance Markets,” *American Economic Review*, 2018, 108 (3), 828–67.
- Aizer, Anna**, “Public Health Insurance, Program Take-Up, and Child Health,” *The Review of Economics and Statistics*, 2007, 89 (3), 400–415.
- Allende, Claudia, Francisco Gallego, and Christopher Neilson**, “Approximating the Equilibrium Effects of Informed School Choice,” Working Paper, Princeton University, 2019.
- Andrabi, Tahir, Jishnu Das, and Asim Ijaz Khwaja**, “Report Cards: The Impact of Providing School and Child Test Scores on Educational Markets,” *American Economic Review*, 2017, 107 (6), 1535–63.
- Berry, Steven T**, “Estimating discrete-choice models of product differentiation,” *The RAND Journal of Economics*, 1994, pp. 242–262.

- Black, Sandra E.**, “Do Better Schools Matter? Parental Valuation of Elementary Education*,” *The Quarterly Journal of Economics*, 1999, 114 (2), 577–599.
- Blake, Thomas, Chris Nosko, and Steven Tadelis**, “Consumer Heterogeneity and Paid Search Effectiveness: A Large-Scale Field Experiment,” *Econometrica*, 2015, 83 (1), 155–174.
- Brown, Jason, Mark Duggan, Ilyana Kuziemko, and William Woolston**, “How Does Risk Selection Respond to Risk Adjustment? New Evidence from the Medicare Advantage Program,” *American Economic Review*, 2014, 104 (10), 3335–64.
- Brown, Zach and Jihye Jeon**, “Endogenous Information and Simplifying Insurance Choice,” Working Paper, University of Michigan and Boston University, 2020.
- Cabral, Marika, Michael Geruso, and Neale Mahoney**, “Do Larger Health Insurance Subsidies Benefit Patients or Producers? Evidence from Medicare Advantage,” *American Economic Review*, 2018, 108 (8), 2048–87.
- Charbi, Alexandra**, “The Fault In Our Stars! Quality Reporting, Bonus Payments and Welfare in Medicare Advantage,” Working Paper, University of Texas-Austin, 2020.
- Currie, Janet**, “The Take Up of Social Benefits,” in David Card Alan Auerbach and John Quigley, eds., *David Card Alan Auerbach and John Quigley, eds., Poverty, the Distribution of Income, and Public Policy*, New York: Russell Sage, 2006, pp. 80–148.
- Curto, Vilsa, Liran Einav, Jonathan Levin, and Jay Bhattacharya**, “Can Health Insurance Competition Work? Evidence from Medicare Advantage,” *Journal of Political Economy*, 2021, 129 (2), 570–606.
- Domurat, Richard, Isaac Menashe, and Wesley Yin**, “The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk: Evidence from a Field Experiment,” *American Economic Review*, forthcoming, 2020.
- Dubois, Pierre, Rachel Griffith, and Martin O’Connell**, “The Effects of Banning Advertising in Junk Food Markets,” *The Review of Economic Studies*, 2018, 85 (1), 396–436.
- Duggan, Mark, Amanda Starc, and Boris Vabson**, “Who Benefits When the Government Pays More? Pass-through in the Medicare Advantage Program,” *Journal of Public Economics*, 2016, 141 (Supplement C), 50 – 67.
- Ericson, Keith M. Marzilli and Amanda Starc**, “How product standardization affects choice: Evidence from the Massachusetts Health Insurance Exchange,” *Journal of Health Economics*, 2016, 50, 71–85.
- Finkelstein, Amy and Matthew J Notowidigdo**, “Take-Up and Targeting: Experimental Evidence from SNAP,” *The Quarterly Journal of Economics*, 2019, 134 (3), 1505–1556.
- , **Nathaniel Hendren, and Mark Shepard**, “Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts,” *American Economic Review*, 2019, 109 (4), 1530–67.
- Goeree, Michelle Sovinsky**, “Limited Information and Advertising in the US Personal Computer Industry,” *Econometrica*, 2008, 76 (5), 1017–1074.
- Goldin, Jacob, Ithai Z Lurie, and Janet McCubbin**, “Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach,” *The Quarterly Journal of Economics*, 2021, 136 (1), 1–49.
- Gollust, Sarah E., Andrew Wilcock, Erika Franklin Fowler, Colleen L. Barry, Jeff Niederdeppe, Laura Baum, and Pinar Karaca-Mandic**, “TV Advertising Volumes Were Associated With Insurance Marketplace Shopping And Enrollment In 2014,” *Health Affairs*, 2018, 37 (6), 956–963.
- Hackmann, Martin B., Jonathan T. Kolstad, and Amanda E. Kowalski**, “Adverse Selection and an Individual Mandate: When Theory Meets Practice,” *American Economic Review*, 2015, 105 (3), 1030–66.

- Handel, Ben, Igal Hendel, and Michael D. Whinston**, “Equilibria in Health Exchanges: Adverse Selection versus Reclassification Risk,” *Econometrica*, 2015, 83 (4), 1261–1313.
- Handel, Benjamin R.**, “Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts,” *American Economic Review*, 2013, 103 (7), 2643–82.
- , **Jonathan T. Kolstad, and Johannes Spinnewijn**, “Information Frictions and Adverse Selection: Policy Interventions in Health Insurance Markets,” *The Review of Economics and Statistics*, 2019, 101 (2), 326–340.
- , —, **Thomas Minten, and Johannes Spinnewijn**, “The Social Determinants of Choice Quality: Evidence from Health Insurance in the Netherlands,” working paper, UC Berkley and LSE, 2020.
- Hastings, Justine, Ali Hortaçsu, and Chad Syverson**, “Sales Force and Competition in Financial Product Markets: The Case of Mexico’s Social Security Privatization,” *Econometrica*, 2017, 85 (6), 1723–1761.
- Hastings, Justine S. and Jeffrey M. Weinstein**, “Information, School Choice, and Academic Achievement: Evidence from Two Experiments,” *The Quarterly Journal of Economics*, 2008, 123 (4), 1373–1414.
- Hendren, Nathaniel**, “The Policy Elasticity,” *Tax Policy and the Economy*, 2016, 30 (1), 51–89.
- Ho, Kate and Robin S. Lee**, “Equilibrium Provider Networks: Bargaining and Exclusion in Health Care Markets,” *American Economic Review*, 2019, 109 (2).
- Holmes, Thomas J.**, “The Effect of State Policies on the Location of Manufacturing: Evidence from State Borders,” *Journal of Political Economy*, 1998, 106 (4), 667–705.
- Hortaçsu, Ali, Seyed Ali Madanizadeh, and Steven L. Puller**, “Power to Choose? An Analysis of Consumer Inertia in the Residential Electricity Market,” *American Economic Journal: Economic Policy*, November 2017, 9 (4), 192–226.
- Ito, Koichiro, Takanori Ida, and Makoto Tanaka**, “Information Frictions, Inertia, and Selection on Elasticity: A Field Experiment on Electricity Tariff Choice,” Working paper, University of Chicago, 2017.
- Jin, Ginger Zhe and Alan T. Sorensen**, “Information and consumer choice: The value of publicized health plan ratings,” *Journal of Health Economics*, 2006, 25 (2), 248–275.
- **and Phillip Leslie**, “The Effect of Information on Product Quality: Evidence from Restaurant Hygiene Grade Cards*,” *The Quarterly Journal of Economics*, 05 2003, 118 (2), 409–451.
- Johnson, Eric J, Stephan Meier, and Olivier Toubia**, “What’s the Catch? Suspicion of Bank Motives and Sluggish Refinancing,” *The Review of Financial Studies*, 05 2018, 32 (2), 467–495.
- Karaca-Mandic, Pinar, Andrew Wilcock, Laura Baum, Colleen L. Barry, Erika Franklin Fowler, Jeff Niederdeppe, and Sarah E. Gollust**, “The Volume Of TV Advertisements During The ACA’s First Enrollment Period Was Associated With Increased Insurance Coverage,” *Health Affairs*, 2017, 36 (4), 747–754.
- Kosar, Kevin R.**, “Advertising by the Federal Government: An Overview,” Congressional Research Service Report for Congress , 2014.
- Lee, Peter V, Vishaal Pegany, James Scullary, and Colleen Stevens**, “Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Insurance Markets,” Technical Report, Covered California, 2017.
- Lewis, Randall A. and Justin M. Rao**, “The Unfavorable Economics of Measuring the Returns to Advertising,” *Quarterly Journal of Economics*, 2015, 130 (4), 1941–1973.
- Li, Xing, Wesley R. Hartmann, and Tomomichi Amano**, “Preference Externality Estimators: A Comparison of Border Approaches and IVs,” Working paper, Peking University, Stanford GSB, and Harvard Business School, 2020.

- Milgrom, Paul and John Roberts**, “Price and advertising signals of product quality,” *The Journal of Political Economy*, 1986, pp. 796–821.
- Moshary, Sarah**, “Price discrimination in political advertising: Evidence from the 2012 presidential election,” *The RAND Journal of Economics*, 2020, 51 (3), 615–649.
- Pollitz, Karen, Jennifer Tolbert, and Ashley Semanskee**, “2016 survey of health insurance marketplace assister programs and brokers,” Report, Kaiser Family Foundation, 2016.
- Polyakova, Maria**, “Regulation of Insurance with Adverse Selection and Switching Costs: Evidence from Medicare Part D,” *American Economic Journal: Applied Economics*, 2016, pp. 165–195.
- **and Stephen Ryan**, “Subsidy Targeting and Market Power,” working paper, Stanford University and Washington University in St. Louis, 2019.
- Sen, Aditi P. and Thomas DeLeire**, “How does expansion of public health insurance affect risk pools and premiums in the market for private health insurance? Evidence from Medicaid and the Affordable Care Act Marketplaces,” *Health Economics*, 2018, 27 (12), 1877–1903.
- Shafer, Paul R., David M. Anderson, Seciah M. Aquino, Laura M. Baum, Erika Franklin Fowler, and Sarah E. Gollust**, “Competing Public and Private Television Advertising Campaigns and Marketplace Enrollment for 2015 to 2018,” *RSF: The Russell Sage Foundation Journal of the Social Sciences*, 2020, 6 (2), 85–112.
- Shapiro, Bradley**, “Positive Spillovers and Free Riding in Advertising of Prescription Pharmaceuticals: The Case of Antidepressants,” *Journal of Political Economy*, 2018, 126 (1), 381–437.
- **, Günter J. Hitsch, and Anna Tuchman**, “TV Advertising Effectiveness and Profitability: Generalizable Results from 288 Brands,” *Econometrica*, forthcoming, 2021.
- Shepard, Mark**, “Hospital Network Competition and Adverse Selection: Evidence from the Massachusetts Health Insurance Exchange,” Working paper, Harvard University, 2016.
- Sinkinson, Michael and Amanda Starc**, “Ask Your Doctor? Direct-to-Consumer Advertising of Pharmaceuticals,” *The Review of Economic Studies*, 2018, 86 (2), 836–881.
- Spenkuch, Jörg L. and David Toniatti**, “Political Advertising and Election Results,” *The Quarterly Journal of Economics*, 2018, 133 (4), 1981–2036.
- Tebaldi, Pietro**, “Estimating Equilibrium in Health Insurance Exchanges: Price Competition and Subsidy Design under the ACA,” Working paper, University of Chicago, 2017.
- Tuchman, Anna E.**, “Advertising and Demand for Addictive Goods: The Effects of E-Cigarette Advertising,” *Marketing Science*, 2019, 38 (6), 994–1022.
- Waldfogel, Joel**, “Preference Externalities: An Empirical Study of Who Benefits Whom in Differentiated-Product Markets,” *The RAND Journal of Economics*, 2003, 34 (3), 557–568.

Online Appendix (Not For Publication)

A Discussion of the Border Strategy

A.1 Characteristics of Border Counties

Differences between Pairs of Border Counties Table 14 compares market characteristics between border counties with low and high federal and state government and market-level private advertising spending. For each of the three types of advertising, we identify which border county within a border pair has a smaller expenditure. We collect such border counties with respect to federal, state, and private advertising spending for Columns (1), (3), and (5), respectively. For even-numbered columns, we collect border counties with higher expenditures within border pairs.

The table shows that border counties with lower and higher advertising expenditures are very similar in terms of market characteristics except for advertising spending. First, the number of insurers selling marketplace plans, the degree of market concentration (measured by HHI), and the market size are very similar between border counties with low and high advertising spending. Moreover, distributions of incomes and ages among potential enrollees are also very similar between the two groups of border counties. Employment rates, one of the statistics that predicts the size of the market size of marketplaces, are also almost identical between the two groups. Lastly, average health statuses measured by market-level shares of individuals with various health conditions are also almost identical between the two groups of border counties. These results suggest that the identifying assumption is plausible. Moreover, these results suggest that the targeting of advertising we documented in Section 3.3 is likely to be driven by non-border counties, which do not share advertising market borders.

Differences between Border and Non-Border Counties An important caveat to the border strategy is that the estimated effect is only local to potential marketplace enrollees in border counties. Thus one must be cautious in generalizing the estimated effect to non-border counties). To ascertain how serious this issue is in our setting, we compare market-level characteristics between the border and non-border counties. Table 15 presents market-level characteristics between the border and non-border counties. Although there are differences between the two groups of counties, the differences are small. For example, the differences in the number of insurers and HHIs do not exceed 10% of their unconditional averages. The distributions of ages and income groups are also similar between the border and non-border counties. Lastly, the differences in county-level health statuses also do not exceed 10% of their unconditional averages. Thus, these findings suggest a significant overlap in observables between the border and non-border counties. This suggests that

the estimated effect of advertising could be generalizable to even non-border counties.

A.2 Variation in Advertising in Border Analysis

One concern about the border strategy is that the extensive set of fixed effects employed by the strategy could leave very little variation in advertising spending. Thus, it is important to check whether the remaining variation in advertising is sufficiently large.

We report the county-level residual variation in federal advertising, state advertising, and county-level private advertising. We also report insurer-level residual variation in insurer-level private advertising. The county-level residual variation is obtained by regressing each of the three advertising variables on the fixed effects for border pair-by-year (ξ_{bt}), county (ξ_c), and rating area-by-year ($\xi_{r(c)t}$), which appear in Equation (2). The insurer-level residual variation in private advertising is obtained by regressing insurer-level private advertising spending on the fixed effects for insurer-by-border pair-by-year (ξ_{jbt}), insurer-by-county ($\xi_{jr(c)t}$), and insurer-by-rating area-by-year (ξ_{jrc}), which appear in Equation (6).

Figure 4 reports the distribution of these residuals, and Column (1) of Table 16 reports the ratio of the standard deviation of residual advertising spending to the unconditional mean of advertising spending. For each advertising sponsor type, there is a reasonable amount of variation in residual advertising spending. We find that the ratios range from 0.3 to 0.5, which are still sizable compared to the ratio of the standard deviation of the raw advertising spending to its unconditional mean in Column (2). In the figure for insurer-level private advertising, a mass of insurers with zero advertising spending during the entire sample period results in a large spike at zero. However, the ratio for the insurer-level private spending is still larger than the ratios for most other advertising types, which suggests that there is still a reasonable amount of variation in its residual advertising spending.

A.3 Additional Suggestive Evidence about the Validity of the Identification Assumption

A potential threat to the border identification strategy arises if other unobserved marketing activities are adjusted along the DMA border in a sophisticated way. We now examine the relationship between other marketing activities and advertising. We obtain the California state government's agent database for California's state marketplace (Covered California).⁴³ The first measure is the number of Certified Enrollment Counselors (CEC), who provide in-person counseling and assistance to consumers in need of help applying for Covered California programs. Another measure is

⁴³We thank to Honglin Li for helping us with obtaining this data.

the number of Certified Enrollment Entities (CEE), which are entities and organizations to provide in-person assistance to consumers in applying for Covered California health plans. The data provide information about the two measures at the zipcode x year level, and we aggregate them up to the county-year level. For our analysis, we calculate the number for CEC and CEE per capita by dividing them by the market size.

First, we regress these two measures on advertising, controlling for county and year fixed effects using counties in California. Thus, we are interested in how within-county changes in advertising by the CA state government are correlated with within-county changes in each of the two measures. Table 17 reports the estimates. We find that the coefficient estimates of CA state advertising are very small and statistically insignificant for both CEC and CEE. Thus, this result suggests that other outreach activities are unlikely to bias our estimates of the effectiveness of advertising.

Further, we look at the variation of CEC and CEE in border counties in CA in Table 18. We find that the variation in these two measures is very small between border counties with low and high advertising. We also confirm that these differences are not statistically significant at the 10 percent level. Thus, this result provides additional support to our identification assumption.

B Detailed Discussion of Effects of Advertising Content

In this section, we first discuss details of how we estimate the effect of advertising content on consumer demand and then document our findings. One difficulty in estimating content-level effects is that it is difficult to identify which particular content is effective because an advertisement often contains multiple types of content. Table 10 in the Online Appendix shows which types of content tend to be provided together. As discussed in Section 3, there are many advertisements that feature both OE and FA content. In contrast, the other types of content—healthcare reform, being uninsured, and the penalty for not having health insurance—are much less likely to be provided along with OE or FA. Moreover, the other types of content do not tend to appear together in the same advertisement.

Based on these data patterns, we allow for the separate effect of the following four different types of advertising to reasonably isolate effects of content: (i) advertising that provides both OE and FA content; (ii) advertising that provides content on either OE or FA, but not both; (iii) advertising that provides the other types of content but not contents on OE or FA; (iv) advertising that provides no specific information on the marketplace. Note that there are no federal or state advertisements of type (iv) by definition. In contrast, about 60% of private advertisements did not provide any specific information on the marketplace, as shown in Section 3.

Table 24 in the Online Appendix presents coefficient estimates.⁴⁴ Column (1) reports estimates for a model, where we combine types (ii), (iii), and (iv) into one group while type (i) has its own effects. In Column (2), we allow for each of the four types to have separate effects. We find that the coefficient estimates for federal advertising of type (i)—providing content about *both* OE and FA—are very large and statistically significant in both columns, suggesting complementarity between the two content categories for consumers. Column (1) shows that federal advertising other than type (i)—a combination of types (ii), (iii), and (iv)—has a much smaller estimate that is not statistically significant. Column (2) presents separate estimates for federal advertising of types (ii) and (iii), but neither of the two estimates is statistically significant. Note that as we include more advertising types in the model, we are likely left with less variation in advertising of each type, leading to larger standard errors. The relatively large standard errors for estimates in Table 24 make it difficult to statistically distinguish whether certain types of content are more effective than others. At least, we can show from Column (1) that federal advertising of type (i) is statistically greater than federal advertising of types (ii), (iii), and (iv) combined at the 10% significance level.⁴⁵ Overall, our results indicate that federal advertising that provides both OE and FA content played a major role in driving the market-expansion effect of federal advertising.

In contrast, the coefficient estimate for private advertising of type (i) is small and not statistically significant in either column. Based on the estimates in Column (1), the estimate for private advertising of type (i) is statistically smaller than the estimate for federal advertising of type (i).⁴⁶ Column (1) also shows that the coefficient estimate for non-type (i) private advertising is positive and statistically significant. Column (2) shows separate estimates for types (ii), (iii), and (iv), and we find that only private advertising of type (iv)—not providing any specific information about the marketplace—is statistically significant.⁴⁷

⁴⁴One potential concern about this specification is that because each advertisement enters the regression in the log, the four types of advertising variables do not sum up to the total advertising spending in the log. We also estimate a similar model with the level of each advertising variable as a robustness check. The results are not qualitatively different from the results from the main model and are reported in Table 25.

⁴⁵The standard error of the difference between the two coefficient estimates is 0.17 with a t-statistics of 1.32. However, we cannot reject the null hypothesis that the two coefficients are the same.

⁴⁶The standard error for the difference of the two coefficients is 0.15 with a t-statistic of 1.66. The null hypothesis is that the estimate for private advertising is greater than the estimate for the federal advertising at 5% significance level. With the two-sided test, the null hypothesis that the two coefficients are the same is rejected at a 10% significance level.

⁴⁷The null effect of advertising by private insurers that provide specific contents does not necessarily imply that private advertising is persuasive. It is still possible that private advertising that does not provide specific ACA-related information conveys information about the quality of plans offered by private advertising sponsors. Such information could still be valuable to consumers in selecting a better plan within the marketplace.

C Plan Characteristics

In Section 4.3.1, we examine whether the effectiveness of advertising depends on the insurer’s specific plan characteristics. For this purpose, we estimate the consumer demand model that includes the interaction between advertising and plan characteristics. To do so, we need to create data for insurer-level plan characteristics. For this purpose, we first utilize the CMS plan data to obtain the plan-level product characteristics. We obtain each plan’s premium, financial characteristics (e.g., metal tier, generosity, deductible, and other cost-sharing parameters), and hospital network structure (whether the plan is PPO plan or HMO plan, and whether the plan provides coverage to the hospital care outside the county of residence, etc). We choose the deductible, out-of-pocket-maximum, and coinsurance variables from those associated with tier 1 in-network medical and drug essential health benefits because we have the least number of missing variables among those financial characteristics in our plan data. From these data, we create metal tier-specific plan characteristics at the insurer-county level by averaging each characteristic of plans offered by each insurer within a metal tier. This includes the premium, the plan generosity (within a metal tier), the number of different cost-sharing plans, the proportion of PPO plans, and the proportion of plans with out-of-county hospital coverage.

We estimate how the effective of advertising depends on these insurer-level plan characteristics in Section 4.3.1. In Section 5.2, we look at their correlations with an insurer’s advertising. Note that our demand model incorporates a rich set of fixed effects, including the rating area-insurer-time fixed effects. However, we can still estimate the interaction terms because it is multiplied with advertising variables.

D Detailed Discussion of Heterogeneous Effects

D.1 Heterogeneous Effects across Markets

First, we examine whether the effectiveness of advertising may depend on healthcare policies. We specifically focus on whether the effect of advertising depends on a state’s Medicaid expansion status, which also drives targeting of advertising to some extent. We report in Column (1) of Table 26 in the Online Appendix that the coefficient of the interaction term between federal advertising and the Medicaid expansion status is large and statistically significant. It suggests possible complementarity between federal advertising and Medicaid expansion status.⁴⁸ We also find that the coefficient of the interaction term between private advertising and Medicaid expansion status is positive, but it is small and not significant. These results imply that advertising spending may not

⁴⁸A caveat in interpreting these results is that there can be other factors that also affect the effectiveness of advertising between states with and without Medicaid expansion.

be necessarily larger in markets where advertising is more effective. This finding does not mean that advertising sponsors behave in a suboptimal way. Rather, they may target advertising based on per-enrollee profitability or social welfare weight, which may vary across markets.

D.2 Selection Effects of Advertising

In our main specification, we do not allow the effects of advertising to vary with consumer demographics. In this section, we examine heterogeneous effects across consumer types. These heterogeneous effects are important in health insurance markets because they may potentially affect the degree of adverse or advantageous selection.⁴⁹

Unfortunately, our data do not provide information on enrollee-level health status. However, we can still examine whether the effect of advertising depends on a county-level health measure and whether the effect is different for consumers in different age and income groups. These demographic variables typically are highly correlated with health status.

Column (2) in Table 26 presents the estimates for the specification that allows for interactions between advertising variables and whether a market is “unhealthy.” As in Section 3.3, we use a county’s share of individuals self-reporting poor or fair health as a measure of county-level health status. We define an “unhealthy” market as a market in the top quartile of self-reported poor or fair health, including all markets with greater than 21% of individuals reporting fair or poor health. We find that none of the coefficients of the interaction terms are significant, although the estimates are slightly noisy.

Then, we estimate Equation (7) by allowing heterogeneous effects to vary by age and income using demographic group-level market share data. We consider two age groups and two-income groups: whether an individual age is at least 55 and whether an individual income is less than or equal to 250% of the FPL. To capture demand heterogeneity across demographic groups, all of the usual fixed effects are now interacted with each demographic group. This may capture that consumers in a different demographic group prefer a different mix of insurance plans offered by an insurer. Because we do not have a breakdown of market shares by age or income groups for CA or NY, we exclude the two states from the sample for this analysis.⁵⁰

The main results are reported in Table 27. We find that the coefficients for the interaction terms with demographic groups are relatively small and statistically insignificant, which is indicative of

⁴⁹For example, Handel (2013) and Handel et al. (2019) argue that policies that affect consumer choice frictions have important equilibrium effects by changing the degree of adverse or advantageous selection if consumer choice frictions and their health types are correlated.

⁵⁰Excluding the two states does not appear to change our results very much. We also estimated a model with interactions between the advertising variables and county-level demographic characteristics with the sample that includes CA and NY. As reported in Table 28, the results are not qualitatively different from the results with demographic group-level market shares.

limited heterogeneity across demographic groups.⁵¹

D.3 State Advertising

We also examine whether the effect of state advertising is heterogeneous across states. As discussed earlier, it is reasonable to expect such heterogeneity because each state government organizes its own marketing activities for marketplaces, for which the federal government is not responsible for marketing. We focus on CA, which has spent many resources on marketing campaigns for its own marketplace (Lee et al. (2017)). Table 29 presents estimates of the model in which the effect of state advertising is allowed to be different for CA. In market-level regressions, the point estimate for the coefficient for CA advertising is positive and large, but it is imprecisely estimated, probably because we do not have enough statistical power due to the limited number of markets in CA in the border sample. In insurer-level regressions, the coefficient of state advertising in CA is very large and significant.

This result suggests that the small average effect of state advertising is not homogeneous across all states. Although our goal in this paper is not to understand the reasons why CA advertising is more effective than other state advertising, we conjecture that this result is potentially due to a large number of marketing resources available for the CA marketplace.

E Detailed Discussions of Welfare Impacts of Federal Advertising

We first describe the key welfare effect laid out in our conceptual framework. It describes that the welfare impact of federal advertising depends on not only how many individuals sign up, but also which individuals sign up to the marketplace. Importantly, our demand estimate suggests that there are very limited selection effects of federal advertising (Section 4.5.2). Thus, the marginal effect of increasing in federal advertising on consumer demand is likely to be common across consumers, i.e., $q'_h(ad^f) = \bar{q}'(ad^f)$ for any h . This is equivalent to argue that federal advertising mitigate choice frictions of consumers equally. Given this estimate, the welfare impact of federal advertising depends on the average social welfare \overline{SS} among new enrollment.

We consider the welfare impact of increasing federal advertising spending by 1%. In an average

⁵¹One natural question is whether this limited heterogeneity is due to statistical power from our data. To properly address this question, one must acquire individual-level data, which is currently very challenging for the federal marketplaces. However, the lack of this heterogeneity is certainly plausible. For example, Aizawa and Kim (2018) find in Medicare Advantage that consumers with certain characteristics (e.g., consumers with better cognitive ability) are more responsive to advertising, but many demographic characteristics, including income, are not associated with the effectiveness of advertising. Thus, one must obtain richer measurements for enrollment to further pursue this issue.

market, per-capita advertising spending is \$0.32. Based on our demand estimate, a one-percent increase in federal advertising spending (\$0.0032) raises the marketplace enrollment by 0.05%, which is about an increase in total enrollment by 0.01 pp, given the average enrollment of 20% of the market size. Then, as long as $\overline{SS} > \$32$, a marginal increase in federal advertising enhances welfare.

What is a reasonable estimate of \overline{SS} in the literature? Social welfare from enrolling a consumer should depend on consumer and producer surplus and government spending. Existing studies (e.g., Finkelstein et al. (2019), Tebaldi (2017), and Polyakova and Ryan (2019)) find it difficult to accurately estimate consumer and producer surplus in this context. Often, they tend to find that consumer welfare from marketplace plans is significantly lower than the actual cost of providing the plans or government spending. For example, Finkelstein et al. (2019) show that the median willingness to pay for health insurance among potential enrollees for the subsidized Massachusetts marketplace is about \$100 per month, which is just about 33% of the corresponding median claim cost (\$333 per month). Finkelstein et al. (2019) argue that this is mainly because even uninsured individuals are partially insured through uncompensated care, which the government may finance. Thus, the correct social welfare calculation must account for a reduction of uncompensated care. For example, they argue that the actual out-of-pocket cost of uninsured is just 20% of the total cost and that the rest of the cost is likely to be paid by the government. As a result, if an uninsured individual acquires insurance coverage, the government can potentially save \$266 per month (i.e., 80% of \$333), assuming that the cost of financing uncompensated care is the social cost of having an uninsured individual. Thus, the net change in the social cost of insuring one person would be \$67 per month, which implies that annual welfare gain is about \$396 ($= (100 - 67) \times 12$). Although a more careful analysis in our context is needed, the result suggests that increasing federal advertising is very likely to result in welfare gains.

Note that our analysis can also be interpreted through the framework to evaluate the marginal value of public funds (Hendren (2016); Finkelstein and Notowidigdo (2019)). For example, in their experiments of sending direct mailings to potential SNAP enrollees, Finkelstein and Notowidigdo (2019) interpret that the welfare effect of sending a mailing consists of three components: (i) the effect on consumer surplus (e.g., the reducing consumer's choice frictions), which can be positive; (ii) the direct government expenditure on the program (e.g., government payments for SNAP benefits for additional consumers), which reduces the welfare; (iii) fiscal externality, which is the government's additional expenditure because of a consumer's behavioral responses (e.g., the reduction of tax revenue due to the lower labor supply to be eligible for SNAP), which also reduces the welfare. Note that we considered the first two factors and miss the third factor (fiscal externality) in our welfare calculation. The fiscal externality could happen, for example, if advertising induces a consumer to reduce their working hours to be eligible to premium subsidies in the mar-

marketplace, leading to smaller tax revenues. We, however, view this channel as unrealistic because the subsidies are available for a wide range of incomes (up to 400% of the federal poverty level). The existing studies also support this interpretation (e.g., Aizawa, 2019).

Finally, we did not specify the consumer choice process in our welfare framework. An example of a model consistent with our framework is a model of consideration sets (e.g., Goeree, 2008). In a simple version of such a model, an individual considers the option of choosing a health plan from the marketplace with the probability $\lambda(ad^f)$. Then, an individual would maximize the following utility function:

$$\lambda(ad^f) \max \{U_{hix} + \varepsilon_{hix}, U_o\} + (1 - \lambda(ad^f)) U_o$$

where U_x is the utility from the choice x , and ε_{hix} is a preference shock for choosing a plan from the marketplace with the distribution F . Then, the take-up rate $q(ad^f)$ would be :

$$q(ad^f) = \lambda(ad^f) (1 - F(U_o - U_{hix})).$$

F Comparing the Effectiveness of Federal Advertising with Other Forms of Government Outreach

We compare our estimates of the effect of federal advertising on market-level enrollment to the finding in Goldin et al. (2021), who evaluate the randomized experiment of sending a direct mailing (a reminder) between 2016 and 2017 to individuals who paid the tax penalty because they were uninsured in 2015. They find that such a reminder increases the probability of being insured (at least one month) by 0.85 percentage points, which reduces the probability of being uninsured by 2.7% in their sample. They also show that roughly two-thirds of the marginal individuals enrolled in the marketplace, which implies that the probability of being uninsured decreased by 1.8% through an increase in marketplace take-up. These changes are induced by receiving one direct mailing from the federal government, whose cost is typically estimated to be about \$0.5–\$1.0.

In our estimation sample, those who choose the outside option account for about 80% of the market size. About 75% of them are uninsured, and a quarter of them obtain off-marketplace health plans. For the purpose of this comparison, we assume that the marginal effect of federal advertising is identical regardless of insured status. Then, our estimate implies that doubling federal advertising will reduce the total marketplace enrollment by 1 pp and thus the uninsured rate by 0.75 pp. This implies that the uninsured rate decreased by 1.25%. Now, our average federal advertising spending per capita is \$0.32. Because roughly 60% of the population is uninsured, we

can consider that these enrollment changes are induced by \$0.53 (0.32/0.6) spending of federal advertising per uninsured.

These back of envelope calculation suggests that the cost-effectiveness of TV advertising is comparable, 70% or more depending on the precise cost of direct email, to the direct mail experiment reported in Goldin et al. (2021).

G Detailed Discussion of the Advertising Data

Identifying Advertisements Relevant for the Marketplace We exploit detailed information in the database to identify which advertisements are related to marketplaces. Using Amazon Web Services, we transcribed each advertisement and examined its content based on keywords. As a result, we can identify whether an advertisement (i) is related to the marketplace, (ii) merely promotes a private insurer’s brand, or (iii) is related to health insurance but not about the marketplaces (i.e. Medicare). In our analyses, we consider types (i) and (ii) and exclude type (iii).

Depending on advertisement sponsors, we use a slightly different algorithm to classify each advertisement into type (i), (ii), or (iii). First, for advertisements by the federal government, we initially select those with the HHS as their sponsor names.⁵² Among this set, we identify marketplace related advertisements (type (i)) by checking the transcript for mentions of “HealthCare.gov.” Because there are only about 100 distinct advertisements by the HHS, we verified our classification by watching individual advertisements. Type (ii) does not exist for federal advertising, and we exclude type (iii)—for example, advertisements in which HHS promotes Medicare.

Second, for advertising by state governments, we initially select those advertisements with sponsor names that match names of state marketplaces such as Covered California and New York State of Health. Among this set, we again identified marketplace related advertisements (type (i)) by checking advertisement transcripts and individual advertisement videos visually. Type (ii) advertisements from state governments do not exist, and we exclude type (iii) advertisements from state governments—for example, those about Children’s Health Insurance Programs.

Third, for private advertising, we rely only on transcripts because it is not feasible to watch each of the thousands of distinct advertisements by private insurers. We first exclude advertisements with type (iii) keywords such as “Medicare Advantage,” “Medicare Part D,” “Medigap,” and “employer-sponsored insurance.” Among the remaining advertisements, we identify type (i) with keywords related to the marketplace such as “open enrollment” and “financial assistance.” The remainder are classified as type (ii).

⁵²We also checked whether there are other federal sponsors that would place marketplace-related advertisements. However, federal advertising seems to be done exclusively by the HHS.

Identifying Advertising Content We use Amazon Web Services (AWS) to transcribe the video of each advertisement. AWS automatically translates transcripts of advertisements in Spanish into English. We then view a sample of advertisements and generate a list of keywords that characterize the contents of the advertisement. Each advertisement in the sample is then classified based on these keywords and a set of dummy variables indicating the presence of each type of content is generated. Although this approach is necessarily ad hoc, we find that it performs well in ex-post manual verification. The list of content types and keywords are shown below:

- **Reform:** This dummy variable is equal to one if an advertisement contains at least one of the following terms: "affordable care act", "new law", "health care law", "health care reform law", "health care reform", "new health care", "reform", "health care act", "recent changes in health care", "changes that are coming in the health care system", "health care changes", or "changes in our health care".
- **Open Enrollment:** This dummy variable is equal to one if an advertisement contains at least one of the following terms: "open enrollment", "deadline", "choose or change plan", "last day", "enrollment period", "registration period", "open registration", "enrollment is now open", "February fifteen", "fifteenth of February", "December fifteen", "fifteen of December", "march thirty", "December 15", "January thirty first", "enroll-a-thon". If advertising contains "open enrollment for state and county employees", "April thirtieth", then we assign the dummy to take zero.
- **Uninsured:** This dummy variable is equal to one if an advertisement contains at least one of the following terms: "uninsured", "still need health insurance", or "existing condition".
- **Penalty:** This dummy variable is equal to one if an advertisement contains at least one of the following terms: "penalty", "penalties", "the fine", "required to have health insurance", "required by law", "requirement", "required to have".
- **Financial:** This dummy variable is equal to one if an advertisement contains at least one of the following terms: "financial assistance", "financial help", "income information", "estimated income", "tax credit", "financial aid", "subsidy", "subsidies", "federal assistance", "government aid", "government to help", "money from the government", "qualify for assistance", "help pay", "help with their monthly payment", "eligible for money", "how much money you could get from the government", "government helping to pay", "federal help", "assistance to pay", "eligible for money", "getting money to help", "sum city", "financial health", "national assistance", "receive financial", "qualify for assistance", or "aid for your health insurance".

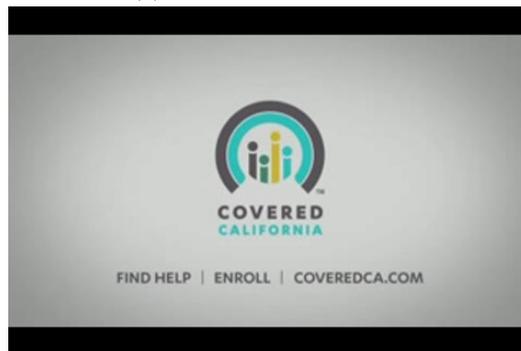
- ACA: this dummy variable is equal to one if at least one of dummy variables created above is equal to one.

H Additional Figures and Tables

Figure 3: Screenshots of ACA-related Advertisements by Federal and State Governments and Private Insurers



(a) Federal Government

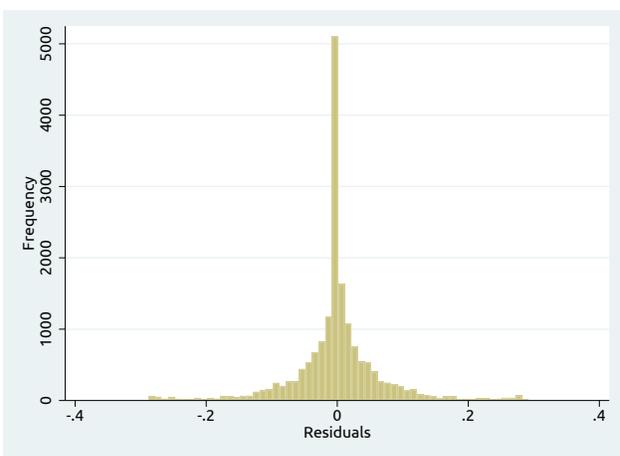


(b) California State Government

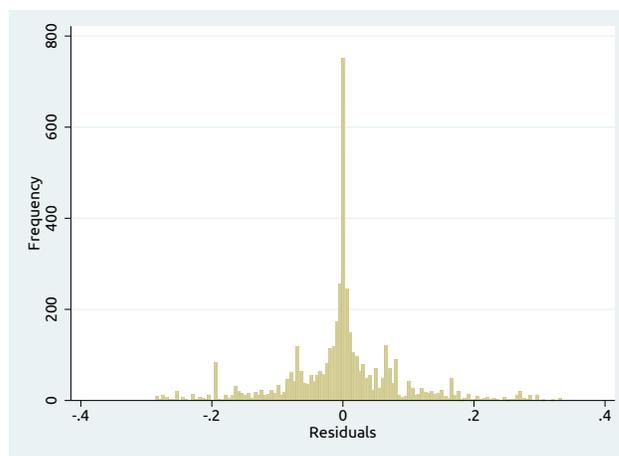


(c) Private Advertising (UnitedHealth)

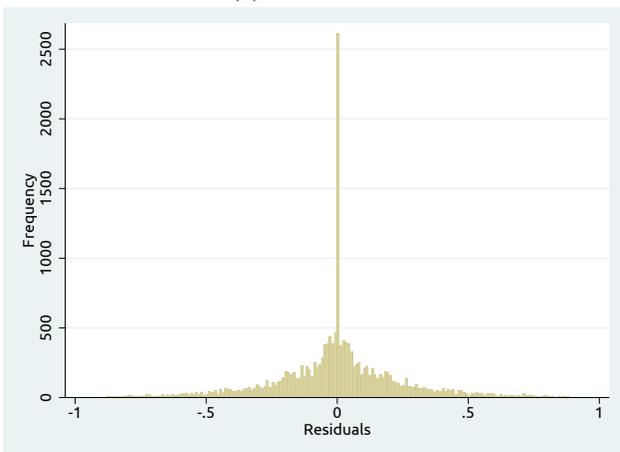
Figure 4: Residual Variation in Advertising Variables



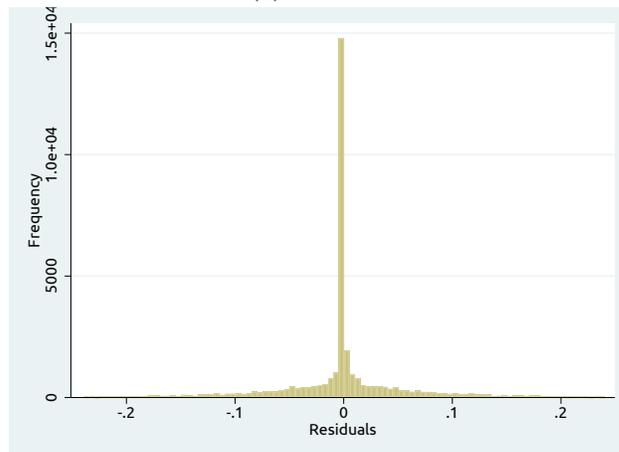
(a) Federal Ad



(b) State Ad



(c) Market-Level Private Ad



(d) Insurer-Level Private Ad

Note: This figure plots the distribution of residual variation in advertising spending by the federal and state governments (Panels (a) and (b)) and private insurers at the market level and at the insurer-level (Panels (c) and (d)). For Panel (b), we excluded counties in states that delegated to the federal government the responsibility for marketing the marketplace because such counties do not have any variation on state advertising due to the institutional feature. Data source: Kantar Media.

Table 10: Cross Tabulation Ad Content Types

	(1)	(2)	(3)	(4)	(5)
	Open Enrollment=1	Financial Assitance=1	Healthcare Reform=1	Uninsured=1	Penalty=1
Share: Open Enrollment	1.00	0.51	0.36	0.11	0.82
Share: Financial Assistance	0.65	1.00	0.39	0.74	0.83
Share: Healthcare Reform	0.18	0.16	1.00	0.29	0.24
Share: Uninsured	0.03	0.14	0.13	1.00	0.09
Share: Penalty	0.20	0.16	0.11	0.10	1.00
N. Obs.	485,656	612,937	283,022	101,405	149,782

Note: This table reports cross tabulation of content types of advertisements by all sponsors during 2014–2018. Each column reports the share of different content types within advertisements that provide a specific content type. The unit of observation is each advertisement occurrence, and reported numbers are averages weighted by each advertisement’s dollar cost.

Table 11: Targeting of Federal Advertising

	(1)	(2)	(3)	(4)	(5)
	ACA-related	Financial	Open Enrollment	Penalty	Reform
Share: Income \leq 138% of FPL (%)	-0.006 (0.012)	-0.001 (0.006)	-0.001 (0.005)	0.000 (0.000)	-0.001 (0.005)
Medicaid Expanded=1	-0.098* (0.058)	-0.043 (0.032)	-0.027 (0.025)	-0.001 (0.001)	-0.027 (0.020)
Medicaid Expanded=1 \times Share: Income \leq 138% of FPL (%)	0.017 (0.015)	0.007 (0.007)	0.006 (0.006)	0.000 (0.000)	0.004 (0.006)
Share: Age from 55 to 64	0.005 (0.007)	-0.002 (0.004)	-0.000 (0.003)	0.000 (0.000)	0.005 (0.003)
Share: Poor or Fair Health (%)	0.008 (0.009)	0.008* (0.004)	0.006* (0.003)	0.000 (0.000)	-0.004 (0.004)
No. of Insurers	0.017*** (0.006)	0.008** (0.003)	0.001 (0.002)	-0.000 (0.000)	0.006** (0.002)
Log of Market Size	0.029*** (0.008)	0.007** (0.003)	0.004 (0.002)	0.000 (0.000)	0.009** (0.003)
Year FE	Y	Y	Y	Y	Y
N. Obs.	784	784	784	784	784
Adj. R^2	0.148	0.466	0.542	0.017	0.366

Note: This table reports estimates of the coefficients in Equation (1). Each column presents estimates from the same specification with the dependent variable of federal spending on advertisements providing a specific message. Because there is no federal advertising spending in 2018, we restricted our sample years to 2014–2017. Standard errors are in parentheses and clustered at the DMA level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 12: Targeting of State Advertising

	(1)	(2)	(3)	(4)	(5)
	ACA-related	Financial	Open Enrollment	Penalty	Reform
Share: Income \leq 138% of FPL (%)	-0.203*** (0.052)	-0.106*** (0.034)	-0.077*** (0.022)	-0.001 (0.005)	-0.014** (0.006)
Share: Age from 55 to 64	-0.080 (0.059)	-0.059* (0.031)	-0.032 (0.020)	0.007 (0.005)	0.002 (0.002)
Share: Poor or Fair Health (%)	0.036 (0.042)	0.028 (0.027)	0.020 (0.016)	0.004 (0.003)	0.005** (0.003)
No. of Insurers	0.116*** (0.025)	0.072*** (0.017)	0.044*** (0.015)	-0.001 (0.003)	-0.001 (0.002)
Log of Market Size	-0.010 (0.053)	-0.008 (0.032)	0.017 (0.020)	0.010** (0.005)	0.003 (0.003)
Year FE	Y	Y	Y	Y	Y
N. Obs.	332	332	332	332	332
Adj. R^2	0.238	0.185	0.184	0.036	0.162

Note: This table reports estimates of the coefficients in Equation (1). Each column presents estimates from the same specification with the dependent variable of state spending on advertisements providing a specific message. State's Medicaid expansion status is not included in covariates because state advertising are done in states expanding Medicaid at DMA level. Standard errors are in parentheses and clustered at the DMA level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 13: Targeting of Private Advertising

	(1)	(2)	(3)	(4)	(5)	(6)
	All	ACA-related	Financial	Open Enrollment	Penalty	Reform
Share: Income \leq 138% of FPL (%)	0.103** (0.051)	0.048** (0.021)	0.034** (0.016)	0.025 (0.016)	0.044*** (0.012)	0.030** (0.015)
Medicaid Expanded=1	0.545** (0.224)	0.195* (0.099)	0.075 (0.075)	0.104 (0.077)	0.159*** (0.051)	0.087 (0.061)
Medicaid Expanded=1 \times Share: Income \leq 138% of FPL (%)	-0.113** (0.057)	-0.032 (0.029)	-0.018 (0.021)	-0.011 (0.023)	-0.039*** (0.015)	-0.018 (0.018)
Share: Age from 55 to 64	0.073** (0.032)	0.014 (0.015)	0.023** (0.010)	0.011 (0.011)	0.016** (0.007)	0.017** (0.007)
Share: Poor or Fair Health (%)	-0.030 (0.028)	-0.008 (0.017)	0.006 (0.012)	0.001 (0.013)	-0.011 (0.008)	0.000 (0.010)
No. of Insurers	0.059*** (0.015)	0.019*** (0.007)	0.012* (0.006)	0.012** (0.006)	0.001 (0.004)	0.006 (0.005)
Log of Market Size	0.147*** (0.025)	0.074*** (0.013)	0.052*** (0.009)	0.054*** (0.010)	0.021*** (0.006)	0.028*** (0.006)
Year FE	Y	Y	Y	Y	Y	Y
N. Obs.	983	983	983	983	983	983
Adj. R^2	0.212	0.210	0.178	0.165	0.131	0.288

Note: This table reports estimates of the coefficients in Equation (1). Each column presents estimates from the same specification with the dependent variable of private spending on advertisements providing a specific message. Standard errors are in parentheses and clustered at the DMA level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 14: Comparing Either Side of Border Pairs

	Federal Ad		State Ad		Priv Ad	
	(1) Low	(2) High	(3) Low	(4) High	(5) Low	(6) High
Fed Spend	0.227 (0.202)	0.582 (0.497)	0.266 (0.374)	0.177 (0.180)	0.243 (0.329)	0.275 (0.377)
State Spend	0.161 (0.489)	0.100 (0.448)	0.515 (0.845)	1.462 (1.246)	0.205 (0.652)	0.269 (0.776)
Priv Spend	0.879 (1.404)	0.955 (1.375)	1.014 (1.439)	1.306 (1.582)	0.567 (0.890)	1.624 (1.948)
No. of Insurers	2.552 (1.458)	2.553 (1.488)	2.863 (1.379)	2.903 (1.413)	2.494 (1.422)	2.521 (1.439)
HHI among Insurers	0.697 (0.242)	0.707 (0.244)	0.661 (0.236)	0.654 (0.231)	0.708 (0.242)	0.705 (0.242)
Log of Market Size	1.542 (1.197)	1.565 (1.217)	1.496 (1.281)	1.518 (1.307)	1.491 (1.210)	1.539 (1.244)
Share: Income \leq 138% of FPL	0.245 (0.088)	0.243 (0.085)	0.208 (0.079)	0.210 (0.080)	0.244 (0.088)	0.243 (0.089)
Share: Age from 55 to 64	0.194 (0.053)	0.194 (0.052)	0.210 (0.057)	0.215 (0.054)	0.196 (0.053)	0.197 (0.053)
Employment Rate	0.638 (0.072)	0.636 (0.072)	0.660 (0.067)	0.657 (0.066)	0.635 (0.072)	0.635 (0.072)
Share: Poor or Fair Health	0.179 (0.052)	0.179 (0.051)	0.164 (0.047)	0.161 (0.046)	0.181 (0.050)	0.181 (0.051)
Share: Obesity	0.319 (0.040)	0.320 (0.040)	0.300 (0.040)	0.296 (0.043)	0.319 (0.042)	0.318 (0.043)
Share: Diabetes	0.118 (0.023)	0.118 (0.023)	0.106 (0.020)	0.106 (0.020)	0.118 (0.024)	0.118 (0.024)
Healthcare Cost (in \$1000s)	9.687 (1.503)	9.698 (1.356)	8.886 (1.271)	8.844 (1.265)	9.662 (1.498)	9.625 (1.443)
N. Obs.	4,758	4,758	2,181	2,181	8,496	8,496

Note: This table compares market characteristics between border counties with low and high federal, state and private advertising spending. For the first two columns, we collect border counties with lower federal advertising spending within each of border pairs in Column (1) and border counties with higher federal advertising spending within each of border areas in Column (2). We excluded border pairs with zero government advertising in both sides of borders from the sample used to produce the table. For Columns (3) and (4), we group border counties similarly based on state advertising spending. For Columns (5) and (6), we group border counties similarly based on market-level private advertising spending. Standard errors are in parentheses.

Table 15: Comparing Border and Non-Border Counties

	(1) Border Counties	(2) Non-Border Counties	(3) Overall
No. of Insurers	2.685 (1.559)	2.451 (1.415)	2.540 (1.476)
HHI among Insurers	0.676 (0.243)	0.716 (0.242)	0.700 (0.243)
Log of Market Size	8.754 (1.623)	8.376 (1.241)	8.521 (1.412)
Share: Income \leq 138% of FPL	0.229 (0.082)	0.240 (0.087)	0.236 (0.085)
Share: Age \geq 55	0.187 (0.051)	0.197 (0.054)	0.193 (0.053)
Employment Rate	0.656 (0.070)	0.637 (0.073)	0.644 (0.072)
Share: Poor or Fair Health	0.166 (0.048)	0.180 (0.051)	0.175 (0.050)
Share: Obesity	0.309 (0.042)	0.318 (0.042)	0.315 (0.042)
Share: Diabetes	0.109 (0.022)	0.117 (0.024)	0.114 (0.023)
Healthcare Cost (in \$1000s)	9.543 (1.529)	9.632 (1.474)	9.598 (1.496)
N. Obs.	5,165	8,334	13,499

Note: This table presents market-level characteristics between border and non-border counties. Column (1) and (2) present characteristics of border and non-border counties, respectively. Column (3) present characteristics of all counties. Standard errors are in parentheses.

Table 16: Residual Variation in Advertising Variables

	(1)	(2)
	Residual Variation	Raw Variation
Federal	0.43	1.06
State	0.51	2.67
Market-level Private	0.32	1.58
Insurer-level Private	0.44	1.99

Note: This table presents the variation in advertising spending by each sponsor. Column (1) reports the ratio of the standard deviation of residual advertising spending over the mean of unconditional advertising spending for each advertising sponsor. Column (2) reports the ratio of the standard deviation of unconditional advertising spending over the mean of unconditional advertising spending for each advertising.

Table 17: Correlation between State Outreach and State Advertising

	(1)	(2)
	CEC Per Capita	CEE Per Capita
State Spend	0.0778 (0.1532)	-0.0206 (0.0412)
No. Insurers	-0.0207 (0.0282)	-0.0024 (0.0082)
Market Size	-2.31e-07 (3.52e-07)	1.35e-07 (6.10e-08)
Year FE	Y	Y
County FE	Y	Y
N. Obs	212	212
Adj. R^2	0.714	0.719

Note: This table presents the relationship between state advertising and state government outreach activities, measured by CEC per capita and CEE per capita. The unit of both measures is in thousands. The standard deviation of CEC per capita is 0.634, and the standard deviation of CEE per capita is 0.144. State Spend is the log of state advertising per capita plus one. The standard error is clustered at the DMA and year level.

Table 18: Alternative Outreach Activities in Either Side of Border Pairs in CA

	State Ad		Priv Ad	
	(1) Low	(2) High	(3) Low	(4) High
Certified Enrollment Counselors Per Capita (in 1000s)	0.782 (0.548)	0.760 (0.679)	0.787 (0.615)	0.730 (0.622)
Certified Enrollment Entities Per Capita (in 1000s)	0.183 (0.158)	0.168 (0.179)	0.161 (0.136)	0.177 (0.192)
N. Obs.	220	220	206	206

Note: This table compares alternative outreach activities done by the CA state government between border counties with low and high state and private advertising spending. For the first two columns, we collect border counties with lower state advertising spending within each of the border pairs in Column (1) and border counties with higher state advertising spending within each border area in Column (2). We excluded border pairs with zero government advertising in both sides of borders from the sample used to produce the table. For Columns (3) and (4), we group border counties similarly based on market-level private advertising spending. Standard errors are in parentheses.

Table 19: Market-Level Demand Analysis: Federal vs Non-federal Advertising

	(1) Log ($\ln(1 + ad)$)	(2) Level (ad)
Fed Spend	0.053** (0.021)	0.033** (0.013)
Non-fed Spend	0.005 (0.009)	0.002* (0.001)
No. of Insurers	0.012 (0.008)	0.012 (0.008)
Market Size	-0.026*** (0.006)	-0.026*** (0.006)
BorderYear FE	Y	Y
County FE	Y	Y
RatingYear FE	Y	Y
N. Obs.	18,182	18,182
Adj. R^2	0.919	0.919

Note: Non-fed Spend is the combined advertising spending by all sponsors other than the federal government: state governments, private insurers, navigators, Democrats, and Republicans. Column (1) and (2) report estimates with the specifications, where the advertising variables enter in log and in level, respectively. In both columns, we can reject the null that the coefficient estimate for federal advertising is different from non-federal advertising at the 5% level. All specifications include Border \times Year fixed effects, County fixed effects, and Rating Area \times Year fixed effects. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA \times Year level and the County level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 20: Reduced-Form Effect of Advertising on Insurer-Level Enrollment

	(1)	(2)	(3)
Fed Spend	0.087* (0.046)	0.088* (0.047)	0.091* (0.047)
State Spend	-0.052 (0.066)	-0.057 (0.066)	-0.057 (0.065)
Priv Spend	0.089** (0.045)	0.088** (0.044)	0.086* (0.044)
Rival Spend	-0.031 (0.041)	-0.080* (0.047)	-0.084* (0.048)
1[Num of Rivals with Positive Ads \geq 2]=1 \times Rival Spend		0.192** (0.078)	0.194** (0.078)
1[Num of Rivals with Positive Ads \geq 2]=1		-0.099* (0.059)	-0.101* (0.058)
No. of Insurers	-0.095*** (0.023)	-0.095*** (0.023)	-0.094*** (0.023)
Market Size	0.006* (0.003)	0.006* (0.003)	0.006* (0.003)
Navi Spend			-0.236 (0.232)
Dem Spend			0.031 (0.036)
Rep Spend			0.020 (0.018)
FirmBorderYear FE	Y	Y	Y
FirmCounty FE	Y	Y	Y
FirmRatingYear FE	Y	Y	Y
N. Obs.	36,622	36,622	36,622
Adj. R^2	0.956	0.956	0.957

Note: This table reports estimates of effects of advertising on the log of insurer-level enrollment size. Each column reports estimates based on a different combination of advertising variables. Column (1) includes federal, state, private, and rival advertising. Column (2) includes adds the dummy of whether the number of rival advertisers is at least two, and its interaction with rival advertising. Column (3) adds navigator, Democrats and Republican advertising. All specifications include Firm \times Border \times Year fixed effects, Firm \times County fixed effects, and Firm \times Rating Area \times Year fixed effects. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA \times Year level and the Firm \times County level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 21: Robustness: Market-Level Demand Analysis

	Log ($\ln(1 + ad)$)				Level (ad)			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Fed Spend	0.050** (0.021)	0.049** (0.021)	0.050** (0.020)	0.049** (0.020)	0.031** (0.013)	0.030** (0.012)	0.031*** (0.012)	0.031*** (0.012)
State Spend	-0.011 (0.034)	0.005 (0.041)	-0.018 (0.034)	-0.006 (0.041)	0.001 (0.016)	0.007 (0.016)	-0.003 (0.016)	0.003 (0.017)
Priv Spend	0.023 (0.018)	0.028 (0.019)	0.016 (0.018)	0.021 (0.018)	0.010 (0.006)	0.010* (0.006)	0.006 (0.006)	0.007 (0.006)
1[Fed Spend>0]		0.233** (0.095)		0.269*** (0.085)		0.236** (0.095)		0.273*** (0.086)
1[State Spend>0]		-0.022 (0.019)		-0.017 (0.019)		-0.025 (0.017)		-0.022 (0.017)
1[Priv Spend>0]		-0.009 (0.016)		-0.007 (0.016)		-0.004 (0.015)		-0.003 (0.015)
No. of Insurers	0.012 (0.008)	0.012 (0.008)	0.016* (0.009)	0.015* (0.009)	0.013 (0.008)	0.013 (0.008)	0.016* (0.009)	0.016* (0.009)
Market Size	-0.026*** (0.006)	-0.026*** (0.006)	-0.036*** (0.006)	-0.036*** (0.006)	-0.026*** (0.006)	-0.026*** (0.006)	-0.036*** (0.006)	-0.036*** (0.006)
Sample	Baseline	Baseline	Rating Area	Rating Area	Baseline	Baseline	Rating Area	Rating Area
BorderYear FE	Y	Y	Y	Y	Y	Y	Y	Y
County FE	Y	Y	Y	Y	Y	Y	Y	Y
RatingYear FE	Y	Y	Y	Y	Y	Y	Y	Y
N. Obs.	18,182	18,182	10,224	10,224	18,182	18,182	10,224	10,224
Adj. R^2	0.919	0.919	0.912	0.912	0.919	0.919	0.912	0.912

Note: Column (1) of this table reports the estimates reported in Column (3) in Table 4. Column (2) reports the estimates of the specification that includes the dummy variables that equal to one if sponsor k ($k = f, s, mp$) has positive advertising spending. Columns (3) and (4) report the estimates of the same specifications as in Column (1) and (2) with the sample that includes only border pairs in the same rating area. Columns (4) through (8) report the estimates of the specifications in Columns (1) through (4), but we replace advertising variables $\ln(1 + ad)$ with the level ad . All specifications include Border \times Year fixed effects, County fixed effects, and Rating Area \times Year fixed effects. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA \times Year level and the County level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 22: Robustness: Insurer-level Demand Analysis

	Log ($\ln(1 + ad)$)				Level (ad)			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Fed Spend	0.125** (0.053)	0.123** (0.054)	0.134** (0.057)	0.134** (0.057)	0.070** (0.031)	0.069** (0.031)	0.077** (0.034)	0.078** (0.034)
State Spend	-0.033 (0.070)	-0.013 (0.084)	0.006 (0.072)	0.003 (0.086)	-0.025 (0.032)	-0.020 (0.033)	-0.013 (0.032)	-0.016 (0.034)
Priv Spend	0.093* (0.048)	0.101** (0.051)	0.090* (0.050)	0.104* (0.054)	0.035** (0.016)	0.035** (0.016)	0.034** (0.017)	0.035** (0.017)
1[Fed Spend>0]		0.322* (0.164)		0.317** (0.146)		0.323** (0.163)		0.315** (0.145)
1[State Spend>0]		-0.032 (0.058)		-0.002 (0.062)		-0.025 (0.050)		0.009 (0.055)
1[Priv Spend>0]		-0.010 (0.034)		-0.018 (0.035)		0.003 (0.032)		-0.005 (0.033)
No. of Insurers	-0.091*** (0.024)	-0.091*** (0.024)	-0.066** (0.027)	-0.067** (0.027)	-0.090*** (0.024)	-0.091*** (0.024)	-0.065** (0.027)	-0.066** (0.027)
Market Size	-0.021*** (0.005)	-0.021*** (0.005)	-0.038*** (0.008)	-0.038*** (0.008)	-0.021*** (0.006)	-0.021*** (0.006)	-0.038*** (0.008)	-0.038*** (0.008)
Sample	Baseline	Baseline	Rating Area	Rating Area	Baseline	Baseline	Rating Area	Rating Area
FirmBorderYear FE	Y	Y	Y	Y	Y	Y	Y	Y
FirmCounty FE	Y	Y	Y	Y	Y	Y	Y	Y
FirmRatingYear FE	Y	Y	Y	Y	Y	Y	Y	Y
N. Obs.	36,558	36,558	19,712	19,712	36,558	36,558	19,712	19,712
Adj. R^2	0.938	0.938	0.926	0.926	0.938	0.938	0.926	0.926

Note: Column (1) of this table reports the estimates reported in Column (4) in Table 5. Column (2) reports the estimates of the coefficients of the specification that includes the dummy variables that equal to one if sponsor k ($k = f, s, p$) has positive advertising spending. Columns (3) and (4) report the estimates of the same specifications as in Column (1) and (2) with the sample that includes only border pairs in the same rating area. Columns (4) through (8) report the estimates of the specifications in Columns (1) through (4), but we replace advertising variables $\ln(1 + ad)$ with the level ad . All specifications include Firm \times Border \times Year fixed effects, Firm \times County fixed effects, and Firm \times Rating Area \times Year fixed effects. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA \times Year level and the Firm \times County level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 23: The Effects of Advertising: New vs Mature Markets

	(1) Up to 2016	(2) Up to 2018	(3) Linear Trend
Fed Spend	0.119** (0.058)	0.125** (0.053)	0.102 (0.066)
State Spend	0.047 (0.090)	-0.033 (0.070)	-0.027 (0.082)
Priv Spend	0.134** (0.064)	0.093* (0.048)	0.080 (0.053)
Linear Trend × Fed Spend			0.048 (0.043)
Linear Trend × State Spend			-0.001 (0.028)
Linear Trend × Priv Spend			0.016 (0.018)
No. of Insurers	-0.106*** (0.026)	-0.091*** (0.024)	-0.090*** (0.024)
Market Size	-0.023*** (0.007)	-0.021*** (0.005)	-0.021*** (0.005)
FirmBorderYear FE	Y	Y	Y
FirmCounty FE	Y	Y	Y
FirmRatingYear FE	Y	Y	Y
N. Obs.	25,074	36,558	36,558
Adj. R^2	0.942	0.938	0.938

Note: Columns (1) of this table presents the estimates with the sample period up to 2016; Column (2) presents the estimates with the full sample, which is up to 2018. Column (3) reports the estimates of the specification that includes interactions between the linear time trend and each of federal, state, and private advertising spending. All specifications include Firm×Border×Year fixed effects, Firm×County fixed effects, and Firm×Rating Area×Year fixed effects. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA×Year level and the Firm×County level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 24: Coefficient Estimates for Advertising Content (Log)

	(1)	(2)
Fed Spend:		
Open Enrollment and Financial	0.316** (0.135)	0.325** (0.141)
Fed Spend:		
Not Both Open Enrollment And Financial	0.089 (0.060)	
Fed Spend:		
Either Open Enrollment or Financial (not both)		-0.056 (0.237)
Fed Spend:		
Other ACA-related		0.102 (0.068)
State Spend:		
Open Enrollment and Financial	0.092 (0.108)	0.121 (0.110)
State Spend:		
Not Both Open Enrollment And Financial	-0.048 (0.072)	
State Spend:		
Either Open Enrollment or Financial (not both)		0.094 (0.085)
State Spend:		
Other ACA-related		-0.100 (0.075)
Priv Spend:		
Open Enrollment and Financial	0.058 (0.064)	0.076 (0.069)
Priv Spend:		
Not Both Open Enrollment And Financial	0.096** (0.048)	
Priv Spend:		
Either Open Enrollment or Financial (not both)		0.072 (0.072)
Priv Spend:		
Other ACA-related		-0.062 (0.063)
Priv non-ACA Spend		0.121** (0.055)
No. of Insurers	-0.089*** (0.024)	-0.088*** (0.025)
Market Size	-0.021*** (0.005)	-0.021*** (0.005)
FirmBorderYear FE	Y	Y
FirmCounty FE	Y	Y
FirmRatingYear FE	Y	Y
N. Obs.	36,558	36,558
Adj. R^2	0.938	0.938

Note: This table reports the estimates of the coefficients in specifications that include advertising content types. We use the log transformation of advertising spending in the estimation. The set of advertising content types considered in Column (1) is: (i) advertisements that provide information about the open enrollment period and financial assistance and (ii) the rest of advertisements. The set of advertising content considered in Column (2) is: (i) advertisements that provide information about the open enrollment period and financial assistance, (ii) advertisements that provide content about the open enrollment period or financial assistance, but not both, (iii) the rest of ACA-related advertisements, and (iv) non-ACA related advertisements. The non-ACA related advertisements only exist for private insurers because advertisements by the federal or state governments are ACA-related by definition. All specifications include Firm×Border×Year fixed effects, Firm×County fixed effects, and Firm×Rating Area×Year fixed effects. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA×Year level and the Firm×County level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 25: Robustness Check: Coefficient Estimates for Advertising Content (Level)

	(1)	(2)
Fed Spend:		
Open Enrollment and Financial	0.262*** (0.101)	0.272*** (0.103)
Fed Spend:		
Not Both Open Enrollment And Financial	0.052 (0.034)	
Fed Spend:		
Either Open Enrollment or Financial (not both)		-0.054 (0.161)
Fed Spend:		
Other ACA-related		0.063* (0.038)
State Spend:		
Open Enrollment and Financial	-0.010 (0.070)	0.020 (0.070)
State Spend:		
Not Both Open Enrollment And Financial	-0.027 (0.036)	
State Spend:		
Either Open Enrollment or Financial (not both)		0.060 (0.053)
State Spend:		
Other ACA-related		-0.059 (0.038)
Priv Spend:		
Open Enrollment and Financial	0.026 (0.029)	0.034 (0.032)
Priv Spend:		
Not Both Open Enrollment And Financial	0.040** (0.016)	
Priv Spend:		
Either Open Enrollment or Financial (not both)		0.048 (0.044)
Priv Spend:		
Other ACA-related		-0.024 (0.029)
Priv non-ACA Spend		0.048*** (0.018)
No. of Insurers	-0.089*** (0.024)	-0.087*** (0.025)
Market Size	-0.021*** (0.005)	-0.021*** (0.005)
FirmBorderYear FE	Y	Y
FirmCounty FE	Y	Y
FirmRatingYear FE	Y	Y
N. Obs.	36,558	36,558
Adj. R ²	0.938	0.938

Note: This table reports the estimates of the coefficients in specifications that include advertising content types. We use the level of advertising spending in the estimation. The set of advertising content types considered in Column (1) is: (i) advertisements that provide information about the open enrollment period and financial assistance and (ii) the rest of advertisements. The set of advertising content considered in Column (2) is: (i) advertisements that provide information about the open enrollment period and financial assistance, (ii) advertisements that provide content about the open enrollment period or financial assistance, but not both, (iii) the rest of ACA-related advertisements, and (iv) non-ACA related advertisements. The non-ACA related advertisements only exist for private insurers because advertisements by the federal or state governments are ACA-related by definition. All specifications include Firm×Border×Year fixed effects, Firm×County fixed effects, and Firm×Rating Area×Year fixed effects. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA×Year level and the Firm×County level. The stars indicate: *** for p<0.01, ** for p<0.05 and * for p<0.1.

Table 26: Heterogeneous Effects Depending on Market Characteristics

	(1) Market Characteristics = Medicaid Expansion	(2) Market Characteristics = CA
Fed Spend	0.002 (0.067)	0.141** (0.058)
Market Characteristic=1 × Fed Spend	0.216** (0.103)	-0.129 (0.081)
State Spend	-0.116 (0.108)	-0.012 (0.073)
Market Characteristic=1 × State Spend	0.105 (0.134)	-0.168 (0.133)
Priv Spend	0.070 (0.088)	0.085* (0.051)
Market Characteristic=1 × Priv Spend	0.050 (0.104)	0.051 (0.058)
No. of Insurers	-0.090*** (0.024)	-0.090*** (0.024)
Market Size	-0.021*** (0.005)	-0.021*** (0.006)
FirmBorderYear FE	Y	Y
FirmCounty FE	Y	Y
FirmRatingYear FE	Y	Y
N. Obs.	36,558	36,558
Adj. R ²	0.938	0.938

Note: This table reports the estimates for the specifications that include interaction terms between market characteristics and advertising variables. Column (1) reports the estimates for the specification with interaction terms between advertising variables and a dummy variable for Medicaid expansion status under the ACA. Note that there are counties in states without Medicaid expansion that had exposure to state advertising if these counties border with other states with Medicaid expansion. Column (2) reports the estimates for the specification with interaction terms between advertising variables and a dummy variable for "unhealthy" markets. A market is defined as unhealthy if the share of individuals with fair or poor self-reported health status in the market is greater than the 75th percentile (21%). All specifications include Firm×Border×Year fixed effects, Firm×County fixed effects, and Firm×Rating Area×Year fixed effects. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA×Year level and the Firm×County level. The stars indicate: *** for p<0.01, ** for p<0.05 and * for p<0.1.

Table 27: Heterogeneous Effects for Demographic Groups

	(1) Demo=Income≤ 250% of FPL	(2) Demo=Age∈ [55,64]
Fed Spend	0.120** (0.053)	0.097** (0.049)
State Spend	-0.096 (0.077)	-0.058 (0.077)
Priv Spend	0.032 (0.051)	0.082 (0.051)
Demo × Fed Spend	0.011 (0.084)	0.061 (0.084)
Demo × State Spend	0.058 (0.119)	-0.052 (0.134)
Demo × Priv Spend	0.024 (0.084)	-0.008 (0.089)
No. of Insurers	-0.117*** (0.021)	-0.137*** (0.022)
Market Size	-0.031*** (0.006)	-0.025*** (0.005)
FirmBorderYearDemo FE	Y	Y
FirmCountyDemo	Y	Y
FirmRatingYearDemo FE	Y	Y
N. Obs.	68,136	68,206
Adj. R^2	0.918	0.911

Note: This table reports the estimates of the coefficients in the specification that includes interaction terms between advertising variables and dummy variables for individuals aged at least 55 and individuals with incomes below 138% of the federal poverty line FPL). For each column, we consider two demographic groups: whether or not an individual's age is at least 55 for Column (1) and whether or not an individual's income is below 138% of the FPL for Column (2). The unit of observation is at the level of each border pair, county, year, insurer, and demographic group. All specifications include Firm×Border×Year× Demographic Group fixed effects, Firm×County× Demographic Group fixed effects, and Firm×Rating Area×Year× Demographic Group fixed effects. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA×Year level and the Firm×County×Demographic Group level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 28: Heterogeneous Effects Across Markets with Different Age and Income Group Compositions

	(1) Demo = Share of Income \leq 250% of FPL	(2) Demo = Share of Age \in [55, 64]
Fed Spend	0.127** (0.055)	0.142** (0.059)
Demo \times Fed Spend	-0.004 (0.041)	0.059 (0.048)
State Spend	-0.051 (0.077)	-0.032 (0.075)
Demo \times State Spend	0.005 (0.044)	-0.057 (0.041)
Priv Spend	0.098* (0.052)	0.098* (0.052)
Demo \times Priv Spend	-0.022 (0.025)	-0.020 (0.019)
No. of Insurers	-0.114*** (0.026)	-0.115*** (0.026)
Market Size	-0.027*** (0.007)	-0.026*** (0.007)
FirmBorderYear FE	Y	Y
FirmCounty FE	Y	Y
FirmRatingYear FE	Y	Y
N. Obs.	34,208	34,208
Adj. R^2	0.936	0.936

Note: This table reports the estimates of the coefficients in the specification that includes interaction terms between advertising variables and county-level demographic variables. The demographic variables we consider are the share of potential marketplace enrollee aged at least 55 for Column (1), and the share of potential marketplace enrollees with incomes below 138% of the Federal Poverty Level for Column (2). The average shares (standard deviations) of the former and the latter are 0.20 (0.054) and 0.23 (0.085), respectively. All specifications include Firm \times Border \times Year fixed effects, Firm \times County fixed effects, and Firm \times Rating Area \times Year fixed effects. Standard errors are in parentheses and two-way clustered at the DMA \times Year level and the Firm \times County level. The unit of the market size (the number of potential enrollees) is in thousands. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 29: Heterogeneous Effects of State Advertising in California

	Market-Level		Insurer-Level		
	(1)	(2)	(3)	(4)	(5)
Fed Spend	0.050** (0.021)	0.050** (0.021)	0.124** (0.053)	0.124** (0.053)	0.128** (0.054)
State Spend	-0.016 (0.036)	-0.013 (0.035)	-0.053 (0.074)	-0.049 (0.074)	-0.048 (0.073)
1[State=CA]=1 × State Spend	0.085 (0.088)	0.095 (0.086)	0.298** (0.145)	0.300** (0.143)	0.300** (0.143)
Priv Spend	0.022 (0.018)	0.023 (0.017)	0.094** (0.048)	0.093* (0.048)	0.091* (0.047)
Rival Spend				-0.038 (0.047)	-0.043 (0.047)
Navi Spend		-0.054 (0.122)			-0.384 (0.240)
Dem Spend		0.050*** (0.016)			0.050 (0.037)
Rep Spend		-0.015* (0.008)			0.016 (0.018)
No. of Insurers	0.012 (0.008)	0.013 (0.008)	-0.092*** (0.024)	-0.091*** (0.024)	-0.088*** (0.024)
Market Size	-0.027*** (0.006)	-0.026*** (0.006)	-0.021*** (0.005)	-0.021*** (0.005)	-0.022*** (0.005)
BorderYear FE	Y	Y			
County FE	Y	Y			
RatingYear FE	Y	Y			
FirmBorderYear FE			Y	Y	Y
FirmCounty FE			Y	Y	Y
FirmRatingYear FE			Y	Y	Y
N. Obs.	18,182	18,182	36,558	36,558	36,558
Adj. R ²	0.919	0.919	0.938	0.938	0.938

Note: This table reports the estimates of the coefficients in the specification that includes the interaction term between the California (CA) dummy and state advertising. Columns (1) and (2) are based on the market-level demand model. Columns (3) and (4) are based on the insurer-level demand model. The specifications in Columns (1) and (2) include Border×Year fixed effects, County fixed effects, and Rating Area×Year fixed effects. The specifications in Columns (3) and (4) include Firm×Border×Year fixed effects, Firm×County fixed effects, and Firm×Rating Area×Year fixed effects. The unit of the market size (the number of potential enrollees) is in thousands. Standard errors are in parentheses and two-way clustered at the DMA×Year level and the County level (or the Firm×County level for Columns (3) and (4)). The stars indicate: *** for p<0.01, ** for p<0.05 and * for p<0.1.

Table 30: Coefficient Estimates: Interaction between Federal and Private advertising

	(1)	(2)
	Log ($\ln(1 + ad)$)	Level (ad)
Fed Spend	0.117* (0.064)	0.062* (0.033)
State Spend	-0.034 (0.070)	-0.025 (0.032)
Priv Spend	0.087* (0.051)	0.029* (0.017)
Fed Spend \times Priv Spend	0.022 (0.086)	0.010 (0.012)
No. of Insurers	-0.091*** (0.024)	-0.090*** (0.024)
Market Size	-0.021*** (0.005)	-0.021*** (0.006)
FirmBorderYear FE	Y	Y
FirmCounty FE	Y	Y
FirmRatingYear FE	Y	Y
N. Obs.	36,558	36,558
Adj. R^2	0.938	0.938

Note: This table reports the estimates of the coefficients for the specification includes the interaction term between federal and private advertising. The specification include Firm \times Border \times Year fixed effects, Firm \times County fixed effects, and Firm \times Rating Area \times Year fixed effects. Standard errors are in parentheses and two-way clustered at the DMA \times Year level and the Firm \times County level. The unit of the market size (the number of potential enrollees) is in thousands. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 31: Coefficient Estimates: Plan Characteristics (Bronze)

	(1) Characteristic = Num of plans	(2) Characteristic = Share of PPO plans	(3) Characteristic = Out-of-country cov.	(4) Characteristic = Premium	(5) Characteristic = Fin. Generosity	(6) Characteristic = Deductible	(7) Characteristic = Out-of-pocket max	(8) Characteristic = Coinsurance
Fed Spend	0.129** (0.054)	0.153*** (0.058)	0.157*** (0.057)	0.135** (0.055)	0.155*** (0.050)	0.147** (0.057)	0.217*** (0.060)	0.143*** (0.052)
Characteristic × Fed Spend	-0.001 (0.059)	-0.025 (0.057)	-0.035 (0.074)	-0.064 (0.050)	0.086 (0.055)	0.012 (0.049)	0.097* (0.051)	0.022 (0.053)
State Spend	-0.076 (0.076)	-0.079 (0.076)	-0.055 (0.073)	-0.041 (0.074)	-0.070 (0.072)	-0.036 (0.080)	-0.052 (0.074)	-0.081 (0.081)
Characteristic × State Spend	-0.017 (0.052)	0.036 (0.060)	-0.036 (0.055)	0.053 (0.074)	0.065 (0.040)	0.044 (0.050)	0.030 (0.044)	0.056 (0.066)
Priv Spend	0.105** (0.053)	0.105* (0.061)	0.057 (0.051)	0.123** (0.055)	0.085* (0.052)	0.078 (0.056)	0.104** (0.052)	0.090 (0.056)
Characteristic × Priv Spend	-0.047 (0.045)	-0.027 (0.046)	0.104** (0.048)	0.054 (0.040)	-0.043 (0.036)	-0.019 (0.032)	0.019 (0.024)	0.015 (0.037)
FirmBorderYear FE	Y	Y	Y	Y	Y	Y	Y	Y
FirmCounty FE	Y	Y	Y	Y	Y	Y	Y	Y
FirmRatingYear FE	Y	Y	Y	Y	Y	Y	Y	Y
N. Obs.	33,484	33,158	33,158	33,158	33,158	31,574	33,016	31,852
Adj. R ²	0.937	0.937	0.937	0.938	0.937	0.938	0.937	0.938

Note: This table reports the estimates of the coefficients in specifications that include interactions between advertising and the average characteristics of bronze plans offered by each insurer. We normalized that each plan characteristic by subtracting its mean and standard deviation. All specifications include the number of insurers, the market size, and Firm×Border×Year fixed effects, Firm×County fixed effects, and Firm×Rating Area×Year fixed effects. Standard errors are in parentheses and two-way clustered at the DMA×Year level and the Firm×County level. The stars indicate: *** for p<0.01, ** for p<0.05 and * for p<0.1.

Table 32: Coefficient Estimates: Plan Characteristics (Gold)

	(1) Characteristic = Num of plans	(2) Characteristic = Share of PPO plans	(3) Characteristic = Out-of-country cov.	(4) Characteristic = Premium	(5) Characteristic = Fin. Generosity	(6) Characteristic = Deductible	(7) Characteristic = Out-of-pocket max	(8) Characteristic = Coinsurance
Fed Spend	0.140** (0.056)	0.139** (0.061)	0.141** (0.061)	0.119** (0.057)	0.132** (0.054)	0.108** (0.050)	0.127** (0.060)	0.121** (0.047)
Characteristic × Fed Spend	-0.002 (0.041)	-0.007 (0.060)	-0.001 (0.081)	-0.085 (0.064)	-0.019 (0.066)	0.065 (0.071)	-0.021 (0.060)	0.020 (0.051)
State Spend	-0.080 (0.074)	-0.104 (0.079)	-0.081 (0.073)	-0.076 (0.072)	-0.089 (0.072)	-0.067 (0.085)	-0.075 (0.071)	-0.064 (0.088)
Characteristic × State Spend	-0.052 (0.049)	0.038 (0.067)	-0.028 (0.055)	-0.008 (0.063)	-0.031 (0.051)	0.189* (0.114)	0.068 (0.057)	0.104 (0.103)
Priv Spend	0.132** (0.055)	0.129** (0.062)	0.076 (0.053)	0.139** (0.056)	0.108** (0.053)	0.082 (0.067)	0.119** (0.056)	0.117* (0.070)
Characteristic × Priv Spend	-0.070** (0.025)	-0.044 (0.047)	0.101** (0.048)	0.058 (0.037)	-0.023 (0.023)	-0.012 (0.015)	0.042 (0.034)	0.093* (0.048)
FirmBorderYear FE	Y	Y	Y	Y	Y	Y	Y	Y
FirmCounty FE	Y	Y	Y	Y	Y	Y	Y	Y
FirmRatingYear FE	Y	Y	Y	Y	Y	Y	Y	Y
N. Obs.	33,484	32,724	32,724	32,724	32,724	18,742	32,322	18,818
Adj. R ²	0.937	0.937	0.937	0.938	0.937	0.945	0.937	0.945

Note: This table reports the estimates of the coefficients in specifications that include interactions between advertising and the average characteristics of gold plans offered by each insurer. We normalized that each plan characteristic by subtracting its mean and standard deviation. All specifications include the number of insurers, the market size, and Firm×Border×Year fixed effects, Firm×County fixed effects, and Firm×Rating Area×Year fixed effects. Standard errors are in parentheses and two-way clustered at the DMA×Year level and the Firm×County level. The stars indicate: *** for p<0.01, ** for p<0.05 and * for p<0.1.

Table 33: Correlation between Private Advertising and Plan Characteristics for Bronze Plans

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Number of Plans	0.074*** (0.016)						0.069*** (0.014)
Share of PPO Plans		0.070*** (0.022)					0.073*** (0.019)
Share of Plans with Out-of-Country Coverage			0.046** (0.019)				0.043*** (0.016)
Premium				-0.028 (0.024)			-0.052 (0.032)
Financial Generosity					-0.013 (0.022)		-0.013 (0.017)
Out-of-Pocket Max						-0.001 (0.039)	0.036 (0.034)
County X Year FE	Y	Y	Y	Y	Y	Y	Y
N. Obs.	27,849	27,452	27,452	27,452	27,452	27,260	27,260
Adj. R^2	0.097	0.086	0.066	0.049	0.047	0.040	0.158

Note: Each column reports the estimated coefficient of insurer-level plan characteristics of bronze plans on insurer's advertising. The regressors are normalized by dividing the original variables by their standard deviations. The coefficient estimate measures how a standard-deviation change of a regressor is correlated with advertising. Standard errors are clustered at the insurer level and the county \times year level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.

Table 34: Correlation between Private Advertising and Plan Characteristics for Gold Plans

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Number of Plans	0.087*** (0.014)						0.070*** (0.015)
Share of PPO Plans		0.079*** (0.023)					0.072*** (0.020)
Share of Plans with Out-of-Country Coverage			0.049*** (0.019)				0.032** (0.015)
Premium				0.010 (0.022)			-0.015 (0.021)
Financial Generosity					0.021 (0.023)		-0.001 (0.019)
Out-of-Pocket Max						-0.054*** (0.020)	-0.033* (0.018)
County X Year FE	Y	Y	Y	Y	Y	Y	Y
N. Obs.	27,849	27,078	27,078	27,078	27,078	26,586	26,586
Adj. R^2	0.114	0.094	0.067	0.044	0.048	0.059	0.166

Note: Each column reports the estimated coefficient of insurer-level plan characteristics of gold plans on insurer's advertising. The regressors are normalized by dividing the original variables by their standard deviations. The coefficient estimate measures how a standard-deviation change of a regressor is correlated with advertising. Standard errors are clustered at the insurer level and the county×year level. The stars indicate: *** for $p < 0.01$, ** for $p < 0.05$ and * for $p < 0.1$.



TRENDS IN THE U.S. UNINSURED POPULATION, 2010-2020

The number of uninsured nonelderly Americans fell from 48 million in 2010 to 28 million in 2016, before rising to 30 million in the first half of 2020.

Kenneth Finegold, Ann Conmy, Rose C. Chu, Arielle Bosworth, and Benjamin D. Sommers

KEY POINTS

- 30 million U.S. residents lacked health insurance in the first half of 2020, according to newly released estimates from the National Health Interview Survey (NHIS).
- This number reflects a sharp decline in the number of uninsured Americans since 2010, before implementation of the large coverage expansions under the Affordable Care Act (ACA). The ACA produced particularly large coverage gains for Blacks, Latinos, Asian Americans, and Native Americans, as well for lower-income families.
- However, the uninsured rate has increased since 2016, even prior to the COVID-19 pandemic. From 2017-2019, the uninsured rate rose by 1.7 percentage points, most likely due to new policy changes to coverage options available under the ACA and Medicaid.
- Estimates from the NHIS show no significant change in uninsured rates during the early months of the COVID-19 pandemic. However, the pandemic itself created challenges in conducting the survey that may affect estimates of the uninsured, due to reduced response rates and a temporary shift from an in-person survey to a telephone survey.
- Compared with other Americans, the uninsured are disproportionately likely to be Black or Latino; be young adults; have low incomes; or live in states that have not expanded Medicaid.

BACKGROUND

Health insurance is a critical determinant of access to health care. Efforts to expand coverage are central to improving health equity and responding to the health and economic challenges of the COVID-19 pandemic. Newly released estimates from the Centers for Disease Control and Prevention (CDC) National Health Interview Survey (NHIS) provide federal survey data on health coverage for the early period of the COVID-19 pandemic and show that 30 million U.S. residents lacked health insurance in the first half of 2020.¹

In this Issue Brief, we review the new NHIS findings in the context of health coverage trends from 2010 through 2020 and the policy changes occurring during this period. We also examine disparities in coverage rates by race/ethnicity, income, age, and state Medicaid expansion status. We conclude with an overview of current efforts to expand health coverage including a new Executive Order on coverage and a Special Enrollment Period for the ACA Marketplaces beginning February 15, 2021.

ESTIMATES OF THE UNINSURED OVER TIME

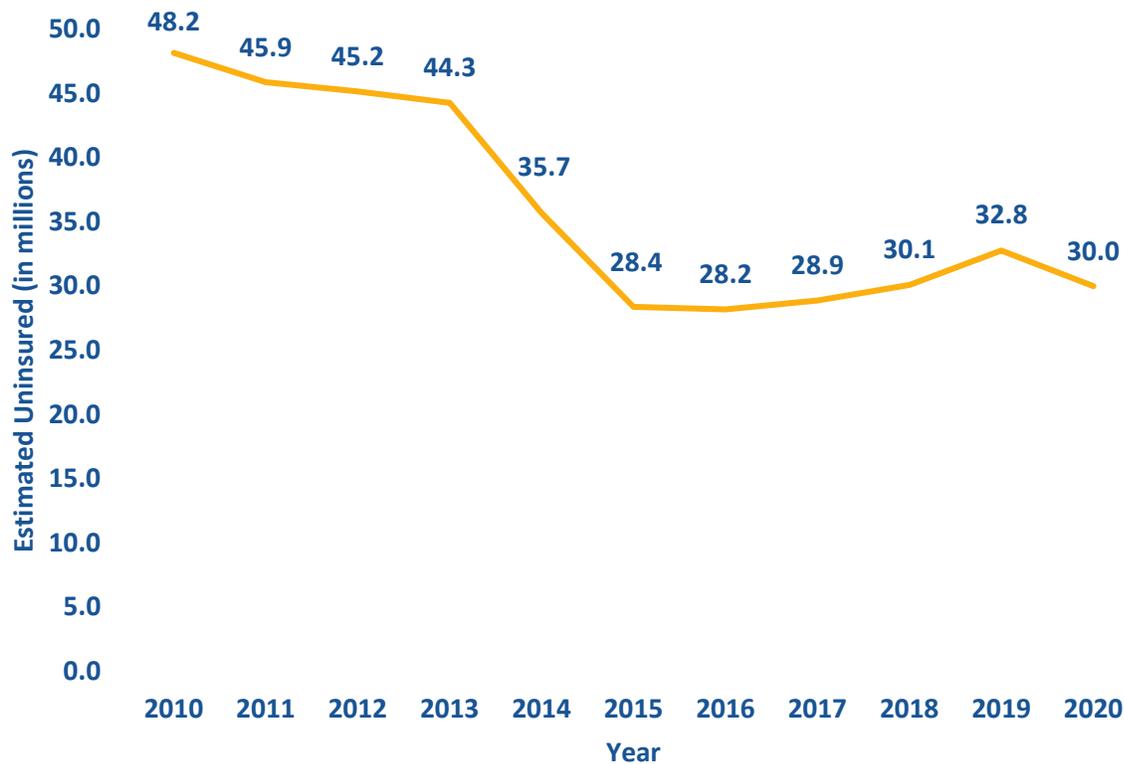
NHIS provides reliable federal survey data that tracks changes in health coverage, including the number of uninsured, since 1972.² These data suggest the considerable impact of the ACA on coverage since its enactment in 2010. The number of nonelderly (under 65) uninsured fell from 48.2 million in 2010 to 44.3 million in 2013 as the dependent coverage provisions of the ACA took effect (allowing young adults to stay on a parent's plan until age 26), and the economy improved after the Great Recession (Figure 1).

In 2014, the uninsured population began to decrease substantially, when Medicaid expansion was implemented in selected states and Marketplace coverage became available with Premium Tax Credits and Cost-Sharing Reductions for those who qualified based on income. The number of nonelderly uninsured fell to 35.7 million in 2014, with additional declines in 2015 and 2016 as more states expanded Medicaid and Marketplace enrollment grew. By 2016, the number of uninsured individuals had fallen by 20.0 million people (more than 40 percent) since 2010, with 28.2 million nonelderly uninsured at that time.

However, from 2017 to 2019, the number of uninsured rose each year, despite the strong economic conditions during this period. By 2019, the last pre-pandemic NHIS estimate was that there were 32.8 million nonelderly people without health insurance, an increase of 4.6 million (or 14 percent) from 2016.

Data for the first two quarters of 2020, shown in Figure 1, suggest that on average 30.0 million nonelderly were uninsured over the course of those six months.³ As noted above, earlier predictions that the loss of employment in the March/April period would trigger a commensurate rise in the uninsured were not evident in the newest NHIS estimates. However, the pandemic itself introduced several methodological challenges to conducting the survey, including a shift from an in-person survey to a telephone survey and a lower response rate, particularly among younger and lower-income respondents.⁴ These changes may have affected the new coverage estimates, as discussed at more length later in this report.

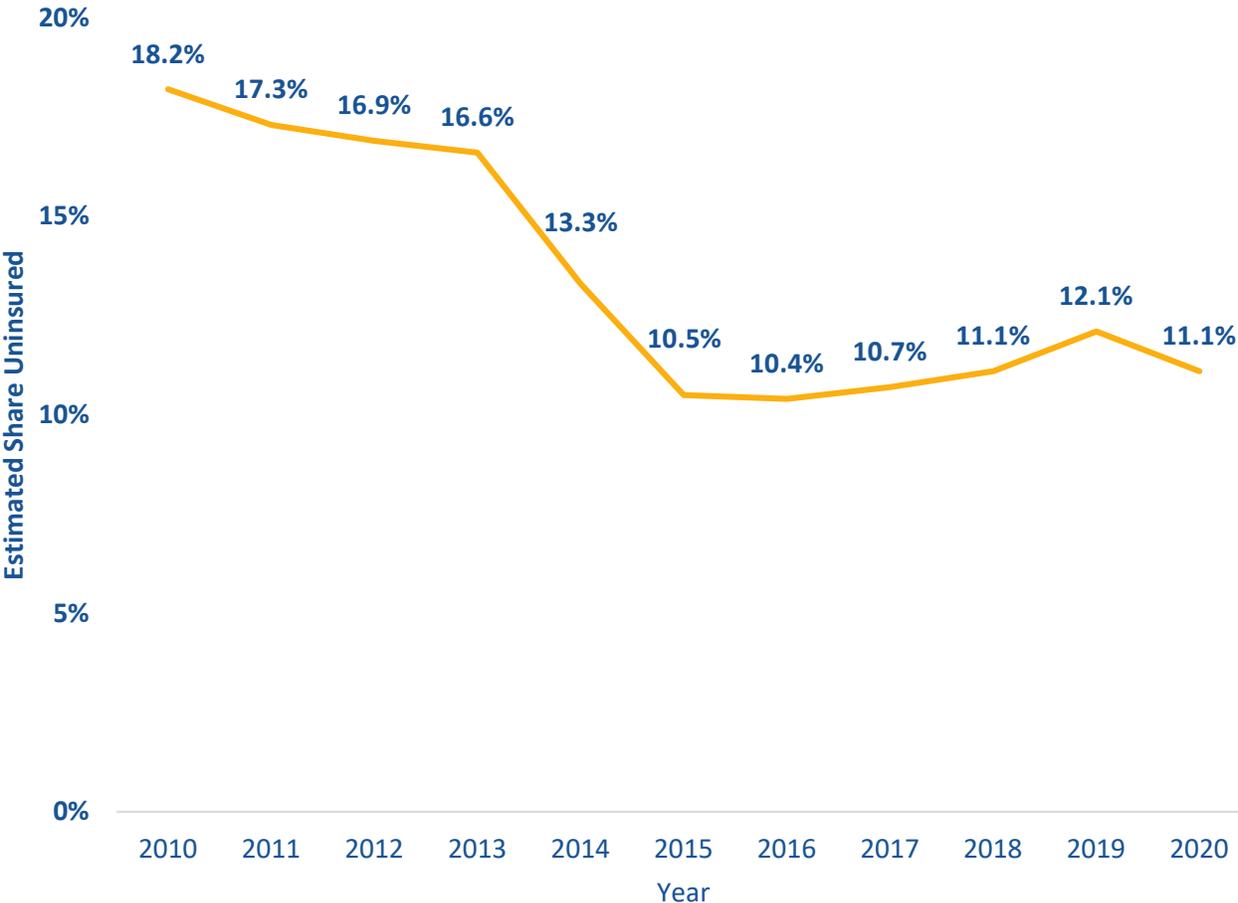
Figure 1. U.S. Nonelderly Uninsured Population, 2010-2020 (in millions)



Source: Early release of estimates from the National Health Interview Survey, 2010-2020. National Center for Health Statistics. Available from <https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm>. 2020 estimates are for January-June only.

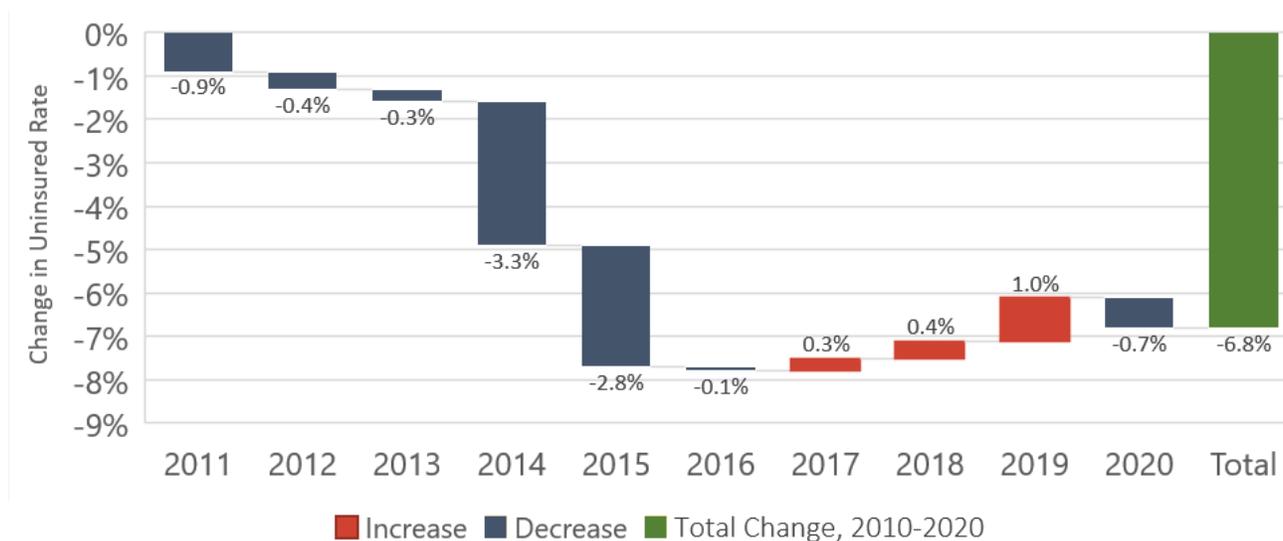
Figure 2 presents annual percentages of the uninsured from 2010-2020. With the implementation of several major provisions of the Affordable Care Act in 2014, the uninsured rate of nonelderly individuals dropped precipitously and continued to decrease until 2017. From 2016 to 2019, the rate of uninsured persons increased by a total of 1.7 percentage points, from 10.4 percent in 2016 to 12.1 percent in 2019. Over the entire observation period, the uninsured rate decreased by 6.8 percentage points, from 18.2 percent in 2010 to 10.8 percent in the second quarter of 2020. Figure 3 shows the annual declines in the uninsured rate from 2010 to 2016, the increases from 2016 to 2019, and the change from 2019 to the first half of 2020. The last column sums those year-by-year changes to show the cumulative change from 2010 to 2020.

Figure 2. Uninsured Share of U.S. Nonelderly, 2010-2020



Source: Early release of estimates from the National Health Interview Survey, 2018-2020. National Center for Health Statistics. Available from <https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm>. 2020 estimates are for January-June only.

Figure 3. Changes in percent of persons under age 65 who were uninsured at the time of interview, 2010–2020

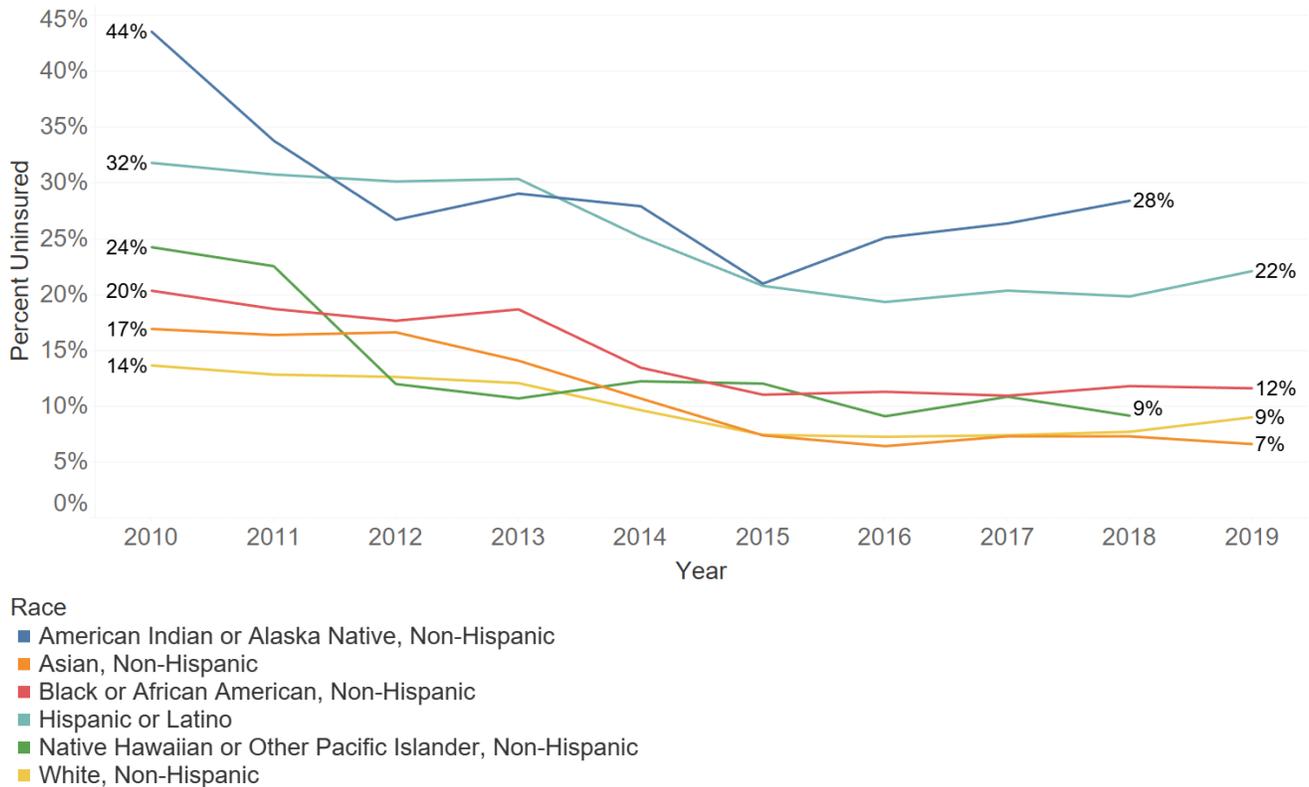


Source: Early release of estimates from the National Health Interview Survey, 2018-2020. National Center for Health Statistics. Available from <https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm>. 2020 estimates are for January-June only.

RACIAL, ETHNIC, AND INCOME-BASED DISPARITIES IN THE UNINSURED RATE

Throughout the past decade, there have been large racial and ethnic disparities in rates of insurance coverage (Figure 4). While these coverage gaps have narrowed since implementation of the ACA, most minority groups remained at persistently higher rates of uninsurance in 2019 than Whites. Individuals who identified as American Indian or Alaskan Native were most likely to be uninsured; in part, this reflects that individuals who only have coverage through the Indian Health Service are classified by NHIS and other federal surveys as being uninsured. Individuals who identified as Hispanic or Latino had the second highest rate of uninsured individuals, with 32 percent in 2010. From 2010 to 2019, the rate of uninsured Hispanic individuals decreased by nearly one third, but at 22 percent in 2019 it is still almost 2.5 times the rate for White individuals (whose uninsured percentage dropped from 14 to 9). Asian Americans’ uninsured rate decreased from 17 percent to 7 percent. Native Hawaiians and Other Pacific Islanders also experienced a large decrease in the uninsured rate.

Figure 4. Percent of individuals under age 65 who were uninsured at time of interview, by race, 2010 – 2019

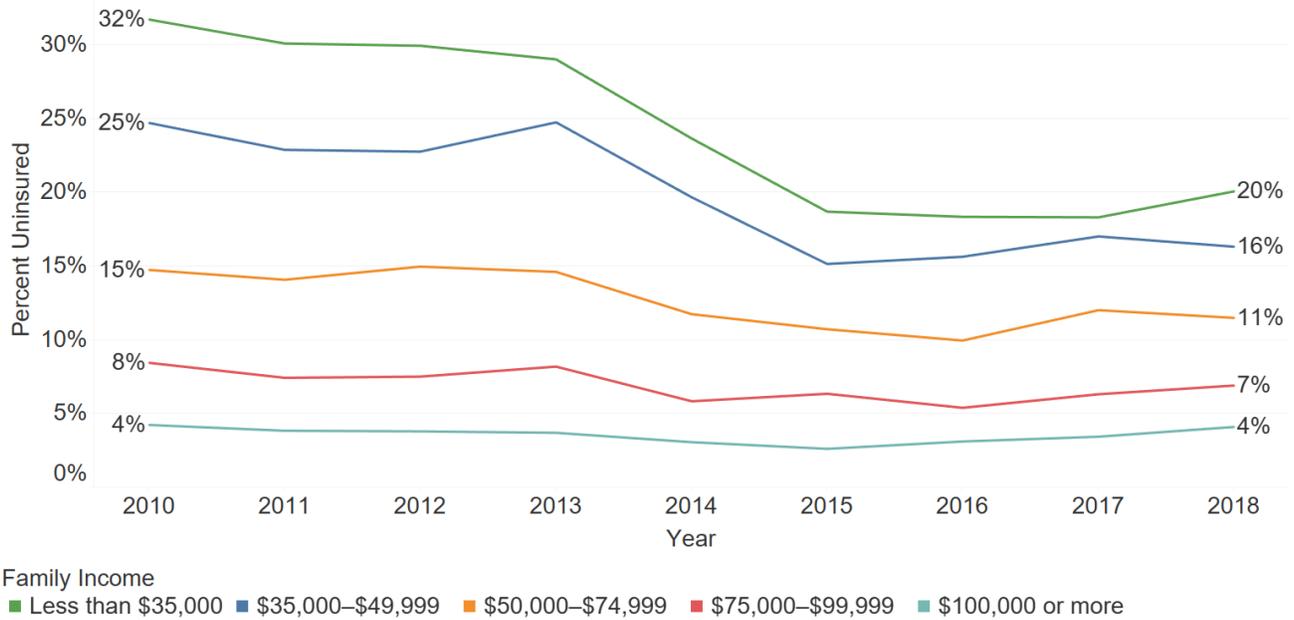


Sources: National Center for Health Statistics, National Health Interview Survey, 2010-2019⁵

Notes: In this analysis, individuals were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children’s Health Insurance Program (CHIP), state-sponsored or other government plan, or military plan. Individuals were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. Data are based on household interviews of a sample of the civilian non-institutionalized population. Native Hawaiian or Other Pacific Islander and American Indian or Alaska Native populations did not have estimates available for 2019 due to sample size considerations.

Figure 5 indicates that the decline in the uninsured rate in 2014 and 2015 disproportionately occurred among lower and lower-middle income populations. In contrast, between 2016 and 2018, the uninsured population grew modestly in most income groups. The relative gap in insurance coverage by income narrowed over the 2010 to 2018 period but coverage rates continue to vary widely by household income.

Figure 5. Percent of persons under age 65 who were uninsured at the time of interview by family income, 2010 – 2018



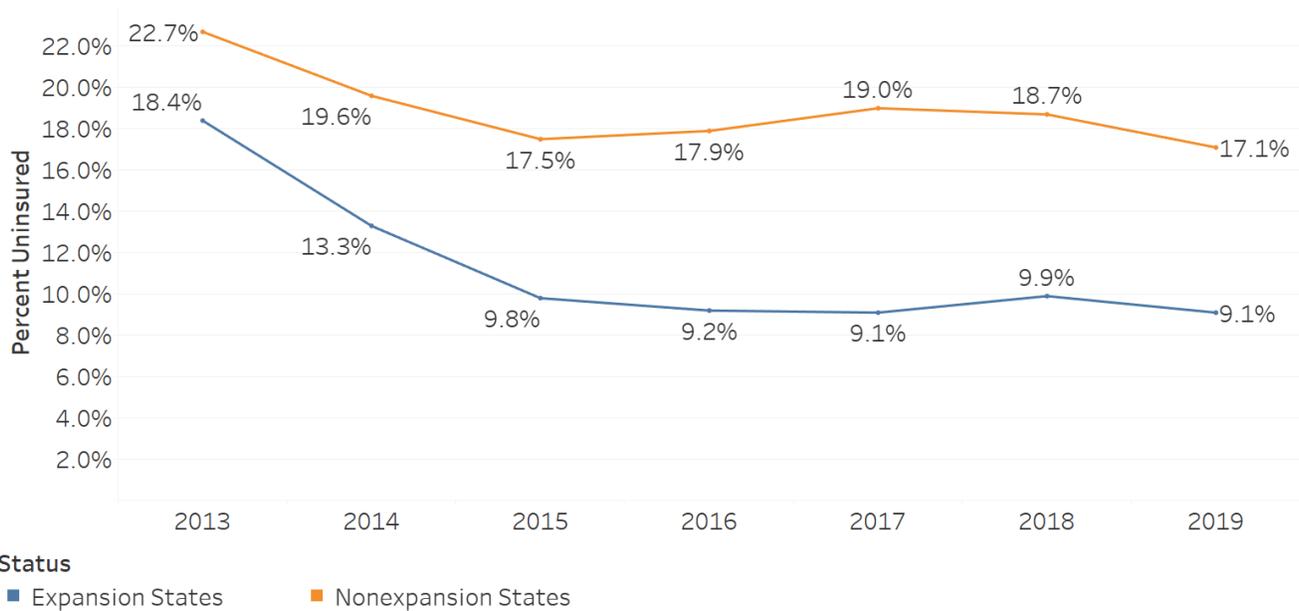
Sources: National Center for Health Statistics, National Health Interview Survey, 2010-2018⁶

Notes: Estimates are based on household interviews of a sample of the civilian noninstitutionalized population. This table is based on responses about all persons in the family. Data came from the Person file and were weighted using the Person weight. Unknowns for the columns were not included in the denominators when calculating percentages.

STATE-BASED DIFFERENCES IN INSURANCE COVERAGE

While the country as a whole experienced a significant reduction in the rate of uninsured individuals in 2014 and 2015, the changes were largest in the states that have expanded Medicaid under the ACA.⁷ The uninsured rate among adults 18-64 in expansion states was cut in half from 18.4 percent in 2013 to 9.2 percent in 2016, and was 9.1 percent in 2019. In non-expansion states, there were modest reductions in the uninsured rate from 2013 to 2016 (from 22.7 percent to 17.9 percent), but the uninsured rate has remained nearly twice as high as that in expansion states in 2019 (17.1 percent vs. 9.1 percent) (Figure 6).

Figure 6. Percentage of adults aged 18–64 who were uninsured at the time of interview, by year and state Medicaid expansion status: United States, 2013–2019



Sources: 2010-2019: Cohen RA, Terlizzi EP, Martinez ME. Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2018. National Center for Health Statistics. May 2019. Available from: <https://www.cdc.gov/nchs/nhis/releases.htm>.

Notes: For 2013 and 2014, there were 26 Medicaid expansion states including District of Columbia. For 2015, there were 29 Medicaid expansion states. For 2016–2018, there were 32 Medicaid expansion states.

The impact of states electing to expand Medicaid is also evident in Table 1, which shows coverage totals by state based on data from the Census Bureau’s 2019 American Community Survey Public Use Microdata Sample (ACS PUMS), currently the most recent year of data available for state-by-state estimates. Texas and Florida, with the second and third largest populations of any state and no Medicaid expansion, account for 5.4 million and 2.9 million of the nonelderly uninsured. The two other largest non-expansion states, Georgia and North Carolina, each have more than one million uninsured individuals. As of 2019, more than one in three of the nation’s nonelderly uninsured population resided in these four states.

Table 1. Type of Health Coverage Among the Nonelderly Population, Number of People, by State (2019)

State	Type of Coverage						Total
	Medicare	Military	Medicaid	Employer	Nongroup	Uninsured	
Alabama	194,481	188,291	732,350	2,172,176	271,491	490,226	4,049,015
Alaska*	12,451	90,551	124,742	303,118	25,065	82,446	638,373
Arizona*	170,365	211,839	1,269,166	3,107,576	373,416	840,445	5,972,807
Arkansas*	121,519	80,464	652,397	1,193,370	160,606	287,170	2,495,526
California*	708,146	775,004	8,455,982	18,056,451	2,602,647	3,078,622	33,676,852
Colorado*	94,291	252,150	809,532	2,901,095	394,271	460,110	4,911,449
Connecticut*	73,415	53,587	633,833	1,793,412	174,762	205,946	2,934,955
Delaware*	24,454	36,747	162,838	450,343	41,616	68,673	784,671
District of Columbia*	16,003	19,445	140,967	362,656	53,957	25,027	618,055
Florida	556,080	674,497	2,770,980	8,140,138	1,977,990	2,860,759	16,980,444
Georgia	279,746	423,510	1,433,637	4,905,289	581,876	1,469,494	9,093,552
Hawaii*	23,976	138,018	197,569	672,624	56,734	58,073	1,146,994
Idaho	42,592	51,933	226,957	834,320	157,256	185,556	1,498,614
Illinois*	269,594	184,333	2,003,514	6,593,396	651,758	924,271	10,626,866
Indiana*	186,345	125,886	1,004,163	3,429,889	304,588	598,268	5,649,139
Iowa*	67,556	59,621	515,991	1,650,908	155,522	151,806	2,601,404
Kansas	68,958	112,647	327,492	1,490,005	163,349	272,630	2,435,081
Kentucky*	187,066	120,832	943,956	1,987,177	175,466	297,357	3,711,854
Louisiana*	158,609	125,306	1,147,881	1,817,069	222,450	436,211	3,907,526
Maine*	53,040	38,972	191,379	588,312	77,681	108,374	1,057,758
Maryland*	142,998	226,763	950,586	3,083,026	323,828	356,975	5,084,176
Massachusetts*	148,275	67,879	1,213,697	3,688,838	393,644	208,673	5,721,006
Michigan*	313,114	128,934	1,781,040	4,882,244	527,149	589,382	8,221,863
Minnesota*	94,523	79,208	835,183	3,146,106	289,735	274,202	4,718,957
Mississippi	114,424	94,535	552,600	1,180,083	142,491	404,288	2,488,421
Missouri	190,969	165,212	710,237	3,022,263	354,516	634,023	5,077,220
Montana*	26,292	38,967	189,262	432,076	84,616	88,745	859,958
Nebraska	35,259	58,858	190,771	1,047,729	130,353	157,526	1,620,496
Nevada*	59,327	102,882	460,604	1,437,122	164,981	357,790	2,582,706
New Hampshire*	33,821	27,192	151,617	731,203	76,555	87,559	1,107,947
New Jersey*	183,434	92,113	1,228,466	4,718,618	482,308	700,005	7,404,944
New Mexico*	63,819	77,584	575,250	710,237	82,586	209,125	1,718,601
New York*	452,244	196,180	4,093,603	9,249,030	1,146,726	1,019,979	16,157,762
North Carolina	290,485	481,858	1,507,633	4,571,836	697,123	1,188,786	8,737,721
North Dakota*	12,672	35,728	74,104	398,003	66,529	54,817	641,853
Ohio*	301,496	195,363	2,006,996	5,883,001	465,425	793,092	9,645,373
Oklahoma	130,799	159,900	551,188	1,669,199	216,232	599,504	3,326,822
Oregon*	95,825	87,388	737,077	1,989,203	237,389	303,249	3,450,131
Pennsylvania*	360,370	198,827	2,104,571	6,313,695	668,272	765,682	10,411,417
Rhode Island*	33,583	19,950	167,890	535,625	71,309	43,576	871,933
South Carolina	155,448	230,018	771,277	2,185,983	306,718	562,070	4,211,514
South Dakota	20,863	29,573	91,143	430,172	72,879	85,410	730,040
Tennessee	195,567	224,531	1,086,653	3,085,238	384,698	716,011	5,692,698
Texas	575,264	860,495	3,767,819	13,044,068	1,607,854	5,400,579	25,256,079
Utah	40,983	67,209	245,430	1,880,024	295,986	311,514	2,841,146
Vermont*	18,936	12,761	119,203	288,042	33,128	26,786	498,856
Virginia*	194,348	704,649	948,558	4,204,695	439,622	684,085	7,175,957
Washington*	149,908	318,210	1,282,374	3,786,689	374,748	494,757	6,406,686
West Virginia*	80,228	46,349	386,923	739,895	47,440	125,043	1,425,878
Wisconsin	125,344	96,061	751,635	3,181,181	306,026	344,232	4,804,479
Wyoming	12,626	19,123	53,349	282,011	40,750	71,306	479,165
Total	7,961,931	8,907,933	53,332,065	154,246,459	19,154,117	30,560,235	274,162,740

Notes: * Medicaid expansion state in 2019. Among states shown as non-expansion in 2019, Idaho, Nebraska, and Utah expanded in 2020; Missouri and Oklahoma votes approved Medicaid expansion and implementation is planned in both states for July 2021. Individuals reporting more than one type of coverage are assigned using hierarchy of Medicare, Military (Tricare and VA), Medicaid/CHIP, Employer-Sponsored Insurance, and Nongroup (Marketplace and off-Marketplace). Individuals reporting no coverage or coverage from Indian Health Service only are assigned as Uninsured.

Source: ASPE analysis of 2019 American Community Survey Public Use Microdata Sample (ACS PUMS).

Table 2 shows each state’s distribution of health insurance coverage by type of coverage. Texas, at 21.4 percent, has the highest percentage of nonelderly who are uninsured, and the next five states with the highest share of uninsured (Oklahoma, Florida, Mississippi, Georgia, and Wyoming) are also non-expansion states. The share of the under-65 population with Medicare is small, about 3 percent, because it is only available to those with disabilities or End-Stage Renal Disease. Military coverage for families of active service members and veterans is high in Alaska, Hawaii, and Virginia due to the locations of defense facilities. The highest Medicaid share is in New Mexico, which expanded Medicaid.

Table 2. Type of Health Coverage Among the Nonelderly Population, By State (2019)

State	Type of Coverage						Total
	Medicare	Military	Medicaid	Employer	Nongroup	Uninsured	
Alabama	4.8%	4.7%	18.1%	53.6%	6.7%	12.1%	100.0%
Alaska*	2.0%	14.2%	19.5%	47.5%	3.9%	12.9%	100.0%
Arizona*	2.9%	3.5%	21.2%	52.0%	6.3%	14.1%	100.0%
Arkansas*	4.9%	3.2%	26.1%	47.8%	6.4%	11.5%	100.0%
California*	2.1%	2.3%	25.1%	53.6%	7.7%	9.1%	100.0%
Colorado*	1.9%	5.1%	16.5%	59.1%	8.0%	9.4%	100.0%
Connecticut*	2.5%	1.8%	21.6%	61.1%	6.0%	7.0%	100.0%
Delaware*	3.1%	4.7%	20.8%	57.4%	5.3%	8.8%	100.0%
District of Columbia*	2.6%	3.1%	22.8%	58.7%	8.7%	4.0%	100.0%
Florida	3.3%	4.0%	16.3%	47.9%	11.6%	16.8%	100.0%
Georgia	3.1%	4.7%	15.8%	53.9%	6.4%	16.2%	100.0%
Hawaii*	2.1%	12.0%	17.2%	58.6%	4.9%	5.1%	100.0%
Idaho	2.8%	3.5%	15.1%	55.7%	10.5%	12.4%	100.0%
Illinois*	2.5%	1.7%	18.9%	62.0%	6.1%	8.7%	100.0%
Indiana*	3.3%	2.2%	17.8%	60.7%	5.4%	10.6%	100.0%
Iowa*	2.6%	2.3%	19.8%	63.5%	6.0%	5.8%	100.0%
Kansas	2.8%	4.6%	13.4%	61.2%	6.7%	11.2%	100.0%
Kentucky*	5.0%	3.3%	25.4%	53.5%	4.7%	8.0%	100.0%
Louisiana*	4.1%	3.2%	29.4%	46.5%	5.7%	11.2%	100.0%
Maine*	5.0%	3.7%	18.1%	55.6%	7.3%	10.2%	100.0%
Maryland*	2.8%	4.5%	18.7%	60.6%	6.4%	7.0%	100.0%
Massachusetts*	2.6%	1.2%	21.2%	64.5%	6.9%	3.6%	100.0%
Michigan*	3.8%	1.6%	21.7%	59.4%	6.4%	7.2%	100.0%
Minnesota*	2.0%	1.7%	17.7%	66.7%	6.1%	5.8%	100.0%
Mississippi	4.6%	3.8%	22.2%	47.4%	5.7%	16.2%	100.0%
Missouri	3.8%	3.3%	14.0%	59.5%	7.0%	12.5%	100.0%
Montana*	3.1%	4.5%	22.0%	50.2%	9.8%	10.3%	100.0%
Nebraska	2.2%	3.6%	11.8%	64.7%	8.0%	9.7%	100.0%
Nevada*	2.3%	4.0%	17.8%	55.6%	6.4%	13.9%	100.0%
New Hampshire*	3.1%	2.5%	13.7%	66.0%	6.9%	7.9%	100.0%
New Jersey*	2.5%	1.2%	16.6%	63.7%	6.5%	9.5%	100.0%
New Mexico*	3.7%	4.5%	33.5%	41.3%	4.8%	12.2%	100.0%
New York*	2.8%	1.2%	25.3%	57.2%	7.1%	6.3%	100.0%
North Carolina	3.3%	5.5%	17.3%	52.3%	8.0%	13.6%	100.0%
North Dakota*	2.0%	5.6%	11.5%	62.0%	10.4%	8.5%	100.0%
Ohio*	3.1%	2.0%	20.8%	61.0%	4.8%	8.2%	100.0%
Oklahoma	3.9%	4.8%	16.6%	50.2%	6.5%	18.0%	100.0%
Oregon*	2.8%	2.5%	21.4%	57.7%	6.9%	8.8%	100.0%

State	Type of Coverage						Total
	Medicare	Military	Medicaid	Employer	Nongroup	Uninsured	
Pennsylvania*	3.5%	1.9%	20.2%	60.6%	6.4%	7.4%	100.0%
Rhode Island*	3.9%	2.3%	19.3%	61.4%	8.2%	5.0%	100.0%
South Carolina	3.7%	5.5%	18.3%	51.9%	7.3%	13.3%	100.0%
South Dakota	2.9%	4.1%	12.5%	58.9%	10.0%	11.7%	100.0%
Tennessee	3.4%	3.9%	19.1%	54.2%	6.8%	12.6%	100.0%
Texas	2.3%	3.4%	14.9%	51.6%	6.4%	21.4%	100.0%
Utah	1.4%	2.4%	8.6%	66.2%	10.4%	11.0%	100.0%
Vermont*	3.8%	2.6%	23.9%	57.7%	6.6%	5.4%	100.0%
Virginia*	2.7%	9.8%	13.2%	58.6%	6.1%	9.5%	100.0%
Washington*	2.3%	5.0%	20.0%	59.1%	5.8%	7.7%	100.0%
West Virginia*	5.6%	3.3%	27.1%	51.9%	3.3%	8.8%	100.0%
Wisconsin	2.6%	2.0%	15.6%	66.2%	6.4%	7.2%	100.0%
Wyoming	2.6%	4.0%	11.1%	58.9%	8.5%	14.9%	100.0%
Total	2.9%	3.2%	19.5%	56.3%	7.0%	11.1%	100.0%

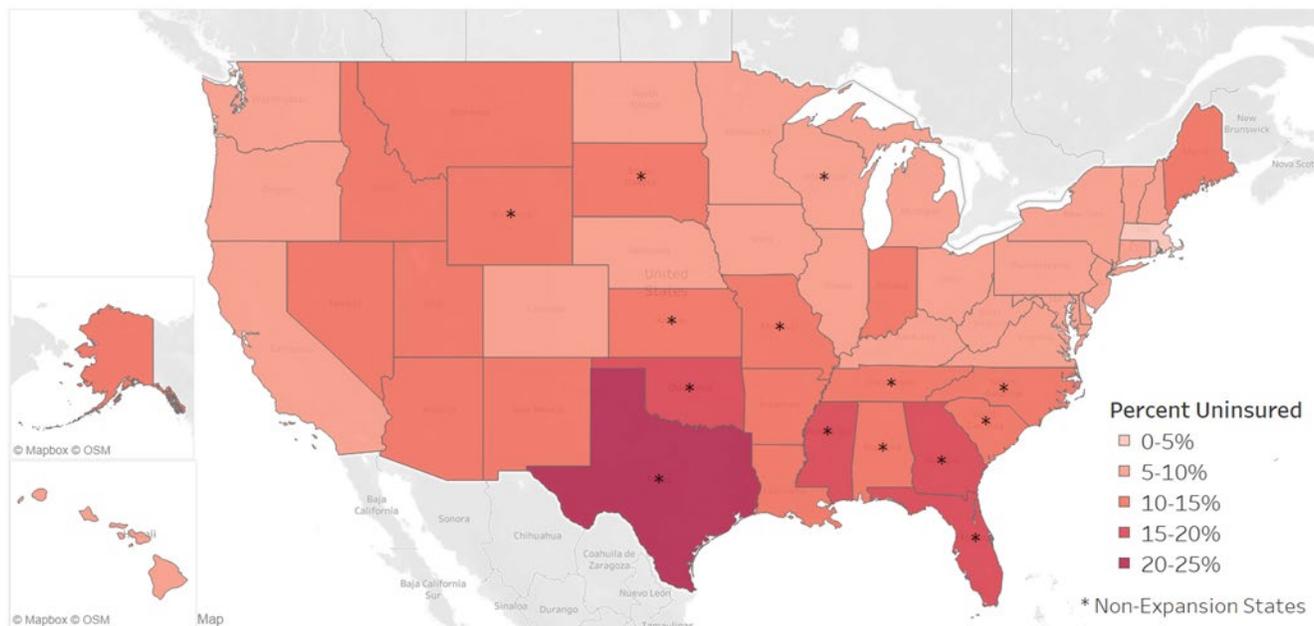
Notes: * Medicaid expansion state in 2019. Among states shown as non-expansion in 2019, Idaho, Nebraska, and Utah expanded in 2020; Missouri and Oklahoma votes approved Medicaid expansion and implementation is planned in both states for July 2021. Individuals reporting more than one type of coverage are assigned using hierarchy of Medicare, Military (Tricare and VA), Medicaid/CHIP, Employer-Sponsored Insurance, and Nongroup (Marketplace and off-Marketplace). Individuals reporting no coverage or coverage from Indian Health Service only are assigned as Uninsured.

Source: ASPE analysis of 2019 American Community Survey Public Use Microdata Sample (ACS PUMS).

More than half the nonelderly have employer coverage nationally, as well in most states, with lower rates in Alaska, Arkansas, Florida, Louisiana, Mississippi, and New Mexico. The low rate of employer coverage in Florida contributes to its high rate of nongroup coverage and – combined with the lack of Medicaid expansion – its high percentage of uninsured.⁸

Figure 7 shows the percent of persons under age 65 who were uninsured in 2019 by state. As discussed previously, states that have not expanded Medicaid coverage had significantly higher uninsured rates. Oklahoma and Texas had the highest uninsured rate.

Figure 7. Nonelderly Health Insurance Coverage by State, 2019



Source: ASPE analysis of 2019 American Community Survey Public Use Microdata Sample (ACS PUMS).

DISCUSSION

The Affordable Care Act's Effects on the Uninsured Rate

The ACA's coverage provisions resulted in 20 million adults gaining health insurance coverage from 2010 through early 2016. These large health insurance gains occurred broadly across population groups.⁹ For instance, ASPE has previously estimated that:

- About 3 million Black nonelderly adults gained coverage.
- About 4 million Hispanic nonelderly adults gained.
- About 8.9 million White non-Hispanic nonelderly adults gained coverage.

Groups that had high uninsured rates prior to 2014—including low income adults and minority populations—had the largest coverage gains through 2016, especially in states that expanded Medicaid.¹⁰ Almost all the decline in the uninsured rate occurred among nonelderly adults.

Post-2016 Increases in the Uninsured Rate

Starting in 2017, the earlier reductions in the uninsured population were followed by small increases each year. The increase in the uninsured rate during this period can potentially be explained by several factors.

Overall, 1.9 million fewer individuals were enrolled in Medicaid and CHIP in July 2019, compared to December 2017.¹¹ The number of children declined by about 1.1 million and the number of adults declined by about 750,000. About 70 percent of states (36 states) experienced decreases in Medicaid and CHIP enrollment between December 2017 and July 2019. Some of this change was associated with improvement in the economy (with some switching from Medicaid to employer coverage, or from Medicaid to CHIP; in fact, CHIP enrollment rose during this period, but by less than the decline in Medicaid enrollment). But another factor

contributing to the increase in the uninsured population was state Medicaid policies and processes that made it more difficult to enroll, renew, and maintain coverage.¹²

Other potential factors causing the increase in the uninsured population from 2017 to 2019 include reduced funding for outreach and enrollment in the ACA Marketplaces, and changes in policies and proposals regarding immigration, deportation, and enforcement of the public charge rule that have made some families reluctant to enroll in subsidized health insurance.¹³

COVID-19 Effects on the Uninsured

During the early months of the COVID-19 pandemic and the resulting economic recession, many research groups released a wide range of initial estimates of the potential shifts in health insurance in response to the COVID-19 pandemic.¹⁴ Medicaid enrollment and spending typically increase during economic downturns. About 56 percent of the population has health insurance from an employer, and the increase in unemployment during the pandemic may indicate loss of health insurance coverage as well.

The NHIS 2020 health insurance release is the first comprehensive report of health insurance coverage during the first domestic peak of COVID-19 cases (the second quarter of 2020). However, other groups have released survey results estimating how coverage changed during 2020.¹⁵ The 2020 Commonwealth Fund's Biennial Health Insurance Survey was conducted during the first and second quarters of the year and found 12.5 percent of adults were uninsured.¹⁶ Compared to results of the 2018 Commonwealth Fund survey, there were no statistically significant changes in reported health insurance coverage in the first half of 2020.

In response to the COVID-19 pandemic and corresponding economic recession, the U.S. Census Bureau developed a new experimental household survey to collect information of how people's lives have changed since the pandemic, including health insurance coverage. The COVID-19 Census Household PULSE Survey data on health insurance showed a 22% relative *decrease* in the number of participants reporting being uninsured at the time of interview from April 23 to May 5, 2020, to January 6 to 18, 2021, suggesting the number of uninsured from the recent NHIS release may decline in the coming quarters.¹⁷ However, the small sample sizes of those weekly estimates may limit their usefulness, and the NHIS data represent a more robust and validated data source.

A driving factor for fear of increases in the uninsured was the high unemployment rate during the beginning months of the COVID-19 pandemic. Since spring 2020, the unemployment rate has improved, while remaining above the pre-pandemic baseline.¹⁸ The Congressional Budget Office estimates the number of uninsured individuals increased from 30.5 million in 2019 to 31 or 32 million by the end of 2020.¹⁹

Since the release of initial projections of changes in health insurance due to the COVID-19 pandemic, available data including the new NHIS estimates suggest that the shift in coverage during 2020 was smaller than originally expected. Potential factors that may explain the smaller increase in the uninsured rate include:

- Pre-pandemic research suggests that the ACA plays a critical role in helping people maintain coverage after job losses, which may have mitigated coverage changes due to unemployment;²⁰
- Many of those individuals who lost some form of employment had low incomes or were in jobs without health benefits, and either enrolled in Medicaid or were already uninsured before their job losses;²¹
- Economic stimuli from the Families First Coronavirus Response Act (FFCRA) and CARES Acts leading to partial economic recovery;
- Employers opting to temporarily layoff or furlough their employees and continue their benefits rather than implement permanent layoffs with loss of benefits;²²

- Individuals who lost employer coverage may have been able to enroll in coverage through a Federally-Facilitated (FFM) special enrollment period (SEP) or State-based Marketplace (SBM) SEPs, and all but one SBM had COVID-19 SEPs starting in March 2020 for the uninsured;²³
- Those enrolled in Medicaid during the COVID-19 public health emergency (PHE) cannot be disenrolled even if their eligibility changes, as part of the maintenance-of-effort requirements states must meet to receive increased Medicaid funding under section 6008 of the FFCRA. As a result of this policy, as well as the pandemic effects, combined Medicaid and CHIP enrollment grew by 9.5 percent between February and September 2020 (from 70.6 million to 77.3 million).²⁴

COVID-19 Effects on Surveys

The COVID-19 pandemic makes in-person data collection more challenging.²⁵ Beginning in March 2020, the NHIS temporarily converted to a telephone-only survey, resulting in a varied response rate.²⁶ Between the first and second quarter of 2020, the response rate dropped from 60.0 percent to 42.7 percent. While the telephone-first strategy continued throughout 2020, in July some in-person data collection resumed in certain areas and fully resumed in September. Even so, the NHIS response rate remained below pre-pandemic baseline, at approximately 54 percent in the fourth quarter of 2020. In turn, the sample composition overrepresented older adults, those with higher incomes, and those with more education, all groups that have higher coverage rates than the general population. Populations at greater risk for being uninsured may have been more difficult to contact during the pandemic, which may have led to an underestimate of the uninsured rate during this period. In addition, no single survey source on the uninsured rate is definitive, and estimates from different sources typically vary to some extent.²⁷ The challenges associated with survey data collection during the COVID-19 pandemic are likely to affect other surveys in addition to the NHIS, adding uncertainty and potentially even greater variation in coverage estimates across surveys in 2020.²⁸

POLICY APPROACHES FOR INCREASING COVERAGE

The President signed an Executive Order on Strengthening Medicaid and the Affordable Care Act on January 28, 2021.²⁹ HHS is implementing a Special Enrollment Period (SEP) according to the Executive Order. The SEP for Federally facilitated Marketplaces will be available from February 15 to May 15, 2021, for new enrollees and current enrollees with no requirements for SEP applicants to have previously had coverage. At least fourteen of the fifteen State-based Marketplaces (SBMs) have followed the FFM and are implementing SEPs with the same or similar time period.³⁰

All but one of the 13 SBMs operating in 2020 also had 2020 COVID SEPs allowing those without insurance coverage to enroll after the 2020 Open Enrollment Period (OEP). Comparing mid-year enrollments in 2020 vs. 2019 (which include both standard SEP and COVID-related SEP enrollment), six SBMs had a larger percentage increase than the 30 percent increase in the FFM, showing the possibility of the new pandemic SEPs to boost health coverage.³¹

An Urban Institute survey of uninsured adults in September 2020 showed that 46 percent knew only a little or nothing at all about the ACA Marketplaces and 65 percent knew only a little or nothing about the Marketplace subsidies.³² Many people need assistance to enroll in coverage. Despite the availability of Marketplace Call Centers in each state and a listing of in-person assistance on HealthCare.gov, half of consumers looking for coverage during the 2020 open enrollment had difficulties enrolling and almost 5 million consumers couldn't get in-person help.³³ The most common reason given in a 2019 NHIS survey for being uninsured was that the coverage was not affordable, with 73.7 percent answering with that reason.³⁴ About a quarter (25.3 percent) did not think they were eligible for coverage, 21.3 percent said they did not need or want health insurance, and 18.4 percent thought signing up was too difficult or confusing.

Given these findings, policies around marketing, outreach, and enrollment assistance can play an important role in expanding coverage. Covered California marketing and outreach in 2016 and 2017 was estimated to have lowered premiums by 6-8 percent with more than 3:1 return on investment by enrolling a healthier risk pool.³⁵ More funding for FFM marketing, outreach, and assisters could help educate uninsured adults and increase coverage. Funding for FFM navigators and enrollment assisters was about \$20 million in FY 2019 and FY 2020, roughly one-fifth of what it was in FY 2013 (\$107 million) and FY 2014 (\$100 million).³⁶ Similarly, funding for consumer education and outreach shrank from \$77 million in FY 2013 and \$101 million in 2014 to \$11 million in each of the years FY 2018-FY 2020.³⁷

Overall, the number of nonelderly uninsured is higher now than it was in 2016, and the COVID-19 pandemic has created new threats to coverage. New policy approaches may help reduce the number of uninsured people in the U.S., particularly for communities at the highest risk for lacking insurance – racial and ethnic minorities, young adults, and populations with low incomes.

NOTES

¹ Cohen RA and Terlizzi EP. Health insurance coverage: Early release of quarterly estimates from the National Health Interview Survey, April 2019–June 2020. National Center for Health Statistics. February 2021. Available from: <https://www.cdc.gov/nchs/nhis/releases.htm>.

² Cohen RA, Makuc DM, Bernstein AB, Bilheimer LT, Powell-Griner E. Health insurance coverage trends, 1959–2007: Estimates from the National Health Interview Survey. National health statistics reports; no. 17. Hyattsville, MD: National Center for Health Statistics. 2009. <https://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf>.

³ Cohen RA, Terlizzi EP, Cha AE, Martinez ME. Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–June 2020. National Center for Health Statistics. February 2021. DOI: <https://dx.doi.org/10.15620/cdc:100469>.

⁴ Dahlhamer JM, Bramlett MD, Maitland A, Blumberg SJ. Preliminary evaluation of nonresponse bias due to the COVID-19 pandemic on National Health Interview Survey estimates, April–June 2020. Hyattsville, MD: National Center for Health Statistics. February 2021. Available from: <https://www.cdc.gov/nchs/data/nhis/earlyrelease/nonresponse202102-508>.

⁵ 2010: Adams PF, Martinez ME, Vickerie JL, Kirzinger WK. Summary health statistics for the U.S. population: National Health Interview Survey, 2010. National Center for Health Statistics. Vital Health Stat 10(251). 2011.

2011: Adams PF, Kirzinger WK, Martinez ME. Summary health statistics for the U.S. population: National Health Interview Survey, 2011. National Center for Health Statistics. Vital Health Stat 10(255). 2012.

2012: Adams PF, Kirzinger WK, Martinez ME. Summary health statistics for the U.S. population: National Health Interview Survey, 2012. National Center for Health Statistics. Vital Health Stat 10(259). 2013.

2013: Adams PF, Martinez ME, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2013 National Health Interview Survey. 2015. Available from: <http://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

2014: Adams PF, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2014 National Health Interview Survey. 2015. Available from: <http://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

2015: Lucas JW, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2015 National Health Interview Survey. National Center for Health Statistics. 2017. Available from: <http://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

2016: Lucas JW, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2016 National Health Interview Survey. National Center for Health Statistics. 2018. Available from: <https://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

2017: Lucas JW, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2017 National Health Interview Survey. National Center for Health Statistics. 2019. Available from: <https://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

2018: Lucas JW, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2018 National Health Interview Survey. National Center for Health Statistics. 2019. Available from: <https://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

2019: Cohen RA, Cha AE, Martinez ME, Terlizzi EP. Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2019. National Center for Health Statistics. September 2020. Available from: <https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm>.

⁶ 2010: Adams PF, Martinez ME, Vickerie JL, Kirzinger WK. Summary health statistics for the U.S. population: National Health Interview Survey, 2010. National Center for Health Statistics. Vital Health Stat 10(251). 2011.

2011: Adams PF, Kirzinger WK, Martinez ME. Summary health statistics for the U.S. population: National Health Interview Survey, 2011. National Center for Health Statistics. Vital Health Stat 10(255). 2012.

2012: Adams PF, Kirzinger WK, Martinez ME. Summary health statistics for the U.S. population: National Health Interview Survey, 2012. National Center for Health Statistics. Vital Health Stat 10(259). 2013.

2013: Adams PF, Martinez ME, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2013 National Health Interview Survey. 2015. Available from: <http://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

2014: Adams PF, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2014 National Health Interview Survey. 2015. Available from: <http://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

2015: Lucas JW, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2015 National Health Interview Survey. National Center for Health Statistics. 2017. Available from: <http://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

2016: Lucas JW, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2016 National Health Interview Survey. National Center for Health Statistics. 2018. Available from: <https://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

2017: Lucas JW, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2017 National Health Interview Survey. National Center for Health Statistics. 2019. Available from: <https://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

2018: Lucas JW, Benson V. Tables of Summary Health Statistics for the U.S. Population: 2018 National Health Interview Survey. National Center for Health Statistics. 2019. Available from: <https://www.cdc.gov/nchs/nhis/SHS/tables.htm>.

⁷ This count includes the District of Columbia as a state and excludes Missouri and Oklahoma, which have approved but not yet implemented Medicaid expansion under the ACA. The other non-expansion states are Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming. See Kaiser Family Foundation, State Health Facts, Status of State Action on the Medicaid Expansion Decision, available at <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D> (downloaded February 4, 2021).

⁸ Estimates of nongroup coverage are higher in the American Community Survey than in other data sources. Turner, J., and M. Boudreaux. "Health Insurance Coverage in the American Community Survey: A Comparison to Two Other Federal Surveys." National Academies Press. 2010.

⁹ Uberoi, N et al. Health Insurance Coverage and the Affordable Care Act, 2010-2016. HHS ASPE Brief, March 3, 2016. Accessed at: <https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf>.

¹⁰ Garfield, R. et al. The Uninsured and the ACA: A Primer – Key Facts about Health Insurance and the uninsured amidst Changes to the Affordable Care Act. Kaiser Family Foundation, January 25, 2019. Accessed at: <https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/>.

¹¹ Analysis of Recent Declines in Medicaid and CHIP Enrollment. Kaiser Family Foundation, November 25, 2019. Accessed at: <https://www.kff.org/medicaid/fact-sheet/analysis-of-recent-declines-in-medicaid-and-chip-enrollment/>.

¹² Broadus, M. (2019). Research Note: Medicaid Enrollment Decline Among Adults and Children Too Large to Be Explained by Falling Unemployment. Center on Budget and Policy Priorities.

¹³ Pollitz et al. Limited Navigator Funding for Federal Marketplace States. Kaiser Family Foundation, November 2019. Accessed at: <https://www.kff.org/private-insurance/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/>; Tolbert, J. et al. Impact of Shifting Immigration Policy on Medicaid Enrollment and Utilization of Care among Health Center Patients. Kaiser Family Foundation, October 2019. Accessed at: <https://www.kff.org/medicaid/issue-brief/impact-of-shifting-immigration-policy-on-medicaid-enrollment-and-utilization-of-care-among-health-center-patients/>.

¹⁴ Health Management Associates. COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, May 2020. Accessed at: <https://www.healthmanagement.com/wp-content/uploads/HMA-Updated-Estimates-of-COVID-Impact-on-Health-Insurance-Coverage-May-2020.pdf>; Dorn, S. The COVID-19 Pandemic and Resulting Economic Crash Have Caused the Greatest Health Insurance Losses in American History, July 17, 2020. Families USA Accessed at: https://familiesusa.org/wp-content/uploads/2020/07/COV-254_Coverage-Loss_Report_7-17-20.pdf;

Garfield, R., et al. Eligibility for ACA Health Coverage Following Job Loss, May 13, 2020. The Kaiser Family Foundation. Accessed at: <https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/>;

Garrett, B and Gangopadhyaya, A. How the COVID-19 Recession Could Affect Health Insurance Coverage, May 4, 2020. The Urban Institute. Accessed at: <https://www.urban.org/research/publication/how-covid-19-recession-could-affect-health-insurance-coverage>; Banthin J., Simpson, M., Buettgens, M., Blumberg, L., and Wang, R. Changes in health insurance coverage due to the COVID-19 recession: Preliminary estimates using microsimulation. Urban Institute. July 13, 2020. Accessed at: <https://www.urban.org/research/publication/changes-health-insurance-coverage-due-covid-19-recession>.

¹⁵ Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty. Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018. February 2019. The Commonwealth Fund. Accessed at: https://www.commonwealthfund.org/sites/default/files/2019-02/PDF_Collins_2018_biennial_topline_exhibits.pdf.

¹⁶ Collins, S., Gunja, M., and Aboulafia, G. U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability. August 19, 2020. Accessed at: <https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial>.

¹⁷ Estimates from the Household Pulse Survey are not directly comparable to estimates from NHIS or ACS due to differences in methodology. For example, “don’t know” or missing survey responses are imputed in the NHIS and ACS data, but not in the Pulse data, and the Household Pulse Survey estimates do not include children. U.S. Census Bureau. Household Pulse Survey Data Tables. January 23, 2021. Accessed at: <https://www.census.gov/programs-surveys/household-pulse-survey/data.html>.

Centers for Diseases Control and Prevention, National Center for Health Statistics. Health Insurance Coverage, Household Pulse Survey. January 27, 2021. Accessed at: <https://www.cdc.gov/nchs/covid19/pulse/health-insurance-coverage.htm>

- ¹⁸ U.S. Bureau of Labor Statistics. Employment Situation News Release, January 2021. Accessed at: https://www.bls.gov/news.release/archives/empsit_02052021.htm.
- ¹⁹ Congressional Budget Office. Federal Subsidies for Health Coverage for People Under 65: 2020 to 2030. September 29, 2020. Accessed at: <https://www.cbo.gov/publication/56571>.
- ²⁰ Agarwal, S.D., and Sommers, B.D., Insurance Coverage after Job Loss — The Importance of the ACA during the Covid-Associated Recession, *New England Journal of Medicine* 383:1603-1606, October 22, 2020 (<https://www.nejm.org/doi/full/10.1056/NEJMp2023312>).
- ²¹ Parker, K., Minkin, R., and Bennett, J. Economic Fallout From COVID-19 Continues To Hit Lower-Income Americans the Hardest, September 24, 2020. Pew Research Center. Accessed at <https://www.pewsocialtrends.org/2020/09/24/economic-fallout-from-covid-19-continues-to-hit-lower-income-americans-the-hardest/#:~:text=Overall%2C%2025%25%20of%20U.S.%20adults,has%20occurred%20in%20their%20household>
- ²² U.S. Bureau of Labor Statistics. Unemployment rate falls to 6.9 percent in October 2020. TED: The Economics Daily. Accessed at: <https://www.bls.gov/opub/ted/2020/unemployment-rate-falls-to-6-point-9-percent-in-october-2020.htm#:~:text=That%20was%20the%20sixth%20consecutive,and%208.8%20percent%20for%20Hispanics>.
- ²³ Rakotoniaina, A. How States are Increasing Coverage through Special Enrollment Periods. National Academy for State Health Policy, September 28, 2020. Accessed at: <https://www.nashp.org/how-states-are-increasing-coverage-through-special-enrollment-periods/>.
- ²⁴ Centers for Medicare and Medicaid Services. Medicaid and CHIP Enrollment Trends Snapshot through September 2020. Accessed at: <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/september-medicaid-chip-enrollment-trend-snapshot.pdf>.
- ²⁵ Berchick, E., Mykyta, L and Stern, S. The Influence of COVID-19-related Data Collection Changes on Measuring Health Insurance Coverage in the 2020 CPS ASEC. September 15, 2020. US Census Bureau. Accessed at: <https://www.census.gov/library/working-papers/2020/demo/SEHSD-WP2020-13.html>
- Dahlhamer, J.M., Bramlett, M.D., Maitland, A. and Blumberg, S. Preliminary Evaluation of Nonresponse Bias Due to the COVID-19 Pandemic on National Health Interview Survey Estimates, April-June 2020. February 2021. Accessed at: <https://www.cdc.gov/nchs/data/nhis/earlyrelease/nonresponse202102-508.pdf>
- ²⁶ National Center for Health Statistics, National Health Interview Survey (NHIS). 2020 NHIS. February 4, 2021. Accessed at: <https://www.cdc.gov/nchs/nhis/2020nhis.htm>.
- ²⁷ Uberoi, N et al. Health Insurance Coverage and the Affordable Care Act, 2010-2016. HHS ASPE Brief, March 3, 2016. Accessed at: <https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf>.
- ²⁸ McIntyre, A., Braut, M.W., Sommers, B.D. Measuring Coverage Rates in a Pandemic: Policy and Research Challenges. *JAMA Health Forum*. Published online October 26, 2020. Accessed at: [doi:10.1001/jamahealthforum.2020.1278](https://doi.org/10.1001/jamahealthforum.2020.1278)
- ²⁹ Strengthening Medicaid and Affordable Care Act. White House Executive Order, January 28, 2021. Accessed at: <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/>.
- ³⁰ See state profiles at <https://www.healthinsurance.org/states/> and <https://agency.accesshealthct.com/access-health-ct-announces-a-special-enrollment-period-for-uninsured-residents-due-to-ongoing-public-health-crisis>.
- ³¹ Lueck, S. and Broaddus, M. Emergency Special Enrollment Period Would Boost Health Coverage Access at a Critical Time. Center on Budget and Policy Priorities, July 30, 2020. Accessed at: <https://www.cbpp.org/research/health/emergency-special-enrollment-period-would-boost-health-coverage-access-at-a-critical>.
- Special Trends Report: Enrollment Data and Coverage Options for Consumers During the COVID-19 Public Health Emergency. Centers for Medicare & Medicaid Services Center for Consumer Information and Insurance Oversight, November 2020. Accessed at: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report-Nov-2020.pdf>.
- ³² Haley, JM. and Wengle E. Many Uninsured Adults Have Not Tried to Enroll in Medicaid or Marketplace Coverage. Robert Wood Johnson Foundation, January 28, 2021. Accessed at: <https://www.urban.org/research/publication/many-uninsured-adults-have-not-tried-enroll-medicaid-or-marketplace-coverage>.
- ³³ Pollitz, K. and Tolbert, J. Opportunities and Resources to expand Enrollment During the Pandemic and Beyond. Kaiser Family Foundation, January 25, 2021. Accessed at: <https://www.kff.org/health-reform/issue-brief/opportunities-and-resources-to-expand-enrollment-during-the-pandemic-and-beyond/>.

³⁴ Cha, A. and Cohen, R. Reasons for Being Uninsured Among Adults Aged 18-64 in the U.S., 2019. National Health Interview Survey, September 2020. Accessed at: <https://www.cdc.gov/nchs/products/databriefs/db382.htm>.

³⁵ Lee, P. et al. Marketing Matters: How Marketing and Outreach Builds Stable Marketplaces and Pays Off for the Federal Government, 2017. Accessed at: https://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

³⁶ Pollitz, K. and Tolbert, J. Opportunities and Resources to expand Enrollment During the Pandemic and Beyond. Kaiser Family Foundation, January 25, 2021. Accessed at: <https://www.kff.org/health-reform/issue-brief/opportunities-and-resources-to-expand-enrollment-during-the-pandemic-and-beyond/>.

³⁷ Pollitz, K. and Tolbert, J. Opportunities and Resources to expand Enrollment During the Pandemic and Beyond. Kaiser Family Foundation, January 25, 2021. Accessed at: <https://www.kff.org/health-reform/issue-brief/opportunities-and-resources-to-expand-enrollment-during-the-pandemic-and-beyond/>.

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A Closer Look at the Uninsured Marketplace Eligible Population Following the American Rescue Plan Act

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Issue Brief

The American Rescue Plan Act (ARPA) was passed by Congress and signed into law by President Biden in March 2021. The ARPA includes provisions that increase subsidies for Marketplace shoppers who were already eligible for financial assistance and removes the upper income cap on subsidy eligibility, eliminating what was known as the “subsidy cliff.” (<https://www.kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people/>) As a result, KFF estimated (<https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/>) that roughly 3.7 million more Americans, more than a third of whom are uninsured, are newly eligible for financial assistance to buy their own coverage on the exchanges, and millions more are eligible for increased financial assistance.

As of April 30, nearly 1 million people (<https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-1>) had enrolled in a HealthCare.gov plan during the ongoing special enrollment period, which lasts through August 15. The Centers for Medicare and Medicaid Services (CMS) announced an outreach campaign (<https://www.cms.gov/newsroom/press-releases/2021-special-enrollment-period-marketplace-coverage-starts-healthcaregov-monday-february-15>) to inform people about Marketplace enrollment opportunities and the enhanced financial assistance. For 2021 and 2022, CMS released over \$80 million (<https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance>) in grants to Navigators and related organizations that help consumers enroll in coverage and provide outreach and educational services. The Trump administration had made substantial cuts (<https://www.kff.org/private-insurance/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/>) to ACA marketing activities and Navigator programs, which received just \$10 million in grants in both 2018 and 2019.

In this analysis, we examine key demographic characteristics of the 10.9 million uninsured people who are eligible for Marketplace subsidies, including 6 million uninsured individuals eligible for tax credits that cover the full cost of a Marketplace plan. We exclude people who are eligible for Medicaid, Medicare, or affordable

employer coverage, as well as those who are undocumented immigrants. We also exclude people who fall into the [Medicaid coverage gap](https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/) (<https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>), since Marketplace coverage is generally unaffordable to people with incomes below poverty.

We find that relatively large shares of uninsured people eligible for significant assistance to buy Marketplace coverage are young adults without college educations, Hispanic, non-native English speakers, and working in the fields of entertainment, recreation, and construction. Most people eligible for free Marketplace coverage are concentrated in a handful of states (Texas, Florida, North Carolina, and Georgia). These findings can inform marketing, outreach, and enrollment assistance activities as the 2021 special enrollment period continues and consumers begin shopping for 2022 coverage later this year.

Findings

We estimate there are approximately 12.1 million¹ uninsured potential Marketplace shoppers, of whom the vast majority (10.9 million) are eligible for subsidies under the ACA and ARPA to help lower the cost of coverage.

Nationally, certain groups are overrepresented among the uninsured who are eligible for Marketplace subsidies following the enactment of the ARPA. We find that 30% of uninsured people eligible for Marketplace subsidies are Hispanic (compared to 20% of non-elderly people in the U.S.), 59% have a high school diploma or less (compared to 36% of non-elderly adults in the U.S.), and 42% are young adults ages 19 to 34 (compared to 25% of non-elderly people in the U.S.). In total:

- 10.9 million uninsured people could purchase Marketplace coverage for a reduced premium. Although subsidies for this group may not cover the full premium, they can significantly lower the premium and/or out-of-pocket liability. Even so, some people in this group may still find Marketplace coverage unaffordable or unattractive due to high deductibles.
- At least 6.0 million uninsured people could get a free Marketplace plan (with a \$0 premium payment, after accounting for subsidies). As explained in our [earlier brief](https://www.kff.org/policy-watch/millions-of-uninsured-americans-are-eligible-for-free-aca-health-insurance/) (<https://www.kff.org/policy-watch/millions-of-uninsured-americans-are-eligible-for-free-aca-health-insurance/>) and in some detail below, people in this group would clearly benefit from getting Marketplace coverage rather than continuing to go without coverage.
- Of uninsured people who are eligible for \$0 premium plans, 1.3 million have incomes below 150% of poverty, which makes them eligible for a free benchmark silver plan and substantial cost-sharing reductions (CSRs) that would make their plan more similar to platinum level coverage (which an average deductible of **\$177** (<https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace/>) in 2021). Some people with incomes just above 150% of poverty may also qualify for zero-premium silver plans depending on the gap in price between the benchmark (second-lowest cost) silver plan and the lowest-cost silver plan in their area.

- In addition, under the ARPA, any person who qualifies to purchase a Marketplace plan and receives unemployment compensation in 2021 is similarly eligible for a benchmark silver plan with a \$0 premium and cost-sharing assistance. Therefore, our estimate of the number of uninsured people eligible for zero-premium plans is likely an undercount.

SUBSIDY ELIGIBLE UNINSURED: KEY CHARACTERISTICS

We estimate that 10.9 million non-elderly uninsured people in the U.S. are eligible for some level of subsidy to help purchase a Marketplace plan. Relative to the general non-elderly population in the U.S., uninsured people eligible for Marketplace subsidies are more likely to be:

- **High school educated:** 59% of subsidy eligible adults have a high school education or less, compared to 36% of non-elderly adults in the U.S.
- **Young Adults:** 42% of subsidy eligible uninsured people are ages 19-34, compared to 25% of the non-elderly U.S. population.
- **Hispanic:** 30% of subsidy eligible uninsured people are Hispanic, compared to 20% of the non-elderly U.S. population.
- **Living in rural areas:** 16% of subsidy eligible uninsured people live in non-metro areas, compared to 13% of the non-elderly U.S. population.
- **Lacking internet access:** 11% of subsidy eligible uninsured people do not have internet access at home, compared to 6% of the non-elderly U.S. population.

Table 1: Characteristics of the Uninsured Marketplace Eligible Population, by Subsidy Eligibility in 2021

	Uninsured Eligible Marketplace Subsidies	Uninsured Eligible for Free Plan*	Uninsured Eligible for Free Platinum-Like Silver Plan	Nationwide Non-Elderly Total (%)
Total	10,933,600	6,034,300	1,297,600	-
Hispanic	3,344,600 (30%)	1,937,800 (32%)	525,800 (41%)	20%
Young Adults (Age 19-34)	4,618,200 (42%)	2,536,300 (42%)	645,900 (49%)	25%
High School Education or Less	6,507,200 (59%)	3,736,300 (62%)	846,100 (65%)	36%
Non-Metro Resident	1,755,700 (16%)	1,073,300 (18%)	188,200 (15%)	13%
Work in Arts / Entertainment / Construction	3,326,100 (30%)	1,872,900 (32%)	425,000 (33%)	22%
No Internet Access at Home	1,223,600 (11%)	788,300 (13%)	200,100 (15%)	6%
Language Other Than English Spoken at Home	3,670,570 (33%)	2,119,000 (35%)	602,300 (46%)	23%
Income				
< 200% FPL**	4,589,700 (42%)	4,307,600 (71%)	1,297,600 (100%)	29%
200% – 400% FPL	5,055,100 (46%)	1,681,200 (28%)	-.***	29%
> 400% FPL	1,244,346 (11%)	45,700 (1%)	-.***	41%

NOTES: *The Uninsured Eligible for Free Plan category includes people who would also qualify for a Free Platinum-Like Silver Plan. **FPL stands for Federal Poverty Level (\$12,760 for individual in 2020). ***Estimates do not account for unemployment insurance received in 2021, which would qualify Marketplace eligible individuals for free benchmark silver plans. Uninsured Marketplace eligible population does not include people with incomes below poverty who fall into the Medicaid coverage gap. People age 65 and over are excluded from this analysis. Estimates may not add to 100% due to rounding.

SOURCE: KFF analysis of 2019 American Community Survey.

UNINSURED ELIGIBLE FOR ZERO PREMIUM PLANS: KEY CHARACTERISTICS

We estimate that at least 6.0 million uninsured people in the U.S. could get a bronze or silver plan on the ACA Marketplace with a \$0 premium contribution, after accounting for their subsidy. Compared to the total subsidy-eligible uninsured population and the general U.S. population, uninsured people eligible for free Marketplace plans are more likely to be:

- **High school educated:** 62% of free bronze eligible uninsured adults and 65% of the free silver eligible uninsured people have a high school education or less, compared to 59% of all subsidy-eligible uninsured people and 36% of all non-elderly adults in the U.S.

- **Hispanic:** 32% of free bronze eligible uninsured people and 41% of the free silver eligible uninsured people are Hispanic, compared to 30% of all subsidy eligible uninsured people and 20% of the total non-elderly population.
- **Lacking internet access:** 13% of the free bronze eligible uninsured people and 15% of free silver eligible uninsured people do not have internet access at home, compared to 11% of all subsidy eligible uninsured people and 6% of the total non-elderly population.
- **Non-English speaker at home:** 35% of free bronze eligible uninsured people and 46% of free silver eligible uninsured people speak a language other than English at home, compared to 23% of the U.S. non-elderly population.

In addition to the 1.3 million uninsured people who qualify for zero-premium benchmark silver plans because their income is less than 150% of poverty, there are likely many more uninsured people who qualify for free silver plans because the ARPA ensures that any enrollee receiving unemployment insurance at some point in 2021 is eligible for zero-premium platinum-like coverage. As noted above, there are also some uninsured people with incomes just above 150% of poverty who would have to pay a small premium for a benchmark silver plan, but may receive enough in subsidies to cover the full cost of the lowest-cost silver plan in their area. Further, there are many counties (<https://www.kff.org/private-insurance/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2021/>) in the U.S. where the lowest-cost gold plan is cheaper than the lowest-cost silver plan. Lower-income Marketplace shoppers in these areas could potentially purchase a free gold plan with lower cost-sharing and more financial protection than plans in lower metal levels.

As we have explained in earlier analyses (<https://www.kff.org/policy-watch/millions-of-uninsured-americans-are-eligible-for-free-aca-health-insurance/>), many people who are eligible for a free bronze plan are also eligible for a low-cost silver plan with a substantially lower deductible due to CSRs. The average annual deductible (<https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace/>) for people with incomes between 150-200% of poverty who choose to enroll in a silver plan with a CSR is \$800. Many people in this group, therefore, could be better off buying a silver plan with a small premium than a zero-premium bronze plan.

Even so, *all* of the uninsured eligible for a free bronze or a free silver plan would be better off taking advantage of that \$0 premium coverage instead of remaining uninsured. People in this group may need help understanding the tradeoff between silver and bronze coverage (i.e. affordability of the premium and deductible), as well as help understanding the benefits that even a high-deductible bronze plan offers over being uninsured (i.e. free preventive care, limited out-of-pocket liability, lower negotiated payment rates to providers, and often at least some covered benefits before having to meet the deductible).

Almost half of the uninsured who could get a free bronze plan live in Texas, Florida, North Carolina, or (Figure 1). A detailed table in the appendix provides demographic characteristics of people eligible for free Marketplace coverage in each state.

<https://embeds.kff.org/protected-iframe/aceeae8f7b5ed17d016689cd986e42f>

<https://embeds.kff.org/protected-iframe/aceeae8f7b5ed17d016689cd986e42f>

```
( function() {
var func = function() {
var iframe = document.getElementById('wpcom-iframe-
aceeae8f7b5ed17d016689cd986e42f')
if ( iframe ) {
iframe.onload = function() {
iframe.contentWindow.postMessage( {
'msg_type': 'poll_size',
'frame_id': 'wpcom-iframe-aceeae8f7b5ed17d016689cd986e42f'
}, "https://embeds.kff.org" );
}
}

// Autosize iframe
var funcSizeResponse = function( e ) {

var origin = document.createElement( 'a' );
origin.href = e.origin;

// Verify message origin
if ( 'embeds.kff.org' !== origin.host )
return;

// Verify message is in a format we expect
if ( 'object' !== typeof e.data || undefined === e.data.msg_type )
return;

switch ( e.data.msg_type ) {
case 'poll_size:response':
var iframe = document.getElementById( e.data._request.frame_id );

if ( iframe && " === iframe.width )
iframe.width = '100%';
if ( iframe && " === iframe.height )
iframe.height = parseInt( e.data.height );

return;
default:
return;
}
}
```

```
if ( 'function' === typeof window.addEventListener ) {  
window.addEventListener( 'message', funcSizeResponse, false );  
} else if ( 'function' === typeof window.attachEvent ) {  
window.attachEvent( 'onmessage', funcSizeResponse );  
}  
}  
if ( document.readyState === 'complete' ) { func.apply(); /* compat for infinite scroll */ }  
else if ( document.addEventListener ) { document.addEventListener(  
'DOMContentLoaded', func, false ); }  
else if ( document.attachEvent ) { document.attachEvent( 'onreadystatechange', func ); }  
}());
```

```
document.querySelectorAll('iframe.wpcom-protected-iframe').forEach( item => {  
item.scrolling = 'no';  
})
```

Discussion

The findings of this analysis can inform government agencies, insurers, or Navigators tasked with outreach and marketing responsibilities, helping them to target specific groups that are more likely to be uninsured but eligible for significant financial assistance. The Department of Health and Human Services has announced concerted efforts to reach historically uninsured communities during the ongoing special enrollment period. Relatively large shares of uninsured people eligible for significant assistance to buy Marketplace coverage are young adults without college educations, Hispanic, non-native English speakers, and working in the fields of entertainment, recreation, and construction. Most people eligible for free bronze or silver coverage are concentrated in a handful of states (including Texas, Florida, Georgia, and North Carolina).

In addition to the findings highlighted above, the appendix of this brief provides detailed demographics about the uninsured population eligible for fully-subsidized coverage in each state.

Methodology

2021 Premiums come from KFF analysis of premium data from Healthcare.gov and state rating filings. Data on population, income, and eligibility for subsidies come from KFF analysis of the Census Bureau's 2019 American Community Survey (ACS). The ACS includes a 1% sample of the US population and allows for precise state-level estimates. The ACS asks respondents about their health insurance coverage at the time of the survey. Respondents may report having more than one type of coverage; however, individuals are sorted into only one category of insurance coverage. The 2019 ACS

collected income and coverage data from respondents before the pandemic, but there are various reasons that the data are still a reasonable basis for current uninsured eligibility analyses. First, the national uninsured rate has stabilized in recent years (<https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>) and expectations are that it has remained relatively flat (<https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/>) thus far during the pandemic. Second, at least prior to enhanced subsidies outlined in the ARPA, the number of uninsured people eligible and ineligible for subsidies have also stayed generally consistent. Under the previous ACA subsidy structure, KFF estimated the number of uninsured people eligible for free bronze plans had fluctuated between 4.0 (https://www.kff.org/private-insurance/issue-brief/marketplace-eligibility-among-the-uninsured-implications-for-a-broadened-enrollment-period-and-aca-outreach/?utm_campaign=KFF-2021-Uninsured&utm_medium=email&hsmi=2&hsenc=p2ANqtz-8RMHaS4IbxpDetr) and 4.7 million (<https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020/>) the past three years.

This analysis does not include individuals who are over the age of 65, who are eligible for Medicaid in 2021, who have incomes below poverty, or are undocumented immigrants. We exclude individuals who are uninsured but have an affordable offer of employer-based coverage. Under the current ACA structure, workers and their family members are ineligible for tax credits if any worker in the household is offered “affordable” health insurance through their employer. Employer coverage is considered affordable if the worker’s premium contribution for self-only amounts to less than 9.83% of household income.

Unsubsidized premiums used in this analysis are the full price of plans, rather than specifically the portion that covers essential health benefits (EHB). Since premium tax credits can only be used to cover the EHB portion of premiums, some of the individuals denoted as having access to a “free” bronze plan might actually have to pay a very small premium for non-essential health benefits if they enrolled in a bronze plan with added benefits. The ACA does not permit federal subsidies to pay for abortion (<https://www.kff.org/womens-health-policy/issue-brief/interactive-how-state-policies-shape-access-to-abortion-coverage/>) coverage and requires plans to collect no less than \$1.00 per month for this coverage. In CA, IL, NY, ME, OR, and WA, state law requires that that all state regulated plans include abortion coverage. Policyholders who live in these states must pay the abortion surcharge even though they may qualify for subsidies that provide the full cost of premiums if they select a bronze plan. Providence Health Plans in OR and WA have a religious exemption allowing them to exclude abortion coverage.

Appendix

Appendix Table 1: Characteristics of the Uninsured Population Eligible for Zero Premium Bronze Marketplace Plan, by State, 2021

State	Total	Hispanic	Young Adults (Age 19-34)	High School Education or Less	Non-Metro
US Total	6,034,300	1,937,800 (32%)	2,536,300 (42%)	3,736,300 (62%)	1,073,300 (18%)
Alabama	158,300	12,200 (8%)	71,900 (45%)	103,900 (66%)	41,500 (26%)
Alaska	20,600	4,700 (23%)	12,500 (61%)	11,100 (54%)	4,000 (19%)
Arizona	108,100	49,100 (45%)	39,400 (36%)	68,500 (63%)	9,900 (9%)
Arkansas	32,100	1,900 (6%)	11,400 (35%)	19,500 (61%)	12,400 (39%)
California	323,100	196,500 (61%)	134,100 (42%)	192,600 (60%)	12,000 (4%)
Colorado	38,200	12,800 (33%)	16,400 (43%)	19,300 (50%)	6,000 (16%)
Connecticut	35,800	10,900 (30%)	13,800 (38%)	20,000 (56%)	1,300 (4%)
Delaware	11,300	900 (8%)	4,900 (43%)	7,000 (62%)	-
Florida	798,200	277,900 (35%)	332,600 (42%)	477,700 (60%)	37,900 (5%)
Georgia	357,000	56,900 (16%)	154,400 (43%)	227,900 (64%)	79,800 (22%)
Hawaii	6,100	700 (12%)	2,100 (34%)	1,500 (25%)	700 (12%)
Idaho	40,400	8,800 (22%)	16,000 (40%)	24,100 (60%)	14,100 (35%)
Illinois	95,500	20,400 (21%)	36,900 (39%)	47,200 (49%)	20,900 (22%)
Indiana	70,200	7,800 (11%)	26,900 (38%)	43,300 (62%)	16,300 (23%)
Iowa	34,400	2,500 (7%)	14,500 (42%)	20,600 (60%)	15,200 (44%)
Kansas	69,100	15,000 (22%)	27,500 (40%)	41,200 (60%)	25,600 (37%)
Kentucky	56,900	5,800 (10%)	22,000 (39%)	34,300 (60%)	23,300 (41%)
Louisiana	70,800	8,800 (12%)	25,100 (35%)	47,300 (67%)	10,400 (15%)
Maine	16,600	700 (4%)	5,300 (32%)	11,200 (67%)	9,300 (56%)
Maryland	43,300	8,400 (19%)	21,100 (49%)	23,300 (54%)	900 (2%)
Massachusetts	15,600	2,200 (14%)	8,100 (52%)	7,800 (50%)	600 (4%)
Michigan	86,600	8,100 (9%)	30,700 (35%)	51,200 (59%)	27,200 (31%)
Minnesota	4,500	500 (12%)	1,000 (22%)	2,700 (60%)	200 (5%)
Mississippi	79,800	3,900 (5%)	33,500 (42%)	51,300 (64%)	45,200 (57%)
Missouri	104,200	7,600 (7%)	43,300 (42%)	68,200 (65%)	32,300 (31%)
Montana	16,400	700 (4%)	6,100 (37%)	9,100 (56%)	9,800 (60%)
Nebraska	37,200	6,600 (18%)	14,700 (39%)	17,500 (47%)	12,800 (35%)
Nevada	44,200	20,000 (45%)	16,200 (37%)	25,600 (58%)	4,400 (10%)
New Hampshire	16,900	3,400 (20%)	5,900 (35%)	10,900 (65%)	6,600 (39%)
New Jersey	78,500	33,500 (43%)	34,700 (44%)	48,100 (61%)	00 (%)
New Mexico	32,600	14,900 (46%)	11,500 (35%)	15,900 (49%)	15,700 (48%)

New York	68,800	23,300 (34%)	31,300 (46%)	37,600 (55%)	4,100 (6%)
North Carolina	368,600	66,300 (18%)	159,100 (43%)	222,000 (60%)	95,300 (26%)
North Dakota	12,000	200 (2%)	3,200 (27%)	7,600 (64%)	7,500 (62%)
Ohio	126,800	8,300 (7%)	48,600 (38%)	82,700 (65%)	31,900 (25%)
Oklahoma	123,400	19,700 (16%)	48,000 (39%)	78,800 (64%)	61,000 (49%)
Oregon	50,100	12,200 (24%)	21,900 (44%)	27,300 (55%)	12,400 (25%)
Pennsylvania	136,600	14,600 (11%)	54,600 (40%)	81,900 (60%)	22,500 (16%)
Rhode Island	5,000	1,300 (26%)	2,300 (47%)	2,800 (57%)	-
South Carolina	172,700	15,400 (9%)	70,900 (41%)	115,300 (67%)	18,900 (11%)
South Dakota	31,200	2,300 (7%)	14,300 (46%)	19,600 (63%)	15,100 (48%)
Tennessee	210,100	29,500 (14%)	85,000 (40%)	142,700 (68%)	48,000 (23%)
Texas	1,443,800	855,200 (59%)	644,600 (45%)	946,300 (66%)	162,200 (11%)
Utah	63,900	14,200 (22%)	26,700 (42%)	33,800 (53%)	12,500 (20%)
Vermont	5,500	400 (7%)	2,400 (44%)	3,800 (69%)	4,400 (80%)
Virginia	117,400	26,400 (22%)	44,600 (38%)	70,400 (60%)	20,100 (17%)
Washington	71,300	17,900 (25%)	29,800 (42%)	39,200 (55%)	7,100 (10%)
West Virginia	9,600	400 (4%)	2,200 (23%)	5,800 (61%)	2,700 (29%)
Wisconsin	84,400	20,100 (24%)	39,300 (47%)	52,800 (63%)	31,000 (37%)
Wyoming	30,700	5,900 (19%)	12,900 (42%)	16,000 (52%)	20,200 (66%)

NOTES: * Education category is among adults age 25 to 64. Industry category is among working adults age 18 to 64. Counts are rounded to the nearest 100. This analysis does not include individuals who are over the age of 65, who are eligible for Medicaid, who have incomes below poverty, or are undocumented immigrants. DC is not included due to an insufficient sample size in the ACS. Cells with less than 1,000 observations are suppressed. SOURCE: 2021 Premiums come from KFF analysis of premium data from Healthcare.gov and review of state rating filings. Data on population and eligibility for subsidies come from KFF analysis of the American Community Survey (ACS) for 2019.

Endnotes

Issue Brief

1. This estimate includes people who are subsidy eligible and people who are ineligible for subsidies because their premiums are too low relative to their incomes. It excludes people who are eligible for Medicare, Medicaid, or affordable employer coverage, as well as those who are undocumented immigrants. People who fall into the [Medicaid coverage gap](https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/) (<https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>) are also excluded because Marketplace coverage is generally unaffordable for people with incomes below

poverty. If we include people with affordable employer offers of coverage, there are approximately 15 million uninsured people who are eligible to purchase ACA Marketplace plans.

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Navigator Funding Restored in Federal Marketplace States for 2022

Karen Pollitz (<https://www.kff.org/person/karen-pollitz/>) ,

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Published: Sep 29, 2021



On August 27, 2021, the Centers for Medicare and Medicaid Services (CMS) announced **\$80 million** (<https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>) in funding for **60 Navigator programs** (<https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf>) serving consumers in 30 Federally-Facilitated Marketplace (FFM) states for the 2022 plan year. Navigator programs help consumers understand their plan choices and complete their application for financial help for Marketplace coverage or for Medicaid or CHIP. The multi-year award provides \$80 million annually for 3-years; awardees must comply with grant terms and conditions to receive funding each year. Shortly after the funding announcement, CMS also finalized certain changes to **regulatory standards for navigators** (<https://www.federalregister.gov/documents/2021/09/27/2021-20509/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver>) in the federal marketplace.

The 2021 funding is significantly higher than the \$10 million in annual funding awarded in 2018-2020 during the Trump Administration and more than the \$63 million awarded in the final year of the Obama Administration. Total funding announced this year is 27% higher than the total announced in 2016, though funding changes vary considerably by state (Table 1). Four FFM states (Georgia, Hawaii, Iowa and South Carolina) received less navigator funding than in 2016, while in five other states (Kansas, Montana, New Hampshire, South Dakota, and Tennessee) funding more than doubled. In Delaware, federal navigator funding is more than three times the 2016 total.

<p>Table 1: Changes in Federal Navigator Funding, 2016-2021</p>
--

State	2021 Total Funding	2020 Total Funding	20
Alabama	\$1,842,245	\$200,000	\$1
Alaska	\$1,000,000	\$100,000	\$6
Arizona	\$2,340,145	\$373,424	\$1
Delaware	\$1,856,770	\$100,000	\$6
Florida	\$14,408,315	\$1,600,000	\$9
Georgia	\$2,540,273	\$700,000	\$3
Hawaii	\$245,347	\$100,000	\$4
Illinois	\$4,009,133	\$305,368	\$2
Indiana	\$1,802,859	\$300,000	\$1
Iowa	\$462,259	\$100,000	\$6
Kansas	\$1,686,793	\$213,317	\$7
Louisiana	\$1,525,570	\$200,000	\$1
Maine	*	*	\$6
Michigan	\$3,295,435	\$339,452	\$2
Mississippi	\$1,368,670	\$300,000	\$9
Missouri	\$2,604,421	\$350,000	\$1
Montana	\$1,000,000	\$100,000	\$4
Nebraska	\$1,000,000	\$100,000	\$6
New Hampshire	\$1,604,745	\$100,000	\$6
New Jersey	*	*	\$1
North Carolina	\$5,328,752	\$700,000	\$3
North Dakota	\$999,472	\$100,000	\$6
Ohio	\$2,600,849	\$476,880	\$1
Oklahoma	\$1,884,390	\$373,424	\$1
Pennsylvania	*	*	\$3
South Carolina	\$1,179,401	\$0	\$1
South Dakota	\$1,450,000	\$100,000	\$6
Tennessee	\$3,482,153	\$373,424	\$1
Texas	\$13,356,589	\$1,894,711	\$9
Utah	\$1,223,773	\$0	\$9
Virginia	*	*	\$2
West Virginia	\$1,000,000	\$100,000	\$6
Wisconsin	\$1,901,875	\$200,000	\$1

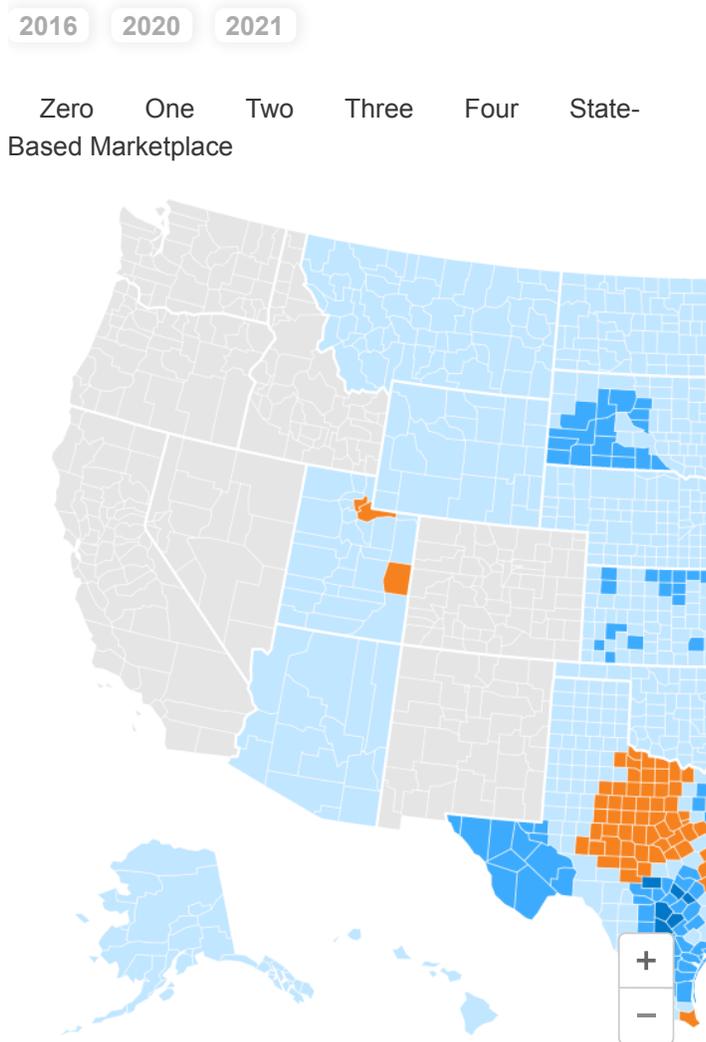
Wyoming	\$999,766	\$100,000	\$€
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Increased funding will support growth in the number of navigator programs – which had fallen to 30 by the end of the Trump Administration. Compared to the first year the FFM was open, when more than 100 Navigator programs received grants, a smaller number of grantees will begin work this fall; however, nearly half of the FFM navigators (29) will operate statewide programs, and most of those (20) will coordinate and share funding with a network of local partners. By contrast, in 2016 (<https://www.kff.org/report-section/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers-section-1-assister-programs-characteristics-and-people-helped/>), coordination among marketplace assister programs was more limited, although those that did so regularly said coordination was important to their effectiveness.

Federal regulatory standards for navigators previously required that there be a minimum of two navigators per state, at least one of which should be a community-based nonprofit. These requirements were eliminated during the Trump Administration and have not been restored. In all but two of the FFM states (Utah and Texas), every county will be included in the service area of at least one navigator program and nearly one in five (19%) counties in FFM states will be included in the service area of at least two programs (Figure 1). Although the funding awards posted by CMS do not indicate the type of grantee organization, it appears that nearly two-thirds (38 of 60) of navigator grantees are community-based nonprofits, another 15 are providers or provider groups—federally qualified health centers, primary care associations, or hospitals—and 4 are public universities, government agencies, or tribal organizations. Until 2017, federal navigators were required to maintain a physical presence in their state. This requirement also was eliminated during the Trump Administration and has not been restored, though CMS did encourage grant applicants to meet this standard. One of the non-physically-present grantees funded during the Trump years has been funded to provide statewide services in three states during the 2022 plan year and apparently will offer only call-center assistance in the state of Iowa.

Figure 1

Number of Navigator Programs by County in FFM States, 2021



Discussion

A [2020 KFF national survey on consumer assistance](https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/) (<https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/>) documented significant unmet need for enrollment help by consumers seeking coverage through the marketplace. Since then, the COVID-19 epidemic has increased reliance on marketplace coverage and Medicaid. Following enactment of subsidy increases and expanded enrollment periods during the pandemic, enrollment in marketplace plans increased by [2.8 million](https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf) (<https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf>) this year, including 2.1 million in HealthCare.gov states. Recently published regulations will extend the federal marketplace open enrollment period for the 2022 plan year

from 6 weeks to 8 weeks (November 1 – January 15), and will allow people with income up to 150% of the federal poverty level (or \$19,320 for an individual in 2021) to enroll throughout the year. Assuming the public health emergency ends in 2022, the moratorium on Medicaid disenrollment will be lifted and many more low-income people may need to transition to marketplace plans if their Medicaid eligibility is terminated. The restoration of federal navigator funding comes at a time when the need for consumer assistance may reach new, higher levels.

In addition to increasing funding for navigators, ensuring consumers are aware that navigator assistance is available and where to find it can help improve access to enrollment assistance. In recent years CMS has taken various steps to facilitate consumer access to agents and brokers – including a “[Help On Demand \(https://localhelp.healthcare.gov/#/get-contacted\)](https://localhelp.healthcare.gov/#/get-contacted)” feature of HealthCare.gov that connects individual consumers directly with brokers. CMS has also promoted the use of web broker sites, called enhanced direct enrollment entities (EDE), that offer online dashboards and other technological tools to make broker-assisted enrollments faster and more efficient. Comparable initiatives have not been undertaken to promote and facilitate enrollment assistance by marketplace navigators. Because CMS accumulated more than [\\$1 billion \(https://www.kff.org/health-reform/issue-brief/opportunities-and-resources-to-expand-enrollment-during-the-pandemic-and-beyond/\)](https://www.kff.org/health-reform/issue-brief/opportunities-and-resources-to-expand-enrollment-during-the-pandemic-and-beyond/) in unspent marketplace user fee revenue during the Trump Administration, additional resources are available to increase support for enrollment assistance if needed.

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Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period

By Dania Palanker and
JoAnn Volk

October 2021

Background

Millions of Americans are eligible for health insurance plans with little or no premium and significantly reduced cost-sharing this coming open enrollment period thanks to historic enhanced marketplace subsidies under the American Rescue Plan (ARP).¹ But a secret shopper study conducted during the recent COVID-19 special enrollment period suggests that some consumers shopping for coverage during the upcoming open enrollment period will likely be directed, by misleading marketing practices, to alternative plans without the protections of the ACA.²

These alternative plans—including fixed indemnity plans, short-term health plans, and health care sharing ministries—fail to protect people with preexisting conditions, exclude many essential health benefits, and leave enrollees vulnerable to catastrophic medical bills.³ Despite these gaps, enrollment in these types of products has increased in recent years, rising at least in part from deceptive and misleading marketing of these products to individuals who are searching for comprehensive major medical coverage.⁴

Several studies and investigations—including a 2019 Georgetown study, a year-long investigation by the House Energy and Commerce Committee, an undercover investigation by the U.S. Government Accountability Office, and secret shopper analysis by researchers at Brookings—have documented misleading or deceptive marketing practices associated with alternative plans.⁵ These analyses all reach similar conclusions—sales representatives often misrepresent the coverage to consumers, urge consumers to purchase plans over the phone without written information, or fail to disclose major coverage limitations, including limitations and coverage for COVID related services.⁶ Once enrolled in alternative plans, these limitations can leave consumers on the hook for their full medical bills.⁷ Preexisting condition exclusions have been found to leave consumers with tens of thousands of dollars in uncovered medical bills.⁸ Some alternative plans, including short-term plans, are known to rescind coverage—a practice where the insurer determines an enrollee has a preexisting condition after a medical claim is filed and uses that condition as justification to retroactively cancel coverage.⁹

To assess whether these practices have continued throughout 2021, this study replicated a prior secret shopper study from 2019.¹⁰ The goal of this study is to see if shoppers were still being directed towards alternative coverage at a time when the ACA coverage was broadly available and more affordable than ever because of the enhanced premium subsidies under the ARP.

With expanded subsidies under ARP, millions of people were eligible for plans with \$0 premiums during the recent COVID-19 special enrollment period.¹¹ Many of those eligible for low or \$0 premium plans were also eligible for cost-sharing reduction plans that reduced deductibles, copayments, and other cost-sharing.¹² And, for the first time ever, the ARP extended marketplace subsidies to individuals with higher incomes.¹³ The expanded income eligibility includes many people who may have previously been priced out of marketplace coverage and thus are more likely to enroll in non-ACA coverage options such as short-term plans.

Findings

Despite the broad expansion of affordable coverage because of the change in federal policy, the results of this study largely mirrored the results from the 2019 Georgetown study and other studies.

- Online consumers are still being directed to agents, brokers, or other sales representatives [herein representatives] selling, by phone, alternative coverage that costs more and covers less than the ACA plans available during the special enrollment period. Ten out of the top 12 search results directed consumers to websites that collected personal information that resulted in calls, emails, and text messages. Of phone calls with 20 representatives, only five recommended marketplace coverage.
- Consumers were far more likely to be referred to fixed indemnity plans, health care sharing ministries, short-term plans, and other non-ACA products that were impossible to categorize based on the information provided. These alternative plans were typically more expensive than marketplace coverage and had higher cost-sharing. Representatives repeatedly provided misleading information about the alternative plans they were selling as well as false statements about the cost and features of marketplace plans.

Overview of Methodology

This study was based on the 2019 Georgetown secret shopper study and was conducted from June 25 to July 10, 2021.¹⁴ Researchers developed two consumer profiles: 1) 28-year old Dani without any preexisting conditions; and 2) 48-year old Jen who takes a generic medication for high cholesterol and has an unspecified heart condition. Both were in a one-person household with an annual income of \$20,000 and searching for new coverage because of a loss of employer coverage and a planned move to Texas. These consumers were eligible to enroll in marketplace plans during the COVID-19 special enrollment period and for a separate special enrollment period for loss of coverage as of August 1, 2021.

To see how the two profiles would be treated, researchers performed internet searches for four terms that might be used by consumers shopping for health insurance (“ACA enroll,” “cheap health insurance,” “healthcare.gov” and “Obamacare plans”) and visited the three most common websites that appeared in the first three search results (including advertisements appearing as results) and entered the contact information for the profiles into the webforms on these websites. Researchers spoke with ten sales representatives over the phone for each profile, for a total of 20 representatives.

The Results: Agents, Brokers and Sales Representatives Continue to Provide Misleading Information

As noted above, Dani and Jen were overwhelmingly referred to non-ACA plans but were often not informed about what they would be purchasing. Just one representative identified the type of coverage they were selling (a health care sharing ministry). The other representatives did not identify the type of coverage, but researchers were able to identify one plan as a short-term plan based on a mention of coverage for a six-month duration and four plans as fixed indemnity insurance based on the cost-sharing structure. While researchers could not identify the remaining plan types based on the information shared, it was clear that it was not marketplace coverage nor did it appear to be another type of major medical coverage.

Most representatives did not suggest marketplace coverage. Because of the enhanced ARP subsidies, both women would be eligible for a silver marketplace plan with premiums starting at just \$2 a month and greatly reduced cost-sharing. Yet, only 5 out of 20 representatives recommended a marketplace plan. Eleven of the representatives offered alternative plans with monthly premiums that ranged from \$70 to \$300. In all instances, the alternative plans that representatives

recommended were more expensive than marketplace plans available to Dani and Jen. In addition, three representatives mentioned a one-time enrollment fee as high as \$99. (It is common for alternative plans to be sold through associations that have a non-refundable enrollment fee or membership fee.¹⁵ One representative suggested the existence of an association by referring to the plan as group coverage).

Consistent with the 2019 report, representatives continued to use misleading sales practices when discussing marketplace plans and the alternative products.¹⁶ Representatives did not disclose accurate information about the affordability of marketplace plans, with one representative saying that marketplace plans “are just going to end up costing you more money.” Even though both women were eligible for bronze plans with a \$0 premium and a silver plan with reduced cost sharing that had a \$2 premium, one representative stated that marketplace premiums start at \$379 per month and another quoted \$421 per month for a marketplace plan with a \$2,000 deductible. Representatives also provided false reasons for high premiums: two representatives said premiums are higher now, in 2021, because of COVID-19.

Based on these calls, Dani and Jen would never know that they qualified for a marketplace plan with significantly reduced cost-sharing. One representative said that, while Jen did qualify for a marketplace plan with no premium, the deductible would be \$6,500. While this may be true for someone with a higher income, the representative failed to mention that Jen qualified for cost-sharing reductions and thus a plan with a \$250 deductible for just \$2 a month.

The alternative plans being offered also had significant gaps that were typically not disclosed by the representatives. Two representatives stated that services for Jen's cholesterol and heart condition would be covered. One responded "sure, sure, absolutely" when asked if the plan would cover Jen for a heart attack. Only one representative selling alternative plans mentioned a preexisting condition exclusion, stating from the start that the plans he sells would not cover care Jen needed for the first 12 months. Rather than actual insurance coverage of prescription drugs, one representative stated that a prescription discount card is included. Two others mentioned patient assistance programs to Jen as a way to afford her medication. Two representatives said that substance use treatment is not covered, and one representative said that costs are lower because there is no maternity care.

Even when asked directly, representatives refused to provide more information to better understand the plan until after the consumer provided payment. Only one

representative selling alternative coverage agreed to send any written information before moving forward to confirming eligibility (i.e. health status) and completing enrollment. None of the other representatives would provide written information until after payment was made for the first month's coverage and any applicable enrollment fee. Two representatives said that sharing benefit information over email would create a contract, while another said that shoppers can only see plan information before enrolling during open enrollment. One broker incorrectly invoked the Health Insurance Portability and Accountability Act (HIPAA) as the reason why a prospective enrollee could not get information about their plan before enrolling in it.

It's likely a typical consumer would be unable to fully understand what they were buying based on these calls and without seeing plan information in writing. Cost-sharing was described for only a few services. Representatives typically only mentioned one or two excluded benefits, if they mentioned anything about specific benefits being excluded. Coupled with the lack of or misleading information about the availability of affordable marketplace plans, these sales practices mean many online shoppers may have unwittingly enrolled in alternative plans during the recent special enrollment period as a result of continued misleading practices.

Implications

Even with an extended enrollment period and enhanced financial help for marketplace plans, consumers shopping online for health insurance continue to be misdirected to representatives selling alternative plans that discriminate against people with preexisting conditions and lack consumer protections found in plans sold through the ACA marketplaces. These alternative plans can be hundreds of dollars more per month than marketplace plans and have significantly higher cost-sharing, especially for lower-income consumers. But the true cost differentials and lack of consumer protections were not disclosed when talking with most representatives. Instead, consumers continue to be fed false or misleading information during brief phone interactions.

This information is far from harmless. Enrollees that unwittingly enroll in these alternative plans can find themselves left with catastrophic medical bills when claims go unpaid. Patients may forgo important medical care because they cannot afford the high cost of care without real coverage. Other patients may be forced into medical bankruptcy. The results of this study underscore the well-documented need for federal and state action to protect consumers from alternative plans that lack critical consumer protections and the sales representatives and entities selling them.¹⁷

Endnotes

- ¹ Katie Keith, "[The American Rescue Plan Expands The ACA](#)," *Health Affairs* 50, no. 5 (April 2021).
- ² See, e.g., Michael S. Fischer, "[Health Group to Pay \\$2M for Misleading Clients](#)," Think Advisor, August 20, 2021.
- ³ Christen Linke Younge and Kathleen Hannick, "[Fixed Indemnity Health Coverage is Problematic Form of 'Junk Insurance'](#)," USC-Brookings Schaeffer Initiative for Health Policy, August 2020; Christen Linke Younge, "[Taking a Broader View of 'Junk Insurance'](#)," USC-Brookings Schaeffer Initiative for Health Policy, July 2020; Dania Palanker, Emily Curran, and Arreyellen Salyards, "[Limitations of Short-Term Health Plans Persist Despite Predictions That They'd Evolve](#)," To The Point Blog, The Commonwealth Fund, July 22, 2020; JoAnn Volk, Justin Giovannelli, and Christina L. Goe, "[States Take Action on Health Care Sharing Ministries, But More Could Be Done to Protect Consumers](#)," To The Point Blog, The Commonwealth Fund, February 19, 2020; and Leukemia and Lymphoma Society, et al., "[Under-Covered: How 'Insurance-Like' Products Are Leaving Patients Exposed](#)," March 2021.
- ⁴ Dania Palanker and Kevin Lucia, "Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk," To The Point Blog, The Commonwealth Fund, September 10, 2021.
- ⁵ Christen Linke Young and Kathleen Hannick, "[Misleading Marketing of Short-Term Health Plans Amid COVID-19](#)," USC-Brookings Schaeffer Initiative for Health Policy, March 2020; Government Accounting Office, "[Private Health Coverage: Results of Covert Testing for Selected Offerings](#)," August 2020; Sabrina Corlette, et al., "[The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses](#)," The Urban Institute and Robert Wood Johnson Foundation, January 2019; and U.S. House of Representatives, Committee on Energy and Commerce, "[Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk](#)," June 2020.
- ⁶ Christen Linke Young and Kathleen Hannick, "[Misleading Marketing of Short-Term Health Plans Amid COVID-19](#)," op. cit.; Government Accounting Office, op. cit.; Sabrina Corlette, et al., op. cit.; and U.S. House of Representatives, Committee on Energy and Commerce, op. cit.
- ⁷ Leukemia and Lymphoma Society, et al., op. cit.
- ⁸ Ibid.
- ⁹ Reed Abelson, "[Without Obamacare Mandate, 'You Open the Floodgates' for Skimpy Health Plans](#)," *The New York Times*, November 30, 2017.
- ¹⁰ Sabrina Corlette, et al., op. cit.
- ¹¹ Centers for Medicare and Medicaid Services, "[American Rescue Plan Lowers Health Insurance Costs for Americans Who May Have Lost Their Job](#)," June 2021.
- ¹² Office of the Assistant Secretary for Planning and Evaluation, "[Access to Marketplace Plans with Low Premiums: Current Enrollees and the American Rescue Plan](#)," April 2021.
- ¹³ Katie Keith, op. cit.
- ¹⁴ Sabrina Corlette, et al., op. cit.
- ¹⁵ Emily Curran, Dania Palanker, and Sabrina Corlette, "[Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections](#)," To The Point Blog, The Commonwealth Fund, January 31, 2019.
- ¹⁶ Sabrina Corlette, et al., op. cit.
- ¹⁷ Christen Linke Younge, "Taking a Broader View of 'Junk Insurance,'" op. cit.; Dania Palanker, Maanasa Kona, and Emily Curran, "[States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans](#)," The Commonwealth Fund, May 2, 2019; and Leukemia and Lymphoma Society, et al., op. cit.

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"Georgia's 1332 waiver comments"

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And the Advocacy Committee of the American Medical Women's Association, GA Branch

January 5, 2022

The American Medical Women's Association Georgia Chapter Comments on 1332 Waiver

The Georgia chapter of the American Medical Women's Association (AMWA) supports sound policies and programs to improve public health access to healthcare. AMWA supports Medicaid Expansion in Georgia and has reviewed the proposed reinsurance program and understands that reduced premiums and market stability is a component of the program.

AMWA has concerns, however, aspects of the proposal would limit patients' choice for health coverage. By eliminating the option for patients to use the one-stop-shop HealthCare.gov platform the number of individuals for whom comprehensive coverage will be available will be decreased.

As physicians, we see the problem every year when our patients transition from one insurance plan to another. This can happen even without a change of employment as a company changes plans. Frequently, patients lose their physician through no fault of their own, when a change in insurance occurs. Many do not even know this has happened until they try to make an appointment or refill their medications. The loss of continuity of care, leads to catastrophic effects in the downstream health of individuals, often resulting in more costs to the state. For example, a patient needed a refill of their insulin and did not realize they were no longer under the care of their original primary care physician, as the insurance had changed and they had been reassigned. They were unable to get established with their newly assigned physician for a few months and had to use their insulin sparingly to make it last.

Preventive services are specifically needed to prevent more costly conditions and diseases and those patients with continuous access to their primary care physician (PCP) are more likely to receive services such as vaccinations, cancer screenings and diabetes screens. Having a PCP who knows you reduces barriers to receiving care when needed as one is more likely to be able to be seen for an urgent concern. Having an established relationship with a PCPs is associated with decreased hospitalizations, decreased spending for other non-PCP specialties, and improvement in morbidity & mortality. Shifting away from the HealthCare.gov platform, also inhibits a patient's access to medication, medical records, and delays care. Additionally, there has not been funding allocated for the transition process, and many of our patients will be dropped unwittingly. Lack of knowledge

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about the transition process is also likely to cause a decline in enrollment among Georgia consumers.

AMWA- GA believes that the number of uninsured persons is unacceptably high. As of 2019, Georgia's uninsured rate was the third worst in the United States at 13.4 percent and significantly higher than the national average of 9.2 percent.¹ Approximately 1.4 million Georgians do not have health insurance.² Coverage is disproportionately worse in rural areas and the uninsured rate is feared to reach 24 percent by 2026.³

AMWA supports The Patients First Act, signed into law by Governor Brian P. Kemp on March 27, 2019, which authorized the "Georgia Pathways to Coverage" Medicaid Section 1115 Demonstration Waiver and the "Georgia Access 1332 State Relief and Empowerment Waiver" to the federal government.⁴ Currently, 267,000 uninsured Georgians make too little to get financial help to buy health insurance through the marketplace, yet do not qualify for Medicaid.⁵ These Georgians have incomes falling below the poverty line, (less than \$12,880 a year for individuals or \$21,720 a year for a family of three), and fall into the coverage gap with no affordable health insurance options.⁵ Additionally, there are another 240,000 uninsured Georgians who make slightly above the poverty line, (between 100 and 138 percent of the poverty line).⁶ Most of this category does qualify for premium subsidies through the marketplace, but they may be unable to use the coverage because of high deductibles and copayments.⁵ Importantly, Medicaid does not have deductibles and has small copayments based on income. In total, over 470,000 Georgians would be able to see health providers, receive preventive and promotive health care, and avoid facing exorbitant medical debt if the state expanded Medicaid.⁶

The Affordable Care Act (ACA) expanded eligibility through Medicaid in States which implemented expansion, simplified enrollment and renewal, and increased outreach and enrollment. The ACA directly led to increased Medicaid coverage and decreased the level of uninsured by expanding eligibility to nonelderly adults with incomes up to 138 percent of the federal poverty level, expanded coverage of children through Children's Health Insurance Program (CHIP), and replaced the "asset test" with the Modified Adjusted Gross Income standard to simplify enrollment and renewal.⁷

Providing coverage to more Georgians will help the "safety net" of physicians, hospitals, and academic medical centers better serve their low-income patients and reduce cost-shifting to the rest of Georgians.⁸ Expanding Medicaid coverage reduces mortality. For example, one study concluded that mortality declined after states expanded their Medicaid programs, particularly among those aged 35-64 years, minorities and people living in poorer areas. Closing the coverage gap also would benefit the state economically.⁸ Job creation in Georgia is expected to total 56,000 jobs created, (12,000 of which in rural communities), and boost Georgia's economic output by \$6.5 billion annually, (\$1.3 billion in rural communities).⁹

The waiver however would not provide the coverage for Georgians needed. The waiver would cause many Georgians to have less affordable or less comprehensive coverage.

American Medical Women's Association GA Branch

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American Medical Women's Association
The Vision and Voice of Women in Medicine since 1915

The health of Georgians is at stake. AMWA supports Medicaid Expansion for the state of Georgia and asks our elected officials to put politics aside and make Georgia a healthy place to live and work. While we appreciate the efforts put forth in the 1335 waiver, it would not assist Georgians as it fails the Affordable Care Act (ACA) for coverage, comprehensiveness and affordability.

Expanding Medicaid thru the ACA, would allow Georgians, along with the other states that have yet to expand, to collectively avoid more than 13,000 deaths each year.¹⁵ A study from the Center on Budget and Policy Priorities found that from 2014 to 2017, Medicaid expansion saved an estimated 19,000 lives among older adults ages 55 to 64.¹⁶ A 2017 study by Harvard researcher Benjamin D. Sommers estimated that Medicaid expansion was associated with one fewer death for every 239 to 316 people who gained insurance.⁴⁸ Medicaid coverage can also improve maternal and infant health, an area where the United States lags behind its peer nations. States that expanded Medicaid subsequently had lower rates of mortality among both mothers and babies.¹⁷ A recent study found that Medicaid expansion may have prevented as many as 8,132 opioid overdose deaths from 2015 to 2017.²¹

AMWA understands that Medicaid expansion can improve people's lives in many ways including those of family members and others not directly affected by the ACA's more generous eligibility thresholds. Medicaid expansion is associated with lower rates of housing evictions among low-income families,¹⁸ lower rates of medical debt, and higher rates of satisfaction with household finances.¹⁹

The proposed 1335 waiver does not cover the millions of people previously uninsured or underinsured and runs the risk of increasing hospitals' costs of uncompensated care,²³ which worsens the financial sustainability of rural hospitals in particular. In rural areas, hospital closures can exacerbate problems with access to care and increase patients' travel times for emergency care.²⁴ Yet while more than 121 rural hospitals have closed since 2010 due to strained finances and changes in the hospital industry,²⁵ a 2018 study by the U.S. Government Accountability Office found that states that expanded Medicaid eligibility and enrollment were less likely to experience rural hospital closures.²⁶

AMWA supports Medicaid expansion in Georgia but is not in support of the waiver as it will not provide the coverage needed.

References:

1. Keisler-Starkey, K., & Bunch, L. N. (2020, September). *Health Insurance Coverage in the United States: 2019*. U.S. Department of Commerce. United States Census Bureau.

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- <https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf#page=13>
2. Berchick, Edward et al. (2019, November). *Health Insurance Coverage in the United States: 2018*. U.S. Department of Commerce. United States Census Bureau. Health Insurance Coverage in the United States: 2018 (census.gov).
<https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>
 3. Harker, L. (2020, January 14). *Governor's Vision for Georgia Omits Help for Struggling Health Care System*. Georgia Budget and Policy Institute. <https://gbpi.org/governors-vision-georgia-omits-help-struggling-health-care-system/>.
 4. State of Georgia. (n.d.). *Patients First Act*. Georgia Medicaid.
<https://medicaid.georgia.gov/patientsfirst>.
 5. Garfield, R., Orgera, K., & Damincio, A. (2021, July 29). *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*. Medicaid. KFF. <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.
 6. Norris, L. (2021, July 9). *Georgia and the ACA's Medicaid expansion*. healthinsurance.org.
<https://www.healthinsurance.org/medicaid/georgia/>.
 7. Rosenbaum, S., Rothenberg, S., Gunsalus, R., & Schmucker, S. (2017, January 17). *Medicaid's Future: What Might ACA Repeal Mean?* How Affordable Care Act repeal legislation could affect Medicaid. <http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/medicaids-future-aca-repeal>.
 8. Sommers, B. D., Baicker, K., & Epstein, A. M. (2012). Mortality and access to care among adults after state Medicaid expansions. *New England Journal of Medicine*, 367(11), 1025–1034.
<https://doi.org/10.1056/nejmsa1202099>
 9. Harker, L. (2020, January 14). *Georgia's ready to close the coverage gap*. Georgia Budget and Policy Institute. <https://gbpi.org/georgia-ready-close-coverage-gap/>.
 10. [42 U.S.C.S. § 1396-1 \(LexisNexis, Lexis Advance through Public Law 117-38, approved August 25, 2021\)](#)
 11. [42 U.S.C.S. § 1396 \(LexisNexis, Lexis Advance through Public Law 117-38, approved August 25, 2021\)](#)
 12. Harker, L. (2020, July 28). *Fast facts on Medicaid expansion*. Georgia Budget and Policy Institute.
<https://gbpi.org/fast-facts-on-medicaid-expansion/>.

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AWHIB

The Association of Web-Based Health Insurance Brokers

January 7, 2022

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight (CCIIO)
U.S. Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244
stateinnovationwaivers@cms.hhs.gov

Dear Director Montz:

Thank you in advance for providing an opportunity for the Association of Web-Based Health Insurance Brokers (AWHIB) to comment on Part II of the state of Georgia's approved Section 1332 Waiver, the Georgia Access Model. AWHIB is a trade association of web-broker entities (WBEs) that have signed agreements with the Centers for Medicare and Medicaid Services (CMS) and are currently leveraging the Federally Facilitated Exchange's (FFE) direct enrollment and enhanced direct enrollment application programming interfaces (APIs). Our members include brokerage firms that sell health insurance online directly to consumers, private health insurance exchanges, and technology companies that support individual agents and brokers. AWHIB seeks to collaborate with consumers, issuers, regulators, lawmakers, and other industry groups to continually develop technologies and enrollment strategies that provide Americans with the greatest access to health insurance products and services.

AWHIB members recognize that Georgia has been working with CMS' Center for Consumer Information and Insurance Oversight (CCIIO) staff to prepare for Georgia Access' implementation. Georgia has engaged a number of stakeholders, including web-brokers and issuers, and has made significant human and financial investments as it implements and prepares to operationalize Georgia Access.

The Georgia Access model is unique in that it will provide consumers with access to comprehensive ACA coverage solely through private sector enrollments partners, including plan selection, collection of application information, display of eligibility results, enrollment and post-enrollment communications. AWHIB members understand that this model may present new flexibility for the State of Georgia in reaching or supporting its citizens, though it does not come without challenges, including transitioning consumers from the FFE to private sector enrollment

partners, reaching all of the various consumer communities and stakeholders to promote awareness and enroll consumers, and scaling up to meet consumer demand absent a public sector enrollment portal. Our members are committed to working with the state of Georgia and CMS to address these challenges if the program moves forward.

Should Georgia Access be permitted to proceed with its implementation, many AWHIB members will participate in the program as Georgia Access Enrollment Partners since our members currently serve Georgians currently in the FFE. Each AWHIB member that would participate in Georgia Access is currently an EDE partner in the FFE. In this capacity as certified enrollment partners, our members will seek to enroll the maximum number of consumers enroll in coverage through Georgia Access, whether that be through qualified health plan coverage, or through Medicaid or CHIP coverage should consumers qualify. Our members would strive to make sure that Georgia Access operates in accordance with the Section 1332 waiver's guardrails. Our members would take the following actions:

- **Scale Up to Meet Statewide Volume** – Enrollment partners plan to expand operational capacity to service the increased volume of consumers in absence of a public sector enrollment platform like Healthcare.gov. Georgia Access enrollment partners would not be starting from scratch, but would instead be leveraging an existing and expanding FFE footprint. For PY 2021 Open Enrollment, EDE and DE partners supported 37% of FFE plan selections. For PY 2022 Open Enrollment, we understand that the percentage of EDE and DE supported FFE plan selections should be even greater. AWHIB members have expanded capacity to meet the increase consumer demand generated by the expanded premium tax credits authorized under the American Rescue Plan and the 2021 COVID-19 SEP. In preparation for Georgia Access, AWHIB members will continue to expand operational capacity to support the increased enrollment volume expected through the Georgia Access model.
- **Grow Existing Marketing Footprint and Emphasize Multiple Contacts** – AWHIB members plan to invest in marketing and communications campaigns so that Georgians who qualifies for premium tax credits receive multiple communications touchpoints and opportunities to enroll. Working with the state of Georgia, our members would build upon their existing online marketing presence to raise awareness and draw consumers to their enrollment sites. In our experience, many consumers who could qualify for coverage often believe that they cannot afford it. As a result, our members emphasize affordability, using repeated and multiple contacts to help drive the point home. AWHIB members would continue this approach for Georgia Access consumers.
- **Expand Outreach** – A critical component of this model will be demonstrating its ability to reach all of the different segments of consumers in the Georgia market. As EDE partners in the FFE, AWHIB members have already been outreaching to a broad range of consumers, including small businesses, independent contractors and gig economy workers, early retirees, minority-owned businesses and other hard to reach populations.

Some of our members also focus specifically on reaching Spanish-speaking populations in southeastern states, including Georgia. But in preparation for Georgia Access, AWHIB members would build upon these current outreach efforts by expanding their extensive networks of Georgia agents and brokers, as well as establishing partnerships with faith-based organizations; community-based organizations in African American, Latino and Asian American communities; American Indian tribes, rural health organizations, and organizations serving the LGBTQ communities.

- **Ensuring Access to Medicaid and CHIP Coverage** – AWHIB members will continue to provide broad access to coverage, enrolling Georgia Access consumers not only in QHP coverage, but in Medicaid and CHIP should they qualify for it. As experienced EDE partners, AWHIB members currently enroll consumers with Medicaid and CHIP in the FFE, oftentimes in significant numbers. Some AWHIB members report that Medicaid applicants comprise nearly 25% of their FFE enrollment traffic. AWHIB members would continue this approach under Georgia Access so as to provide broad access to coverage for Georgians.

AWHIB understands that Georgia has yet to update its actuarial analysis to reflect the expanded premium tax credits authorized under the American Rescue Plan, which are set to expire at the end of PY 2022 under current law. AWHIB strongly supports extending the expanded premium tax credits authorized under the American Rescue Plan beyond PY 2022, making them permanent or extending them for at least another three years. Should Congress and the President enact such an extension, AWHIB believes that the actuarial baseline underlying coverage estimates for Part II of the Georgia Access waiver should be updated at that time.

If you would like more information about AWHIB, please contact AWHIB's advisor, Pete Nakahata, at pete@ptn-consulting.com or 714-369-8894. Thank you again for your willingness to consider AWHIB's comments on Part II of Georgia's Section 1332 waiver.

Sincerely,

AWHIB Board of Directors

January 7, 2022

Submitted by email to: stateinnovationwaivers@cms.hhs.gov

Subject: Georgia Access Model section 1332 waiver comments

To:

The Honorable Xavier Becerra, Secretary, Department of Health and Human Services
The Honorable Janet Yellen, Secretary, Department of the Treasury
The Honorable Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services

From:

Charles R. Bliss
Director of Advocacy
Atlanta Legal Aid Society, Inc.
54 Ellis St. NE
Atlanta, GA 30303
crbliss@atlantalegalaid.org

Dear Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the Departments' further evaluation of Georgia's Section 1332 Waiver Request relating to the "Georgia Access Model." We are writing on behalf of the Atlanta Legal Aid Society, Inc. (ALAS) to express our organization's concern about the Section 1332 Waiver. Since 1924, Atlanta Legal Aid Society has offered free civil legal aid for low income citizens across metro Atlanta. We are home to a Health Law Unit that helps clients with chronic conditions access health insurance, among other services. We also lead a Health Law Partnership that assists low-income children with accessing quality health care and tackling socioeconomic barriers to maintaining good health. Because of our commitment to health-related legal issues, we are well-positioned to identify issues with the proposed 1332 Waiver. Further evaluation of the 1332 Waiver proposal should lead to disapproval of that Waiver.

Georgians are in dire need of comprehensive and affordable health insurance options. The Georgia Access Model portion of the 1332 Waiver would create a number of barriers to accessing health insurance and may ultimately undermine the state's goal of increasing coverage across Georgia. The model would eliminate the consumer's option to access coverage through the unbiased platform offered by the federally facilitated exchange, HealthCare.gov

(FFE). This change would decrease transparency for consumers and would ignore the misalignment of incentives for web-brokers and insurance companies. The Waiver’s proposed exit from the FFE could cause many Georgians to fall through the cracks and lose coverage altogether, while others may end up enrolling in high cost plans with subpar coverage. We urge you to not approve the Georgia Access Model portion of the waiver request.

The “Georgia Access Model” would eliminate Georgians’ access to HealthCare.gov — a centralized platform that displays and allows enrollment in all marketplace health plans.

The Georgia Access Model would eliminate Georgians’ access to HealthCare.gov. Instead, beginning in 2023, Georgia would scatter marketplace functions for more than half a million enrollees among a multitude of private brokers and health insurers. Georgia has not provided a convincing rationale for how depriving potential enrollees of access to an unbiased source for comparative information would improve enrollment. It is not clear how the lack of readily available comparative information will help protect consumers against excessive out of pocket spending.

Georgia’s model cannot produce enrollment comparable to enrollment that would happen absent the waiver.

Fewer Georgians would have health coverage if the Georgia Access Model takes effect, meaning that it fails the “coverage guardrail” that 1332 waivers are required by law to meet. In its application, Georgia projected a negative future for the marketplace and claimed that the Waiver was necessary to stem enrollment losses. But the state’s baseline projections, based on the 2018 plan year, turned out to be incorrect. Georgia’s marketplace enrollment is more than 180,000 higher in August 2021 than in 2018 - a roughly 50 percent increase.

Meanwhile, the state projected its plan would increase marketplace enrollment from about 366,000 in 2018 to 392,000 in 2023. Even if Georgia’s Waiver could generate those coverage gains over 2018, it would fall well short of actual enrollment with the marketplace available. Enrollment is 549,000 as of August 2021. Georgia’s existing projections mean that the state is projecting that the Waiver will not meet the coverage guardrail. Without additional data from the state to show a projection that can meet the coverage guardrail, the Waiver should not go forward.

Georgia’s analysis does not account for significant changes in law that increase enrollment.

For 2021 and 2022, the American Rescue Plan boosted the premium tax credit to reduce marketplace premiums across the board and extended eligibility to people with incomes above 400 percent of the poverty line. While the enhancements are currently set to end in 2022, the Congressional Budget Office (CBO) predicts an enrollment “tail” as more people stay enrolled in 2023, the year the Georgia Access Model would begin. Even if subsidies return to pre-Rescue Plan levels in 2023, as many as 80 percent of Georgia’s enrollees could still be eligible for zero- or low-cost plans, likely boosting enrollment beyond Georgia’s projections.

The Families First Coronavirus Response Act included a provision under which states, to get a higher federal matching percentage for Medicaid costs, must keep Medicaid-eligible people enrolled for the duration of the COVID-19 public health emergency. The Congressional Budget Office anticipates the provision will begin to unwind in July 2022. As it does, some people with income too high for Medicaid might qualify for a premium tax credit in the marketplace and, if the system works well, enroll in marketplace coverage. Georgia’s analysis does not account for this.

Georgia’s analysis does not account for changes in federal rules that increase enrollment and allow some applicants to enroll at any time.

A longer open enrollment period for HealthCare.gov gives people more time to enroll each year and has already contributed to an increase in marketplace enrollment. A rule change allows people with incomes at or below 150 percent of the poverty line to enter the marketplace in any month starting in 2022, rather than needing to have a separate life event to qualify for a special enrollment period (SEP). In Georgia, about 160,000 uninsured adults have incomes between 100 and 150 percent of poverty. This means that the ongoing availability of HealthCare.gov is critical. It seems that Georgia would need to evaluate the likely ability of private providers to meet the year round information needs of potential enrollees in light of the expanded enrollment period for this group.

Georgia would opt out of important federal investments that raise enrollment.

The current Administration made a historic \$100 million investment in nationwide marketing during the six-month emergency enrollment period in 2021. This contrasts to the previous Administration’s \$10 million in annual funding in prior years. This investment demonstrates the current administration’s commitment to making people aware of affordable coverage in the marketplace. Unhooking from HealthCare.gov means Georgia would no longer

benefit from such investment; forgoing government-funded advertising means Georgia can expect lower enrollment under its Waiver.

In 2021, HealthCare.gov navigators received a \$70 million funding increase. Assisters are more likely than agents and brokers to report that their clients were previously uninsured, help with Medicaid or CHIP enrollment, perform public education and outreach activities, or to help Latino clients, people who have limited English proficiency, or people who lack internet at home. Georgia would opt out of this federal investment and would not establish any form of impartial, unbiased help, which means that vulnerable, uninsured people would be less likely to find coverage. Without easily available comparison tools, they will have even more difficulty finding the best coverage to keep down their out of pocket expenses. The state made it illegal to use state funds on navigators so the gap will not be filled from that source.

These additional expenditures on marketing and navigators will assist more people to enroll through HealthCare.gov. This undercuts the premise behind the Georgia Access Model that there is inadequate information to encourage people to enroll in insurance plans.

Georgia's Waiver conflicts with recent Executive Orders on equity and health coverage.

Executive Order 13985 calls on federal agencies to review new and existing policies to assess whether they advance equity for marginalized and historically underserved communities. Georgia did not analyze the Waiver's impact on equity, which should raise the Departments' level of scrutiny.

Executive Order 14009, on strengthening Medicaid and the Affordable Care Act, calls for an immediate review of all federal agency actions, with the goal of making coverage accessible and affordable to everyone. This includes policies that undermine protections for people with pre-existing conditions; waivers that may reduce coverage under Medicaid or the ACA; policies that undermine the marketplace; policies that create unnecessary barriers to families attempting to access ACA coverage; and policies that may reduce the affordability of coverage. Georgia's Waiver conflicts with each of these goals.

Conclusion

The Georgia Access Model offered an implausible approach from the start. The idea that eliminating access to a tool that makes unbiased comparisons of available health plans readily available to consumers would increase enrollment in health plans is counterintuitive. It seems that having comparative information available would help consumers make the complex choice of an appropriate plan and therefore support enrollment.

Now there is data demonstrating that some of the key factual projections on which the waiver request was based were wrong. Enrollment was predicted to drop, but instead has gone up dramatically. There are significant additional investments in providing information from the federal government that will be nullified if the Waiver goes forward.

Finally, the Georgia Access Model conflicts with new executive orders on equity and health coverage.

In light of all these issues, the Georgia Access Model cannot meet the statutory guardrails for approval. The Departments should not approve this waiver request. Thank you for your consideration of this matter.

Sincerely,

(signed) Charles R. Bliss

Charles R. Bliss

Director of Advocacy

Atlanta Legal Aid Society, Inc.



January 7, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Re: Request for Comment on the Georgia Access Model

Dear Secretary Becerra and Secretary Yellen,

The Cancer Support Community (CSC), an international nonprofit organization that provides support, education, and hope to cancer patients, survivors, and their loved ones, welcomes the opportunity to comment on the Georgia Access Model. As the largest provider of social and emotional support services for people impacted by cancer, CSC has a unique understanding of the cancer patient experience. In addition to our direct services, our Research and Training Institute and Cancer Policy Institute are industry leaders in advancing the evidence base and promoting patient-centered public policies.

It's estimated that over 58,000 people in Georgia were diagnosed with cancer in 2021 (American Cancer Society, 2021), and access to quality, timely, comprehensive, and affordable health care is crucial to their health outcomes. Georgia's section 1332 waiver, approved by the previous Administration on November 1, 2020, included a part, the Georgia Access Model, to exit the federal health insurance marketplace, HealthCare.gov, with no substitute. In [CSC's September 2020 comments regarding Georgia's waiver](#), while we supported Georgia's plan to establish a reinsurance program, we outlined our serious concerns with the Georgia Access Model over fears that it would limit access to care for individuals in Georgia. This could prove devastating to people at risk for or living with cancer.

We appreciate that the current Administration opened a federal comment period for local and national stakeholders to provide input on the Georgia Access Model. For the reasons outlined below, CSC has serious concerns with the Georgia Access Model and urge the Department of Health and Human Services and the Department of the Treasury (collectively, the Departments) to revoke its approval from Georgia's 1332 waiver.

Georgia Access Model Violates Affordable Care Act Requirements

Section 1332 of the *Affordable Care Act* (ACA) allows states to apply for a state innovation waiver to pursue innovative strategies to provide their residents with high quality, affordable health care coverage while retaining the basic protections of the ACA. The law requires that innovation plans meet four guardrails:

- Provide coverage that is at least as comprehensive in covered benefits;
- Provide coverage that is at least as affordable (taking into account premiums and excessive cost sharing);
- Provide coverage to at least a comparable number of state residents; and
- Not increase the federal deficit (Tolbert & Pollitz, 2018).

The Georgia Access Model fails to meet the law's guardrails for 1332 waivers. For the reasons outlined below, the model would likely increase the number of uninsured Georgians, and the state would see a reduction, rather than an increase, in covered beneficiaries. Additionally, the coverage that many Georgians would have could be less comprehensive with higher out-of-pocket obligations for patients. Moreover, the state's initial analysis does not account for recent federal policy changes and investments that have increased marketplace enrollment.

Impact on Health Insurance Enrollment

The Georgia Access Model significantly changes the way Georgia consumers shop for and obtain health insurance. In 2020, the vast majority (79%) of Georgia marketplace enrollees used HealthCare.gov to sign up for coverage (Straw, 2020). Under the approved waiver, Georgia would exit HealthCare.gov beginning in 2023 without creating a state-based marketplace (SMB) to replace it. This would eliminate the most common source of help for the more than half a million Georgians who enroll in private health plans or Medicaid through HealthCare.gov (CMS, 2021), leaving them to navigate among private insurers and brokers to compare plans, apply for financial assistance, and enroll in coverage.

As CSC outlined in our 2020 comments, by taking away HealthCare.gov, the Georgia Access Model has the potential to cause many Georgians to fall through the cracks and lose coverage altogether. Purchasing health insurance is a complicated undertaking and eliminating the federal marketplace could confuse and discourage consumers, hindering enrollment. The increase in confusion about where and how to access good-quality health coverage could prompt many people to give up and become uninsured. Further, under the Georgia Access Model, patients would lose access to the auto-enrollment function of HealthCare.gov, which automatically re-enrolled 92,000 Georgians in health coverage for 2021 (CMS, 2021), creating the potential for tens of thousands of people to unwittingly lose their health coverage.

In its application, Georgia claimed that the Georgia Access Model was necessary to stem enrollment losses and estimated that privatizing its marketplace would increase enrollment in the individual market by 25,000 people by giving consumers new options to shop for and enroll in plans (Georgia Section 1332 State Innovation Waiver, 2020). However, Georgians already have the option to use a private broker or insurer website when shopping for and obtaining health insurance. The Georgia Access Model does not create any new options for Georgia consumers to enroll in health insurance, and simply takes away the most widely used HealthCare.gov option. Additionally, the state's analysis doesn't account for recent gains in health insurance enrollment via HealthCare.gov. Since the time that the waiver was approved, Georgia's marketplace enrollment has increased by about 50% in August 2021 compared to 2018 numbers (Straw & Levitis, 2021). These enrollment gains, which are not reflected in the state's now outdated estimates, are due in large part to recent changes in federal law and policies aimed at making health care more affordable and expanding the number of people with coverage through the marketplace.

Since the initial approval of Georgia's section 1332 waiver, the federal government has made significant investments in HealthCare.gov marketing and outreach, enrollment activities, and Navigators, and changes in federal law and policy such as the enactment of the *American Rescue Plan Act* (ARP), COVID-19 special enrollment period (SEP), and longer open enrollment period for 2022 coverage. In Georgia, more than 356,000 consumers were able to take advantage of the enhanced Premium Tax Credits provided by ARP and consumers saw an average savings of \$49 per person in their monthly premium (CMS, 2021). Additionally, with the COVID-19 SEP, over 147,000 Georgians signed up for 2021 coverage on HealthCare.gov which was "more than three times the number of Georgia consumers who signed up with a SEP during the same time period in 2020 and more than five times the number in 2019" (CMS, 2021). Moreover, when the Departments approved Georgia's waiver, federal funding for the Navigator program and outreach were significantly lower than they are currently. The Navigator

programs alone saw an eight-fold increase in funding from recent plan years (HHS, 2021) and Georgia received over \$2.5 million in Navigator funding for the 2022 plan year (CMA, 2021).

Georgia projected that the Georgia Access Model would increase marketplace enrollment to 392,000 in 2023 (Straw & Levitis, 2021). As of December 15, 2021, nearly 654,000 Georgians have already selected or were re-enrolled in a health care plan on HealthCare.gov during the extended open enrollment period (CMS, 2021). This is far more than the waiver's initial projection. Additionally, unhooking from HealthCare.gov would mean that Georgia would no longer benefit from many of the aforementioned federal investments like advertising and Navigators. For these reasons, the Georgia Access Model cannot produce enrollment equivalent to enrollment that would happen without the Georgia Access Model, meaning that it fails to meet the guardrail that innovation plans provide coverage to at least a comparable number of state residents.

Impact on Comprehensiveness and Affordability

We believe that access to quality, comprehensive, and affordable health care is critically important for Georgians, particularly those at risk for or living with cancer. The Georgia Access Model would allow short-term, non-ACA compliant plans that subject enrollees to exclusions based on pre-existing conditions, benefit limitations, and caps on plan reimbursements that expose people to potentially high out-of-pocket costs, to be presented alongside comprehensive coverage options. The Georgia Access Model would give insurers and brokers new opportunities to steer healthier consumers toward these substandard plans that expose them to potentially devastating costs if they get sick (Straw & Levitis, 2021). One survey found that one in four marketplace enrollees who were helped by a broker or insurer reported being offered a non-ACA compliant policy as an alternative to marketplace health coverage (Pollitz et al., 2020). Further, the resulting adverse selection could make comprehensive coverage more expensive for those who need it.

Georgia Access Model Does Not Advance Health Equity

Impact on Health Equity

Many of the new federal investments and policies mentioned above emphasize the Administration's commitment to addressing longstanding coverage disparities in historically underserved populations. The Navigator program, for example, help connect communities that experience greater disparities in access to health care to critical health coverage. The Centers for Medicare & Medicaid Services reported that during the COVID-19 SEP, 15% of enrolled consumers identified as African American, compared to 9% and 11% in 2019 and 2020, respectively, and the percentage of enrolled consumers identified as Hispanic/Latino increased to 19%, from 16% in 2019 and 2020 (CMS, 2021).

The Georgia Access Model also conflicts with recent Executive Order 13985, which calls on federal agencies to assess whether policies advance equity for "people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality" (The White House, 2021). However, Georgia did not analyze the waiver's impact on equity. The Georgia Access Model also conflicts with each of the goals in Executive Order 14009, focused on strengthening Medicaid and the ACA, which aims to make health coverage accessible and affordable for all. The recent order, which also created the COVID-19 SEP, calls for an immediate review of federal agency actions. This includes policies that "undermine protections for people with pre-existing conditions; waivers that may reduce coverage under Medicaid or the ACA; policies that undermine the marketplace; policies that create unnecessary barriers to families attempting to access ACA coverage; and policies that may reduce the affordability of coverage" (Straw & Levitis, 2021). The order directs federal agencies to consider whether to "suspend, revise, or rescind" (The White House, 2021) such agency actions, which would include the approved Georgia section 1332 waiver.

The Administration's commitment to making health coverage accessible and affordable for all is undermined if Georgia's plan to eliminate HealthCare.gov and instead rely solely on private brokers and insurers to help consumers compare plans, apply for financial assistance, and enroll in coverage comes to fruition.

Impact on Medicaid Coverage

In 2021, at least 35,000 Georgians enrolled in Medicaid via HealthCare.gov (CMS, 2021). Currently, HealthCare.gov screens individuals for eligibility for premium tax credits, and lets consumers know if they are eligible for Medicaid coverage. Under the approved waiver, people who are eligible for Medicaid could have a much harder time finding help with enrollment since Medicaid generally does not pay commissions. Private brokers and insurers have no incentive to fill the gap left for this population that would result from eliminating HealthCare.gov. For example, a search on HealthCare.gov displays more than 1,100 agents and brokers that enroll people in individual or family coverage in one Atlanta ZIP code, but zero agents and brokers that say they'll assist with Medicaid or CHIP enrollment (Straw, 2020).

Also concerning is that some private brokers and insurers who operate through HealthCare.gov have ignored consumers' potential Medicaid eligibility altogether unless at least one household member is eligible for subsidized marketplace coverage. Some have failed to alert consumers of Medicaid eligibility and move Medicaid-eligible consumers into other types of plans (Straw, 2019).

Conclusion

Thank you again for the opportunity to provide comments on the Georgia Access Model. Access to quality, comprehensive, and affordable health care is critically important for Georgians living with cancer, and the Georgia Access Model jeopardizes beneficiaries' access to care. Should you have any questions, please contact Phylcia L. Woods, Executive Director of the Cancer Policy Institute at the Cancer Support Community at pwoods@cancersupportcommunity.org.

Sincerely,



Phylcia L. Woods, JD, MSW
Executive Director – Cancer Policy Institute
Cancer Support Community Headquarters

References

- American Cancer Society. (2021). *Cancer Facts & Figures 2021*. Retrieved from <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2021/cancer-facts-and-figures-2021.pdf>.
- Centers for Medicare & Medicaid Services. (2021). *2021 Marketplace Open Enrollment Period Public Use Files*. Retrieved from <https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files>.
- Centers for Medicare & Medicaid Services. (2021). *Marketplace Weekly Enrollment Snapshot: Week 6*. Retrieved from <https://www.cms.gov/newsroom/fact-sheets/marketplace-weekly-enrollment-snapshot-week-6>.

- Centers for Medicare & Medicaid Services. (2021). *Request for Comment on the Georgia Access Model*. Retrieved from <https://www.cms.gov/files/document/1332-ga-access-public-comment-request.pdf>.
- Georgia Section 1332 State Innovation Waiver as submitted to CMS on July 31, 2020; https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.
- Pollitz, K., Tolbert, J., Hamel, L., & Kearney, A. (2020). Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need. *Kaiser Family Foundation*. Retrieved from <https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/>.
- Straw, T. & Levitis, J. (2021). Georgia's Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked. *Center on Budget and Policy Priorities*. Retrieved from https://www.cbpp.org/research/health/georgias-plan-to-exit-marketplace-will-leave-more-people-uninsured-should-be#_ftn3.
- Straw, T. (2019). "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm. *Center on Budget and Policy Priorities*. Retrieved from <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.
- Straw, T. (2020). Tens of Thousands Could Lose Coverage Under Georgia's 1332 Waiver Proposal. *Center on Budget and Policy Priorities*. Retrieved from https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal#_ftnref12.
- The White House. (2021). *Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*. Retrieved from <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.
- The White House. (2021). *Executive Order on Strengthening Medicaid and the Affordable Care Act*. Retrieved from <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/>.
- Tolbert, J., Pollitz, K. (2018). New Rules for Section 1332 Waivers: Changes and Implications. *Kaiser Family Foundation*. Retrieved from <https://www.kff.org/health-reform/issue-brief/new-rules-for-section-1332-waivers-changes-and-implications/>.
- U.S. Department of Health & Human Services. (2021). *HHS Announces the Largest Ever Funding Allocation for Navigators and Releases Final Numbers for 2021 Marketplace Open Enrollment*. Retrieved from <https://www.hhs.gov/about/news/2021/04/21/hhs-announces-the-largest-ever-funding-allocation-for-navigators.html>.



January 7, 2022

Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Submitted via electronic mail: stateinnovationwaivers@cms.hhs.gov

Dear Secretary Becerra and Secretary Yellen:

Thank for you for the opportunity to comment on Part II of Georgia's section 1332 waiver application, which details the Georgia Access Model and its compliance with the statutory guidelines set forth in section 1332(b1)(1)(A)-(D) of the Affordable Care Act (ACA). This comment is submitted on behalf of the Center for American Progress (CAP), an independent, nonpartisan policy institute based in Washington, D.C.

We applaud the commitment of the Department of Health and Human Services (HHS) and the Department of the Treasury to helping states develop health insurance market reforms that expand coverage, lower costs, and ensure that health care is accessible to all Americans. Since 2017, section 1332 state innovation waivers have provided 16 states with the flexibility to develop and implement strategies and reforms designed to address local market challenges related to coverage affordability and access while maintaining the core protections and intentions of the ACA.¹

The COVID-19 pandemic and public health emergency, coupled with legislation and administrative actions during the Biden administration, have significantly altered Georgia's health coverage landscape. These changes necessitate re-evaluation of the previously approved Georgia Access Model to determine whether it satisfies the statutory guardrails in the current environment.

In this letter, we highlight the implications of recent federal legislative and regulatory changes on coverage and discuss additional operational factors to be taken into consideration during the Departments' evaluation of whether the waiver meets the guardrails.

¹ Centers for Medicare and Medicaid Services, "Section 1332: State Innovation Waivers," available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.

Implications of Federal Legislative and Regulatory Changes on Key Underlying Assumptions in Georgia’s 1332 Waiver Application

A variety of federal policy changes have been implemented since the Centers for Medicare and Medicaid Services (CMS) approved Georgia’s section 1332 waiver application in November 2020. In 2021, Congress passed major pieces of legislation that included provisions related to marketplace coverage, and the Biden administration carried out executive actions to stem employment-related coverage losses during the COVID-19 pandemic, to reduce the number of uninsured, and to expand coverage and affordability. Notably, Congress passed the American Rescue Plan Act (ARPA) in March 2021, providing enhanced premium tax credits to new and existing marketplace enrollees. In addition, the federal COVID-19 special enrollment period (SEP) for HealthCare.gov, which ran from February 15 to August 15, 2021, improved access to coverage and facilitated enrollment for over 2.8 million Americans.²

These federal interventions have altered Georgia’s health marketplace dynamics, impacting the enrollment projections and affordability assumptions underlying analyses in the approved 1332 waiver application. A sound assessment of Georgia’s compliance with the statutory guardrails for the waiver requires re-baseline.

Enrollment

Georgia’s 1332 waiver application described the state’s individual market for health insurance as one of decline, with steadily dwindling marketplace enrollment. In 2019, Georgia had the third-highest uninsured population in the nation at 1.4 million (14.8 percent of total population) and 458,437 Georgians enrolled in individual market coverage.³ Between 2016 and 2019, there was a 22 percent decrease in marketplace enrollment, with 129,000 fewer Georgians covered through marketplace plans.⁴

Georgia asserted that state intervention, via the section 1332 waiver, was needed to increase enrollment and stabilize the market. Under the proposed Georgia Access Model, the state would leave the federally facilitated marketplace (FFM) starting with enrollment for plan year 2023, and Georgia consumers would instead rely on private insurance brokers, vendors, and agents for enrollment. Insurers and agents would conduct annual marketing and outreach to consumers ahead of open enrollment. Rather than use the HealthCare.gov portal for plan shopping and selection, Georgians would instead visit a state webpage that would direct them to privately operated websites for plan shopping and to commercial-market web brokers or carriers directly for application and enrollment. Using a 2018 baseline marketplace enrollment of 367,562, Georgia officials estimated that the model would generate a 6.8 percent increase in ACA-compliant

² United States Department of Health and Human Services, “2021 Final Marketplace Special Enrollment Period Report” (Washington: 2020), available at <https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf>.

³ State of Georgia, “Georgia Section 1332 State Innovation Waiver,” available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-#please_visit_the_Georgia_waiver_section_of_this_webpage_below.

⁴ Ibid.

individual market enrollment in Plan Year 2023.⁵ According to Georgia's waiver application, this enrollment increase would be driven by new marketing and consumer outreach as well as lower premiums due to the implementation of a state reinsurance program and the Georgia Access Model.

Coverage trends have deviated from the enrollment baseline in Georgia's waiver application. Recent federal action has contributed to substantial enrollment growth, with marketplace plan selections reaching an all-time high of 13.6 million nationally as of December 2021.⁶ Even prior to the open enrollment period currently underway, Georgia's marketplace enrollment was bolstered by both APRA and the HealthCare.gov COVID-19 SEP. During the six-month COVID-19 SEP, there were 147,463 new plan selections in Georgia.⁷ This marks a more than three-fold increase from SEP plan selections during the same timeframe in years prior: 41,138 in 2020 and 25,656 in 2019.⁸ Overall, by August 2021, Georgia's effectuated individual market enrollment was 549,066, an increase of 49.3 percent from the 2018 baseline included in their waiver application.⁹

Marketplace enrollment continues to increase due to federal regulatory action. For 2022 coverage, CMS extended the open enrollment period for HealthCare.gov by 30 days, providing additional time for consumers to elect or make changes to their coverage.¹⁰ While the current open enrollment period does not close until January 15, the most recent CMS enrollment report notes continued growth, with 5.8 million Americans (including 653,990 Georgians) selecting marketplace plans as of December 15, 2021.¹¹ The Biden Administration has invested \$100 million in advertising, outreach, and marketing to improve awareness around marketplace coverage, and it supported in-person assistance with \$80 million in funding for navigator organizations.¹² These consumer-focused investments will likely continue to boost marketplace enrollment; given this, it is unclear whether the effects of the marketing and outreach activities under the Georgia Access

⁵ Centers for Medicare and Medicaid Services, "Georgia: State Innovation Waiver under section 1332 of the PPACA" (Baltimore: 2020), available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Fact-Sheet.pdf.

⁶ United States Department of Health and Human Services, "All Time High: 13.6 Million People Signed Up for Health Coverage on the ACA Insurance Marketplaces With a Month of Open Enrollment Left to Go," Press release, December 22, 2021, available at <https://www.hhs.gov/about/news/2021/12/22/all-time-high-13-million-people-signed-up-for-health-coverage.html>.

⁷ United States Department of Health and Human Services, "2021 Final Marketplace Special Enrollment Period Report" (Washington: 2021), available at <https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf>.

⁸ Ibid.

⁹ Centers for Medicare and Medicaid Services, "Total Effectuated Enrollment by State, August 2019-2021" (Baltimore: 2021) available at <https://www.cms.gov/files/document/2019-2021-aug-effectuated-enrollment.xlsx>.

¹⁰ Healthcare.gov, "Dates and deadlines for 2022 health insurance," available at <https://www.healthcare.gov/quick-guide/dates-and-deadlines/>.

¹¹ Centers for Medicare and Medicaid Services, "Marketplace Weekly Enrollment Snapshot: Week 6," Press release, December 22, 2021, available at <https://www.cms.gov/newsroom/press-releases/hhs-announces-increased-marketplace-enrollment-trends-nearly-46-million-new-plan-selections-open>.

¹² U.S. Department of Health and Human Services, "HHS Announces the Largest Ever Funding Allocation for Navigators and Releases Final Numbers for 2021 Marketplace Open Enrollment," Press release, April 21, 2021, available at <https://www.hhs.gov/about/news/2021/04/21/hhs-announces-the-largest-ever-funding-allocation-for-navigators.html>.

Model can be expected to raise enrollment to the same degree projected using the 2018 baseline.

Affordability

The affordability conditions described in Georgia's waiver application have also changed profoundly due to federal legislation. In its waiver application, Georgia attributed its high uninsured rate to a lack of affordability, citing high premiums and out-of-pocket costs for marketplace coverage. The state estimated that in 2018, more than half of its uninsured population (795,000) had family incomes between 100 and 400 percent of the federal poverty level (FPL) yet remained unenrolled despite having incomes in the range eligible for marketplace financial assistance.¹³

The American Rescue Plan Act (ARPA) impacted the affordability assumptions in Georgia's waiver application. For 2021 and 2022, the American Rescue Plan Act enhances financial assistance for low- and middle-income families by lowering the percentage of income a subsidy-eligible enrollee owes toward the benchmark silver plan. ARPA also enables those with family incomes up to 150 percent of the FPL to enroll in that plan with no premium cost and makes premium tax credits newly available to people with family incomes above 400 percent of the FPL, who were not previously eligible for financial assistance.¹⁴

The enhanced financial assistance under ARPA has lowered marketplace enrollees' net premiums and contributed to growth in enrollment.¹⁵ HHS estimated that 127,100 uninsured Georgians were newly eligible for premium tax credits thanks to ARPA and that 134,900 uninsured Georgians were eligible for \$0 premium benchmark coverage.¹⁶ HHS has encouraged existing enrollees to return to HealthCare.gov to claim the expanded financial assistance as advance premium tax credits. Among the 356,487 Georgia enrollees who returned to the marketplace to select a new plan or update their plan during the COVID-19 SEP, the average reduction in average monthly net premium was 54 percent.¹⁷ ARPA also appears to be boosting open enrollment plan selections: as of mid-December, over 400,000 people had signed up to receive premium tax credits for 2022 coverage "that would have been inaccessible to them prior to the ARP," according to CMS.¹⁸

¹³ State of Georgia, "Georgia Section 1332 State Innovation Waiver."

¹⁴ Emily Gee and Thomas Waldrop, "Policies To Improve Health Insurance Coverage as America Recovers From COVID-19," Center for American Progress, March 11, 2021, available at <https://www.americanprogress.org/article/policies-improve-health-insurance-coverage-america-recovers-covid-19/>.

¹⁵ Center for Consumer Information and Insurance Oversight, "Plan Year 2022 Qualified Health Plan Choice and Premiums in Healthcare.gov States" (Washington: Centers for Medicare and Medicaid Services, 2021), available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2022QHPPremiumsChoiceReport.pdf>.

¹⁶ U.S. Department of Health and Human Services, "Fact Sheet: The American Rescue Plan: Reduces Health Care Costs, Expands Access to Insurance Coverage and Addresses Health Care Disparities," Press release, March 12, 2021, available at <https://www.hhs.gov/about/news/2021/03/12/fact-sheet-american-rescue-plan-reduces-health-care-costs-expands-access-insurance-coverage.html>

¹⁷ U.S. Department of Health and Human Services, "2021 Final Marketplace Special Enrollment Period Report."

¹⁸ Centers for Medicare and Medicaid Services, "All-Time High: 13.6 Million People Signed Up for Health Coverage on the ACA Insurance Marketplaces With a Month of Open Enrollment Left to Go."

In fact, the Congressional Budget Office (CBO) had projected that ARPA's subsidy changes would substantially increase marketplace enrollment.¹⁹ CBO forecast that 1.7 million more people would be enrolled in marketplace plans in 2022, including 1.3 million who would have otherwise been uninsured, and that increase in enrollment would "would persist beyond 2022" into 2023.²⁰

In addition, the Build Back Better Act under consideration in Congress would further expand coverage and improve affordability, including during years in which the proposed Georgia Access Model is in effect. The House-passed version of the Build Back Better legislation would close the Medicaid coverage gap in Georgia and other non-expansion states, making individuals with family incomes up to 138 percent FPL eligible to obtain marketplace plans with no premium and a 99 percent actuarial value so that they would face only minimal out-of-pocket costs.²¹ An estimated 269,000 low-income, uninsured Georgians currently fall into the Medicaid coverage gap and are eligible neither for Medicaid nor for marketplace financial assistance.²² In addition, the legislation would extend the ARPA premium subsidy enhancements and eligibility changes through 2025.

Compliance Implications

ARPA's enhanced subsidies and the HealthCare.gov COVID-19 SEP contributed to record-high marketplace enrollment in 2021.²³ Georgia's marketplace enrollment at the conclusion of 2021 is markedly different from the 2018 baseline provided in its waiver application and as a result, the state's pre-ARPA impact analysis did not account for this increase in enrollment. An updated analysis reflecting the considerable coverage gains resulting from both ARPA expansion and the federal COVID-19 SEP would enable CMS to properly determine Georgia's compliance with the 1332 scope of coverage guardrail.

Implementation Impacts of Georgia Access Model

There are additional operational elements of the Georgia Access Model that should also be considered when determining its compliance with 1332 guardrails as well as its alignment with principles of equity, coverage affordability, and accessibility.

¹⁹ Congressional Budget Office, "Reconciliation Recommendations of the House Committee on Ways and Means" (Washington: 2021), available at <https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf>

²⁰ Ibid.

²¹ Nicole Rapfogel, Thomas Waldrop, Emily Gee, Natasha Murphy, Jill Rosenthal, "The Build Back Better Act Would Improve Health Care and Lower Costs, Center for American Progress, December 6, 2021, available at <https://www.americanprogress.org/article/the-build-back-better-act-would-improve-health-care-and-lower-costs/>.

²² Rachel Garfield, Kendal Orgera, and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid," Kaiser Family Foundation, January 21, 2021, available at <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

²³ Katie Keith, "Record-High Marketplace Enrollment, New Census Data, And More," Health Affairs Forefront, September 21, 2021, available at <https://www.healthaffairs.org/doi/10.1377/forefront.20210921.302725/full/>

Erosion of Consumer Assistance

The Georgia Access Model intends to replace federally trained and funded Navigators with private sector brokers for consumer outreach, education, and enrollment. Since the ACA's inception, navigators have provided professional consumer assistance to millions of Americans.²⁴ In its application, Georgia contends that this transition will provide marketplace consumers with improved customer service, contributing to enrollment increases. However, the absence of Navigators will likely have an adverse impact on enrollment, especially for harder-to-reach populations. Unlike agents and brokers, Navigators are prohibited from receiving commissions and are thus financially disinterested in consumers' plan selections.²⁵ A 2020 Kaiser Family Foundation analysis found that private brokers were less likely than Navigators to assist consumers with complex applications, including for those who were uninsured, needed help in another language, did not have computer or internet access, or needed to apply for Medicaid.²⁶

The inability of the Georgia Access Model to equitably respond to the needs of diverse populations and historically marginalized communities is concerning, and it is out of alignment with the Biden Administration's priorities. Executive Orders 13985 and 14009 request federal agencies to conduct an equity assessment of new and existing policies and require review (and subsequent suspension, revisions or rescission) of federal actions that undermine coverage accessibility and affordability.

Enrollment Diversion

Consistent with the Affordable Care Act's "no wrong door" philosophy, the federal marketplace enrollment application directs consumers to the appropriate health insurance program based on their household characteristics, including income and family size. When appropriate, applicants visiting HealthCare.gov are re-routed to other programs, including Medicaid/CHIP, based on their eligibility. This ensures that people seeking marketplace coverage are guided to more affordable options for comprehensive coverage if their incomes render them ineligible for marketplace financial assistance.

By relying on private enrollment entities, the Georgia Access Model does not replicate "no wrong door," leaving low-income Georgians vulnerable to ending up in coverage that does not meet their needs. While Georgia proposes to integrate the Access Model directly with the Medicaid eligibility system, consumers are likely to need assistance after their eligibility determination including understanding their new coverage (provider selection, premiums, appeals) and renewal. Moreover, the services provided by Navigators and brokers are not interchangeable:²⁷ Private brokers are not incentivized to enroll Medicaid/CHIP-eligible consumers into public coverage and may instead steer them toward private coverage for which they receive commissions, including plans that may not be affordable or that do not provide comprehensive coverage.²⁸ Furthermore, the higher

²⁴ Karen Pollitz and others, "Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need," Kaiser Family Foundation, August 7, 2020, available at <https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/>.

²⁵ 45 C.F.R. §§ 155.210(d)(1)-(4) and 155.215(a)(1)

²⁶ Pollitz, "Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need."

²⁷ Ibid.

²⁸ Tara Straw, "'Direct Enrollment' in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm," Center on Budget and Policy Priorities, (Washington: 2019), available at

commissions for and profitability of non-ACA compliant plans, such as short-term limited duration plans, can encourage insurance companies, agents, and brokers to divert consumers to substandard coverage.²⁹ Such plans are not obligated to provide the ACA's essential health benefits—basic services like prescription drug coverage or maternity care—and are not bound by the ACA's medical loss ratio rules.

The increase in marketplace enrollment under ARPA and the current regulatory environment means that the potential for diversion of new or renewing customers could be even greater than at the time of the original waiver projections. As CMS considers new analysis of the Georgia Access Model, we encourage the agency to evaluate whether it could violate the statutory guardrails by causing diversion of consumers into plans that are not at least as comprehensive as ACA plans and, in turn, result in fewer Georgians covered than without the waiver.

Conclusion

The enrollment baseline and affordability conditions undergirding the Georgia Access Model were significantly altered by the enactment of the American Rescue Plan and executive actions related to marketplace outreach, the COVID-19 special enrollment period, and the duration of open enrollment for HealthCare.gov. These policy changes have resulted in record-high marketplace enrollment,³⁰ and these gains will likely persist under the current statutory and regulatory environment. We support CMS's demand that Georgia provide updated analysis reflecting the current status quo and demonstrate that the Georgia Access Model would sustain current levels of marketplace enrollment in compliance with the coverage guardrail. In addition, the Departments should consider the Georgia Access Model's misalignment with the Administration's stated commitment to equity, accessibility, and affordability.

We appreciate the opportunity to provide comment and thank the Departments for considering our recommendations.

Sincerely,

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<https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

²⁹ Ibid.

³⁰ United States Department of Health and Human Services, "All Time High: 13.6 Million People Signed Up for Health Coverage on the ACA Insurance Marketplaces With a Month of Open Enrollment Left to Go."



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January 4, 2022

U.S. Department of Health and Human Services (HHS) and
The U.S. Department of Treasury
stateinnovationwaivers@cms.hhs.gov

Re: Georgia Access Model Section 1332 Waiver Comments

Center for Civil Justice (CCJ) submits the following comments on the Georgia Access Model Section 1332 Waiver concerning Georgia's exit from HealthCare.gov starting in 2023.

CCJ is a Michigan law firm that focuses on addressing legal and policy issues surrounding the programs, services and opportunities that are intended to help low-income people. CCJ also has a commitment to advance racial justice and equity. We write to express our strong opposition to Georgia's plan to eliminate HealthCare.gov as it violates the 1332 coverage guardrails because it would result in fewer Georgia residents having health care coverage.

Georgia's Section 1332 Waiver did not analyze the impact on equity to ensure that all people, including those that have been underserved, marginalized and adversely affected by poverty and inequality, are afforded health care coverage. President Biden, in his Executive Order 13985,¹ called on the heads of each federal agency to select programs and policies for review to assess whether underserved communities face systemic barriers to accessing benefits and services in Federal programs. Without the marketing and outreach investment of the federal government for enrollment using HealthCare.gov, it is likely that Georgia's waiver will not increase enrollment in the marketplace but will reduce enrollment and leave more Georgian's uninsured. Furthermore, by using brokers and insurers that make a commission by selling insurance, low-income consumers may be led to purchase private coverage instead of being informed that they are eligible for comprehensive coverage through Medicaid or CHIP. Since it is anticipated there will be a decrease in enrollment and people will be wrongfully directed to private coverage, there will be a negative impact on the underserved, marginalized and people living in poverty.

¹ Federal Register, Executive Order 13985 of January 20, 2021
<https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government>

Georgia's waiver allowing for the exit from HealthCare.gov, will eliminate the help that navigators bring to individuals and families. Having a navigator makes it easier for individuals and families to understand their health insurance options. Navigators are federally funded and not only help with enrollment, but also help people determine eligibility and select plans. Navigators are skilled at reaching underserved populations. Navigators do outreach and are able to help people with limited English proficiency. Navigators are also helpful for those that do not have internet access. In fact, a recent study found that cuts in the navigator program led to a decline in coverage to underserved populations.² Without the assistance of navigators, vulnerable uninsured people would be less likely to enroll in health insurance coverage.

Georgia's 1332 Waiver does not comply with federal requirements because it will lead to more people being uninsured than would happen if there was no waiver at all. In light of the pandemic, this is not the time to turn our backs on people needing health care coverage.

CCJ requests the administration revoke Georgia's harmful 1332 Waiver.

Thank you for the opportunity to submit comments.

Respectfully submitted,



Kelly L. Bidelman
Executive Director
Center for Civil Justice
kbidelman@ccj-mi.org

² Rebecca Myerson and Honglin Li, "Information Gaps and Health Insurance Enrollment: Evidence from the Affordable Care Act Navigator Programs," posted at SSRN, November 11, 2021, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3966511.

January 6, 2022

To: The Honorable Xavier Becerra, Secretary, Department of Health and Human Services
The Honorable Janet Yellen, Secretary, Department of Treasury
The Honorable Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services

Subject: Georgia Section 1332 Waiver Comments
From: Suzanne Wikle, Center for Law and Social Policy (CLASP)
Submitted electronically via stateinnovationwaivers@cms.hhs.gov

Dear Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure,

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, organization working to reduce poverty, promote economic security, and advance racial equity. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. CLASP appreciates the opportunity to submit comments again on Georgia's 1332 waiver application, the "Georgia Access Model". CLASP strongly urges CMS to revoke federal approval for the Georgia Access Model and prevent the state from exiting the federal exchange and forcing Georgians to rely on a patchwork of agents and brokers to find health insurance.

The Proposal Will Insure Fewer People and Encourage Enrollment in Subpar Plans

The ACA 1332 waiver would change where and how consumers purchase health coverage. In 2020, the vast majority (79 percent) of Georgia marketplace enrollees used HealthCare.gov to sign up for coverage, even though they already had the option to use a private broker or insurer website. Georgia's waiver would eliminate the one-stop shop of HealthCare.gov, without creating a state-based marketplace, *requiring* people in the state to use private insurance companies and brokers to compare plans, apply for financial assistance, and enroll in coverage. This would undoubtedly increase confusion about where and how to access good-quality health coverage, hindering enrollment and prompting many people to give up and become uninsured. Contrary to the promise of expanded choices, this waiver would rob consumers of their only option for a guaranteed, central source of unbiased information on the comprehensive coverage available to them.

CLASP has engaged in extensive work examining the barriers to people enrolling in programs for which they are eligible, such as Medicaid and Advanced Premium Tax Credits (APTCs). The evidence is clear that the less streamlined and more cumbersome an application process it, the fewer people will enroll. Healthcare.gov provides a streamlined approach to health insurance enrollment, whether people are eligible for Medicaid or APTCs, or are purchasing insurance without APTCs. Removing this tool and instead relying on individual brokers or insurer websites adds unnecessary layers and burdens that will result in people not completing the process to enroll in health insurance.

Moreover, private brokers and insurers have a track record of failing to alert consumers of Medicaid eligibility and picking and choosing the plans they offer, often based on the size of plan commissions.¹ Indeed, in the system Georgia is proposing, people who are eligible for Medicaid could have a much harder time finding help with enrollment because Medicaid generally doesn't pay commissions and agents and brokers have no incentive to fill the gap left for this population that would result from eliminating HealthCare.gov. By contrast, HealthCare.gov automatically transfers the applications of people who are assessed eligible for Medicaid to the state agency.

Georgia's waiver proposes that substandard plans, such as short-term plans, would be presented alongside comprehensive insurance. Even now, brokers sometimes steer people into such plans, which often come with higher commissions, a tactic that has continued during the pandemic.² People enrolled in subpar plans are subject to punitive exclusions of their pre-existing conditions, benefit limitations, and caps on plan reimbursements that expose them to potentially high out-of-pocket costs. A study of short-term plans in Atlanta in 2020 showed that even though people would pay lower premiums up-front, they could be responsible for out-of-pocket costs several times higher for common or serious conditions, such as diabetes or a heart attack. The most popular plan in Atlanta refused to cover prescription drugs, mental health services, or maternity services, had pre-existing condition exclusions, and had a deductible three times as high as an ACA-compliant plan.³

Georgia's plan doesn't account for changes in federal law

Since Georgia's waiver application and approval, there have been significant changes in federal law related to marketplace health coverage. These changes provide more reasons for the approval of the Georgia Access Model to be revoked.

For 2021 and 2022, the American Rescue Plan (ARP) increased the premium tax credit to reduce marketplace premiums across the board, and extended eligibility to people with incomes above 400 percent of the poverty line. While the increased premium tax credits are currently set to end in 2022, the Congressional Budget Office (CBO) predicts an enrollment "tail" as more people stay enrolled in 2023, the year the Georgia Access Model would begin. Even if premium tax credits return to pre-ARP levels in 2023, as many as 80 percent of Georgia's enrollees could still be eligible for zero-cost or low-cost plans, likely boosting enrollment beyond Georgia's predictions.

The Families First Coronavirus Response Act included a provision under which states must keep those enrolled in Medicaid on or after March 18, 2020 enrolled through the end of the month in which the Public Health Emergency (PHE) ends, in exchange for increased federal Medicaid dollars. This provision is still in place. Georgia's analysis does not account for the number of people who, after Georgia resumes Medicaid disenrollments, will be eligible for tax credits in the Marketplace.

In addition to not accounting for federal law changes that increase Marketplace coverage through enhanced affordability, Georgia's plan also does not account for federal law changes that will increase Marketplace coverage due to fewer restrictions around when someone may enroll. A longer open enrollment period for the federal marketplace gives people more time to enroll each year and has already contributed to a surge in marketplace enrollment. Another rule change allows people with incomes below 150 percent of poverty to enter the marketplace in any month starting in 2022, rather than needing to have a separate life event to qualify for a

special enrollment period. In Georgia, about 160,000 uninsured adults have incomes between 100 and 150 percent of poverty.

Georgia’s waiver conflicts with recent Executive Orders on equity, health coverage, and customer experience

Executive Order 13985 calls on federal agencies to review new and existing policies to assess whether they advance equity for marginalized and historically underserved communities. CLASP is sure that a CMS review through this lens will find that the Georgia Access Model does not advance equity for marginalized and historically underserved communities. Eliminating streamlined information and unbiased information through HealthCare.gov will increase disparities and inequities in access to care. Forcing people to navigate a cumbersome network of brokers and agents, and then requiring people to decipher the information received from brokers and agents will be difficult for many reasons. Some people, particularly those in the most marginalized communities, may not have physical access to a broker or agent’s office. The available hours of brokers and agents cannot match the available hours of HealthCare.gov. Brokers and agents may present biased information about health plans in order to steer customers to one insurer over others. Health insurance is notoriously difficult to navigate, and Georgia’s plan will only increase this difficulty, and more so for people who have fewer resources (time, knowledge about health insurance, etc.) to devote to navigating the system.

Executive Order 14009, on strengthening Medicaid and the Affordable Care Act (ACA), calls for an immediate review of all federal agency actions, with the goal of making coverage accessible and affordable to everyone. This includes policies that undermine protections for people with preexisting conditions; waivers that may reduce coverage under Medicaid or the ACA; policies that undermine the marketplace; policies that create unnecessary barriers to families attempting to access ACA coverage; and policies that may reduce the affordability of coverage. Georgia’s waiver conflicts with each of these goals.

Executive Order 14058 calls on federal agencies to transform customer experience and service delivery to rebuild trust in government. HHS is specifically directed to support coordination between benefit programs to ensure applicants and beneficiaries are automatically enrolled in other programs for which they are eligible, and streamlining of state enrollment and renewal processes. Georgia’s waiver is inconsistent with this goal

In summary, CLASP opposes the Georgia Access Model and encourages CMS to revoke its approval. If implemented, the Georgia Access Model would increase disparities and inequities in access to health insurance, lead to decreased enrollment, and likely increase out of pocket costs for Georgians.⁴ The landscape changes in federal law and rules since Georgia’s waiver submission and approval warrant careful review of the approval, and CLASP believes the review will show that revoking the approval is the best way to continue on the path toward decreasing disparities in health insurance coverage and ensuring that all Georgians who are eligible to benefit from the provisions in ARP and the Families First Coronavirus Response Act are able to access those benefits.

Thank you for considering CLASP’s comments. Contact Suzanne Wikle (swikle@clasp.org) with questions.

¹ Tara Straw, ““Direct Enrollment” in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm,” Center on Budget and Policy Priorities, March 15, 2019, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>

² Christen Linke Young and Kathleen Hannick, “Misleading marketing of short-term health plans amid COVID-19,” Brookings Institution, March 24, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

³ Dane Hansen and Gabriela Dieguez, “The impact of short-term limited-duration policy expansion on patients and the ACA individual market,” Milliman, February 2020, <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>; Kelsey Waddill, “Do Short-Term Limited Duration Plans Deserve Industry Skepticism?,” HealthPayerIntelligence, March 4, 2020, <https://healthpayerintelligence.com/news/do-short-term-limited-duration-plans-deserve-industry-skepticism>.

⁴ Tara Straw and Jason Levitis “Georgia’s Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked,” Center on Budget and Policy Priorities, December 17, 2021, <https://www.cbpp.org/research/health/georgias-plan-to-exit-marketplace-will-leave-more-people-uninsured-should-be>



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January 9, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicaid and Medicaid Services
Department of Health and Human Services
Attention: CMS-9906-P
PO Box 8016
Baltimore, MD 21244-8016

Submitted Electronically to stateinnovationwaivers@cms.hhs.gov

RE: Request for Comment on the Georgia Access Model

Dear Administrator Brooks-LaSure:

The following comments are provided in response to request for comments from the Centers for Medicare & Medicaid Services (CMS) on whether and how the recent changes in law and policy influence whether the Georgia Access Model continues to comply with the statutory guardrails governing waivers from the Affordable Care Act (ACA) under section 1332 of the law. The request for comment references two prior letters to the state of Georgia. While each letter leads by affirming a commitment to work with states in partnership “to advance health care coverage policies,” the substance of the letters and this request for comment suggest otherwise. Rather, CMS is taking these actions outside of their regulatory authority and in violation of the specific terms and conditions (STCs) of the duly approved waiver. Moreover, nothing has changed in law or policy to suggest the Georgia waiver would no longer meet the statutory guardrails.

The first CMS request for updated economic and actuarial analyses on Georgia’s waiver sent on June 3, 2021 revealed there was no genuine interest from the agency in an update and that, rather, the agency was working to land at a predetermined outcome in a potentially illegal effort to revoke the waiver. It is noteworthy that, while this request for public comment provides 60 days to respond, CMS only provided Georgia 30 days to provide updated economic and actuarial analyses. Based on the agency’s prior work with Georgia on these analyses, CMS must have known 30 days would be too short of a time to provide such an update. Moreover, CMS certainly knew updates depended on data—e.g., special enrollment period data and navigator versus enhanced direct enrollment data—the state would depend on CMS to provide. To the best of our knowledge, these data were not made available to the state or the public. Yet CMS

demanded updates in 30 days. Without there being any substantive data to update these analyses, the first CMS request reveals the agency was not, in fact, interested in an update. Instead, the agency was interested in advancing a different goal to end the partnership, in violation of the STCs.

Not only did CMS fail to act in good faith in its request for updated economic and actuarial analyses from Georgia, even if such data were made available, it would not give CMS any basis to re-open approval of the waiver, a final agency decision reflected in the contract between Georgia and CMS.

Both CMS's first and second letter inappropriately threatened Georgia that CMS may find the state in violation of the STCs if they failed to provide the requested updates. The first letter referenced STCs that might be relevant, but without giving Georgia a clear basis for the agency's authority and what was expected. This suggests the agency was itself not clear on their authority and was still considering this issue.

Despite the failure of CMS to provide a clear legal basis, the letter suggested the agency relied on STC 7 and 15 to demand the update. In response, Center of the American Experiment published a report in July 2021 explaining why neither of these STC's give CMS the authority to request updated analyses. Instead, the STCs, which are legally binding on both CMS and Georgia, obligated CMS to implement the waiver. The report is attached to this letter as part of the official record for this request for comment. Georgia appropriately responded to the first letter on July 2, 2021 expressing their understanding that the STCs do not give CMS authority to make these requests, asked for clarification, and affirmed their intent to comply with the statutory guardrails.

In response to these objections to the legality and usefulness of these updated analyses, CMS sent a second letter to Georgia on July 30, 2021 which again failed to provide a sufficient legal or regulatory basis for its request. Instead, the letter made vague references to the STCs and federal regulations for their authority without providing much detail on how they apply. As such, the second letter represents further evidence the agency is not interested in dialogue or partnering in good faith with Georgia to help its citizens access health coverage.

Without receiving a valid or constructive response from CMS, Georgia replied on August 26, 2021 with an in-depth legal analysis focused on outlining why STCs 7 and 15 do not give CMS authority to reevaluate the waiver. The letter further explained how nothing in the changes to federal law cited by CMS "changes the fact that Georgia's 1332 Waiver remains in compliance with the guardrails."

CMS then issued this request for comment on November 9, 2021 which again failed to articulate a sound legal basis to request these updated analyses and reevaluate the waiver.

On top of their being no legal basis to reevaluate the waiver, there is no legal basis for opening this comment period. CMS regulations provide a detailed framework for federal and state procedures to collect public comment and input. Regulations clearly require the state and federal

governments to provide for 1) input to inform the approval of the waiver¹ and 2) input for after the waiver is implemented.² If CMS wants to gather public input outside this regulatory process, the agency must do so by amending these federal regulations through the notice and comment rulemaking process governed by the Administrative Procedures Act (APA).

CMS has warned Georgia that it may consider the state to be in violation of the STCs if it does not provide the requested updated analyses. To the contrary, CMS is demanding these updates and opening public comments outside the prescribed regulatory process in violation of the STCs.

If CMS continues to follow this path of delay and obfuscation, it will only be undermining access to coverage for the people of Georgia. Good faith collaboration has always been necessary to deliver the best outcome for Georgia, but CMS is not currently working in good faith. Increasing enrollment in comprehensive coverage has always been the goal of the Georgia waiver.

The ACA included waivers from certain requirements to give states flexibility to try alternatives, so long as the alternatives met certain statutory guardrails. CMS determined the approved waiver would meet these guardrails and approved the waiver in 2020. In their August 26, 2021 letter, Georgia affirmed their intent to meet these guardrails and explained how the waiver would continue to meet the guardrails despite the changes in law and policy CMS cited.

Georgia's response is sound and demonstrates why the waiver continues to meet the guardrails. There is no impact on the comprehensiveness guardrail because Georgia will implement the same benefit standards for qualified health plans as federal rules require. There will be no impact on the affordability guardrail because Georgia will implement the same advanced premium tax credits and cost sharing reductions as federal rules require. There will be no impact on the deficit because any increase in APTCs due to higher subsidized enrollment will be offset by lower premiums under the waiver's reinsurance program.

The CMS request for updated analyses suggest the waiver may no longer meet the coverage guardrail based on changes in law and the amount of funding provided for navigators and outreach. As CMS knows, the changes in law that temporarily expands eligibility for and increased the value of premium tax credits will expire before the waiver is implemented. Therefore, this change in law is clearly irrelevant to the coverage guardrail. As the CBO explains, enrollment "would gradually return to current law levels by 2024."³ Even if enrollment stayed higher for longer or if the law became permanent, this does not implicate the way the waiver operates to boost enrollment by taking better advantage of private sector enrollment pathways.

Increased funding for navigators and outreach also fails to counter the expanded enrollment projected with shifting to private sector enrollment. Despite generous federal funding for navigators in prior years, navigators accounted for less than 1 percent of enrollments through the

¹ 45 CFR § 155.1312 and 45 CFR § 155.1316.

² 45 CFR § 155.1320.

³ Congressional Budget Office, Reconciliation Recommendations of the House Committee on Ways and Means, February 15, 2021, available at <https://www.cbo.gov/publication/57005>.

Federally-Facilitated Exchange (FFE).⁴ There's no reason to think reviving funding levels will measurably increase enrollment. Likewise, there's no clear link between federal outreach funding and enrollment. When outreach funding increased to \$100 million for the 2017 benefit year, enrollment declined.

By comparison, enrollments through private agents and brokers have been growing. Nearly half of all enrollments through the FFE were assisted by private agents and brokers for the 2020 benefit year.⁵ Enrollment through enhanced direct enrollment (EDE)—the pathway most similar to the Georgia Access Model—increased from 8 percent for the 2020 benefit year to 17 percent for 2021.⁶ Georgia's waiver to take advantage of these proven enrollment platforms is projected to increase enrollment. Increasing CMS funding for approaches that failed to deliver enrollment results in the past do not undermine the benefits of shifting to the Georgia Access Model.

The people of Georgia deserve a fair chance to let the Georgia Access Model prove its worth. CMS should continue to work in good faith with the state of Georgia to put the waiver on solid footing to improve Georgia's individual health insurance market for every Georgia citizen who depends on it.

Sincerely,

/s/

Peter Nelson
Senior Policy Fellow

⁴ Press Release, Centers for Medicare & Medicaid Services, "CMS Announces New Funding Opportunity Announcement for the Federally-Facilitated Exchange Navigator Program," July 10, 2018.

⁵ Centers for Medicare & Medicaid Services, Agents and Brokers in the Marketplace (October 30, 2020).

⁶ Centers for Medicare & Medicaid Services, Impact of Enhanced Direct Enrollment During the Open Enrollment Period for 2021 Coverage (January 2021).

JULY 2021

CMS Impermissibly Seeks to Reopen Georgia's 1332 Waiver Application and Approval Process

PETER J. NELSON • SENIOR POLICY FELLOW

Introduction

On June 3, President Biden's new Centers for Medicare & Medicaid Services (CMS) Administrator, Chiquita Brooks-LaSure, sent a letter to Gov. Brian Kemp of Georgia requesting an updated analysis of the state's waiver of certain Affordable Care Act (ACA) provisions that was approved by the Trump Administration last Fall.¹ CMS gave the state a 30-day deadline. Georgia responded on July 2 expressing concerns that the request falls outside the Specific Terms and Conditions (STCs) governing the waiver and that it suggests the Biden administration "wish[es] to reopen approval of the waiver—an action not permitted by the STCs." As the request does not appear to fit the process, Georgia asked for a meeting with CMS for further clarification.

Georgia's concerns are well-founded. Administrator Brooks-LaSure's request openly declares that the state's updated analysis will be subject to new 30-day federal public comment period and then be used to further evaluate whether the waiver meets certain statutory requirements. This certainly appears to be a reopening of the application as these are all key elements of the application and approval process

the state already completed last Fall. Given how the request effectively requires the state to reopen the application, its premature timing, the tight 30-day deadline, and a dubious reference to authority to terminate the waiver, this appears to be the Biden administration's first step toward undoing Georgia's waiver. While Administrator Brooks-LaSure claims to be "committed to working in partnership with states," this is not how a good faith partner operates.

This analysis assesses both the legal and practical basis for the CMS request. Though CMS cites to the STCs for authority to request these updated analyses, a close examination shows these STCs are not relevant to the current situation. Therefore, there does not appear to be any legal basis for the CMS request. Even if there were a legal basis, any updated analyses would be premature. The changed cir-

cumstances CMS cites—including the temporary expansion of premium tax credits in the American Rescue Plan Act (ARPA), increased federal funding for Navigators, and the COVID special enrollment period—are just now taking shape in the insurance market and the data necessary to make a meaningful assessment of these changes is not yet available. Moreover, though some circumstances may

“There does not appear to be any legal basis for the CMS request. Even if there were a legal basis, any updated analyses would be premature.”

have changed, the underlying dynamics driving the results in the actuarial and economic analyses have not changed. Thus, there's little reason to think the changes would upset the positive forces the Georgia waiver will introduce to increase affordability and access to health coverage.

Background

Section 1332 of the ACA provides for a "Waiver for State Innovation," which allows states to waive certain provisions of the law to implement innovative new State health care plans. This ACA provision clearly recognizes the value in giving states flexibility to experiment with different approaches to providing access to health coverage through the individual health insurance market. The law allows these waivers so long as the waiver meets specific criteria, often called guardrails, to help ensure a comparable number of people retain access to coverage that is as comprehensive and affordable as without the waiver. In addition, a waiver must be deficit neutral to the federal government.

In 2019, Georgia applied for a Section 1332 Waiver to address serious challenges the state's individual market was facing, including "drastic premium increases, low carrier participation in several counties across the state, and declining enrollment."² After ongoing discussions and deliberations with CMS and stakeholders, the state eventually settled on a waiver that included two main parts. Part I implements a state reinsurance program to lower premiums. This is similar to programs in other states that fund claims for people with high costs, which removes the cost from the risk pool and lowers premiums for everyone in the market. Part II implements the Georgia Access Model, which will transition Georgia from relying on HealthCare.gov to a new health insurance delivery mechanism that takes advantage of private market resources to expand consumer access and enrollment by delivering a better consumer experience.

"There is no other provision in statute or regulation giving CMS the authority to make these demands."

CMS approved Georgia's 1332 waiver plan last Fall after concluding the plan met the law's guardrails. This conclusion was based on a finding that the state's economic and actuarial analyses provided reasonable projections establishing how the waiver will meet the comprehensiveness, affordability, coverage, and deficit neutrality guardrails.

CMS Request for Updated Analyses

The transition from the Trump administration to the Biden administration brought a substantial shift in policies and priorities, and so it is no surprise that CMS is now underway reviewing all agency actions as directed by Executive Order 14009.³ Citing this order, CMS sent a letter to Gov. Kemp requesting an updated analysis of the waiver by July 3, just 30 days from the date of the letter.

The letter requests that the updated analysis account for recent changes in federal law under ARPA, the increase in federal funding for outreach marketing and navigators, and the COVID special enrollment period. Upon submission, CMS states they will provide a 30-day federal comment period and then evaluate whether the waiver continues to satisfy the guardrails.

As the basis for this request, CMS primarily cites two provisions of the Specific Terms and Conditions (STCs) of the waiver. These STCs operate as the contract between CMS and the state of Georgia for the administration of the waiver. CMS cites authority under STC 15 to request further information for ongoing monitoring and oversight of a waiver and authority under STC 7 to "amend, suspend, or terminate the waiver ... as necessary to bring the waiver ... into compliance with changes to existing applicable federal statutes enacted by Congress or applicable new statutes enacted by Congress." Neither of these provisions, however, provides the authority CMS asserts. Moreover, there is no other provision in statute or regulation giving CMS the authority to make these demands.

STC 15 Is Not Yet Relevant

Federal law provides that all 1332 waivers must undergo periodic evaluations by CMS and the Department of the Treasury (the Departments).⁴ Federal regulations go on to require the Departments to “periodically evaluate the implementation of a program under a Section 1332 waiver.”⁵ As CMS recently characterized this requirement in preamble to proposed ruling making, the Departments are responsible “for conducting evaluations to determine the impact of the section 1332 waiver.”⁶ CMS Regulations further require states to “fully cooperate” with the Departments on an evaluation and provide them with all requested data and information.⁷ This cooperation is formalized in the agreement between Georgia and the Departments in STC 15.

Under this framework, STC 15 focuses on information related to the actual implementation and impact of the waiver to ensure the waiver is working as intended. Indeed, the clear purpose of a “periodic evaluation” is to regularly review the impact of an activity after it starts. At this point, there is nothing to evaluate because the waiver will not be implemented until 2023 and, therefore, STC 15 is not yet relevant to the process outlined in federal regulation or the STCs.

Request Impermissibly Asks Georgia to Reopen the Waiver Application and Approval Process

If CMS were able to exercise the authority they assert, then they would effectively have authority to reopen the waiver application and approval process, which it clearly does not have authority to do under the statute, regulations or the STCs. The agency’s explanation of what it plans to do with the information lays bare its intent to reopen the application and approval process. On top of requesting updated actuarial and economic analyses, the CMS

request notifies Georgia that the federal government will then provide another 30-day public comment period on the state’s updated analyses to inform whether the already approved waiver should begin. Actuarial and economic analyses, comment periods, and responses to comments form the substance of a final and complete application. As such, redoing all of these elements would, as a process matter, function to reopen the application and approval process.

Leading up to the approval of the waiver, the state engaged in a rigorous application process to ensure the waiver met all of the necessary standards for approval. The application process included four

state and federal public comment periods, providing the public an opportunity to comment for over 100 days. Both the Departments and the state carefully considered these comments in approving the waiver. In response to comments, Georgia initially modified the waiver after the initial rounds and then updated the waiver with additional detail and clarifications after later rounds. The process also included independent analyses and affirmation by the Department of Treasury and the Office of the Actuary of CMS.

“Leading up to the approval of the waiver, the state engaged in a rigorous application process to ensure the waiver met all of the necessary standards for approval.”

The STCs operate as a signed, binding contract between the federal and state governments and there is no provision with the STCs for any party to unilaterally reopen and amend the contract. As stated in STC 17, the Departments may only amend the waiver in cases where the state fails to comply with the STCs or fails to meet the guardrails. Neither of these events have occurred. The state is in full compliance with the STCs and, until 2023, there will be no experience from implementing the waiver to demonstrate failure. Moreover, the state’s response to the CMS request affirms that “Georgia has every intention of complying with the guardrails throughout the life of the waiver.” Therefore, there is no avenue for CMS to reopen and amend the waiver at this time.

The binding nature of this contract, and the reliance the state of Georgia places on this contract for moving forward and investing in this new and innovative state health program, would be entirely undermined if CMS could continually revisit all of the work that went into the application and approval process. Yet, that is exactly what CMS is asserting it can do, which is not permissible under the STCs negotiated between the Departments and the state.

ARPA Does Not Trigger STC 7

Because there is no clear path to reopen and amend the waiver under STC 17, CMS cites STC 7 to claim discretion to amend, suspend, or terminate the waiver to bring it into compliance with a change in federal law. Like STC 15, STC 7 is not relevant to these circumstances. STC 7 is clearly directed at circumstances where a change in federal law adds or changes requirements on states or contravenes the policies established by the waiver. In the current circumstance, there has been no change in federal requirements that would trigger state action to comply.

Following the approval of a waiver, federal regulations require that “a State must comply with all applicable Federal laws ... unless expressly waived.”⁸ The regulation goes on to require that “[a] State must ... come into compliance with any changes in Federal law ..., unless the provision being changed is expressly waived.”⁹ In other words, while a state can waive certain provisions of federal law, a state must still comply with the rest of the law under a waiver, even if the law changes after the waiver is approved. This requirement is formalized in STC 7. Helpfully, STC 7 provides examples of requirements a state may need to change to ensure compliance, such as rate review and consumer noticing requirements. Since approval of the waiver, there has been no change in such federal requirements.

“In the current circumstance, there has been no change in federal requirements that would trigger state action to comply.”

Nonetheless, CMS suggests STC 7 is implicated because ARPA temporarily changed federal law to expand eligibility for and enhance the value of premium tax credits for plan years 2021 and 2022. This change in federal law only changed the benefits available to individuals and did not add requirements that require compliance or amend any statutory language in section 1332. Moreover, the change is temporary and ends on December 31, 2022 before Part II of the Georgia waiver starts.

Regardless, CMS suggests the change in federal law is relevant to STC 7 because it may implicate enrollment during the waiver period, suggesting enrollment gains can “persist” after the federal policy changes end. But this is only a change in the circumstances driving the market dynamics, which is no different from any change in the economy or otherwise that changes market dynamics. If this change implicates STC 7, then nearly any change in federal law that impacts the economy implicates STC 7. Clearly that is not the intent behind STC 7.

Furthermore, while the Congressional Budget Office (CBO) agrees enrollment gains may persist somewhat, they estimate enrollment “would gradually return to current law levels by 2024.”¹⁰ Thus, according to CBO, enrollment would only be impacted in the first year of the Georgia Access Model, hardly the persistence that requires a reopening of the waiver as CMS asserts.

Any Analysis is Premature

While there is no authority for CMS to request these updated analyses from Georgia, it would be premature for anyone to begin this type of analysis because it aims to account for policies that are just starting to take shape. At the time CMS requested the updated analyses, CMS had released some data on SEP plan selections for the period covering February 15 to April 30, which covered only the first month of the availability of enhanced premium tax credits under ARPA.¹¹

In addition, the data released by CMS indicates only new enrollments and does not account for dropped enrollments, which can only be gleaned publicly from CMS reports on effectuated enrollment—the actual number of people enrolled in a given month who paid premium—that will be released later this year.¹²

To truly understand new market dynamics, it would also be important for any new analysis to incorporate data that reflects the transition to this new post-lockdown period when the economy is reopening and people are re-entering the workforce. Indeed, as we learned last year, insurance coverage responses to COVID-19 have been unpredictable. A recent report published by the Department of Health and Human Services admits that the “shift in coverage was smaller than originally expected” and offers several points as to why.¹³ Considering the difficulty in projecting the 2020 impact of COVID-19, it’s not reasonable to expect anyone to provide an informed analysis on what to expect for 2021 and beyond without at least some preliminary data points on the impact of the new policies and the response to lockdowns lifting.

Even if the STCs authorized CMS to request this information, without new data there is no reason to think there will be any material changes to the actuarial and economic analyses. Even if new data shows enrollment increased and market dynamics changed, there is no compelling reason to anticipate this would materially change the results either. CMS theorizes that changes in federal law and policy may lead to a smaller base of uninsured consumers to enroll, which would thereby reduce incentives for

private sector entities to participate and enroll people. However, what matters to the private sector is the entire base of possible consumers, including the already insured and the uninsured. In fact, if there is higher enrollment, then that will only increase the incentives for the private sector to participate so long as they know their efforts won’t be crowded out and duplicated by HealthCare.gov.

CMS Should Withdraw the Request and Move Forward in Good Faith

Ultimately, there is no provision to reopen an approved waiver based on conjecture regarding future impacts of changes in law or policy that might influence future market dynamics. This is true even if there were adequate data immediately available to update the actuarial and economic analyses that accompanied and supported an approved waiver. Under the process outlined in regulation and the STCs, CMS must allow the waiver to go forward and, following implementation, evaluate the waiver’s effects to ensure that it complies with the section 1332 guardrails. If future evaluations show the waiver is not working as expected, there are provisions in the STCs for working with the state to bring the waiver into compliance.

CMS and the Department of the Treasury made a good faith agreement with the state and they are bound to follow through on that agreement. CMS should withdraw the request and continue working with the state to ensure their innovative waiver succeeds. A withdrawal of the request would send the appropriate signal that the Departments continue to be willing to work with Georgia in good faith. ■

“CMS and the Department of the Treasury made a good faith agreement with the state and they are bound to follow through on that agreement.”

Endnotes

1 Letter, Administrator Chiquita Brooks-LaSure to Governor Brian Kemp, June 3, 2021, available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Request-Updated-GA-Analysis-Letter.pdf>

2 State of Georgia Office of the Governor, Georgia Section 1332 State Empowerment and Relief Waiver Application, December 23, 2019, available at <https://medicaid.georgia.gov/document/document/georgia1332draftwaiver11042019pdf/download>.

3 86 FR 7793 (February 2, 2021), available at <https://www.federalregister.gov/documents/2021/02/02/2021-02252/strengthening-medicare-and-the-affordable-care-act>

4 PPACA § 1332(a)(4)(B)(v).

5 45 CFR 155.1328.

6 86 FR 35156, Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule, July 1, 2021, available at <https://www.federalregister.gov/documents/2021/07/01/2021-13993/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver>.

7 45 CFR 155.1320(f).

8 45 CFR 155.1320(a).

9 Id.

10 Congressional Budget Office, Reconciliation Recommendations of the House Committee on Ways and Means, February 15, 2021, available at <https://www.cbo.gov/publication/57005>.

11 Centers for Medicare & Medicaid Services, Fact Sheet, “2021 Marketplace Special Enrollment Period Report,” at <https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-1>.

12 CMS recently released the early snapshot for 2021 effectuated enrollment, but this snapshot captures enrollment through February and so it captures only the first two weeks of the 2021 Marketplace Special Enrollment opportunity and none of the time the enhance premium tax credits are available.

13 Assistant Secretary for Planning and Evaluation, U.S. Department of Human Services, Trends in the U.S. Uninsured Population, 2010-2020 (February 11, 2021), at <https://aspe.hhs.gov/system/files/pdf/265041/trends-in-the-us-uninsured.pdf>.



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The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Ave NW
Washington, DC 20220

January 9, 2022

Comments submitted via stateinnovationwaivers@cms.hhs.gov

Re: Georgia 1332 Waiver

Dear Secretary Becerra and Secretary Yellen:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax, and programmatic issues affecting individuals and families with low or moderate incomes. We appreciate the opportunity to comment on the reconsideration of Georgia’s 1332 waiver, as administered by the Department of Health and Human Services and the Department of the Treasury (“the Departments”).

On November 1, 2020, the Trump Administration approved a section 1332 State Innovation Waiver permitting Georgia to leave the federal health insurance marketplace beginning in 2023 and instead permit people to enroll only with insurers or through online enrollment vendors, agents, or brokers. The waiver proposal was flawed from the start¹ but is now even more clearly in violation of the statutory approval criteria, or “guardrails,” because it would result in fewer Georgians getting health coverage than would be the case without the waiver. Georgia’s waiver should be reviewed in light of substantial statutory, regulatory, and policy changes that affect its baseline. These changes — including passage of the American Rescue Plan and increased support for outreach and in-person assistance — render the waiver’s baseline and goals obsolete. Georgia rebuffed two requests for an updated analysis to account for these factors, adding to the ample reasons why the Biden Administration should revoke the waiver.

Background

On November 1, 2020, the Trump Administration approved Georgia’s section 1332 waiver for what the state calls the Georgia Access Model.² The ACA’s Section 1332 allows a state to obtain permission to waive parts of the law and design its own health coverage program as long as the proposal meets certain statutory guardrails. If the waiver reduces federal costs, the state can receive federal funds equal to those savings, known as pass-through payments.

The Georgia Access Model would eliminate Georgians’ access to HealthCare.gov — a centralized shopping platform that displays and allows enrollment in all marketplace health plans — without creating a

¹ Tara Straw, “Tens of Thousands Could Lose Coverage Under Georgia’s 1332 Waiver Proposal,” CBPP, September 1, 2020, <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>, and Christen Linke Young and Jason Levitis, “Georgia’s latest 1332 proposal continues to violate the ACA,” Brookings Institution, August 28, 2020, <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>.

² A second portion of the waiver establishing a reinsurance program was also approved but is not open for public comment and is proceeding in 2022.

comparable state substitute.³ Instead, beginning in 2023, Georgia would scatter marketplace functions for more than half a million enrollees among a multitude of private brokers and health insurers, akin to the insurance market prior to the ACA. The state would also rely on these private entities to conduct marketing and outreach, in place of federal investments in these activities which have proven highly effective. People could still enroll in plans that would have been available through HealthCare.gov, and access federal subsidies if they qualify, but this process would be more difficult, and many other plans that do not meet ACA standards and are not eligible for subsidies would also be on offer. The state's actuarial analysis, required for states seeking a 1332 waiver, projected the Georgia Access Model would modestly increase marketplace enrollment in 2023 and slightly lower premiums compared to a 2018 baseline.⁴ But this analysis was flawed when first released and is even more implausible now.

In letters dated June 3 and July 30 of 2021, the Departments under the Biden Administration asked the state for a revised actuarial analysis to account for changes in federal law and policy that significantly raised the baseline against which the waiver must be judged. Georgia refused to update its analysis and challenged the federal government's authority to ask for the revision. The Departments are asking for public comment on the validity of the state's data and whether the Georgia Access Model complies with the statutory guardrails, which are designed to ensure that at least as many people are covered under the waiver as would have been the case without it and that the coverage meets ACA standards for comprehensiveness and affordability and does not increase federal costs.

Georgia Cannot Match HealthCare.gov's Enrollment

Section 1332 waivers are required to cover in each year at least a comparable number of people as would be the case without the waiver. Georgia's waiver application was built around the premise that, unless the state intervened, marketplace enrollment would decline from its 2018 level, an already low enrollment count after deep cuts to marketing, outreach, and in-person assistance by the Trump Administration. But HealthCare.gov has been more effective than Georgia's baseline assumed. Enrollment rebounded in the 2019 and 2020 plan years as premiums stabilized, showing the waiver's projections were wrong before it was even approved. Then enrollment reached a historic high with the 2021 special enrollment period and Biden Administration policy changes and investments.

Georgia's own goals under the waiver won't produce enrollment comparable to today's coverage numbers. The state's application projected that without the waiver marketplace enrollment would fall slightly from about 368,000 in 2018 to 366,000 in 2022 through 2026. The state claimed the Georgia Access Model could do better, increasing coverage to 393,000 in 2023 through 2026.⁵ As discussed elsewhere, these projections are not reasonable for a waiver that eliminates the primary means of enrollment. But even accepting that Georgia can achieve these numbers, the waiver would still lead to a huge coverage reduction. That's because recent experience has shown baseline coverage far in excess of what Georgia said it could achieve. In August 2021, there were 549,000 people enrolled in marketplace coverage, almost 40 percent more than Georgia's

³ Straw, *op. cit.*

⁴ Georgia projected marketplace enrollment would as increase by about 26,500 enrollees in 2023, inclusive of the state's reinsurance waiver, which is projected to have minimal impact on enrollment. Waiver, p. 60. The waiver application, approval, and correspondence are found at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-. Gross (unsubsidized) marketplace premiums would decrease by 3.6-3.7 percent, not including the significant premium decline due to a reinsurance waiver. Waiver, *op. cit.*, p. 59.

⁵ Waiver, *op. cit.*, p. 60.

goal, and as of December 15, nearly 654,000 Georgians selected marketplace plans, exceeding Georgia’s target enrollment by 261,000 people.⁶

Any reasonable updated analysis of the state’s waiver would show that it can’t match, let alone surpass, today’s enrollment baseline. That’s true in part because recent legislation and other developments have boosted coverage and created new opportunities to boost it further, and Georgia’s plan has not adjusted to increase its administrative capacity or take advantage of these opportunities. And it’s in part because the waiver would eliminate federal investments in the marketing, outreach, and in-person assistance that have been crucial to expanding coverage in the marketplace in recent years. The Congressional Budget Office (CBO) seems to agree that these policies will lead to a higher enrollment baseline. In 2020 it predicted 2030 marketplace enrollment of 8 million people, but in 2021, it boosted this estimate to 10 million.⁷

Changes in Rules and Law Boost Baseline Enrollment Beyond Georgia’s Goal

New federal statutes and regulations have increased coverage numbers prior to implementation of the Georgia Access Model and will continue to promote strong enrollment that the state has not accounted for in its baseline. The historically high enrollment figures that must be factored into the baseline make it highly unlikely the state’s plan could satisfy the coverage guardrail. And if Congress passes economic-recovery legislation it is now considering, its provisions would only add to the reasons that Georgia’s waiver violates 1332 standards.

New Statutes Increase Enrollment

The American Rescue Plan, enacted in 2021, boosts the premium tax credit to reduce marketplace insurance premiums across the board in 2021 and 2022 and extends eligibility to people with incomes above 400 percent of the poverty line. It lowered premiums nationwide, and by 54 percent for existing enrollees in Georgia, which was one factor that led to robust marketplace enrollment in 2021 — a trend likely to continue in 2022.⁸ While the premium tax credit enhancements are currently set to end in 2022, CBO predicts an enrollment “tail” as more people stay enrolled compared to the baseline without the Rescue Plan.⁹ HealthCare.gov’s historically strong enrollment retention could also buoy coverage levels. In the 2021 open enrollment period — prior to enactment of the Rescue Plan — 77 percent of signups were returning enrollees.¹⁰ Even if subsidies return to pre-Rescue Plan levels, most HealthCare.gov enrollees would likely be eligible for zero-premium or low-premium plans to make coverage affordable, making them prone to remain covered after 2022. In Georgia, 80 percent of 2021 enrollees were eligible for such plans before the Rescue

⁶ Centers for Medicare & Medicaid Services, “Marketplace Weekly Enrollment Snapshot: Week 6,” December 22, 2021, <https://www.cms.gov/newsroom/fact-sheets/marketplace-weekly-enrollment-snapshot-week-6>.

⁷ Compare CBO, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT’s September 2020 Projections,” August 29, 2020, <https://www.cbo.gov/system/files/2020-10/51298-2020-09-healthinsurance.pdf> and CBO, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT’s July 2021 Projections,” July 2021, <https://www.cbo.gov/system/files/2021-08/51298-2021-07-healthinsurance.pdf>.

⁸ Department of Health and Human Services, “2021 Final Marketplace Special Enrollment Period Report,” October 20, 2021, <https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf>.

⁹ CBO, “Reconciliation Recommendations of the House Committee on Ways and Means,” February 15, 2021, <https://www.cbo.gov/publication/57005>.

¹⁰ Centers for Medicare & Medicaid Services, “2021 Federal Health Insurance Exchange Weekly Enrollment Snapshot: Final Snapshot,” January 12, 2021, <https://www.cms.gov/newsroom/fact-sheets/2021-federal-health-insurance-exchange-weekly-enrollment-snapshot-final-snapshot>.

Plan's premium enhancements took effect.¹¹ Georgia's analysis does not account for these enrollment increases. In addition, the current-law expiration of key American Rescue Plan provisions at the end of 2022 will lead to complex coverage transitions and decisions for many consumers, requiring additional assistance that would be available via HealthCare.gov but that Georgia's plan does not speak to.

In addition, the Families First Coronavirus Response Act created a Medicaid continuous coverage requirement under which states, in exchange for getting a higher federal matching percentage of Medicaid costs covered, must keep Medicaid-eligible people enrolled for the duration of the COVID-19 public health emergency. CBO anticipates that the provision will begin to unwind in July 2022. As it does, some people whose income is too high for Medicaid might qualify for a premium tax credit in the marketplace and, if the system works well, will enroll in marketplace coverage. Georgia's analysis does not account for this eventuality, ignoring a key part of the enrollment landscape. The state's failure to articulate a strategic plan could result in the thousands of people losing Medicaid being unable to enroll in subsidized coverage due to the inefficiencies created by the waiver and the state's inability to point people to a single enrollment source in its waiver-fractured market. This means Georgia could forgo the opportunity for significant enrollment gains in subsidized private coverage. While federal and state marketplaces are engaging in detailed planning with their Medicaid agencies, Georgia has disclosed no such planning under the waiver or how it would address the unwinding of the COVID-related Medicaid coverage just as its waiver would result in the loss of major federal enrollment tools and assets. This unwinding will likely coincide with the first open enrollment period of the Georgia Access Model's implementation, a time when even the most sophisticated insurance shoppers will face new roadblocks to coverage. Finally, Georgia's analysis was predicated on the assumption that it would have capacity to handle the volume of consumers that was expected before these changes. Georgia has not indicated that it will make any adjustments to account for the larger expected volume. This is both a recipe for chaos and a missed opportunity for growing marketplace enrollment – as the result of the waiver.

New Regulations Further Boost Enrollment

Several new marketplace regulations finalized in September 2021 will encourage enrollment and retention, especially among low-income people, and are not accounted for in Georgia's baseline enrollment projections. First, the federal marketplace will extend the open enrollment period by 30 days, to January 15. Research shows that December, a time of mental and financial stress for many people and the month when the open enrollment period ended in recent years, is the "worst time of the year to require complex enrollment decisions."¹² As such, giving people more time to enroll and stretching open enrollment into the early part of each year is likely to boost the number of people covered to a higher level than Georgia's analysis has accounted for.

Another policy that could bolster enrollment during the year is the recent rule change allowing people with incomes at or below 150 percent of the poverty line to enter the marketplace in any month starting in 2022, rather than needing to have a separate life event to qualify for a special enrollment period (or SEP; this is distinct from the recent six-month, pandemic-related SEP). The enrollment effects could be significant in Georgia, where about 160,000 uninsured adults have incomes between 100 and 150 percent of poverty. This is a new avenue to enroll for people who need coverage but miss the annual open enrollment period. Having

¹¹ D. Keith Branham *et al.*, "Access to Marketplace Plans with Low Premiums of the Federal Platform, Part I: Availability Among Uninsured Non-Elderly Adults and HealthCare.gov Enrollees Prior to the American Rescue Plan," Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, March 29, 2021, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//199686/low-premium-plans-issue-brief.pdf.

¹² Katherine Swartz and John A. Graves, "Shifting The Open Enrollment Period For ACA Marketplaces Could Increase Enrollment And Improve Plan Choices," *Health Affairs*, July 2014, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.0007>.

a central enrollment platform is particularly critical in taking advantage of this SEP, since agents and brokers are often paid much lower commissions outside open enrollment, demonstrating a weakness of the profit-maximization strategy central to Georgia's plan.

Georgia's Plan Jettisons Policies That Expand Marketplace Enrollment

Many people remain unaware of the financial help they can receive to purchase health insurance. This knowledge barrier indicates that more, not less, needs to be done to reach people who are eligible. The Georgia waiver would withdraw from federal initiatives to promote coverage — notably marketing and unbiased, in-person assistance — and do nothing to replace them, exacerbating the knowledge barrier and driving down enrollment.

Increased Outreach and Marketing Driving Higher Enrollment

The Biden Administration made a historic \$100 million investment in nationwide marketing to make people aware of affordable coverage in the marketplace during the six-month emergency SEP, in contrast to the Trump Administration's \$10 million in annual funding in prior years. The investment will remain high in 2023: the Administration plans to spend \$140 million more than in 2022 on outreach and education and eligibility and enrollment functions that will improve the level of service available to consumers.¹³

Marketing is a powerful tool to drive enrollment.¹⁴ In 2016 the Centers for Medicare & Medicaid Services (CMS) determined that 1.8 million of the marketplace's 9.6 million enrollees enrolled due to advertising, and by 2017, an estimated 37 percent of enrollments were attributed to advertising.¹⁵ Covered California, a state-run marketplace, found that outreach and marketing reduced premiums for Californians and the federal government by 6 to 8 percent in 2015 and 2016. This is because marketing nudges into coverage healthier people who are less inclined to purchase insurance, lowering the marketplace's risk profile, which translates into lower premiums and higher enrollment overall.¹⁶ Kentucky's television advertising was also credited with 40 percent of the unique visitors and web-based applications in Kentucky for plan years 2014 and 2015.¹⁷

Georgia's intent to rely on insurer and broker advertising to attract enrollees — instead of federal government advertising driving traffic to one central enrollment platform — is misguided. Research has shown that government advertising is more effective than private advertising. For example, one study found that government advertising was correlated with increased take-up of health insurance and Medicaid, whereas

¹³ "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023," 87 Fed. Reg. 3, January 5, 2022, <https://www.govinfo.gov/content/pkg/FR-2022-01-05/pdf/2021-28317.pdf>.

¹⁴ Tara Straw, "Marketplaces Poised for Further Gains as Open Enrollment Begins," CBPP, October 29, 2021, <https://www.cbpp.org/research/health/marketplaces-poised-for-further-gains-as-open-enrollment-begins>.

¹⁵ This included a combination of television, radio, direct response (text messaging, email, and autodial), internet search buys, and paid digital ads, and reflected the results of a partial open enrollment period. Centers for Medicare & Medicaid Services, "Preliminary OE4 Lessons Learned," <https://downloads.cms.gov/files/359411146-preliminary-oe4-lessons-learned.pdf>.

¹⁶ Peter V. Lee *et al.*, "Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets," Covered California, September 2017, https://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

¹⁷ Paul R. Shafer *et al.*, "Television Advertising and Health Insurance Marketplace Consumer Engagement in Kentucky: A Natural Experiment," *Journal of Medical Internet Research*, Vol. 20, No. 10, October 2018, <https://www.jmir.org/2018/10/e10872/PDF>.

private spending by insurers was not, despite being more prevalent.¹⁸ Another found that government advertising was more likely to expand enrollment and to do so in a unbiased way, without directing consumers to any particular insurer, while health plan advertising tended to reach only existing private market enrollees.¹⁹ Contrary to Georgia’s assertion that private market promotion could accomplish equivalent or greater enrollment results than government efforts, this study “robustly reject[s] that private advertising is more effective in expanding total enrollment than federal advertising.”²⁰ Evidence shows that rural areas might also be shut out from the majority of private advertising, since that marketing tends to be focused in areas that are most profitable, such as those with more densely populated areas; this compares to government advertising, which is less dependent on market size. And, whereas Georgia implies that government spending crowds out private spending, this research finds otherwise. Further, reductions in federal spending are not necessarily offset by increases in private spending. For example, one recent study of open enrollment periods between 2015 and 2019 shows that cuts to navigator programs did not increase the amount of private-sector advertising.²¹

Pulling out of HealthCare.gov means that Georgia will no longer benefit from this federal investment in marketing and outreach. Without government-funded advertising, Georgia can expect to have lower enrollment than would occur without the waiver, a factor that the state did not account for in its waiver application.

Bolstered In-Person Assistance Increasing Enrollment, Especially in Hard-to-Reach Communities

Enrolling in insurance can be complicated and many uninsured people say they need help to understand their options.²² Navigators are federally funded, unbiased groups that provide this help to consumers at all stages of the coverage process, from determining eligibility to plan selection to using their coverage. In 2021, HealthCare.gov navigators received a more than \$70 million increase in funding. Georgia navigators saw a \$2.15 million increase, with funding rising from \$700,000 when the waiver was approved to \$2.85 million today.²³

Unlike the brokers Georgia’s plan relies on, assisters — navigators and unfunded application counselors — are knowledgeable and skilled at reaching underserved populations. They are five times more likely than agents and brokers to report that their clients were previously uninsured, according to a 2016 national survey

¹⁸ Pinar Karaca-Mandic *et al.*, “The Volume Of TV Advertisements During The ACA’s First Enrollment Period Was Associated With Increased Insurance Coverage,” *Health Affairs*, April 2017, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1440>.

¹⁹ Naoki Aizawa and You Suk Kim, “Public and Private Provision of Information in Market-Based Public Programs: Evidence from Advertising in Health Insurance Marketplaces,” NBER Working Paper No. 27695, revised April 2021, <https://www.nber.org/papers/w27695>.

²⁰ Aizawa and Kim, *op. cit.*

²¹ Rebecca Myerson and David M. Anderson *et al.*, “Cuts to navigator funding were not associated with changes to private sector advertising in the ACA marketplaces,” pre-publication version, December 9, 2021, <https://drive.google.com/file/d/1uoQt0Pep1BjNrxrtBS2OFGoGHpzYhajs/view>.

²² Karen Pollitz, Jennifer Tolbert, and Ashley Semanskee, “2016 Survey of Health Insurance Marketplace Assister Programs and Brokers,” Kaiser Family Foundation, June 2016, <https://files.kff.org/attachment/2016-Survey-of-Marketplace-Assister-Programs-and-Brokers>.

²³ Karen Pollitz, Jennifer Tolbert, and Kendal Orgera, “Navigator Funding Restored in Federal Marketplace States for 2022,” Kaiser Family Foundation, September 29, 2021, <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>. In December, supplemental funding of nearly \$350,000 was awarded to Georgia’s navigator programs. CCIHO, “2021-2022 Navigator Supplemental Funding Amounts,” December 16, 2021, <https://www.cms.gov/files/document/navigator-supplemental-funding-award-amounts-12-16-2021.pdf>.

by the Kaiser Family Foundation.²⁴ Nine in ten assister programs helped eligible individuals enroll in Medicaid or the Children’s Health Insurance Program (CHIP), compared to fewer than half of brokers. While navigators must perform public education activities on the availability of marketplace coverage and do so in a linguistically and culturally appropriate manner, brokers don’t. Research shows brokers are significantly less likely to perform public education and outreach activities or to help Latino clients, people who have limited English proficiency, or people who lack internet at home. A recent study found that cuts to the navigator program in 2019 led to declines in coverage by people with incomes between 150 and 200 percent of poverty, consumers under age 45, consumers who identified as Hispanic, and consumers who spoke a language other than English at home.²⁵

Under its waiver, Georgia would opt out of this federal investment in in-person assistance and would fail to establish any form of impartial, unbiased help, which means that vulnerable uninsured people would be less likely to find coverage, contrary to the intent of recent 1332 waiver regulations.²⁶ In fact, the state made it *illegal* to use state funds on navigators.²⁷

Executive Orders Point to Continued Commitment to Enrollment Growth, Equity

President Biden has issued three executive orders that emphasize the Administration’s commitment to expanding health coverage, helping the underserved, eliminating administrative barriers to health care, and ameliorating the effects of structural racism in health coverage rates. They all demand reconsideration of Georgia’s waiver.

Executive Order 13985 asks all federal agencies to review new and existing policies to assess whether they advance equity for marginalized and historically underserved communities.²⁸ Georgia’s waiver doesn’t analyze its impact on equity, which should raise the Departments’ level of scrutiny. The preamble of recent section 1332 regulations emphasizes helping underserved communities and makes clear that a “1332 waiver would be highly unlikely to be approved by the Secretaries if it would reduce coverage for these populations, even if the waiver would provide coverage to a comparable number of residents overall.”²⁹

In practice, hard-to-reach and marginalized communities are more likely to become uninsured under the state’s plan due to cuts to in-person assistance, which disproportionately helps people with lower incomes

²⁴ Pollitz, Tolbert, and Semanskee, *op. cit.*

²⁵ Rebecca Myerson and Honglin Li, “Information Gaps and Health Insurance Enrollment: Evidence from the Affordable Care Act Navigator Programs,” posted at SSRN, November 11, 2021, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3966511.

²⁶ “Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond,” 86 Fed. Reg. 184, September 27, 2021, <https://www.federalregister.gov/documents/2021/09/27/2021-20509/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver>.

²⁷ GA Code § 33-1-23 (2020). “Neither the state nor any department, agency, bureau, authority, office, or other unit of the state, including the University System of Georgia and its member institutions, nor any political subdivision of the state shall establish, create, implement, or operate a navigator program or its equivalent.”

²⁸ Executive Order 13095, “Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,” January 20, 2021, <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.

²⁹ “Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule,” 86 Fed. Reg. 124, July 1, 2021, <https://www.federalregister.gov/documents/2021/07/01/2021-13993/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver>.

and those who speak a language other than English in the home, as explained above. For example, among the more than 1,500 agents and brokers advertising marketplace services in one Georgia ZIP code, only 14 offer services in Spanish.³⁰ Also, as noted above, there is evidence that health insurers concentrate their advertising in more populous areas than in underserved rural communities, leading to disproportionate coverage losses in those areas.³¹

Executive Order 14009, on strengthening Medicaid and the Affordable Care Act, calls for an immediate review of all federal agency actions with the goal of making coverage accessible and affordable to everyone.³² This includes policies that undermine protections for people with pre-existing conditions; waivers that may reduce coverage under Medicaid or the ACA; policies that undermine the marketplace; policies that create unnecessary barriers to families attempting to access ACA coverage; and policies that may reduce the affordability of coverage. Georgia's waiver violates each of these goals. Agencies are directed to "suspend, revise, or rescind" such prior agency actions, which would include having granted Georgia's waiver.

Executive Order 13610, on identifying and reducing administrative burdens, requires the HHS Secretary to support the streamlining of state enrollment and renewal processes for public benefit programs.³³ By eliminating the most successful enrollment pathway used today and forcing consumers to navigate new administrative processes that are less likely to meet their needs, Georgia's waiver conflicts with the central purpose of this Order.

The Departments Have Clear Authority to Collect Additional Information, Evaluate the Waiver, and Terminate it if Necessary

In response to the Departments' request for additional information to evaluate the waiver, Georgia claims that the Departments lack authority to request this information or evaluate the waiver at the present time. These assertions are clearly wrong. In fact, section 1332, the applicable regulations, and the Specific Terms and Conditions (STCs) give the Departments clear authority *at any time* to require that Georgia submit additional information, to evaluate the waiver, and to terminate it if it fails to continue to satisfy the conditions for approval.

Robust Regime for Post-Approval Monitoring and Compliance Exists

Given section 1332's wide-ranging power to alter federal law, Congress carefully bound it through the statutory guardrails. Guardrail compliance must be projected not only at the moment of approval but also thereafter through ongoing monitoring and evaluation.

The statutory basis for the monitoring and evaluation regime is section 1332(a)(4)(B). It requires the Departments to "promulgate regulations...that provide...(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and (v) a process for the periodic evaluation by the Secretary of the program under the waiver."

³⁰ CBPP analysis using HealthCare.gov, ZIP code 30318.

³¹ Aizawa and Kim, *op. cit.*

³² Executive Order 14009, "Strengthening Medicaid and the Affordable Care Act," January 28, 2021, <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicare-and-the-affordable-care-act/>.

³³ Executive Order 13610, "Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government," December 13, 2021, <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/12/13/executive-order-on-transforming-federal-customer-experience-and-service-delivery-to-rebuild-trust-in-government/>.

The required regulations are in section 45 CFR 155.1320, which has generally stood unchanged since 2012, with further elaboration in the STCs. The rules make clear that post-approval a state must continue to comply with “all applicable federal law and regulations” – including new changes – “unless expressly waived.”³⁴ They require the Departments to conduct implementation reviews to “examine compliance” with the statutory guardrails.³⁵ The State must “fully cooperate” with these reviews, which may cover “any component” of a waiver, and must “submit all requested data and information.”³⁶ The Departments “reserve the right to suspend or terminate”³⁷ a waiver for at least three separate reasons: (1) due to changes in federal law or regulations,³⁸ (2) “at any time” they determine the a State has “materially failed to comply with the terms” of a waiver,³⁹ or (3) “at any time” the state fails to meet the statutory guardrails.⁴⁰

Given this framework, it is clear that the Departments have authority to request additional information, that Georgia must provide it, and that the Departments may evaluate the waiver at this point and revoke approval for a range of reasons. Yet Georgia appears to misunderstand these rules and its responsibilities on several fronts.

Georgia’s Claim that the Right to Review Applies Only After Full Implementation is Clearly Contradicted

Georgia claims the waiver terms’ requirement to provide additional information for review applies only after a waiver has been fully implemented, not during the period between approval and full implementation. Focusing on the monitoring rules in STC 15, Georgia argues that they are “plainly contemplating monitoring ... once a waiver has gone into force,” since “there is nothing new for the state to report.”⁴¹

But this contention is clearly contradicted by the regulations and STCs, the underlying statutory structure, and how section 1332 waivers work in practice.

As noted above, the statute, regulations, and STCs lay out a robust regime for monitoring and oversight. These rules plainly provide for the Departments to conduct monitoring and oversight throughout the post-approval period. Section 1332(a)(4)(B) calls for “periodic evaluation” of a waiver, with no constraints on when evaluations are to be conducted. STC 15 refers to “oversight of an approved waiver” – not merely those that have been fully implemented. Section 155.1320(a) requires the state to comply with all federal policies “following the final decision” – not following full implementation. Section 155.1320(d) and STC 17

³⁴ Section 155.1320(a)(1). Similarly, STC 6 provides that “the state must comply with all applicable federal laws and regulations, unless a law or regulation has been specifically waived.”

³⁵ Section 155.1320(a)(2). Similarly, STC 15 provides that “Departments will evaluate the waiver using federal data, state reporting, and the application itself to ensure that the Departments can exercise appropriate oversight of the approved waiver.”

³⁶ Section 155.1320(f). Similarly, STC 15 provides that “if requested by the Departments, the state must fully cooperate with the Departments or an independent evaluator selected by the Departments in consultation with the state, to undertake an independent evaluation of any component of the waiver. As part of this required cooperation, the state must submit all requested data and information to the Departments or the independent evaluator.”

³⁷ This same language is used in Section 155.1320(d), STC 7, and STC 17.

³⁸ STC 7.

³⁹ Section 155.1320(d). Section 155.1320(d) includes nearly identical language.

⁴⁰ STCs 17.

⁴¹ GA Aug. 26 letter.

authorize the Departments to terminate a waiver “at any time.” This would be impossible if they were prohibited from collecting information about and evaluating the waiver before it was fully implemented.

Ongoing oversight also seems necessary given how section 1332 waivers work in practice. While Georgia claims that “there is nothing new for a state to report” before full implementation, in fact the implementation of a waiver is an iterative process requiring decision-making in numerous specific issues. For a complex waiver, implementation is likely to be a long and complex process. A state may request that a waiver be approved years in advance to provide sufficient implementation time – more than two years in Georgia’s case. During that time, the federal and state rules and facts on the ground may change in ways that make guardrail compliance implausible. It would defeat Congress’s purposes in creating the statutory guardrails if, during this window of time, a waiver could not be monitored to ensure it remains in compliance.

Georgia also claims that allowing information collection at this point in time would render the STCs and section 155.1320 “surplusage.” It is not clear what Georgia means by this. Generally, surplusage means language that has no effect because other language covers the same ground. But the STCs and section 155.1320 have the clear effect of creating the monitoring and evaluation regime described above – pursuant to the clear statutory directive in section 1332(a)(4)(B). Contrary to Georgia’s contention, failing to give these provisions their stated effect is closer to the meaning of surplusage.

As discussed in more detail below, providing information as requested is also necessary for the successful functioning of a waiver, including the Departments’ annual calculation of pass-through funding, as required by section 1332(a)(3).

Departments are Authorized to Review the Waiver Under a Wide Range of Circumstances

A central element of Georgia’s refusal to cooperate is the claim that the Departments may evaluate ongoing guardrail compliance only when there is a change in federal statute. Thus, Georgia asserts that federal policy changes – such as new regulations and increases in navigator and outreach funding – cannot trigger and are irrelevant to any current evaluation.

To make this argument, Georgia focuses on STC 7, which indeed focuses exclusively on changes in federal statute. Georgia claims that no relevant legislation has been enacted and so STC 7 provides no grounds for review.

As an initial matter, it is also worth noting that Georgia is wrong that no relevant legislation has been enacted since approval. As noted above, CBO has made clear that it expects the American Rescue Plan to affect enrollment in 2023, and the expiration of the Rescue Plan’s provisions under current law would create new complications for the first open enrollment period under Georgia’s proposal.

But more importantly, STC 7 is not the only one that provides grounds for evaluation and potential termination. STC 17 – which the Departments’ letters cite but which Georgia fails to address – separately provides that the Departments “reserve the right to amend, suspend, or terminate, the waiver (in whole or in part) at any time only if the Departments determine that the state has materially failed to comply with these STCs, or if the state fails to meet the specific statutory requirements or ‘guardrails.’” There is no restriction on the circumstances that may occasion or be considered in assessing such compliance.

The breadth of review authority is reinforced by STC 6, which requires the state to “comply with all applicable federal laws and regulations, unless a law or regulation has been specifically waived.” The guardrails have not been specifically waived, nor can they be.

Thus, the STCs clearly authorize post-approval evaluation of guardrail compliance for reasons far beyond statutory changes.

Beyond the STCs, Section 155.1320 also makes this authority clear. Section 155.1320(a) calls for ongoing review of compliance with the statutory guardrails, and section 155.1320(d) reserves the Departments' right to suspend or terminate a waiver "at any time before the date of expiration, whenever [they] determine[] that a State has materially failed to comply with the terms of a section 1332 waiver." These terms include, of course, satisfying the guardrails. The breadth of this authority is reinforced by 155.1320(f), which notes the evaluation may examine "any component" of a waiver.

In short, Georgia's argument for limiting the scope of review requires focusing on a single provision and ignoring others that authorize the Departments to broadly examine a waiver's ongoing compliance.⁴²

Georgia's Refusal to Provide Additional Information Is Sufficient Grounds to Terminate the Waiver

The Departments' June 3, 2021 letter gave Georgia 30 days to provide updated actuarial and economic analysis to support its assertion that the Georgia Access Model will comply with the statutory guardrails, as well as information about the data and assumptions used in conducting this analysis.⁴³ But Georgia first expressed confusion about this request⁴⁴ and later refused to comply.⁴⁵ By refusing to provide this information, Georgia has provided two separate grounds for revoking the waiver.

Georgia Has Violated the Requirements in the Regulations and STCs to Provide Additional Information as Requested

As explained above, both section 155.1320(f) of the section 1332 regulations and STC 15 plainly require a state to provide relevant information as requested by the Departments for purposes of monitoring and evaluation, at any time. Georgia's letter of August 26 recognizes that this information has been requested and baldly refuses to provide it. By refusing to provide the information requested, Georgia is in violation of the regulations and STCs. Under STC 17 and section 155.1320(d), this violation alone provides sufficient grounds for the Departments to terminate the waiver.

Georgia's Refusal to Provide Requested Information Likely Makes Implementation Infeasible

This refusal to cooperate also has practical implications that may make it impossible for the waiver to proceed. A successful section 1332 waiver is always a collaboration between the federal government and a state. Without the state's cooperation, implementation is likely infeasible.

This is perhaps most readily apparent in the process for calculating pass-through funding. Section 1332(a)(3) requires the Departments to calculate pass-through funding *annually*. To do that, the Departments customarily require states with approved waivers to provide up-to-date information about their market

⁴² Section 128 arguably also provides authority for review of the waiver's compliance with guardrails. It provides that they the Departments "shall periodically evaluate the implementation...consistent with [guardrail regulations] and interpretive guidance published by the [Departments], and [the STC]"

⁴³ Letter from CMS Administrator Chiquita Brooks-LaSure to Governor Brian Kemp, June 3, 2021, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Request-Updated-GA-Analysis-Letter.pdf>.

⁴⁴ See Letter from Georgia Health Strategy and Coordination Office Director Grant Thomas to Administrator Chiquita Brooks-LaSure, July 2, 2021, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Response-1332-GA-request-Updated-GA-Analysis-Letter.pdf>.

⁴⁵ See Letter from CMS Administrator Chiquita Brooks-LaSure to Director Grant Thomas, July 30, 2021, <https://www.cms.gov/files/document/response-1332-ga-depts-follow-letter.pdf> and Letter from Director Grant Thomas to Administrator Chiquita Brooks-LaSure, Aug. 26, 2021, <https://www.cms.gov/files/document/1332-georgia-letter-cms-82621.pdf>.

conditions.⁴⁶ The Departments must vet this information to ensure it reasonably justifies the pass-through funding provided, and then use it to perform calculations, which may be quite complex.⁴⁷ Georgia's waiver is orders of magnitude more complex than any waiver previously approved. Analyzing the waiver's impact on enrollment, premiums, and federal subsidies would be complicated under the best of circumstances and require substantial lead time. Without analysis updated to reflect current conditions, it seems infeasible for the Departments to meet their responsibility to calculate pass-through funding with sufficient confidence. Thus Georgia has seemingly made it practically impossible for its waiver to proceed.

Previous Flaws Still Exist in Violation of Guardrails

In addition to the new reasons for termination, the waiver's underlying flaws merit reconsideration of whether it complies with the guardrails. Eliminating HealthCare.gov threatens to reduce coverage due to consumer confusion, and many of the people who start their applications on HealthCare.gov but are assessed as eligible for Medicaid would likely hit an enrollment roadblock under the Georgia Access Model, as private insurers and brokers frequently lack the financial incentive to facilitate Medicaid enrollments. Further, reliance on brokers — both web brokers and individual sellers — could result in more people getting coverage that is less comprehensive than they'd otherwise have, since there are strong incentives to lure people into non-compliant coverage. This steering could also raise premiums: healthier people might be pushed to lower-benefit plans, leaving only sicker people in ACA-qualifying plans and driving up their cost.

Privatizing Marketplace Would Reduce Enrollment, Not Increase It

Georgia claims that privatizing its marketplace would increase enrollment in the individual market by about 28,000 people by giving consumers new options to shop for and enroll in plans.⁴⁸ But even if one were to grant Georgia's unsubstantiated claim that allowing enrollment through insurers and brokers increases coverage, the premise underlying the state's coverage projection is flawed: the waiver does not add meaningful new enrollment options. Consumers already can enroll in marketplace coverage directly through insurers or brokers — including the web brokers the proposal heavily relies on. At least 17 insurers and web brokers offer these services in Georgia for the 2022 plan year.⁴⁹ The waiver itself notes these options are widely available. This means the waiver subtracts pathways to coverage, rather than creating net new pathways.

Meanwhile, the waiver analysis entirely ignores countervailing threats to enrollment posed by dismantling the enrollment and consumer support system that more than half of enrolled Georgians use. Abandoning HealthCare.gov would leave the majority of enrollees without their chosen enrollment platform, almost certainly reducing enrollment significantly.⁵⁰ First, fragmenting the health insurance market across brokers and insurers would make insurance-buying less accessible and more confusing for consumers. Second, people who are eligible for Medicaid could have less enrollment assistance. And last, the transition itself would

⁴⁶ See, for example, "State Specific Premium Data for Section 1332 Waiver 2021 Pass-through Calculations (XLSX)," available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-

⁴⁷ See, for example, "2021 U.S. Department of the Treasury Method for Calculation of Section 1332 Waiver Premium Tax Credit Pass-through Amount for New Jersey (with addendum) (PDF)," November 3, 2021, available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-

⁴⁸ Waiver, *op. cit.*, p. 60.

⁴⁹ CBPP analysis of enrollment partners on HealthCare.gov in December 2021. The number of web brokers has not been influenced by the new business opportunities anticipated by the approval of the waiver in November 2020. In January 2020, there were already 16 web brokers in the marketplace.

⁵⁰ Of those enrolled in 2020, about one-fifth were through brokers or insurers. Waiver, *op. cit.*, p. 82.

inevitably cause consumers to fall through the cracks, as occurred in states moving between federal and state enrollment platforms, a transition much simpler for consumers than Georgia's proposed transition from the federal platform to a wholly fragmented enrollment system.

Fragmentation, Loss of HealthCare.gov Would Likely Cause Coverage Losses

Under Georgia's waiver, enrollment would likely fall because buying insurance would become harder. It's well documented that having too many choices can stymie consumers.⁵¹ For example, one study of Medicare Part D plans found that having fewer than 15 options raised enrollment, whereas having 15 to 30 options did not, and having more than 30 options actually lowered enrollment.⁵² A marketplace consumer in Atlanta has 142 plan options in 2022.⁵³ And consumers who manage to enroll despite being overwhelmed by choice are more likely to delegate their choice to others, regret their selection, and be less confident in the choices they make.⁵⁴ Confusion could be even greater under a system that requires consumers to choose among legions of sellers before beginning the process of selecting a specific health plan, with no guarantee of a single platform on which to see and compare all plan choices on equal terms. That same Atlanta consumer has more than 1,500 individual agents and brokers to choose from, with no guarantee that any given broker they choose will sell all available marketplace plans.⁵⁵

HealthCare.gov was created to simplify this complex decision-making process. It allows people to navigate one website to get an unbiased view of all plans eligible for financial assistance and provides tools to compare plans by premium, deductible, out-of-pocket cost, in-network status of preferred providers, and prescription drug coverage, among other features. All plans are guaranteed to meet the ACA's insurance market standards, like covering the law's ten essential health benefits and having no lifetime or annual limits on benefits.

Instead of the one-stop shopping experience of the marketplace, Georgia's waiver proposes a free-for-all run largely by web brokers and insurers. The system would be similar to the current system for purchasing individual coverage off-marketplace, which survey evidence suggests leads to more challenges choosing a plan and to worse experience overall, especially for individuals with chronic conditions.⁵⁶ Georgia's waiver relies on a process known as enhanced direct enrollment, under which people apply for marketplace enrollment and select a plan through websites operated by private web brokers and insurers, while eligibility for premium tax credits is determined behind the scenes by the federal government. The waiver says that Georgia will reference federal standards for how web brokers and insurers can display plans, but even these rules leave critical gaps. For instance, insurers show only their own plans, not the full array of plans available through HealthCare.gov. Web brokers are required to show all plans under federal rules but can display plans that pay commissions more prominently and show scant information about other plans, even omitting the premium amount. The standards for the online enrollment process, as set by the federal government, don't extend to individual agents and brokers. And these various entities — web brokers, insurers, and individual brokers and

⁵¹ Consumers Union, "The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making," November 2012, https://advocacy.consumerreports.org/wp-content/uploads/2012/11/Too_Much_Choice_Nov_2012.pdf.

⁵² J. Michael McWilliams *et al.*, "Complex Medicare Advantage Choices May Overwhelm Seniors — Especially Those With Impaired Decision Making," *Health Affairs*, September 2011, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.0132>.

⁵³ CBPP analysis using HealthCare.gov, ZIP code 30318.

⁵⁴ Consumers Union, *op. cit.*

⁵⁵ CBPP analysis using HealthCare.gov, ZIP code 30318.

⁵⁶ Joachim Hero *et al.*, "Decision-Making Experiences Of Consumers Choosing Individual-Market Health Insurance Plans," *Health Affairs*, March 2019, <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05036>.

agents — frequently sell plans that fail to meet ACA standards.⁵⁷ Indeed, displaying additional categories of options, including coverage that isn't comprehensive, is a stated goal of the waiver.⁵⁸ This would make shopping for health insurance much more complicated — and could lead more consumers to select lower-value coverage without the ACA's protections, out of confusion rather than true preference.

Failure to successfully build a robust, reliable technology system that helps existing enrollees re-enroll under the new regime could cause consumers to lose coverage or subsidies in 2023, the first year of the new system. But even if the state mostly succeeded in launching the new system, enrollment would likely fall due to the transition, which at a minimum would require many consumers to use a new interface. Georgia predicts losing only about 2 percent of otherwise-returning enrollees due to the change, but other states' experiences show this figure is unrealistic.⁵⁹ Kentucky's marketplace enrollment fell 13 percent when it transitioned to the federal marketplace in 2017, compared to a 4 percent decline nationally; Nevada's enrollment fell 7 percent for the 2020 plan year after its transition to a state-based marketplace, compared to flat enrollment nationally.⁶⁰ Similar percentage declines in Georgia would translate into a drop of 38,000-71,000 people in marketplace enrollment.⁶¹ And in these cases, consumers had a new, clearly identified marketplace to turn to and meaningful public outreach and enrollment efforts aimed at smoothing the transition. Georgia would require consumers accustomed to a marketplace to choose among multiple options and navigate a whole new type of portal. This would likely lead to far larger coverage losses than Kentucky and Nevada saw.

Challenges during transitions away from HealthCare.gov include maintaining communication with existing enrollees, conducting strong outreach to potential new consumers, and transferring account information to facilitate automatic re-enrollment for existing enrollees. Each challenge would likely be especially pronounced in Georgia, which would lack a central system to receive consumer information transferred from HealthCare.gov. While the state claims it would engage in a “robust” transition plan with a “detailed transition strategy,” the waiver provides no details.

The STCs require that by this point the state should have submitted both an “operational report”⁶² and an “outreach and communications plan.”⁶³ But these documents are not publicly available, and as far as we know these have not been submitted. If they have been submitted, stakeholders representing consumers have been shut out of the process of developing or commenting on the plan and neither the state nor HHS have made the plan publicly available. In addition to submitting plans to the Departments, STC 3 requires the state to notify the public of the open enrollment dates for plan year 2023. This has not happened. The Departments' waiver approval letter also committed that the state would “closely engag[e] with local community

⁵⁷ Web brokers can sell any type of health plan but must separate them from the ACA-qualifying health plans under federal rules; it's unclear whether Georgia would adopt those rules.

⁵⁸ Waiver, *op. cit.*, p. 4.

⁵⁹ Waiver, *op. cit.*, p. 78.

⁶⁰ CBPP calculations from CMS public use files. See also Sarah Lueck, “Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges,” CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

⁶¹ States that transitioned for 2021 did not see coverage reductions on net, likely because of other factors that led to large coverage increases nationwide for 2021.

⁶² STC 12.

⁶³ STC 3.

organizations, advocacy groups, and other stakeholders who work directly with vulnerable populations to provide the necessary support to these individuals.”⁶⁴ This has not occurred.

Many Georgians Would Likely Lose Medicaid Coverage

HealthCare.gov also facilitates Medicaid enrollment with a “no-wrong-door” application that routes a person to the program for which they’re eligible based on their family size, income, and other factors. In many cases, this prevents someone from needing to complete multiple applications to connect with the correct program. In the open enrollment period for 2021, about 35,000 Georgians who started the process at HealthCare.gov were assessed eligible for Medicaid — more than the number of total enrollees the state projected to gain through the waiver.⁶⁵

But Medicaid (including Medicaid managed care organizations) generally doesn’t pay commissions. That means brokers and insurers have no incentive to provide information and assistance to consumers who turn out to be eligible for Medicaid rather than subsidized marketplace coverage, so they might not provide these consumers with any help to enroll. For example, a search on HealthCare.gov displays more than 1,500 agents and brokers that enroll people in individual or family coverage in one Atlanta ZIP code but *zero* agents and brokers that say they’ll assist with Medicaid or CHIP enrollment.⁶⁶

The number of Medicaid-eligible people coming through the marketplace could be much higher as the Medicaid continuous coverage requirement linked to the public health emergency unwinds, as explained elsewhere. This is because many enrollees who lose Medicaid will fall off for procedural reasons, though they remain eligible. As they look for other coverage, thousands could come to the marketplace. HealthCare.gov is equipped and obligated to help them enroll in Medicaid, whereas insurers and brokers have no financial incentive or requirement to assist them, which would cause many Medicaid-eligible people to go without coverage.

Brokers and insurers could also steer low-income consumers toward private coverage, including lower-premium, limited-benefit substandard plans, without explaining that they are eligible for comprehensive coverage through Medicaid. Brokers and insurers receive commissions or make a profit as long as a few of these consumers enroll, even if most are deterred by the premiums or out-of-pocket costs and remain uninsured. Consistent with these incentives, some web brokers already neglect to identify certain children as Medicaid eligible. Consider, for example, a parent and child with household income of \$15,000, which in Georgia would qualify the child (though not the parent) for Medicaid. The web broker GoHealth fails to identify the child as likely Medicaid eligible, saying explicitly that “you may not qualify for government subsidies” and instead displays a list of full-price marketplace plans that include both the parent and Medicaid-eligible child.⁶⁷ Eliminating HealthCare.gov as an unbiased eligibility and enrollment option could significantly decrease enrollment among some of the most vulnerable Georgians.

Privatization Could Steer Healthier Consumers to Non-ACA Plans

⁶⁴ Approval letter, p. 23.

⁶⁵ Centers for Medicare & Medicaid Services, 2021 Marketplace Open Enrollment Period Public Use Files, April 21, 2021, <https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files>. This does not include the number of Medicaid-eligible people who initially applied through the marketplace during the six-month SEP.

⁶⁶ CBPP analysis. HealthCare.gov search conducted on December 8, 2021, using the 30318 ZIP code.

⁶⁷ CBPP analysis as of December 10, 2021. The website also encourages people to alter their income projections to qualify for subsidies.

The waiver estimates premiums would fall 3.6 to 3.7 percent due to the Georgia Access Model.⁶⁸ Not only is that estimate based on the flawed premise that the state’s plan will increase enrollment, but it fails to account for the potential for greater enrollment in substandard plans, which could raise premiums for ACA-compliant coverage (and greatly increase consumers’ exposure to catastrophic medical expenses) by pulling healthy people out of comprehensive coverage.

An explicit goal of the waiver is to increase access to coverage that doesn’t meet ACA standards.⁶⁹ It envisions an enrollment system that promotes “the full range of health plans licensed and in good standing” in the state, including short-term, fixed indemnity, accident, and single-disease plans, which normally can’t be sold alongside ACA plans through enhanced direct enrollment. Short-term plans, in particular, pose a considerable risk to consumers but have grown in popularity, especially in Georgia, since the Trump Administration expanded them in 2018.⁷⁰ One review of the most popular short-term plan in Atlanta found that although it had lower premiums, its deductible and maximum out-of-pocket costs were more than 2.5 times higher than the most popular bronze ACA plan, and it offered no coverage of prescription drugs, mental health services, or maternity care.⁷¹

Brokers have an incentive to steer consumers toward short-term plans because they tend to pay higher commissions — the waiver notes that brokers selling short-term coverage receive average commissions that are up to 22 percent higher than those for ACA-compliant plans.⁷² In addition, even some insurers that offer commissions during open enrollment offer smaller or no commissions outside of it, which amplifies brokers’ incentives to steer people into higher-commission plans and causes the subsidized population to unnecessarily dwindle throughout the year.⁷³ In one study, sixty percent of brokers said at least some insurers stopped paying commissions on marketplace policies sold outside of open enrollment, and one-third reported most or all insurers have stopped paying SEP commissions for marketplace policies.⁷⁴ Insurers also profit on short-term plans, which aren’t required to meet the medical loss ratio standards for ACA-compliant plans: short-

⁶⁸ Waiver, *op. cit.*, p. 59.

⁶⁹ Waiver, *op. cit.*, p. 4.

⁷⁰ Indemnity plans have also been found to be risky and confusing to consumers. See Christen Linke Young and Kathleen Hannick, “Fixed indemnity health coverage is a problematic form of ‘junk insurance,’” Brookings Institution, August 4, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance/>.

⁷¹ Dane Hansen and Gabriela Dieguez, “The impact of short-term limited-duration policy expansion on patients and the ACA individual market,” Milliman, February 2020, <https://www.lls.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>. For a comprehensive report detailing problematic short-term plan practices, see Energy and Commerce Committee (Democratic Staff), U.S. House of Representatives, “Shortchanged: How the Trump Administration’s Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk,” June 2020, https://drive.google.com/file/d/1uiL3Bi9XV0mYnxpyaIMeg_Q-BJaURXX3/view. (Hereafter, House report.) Also see Sarah Lueck, “Key Flaws of Short-Term Health Plans Pose Risks to Consumers,” CBPP, September 20, 2018, <https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers>. For context on the ACA’s metal-tiering of plans, see CBPP, “Cost-Sharing Charges in Marketplace Plans, Answers to Frequently Asked Questions,” updated August 2020, <http://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-answers-to-frequently-asked-questions/>.

⁷² Waiver, *op. cit.*, p. 79.

⁷³ Virgil Dickson, “As commissions on ACA plans vanish, some brokers stop selling them,” Modern Healthcare, April 8, 2017, <https://www.modernhealthcare.com/article/20170408/MAGAZINE/304089873/as-commissions-on-aca-plans-vanish-some-brokers-stop-selling-them>.

⁷⁴ Pollitz, Tolbert, and Semanskee, *op. cit.*

term plans spent only about 53 percent of premium revenue on medical care, compared to at least 80 percent for ACA plans.⁷⁵

Steering can happen in many ways.⁷⁶ For example, some web brokers collect information that is useful in the medically underwritten market (such as height and weight) and feed the information to a broker call center, where the web broker rules prohibiting certain types of steering do not apply.⁷⁷ Consumers visiting web broker sites often must agree to telephone solicitation by the web broker, insurance agents, insurance companies, and partner companies, making them ripe for pressure tactics in the future. In addition to the data the consumer voluntarily submits, other information, like browser tracking data, could be gathered and sold. Based on these data, a consumer may see targeted advertisements for alternative non-ACA plans or receive phone solicitations now and in the future, including during the next open enrollment period for ACA plans.

Even under current law, 1 in 4 marketplace enrollees that sought help from a broker or insurer said they were offered a non-ACA-compliant policy as an alternative to marketplace coverage.⁷⁸ And consumers are often subjected to aggressive or even fraudulent marketing tactics.⁷⁹ One study, for example, showed that most brokers gave ambiguous, misleading, or demonstrably false information regarding short-term plan coverage for COVID-19-related illnesses.⁸⁰ Indeed, some agents and brokers, especially those found through online search engines, offer short-term plans in a majority of cases, even when an applicant is eligible for generous subsidies. One secret shopper study found that in phone calls with 20 brokers, only 5 recommended marketplace plans; others commonly recommended plans that cost more and covered less. Representatives also often provided false or misleading information about the plans.⁸¹ Georgia's waiver would create many new opportunities for deceptive and aggressive marketing.

Healthier people would be more likely to opt for short-term plans, since less healthy people are less likely to qualify for a policy, face higher premiums when they do, and might be more apt to recognize absent benefits and other limitations. If healthier consumers exited the ACA-compliant market, its risk pool would become less healthy, on average, driving up premiums; in states that took advantage of the Administration's expansion of short-term plans — like Georgia, which has few restrictions — premiums for comprehensive coverage went up by about 4 percent.⁸² The waiver doesn't account for short-term plan enrollment, its impact

⁷⁵ National Association of Insurance Commissioners, "2020 Accident and Policy Experience Report," July 2021, <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf>.

⁷⁶ Tara Straw, "'Direct Enrollment' in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm," CBPP, March 15, 2019, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

⁷⁷ Sabrina Corlette *et al.*, "The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses," Urban Institute, January 31, 2019, <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>.

⁷⁸ Karen Pollitz *et al.*, "Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need," Kaiser Family Foundation, August 7, 2020, <https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/>.

⁷⁹ House report, *op. cit.*, p. 29; Corlette *et al.*

⁸⁰ Christen Linke Young and Kathleen Hannick, "Misleading marketing of short-term health plans amid COVID-19," Brookings Institution, March 24, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

⁸¹ Dania Palanker and JoAnn Volk, "Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period," Georgetown University Health Policy Institute, Center on Health Insurance Reforms, October 2021, <https://georgetown.app.box.com/s/mn7kgnhibn4kapb46tqmv6i7putry9gt>.

⁸² Hansen and Dieguez, *op. cit.*, p. 3.

on ACA-compliant coverage enrollment, the risk profiles of enrollees in short-term or ACA-compliant plans, or the likelihood of premium increases in the ACA-compliant market.

Then and Now, Waiver Fails Federal Tests for Approval

The Georgia Access Model fails the statutory tests for 1332 waivers. Both prior to approval and even more so now, it does not meet the requirements that waivers cover as many people, with coverage as affordable and comprehensive as would have been covered without the waiver.⁸³

Coverage. Georgia's waiver baseline doesn't reflect the increased enrollment due to laws, regulations, and policies that have been put into place since the waiver was approved. Therefore, Georgia fails to show that its plan can achieve coverage numbers that are comparable to the enrollment otherwise expected without the waiver. In fact, the plan would likely decrease enrollment. Georgia's claim that the waiver would increase enrollment rests on the flawed premise that it would introduce a new enrollment option; in reality, it would *eliminate* the option to compare plans and enroll in coverage through a neutral platform. In addition, as discussed above, privatizing the marketplace would make it more difficult for some consumers to enroll in coverage. Transitioning existing enrollees from HealthCare.gov to the new system could lead to additional coverage losses, and there would be no coordinated plan to get new enrollees. In all, the expected effect of the waiver is to reduce coverage, failing the statutory test.

Affordability. The Georgia Access Model would likely *increase* premiums for comprehensive coverage. That's partly because it is very unlikely to increase marketplace enrollment, an assumption on which its projected 3.4 percent premium reduction is based. In addition, driving more healthy consumers to less comprehensive underwritten plans would likely increase marketplace premiums through adverse selection, something Georgia's actuarial analysis doesn't account for. And given the waiver's reliance on incentives for agents and brokers in the private market, commissions would likely increase, further raising premiums. The state's flawed, incomplete actuarial analysis makes it impossible to know whether the affordability guardrail can be met, on balance.

Comprehensiveness. Georgia's privatization proposal creates new opportunities for brokers and insurers to steer healthy people toward substandard plans that do not meet ACA requirements. Thus, it would likely result in more Georgians enrolled in non-comprehensive plans that expose them to catastrophic costs if they get sick.

Georgia's is Waiver Even More Clearly Deficient if Build Back Better Becomes Law

Build Back Better (BBB),⁸⁴ which has passed the House, would extend through 2025 the American Rescue Plan's premium tax credit enhancements and provide financial help to people with income below the poverty line in states that did not expand Medicaid. If BBB becomes law, Georgia's 1332 baseline projections (its estimates of what would happen without the Georgia Access Model) would be even less moored to on-the-ground coverage conditions, and the waiver's coverage goals would be even more underwhelming

BBB would do many things to bolster enrollment, including for marginalized groups, but Georgia does not address these factors in its analysis:

- It would extend the Rescue Plan's premium tax credit enhancements to 2025, lowering premiums for people with incomes between 100 and 400 percent of the poverty line and allowing people with income over 400 percent of the poverty line to claim the credit;

⁸³ Linke Young and Levitis, *op cit.*

⁸⁴ Build Back Better Act, H.R. 5376, <https://www.congress.gov/bill/117th-congress/house-bill/5376>.

- It would make people who live in states that did not expand Medicaid newly eligible for a premium tax credit through the marketplace — including 275,000 uninsured Georgians, a plurality of whom, due largely to structural inequities and disparities in coverage rates, are Black;⁸⁵
- It would dedicate new funding to outreach and enrollment, including in-person assistance, for people formerly in the Medicaid coverage gap;
- It would make employer coverage more affordable for some workers, by allowing them to claim a premium tax credit when premiums cost more than 8.5 percent of income rather than 9.5 percent and by ensuring that people with income below 138 percent of poverty would not be blocked from premium tax credit eligibility due to an employer offer; and
- It would likely lead people to transition from Medicaid to the marketplace, by phasing out the financial incentives for the Medicaid continuous coverage requirement related to the public health emergency, meaning some people whose income now exceeds Medicaid eligibility levels would be eligible for a premium tax credit in the marketplace.

Newly providing coverage to individuals in the coverage gap would greatly increase the operational and outreach challenges for the Georgia Access Model, forcing it to shoulder greater burdens than Georgia has designed it for. This would likely increase coverage losses.

In addition, BBB's anticipated enrollment gains would need to be factored into the baseline to evaluate whether the waiver meets the statutory guardrails; if Georgia can't achieve enrollment at least comparable to what would occur without the waiver, its waiver would violate the coverage guardrail. At a minimum, the failure to provide new analysis to account for the effects of BBB would make it impossible for the Departments to calculate the pass-through payments Georgia would receive under the waiver. Operating under an artificially low baseline would generate a higher pass-through payment than the state would otherwise be entitled to receive.

⁸⁵ Gideon Lukens and Breanna Shearer, "Closing Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities," CBPP, June 14, 2021, <https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial>.



CITYBLOCK HEALTH
495 FLATBUSH AVENUE 5C
BROOKLYN, NY 11225

December 1, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Thank you for the opportunity to comment on the Georgia Access Model proposed under Section 1332 of the Affordable Care Act. Please accept the following comments from Cityblock Health, Inc. (Cityblock). Cityblock is a provider organization providing physical, behavioral, and social care to Medicaid, dually eligible, and other members living in lower-income neighborhoods that have historically had poor access to health care services.

Health equity is at the core of our mission. While Cityblock does not currently operate in Georgia, we are growing quickly and are committed to promoting equitable access to coverage and care for individuals in underserved communities nationwide.

We are concerned that by allowing Georgia to forgo the HealthCare.gov marketplace, leaving consumers to shop for insurance directly through insurance brokers or other avenues, the Georgia Access Model would create barriers to comprehensive coverage for low-income individuals. Community Catalyst, a national health advocacy organization focused on advancing health equity, has also voiced these concerns, including:

1. **Impeding access to coverage from private insurers.** In 2020, 79 percent of Georgia marketplace enrollees used HealthCare.gov to sign up for coverage, even though they already had the option of using a private broker or insurer website. The HealthCare.gov site facilitates consumers' coverage selections by providing an objective comparison of all options in one place. In the absence of HealthCare.gov, consumers would no longer have a one-stop opportunity to determine which insurance options are most affordable for themselves and their families, and whether the benefits of a particular insurance option meet their needs.



2. **Impeding access to Medicaid.** One of the benefits of HealthCare.gov is that through the website, consumers can easily learn whether they are eligible for Medicaid, and if so, how to enroll. Medicaid enrollment trends show that one-stop government-run marketplaces have led to growth in Medicaid enrollment. This mechanism for people to learn that they are Medicaid-eligible and enroll would be eliminated under the Georgia Access Model. According to CMS public use files, and as reported by the nonpartisan Center on Budget and Policy Priorities, 38,000 Georgians enrolled in Medicaid via HealthCare.gov in 2020.

We also believe the Georgia Access Model conflicts with the statutory guardrails outlined in the Affordable Care Act to ensure coverage under 1332 waivers is at least as comprehensive as it would be absent those waivers. Specifically, as outlined above, we believe the Georgia Access Model component of the proposed 1332 waiver would not result in coverage for a comparable number of individuals or provide coverage options that are at least as affordable (in terms of out-of-pocket spending) as absent the waiver.

We strongly urge CMS to disapprove the Georgia Access Model, with a view to equitable access to coverage and care for individuals in underserved communities.

Sincerely,

Toyin Ajayi

President, Cityblock Health, Inc.

toyin@cityblock.com



January 4, 2022

U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, D.C. 20201

RE: Georgia Section 1332 Waiver Comments

The Colorado Consumer Health Initiative (CCHI) appreciates this opportunity to comment on Georgia’s 1332 Waiver request. CCHI is a nonprofit, consumer-oriented, membership-based health advocacy organization that serves Coloradans whose access to health care and financial security are compromised by structural barriers, affordability, poor benefits, or unfair business practices of the health care industry.

CCHI is deeply concerned by Georgia’s 1332 waiver proposal to eliminate use of the federal marketplace and we strongly urge the Department of Health and Human Services to deny this waiver request and any others of a similar form. Georgia’s proposal to exit HealthCare.gov would create massive logistical and financial challenges for consumers trying to navigate the health insurance market. Eliminating the one-stop-shop marketplace would make it incredibly difficult for consumers to compare health insurance options to find plans that best meet their needs. In Colorado alone, having a centralized marketplace benefits roughly 225,000 people each year.¹

Without a marketplace to consolidate this information or unbiased Navigators to aid in the process, it would be increasingly difficult for consumers to know if they are eligible for Medicaid (and CHIP) or advanced premium tax credits (APTCs) to defray the cost of coverage up front. The unclear system to access APTCs in and of itself should be reason enough to reject this waiver, as there is no other clear method for consumers to access tax credits or cost-sharing reductions (CSRs) to make coverage affordable up front. Added to that, by forcing Georgians to navigate a fragmented system of private web brokers and insurance companies, Georgia’s proposal would make it harder for them to get information they can trust and enroll in a good-quality private plan or Medicaid. Lack of a clear process for APTCs, CSRs, or any centralized mechanism to check eligibility and compare and shop for plans will undoubtedly leave tens of thousands more people in Georgia uninsured.

Many other people could also end up in substandard plans that expose them to high costs if they get sick. That’s because Georgia would give private web brokers and insurers new opportunities to use aggressive or deceptive marketing to lure people into higher cost or junk plans that earn companies or brokers higher profits but offer little actual coverage—making existing coverage less comprehensive and more unaffordable and disrupting the insurance risk pool.² These changes will have a disproportionate impact on those who already face barriers to enrollment, including but not limited to low income folks, communities of color, and non-native English speakers.

¹ <https://c4-media.s3.amazonaws.com/wp-content/uploads/2021/04/07154007/2021-By-the-Numbers-final.pdf>

² <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>



Colorado Consumer Health Initiative

For all the reasons described above, CCHI has serious concerns that the proposed waiver will harm consumers in Georgia by limiting information and undermining choice in the health insurance enrollment process. This waiver would set an extremely dangerous precedent should other states follow in Georgia's footsteps, which consumers across the country would suffer from. We strongly urge that this waiver be denied.

Thank you for this opportunity to comment on this proposed waiver. If you have any questions regarding the comments above please contact Adam Fox, afox@cohealthinitiative.org.

Sincerely,

Adam Fox
Deputy Director
Colorado Consumer Health Initiative
afox@cohealthinitiative.org
303-839-1261



ONE FEDERAL STREET, BOSTON, MA 02110

MAIN: 617.338.6035

FAX: 617.451.5838

www.communitycatalyst.org

January 9, 2022

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Comment on the Georgia Access Model

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to submit comments on the Georgia Access Model. I am writing to express my deep concern about this waiver, which would allow the state to bar Georgians from choosing to enroll in coverage through Healthcare.gov and instead rely exclusively on insurers and brokers. The state's decision to eliminate enrollment through Healthcare.gov was flawed to begin with. Changes in federal rules, law, and funding render the state's original projections and justification even more flawed. Furthermore, the state's refusal to provide updated actuarial and economic analyses are in violation of the statutory, regulatory and procedural requirements of 1332 waivers. I therefore strongly urge the Departments to disapprove the Georgia Access Model portion of the state's 1332 waiver.

Initial Approval of the Georgia Access Model Was Unlawful

Community Catalyst wrote in opposition to the version of the Georgia Access Model that was made available for federal public comment in August and September 2020. We noted that the state's plan would violate the statutory waiver guardrails because it would reduce coverage and encourage enrollment in subpar plans. The Departments approved a version of the Georgia Access Model that was not made available to the public prior to its approval. Once approved, it was clear the state had not addressed the shortcomings of the earlier application and that the approval was unlawful.

Federal Law and Policy Have Changed in Ways that Compound the Flaws of the Georgia Access Model

Multiple federal legislative and regulatory developments since the Departments approved the Georgia Access Model in November 2020 mean the state's waiver is even more clearly in violation of the statutory approval criteria because it would result in fewer Georgians getting coverage than would be

the case without the waiver. Enactment of the American Rescue Plan Act, the COVID-19 Special Enrollment Period (SEP), and new federal investments in outreach and enrollment activities require that the waiver's compliance with federal law be reassessed. In light of these developments, the Departments have a legal obligation to reexamine the state's waiver.¹ We appreciate that the Departments are doing so and that they have recognized the need for public comment as part of that process. In the comments that follow, we respectfully observe that the Georgia Access Model does not and cannot comply with federal law as it now stands and urge that approval be revoked.

Impact on Coverage

The Georgia Access Model would eliminate the primary source for enrollment in marketplace plans. Despite this, Georgia estimated just 8,000 people (or 2% of current enrollees) would lose coverage during the transition from Healthcare.gov. Since that time, federal policies have expanded and will likely continue to expand the number of people with coverage through Georgia's marketplace. The American Rescue Plan Act significantly expanded financial assistance for marketplace coverage. The combination of the increased subsidies and the opening of a lengthy special enrollment opportunity in response to the ongoing pandemic produced nearly 150,000 new plan selections in Georgia between February 15 and August 15 of this year.² These gains since Georgia's earlier analysis, are likely to grow in the near term during an open enrollment period that lasts 30 days longer than what was contemplated in the fall of 2020. What's more, this increased enrollment can be expected to be lasting, even if the enhanced subsidies expire.³ If the Georgia Access Model is permitted to move forward, it would immediately deprive Georgians of their most commonly used pathway to individual coverage. It is highly likely that some of the people who purchased comprehensive marketplace coverage, including many of those who newly did so, will lose it. Coverage losses associated with the transition are thus likely to far exceed what could have been expected in November 2020 and must be newly assessed.⁴

Additionally, when the Departments originally considered Georgia's 1332 waiver, federal funding for outreach and enrollment activities was significantly lower than it is now. Funding for the Navigator program has increased from \$10 million when Georgia's waiver was approved to \$80 million for plan year 2022, including more than \$2.5 million for Navigator organizations in Georgia alone.⁵ This is in addition to significant increase in outreach and enrollment funding the Administration made during the COVID-19 SEP.⁶ The substantial federal investment in outreach and enrollment activities cannot be replaced by increased web-broker marketing as Georgia claimed would be the case.

¹Tara Straw and Jason Levitis, "[Georgia's Plan to Exit Marketplace Will Leave More People Uninsured, Should be Revoked](#)," Center on Budget and Policy Priority, Dec. 17, 2021.

² U. S. Department of Health and Human Services, *2021 Final Marketplace Special Enrollment Period Report*, <https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf>

³ Congressional Budget Office, Reconciliation Recommendations of the House Committee on Ways and Means, Feb. 15, 2021, <https://www.cbo.gov/publication/57005>
<https://www.cbo.gov/publication/57005>

⁴ Straw, *op. cit.*

⁵ U.S. Department of Health and Human Services, "Biden-Harris Administration Quadruples the Number of Health Care Navigators Ahead of HealthCare.gov Open Enrollment Period," Aug. 27, 2021, <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

⁶ Centers for Medicare & Medicaid Services, "2021 Special Enrollment Period in Response to the COVID-19 Emergency," Jan. 28, 2021, <https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency>

Furthermore, research has shown that marketing by insurers and brokers occurs for different reasons and produces different outcomes than what we observe from publicly funded outreach and enrollment activities. While private marketing increases an individual insurer’s share of enrollment, it does not increase overall enrollment as government advertising does.⁷ This strongly suggests that reliance on insurer and broker advertising will be insufficient to compensate for the newly expansive federally funded outreach and enrollment activities they are expected to displace. Plus, private agents and brokers will be less motivated to offer support with Medicaid enrollment. This could have detrimental effects for people with substance use disorders (SUD) and mental illness who rely on Medicaid for health coverage and care. As drug overdose deaths in the United States keep rising to record highs, and COVID drives increases in mental illness, Medicaid coverage continues to be a lifesaver, providing quality health care for both mental illness and substance use.

Finally, relying solely on private entities to conduct outreach and enrollment will undermine the federal government’s new emphasis on reaching historically underserved populations and will fail to measure up to the success of Navigators and assisters in reaching underserved populations.⁸ For example, the 2021 Navigator awards “focus on outreach to people who identify as racial and ethnic minorities, people in rural communities, the LGBTQ+ community, American Indians and Alaska Natives, refugee and immigrant communities, low-income families, pregnant women and new mothers, people with transportation or language barriers or lacking internet access, veterans, and small business owners.”⁹ Further, navigators and unfunded application counselors are five times more likely than agents and brokers to report their clients were previously uninsured.¹⁰ And a recent study found that cuts to the Navigator program in 2019 led to declines in coverage by people with incomes between 150 and 20 percent of poverty, consumers under the age of 45, consumers who identified as Hispanic, and consumers who spoke a language other than English at home.¹¹ Eliminating HealthCare.gov will also put at risk recent gains in Medicaid coverage. In the open enrollment period for 2021, about 35,000 Georgians who started the process at HealthCare.gov were accessed eligible for Medicaid – more than the number of total enrollees the state projected to gain under the waiver.¹²

⁷ Naoki Aizawa and You Suk Kim, “Public and Private Provision of Information in Market-Based Public Programs: Evidence from Advertising in Health Insurance Marketplaces,” National Bureau of Economic Research, Aug. 2020. <https://www.nber.org/papers/w27695>

⁸ See, e.g., Karen Pollitz, Jennifer Tolbert and Kendal Orgera, “Navigator Funding Restored in Federal Marketplace States for 2022,” Kaiser Family Foundation, Sept. 29, 2021, <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>;

⁹ U.S. Department of Health and Human Services, “Biden-Harris Administration Quadruples the Number of Health Care Navigators Ahead of HealthCare.gov Open Enrollment Period,” Aug. 27, 2021, <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

¹⁰ Karen Pollitz, Jennifer Tolbert and Ashley Semanskee, “2016 Survey of Health Insurance Marketplace Assister Programs and Brokers,” Kaiser Family Foundation, June 2016, <https://files.kff.org/attachment/2016-Survey-of-Marketplace-Assister-Programs-and-Brokers>

¹¹ Rebecca Myerson and Honglin Li, “Information Gaps and Health Insurance Enrollment: Evidence from the Affordable Care Act Navigator Programs,” Dec 7, 2021, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3966511

¹² Centers for Medicare & Medicaid Services, 2021 Marketplace Open Enrollment Period Public Use Files, April 21, 2021, <https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files>. This does not include the number of Medicaid-eligible people who initially applied through the marketplace during the six-month SEP.

Impact on Comprehensiveness

Consumers who shop on Healthcare.gov can trust that they are purchasing a comprehensive health insurance plan that meets all the Affordable Care Act protections (ACA). Under the Georgia Access Model, issuers and brokers could sell qualified health plans alongside subpar plans that discriminate against people with pre-existing conditions and will not cover enrollees' medical expenses if they get sick.

Since the approval of Georgia's waiver, evidence of misleading marketing related to short-term and other subpar plans has mounted. This marketing can lead individuals to unwittingly enroll in coverage that lacks key patient protections. Brokers sometimes steer people into such plans, which often come with higher commissions, a tactic that has continued during the pandemic.¹³ A 2020 study of short-term plans in Atlanta showed that even though people would pay lower premiums up-front, they could be responsible for out-of-pocket costs several times higher for common or serious conditions, such as diabetes or a heart attack. The most popular plan in Atlanta refused to cover prescription drugs, mental health services, or maternity services, had pre-existing condition exclusions, and had a deductible three times as high as an ACA-compliant plan.¹⁴ More recently, a secret shopper study conducted by Georgetown University during the COVID-19 SEP found that just 5 of 20 sales representatives recommended a marketplace plan even when their client would have qualified for a \$0 premium plan under the American Rescue Plan Act, instead steering patients towards short-term plans, healthcare sharing ministries and other products that do not offer comprehensive coverage.¹⁵ Georgia's waiver will almost certainly create confusion for patients and lead them to purchase coverage that does not provide comprehensive coverage.

This is particularly concerning for people with mental illness and substance use disorders. The Georgia Access Model would allow insurers to offer substandard plans that do not meet the requirements of the ACA, including the 10 essential health benefits. The substandard plans would likely not include adequate coverage for mental illness and substance use disorders, creating barriers to critical care during a time when suicide and drug-related deaths continue to rise in Georgia. For example, [more than half](#) of the substandard plans do not cover mental health services¹⁶, and can charge more for people with pre-existing conditions like SUD, which would likely affect Georgians of color, rural Georgians, and other communities with limited access to care.

¹³ Christen Linke Young and Kathleen Hannick, "Misleading marketing of short-term health plans amid COVID-19," Brookings Institution, March 24, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

¹⁴ Dane Hansen and Gabriela Dieguez, "The impact of short-term limited-duration policy expansion on patients and the ACA individual market," Milliman, February 2020, <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>; Kelsey Waddill, "Do Short-Term Limited Duration Plans Deserve Industry Skepticism?," HealthPayerIntelligence, March 4, 2020, <https://healthpayerintelligence.com/news/do-short-term-limited-duration-plans-deserve-industry-skepticism>.

¹⁵ <https://georgetown.app.box.com/s/mn7kgnhibn4kapb46tqmv6i7putry9gt>

¹⁶ Karen Pollitz, Michelle Long, Ashely Semanskee, Rabah Kamal, "Understanding Short-Term Limited Duration Health Insurance", Kaiser Family Foundation, April 2018. <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>

Impact on Affordability

Georgia's claim that its waiver would bring down premiums was largely premised on the assumption that the waiver will significantly increase enrollment. These assumptions are now out-of-date in light of the American Rescue Plan Act, COVID-19 SEP, and outreach and enrollment funding and can no longer support the conclusion that the waiver is compliant with federal law. The market fragmentation and consumer confusion caused by the Georgia Access Model risks making the individual market risk pool sicker and more expensive. With this waiver, some individuals, including those who newly enrolled in coverage during the past year, are likely to drop comprehensive coverage and opt for a non-compliant plan or forgo coverage altogether. As non-compliant, non-comprehensive plans are less attractive — and often, because of underwriting practices, inaccessible — to people with preexisting conditions, it is likely that those who shift out of the ACA-compliant market will be disproportionately healthy. By contrast, those who remain in the individual market are likely to have more complex health conditions, causing premiums to be higher than they would be in the absence of the waiver.

Potential Impact of Build Back Better

Congress is currently considering legislation, the Build Back Better Act, that would extend the financial assistance for marketplace coverage provided in the American Rescue Plan Act and allow millions of individuals in states like Georgia that have not expanded their Medicaid programs to purchase \$0 premium marketplace plans. These changes would greatly increase access to quality, affordable coverage through Georgia's marketplace. That in turn would substantially alter the impact of Georgia's waiver on coverage in the state, increasing the risk that thousands of newly covered consumers would end up in non-compliant coverage under the current waiver. These potential changes make it virtually impossible that the Georgia Access Model could comply with the statutory guardrails.

Conclusion

Given the substantial changes in federal law and policy since Georgia's original submission and analysis and the certain failure to meet the statutory criteria for approval, we strongly urge the Departments to revoke approval of the Georgia Access Model portion of the state's 1332 waiver. Thank you for the opportunity to provide comments. For questions or concerns related to the information outlined above, please contact Ashley Blackburn, Policy Manager at Community Catalyst, at ablackburn@communitycatalyst.org.

Sincerely,



Emily Stewart,
Executive Director
Community Catalyst

January 7, 2022

Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244
stateinnovationwaivers@cms.hhs.gov

RE: Georgia Access Model Section 1332 Waiver Comments

Dear Sir/Madam:

On behalf of Delta Dental Insurance Company (Delta Dental), which provides affordable dental benefits to more than 650,000 Georgians, thank you for the opportunity to provide comments on the Georgia Access Model (GAM) Section 1332 Waiver, to which we are OPPOSED.

The waiver, if approved, would eliminate the use of the federal facilitated exchange (FFE) in the state and shift responsibility for marketing, enrollment, and education to brokers and plans through a process called “direct enrollment.” Delta Dental is deeply concerned that the GAM would reduce the availability of dental benefits to individuals who are currently enrolled in coverage through the FFE in Georgia and for those who could potentially seek coverage. The elimination of the FFE creates an uncertain environment for dental plan enrollment that is not adequately addressed in the Georgia waiver.

Dental Effects

On the FFE, an enrollee cannot purchase a stand-alone dental plan (SADP) without first purchasing a medical plan. While brokers may offer a variety of dental benefits options, there is no guarantee that their range of selection will reflect the diverse and comprehensive coverage of SADPs on the exchanges. Furthermore, a broker may not even offer SADPs if their medical plans embed the pediatric dental essential health benefit requirement. This would result in a significant reduction in dental benefit choice for those used to purchasing dental coverage on the Georgia FFE, which has had multiple SADP family dental options available every year since its inception. For example, there are currently 33 plans available through 9 different SADPs on the Georgia FFE. Through November 2021, Delta Dental alone has approximately 6000 paid members with our family dental plans.

Brokers may also offer dental products such as dental membership plans that do not provide comparable coverage to exchange SADPs. This would create a false sense of choice for consumers, who may believe disparate dental products offered alongside each other are similar. The GAM is deficient in its waiver application in that it does not have a clear place for SADPs to continue to offer benefits to the widest possible set of potential enrollees. This could reduce overall dental benefits penetration and jeopardize oral health, which is critical to overall health. From our conversations with Georgia officials, it is apparent they mistakenly thought dental plans had established direct enrollment capabilities, which is simply not the case.

Given these concerns and considerations, Delta Dental strongly encourages CMS to reconsider the approval of the Georgia waiver. Again, thank you for the opportunity to provide feedback for the Georgia Access Model 1332 Waiver. Should you have any questions, please feel free to contact me at jalbum@delta.org.

Sincerely,

A handwritten signature in black ink that reads "Jeff Album". The signature is written in a cursive, flowing style.

Jeff Album
Vice President, Public and Government Affairs
Delta Dental Insurance Company

January 7, 2022

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services

Submitted via Email

The Honorable Janet Yellen, Secretary
U.S. Department of the Treasury

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services

RE: DREDF Comments on Georgia’s Section 1332 Waiver

Dear Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure:

The Disability Rights Education and Defense Fund (“DREDF”) appreciates the opportunity to provide comment on Georgia’s approved Section 1332 Waiver, which permits the State to exit HealthCare.gov—a central source of enrollment and enrollment assistance for the roughly 500,000 Georgians who enroll in private health plans or Medicaid through the platform. DREDF has serious concerns that this waiver does not meet the requirements of Section 1332 of the Affordable Care Act (“ACA”) and its 2023 implementation will have a devastating impact on access to health care for and health outcomes experienced by Georgians with disabilities.

DREDF is a national cross-disability law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. We are committed to increasing accessible and equally effective healthcare for people with disabilities and eliminating persistent health disparities that affect the length and quality of their lives. DREDF's work is based on the knowledge that people with disabilities of varying racial and ethnic backgrounds, ages, genders, and sexual orientations are fully capable of achieving self-sufficiency and contributing to their communities with access to needed services and supports and the reasonable accommodations and modifications enshrined in U.S. law. In particular, DREDF has significant experience in ACA and Medicaid law and policy, given that disabled individuals disproportionately live in poverty and use health care services and devices to support their full lives. Medicaid is by far the largest publicly-funded provider of long-term services and supports, and thus is a very significant or sole source of essential health care for many people with disabilities.

To: Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure
RE: DREDF Comments on Georgia's Section 1332 Waiver
January 7, 2022
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DREDF unequivocally opposes the approved Georgia Section 1332 Waiver, which permits Georgia to withdraw from HealthCare.gov in 2023 and decentralize its healthcare enrollment into a system that forces consumers to search among a multitude of private, profit-drive web brokers and insurers in order to find health coverage. This chaotic and fragmented system will create new barriers to health care enrollment for hundreds of thousands of people, and it will result in the unknowing enrollment in “junk” plans that do not meet an individual’s needs.¹ These large health coverage losses would undermine the express purposes of the ACA. Under Section 1332, which only permits the HHS and USDT Secretaries to approve waivers that will ensure as comparable of enrollment, affordability, and comprehensiveness of coverage as without the waiver, the approval cannot stand. We urge you to rescind the waiver in order to avoid the harms that the program changes will inflict on the residents of Georgia.

I. Georgia’s Waiver Will Reduce Overall Health Care Enrollment and Steer Consumers to “Junk” Plans That Do Not Meet Their Needs

Georgia’s Section 1332 Waiver will change where and how consumers purchase health insurance coverage. In 2020, the vast majority (79 percent) of Georgia marketplace enrollees used HealthCare.gov to sign up for coverage, even though they already had the option to use a private broker or insurer website. Georgia’s waiver will eliminate the one-stop shop of HealthCare.gov, *requiring* people in the state to use private insurance companies and brokers to compare plans, apply for financial assistance, and enroll in coverage. This will undoubtedly increase confusion about where and how to access high-quality health coverage, hindering enrollment and prompting many people to give up and become uninsured. Contrary to the promise of expanded choices, this waiver would rob consumers of their only option for a guaranteed, central source of unbiased information on the comprehensive coverage available to them.

Moreover, private brokers and insurers who operate through HealthCare.gov have a track record of failing to alert consumers of Medicaid eligibility and picking and choosing the plans they offer, often based on the size of plan commissions.² Indeed, in Georgia’s new system, people who are

¹ Tara Straw & Jason Levitis, *Georgia’s Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked*, CENTER ON BUDGET & POLICY PRIORITIES (Dec. 17, 2021), <https://www.cbpp.org/sites/default/files/12-17-21health.pdf>; Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia’s 1332 Proposal*, CENTER ON BUDGET & POLICY PRIORITIES (Sept. 1, 2020), <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>.

² Tara Straw, *“Direct Enrollment” in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm*, CENTER ON BUDGET & POLICY PRIORITIES (Mar. 15, 2019),

To: Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure
RE: DREDF Comments on Georgia's Section 1332 Waiver
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eligible for Medicaid could have a much harder time finding help with enrollment because Medicaid generally does not pay commissions, and agents and brokers have no incentive to fill the gap left for this population that would result from eliminating HealthCare.gov.

Georgia's waiver allows substandard plans, such as short-term plans, to be presented alongside comprehensive insurance. Even now, brokers sometimes steer people into such plans, which often come with higher commissions—a tactic that has continued even during the pandemic.³ People enrolled in subpar or “junk” plans are not protected by the ACA's provisions, instead being subject to punitive exclusions of their pre-existing conditions, benefit limitations, and caps on plan reimbursements that expose them to potentially high out-of-pocket costs. A study of short-term plans in Atlanta earlier this year showed that even though people would pay lower premiums up-front, they could be responsible for out-of-pocket costs several times higher for common or serious conditions, such as diabetes or a heart attack. The most popular plan in Atlanta refused to cover prescription drugs, mental health services, or maternity services, had pre-existing condition exclusions, and had a deductible three times as high as an ACA-compliant plan.⁴

II. Georgia's Waiver Will Have a Disproportionately Negative Impact on People with Disabilities

The implementation of Georgia's Section 1332 Waiver will have a particularly devastating impact on health consumers with disabilities. HealthCare.gov is not only a centralized hub of health insurance plans, but it also offers critical information and assistance to consumers who need help choosing the right health plan for them. In particular, HealthCare.gov provides free “navigators” or assisters to people seeking access to coverage. The navigator program received a \$70 million funding increase in 2021, making it more robust than ever. Assisters are more likely than agents and brokers to help with Medicaid or CHIP enrollment, perform public education and

<https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

³ Christen Linke Young & Kathleen Hannick, *Misleading marketing of short-term health plans amid COVID-19*, BROOKINGS INSTITUTION (Mar. 24, 2020), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

⁴ Dane Hansen & Gabriela Dieguez, *The impact of short-term limited-duration policy expansion on patients and the ACA individual market*, MILLIMAN (Feb. 2020), <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>; Kelsey Waddill, *Do Short-Term Limited Duration Plans Deserve Industry Skepticism?*, HEALTHPAYERINTELLIGENCE (Mar. 4, 2020), <https://healthpayerintelligence.com/news/do-short-term-limited-duration-plans-deserve-industry-skepticism>.

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outreach activities, and to help people with disabilities, people who have limited English proficiency, or people who lack internet at home in finding and enrolling in health coverage. Georgia has opted out of this federal investment and has not established any alternative for impartial, unbiased help. In fact, the State made it illegal to use state funds on navigators. This means that vulnerable, uninsured people will be less likely to find coverage.

Without a central platform to explore plan options, and without navigators, Georgians with disabilities will have a more difficult time finding a plan that meets their unique needs—a problem that will have a ripple effect on the livelihoods of people who cannot find or who unknowingly enroll in a limited coverage plan because of Georgia's new system. Health care services and supports are crucial to ensuring that people with disabilities can maintain employment, pursue education, raise their families, and participate in their communities. Benefits as simple as a wheelchair, physical therapy, prescription medications, cognitive behavioral therapy, or an accurate glucose monitor are essential to ensuring that people with chronic conditions and disabilities can live and function independently. Without sufficient access to these benefits, or enrollment in a the health plan that covers them, many individuals will be denied equal access to society.

Take, for example, coverage of mobility devices such as a wheelchair. For people with mobility disabilities, access to a working and properly fitted wheelchair can be a gateway to full participation in their communities. Without health insurance coverage of appropriate equipment, people are often homebound—unable to work, go to school, or even get out of bed. Others may be forced to obtain lesser devices than what they medically need, putting their health and safety at risk. Still others face institutionalization because they cannot function in their own homes.

Georgia's Section 1332 Waiver will make it exceedingly more difficult for people with disabilities to find a health plan that covers the particular health care services and devices that they need, and it will increase the likelihood that they mistakenly enroll in a health plan that does not even meet the basic requirements of the ACA. The ACA's provisions on comprehensiveness of coverage and prohibitions on pre-existing condition exclusions, for example, would not apply to certain plans that private brokers may steer health consumers towards. This dangerous potential is not what Congress intended in enacting the ACA, and a State "Innovation" Waiver that attempts to implement this unjust framework cannot stand under the law.

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III. Georgia's Waiver Violates the ACA's Statutory Requirements

Section 1332(b)(1) of the ACA only permits the Secretaries to grant a State Innovation Waiver when that waiver "will provide coverage that is at least as comprehensive as the coverage defined in [the ACA's essential health benefit provisions]"; will provide coverage and ensure cost-sharing is "at least as affordable" as without the waiver; and "will provide coverage to at least as comparable number of its residents" as without the waiver. 42 U.S.C. § 18052(b)(1). Here, Georgia's waiver will make coverage less comprehensive, exposing individuals to non-ACA compliant "junk" plans; it will make coverage less affordable and increase out-of-pocket costs for many consumers; and its decentralized, navigator-less system will decrease overall enrollment numbers.⁵

The ACA's Section 1332 Waiver was intended to allow room for state experimentation—innovation that was intended to push the upward bounds of enrollment and further increase comprehensiveness of coverage. It was not intended to allow States to circumvent the ACA's requirements and slide back to pre-ACA fragmented processes.

Georgia's waiver not only fails to meet Section 1332's mandatory guardrails, but it flagrantly contravenes the purposes of the ACA. Under any reasonable legal analysis, it cannot stand. The waiver should be revoked immediately.

IV. Georgia Has Better Options to Address the Waiver's Purported Goals

Not only does Georgia's Section 1332 Waiver fail to meet the ACA's requirements, but there is a simpler solution to its purported goals, endorsed by the ACA itself: Medicaid expansion. Expanding Georgia's Medicaid program has the potential to provide health care coverage to hundreds of thousands of uninsured individuals and families. This expansion would result in significant benefits to Georgia's residents, including improved access to care (including the long-term services and supports that people with disabilities and chronic conditions need to live full lives), fewer premature deaths, and increased financial security for people gaining coverage.⁶

⁵ Tara Straw & Jason Levitis, *Georgia's Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked*, CENTER ON BUDGET & POLICY PRIORITIES (Dec. 17, 2021), <https://www.cbpp.org/sites/default/files/12-17-21health.pdf>.

⁶ Matt Broaddus & Aviva Aron-Dine, *Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds*, CENTER ON BUDGET & POLICY PRIORITIES, (Nov. 6, 2019), <https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds>; CENTER ON BUDGET & POLICY PRIORITIES, *Chart Book: The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion*, (Updated Nov. 6, 2019), <https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid>.

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Georgia should consider this solution—already adopted by 39 other States and the District of Columbia—rather than upending its insurance market at great risk to its residents.

For these reasons, we strongly urge the Departments to immediately rescind approval of Georgia's Section 1332 Waiver.

Thank you for considering our comments. Please do not hesitate to contact us should you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Carly A. Myers". The signature is written in a cursive, flowing style.

Carly A. Myers
Staff Attorney
Disability Rights Education & Defense Fund



January 6, 2022

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Georgia Access Model section 1332 waiver comments

Submitted via stateinnovationwaivers@cms.hhs.gov

Dear Administrator Brooks-LaSure:

We are writing to comment on Part II of Georgia's Section 1332 proposal to waive federal rules under the Affordable Care Act (ACA). Families USA, a leading national, non-partisan voice for health care consumers, is dedicated to achieving high-quality, affordable health care and improved health for all. We strongly urge the Centers for Medicare and Medicaid Services and the Department of the Treasury to revoke approval of Part II of the waiver. That approval was bad for consumers, bad for insurance markets, and in direct conflict with the ACA.

We commented in 2020 that Georgia's proposal, "Georgia Access", to abandon the use of a Marketplace website and instead rely only on private brokers and private direct enrollment websites violates the guardrails for Section 1332 waivers under the ACA because:

- It would not provide coverage to a comparable number of residents;
- It would divert residents away from comprehensive coverage; and
- It would reduce the number of people with coverage and weaken cost-sharing protections against excessive out-of-pocket spending.

We urge CMS to halt implementation of Part II of Georgia's waiver request for the following reasons:

1. There is even more evidence now than when we first commented that implementation of Part II of the waiver would result in a loss of ACA-compliant, comprehensive individual market coverage as well as a loss of Medicaid coverage for Georgia's consumers. Federal action taken since the waiver was approved further undermines the bad faith rationale Georgia put forward for its proposal. In 2021, the provision of increased Marketplace subsidies under the American Rescue Plan and improvements in outreach, marketing, and enrollment for marketplace and Medicaid coverage have further obviated any possible reason for Georgia to depart from use of a marketplace. Further congressional action to enhance coverage in 2023 under the Build Back Better plan is pending.

Enrollment in Georgia's marketplace increased during the 2021 enrollment period, from about 463,900 enrollees in 2020 to 517,100 in 2021ⁱ – so without implementation of Part II of the waiver, enrollment growth has already far surpassed the growth that Georgia sought in its proposal. Moreover, the federal government has enhanced enrollment opportunities and substantially increased funding for outreach and enrollment for 2021-2022. For the 12-month period that began August 27, 2021, CMS has awarded

\$2,540,323 in navigator grantsⁱⁱ to Georgia organizations that have strong ties to the community, as compared to just \$700,000 awarded in 2020.ⁱⁱⁱ The cooperative agreements with these navigator organizations will continue through 2024. As ASPE pointed out in its recent report, research indicates that assisters (including navigators) are five times more likely to serve a predominantly uninsured population than are private health insurance brokers.^{iv}

2. Implementing Part II of Georgia’s waiver would decrease Medicaid enrollments. The Healthcare.gov platform screens for likely Medicaid eligibility and transfers files to the state Medicaid agency when an applicant appears eligible for Medicaid rather than Marketplace coverage. According to the public use file, 35,394 Georgians were assessed as eligible for Medicaid through the Healthcare.gov platform in 2021. We pointed out in a recent Families USA publication^v that there is still much room to improve ACA enrollment systems and further automate “no wrong door” Medicaid eligibility determinations – but without *any* marketplace platform, Georgia would be taking a huge step backwards. Georgia residents would have to rely on private brokers, who do not systematically screen for Medicaid eligibility or have any financial incentive to assist with Medicaid enrollments, and on enhanced direct enrollment sites, many of which do not screen for all categories of Medicaid eligibility or for complex Medicaid enrollment scenarios.^{vi} Their screening tools thus make it difficult for Medicaid-eligible individuals to successfully enroll in the coverage for which they qualify.

Preservation of the healthcare.gov platform that screens for Medicaid, CHIP, and Marketplace coverage is even more important due to recent congressional action taken through the American Rescue Plan, and pending in Build Back Better. Congress suspended Medicaid redeterminations through the pandemic. When the public health emergency ends and Medicaid redeterminations begin again, consumers losing Medicaid will need a reliable and simple way to determine their coverage options. CMS and Treasury should reevaluate the waiver proposal in light of these events.

3. Implementing Part II of Georgia’s waiver would decrease enrollments in comprehensive individual market coverage. Instead of providing a marketplace website, Georgia intends to maintain a list of private brokers and enhanced direct enrollment sites (EDEs) on a state website. To enroll in a plan, consumers would visit the websites of those brokers and/or EDEs. Without a Marketplace-supported website, consumers cannot readily compare their subsidized premium costs in *all* available qualified health plans and distinguish comprehensive plans from non-ACA compliant plans. As a result, implementation of Georgia Access would substantially decrease enrollment in the comprehensive plans offered in the marketplace.

We pointed out in our earlier comments that brokers often fail to show consumers all qualified health plan options and that many enhanced direct enrollment websites that we visited on September 9, 2020 provided incomplete information about special enrollment opportunities. We also cited literature and experiences showing that many brokers and DEDs use sales techniques, screening tools, and marketing information to shift people away from comprehensive coverage into short-term limited duration insurance and other non-ACA compliant plans. These issues remain important concerns.

4. Implementation of the waiver would be contrary to Executive Order 13985 – it would perpetuate systematic barriers to coverage for people of color and underserved communities. As noted above, navigators and assisters are five times as likely to serve uninsured communities as are brokers. Thirty-six percent of Georgia’s nonelderly uninsured population is Black, and twenty-six percent is Hispanic,^{vii} and good outreach to those communities is essential. According to IPUM data analyzed by the Migration

Policy Institute, six percent of Georgia nonelderly adults speak English less than “very well.”^{viii} The Georgia proposal is silent on how it will provide information to people with limited English proficiency. The proposal also is silent on how it will provide information to those with disabilities as required under Section 1557 of the ACA, Sections 504 and 508 of the Rehabilitation Act, and under other federal non-discrimination laws. The persistent disparities in COVID-19 outcomes for people of color show that this is not the time to allow states to jeopardize access to coverage.

5. Legislation and regulations that have improved enrollment in the Marketplace must be taken into account in determining whether Part II of the waiver should be implemented. We concur with analysis provided by Center on Budget and Policy Priorities that the enrollment effects of the American Rescue Plan, Families First Coronavirus Response Act, and regulations extending open enrollment and special enrollment opportunities must be taken into account in evaluating whether Georgia’s waiver continues to meet guardrails or should be amended or terminated.^{ix} Statute and regulations provide for ongoing review of compliance with ACA’s guardrails, and for suspension or termination of waivers that fail to comply. Implementing part II of Georgia’s waiver would not comply with requirements to cover a comparable number of residents, provide comprehensive coverage, and protect them from excessive cost-sharing.

For all of these reasons, we urge the federal government to revoke approval of Part II of Georgia’s waiver.

We appreciate the opportunity to provide the above recommendations and feedback. We request that the full text of material cited, along with the full text of our comment, be considered part of the formal administrative record. Please contact Cheryl Fish-Parcham, Families USA’s Director of Access Initiatives, at CParcham@familiesusa.org for further information.

Sincerely,



Eliot Fishman
Senior Director of Health Policy

ⁱ Kaiser Family Foundation analysis of marketplace enrollment public use files, <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

ⁱⁱ CMS, “2021 CMS Navigator Cooperative Agreement Awardees,” <https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf>

ⁱⁱⁱ CMS, “2020 CMS Navigator Cooperative Agreement Recipients,” <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2020-Navigator-Grant-Recipients.pdf>

^{iv} ASPE, “Reaching the Remaining Uninsured: An Evidence Review on Outreach and Enrollment,” October 2021, <https://aspe.hhs.gov/sites/default/files/documents/b7c9c6db8b17c6fbfd6bb60b0f93746e/aspe-remaining-uninsured-outreach-enrollment.pdf>

^v Stan Dorn and Rebecca Gordon, “Health Care’s Fragmented Eligibility Systems: What Happens When Uninsured Families Enter Through the Wrong Door?” Families USA, December 2021, <https://www.familiesusa.org/resources/health-cares-fragmented-eligibility-systems-what-happens-when-uninsured-families-enter-through-the-wrong-door/>

^{vi} CCIIO provides for three different phases of application functionality. In phase 1 and 2, EDEs do not have to screen for all scenarios. CCIIO memo, “Third Party Auditor Operational Readiness Reviews for the Enhanced Direct Enrollment Pathway,” February 19, 2019, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidelines-for-Third-party-Auditors-EDE-PY19PY20.pdf>.

^{vii} Kaiser Family Foundation estimates based on the Census Bureau’s March Current Population Survey for 2020, <https://www.kff.org/other/state-indicator/distribution-of-the-nonelderly-uninsured-by-race-ethnicity-cps/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

^{viii} Migration Policy Institute State Immigration Data Profiles: Georgia, <https://www.migrationpolicy.org/data/state-profiles/state/language/GA>.

^{ix} Tara Straw and Jason Levitis, “Georgia’s Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked,” Center on Budget and Policy Priorities, December 17, 2021, <https://www.cbpp.org/research/health/georgias-plan-to-exit-marketplace-will-leave-more-people-uninsured-should-be>



January 7, 2022

Secretary Xavier Becerra
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Hubert H. Humphrey Building
200 Independence Avenue SW
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Washington, DC 20201

Secretary Janet Yellen
Department of the Treasury
1500 Pennsylvania Avenue NW
Room 3330
Washington, DC 20220

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Re: Request for Comment on the Georgia Access Model

Dear Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure:

Thank you for the invitation to comment on the Georgia Access Model.¹ The Georgia Access Model is a component of a Section 1332 waiver submitted by the state of Georgia that would change how people enroll in health insurance in Georgia.² The model would eliminate the use of the HealthCare.gov enrollment platform in Georgia and the associated federal outreach activities. Instead, enrollment in individual-market plans would occur exclusively through private insurer agents and brokers, and Medicaid enrollment would occur exclusively through the state.

The comment solicitation from the Department of Health and Human Services and the Department of the Treasury (henceforth “the departments”) asks whether developments since the departments approved Georgia’s Section 1332 waiver should change the departments’ assessment of whether the Georgia Access Model meets the statutory requirements for Section 1332 waivers, including the requirement that waivers cannot reduce the number of people with insurance coverage.³ The departments asked specifically about

¹ The views expressed in this letter are our own and do not necessarily reflect the views of the Brookings Institution, the Urban Institute, their funders, or anyone affiliated with either organization other than ourselves.

² Georgia’s waiver also established a reinsurance program in Georgia starting in 2022. Throughout, we focus exclusively on the Georgia Access Model, as the departments’ comment solicitation indicates this is the only part of the waiver they are currently reevaluating.

³ “Request for Comment on the Georgia Access Model,” Department of Health and Human Services and Department of the Treasury, November 9, 2021, <https://www.cms.gov/files/document/1332-ga-access-public-comment-request.pdf>.

changes in federal law and policy and newly available evidence or experience that would influence assessments of how various factors affect enrollment in health insurance coverage.

In this letter, we discuss two developments since approval of Georgia's waiver in November 2020 that have increased the likelihood that the Georgia Access Model will reduce coverage:

- During 2021, the Centers for Medicare & Medicaid Services (CMS) announced substantial new spending on outreach activities related to the Marketplaces and Medicaid, including an increased marketing budget and new grants for individual enrollment assistance under the Navigator program. These policy changes have increased the number of people expected to obtain insurance coverage if the Georgia Access Model is not implemented. Because these activities will not occur in Georgia if the state's proposal is implemented, these policy changes do not change the number of people expected to obtain insurance coverage if the Georgia model is implemented. Thus, these policy changes have increased the likelihood that implementing the model would reduce coverage.
- Research released in parallel with or after the departments' review of Georgia's waiver (and thus likely too late to be fully incorporated in that review) has provided evidence that (1) the outreach activities currently conducted by the federal government increase insurance enrollment, (2) private marketing activities are less effective in increasing insurance enrollment than comparable public activities per dollar spent and are more likely to steer people into plans that do not meet Affordable Care Act (ACA) benefit standards, and (3) curtailing public outreach efforts is unlikely to increase private outreach efforts. These findings strengthen the case that eliminating current federal outreach activities will reduce insurance enrollment in Georgia while making it less plausible that increases in private outreach efforts would be large enough to offset that decline, as Georgia officials had suggested in waiver application materials.⁴

The new evidence described above joins prior evidence, which we review and cite below, that raised questions about whether increases in private outreach and enrollment efforts would adequately substitute for the loss of HealthCare.gov and associated federal efforts. The loss of the HealthCare.gov enrollment portal in Georgia will likely increase the difficulty of navigating the enrollment process, which prior research conducted in various contexts suggests would significantly decrease enrollment. Earlier evidence also shows that private insurance brokers are less likely than navigators to engage in outreach and education efforts, and that brokers are less likely to provide assistance for people with low incomes, racial and ethnic minorities, and people who are not proficient in English.

In sum, accounting for the current policy landscape and both recent and prior evidence, we believe implementing the Georgia Access Model would meaningfully reduce insurance coverage in Georgia. We believe this reduction in insurance coverage would be even larger if coverage provisions similar to those in the Build Back Better Act, passed by the House, were to become law. The remainder of this letter examines these points in greater detail.

Background on the Georgia Access Model

The Georgia Access Model would eliminate state residents' ability to enroll in health insurance via HealthCare.gov, and the portal would not be replaced with a state website like those used in other states that do not use HealthCare.gov. Instead, people eligible for Medicaid would apply directly with the state Medicaid agency, and applicants eligible for premium tax credits and others interested in individual-market

⁴ "Georgia Section 1332 State Empowerment and Relief Waiver Application," State of Georgia, October 9, 2020, <https://medicaid.georgia.gov/document/document/modified-1332-waiver/download>.

health insurance would enroll through private insurer agents and brokers. This approach would not provide access to any new enrollment avenues, because private agents and brokers and the Medicaid agency are already available in Georgia under current policy. Notably, CMS reports that, during the 2020 open enrollment period, approximately half of all Marketplace plan selections in Georgia did not involve an agent or broker.⁵

Eliminating access to HealthCare.gov would also have implications for the types of outreach activities that occur in Georgia. Many outreach activities currently supported by the federal government—including radio, television, and digital advertising; targeted consumer-level outreach like emails, phone calls, and texts; and funding for individualized assistance via the Navigator program—occur only (or, at least, primarily) in states that use the HealthCare.gov platform. Accordingly, those activities would either be ceased or greatly reduced under Georgia’s proposal.

By law, the secretaries may approve a Section 1332 waiver request only if the proposal meets the statutory “guardrails.” Specifically, the proposal must not reduce the number of state residents with insurance coverage, reduce the affordability or comprehensiveness of that coverage, or increase the federal deficit. Thus, a key question is how the Georgia Access Model would affect insurance coverage. On its own, eliminating the channel that many individual-market enrollees (and many Medicaid enrollees) in Georgia use to enroll in coverage and associated federal outreach activities would be expected to reduce insurance coverage. Georgia officials have argued, however, that increases in private outreach and enrollment efforts would more than offset this decline.⁶

Recent Changes in Federal Policy Related to Outreach

The Georgia Access Model’s effect on coverage depends in part on the extent of the federally supported outreach activities that would occur without the model. More robust federal outreach efforts will likely increase the expected level of coverage without the Georgia model, making it more likely that the model will reduce coverage.

Recent policy actions taken by CMS have substantially expanded federal support for outreach activities. CMS announced \$100 million in funding for marketing and outreach activities to support the HealthCare.gov special enrollment period that occurred during plan year 2021, and the departments’ solicitation for comments on Georgia’s waiver indicates that they intend to maintain funding for these types of HealthCare.gov outreach activities at a similar or higher level in future years.⁷ This is a major departure

⁵ “Agents and Brokers in the Marketplace,” Centers for Medicare & Medicaid Services, October 30, 2020, <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Agents-and-Brokers-in-the-Marketplace.pdf>.

⁶ Georgia, “Section 1332 State Empowerment and Relief Waiver Application.”

⁷ Centers for Medicare & Medicaid Services, “2021 Special Enrollment Period in Response to the COVID-19 Emergency,” news release, January 28, 2021, <https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency>; Centers for Medicare & Medicaid Services, “HHS Secretary Becerra Announces Reduced Costs and Expanded Access Available for Marketplace Health Coverage under the American Rescue Plan,” news release, April 1, 2021, <https://www.cms.gov/newsroom/press-releases/hhs-secretary-becerra-announces-reduced-costs-and-expanded-access-available-marketplace-health>; and Departments of Health and Human Services and the Treasury, “Request for Comment on the Georgia Access Model.”

from CMS's policy at the time of waiver approval. For plan year 2020, CMS's total annual budget for these types of outreach activities was only \$10 million.⁸

CMS has also expanded funding for individualized enrollment assistance via the Navigator program. In August 2021, CMS announced \$80 million in funding for navigators in states using the HealthCare.gov platform for plan year 2022 and indicated that it intends to continue that funding level through at least plan year 2024.⁹ For comparison, annual navigator funding was previously only \$10 million.¹⁰ For Georgia specifically, CMS is now allocating \$2.5 million per year in navigator funding, compared with \$0.7 million under prior policy.¹¹

Notably, the number of Marketplace plan selections for the 2022 plan year is higher than that for the 2021 plan year, including a 26 percent increase in Marketplace plan selections in Georgia.¹² Much of this increase likely reflects the expansion of the premium tax credits included in the American Rescue Plan Act (which we discuss further at the close of this letter). However, particularly in light of the research on the effectiveness of federal outreach activities we discuss in the next section, expanded federal outreach efforts have likely contributed to this increase as well.

Recent Research on the Effectiveness of Public and Private Outreach Activities

The effect of the Georgia Access Model on insurance coverage also depends on the effectiveness of the public outreach activities that would be eliminated and the private activities that might replace them. Multiple recent studies have provided evidence relevant to this question; they find that (1) outreach activities similar to those now conducted by the federal government increase enrollment, (2) private marketing is less effective in increasing overall insurance enrollment than comparable federal activities on a dollar-for-dollar basis and is more likely to steer people into plans that do not meet ACA standards, and (3) curtailing public outreach efforts is unlikely to increase private efforts. These findings strengthen the case that eliminating federal outreach efforts will reduce insurance enrollment in Georgia and make it less plausible that private efforts will offset that decline.

Given the recency of these studies, it is unlikely that they were fully incorporated in the departments' prior assessment of Georgia's waiver. None of these studies were publicly posted before August 2019.

⁸ Centers for Medicare & Medicaid Services, "Federal Health Insurance Exchange 2020 Open Enrollment," news release, October 25, 2019, <https://www.cms.gov/newsroom/fact-sheets/federal-health-insurance-exchange-2020-open-enrollment>.

⁹ Department of Health and Human Services, "Biden-Harris Administration Quadruples the Number of Health Care Navigators ahead of HealthCare.Gov Open Enrollment Period," news release, August 27, 2021, <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>.

¹⁰ Centers for Medicare & Medicaid Services, "CMS Announces New Funding Opportunity Announcement for the Federally-Facilitated Exchange Navigator Program," news release, July 10, 2018, <https://www.cms.gov/newsroom/press-releases/cms-announces-new-funding-opportunity-announcement-federally-facilitated-exchange-navigator-program>.

¹¹ Karen Pollitz, Jennifer Tolbert, and Kendal Orgera, "Navigator Funding Restored in Federal Marketplace States for 2022" (San Francisco: Kaiser Family Foundation, 2021).

¹² Centers for Medicare & Medicaid Services, "Marketplace Weekly Enrollment Snapshot: Week 6," news release, December 22, 2021, <https://www.cms.gov/newsroom/fact-sheets/marketplace-weekly-enrollment-snapshot-week-6>; and Centers for Medicare & Medicaid Services, "2021 Federal Health Insurance Exchange Weekly Enrollment Snapshot: Final Snapshot," news release, January 12, 2021, <https://www.cms.gov/newsroom/fact-sheets/2021-federal-health-insurance-exchange-weekly-enrollment-snapshot-final-snapshot>.

Further, only two became available in their final forms, in August and September 2020, before the departments approved Georgia's waiver in November 2020. We summarize the findings of these studies and their relevance for Georgia's waiver proposal below.

Public Outreach Activities Have Been Shown to Be Effective; Eliminating Them Will Likely Significantly Decrease Insurance Coverage

Domurat, Menashe, and Yin studied the effect of sending letters that reminded consumers of the deadline for enrolling in coverage via Covered California, California's state Marketplace.¹³ These reminders targeted people who had started but not finished an application for coverage and people referred by the state Medicaid program. These letters are similar in many respects to the email, text, and phone reminders that CMS has historically sent to consumers shopping for coverage on HealthCare.gov.¹⁴ This suggests the authors' results are highly relevant to assessing ongoing federal outreach activities.

Domurat, Menashe, and Yin used a high-quality research design in which consumers were randomized to receive one of several types of reminder letters or no reminder letter. They estimated that receipt of a letter increased the share of people who enrolled in coverage through Covered California by 1.3 percentage points, an increase of 16 percent relative to not receiving a letter. They also found that the expected claims spending of people induced to enroll by the receipt of a letter was 37 percent lower than the claims risk of existing enrollees. This latter finding suggests that the reminder letters ultimately reduced premiums and thereby increased enrollment among unsubsidized enrollees.

Goldin, Lurie, and McCubbin evaluated the effect of letters sent by the Internal Revenue Service to almost 4 million households that paid a tax penalty because they lacked health insurance.¹⁵ Relative to the letters studied by Domurat, Menashe, and Yin, these letters are less similar in content and target population to the individualized outreach currently conducted by CMS. However, they still provide useful information on how public outreach affects enrollment.

Like Domurat, Menashe, and Yin, these authors also used a high-quality research design in which people were randomized to receive one of a few types of letters or no letter. The authors estimate that receipt of a letter increased insurance enrollment by 0.7 percentage points, an increase of 1 percent relative to those who did not receive a letter. (Notably, the authors also find that the increase in enrollment spurred by the

¹³ Richard Domurat, Isaac Menashe, and Wesley Yin, "The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk: Evidence from a Field Experiment," *American Economic Review* 111, no. 5 (May 2021): 1549–74, <https://doi.org/10.1257/aer.20190823>; for the working paper version, see Richard Domurat, Isaac Menashe, and Wesley Yin, "The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk: Evidence from a Field Experiment" (Rochester, NY: Social Science Research Network, 2019).

¹⁴ Randy Pate, "Policies Related to the Navigator Program and Enrollment Education for the Upcoming Enrollment Period," Centers for Medicare & Medicaid Services, August 31, 2017, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Policies-Related-Navigator-Program-Enrollment-Education-8-31-2017.pdf>; US Government Accountability Office, *Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance* (Washington, DC: US Government Accountability Office, 2018); and Joshua Peck, "Why Marketing Matters for HealthCare.gov," Medium, February 7, 2018, <https://medium.com/get-america-covered/why-marketing-matters-for-healthcare-gov-46d19534a287>.

¹⁵ Jacob Goldin, Ithai Z. Lurie, and Janet McCubbin, "Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach," *Quarterly Journal of Economics* 136, no. 1 (December 2020): 1–49, <https://doi.org/10.1093/qje/qjaa029>; for the working paper version, see Jacob Goldin, Ithai Lurie, and Janet McCubbin, "Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach" (Rochester, NY: Social Science Research Network, 2019).

letters reduced mortality, though this finding is not directly relevant to whether Georgia’s waiver satisfies the coverage guardrail.)

Aizawa and Kim studied the effect of federal television advertising on Marketplace enrollment.¹⁶ Their study took advantage of the fact that television advertising is purchased at the local market level. Local television markets are defined as collections of counties, and thus advertising exposure can change sharply at county boundaries. The authors estimated that federal advertising for HealthCare.gov meaningfully increases enrollment. Their estimates imply that eliminating federal television advertising would have reduced HealthCare.gov enrollment by approximately 5 percent in the years they studied (2014–17).

We are unaware of research that provides comparable direct evidence on the causal effect of the Navigator program on insurance enrollment. However, recent survey research by the Kaiser Family Foundation examined the use of enrollment assistance among nonelderly adults with Marketplace plans, with Medicaid, and without health insurance when the Navigator program was funded at the low levels that prevailed during the Trump administration.¹⁷ The survey results showed that 12 percent of respondents (including 17 percent of Black respondents and 18 percent of Hispanic respondents), or 5 million people, tried but were unable to find assistance to enroll in health insurance coverage. Additionally, among the 18 percent of consumers who received assistance, 40 percent reported that they would have been unlikely to find coverage without the help they received. These findings suggest there is substantial latent demand for enrollment assistance for the federal Navigator program to seek to meet. They also suggest decreasing the availability of navigators (Georgia’s waiver envisions eliminating them entirely) could create a larger shortfall of assistance than would otherwise be the case, thereby decreasing insurance coverage below levels that might otherwise be realized.

In sum, these studies strongly suggest that many of the main types of outreach activities currently conducted by the federal government increase Marketplace enrollment (and may improve risk mix as well). Therefore, the studies imply that enrollment in health insurance would be expected to fall substantially if those activities were eliminated.

Private Outreach Activities Are Less Likely Than Public Outreach Activities to Increase Insurance Enrollment

Notably, Aizawa and Kim’s study on television advertising described above examined such advertising by private insurers in addition to public advertising. Though the authors’ estimates of the effect of advertising by private insurers are somewhat imprecise, their best estimate is that a 1 percent increase in advertising spending by insurers is less than half as effective in increasing Marketplace enrollment as a 1 percent increase in federal advertising spending. Because insurers spent more on advertising than the federal government during the study period, insurer advertising was likely even less effective than federal advertising when evaluated on a dollar-for-dollar basis. On the other hand, Aizawa and Kim found that private advertising is highly effective in causing enrollees to select an insurer’s own plan instead of a competing insurer’s plan (whereas federal advertising had little effect on which plans consumers selected).

The different effects of federal and insurer advertising likely reflect their differing content. The researchers found that federal advertising focused on the availability of coverage (and, in particular,

¹⁶ Naoki Aizawa and You Suk Kim, “Public and Private Provision of Information in Market-Based Public Programs: Evidence from Advertising in Health Insurance Marketplaces” (Cambridge, MA: National Bureau of Economic Research, 2020).

¹⁷ Karen Pollitz, Jennifer Tolbert, Liz Hamel, and Audrey Kearney, “Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need” (San Francisco: Kaiser Family Foundation, 2020).

subsidized coverage) through the Marketplace and on providing information on how to enroll in coverage and obtain help with enrollment. In contrast, more than 60 percent of private advertisements focused on promoting a particular private insurer's brand. In addition, private advertising was targeted specifically to markets that insurers find to be more profitable, whereas government advertising was targeted to a broader set of markets.

A likely explanation for these differences in advertising approaches and outcomes, as noted by Aizawa and Kim, is that the federal government and private insurers have different objectives. Whereas the federal government was likely primarily interested in increasing aggregate insurance enrollment, private insurers were likely motivated by increasing their profits. Advertising aimed at increasing aggregate enrollment may generate weak returns for an individual private insurer, because much of any increase in enrollment may accrue to the insurer's competitors, particularly in competitive markets. Consequently, insurers may invest little in advertising efforts aimed at increasing overall enrollment and instead focus their advertising efforts on luring enrollees away from competitors.

Insurers face similar incentives when making any marketing decision, not just when deciding on television advertising. Thus, Aizawa and Kim's finding that federal television advertising is more effective in increasing enrollment than private advertising per dollar spent may extend to other outreach activities as well. If so, this suggests the Georgia Access Model would need to spur a very large increase in private outreach spending to offset the reduction in federal outreach spending that the implementation of Georgia's proposal would cause.

Recent evidence also suggests that even when private outreach efforts successfully encourage people to enroll in coverage, they may tend to push people toward less comprehensive forms of insurance coverage. A recent Kaiser Family Foundation survey found that 22 percent of consumers using private health insurance brokers or representatives of private insurance plans to explore their health insurance options were offered policies other than qualified health plans.¹⁸ Thus, with only brokers and insurance company representatives available to provide enrollment assistance, more Georgia consumers will likely be exposed to sales efforts related to these types of non-ACA-compliant plans.

Shifting into these plans is often not in a consumer's best interest. These alternative policies, notably short-term limited-duration plans, typically exclude coverage for preexisting conditions, do not cover all benefits included in Marketplace plans or place significant limits on them (e.g., prescription drugs, mental health care, substance use disorder treatment, maternity care), are not required to comply with medical loss ratio requirements, are not subject to the ACA's modified community rating rules, and cannot be purchased using premium tax credits. For most people, except some healthy consumers ineligible for significant subsidies, these plans likely offer a worse combination of premiums and coverage than ACA-compliant plans. And even consumers who rationally opt for these plans may nevertheless face very high costs in the event of a serious illness or injury.

Though shifting into these plans will often not be in consumers' best interests, this may occur often under the Georgia Access Model. As Baicker and colleagues noted,¹⁹ wide-ranging empirical and theoretical work in behavioral economics demonstrates that the greater the complexity and number of insurance options presented, the less likely people will enroll in coverage or choose their optimal option. Additionally,

¹⁸ Pollitz, Tolbert, Hamel, and Kearney, "Consumer Assistance in Health Insurance."

¹⁹ Katherine Baicker, William J. Congdon, and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *Millbank Quarterly* 90, no. 1 (2012): 107–34, <https://doi.org/10.1111/j.1468-0009.2011.00656.x>.

because brokers have historically received higher commissions for non-ACA-compliant plans than ACA-compliant plans,²⁰ they may be particularly likely to steer consumers toward non-ACA-compliant plans.

Non-ACA-compliant plans generally do not qualify as coverage for the purposes of the Section 1332 coverage guardrail (under the departments' current interpretation of the coverage guardrail, though not under the interpretation that the departments had adopted at the time of waiver approval).²¹ Thus, a substantial shift into these plans would likely cause Georgia's waiver to reduce insurance enrollment as measured for the purposes of the coverage guardrail. (Further, even if these plans were counted as coverage under the coverage guardrail, a shift into these plans would likely cause Georgia's waiver to violate the affordability or comprehensiveness guardrails.)

Finally, because short-term limited-duration plans can deny coverage to people with health problems or set such people's premiums at much higher levels, they tend to pull largely healthy consumers out of the ACA-compliant nongroup health insurance market. Consequently, increased sales of short-term plans can alter the average health care risk of enrollees in the ACA-compliant plans, increasing health insurance premiums.²² This can lead to higher premiums for unsubsidized enrollees in comprehensive coverage and, thereby, reduced enrollment.

Curtailing Public Outreach Will Not Necessarily Increase Private Outreach

Recent research also provides some evidence on whether curtailing public outreach efforts should be expected to increase private outreach efforts. Myerson and colleagues examined reductions in federal funding for the Navigator program that started in 2018 and found that areas that saw larger reductions in Navigator funding did not see larger increases in private outreach efforts, at least as measured by the intensity of private insurers' television advertising.²³

Aizawa and Kim also provided indirect evidence on this question. They found that the effectiveness of private television advertising (in increasing an insurer's own enrollment) does not depend on the level of federal television advertising. This implies that the returns to private outreach efforts may not change when public outreach efforts are cut, so cuts to public outreach are unlikely to cause private insurers to compensate with increased outreach efforts.

These two studies do not speak to all of the possible mechanisms by which the Georgia Access Model could spur increases in private outreach efforts. For example, if eliminating HealthCare.gov made comparison shopping harder, that could increase insurers' incentives to do outreach to the uninsured by increasing the likelihood that a person induced to obtain coverage would enroll in an insurer's own plan rather than a competitor's plan. (On the other hand, making comparison shopping harder could also have direct negative effects on insurance enrollment, as described in the next section.) These studies cannot

²⁰ Lisa L. Gill, "The High Cost of Cheap Health Insurance," Consumer Reports, February 13, 2021, <https://www.consumerreports.org/health-insurance/the-high-cost-of-cheap-health-insurance-a1062352816/>; and US House of Representatives, Committee on Energy and Commerce, *Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans Is Putting Americans at Risk* (Washington, DC: US House of Representatives, 2020).

²¹ Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Fed. Reg. 53469 (Sept. 27, 2021).

²² Linda J. Blumberg, Matthew Buettgens, and Robin Wang, "Updated Estimates of the Potential Impact of Short-Term Limited Duration Policies" (Washington, DC: Urban Institute, 2018).

²³ Rebecca Myerson, David Anderson, Laura Baum, Erika Franklin Fowler, Sarah Gollust, and Paul Shafer, "Cuts to Navigator Funding Were Not Associated with Changes to Private Sector Advertising in the ACA Marketplaces" (Rochester, NY: Social Science Research Network, 2021).

capture these effect (if they exist). Nevertheless, this evidence suggests there is little reason to expect reductions in public outreach *per se* to spur compensating increases in private outreach.

Research Available Well before Waiver Approval

The studies described in the previous section newly contributed to a significant body of literature relevant to assessing the potential ramifications of the Georgia Access Model that existed before waiver approval. These include findings from research on the likelihood of enrolling in benefit programs as a function of the personal “hassle” involved with enrolling²⁴ and research on differences between types of health insurance enrollment assisters.²⁵

Eliminating HealthCare.gov Will Make It Harder to Navigate the Health Insurance Enrollment Process, and Research Indicates This Will Likely Depress Enrollment

A recent book by Herd and Moynihan examined public policies that intentionally or unintentionally increase administrative burdens required to enroll in available programs and benefits.²⁶ The authors found that research in several areas, including health insurance, retirement savings, and welfare programs, shows that as the difficulty of navigating the enrollment process rises, program enrollment decreases. Herd and Moynihan specifically noted that community-based application assisters have been shown to decrease compliance costs and increase Medicaid participation (which, in turn, improves health outcomes) in certain populations, particularly those without English proficiency.²⁷

Eliminating HealthCare.gov would make the health insurance enrollment process harder to navigate in two ways. First, HealthCare.gov provides and displays information on all qualified health plans offered through the Marketplace without any influence from a profit motive. Georgia’s waiver would, in principle, require web brokers to display all available qualified health plans and bar web brokers from preferentially displaying plans for which the web broker can earn higher commissions. However, brokers and agents other than web brokers would not be directly subject to similar standards. Moreover, web brokers likely have strong incentives to find ways around these restrictions, and it is unclear that the restrictions can be effectively enforced even where they apply. Consumers may thus (rationally) be less likely to trust information obtained via agents and brokers, forcing them to invest additional time and intellectual energy in identifying the plans that best meet their needs.

Second, HealthCare.gov is a well-known and well-publicized website that has been widely used by consumers in Georgia (and in most other states) since late 2013. The Georgia Access Model would require consumers to search out private agents and brokers on their own or collect information on participating insurers and web brokers from a new state website and then take the additional step to contact one of them to get enrolled in a plan. And because agents and many brokers work for particular insurers, any given agent or broker may not provide information on the plans a consumer prefers or provide enrollment services for those plans. The additional time-consuming steps necessary to collect objective information suitable for

²⁴ Much of this work is summarized in Pamela Herd and Donald P. Moynihan, *Administrative Burden: Policymaking by Other Means* (New York: Russell Sage Foundation, 2018).

²⁵ Karen Pollitz, Jennifer Tolbert, and Ashley Semanskee, *2016 Survey of Health Insurance Marketplace Assister Programs and Brokers* (San Francisco: Kaiser Family Foundation, 2016).

²⁶ Herd and Moynihan, *Administrative Burden*.

²⁷ Anna Aizer, “Low Take-Up in Medicaid: Does Outreach Matter and for Whom?,” *American Economic Review* 93, no. 2 (May 2003): 238–41, <https://doi.org/10.1257/000282803321947119>.

weighing the advantages and disadvantages of different insurance options and getting enrolled would clearly make navigating the enrollment process more difficult relative to using HealthCare.gov.

Consumers' current enrollment behavior is consistent with the view that many consumers prefer enrolling through HealthCare.gov to enrolling through agents and brokers (whether for the reasons described in the preceding paragraphs or other reasons). Indeed, as noted earlier in this letter, CMS's data indicate that approximately half of Marketplace plan selections in Georgia during the 2020 open enrollment period occurred through HealthCare.gov without any involvement by an agent or broker.

Brokers Are Less Likely Than Federal Assisters to Work with Certain Clients; Relying on Them Alone Will Likely Reduce Coverage and Increase Coverage Inequities

The 2016 Kaiser Family Foundation Survey of Health Insurance Marketplace Assister Programs and Brokers explored differences in the populations served by private insurance brokers versus assisters (navigators, certified applications counselors, federally qualified health centers, and federal enrollment assistance programs).²⁸ The survey's findings indicated that brokers' clients were much less likely than assisters' clients to need language translation help (15 percent of brokers versus 46 percent of assister programs). In addition, 60 percent of brokers reported that few or none of their clients lacked internet access at home, compared with only 24 percent of assister programs. Fewer than half of brokers surveyed (48 percent) said they helped Latino clients, whereas more than three-quarters of assister programs (76 percent) served Latino clients. Brokers were also less likely than assister programs to report that most or nearly all of their clients were uninsured when they sought help (30 versus 56 percent).

Brokers' clientele generally had higher incomes than clients served by assister programs; eight percent of brokers said most or nearly all of their clients had incomes low enough to qualify for Medicaid, compared with 42 percent of assister programs. Brokers were also less likely to report that they helped when clients received notice of a data-match inconsistency from the Marketplace, a situation characteristic of consumers with lower incomes who have multiple jobs or other complex work histories. Plus, brokers were less likely to help people eligible for Medicaid or the Children's Health Insurance Program (47 versus 89 percent).

Taken together, these results provide compelling evidence that brokers are less likely than assisters to serve people who are currently uninsured, people needing language translation services, Latino clients, and people with very low incomes. The large differences in the populations currently served by brokers versus assister programs suggest brokers are poorly positioned to satisfy the unmet demand for enrollment assistance that would be caused by the Georgia Access Model's elimination of Georgia's Navigator program, leaving consumers without the assistance they need to enroll in insurance coverage.

Assister programs were also more likely to be involved in outreach and public education activities than brokers (76 versus 40 percent). Eliminating navigators could reduce people's awareness of the comprehensive, subsidized insurance available to them or the assistance available to help them enroll, compounding the challenges in identifying trusted information on program benefits and eligibility created by the loss of HealthCare.gov.

Implications If the Build Back Better Act Becomes Law

Should the Build Back Better Act (BBBA) become law in something akin to its current form, the Georgia Access Model would likely cause larger reductions in insurance coverage in Georgia. The bill would offer

²⁸ Pollitz, Tolbert, and Semanskee, *2016 Survey of Assister Programs and Brokers*.

Marketplace subsidies to people with incomes below the federal poverty level (who are generally ineligible today for any assistance) as a way of filling the Medicaid coverage gap created by the state's decision not to expand Medicaid eligibility under the ACA. In addition, the BBBA would extend the premium tax credits provided under the American Rescue Plan Act, which expanded subsidy eligibility to higher income levels and increased subsidy generosity across eligibility levels. These reforms have been projected to substantially increase insurance coverage—and Marketplace enrollment specifically—particularly among people with low incomes.²⁹ The sharp increase in Marketplace plan selections described earlier in this letter is consistent with the view that the American Rescue Plan Act subsidy expansions have increased coverage.

The increase in overall Marketplace enrollment under the BBBA will likely magnify the negative effects of the Georgia Access Model. Because more people would enroll in insurance coverage under the BBBA because of more generous subsidies and greater awareness of benefits, the effects of eliminating a preferred enrollment channel (HealthCare.gov) and curtailing federal outreach activities would likely depress insurance coverage to a greater extent. We believe private outreach efforts are unlikely to offset those effects even with the existing Marketplace population, and the influx of more enrollees with very low incomes would make that even less likely. As the analyses discussed above show, brokers are substantially less likely to work with certain clients, such as those with very low incomes, with data mismatches, who need language assistance, or are ethnic minorities. Thus, brokers are less likely than navigators to help newly eligible people obtain coverage, and they are less likely to do the outreach and consumer education necessary to inform these populations of the benefits and assistance newly available to them.

Thank you again for the opportunity to comment. We hope that this information is helpful to you. If we can provide any additional information, please do not hesitate to contact us.

Sincerely,

Linda J. Blumberg
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²⁹ Jessica S. Banthin, Michael Simpson, and Andrew Green, “The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress” (New York: Commonwealth Fund, 2021).



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January 7, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Subject: Georgia Section 1332 Waiver Comments

Dear Secretary Becerra and Administrator Brooks-LaSure:

Thank you for the opportunity to comment on your agency's review of Georgia's Section 1332 State Innovation Waiver first approved in November 2020. First Focus on Children, a bipartisan advocacy organization that makes children and families the priority in budget and policy decisions, is writing once again to express our deep concern about this waiver. Under the waiver, the state would exit the federal marketplace in 2023 with no equitable substitute. This would eliminate the central source of help for the roughly 550,000 Georgians, including nearly 100,000 children and young adults, who enroll in private health plans or Medicaid through HealthCare.gov.

Georgia frames the waiver as a solution for the state's high uninsured rate. However, the best solution to that problem is to join 39 other states and DC and adopt the ACA's expansion of Medicaid to low-income adults and their families. We are distressed that Georgia would utilize a fragmented system that could cause tens of thousands of Georgians to fall through the cracks and lose coverage altogether, while other families with children would likely end up in skimpy plans that impose high costs if they get sick.¹

First Focus on Children vehemently opposes this waiver. As an organization, we support expanding health coverage for children and their families, and the 1332 waiver will do exactly the opposite. In 2019, Georgia had the 5th highest rate of uninsured children in the country, with nearly 217,000 children without health coverage.² To decrease this number, we again propose that Georgia adopt Medicaid expansion, which would sharply reduce the state's uninsured rate, help with responding to the ongoing pandemic, and bring billions in additional federal funding into the state. Research has shown that in states that have expanded

¹ Tara Straw, "Tens of Thousands Could Lose Coverage Under Georgia's 1332 Proposal," Center on Budget and Policy Priorities, September 1, 2020.

<https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>

² Joan Alker and Lauren Roygardner, "The Number of Uninsured Children is on the Rise," Center for Children & Families (CCF) of the Georgetown University Health Policy Institute, October 29, 2019.

<https://ccf.georgetown.edu/2019/10/29/the-number-of-uninsured-children-in-on-the-rise-acs/>

Medicaid for adults, children are less likely to go uninsured because their parents have coverage.³ This waiver is not the way to reduce the high uninsured rate as Medicaid expansion has been shown to be effective in increasing coverage for families and especially children.

The Proposal Will Insure Fewer Families and Children and Encourage Enrollment in Subpar Plans

The ACA 1332 waiver would change where and how families purchase health coverage. In 2021, 37,893 children under the age of 18 in Georgia were enrolled in a marketplace plan found on Healthcare.gov.⁴ At the age of 18, kids age out of the Children's Health Insurance Program (CHIP), also known as PeachCare in Georgia, and many become eligible for marketplace plans. In Georgia, 61,543 young adults from the age of 18 to 25 were enrolled in a marketplace plan, and many of them may have been previously enrolled in PeachCare (CHIP). In the 2021 open enrollment period, 77 percent of enrollees had used Healthcare.gov before, indicating the strong enrollment retention of the federal marketplace site.⁵ Georgia's waiver eliminates the one-stop shop of HealthCare.gov, *requiring* people in the state to use private insurance companies and brokers to compare plans, apply for financial assistance, and enroll in coverage. This would undoubtedly increase confusion about where and how to access good-quality health coverage, hindering enrollment and prompting many people to give up and become uninsured. When parents become uninsured, children are likely to follow, meaning that the uninsured rate for children will increase as well. Contrary to the promise of expanded choices, this waiver would rob families of their only option for a guaranteed, central source of unbiased information on the comprehensive coverage available to them.

Moreover, private brokers and insurers who operate through HealthCare.gov have a track record of failing to alert families of Medicaid and CHIP eligibility and picking and choosing the plans they offer, often based on the size of plan commissions.⁶ Indeed, in the system Georgia would implement in 2023, families who are eligible for Medicaid and children that are eligible for CHIP could have a much harder time finding help with enrollment because Medicaid and CHIP generally do not pay commissions and agents and brokers have no incentive to fill the gap left for this population that would result from eliminating HealthCare.gov. Again, this could lead to the uninsured rate of children to increase, which could have severe consequences on the health of children.

Georgia's waiver states that substandard plans, such as short-term plans, would be presented alongside comprehensive insurance. Even now, brokers sometimes steer people into such plans, which often come with higher commissions, a tactic that has continued during the pandemic.⁷ People enrolled in subpar plans are

³ Maggie Clark, "In Medicaid Expansion States, Fewer Young Children Go Uninsured," Center for Children & Families (CCF) of the Georgetown University Health Policy Institute, January 15, 2020.

<https://ccf.georgetown.edu/2020/01/15/in-medicaid-expansion-states-fewer-young-children-go-uninsured/>

⁴ "2021 Marketplace Open Enrollment Period Public Use Files," Centers for Medicare and Medicaid Services, Updated April 21, 2021. <https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files>

⁵ Centers for Medicare & Medicaid Services, "2021 Federal Health Insurance Exchange Weekly Enrollment Snapshot: Final Snapshot," January 12, 2021,

<https://www.cms.gov/newsroom/fact-sheets/2021-federal-health-insurance-exchange-weekly-enrollment-snapshot-final-snapshot>.

⁶ Tara Straw, "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm," Center on Budget and Policy Priorities, March 15, 2019,

<https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>

⁷ Christen Linke Young and Kathleen Hannick, "Misleading marketing of short-term health plans amid COVID-19," Brookings Institution, March 24, 2020,

<https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

subject to punitive exclusions of their pre-existing conditions, benefit limitations, and caps on plan reimbursements that expose them to potentially high out-of-pocket costs. These plans, especially during a pandemic, would not serve families well. A study of short-term plans in Atlanta in early 2020 showed that even though people would pay lower premiums up-front, they could be responsible for out-of-pocket costs several times higher for common or serious conditions, such as diabetes or a heart attack. The most popular plan in Atlanta refused to cover prescription drugs, mental health services, or maternity services, had pre-existing condition exclusions, and had a deductible three times as high as an ACA-compliant plan.⁸ High out-of-pocket costs can create an undue financial burden on low-income families, taking away money that could have been spent on food, housing, clothing, and other familial expenses.⁹

The Proposal Violates Statutory Requirements

Because it would likely increase the number of uninsured Georgian families and leave many others with worse coverage, this ACA waiver fails to meet the statutory “guardrails” intended to ensure that people who live in states that implement an ACA waiver are not worse off than they would be without the waiver. Section 1332(b)(1) of the ACA requires that ACA waivers cover as many people, with coverage as affordable and comprehensive, as without the waiver. However, under the waiver, the coverage that many Georgians would have would be less comprehensive, and more families would find themselves with less affordable coverage and out-of-pocket costs than would be the case without the waiver. Georgia would likely see a reduction, rather than an increase, in coverage under the 1332 waiver. The waiver therefore does not meet the guardrails under federal law and should be rescinded.

In addition to our concerns about the impact of the waiver on Georgians, we are deeply concerned about the precedent that would be set by a waiver that is expected to result in more families uninsured and more families enrolled in plans that do not provide comprehensive coverage than without the waiver, directly violating the statutory requirements.

Georgia Has Better Options to Address Waiver’s Purported Goals

Notably, the waiver also would establish a reinsurance program. Similar programs have been successfully implemented in other states, reducing premiums for unsubsidized consumers. Georgia could move forward with this proposal while dropping the harmful components of the waiver.

Even more important, Medicaid expansion offers Georgia the opportunity to expand coverage to hundreds of thousands of adults and their children. That would result in significant benefits to the state’s residents, including fewer premature deaths and improved access to care and financial security for people

⁸ Dane Hansen and Gabriela Dieguez, “The impact of short-term limited-duration policy expansion on patients and the ACA individual market,” Milliman, February 2020, <https://www.lls.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>; Kelsey Waddill, “Do Short-Term Limited Duration Plans Deserve Industry Skepticism?,” HealthPayerIntelligence, March 4, 2020, <https://healthpayerintelligence.com/news/do-short-term-limited-duration-plans-deserve-industry-skepticism>.

⁹ Allison Galbraith, Sabrina Wong, Sue Kim, and Paul Newacheck, “Out-of-Pocket Financial Burden for Low-Income Families with Children: Socioeconomic Disparities and Effects of Insurance,” *Health services research* vol. 40,6 Pt 1 (2005): 1722-36. doi:10.1111/j.1475-6773.2005.00421.x <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361224/>

gaining coverage.^{10,11} Affordable Care Act policies, such as Medicaid expansion and subsidized Marketplace coverage, has led to an increase in the number of insured children. Research has shown that such policies create a “welcome mat” effect where children gain coverage when their parents do.¹² When parents have coverage, they are also less likely to struggle with managing personal health problems that could prevent them from being an effective caregiver. Not only that, having insurance is critical in maintaining family economic security, as medical debt can plunge a family into bankruptcy and even poverty, especially for parents of young children who experience the highest poverty rates of any age group.¹³ Medicaid expansion will not only increase coverage rates for parents and their children, but it can also protect the health and economic security of families. Georgia’s section 1332 waiver will prevent families from gaining coverage, which will lead to negative consequences for children. First Focus on Children therefore strongly opposes this waiver , and we urge HHS to rescind its approval.

Thank you for the opportunity to submit this comment. If you have any questions, please contact me at 202-657-0605 or BruceL@Firstfocus.org

Sincerely,

A handwritten signature in blue ink that reads "Bruce Lesley". The signature is written in a cursive, slightly slanted style.

Bruce Lesley
President

¹⁰ Matt Broaddus and Aviva Aron-Dine, “Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds,” Center on Budget and Policy Priorities, November 6, 2019, <https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds>

¹¹ Center on Budget and Policy Priorities, “Chart Book: The Far-Reaching Benefits of the Affordable Care Act’s Medicaid Expansion,” Updated November 6, 2019, <https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid>

¹² Maggie Clark, “In Medicaid Expansion States, Fewer Young Children Go Uninsured,” Center for Children & Families (CCF) of the Georgetown University Health Policy Institute, January 15, 2020. <https://ccf.georgetown.edu/2020/01/15/in-medicaid-expansion-states-fewer-young-children-go-uninsured/>

¹³ “Children in poverty by age group in the United States,” Kids Count Data Center, The Annie E. Casey Foundation, Updated September 2019. <https://datacenter.kidscount.org/data/tables/5650-children-in-poverty-by-age-group?loc=1&loct=1#detailed/1/any/false/37.871.87.0.573.869.36.868.867.133.38/17.18.36/12263.12264>

December 23, 2022

The Honorable Xavier Becerra
Secretary, U.S. Department of Health and
Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary, U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20200

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid
Services
7500 Security Blvd.
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Submitted via stateinnovationwaivers@cms.hhs.gov

Dear Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure,

I am writing on behalf of Florida Policy Institute (FPI) to express our organization's concerns about the "Georgia Access" Section 1332 waiver.

FPI is an independent, nonpartisan, nonprofit organization dedicated to advancing policies and budgets that improve the economic mobility and quality of life for all Floridians. We are committed to public policies which ensure that all people can obtain quality, affordable health care. Our health policy advocacy focuses on increasing coverage for millions of uninsured and under-insured Floridians.

Prior to federal approval of Georgia's plan in 2020, FPI filed comments with the Centers for Medicare and Medicaid Services (CMS). At that time, we urged CMS to reject the waiver application fearing that this proposal would set a dangerous precedent for other states, like Florida, to exit the federal marketplace and put coverage at risk for thousands of Floridians.

Fortunately, CMS has since changed the status of the Georgia proposal from "approved" to "pending" and is providing an additional opportunity for public comment. In response, FPI is submitting its earlier 2020 comments which are still relevant today and additional comments which are set forth below.

Georgia's individual health insurance landscape has drastically changed since CMS initially approved the waiver

When Georgia's 1332 waiver was approved by CMS in November 2020, 463,910 Georgians were enrolled in coverage through [healthcare.gov](https://www.healthcare.gov).¹ In 2021, over 550,000 Georgians are enrolled, a

¹ Georgia Health News, "Exchange Enrollment Hits Record Level in State," September 22, 2021, <https://www.georgiahealthnews.com/2021/09/georgia-exchange-enrollment-hits-record-level/>

difference of about 86,000 new enrollments.² Many of these new enrollments came during the COVID Special Enrollment Period, which ran from February 12 to August 15, 2021.

A major driver of the enrollment increase was the more generous Advanced Premium Tax Credits (APTCs) created through the American Rescue Plan. Along with these increased APTCs, enrollees above 400% FPL received an 8.5% income cushion for repaying subsidies and enrollees between 100-150% FPL were guaranteed access to a \$0 silver-level plan and increased cost-sharing reductions to significantly lower deductibles for this group.³ We have every expectation that Georgians and others nationwide will continue to benefit from this supplemental financial assistance as Congress works to extend the help in the proposed Build Back Better Act.

The Biden Administration also dramatically increased funding for outreach and enrollment assistance. Georgia navigator organizations received \$1,945,303 beginning in August 2021, compared to \$700,000 the year prior—a 177% increase.^{4,5} The increase in navigators and outreach efforts will help more Georgians find more affordable plans by spreading awareness of the increased APTCs.

Finally, five new insurers have joined Georgians health insurance marketplace. Georgia has eleven insurers offering plans on the Marketplace for the 2022 plan year, up from four in 2019 and six in 2021.⁶ An increase in insurers demonstrates that Georgia’s insurance marketplace has stabilized and matured and is benefiting as expected from the state’s reinsurance program.

The recent advances in Georgia’s health insurance marketplace all trend in positive directions that benefit consumers and meaningfully resolve the shortcomings that the Section 1332 waiver was intended to address. Implementation of this waiver would only serve to undercut the progress Georgia has experienced since it was first proposed.

Fragmenting the insurance market would confuse and discourage consumers from enrollment

Under this proposal, enrollment would likely decline because buying insurance would become harder for Georgia consumers. Purchasing health insurance is a complicated and expensive undertaking, especially for people who are uninsured and unfamiliar with the insurance market and multiple insurance products. Nearly 80 percent of Georgia’s marketplace enrollees use HealthCare.gov to

² Kaiser Family Foundation, Marketplace Enrollment 2014 – 2021, <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22georgia%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

³ Kaiser Family Foundation, “Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID 19 Relief on Marketplace Premiums,” March 15, 2020. <https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/>

⁴Centers for Medicaid & Medicare Services, “2021 CMS Navigator Cooperative Agreement Awardees,” August 27, 2021. <https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf>

⁵Centers for Medicaid & Medicare Services, “2020 CMS Navigator Cooperative Agreement Recipients,” August 30, 2020. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2020-Navigator-Grant-Recipients.pdf>

⁶ Kaiser Family Foundation, Navigator Funding Restored in Federal Marketplace States for 2022, September 29, 2021. <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>

complete the enrollment process or shop for and select their health plan.⁷ Eliminating the preferred enrollment platform for most Georgia consumers could not only cause confusion but could also paralyze consumers, keeping them from deciding altogether.

Research shows that having too many choices makes it difficult for consumers to make a choice, much less a fitting choice.^{8,9} The system proposed in the waiver would require consumers to choose among legions of sellers before beginning the process of selecting a specific health plan and would not guarantee access to a single platform on which to see and compare all plan choices on equal terms. As a result, Georgians would be confused at the very least, find it challenging to make an informed choice, and, at the worst, not make a choice at all.

Georgians will lose coverage in the transition from HealthCare.gov to the Georgia Access system

The disruption created by the state's transition away from HealthCare.gov is likely to cause a decline in enrollment among Georgia consumers. The state predicts a loss of about 2 percent (8,000 people) of enrollees due to the change from one system to another. However, other states' experiences show this figure is too low and unrealistic.¹⁰ For example, Kentucky saw a reduction of 13 percent in its marketplace enrollment when the state transitioned to the federal marketplace in 2017, compared to a 4 percent decline nationally.¹¹ More recently, Nevada's 2020 marketplace enrollment dropped 7 percent after the state transitioned to a state-based marketplace, compared to flat enrollment nationally.¹² Similar percentage declines in Georgia would translate into a drop of 25,000-46,000 people from marketplace enrollment.¹³ Enrollment declines of this scope would likely exceed the increases anticipated by the waiver (27,000).

Enrollment declines are especially likely given that Georgia has only allotted one-third of the estimated cost of the waiver to the transition process. This funding seems solely dedicated to the technological transition. The state has not allocated specific funds to help consumers understand the transition, their options for enrollment, or how to access free, unbiased enrollment assistance.

⁷ Georgia Section 1332 State Innovation Waiver as submitted to CMS on July 31, 2020;

https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers- (hereafter, Waiver).

⁸ Consumers Union, "The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making," November 2012, https://advocacy.consumerreports.org/wp-content/uploads/2012/11/Too_Much_Choice_Nov_2012.pdf.

⁹ J. Michael McWilliams *et al.*, "Complex Medicare Advantage Choices May Overwhelm Seniors — Especially Those With Impaired Decision Making," *Health Affairs*, September 2011, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.0132>.

¹⁰ Waiver, *op. cit.*, p. 71.

¹¹ Sarah Lueck, "Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges," CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

¹² CBPP calculations from CMS public use files. See also, Nevada Health Link, "Nevada's State Based Exchange Announces Enrollment Figures for Plan Year 2020," December 23, 2019, https://d1q4hslcl8rmbx.cloudfront.net/assets/uploads/2019/12/FINAL-2020-Nevada-Exchange-Prelim-Enrollment-Release_12.23.19.pdf; Sarah Lueck, "Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges," CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

¹³ As this calculation indicates, enrollment declines due to the Georgia Access Model would likely exceed the modest increases (about 2,000 people) Georgia projects from the reinsurance program and the total increase Georgia projects under the waiver (27,000).

The Georgia Access waiver violates the statutory guardrails set forth in Section 1332 of the Affordable Care Act.

Georgia's proposal does not meet the legal standards for a Section 1332 waiver. They require Section 1332 waivers to cover as many people with coverage as affordable and comprehensive, as would be covered absent the waiver, without increasing the federal deficit. As detailed above, Georgia's waiver would go in the opposite direction. Thousands of Georgians would likely lose coverage and others would likely end up with less affordable or less comprehensive coverage than they would otherwise have.

Therefore, we urge the Departments to withdraw their previous approval of this waiver proposal. Thank you for your consideration of these comments and please contact me if you have questions or need additional information.

Sincerely,

/s/ Anne Swerlick

Anne Swerlick
Senior Policy Analyst & Attorney
Florida Policy Institute
407-440-1421 x 703
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GEORGIA ALLIANCE OF COMMUNITY HOSPITALS

P.O. Box 1572 · Tifton, GA 31793 · (229) 386-8660 · Fax (229) 386-8662 · marcy@gach.org · www.gach.org

January 7, 2022

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight (CCIIO)
U.S. Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244
stateinnovationwaivers@cms.hhs.gov

Dear Director Montz:

My name is Monty Veazey, I am the President of the Georgia Alliance of Community Hospitals. The Alliance is a 92-member association of Georgia's not-for-profit hospitals. Our members run the gamut from single building hospitals to Georgia's largest health system. I am writing to provide comment regarding Part II of Georgia's approved Section 1332 Waiver, the Georgia Access Model.

In light of CMS' decision to open Georgia's approved Section 1332 Waiver back up for federal comment, I want to register my support for Georgia Access and the potentially transformative impact it will have for Georgians across our state. The waiver will allow persons not currently covered to access brokers in their community acquire coverage.

As you are aware, Georgia's approved Section 1332 Waiver represents a first-of-its-kind approach to providing consumers with comprehensive health coverage, shopping, and enrollment services and year-round customer support through certified private-sector entities. It is the exact type of state innovation Section 1332 Waivers are meant to foster. The Georgia Access Model acknowledges the unique challenges facing Georgia's health insurance market and provides market-driven solutions by empowering certified web-brokers, carriers, and agents to provide consumers with a superior shopping and enrollment experience when compared to the federally facilitated exchange (FFE) while still maintaining the consumer protections and eligibility rules for Advanced Premium Tax Credits and Cost Sharing Reductions in place today.

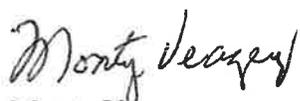
Most Alliance Hospitals have 8-12 % of patients that cannot pay for the healthcare services they receive. Allowing this brokerage model would likely reduce those percentages and bring more patients to care when they need it. It would also likely stabilize some of our financially

vulnerable hospitals. Our rural Georgia hospitals are facing challenges with providing services to patients in need. Increased access to coverage would benefit our patients and those hospitals.

Through its close collaboration with your department's staff, Georgia has demonstrated its commitment to the success of Georgia Access and continues to build momentum through engagement with web brokers, carriers, and agent organizations. Furthermore, the state has made significant human and financial investments in implementing and operationalizing Georgia Access. From hiring dedicated staff to implementing necessary technical upgrades to state systems to planning for a statewide marketing and outreach campaign, the state recognizes the responsibility it has undertaken to reach and support underserved communities across Georgia.

At the core of these efforts is the state's overarching commitment to creating more accessible, affordable health coverage and reducing the number of uninsured Georgians. As the Departments review commentary on the Georgia Access Model, I encourage you to remember the failures of the FFE in serving Georgians in the past. Our state and its citizens require a tailored, state-based approach to delivering accessible health insurance coverage. Our state needs Georgia Access.

Thank you for your consideration.



Monty Veazey

President/CEO, Georgia Alliance of Community Hospitals

Cc: Governor Brian Kemp



December 17, 2021

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight (CCIIO)
U.S. Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244
stateinnovationwaivers@cms.hhs.gov

Dear Director Montz:

On behalf of the Georgia Chamber of Commerce and our statewide network of 47,000 businesses, we would like to provide comment in regard to Part II of Georgia's approved Section 1332 Waiver, the Georgia Access Model.

In light of CMS' decision to open Georgia's approved Section 1332 Waiver back up for federal comment, the Georgia Chamber would like to register its unwavering support for Georgia Access and the potentially transformative impact it will have for Georgians across our state. The Georgia Chamber is supportive of a state-led approach to ensure the viability of our healthcare system by supporting implementation of federal waiver programs, like Georgia Access, to help small businesses with premium assistance. Most importantly it would increase access to care for more Georgians.

As you are aware, Georgia's approved Section 1332 Waiver represents a first-of-its-kind approach to providing consumers with comprehensive health coverage, shopping, and enrollment services and year-round customer support through certified private-sector entities. It is the exact type of state innovation Section 1332 Waivers are meant to foster. The Georgia Access Model acknowledges the unique challenges facing Georgia's health insurance market and provides market-driven solutions by empowering certified web-brokers, carriers, and agents to provide consumers with a superior shopping and enrollment experience when compared to the federally facilitated exchange (FFE) while still maintaining the consumer protections and eligibility rules for Advanced Premium Tax Credits and Cost Sharing Reductions in place today.

The state's public and private market have been focused on implementation of this model. Time and financial resources have been strategically invested in these waivers in order for them to be a success in our state. We have seen Governor Kemp and his administration put the health of our state first during the pandemic. The approval of the 1332 waivers will only help him further his work to achieve a more affordable and healthier Georgia.



Through its close collaboration with your department's staff, Georgia has demonstrated its commitment to the success of Georgia Access and continues to build momentum through engagement with web brokers, carriers, and agent organizations. Furthermore, the state has made significant human and financial investments in implementing and operationalizing Georgia Access. From hiring dedicated staff to implementing necessary technical upgrades to state systems to planning for a statewide marketing and outreach campaign, the state recognizes the responsibility it has undertaken to reach and support underserved communities across Georgia.

At the core of these efforts is the state's overarching commitment to creating more accessible, affordable health coverage and reducing the number of uninsured Georgians. As the Departments review commentary on the Georgia Access Model, I encourage you to remember the failures of the FFE in serving Georgians in the past. Our state and its citizens require a tailored, state-based approach to delivering accessible health insurance coverage. Our state needs Georgia Access.

Thank you for your consideration.

Sincerely,

Chris Clark
President & CEO
Georgia Chamber of Commerce

Congress of the United States
Washington, D.C. 20515

January 6, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20200

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure,

Thank you for your commitment to ensure that Georgians continue to have access to high quality health care and your strong support to uphold the Affordable Care Act (ACA). We, as Members of the Georgia Delegation, have raised concerns regarding Part II of the approved Georgia State Innovation Waiver under section 1332, and appreciate the opportunity to comment further.

As Democratic Members of Congress representing Georgia, we believe that health care is a right and everyone deserves access to quality and affordable health care. Therefore, Georgia's attempt to undermine and limit access to care through Part II of their approved 1332 waiver must be stopped. In the midst of a global pandemic, a time where access to health care is more essential than ever, Georgia should be focused on enrolling more people into affordable plans instead of exacerbating its already high uninsured rate.¹ Rescinding the waiver is critical to ensuring that Georgians have consistent and continuous access to quality and affordable health care.

Section 1332 under the ACA allows states to apply for an innovation waiver in an effort to provide new and creative ways for residents to access health insurance.² To gain approval for these waivers, states must show that they will effectively provide health care coverage to at least as many people and that coverage is as affordable and comprehensive as it would be absent the waiver.³ Despite its name, the Georgia Access Model fails to meet these requirements and actually jeopardizes health care access and coverage for more than 500,000 Georgians.⁴ As such, it should never have been approved by the prior Administration.

The Georgia Access Model would undermine and destabilize the ACA by eliminating consumers' access to HealthCare.gov, the online platform used for the federal Marketplace,

¹ <https://www.gpb.org/news/2019/09/15/rate-of-uninsured-americans-rises-georgia-now-ranks-3rd>

² https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-

³ <https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/>

⁴ <https://www.hhs.gov/about/news/2021/09/15/biden-harris-administration-announces-2-8-million-people-gained-affordable-health-coverage-during-2021-special-enrollment.html>

without introducing any new enrollment pathways for Georgians and their families.⁵ Instead, Georgians would be forced to enroll in coverage on websites owned and operated by private brokers and health insurers, erasing their ability to easily compare plans across carriers without bias.⁶ These websites would have the ability to promote noncompliant health plans that are not eligible for subsidies and do not cover the essential health benefits, something which would not be immediately apparent to the consumer. Further, this direct enrollment-style approach erodes the “no wrong door” model that connects the ACA marketplace with Georgia’s Medicaid enrollment system, putting Medicaid-eligible Georgians at risk of going or remaining uninsured.⁷

Additionally, the landscape for individual health insurance in Georgia has changed since the approval of the waiver on November 1, 2020.⁸ The American Rescue Plan Act (ARPA), which became law in March 2021, provided additional Advanced Premium Tax Credits (APTCs) making plans on the Marketplace more affordable and accessible to people across Georgia. ARPA expanded and increased subsidies for those above the 100 percent federal poverty level (FPL).⁹ In addition to these subsidies, ARPA provided a cushion for repaying subsidies of 8.5 percent for those above the 400 percent FPL and guaranteed access to a \$0 silver-level plan and increased cost-sharing reductions for those between 100-150 percent FPL.¹⁰ These changes are set to end in 2023, but CBO predicts that they will result in some increased enrollment for an additional year.¹¹

Further, the Biden Administration significantly increased funding for outreach and enrollment assistance. Beginning in August 2021, Georgia navigator organizations received an additional \$1.8 million from the Biden Administration than they had the previous year, for a total of \$2,540,273.¹² This increased investment in navigators and outreach efforts will enable more Georgians to enroll through the Marketplace and receive more affordable coverage.¹³

While ARPA provided additional support to Georgians, there have also been changes in the state with five new insurers joining Georgians health insurance marketplace.¹⁴ For plan year 2022 there are now 11 insurers offering plans on the Marketplace in Georgia compared to four in 2019 and six in 2021.¹⁵

Combined, these investments and Marketplace changes have contributed to Georgia’s record high enrollment in ACA plans. As of December 15, 2021, an additional 140,000 Georgians had signed up for health coverage on the Marketplace, totaling 653,990 individuals.¹⁶ Elimination of

⁵ Id.

⁶ https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Fact-Sheet.pdf

⁷ <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>

⁸ https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Fact-Sheet.pdf

⁹ <https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/>

¹⁰ Id.

¹¹ <https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf>

¹² <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>

¹³ <https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf>

¹⁴ <http://www.georgiahealthnews.com/2021/08/insurers-flock-offer-coverage-2022-exchange-years-open-week/>

¹⁵ Id.

¹⁶ <https://www.georgiahealthnews.com/2021/12/georgia-helps-drive-record-enrollment-aca-insurance/>

HealthCare.gov would drastically change how Georgians enroll in health insurance and cause a major disruption for hundreds of thousands of individuals. If Part II of the 1332 waiver was implemented and Georgia was the only state that did not use HealthCare.gov, low-income Georgians would be at a severe disadvantage compared to peers in the other non-expansion states, and all of the investments put into outreach and enrollment programs would be erased.

Therefore, Part II of Georgia's State Innovation Waiver under section 1332 should be revoked because it would harm Georgians and limit access to coverage. The changes in the Georgia Access Model would put low- and moderate-income Georgians at risk of higher health care costs, reduce their access to health care and services, and, in the worst-case scenarios, make individuals and their families uninsured.¹⁷

The country is in the midst of tackling the COVID-19 pandemic, one of the greatest health threats in our lifetime, and Georgia should be focused on improving access to health care, not limiting it. Instead, this attempt to undermine the ACA and push Georgians into health plans that are less comprehensive and more expensive is callous and cruel. We urge you to rescind Part II of Georgia's State Innovation Waiver and continue to work with the state of Georgia to expand and improve access to health care.

Sincerely,



Reverend Raphael Warnock
United States Senator



Jon Ossoff
United States Senator



Carolyn Bourdeaux
Member of Congress



Lucy McBath
Member of Congress



Sanford D. Bishop, Jr.
Member of Congress



Nikema Williams
Member of Congress



David Scott
Member of Congress



Henry C. "Hank" Johnson, Jr.
Member of Congress

¹⁷ <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>

January 5, 2022

The Honorable Xavier Becerra
Secretary, U.S. Department of Health and
Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary, U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20200

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare &
Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted via stateinnovationwaivers@cms.hhs.gov

Dear Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure,

Thank you for the opportunity to comment on Georgia's Section 1332 waiver of federal rules under the Affordable Care Act (ACA) and the updated data the state has provided at CMS's request. I am writing on behalf of Georgians for a Healthy Future to express our organization's concern about the Georgia Access model included in Georgia's ACA Section 1332 waiver.

Georgians for a Healthy Future (GHF) is a state-wide, non-profit consumer health advocacy and policy organization. Our organization's vision is of a day when all Georgians have access to the quality, affordable health care they need to live healthy lives and contribute to the health of their communities. Since 2010, we have been actively engaged in monitoring and advocating on ACA implementation issues that impact health care consumers in our state. GHF regularly fields calls and questions from consumers with individual coverage as they navigate a dynamic health care and coverage landscape.

We believe that the proposed Georgia Access model will put Georgia consumers at risk of becoming un- or under-insured altogether. In addition, Georgians with little or no experience buying or using health insurance, those with limited English proficiency, Georgians with low health literacy skills, and Georgians with low health literacy skills, rural Georgians, people of color in Georgia, and those who are eligible for, but unenrolled, in Medicaid would be most at risk of experiencing adverse consequences from the outlined plan.

Instead of giving consumers more choices to enroll in comprehensive health coverage, as Georgia officials claim, the Georgia Access model would eliminate consumers' option to use the one-stop-shop HealthCare.gov platform. Eliminating the use of the HealthCare.gov platform is likely to sharply reduce the number of Georgians with comprehensive coverage for several reasons:

1. Georgia's individual health insurance landscape has drastically changed since the waiver was approved.

When Georgia's 1332 waiver was approved in November 2020, 463,910 Georgians were enrolled in coverage through healthcare.gov.¹ In 2021, over 550,000 Georgians enrolled, a difference of about 86,000 new enrollments.² Many of these new enrollments came during the COVID Special Enrollment Period, which ran from February 12 to August 15, 2021. Enrollment looks even stronger for 2022 pending the close of the ACA's 2022 open enrollment period. As of December 22, 2021, 653,990 Georgians have enrolled, an increase of 190,000 people (34 percent) above 2020.³

A major driver of the enrollment increase was the more generous Advanced Premium Tax Credits (APTCs) created through the American Rescue Plan. Along with these increased APTCs, enrollees above 400% FPL received an 8.5% income cushion for repaying subsidies and enrollees between 100-150% FPL were guaranteed access to a \$0 silver-level plan and increased cost-sharing reductions to significantly lower deductibles for this group.⁴ We anticipate that Georgians will continue to benefit from this supplemental financial assistance as Congress works to extend it in the proposed Build Back Better Act.

The Biden Administration also dramatically increased funding for outreach and enrollment assistance. Georgia navigator organizations received \$1,945,303 beginning in August 2021, compared to \$700,000 the year prior—a 177% increase.^{5,6} The

¹ Georgia Health News, "Exchange Enrollment Hits Record Level in State," September 22, 2021, <https://www.georgiahealthnews.com/2021/09/georgia-exchange-enrollment-hits-record-level/>

² Kaiser Family Foundation, Marketplace Enrollment 2014–2021, <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22georgia%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

³ Centers for Medicaid & Medicare Services, "Marketplace Weekly Enrollment Snapshot: Week 6." December 22, 2021. <https://www.cms.gov/newsroom/fact-sheets/marketplace-weekly-enrollment-snapshot-week-6>.

⁴ Kaiser Family Foundation, "Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID 19 Relief on Marketplace Premiums," March 15, 2020. <https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/>

⁵Centers for Medicaid & Medicare Services, "2021 CMS Navigator Cooperative Agreement Awardees," August 27, 2021. <https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf>

⁶ Centers for Medicaid & Medicare Services, "2020 CMS Navigator Cooperative Agreement Recipients," August 30, 2020. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2020-Navigator-Grant-Recipients.pdf>

increase in navigators and outreach efforts will help more Georgians find more affordable plans by spreading awareness of the increased APTCs.

Finally, five new insurers have joined Georgia's health insurance marketplace. Georgia has 11 insurers offering plans on the Marketplace for the 2022 plan year, up from four in 2019 and six in 2021.⁷ An increase in insurers demonstrates that Georgia's insurance marketplace has stabilized and matured and is benefiting as expected from the state's reinsurance program.

The recent advances in Georgia's health insurance marketplace all trend in positive directions that benefit consumers and meaningfully resolve the shortcomings that the Georgia Access model was purported to address. Implementation of the Georgia Access proposal would only serve to undercut the progress our state has experienced since it was first put forward. We urge the Departments to withdraw their previous approval of this waiver proposal.

2. Fragmenting the insurance market would confuse and discourage consumers from enrollment.

Under this proposal, enrollment would likely fall because buying insurance would become harder for Georgia consumers. Purchasing health insurance is a complicated and expensive undertaking. Eight out of ten of Georgia's marketplace enrollees use HealthCare.gov to shop for and enroll in their health plan.⁸ Eliminating the preferred enrollment platform of most Georgia consumers could not only cause confusion but could also paralyze consumers, keeping them from making a decision altogether.

Research shows that having too many choices makes it difficult for consumers to make a choice, much less a fitting choice.^{9,10} The system proposed in the waiver would require consumers to choose among legions of sellers before beginning the process of selecting a specific health plan and would not guarantee access to a single platform on which to see and compare all plan choices on equal terms. As a result, Georgians would be confused at the very least, find it challenging to make an informed choice, and, at the worst, not make a choice at all.

⁷ Kaiser Family Foundation, Navigator Funding Restored in Federal Marketplace States for 2022, September 29, 2021. <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>

⁸ Georgia Section 1332 State Innovation Waiver as submitted to CMS on July 31, 2020; https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_innovation_waivers- (hereafter, Waiver).

⁹ Consumers Union, "The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making" November 2012, https://advocacy.consumerreports.org/wp-content/uploads/2012/11/Too_Much_Choice_Nov_2012.pdf.

¹⁰ J. Michael McWilliams *et al.*, "Complex Medicare Advantage Choices May Overwhelm Seniors — Especially Those With Impaired Decision Making," *Health Affairs*, September 2011, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.0132>.

3. Georgians eligible for Medicaid are unlikely to receive assistance from insurers, agents, or brokers.

HealthCare.gov facilitates Medicaid enrollment with a “no-wrong-door” application that routes Georgians to the program for which they’re eligible based on their family size, income, and other factors. In the open enrollment period for 2021, about 35,000 Georgians who started the process at HealthCare.gov were assessed eligible for Medicaid — more than the number of total enrollees the state projected to gain through the waiver.¹¹ Medicaid covers half of all Georgia children, making this enrollment pathway especially important for low- and middle-income Georgia families.

Because Medicaid (and Medicaid managed care organizations) do not generally pay commissions, brokers and insurers have no incentive to provide information and assistance to consumers who turn out to be eligible for Medicaid. For example, a search on HealthCare.gov shows more than 1500 agents and brokers that enroll people in coverage in one Atlanta zip code but zero agents and brokers that say they will assist with Medicaid/CHIP enrollment.¹² Brokers and agents not assisting in Medicaid enrollment is worrisome for Georgia consumers and families because the Medicaid enrollment process can be opaque, confusing, and slow. Without assistance, some consumers may not complete the enrollment process, despite being eligible for the program.

4. Georgians will lose coverage in the transition from HealthCare.gov to the Georgia Access system

The disruption created by the state’s transition away from HealthCare.gov is likely to cause a decline in enrollment among Georgia consumers. Our state’s waiver predicts a loss of about 2 percent (8,000 people) of enrollees due to the change from one system to another. However, other states’ experiences show this figure is unrealistic.¹³ For example, Kentucky saw a reduction of 13 percent in its marketplace enrollment when the state transitioned to the federal marketplace in 2017, compared to a 4 percent decline nationally.¹⁴ More recently, Nevada’s 2020 marketplace enrollment dropped 7 percent after the state transitioned to a state-based marketplace, compared to flat

¹¹ Centers for Medicare & Medicaid Services, 2021 Marketplace Open Enrollment Period Public Use Files, April 21, 2021, <https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files>. This does not include the number of Medicaid-eligible people who initially applied through the marketplace during the six-month SEP.

¹² Center on Budget and Policy Priorities analysis. HealthCare.gov search conducted on December 8, 2021, using the 30318 zip code.

¹³ Waiver, *op. cit.*, p. 71.

¹⁴ Sarah Lueck, “Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges,” CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

enrollment nationally.¹⁵ Similar percentage declines in Georgia would translate into a drop of 25,000-46,000 people from marketplace enrollment.¹⁶ Enrollment declines of this scope would likely exceed the increases anticipated by the waiver (27,000).

Enrollment declines are especially likely given that Georgia has only allotted one-third of the estimated cost of the waiver to the transition process. This funding seems solely dedicated to the technological transition. The state has not allocated specific funds to help consumers understand the transition, their options for enrollment, or how to access free, unbiased enrollment assistance.

5. The steering of healthier consumers towards substandard plans would make comprehensive coverage more expensive for those who need it.

The proposal would give insurers and brokers new opportunities to steer healthier consumers toward substandard plans that expose them to catastrophic costs if they get sick. The resulting adverse selection could make comprehensive coverage more expensive for those who need it, reducing their enrollment as well.

Brokers have an incentive to steer consumers toward substandard plans (e.g., short-term and single-disease plans), which normally cannot be sold alongside ACA plans, because they tend to pay higher commissions. For example, short-term plans pay up to ten times as much as ACA-compliant plans.¹⁷ Insurers also profit on short-term plans, which aren't required to meet the medical loss ratio standards for ACA-compliant plans.¹⁸

Healthier and younger Georgians would be more likely to choose short-term plans. Less healthy people, like those living in rural areas, as well as Black Georgians and other people of color, are less likely to qualify for such a policy and face higher premiums when they do. If healthier consumers leave the ACA-compliant market for these short-

¹⁵ CBPP calculations from CMS public use files. See also, Nevada Health Link, "Nevada's State Based Exchange Announces Enrollment Figures for Plan Year 2020," December 23, 2019, <https://d1q4hslcl8rmbx.cloudfront.net/assets/uploads/2019/12/FINAL-2020-Nevada-Exchange-Prelim-Enrollment-Release-12.23.19.pdf>; Sarah Lueck, "Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges," CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

¹⁶ As this calculation indicates, enrollment declines due to the Georgia Access Model would likely exceed the modest increases (about 2,000 people) Georgia projects from the reinsurance program and the total increase Georgia projects under the waiver (27,000).

¹⁷ House report, *op. cit.*, p. 43. Due to the time it takes to assist marketplace consumers, some brokers report that they lose money on each marketplace enrollment, and so have stopped marketing their services or operate only through referrals. Others say they are uneasy about selling short-term plans despite the higher commissions, given the plans' risks for people with pre-existing conditions. See Sabrina Corlette *et al.*, "Perspective from Brokers: The Individual Market Stabilizes While Short-Term and Other Alternative Products Pose Risks," Urban Institute, April 2020, <https://www.urban.org/research/publication/perspective-brokers-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks>.

¹⁸ House report, *op. cit.*, p. 48.

term plans, the ACA risk pool would become less healthy, causing premiums to rise. (Similarly, the recent expansion of short-term plans nationally caused premiums for comprehensive coverage to go up by an average of 0.5 to 4 percent.¹⁹) The waiver does not take into account these likely outcomes.

6. The enrollment of vulnerable Georgians in substandard plans would threaten their health and economic well-being.

Experience with enhanced direct enrollment programs shows that some brokers and agents screen applicants before sending them down the official enrollment pathway. Some of these applicants are then diverted to substandard plans that pay higher commissions but leave enrollees with chronic conditions and other health needs exposed to catastrophic costs.²⁰ Even in less egregious circumstances, these companies are allowed to show substandard plans alongside comprehensive plans, thus encouraging Georgia consumers to enroll in substandard plans.

Substandard plans are not required to cover all essential health benefits, leaving Georgians potentially without access to necessary health services unless they can pay out of pocket. More than one-third of substandard plans do not cover most prescription drug benefits, for example, and more than half do not cover mental health services.²¹ On top of that, substandard plans are allowed to exclude coverage for pre-existing conditions altogether and charge more for people with pre-existing conditions like substance use disorders, asthma, and now COVID-19. That leaves Georgians of color, rural Georgians, and other groups that experience higher health burdens vulnerable to catastrophic costs, limited access to care, and other negative consequences.

7. The Georgia Access waiver violates the statutory guardrails set forth in Section 1332 of the Affordable Care Act.

The Georgia Access model is not approvable under federal law because it would harm consumers. It fails the ACA's coverage, comprehensiveness, and affordability requirements. Thus, there is a high chance that the waiver would cause thousands of Georgians to lose coverage. There is also no reason to expect it would meaningfully increase coverage. Many Georgians would likely be left with less affordable or less comprehensive coverage.

¹⁹ Hansen and Dieguez, *op. cit.*, p. 3.

²⁰ Tara Straw, "Direct Enrollment in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm," CBPP, March 15, 2019, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

²¹ Kaiser Family Foundation, <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>

Thank you in advance for your consideration of our comments on the Georgia Access model in Georgia's Section 1332 waiver. Please contact us with any questions you have regarding our comments.

Sincerely,



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January 7, 2022

Centers for Medicare and Medicaid Services
stateinnovationwaivers@cms.hhs.gov

RE: Public Comment on Georgia's Section 1332 Waiver Application.

Dear Sir or Madam:

Thank you for the opportunity to comment on Georgia's Section 1332 Waiver. Georgia Legal Services Program is a non-profit law firm that represents low-income Georgians in 154 of Georgia's 159 counties. Through our representation of clients, we become aware of the challenges that face Georgia's low-income citizens. These comments are based on the real-life knowledge we have gained through representation of low-income Georgians in health related and other cases.

In addition to our representation of low-income Georgians in civil legal matters, Georgia Legal Services Program was awarded an ACA Navigator Grant in August 2021. The grant targets the 47 counties in Georgia with the highest uninsured population. To date our Navigators have conducted outreach to more than 1300 Georgia residents. Additionally, the grant allowed us to expand the services we offer our clients to assisting them in enrolling in Marketplace plans and Medicaid. We historically represented clients who are denied Medicaid or have their benefits terminated by filing appeals and representing at hearings; however, we did not generally assist with initial applications. With the ACA Navigator Grant we have knowledgeable, trained staff who can identify clients who may be Medicaid eligible and assist them in applying. In just the few months we have had the grant, we have assisted Georgians to obtain Medicaid who were


LEGAL SERVICES CORPORATION

The Georgia Legal Services Program is a nonprofit corporation whose mission is to provide civil legal services for persons with low incomes, creating equal access to justice and opportunities out of poverty.

Serving Catoosa, Chattooga, Dade, Murray, Walker, and Whitfield Counties
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AN AFFIRMATIVE ACTION/EQUAL OPPORTUNITY EMPLOYER M/F/V/H

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improperly denied coverage. Such application assistance is essential in gaining Medicaid coverage for low-income uninsured Georgians.

In Georgia the Department of Family and Children Services (DFCS) processes all Medicaid applications and reviews. Long before COVID-19, Georgia moved to a centralized system where applications and reviews are processed statewide and not in the county where the applicant or recipient lives. This eliminated individual, local case workers who could assist families who were struggling with the application or review process. During the public health emergency, DFCS offices have been closed to the public creating even more barriers for applicants/recipients in a system that has proven difficult for individuals and families to access for years¹. The increased ACA Navigator funding has increased low-income Georgians access to qualified, knowledge assistance with Medicaid and PeachCare (Georgia's CHIP program) applications.

The Georgia Access Model proposes to: 1. Get rid of a centralized website, HealthCare.gov; 2. Replace the centralized website with multiple websites operated by for profit entities; and 3. Allow non-Qualified Health Plans (QHPs) to be sold alongside QHPs. These comments will focus on how the proposed waiver may affect the low-income Georgians we serve whose uninsured rate is 24.5% for those with income between 100 and 138% of the federal poverty level (FPL) and 15.6% for those with income between 139 and 399% of the FPL.²

Getting rid of HealthCare.gov will reverse the recent gains Georgia has experienced in getting more of its citizens insured.

Georgia suggests that HealthCare.gov is not working by citing a 22% decrease in enrollment through the website since 2016. However, the website did not cause the decline; it is more directly attributable to the tremendous reduction of federal funds for outreach and enrollment assistance since 2016.³ Unlike some states, Georgia did not expend any state funds to replace the over \$3.1 million reduction in federal funds for outreach and enrollment assistance. To further hamper the success of HealthCare.gov and the ACA Marketplace, Georgia passed a law in 2019 prohibiting the state or any department or agency from creating or operating a Navigator program.⁴

Given the federal changes beginning with the American Rescue Plan (ARP) and the increased outreach and navigator funding, Georgia has seen record increases in Marketplace enrollment. Enrollment increased slightly from 2019 to 2020, but increased significantly in 2021 as a result

¹ <https://www.wabe.org/enrollment-drops-eligibility-snags-cyber-errors-in-ga-benefit-programs-spark-concern/>

² https://gbpi.org/2019/leverage-1332-waivers-to-make-health-insurance-more-affordable-and-accessible/#_edn11

³ Pollitz, K., Tolbert, J. & Diaz, M. (2018). Data Note: Further Reductions in Navigator Funding for Federal Marketplace States. Retrieved from <https://kff.org/a1bf174>

⁴ O.C.G.A. 33-1-23 (2021)

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of ARP. Enrollment attributed to ARP increased over 11%.⁵ The increase continued for the 2022 open enrollment period which saw a 27% increase in Marketplace enrollment.⁶

The significant enrollment increases show that Healthcare.gov is not the issue; the problem was the elimination of funding for outreach and navigators. With the federal changes the landscape has changed and Georgia's 1332 waiver no longer meets the statutory guardrail that it will result in coverage to a comparable number of residents. Should the waiver go forward, over 650,000 Georgians will lose the coverage they currently have and be required to learn a new process to sign up for that same coverage in 2023.

Georgia estimates that the waiver will result in an increase in enrollment of approximately 28,000 people, but doesn't explain why this increase will happen.⁷ Georgia residents have always been able to sign up for QHPs through private agents and brokers and will continue to be able to sign up in that manner.⁸ However, the new federal actions have increased enrollment in Georgia by more than 145,000 people. Clearly the issue with decreased enrollment in Georgia was due, at least in a large part, to the drastic reduction in funding for outreach, education, and Navigators.

Replacing Healthcare.gov with multiple web sites designed, maintained, and monitored by for profit insurance brokers and providers will cause confusion and lead many low-income Georgians to unknowingly select non-QHPs.

The proposed Model envisions that for profit entities will expend funds for outreach and enrollment activities, thereby saving the State money. We agree that the current waiver creates a financial incentive for insurance brokers and companies to advertise their plans and sign up as many Georgians as possible. However, they do not have any incentive to assist consumers in choosing the best plan for their situation and many will push those plans that pay the highest commission or create the highest profit.

HealthCare.gov allows consumers to compare all available plans, knowing that all of the plans provide the same coverage. This allows consumers to make an informed choice based on provider network and cost. Under the proposed Model, consumers will have to go to multiple websites and may not realize the site is offering QHPs and non-QHPs. There is no simple way for the consumer to find that another provider/broker offers a plan that would be better for them at a similar or lower cost. Furthermore, brokers and providers do not reveal their commission or

⁵ <https://www.healthinsurance.org/health-insurance-marketplaces/georgia/>

⁶ <https://www.georgiahealthnews.com/2021/12/georgia-helps-drive-record-enrollment-aca-insurance/>

⁷ https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-#please_visit_the_Georgia_waiver_section_of_this_webpage_below

⁸ <https://www.cbpp.org/research/health/georgias-plan-to-exit-marketplace-will-leave-more-people-uninsured-should-be>

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profit on each plan. Many consumers, especially lower income Georgians, will rely on the advice of the “expert” assisting them and will be easily steered toward plans that provide less coverage, but increase the commission or profit of the seller.

Georgia should not completely abandon the idea behind HealthCare.gov by going back to how health insurance was marketed and sold before the Affordable Care Act. If Georgia believes that HealthCare.gov is not working for Georgia, I urge it to replace it with a site run by the State (or a contracted non-profit) that will allow consumers to compare all health plans available, including QHPs and non-QHPs. Additionally, the website must clearly identify non-QHPs and clearly state what essential health benefits are not covered. By offering this unbiased information on one site, consumers can continue to make informed decisions about their health insurance.

Further, the State’s plan to eliminate in-person assistance by trained navigators will deeply impact marginalized communities and the hard-to-reach areas of our state.⁹ For example, a review of 81 agents and brokers for Millen, Georgia on Healthcare.gov showed only one (1) agent offered Spanish language access who is one hour away from Millen. Millen is a rural county and 4% of its population speaks Spanish. Likewise, out of 148 agents and brokers appearing for Dalton, Georgia only two (2) displayed Spanish-speaking services even though 40% of the population of Dalton, Georgia speaks Spanish.¹⁰ Both Millen and Dalton are in counties targeted by our ACA Navigator grant.¹¹

The State’s waiver application acknowledges the concern of commenters that “multiple enrollment sites will place an increased burden on individuals whose first language is not English.”¹² The State’s response that “Web-brokers often provide enhanced services, such as multi-lingual support...” appears wanting as demonstrated by the lack of such services that are shown on Healthcare.gov.¹³ A failure to thoughtfully and intentionally meet this need may work to further exacerbate existing disparities in healthcare and health coverage.

We submit these comments based upon our experience in representing low-income clients outside of the metro Atlanta area with the hope that we will be able to continue using Healthcare.gov to help uninsured Georgians gain health insurance.

We appreciate your consideration of our comments and would be happy to provide any further information that may be useful to you review the waiver for compliance.

⁹ See https://www.cbpp.org/research/health/georgias-plan-to-exit-marketplace-will-leave-more-people-uninsured-should-be#_ftnref28 (citing analysis of Healthcare.gov brokers and agents showing that out of 1500 agents for one Georgia zip code, only 47 offered Spanish language access).

¹⁰ <https://worldpopulationreview.com/us-cities/dalton-ga-population>

¹¹ Georgia Enroll currently has two (2) Spanish speaking Navigators on staff.

¹² [https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-#please_visit_the_Georgia_waiver_section_of_this_webpage_below_\(10/09/20\),_pg._179](https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-#please_visit_the_Georgia_waiver_section_of_this_webpage_below_(10/09/20),_pg._179).

¹³ Id.

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Date: January 7, 2022

Respectfully,

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January 9, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted electronically via: stateinnovationwaivers@cms.hhs.gov

Re: Georgia Access 1332 Waiver - Public Comment

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the *Georgia Access Model 1332 Waiver* on behalf of Peach State Health Plan in Georgia. Our Marketplace offering plays a crucial role in providing care for lower income, uninsured, and underinsured individuals – especially those who are transitioning from Medicaid. As Georgia’s largest Marketplace insurer, we appreciate the State’s collaborative approach to addressing factors contributing to healthcare coverage and access challenges facing many Georgia residents across the state – even further exacerbated by COVID-19.

Peach State Health Plan supports Georgia’s efforts to address healthcare coverage in an innovative manner in the individual market. We applaud the State for proposing options that allow the private sector to innovate – specifically, web-brokers, insurers, and insurance agents – and potentially bring coverage to more uninsured Georgians. In implementing the *Georgia Access Model 1332 Waiver* and new enrollment platforms, we encourage CMS to work with the State to develop clear guidelines for such private entities and develop a consumer-focused outreach program to ensure Georgians understand the new enrollment platforms.

We welcome the opportunity to continue working with CMS and the State to refine policies that may help to further the State’s goals at enhancing access to high-quality and affordable coverage. Should you have any questions, feel free to reach out to me at wakes@centene.com.

Sincerely,

Wade Rakes
President & Chief Executive Officer
Peach State Health Plan

January 4, 2022

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight (CCIIO)
U.S. Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244
stateinnovationwaivers@cms.hhs.gov

Dear Director Montz:

On behalf of the Georgia Public Policy Foundation, I am writing to provide comment regarding Part II of Georgia's approved Section 1332 Waiver, the Georgia Access Model.

After CMS made the unprecedented decision to reopen Georgia's approved Section 1332 Waiver for federal comment, we are providing our support for Georgia Access and the state's approach to strengthen access to private health insurance.

As the Foundation has previously published:

While Republicans nationally struggle to agree on solutions in healthcare and Democrats push for more government control, Georgia is taking a major step forward in altering key aspects of the Affordable Care Act (ACA) to empower consumers and put them at the center of their own healthcare.

Like many other states around the country, Georgia's individual health insurance market fell into crisis under the ACA. From 2016 to 2019, total health insurance exchange enrollment in Georgia dropped by 22%, while premiums for benchmark exchange plans jumped by a whopping 70%. In response to the dire market situation under the ACA, a number of states have used Section 1332 State Innovation Waivers to stabilize their markets and provide relief from unaffordable premiums.

Most Americans want healthcare to look more like Amazon or Travelocity, where transparency, straightforward comparison shopping and customer service are paramount. Yet, Washington, D.C., seems hell-bent on making it look more like the IRS or the DMV. We know that when key decisions are made by government bureaucrats, choice is inevitably taken away and patients are treated like nameless, faceless numbers.

Under the leadership of Gov. Brian Kemp, Georgia is the first state in the country to use the ACA's waiver authority to "Amazon-ize" healthcare and make it more responsive to consumer needs. Besides creating a robust reinsurance program, which promises to lower premiums in the state's individual market by 10% in 2022, the waiver creates an entirely new way for Georgians to shop for health insurance coverage called the Georgia Access Model. Under this model, Georgia would eliminate HealthCare.gov in 2023 and would instead rely

on private-sector brokers and insurers to provide the consumer shopping experience, much like Amazon and Travelocity do today.

While a similar concept was successfully implemented during the Trump administration, it has been largely kept under wraps by the national media. Under the wrongheaded conviction that only the government can sell health insurance, the Obama administration carried out the ACA's health insurance exchange using federally funded "navigators" and a centralized government website, HealthCare.gov. Not surprisingly, this one-size-fits-all approach had the effect of squeezing out private-sector investment in health insurance advertising and outreach. As a result of this and other federal policies, commissions paid by health insurers to licensed insurance agents and brokers plummeted, leading many to abandon the market to focus on selling other lines of insurance. All of this contributed to the ACA's falling short of the Congressional Budget Office's initial enrollment projections, and the law continues to lag behind in reducing the number of uninsured.

But the Trump administration opened up a new pathway that allows private-sector partners to market and sell health insurance directly to consumers without forcing them to go through the government website. This new pathway has worked remarkably well. During the open enrollment period last fall, over 1 million people enrolled through these private-sector partners. Not only that, but partners using the pathway have attracted a higher percentage of new enrollees than the government website.

Georgia's waiver builds on this success by allowing private-sector partners to serve as the primary means for Georgians to shop for and enroll in coverage. Without having to take a backseat to HealthCare.gov or being crowded out by ineffective federally funded navigators, web brokers, insurers, and licensed agents and brokers who live and work in the communities they serve will have more incentive to go out and enroll the uninsured. Web brokers will have increased incentive to design a more appealing, consumer-centric shopping experience that will simplify the daunting task of buying health insurance.

While the waiver's detractors are focused on the fact that the Georgia Access Model "takes away" HealthCare.gov, they fail to recognize that many private-sector partners today provide everything HealthCare.gov provides and more – and that consumers by the millions already are turning to private-sector partners as they shop for coverage.

Through its Section 1332 State Innovation Waiver and the Georgia Access Model, Georgia is leading the nation in putting consumers, rather than bureaucrats, at the center of healthcare. Republicans and Democrats alike who care about getting more people covered should take notice.

The Georgia Public Policy Foundation strongly believes Georgia's 1332 state innovation waiver will help protect patients and consumers and stabilize the individual market. We therefore urge the Department move forward with final approval of the waiver. Thank you for your consideration.

Chris Denson

Director of Policy and Research

chrisd@georgiapolicy.org



January 7, 2021

VIA ELECTRONIC SUBMISSION

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Georgia Access Model section 1332 waiver comments

Dear Secretary Becerra,

Thank you for the opportunity to comment on Georgia's section 1332 waiver. Our comments are limited to the "Georgia Access Model" component of the waiver.

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for children and families. As part of the McCourt School of Public Policy, CCF provides research, develops strategies, and offers solutions to improve the health of children and families, particularly those with low and moderate incomes. In particular, CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA).

We urge HHS to rescind the approval of the Georgia Access Model component of Georgia's 1332 waiver. The Georgia Access Model approval was based on a completely outdated set of enrollment assumptions, and the waiver would now reduce enrollment relative to the "without waiver" status quo. The Marketplace enrollment problems created by the Georgia Access Model would also have negative impacts on health and coverage for children and would worsen health inequities in the state.

The Georgia Access Model Will Reduce Marketplace Enrollment

The Georgia Access Model would eliminate the HealthCare.Gov enrollment portal in the state of Georgia in 2023, replacing it with a maze of hundreds of private brokers and insurance companies. While "brokers often fail to provide consumers with the plan information necessary to inform their purchase" and "push consumers to purchase the

insurance quickly,” HealthCare.Gov is a time-tested, standardized, and unbiased source of information and enrollment support that consumers in Georgia have come to rely upon.¹

The Georgia Access Model was approved by the Trump administration in November 2020, largely based on assumptions built on 2018 data. Those assumptions are no longer valid and there has been a material change in the enrollment landscape since the 2020 approval. There are numerous reasons to expect the Georgia Access Model to *reduce* enrollment in the Marketplace relative to current and expected levels.

The Georgia Access Model was premised on increasing Marketplace enrollment in the state to nearly 392,000 enrollees by 2023. However, due to numerous improvements, Marketplace enrollment is already 549,000 as of August 2021.² Georgia’s coverage impact estimates would represent a sharp *decrease* in enrollment and are otherwise totally obsolete and cannot be the basis of a 1332 waiver. Under the legal “coverage guardrail,” states must show that their section 1332 waivers will not reduce enrollment. *Considering that Georgia is still a year away from beginning the Georgia Access Model and that the state has failed to respond to two HHS requests for updated information, HHS should rescind the Georgia Access Model approval promptly.*

There are numerous reasons to believe that future enrollment will continue to improve without the Georgia Access Model and in ways which the state’s outdated modeling did not consider. For example, federal legislation increased premium tax credits through 2022, and this will have enrollment ripple effects for 2023 and beyond. As of 2022, the annual Open Enrollment period has also been significantly extended compared to prior years, and this will also lead to increased enrollment. In addition, there is new flexibility allowing ongoing enrollment during the year for individuals below 150% of the federal poverty line. Finally, there will likely be a swell of Marketplace enrollment in 2022, if and when the Medicaid “maintenance of effort” requirement related to COVID-19 Public Health Emergency ends and thousands of consumers transition from Medicaid to Marketplace. All of these changes will increase enrollment relative to the original Georgia Access Model assumptions.

The Georgia Access Model did not account for, and would *lose* enrollment relative to, significant national investment increases in HealthCare.Gov enrollment. The annual marketing investments of \$10 million during the Trump years were dwarfed by the spending of the Biden administration in 2021 alone. Likewise, health care enrollment assistance funding was also significantly increased. This funding and increased enrollment would be foregone under the Georgia Access Model, and Georgia Marketplace enrollment would be relatively reduced.

¹ Sabrina Corlette *et al.*, Urban Institute, “The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses,” January 2019, <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>

² Department of Health and Human Services, “Total Effectuated Enrollment by State, August 2019-2021,” August 2021, <https://www.cms.gov/files/document/2019-2021-aug-effectuated-enrollment.xlsx>.

In short, any hypothetical enrollment increases under the Georgia Access Model have been dramatically surpassed by legal and regulatory enrollment improvements implemented (and forthcoming) since the November 2020 approval, and the Georgia Access Model now represents a major step backwards for health coverage in Georgia. This plainly contradicts the mandate of President Biden’s Executive Order 14009, which directs HHS and other agencies to review and as appropriate rescind policies that undermine coverage, including waivers “that may reduce coverage under or otherwise undermine Medicaid or the ACA.” HHS should rescind the Georgia Access Model approval and prevent the impending enrollment losses.

The Georgia Access Model Will Harm Children and Families

The Georgia Access Model will harm Georgia families. The patchwork of private brokers and insurance companies that would replace HealthCare.Gov will be driven by profit, sometimes at the expense of families and their health coverage. And when Georgia parents have coverage problems, their children will suffer too.

Private brokers and insurance companies are more likely to enroll individuals in “junk plans” that may not cover many important health care services, such as mental health services, prescription drugs, and maternity care.³ This results in coverage gaps just when people need care the most, and leads to foregone care, high bills, missed work and school, child care difficulties, lost jobs, and/or housing instability, etc. Enrolling individuals in substandard coverage also would violate the legal “comprehensiveness guardrail” for section 1332 waivers. Private brokers are also less likely than the Marketplace to help individuals enroll in Medicaid and CHIP coverage, meaning many of Georgia’s most vulnerable populations, including children, will be worse off in the Georgia Access Model.⁴

At the same time, Georgians will lose the support of the HealthCare.Gov assistance network. In one national survey, 94% of consumers who got assistance reported it was “very” or “somewhat helpful,” and 40% reported they were “not too likely” or “not all likely” to have been enrolled without the assistance.⁵

As discussed earlier, the Georgia Access Model will result in Marketplace enrollment decreases relative to HealthCare.Gov. While many of these coverage losses will impact adults, children will also be harmed when their parents are uninsured. Parental health has been shown to impact childhood development.⁶ For example, untreated maternal

³ Karen Pollitz et. al, Kaiser Family Foundation, “*Understanding Short-Term Limited Duration Health Insurance*,” April 2010, <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance>.

⁴ Karen Pollitz et al., Kaiser Family Foundation, “Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need,” August 2020, <https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/>.

⁵ *Id.*

⁶ Georgetown University Center for Children and Families, “Healthy Parents and Caregivers are Essential to Children’s Healthy Development,” December 2016, <https://ccf.georgetown.edu/wp-content/uploads/2016/12/Parents-and-Caregivers-12-12.pdf>.

depression is linked to childhood development challenges.⁷ In addition, numerous studies confirm that children are more likely to be insured when their parents have coverage, and lose coverage when their parents do.⁸

The Georgia Access Model Will Worsen Health Inequity

The Georgia Access Model will worsen health inequities in numerous ways. For example, private brokers are less likely to help individuals enroll in Medicaid, which will harm people of color who are disproportionately eligible for Medicaid in Georgia.⁹ In addition, private brokers are less likely to provide types of assistance needed by underserved populations, such as providing service to individuals who need help in another language.¹⁰

President Biden's Executive Order 13985 orders federal agencies to review policies and assess their impact on health equity. The Georgia Access Model will harm health equity and this impact was never assessed in the state's application or the November 2020 approval. As such, we recommend the approval be rescinded. At a minimum, in addition to requiring updated coverage estimates, HHS should require the state to provide a Georgia Access Model impact assessment for underserved populations, based on current circumstances.

Conclusion

Thank you for your willingness to consider our comments. We recommend that HHS rescind the approval of the Georgia Access Model component of Georgia's November 2020 section 1332 waiver.

Our comments include numerous citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

If you need additional information, please contact Joan Alker (jca25@georgetown.edu) or Leo Cuello (Leo.Cuello@georgetown.edu).

⁷ Georgetown University Center for Children and Families, "Medicaid Expansion Promotes Children's Development and Family Success by Treating Maternal Depression," Georgetown Center for Children and Families, July 2016, <https://ccf.georgetown.edu/2016/07/21/medicaid-expansion-promotes-childrens-development-and-family-success-by-treating-maternal-depression/>.

⁸ Georgetown University Center for Children and Families, "Health Coverage for Parents and Caregivers Helps Children," March 2017, <https://ccf.georgetown.edu/wp-content/uploads/2017/03/Covering-Parents-v2.pdf>.

⁹ Karen Pollitz *et al.*, Kaiser Family Foundation, "Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need," August 2020, <https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/>.

¹⁰ *Id.*

Sincerely,

Joan Alker
Executive Director and Research Professor
Center for Children and Families
McCourt School of Public Policy
Georgetown University



HOMETOWN
HEALTH

January 5, 2022

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight (CCIIO)
U.S. Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244
stateinnovationwaivers@cms.hhs.gov

Dear Director Montz:

My name is James C. Lewis, and on behalf of HomeTown Health, LLC, an association of rural hospitals in Georgia, I am writing to provide comment regarding Part II of Georgia's approved Section 1332 Waiver, the Georgia Access Model.

In light of CMS' decision to open Georgia's approved Section 1332 Waiver back up for federal comment, I want to register my unwavering support for Georgia Access and the potentially transformative impact it will have for Georgians across our state.

As you are aware, Georgia's approved Section 1332 Waiver represents a first-of-its-kind approach to providing consumers with comprehensive health coverage, shopping, and enrollment services and year-round customer support through certified private-sector entities. It is the exact type of state innovation Section 1332 Waivers are meant to foster. The Georgia Access Model acknowledges the unique challenges facing Georgia's health insurance market and provides market-driven solutions by empowering certified web-brokers, carriers, and agents to provide consumers with a superior shopping and enrollment experience when compared to the federally facilitated exchange (FFE) while still maintaining the consumer protections and eligibility rules for Advanced Premium Tax Credits and Cost Sharing Reductions in place today.

HomeTown Health, LLC believes that Georgia Access represents a first-of-its-kind approach that leverages the private sector to provide consumers with a comprehensive health coverage enrollment experience and year-round customer support separate from the FFE. Further, we believe that Georgia Access empowers the private market – specifically, web-brokers, insurers, and insurance agents – to provide consumers with a superior enrollment experience that better meets their needs.

HomeTown Health, LLC
3280 Cherry Oak Lane, Suite 100 Cumming, Georgia 30041
1.833.220.9100 | 470.655.6950 | hometownhealthonline.com



As further background, Georgia has historically experienced declining enrollments on the FFE. Between 2016 and 2019, total enrollment on the FFE in Georgia declined 22% with over 129,000 consumers leaving the marketplace. At the same time, Georgia has continued to have one of the highest uninsured rates in the country, even among individuals who would otherwise be eligible for Advanced Premium Tax Credits and Cost Sharing Reductions, which reduce their out-of-pocket costs for insurance. To address these mounting challenges, Georgia submitted its Section 1332 Waiver application to transition its individual market from the FFE to the Georgia Access Model. Among the primary goals of Georgia Access are increased innovation, improved customer service, and expanded choice for Georgia consumers as a result of robust competition among private market web-brokers and carriers. Hundreds of thousands of residents in Georgia continue to opt to go uninsured rather than shop for and enroll through the FFE.

For as much as HomeTown Health, LLC holds these premises to be critical to efficient and effective access to health care, we then believe that this proposed Georgia model is an answer to serious needs for patients in the state of Georgia.

HomeTown Health, LLC also believes that additional benefits of the Georgia Access Model

1. include:
Rather than relying on federally funded Navigators, Georgia Access relies on insurance agents as trusted voices throughout Georgia to help their communities enroll in coverage.
2. Under Georgia Access, consumers will be empowered to build a lasting relationship with their GAEP to meet their health insurance needs.
3. Georgia Access provides consumers with a more streamlined, less cumbersome enrollment process.

Through its close collaboration with your department's staff, Georgia has demonstrated its commitment to the success of Georgia Access and continues to build momentum through engagement with web brokers, carriers, and agent organizations. Furthermore, the state has made significant human and financial investments in implementing and operationalizing Georgia Access. From hiring dedicated staff to implementing necessary technical upgrades to state systems to planning for a statewide marketing and outreach campaign, the state recognizes the responsibility it has undertaken to reach and support underserved communities across Georgia.

At the core of these efforts is the state's overarching commitment to creating more accessible, affordable health coverage and reducing the number of uninsured Georgians. As the



Departments review commentary on the Georgia Access Model, I encourage you to remember the failures of the FFE in serving Georgians in the past. Our state and its citizens require a tailored, state-based approach to delivering accessible health insurance coverage. Our state needs Georgia Access.

Thank you for your consideration.

Regards,

A handwritten signature in black ink, appearing to read "James C. Lewis".

James C. Lewis, CEO
HomeTown Health, LLC

JCL/ssw

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

January 7, 2022

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Submitted by email to: StateInnovationWaivers@cms.hhs.gov

Re: Georgia Section 1332 Waiver Comments

Justice in Aging appreciates the opportunity to comment on the impact of changes in federal law and policy on the Georgia Access Model, Part II of its 1332 waiver, as approved on November 1, 2020. For the reasons discussed below, we urge the Centers for Medicare & Medicaid Services (CMS) to revoke approval of this model.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older Georgians and older adults nationwide. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources, particularly populations that have traditionally lacked legal protection such as women, people of color, LGBTQ individuals, and people with limited English proficiency. We have extensive experience with Medicare, Medicaid, the ACA Marketplaces and other programs serving low-income older Georgians. Justice in Aging conducts trainings and provides technical assistance to attorneys in Georgia and across the country on how to address problems that arise under these programs, and advocates for strong consumer protections at both the state and federal level.

[The Georgia Access Model Would Make It More Difficult for Older Georgians to Get Health Coverage](#)

Under the approved waiver, Georgia plans to create a new individual market and state subsidy program that does not guarantee subsidies to all eligible individuals nor require subsidy-eligible plans to meet ACA standards, and puts private insurers and brokers in charge of enrollment. This waiver fails to meet Section 1332's "guardrails" intended to ensure that people who live in states that implement an ACA waiver are not worse off than they would be without the waiver because it would likely increase the number of uninsured Georgians and leave many others with less-comprehensive coverage.



The federally facilitated Marketplace, premium tax credits, and cost-sharing reductions enabled over 517,000 Georgians to obtain comprehensive health insurance in 2021.¹ Nearly half of those enrollees are over age 45, and more than 1 in 4 are over age 55.² In 2020, the average premium tax credit received by over 380,000 Georgians was \$494 per month, higher than the national average.³ This adds up to an estimated \$2.2 billion in premium tax credits benefiting low- and middle-income Georgians. The waiver would weaken this assistance. Even if the state could make subsidies available to an additional 16,000 Georgians at the proposed funding level, this is well-short of helping the 1.3 million uninsured Georgians access coverage. In fact, over 500,000 uninsured individuals are already eligible for premium tax credits in 2021 but not enrolled.⁴ In addition, the state would be able to cover nearly 500,000 more Georgians by fully expanding Medicaid. Therefore, to help the most Georgians get affordable coverage, the state should fully expand Medicaid and invest in robust enrollment and outreach while maintaining the entirely federally funded marketplace subsidies.

Allowing plans that do not meet the quality and minimum coverage standards for Qualified Health Plans (QHPs) will take Georgia back to the days before the Affordable Care Act when people were dangerously underinsured and insurance companies could price people out of comprehensive coverage. The state's assumption that QHP premiums would only increase by 1.1% and that only 10% of current QHP enrollees would opt for a non-QHP plan does not take into full account the combination of factors that will drive people to choose non-QHP coverage. Namely, in addition to the increase in QHP premiums, QHPs will be marketed by biased insurance companies and brokers alongside less expensive non-QHPs that are eligible for tax credits. The state did not explain any guardrails to prevent or limit the gap in premiums between QHPs and non-QHPs. This will hurt older adults the most because they are more likely to need comprehensive coverage from QHPs given that they are more likely to have chronic health conditions than younger adults. Thus, older adults will be faced with higher and higher premiums, amounting to another "age tax" on top of the already allowable premium increases based on age.

We are also concerned about requiring Georgians to use private insurers and brokers to obtain health insurance. Private brokers and insurers can and do push enrollment in plans based on the commission they receive rather than on the consumer's best interest. Unfortunately, we have seen that this means even those who operate through HealthCare.gov do not always

¹ Kaiser Family Foundation, Marketplace Enrollment, 2014-2021, www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

² Kaiser Family Foundation, Marketplace Plan Selections by Age: 2021, <https://www.kff.org/health-reform/state-indicator/marketplace-plan-selection-by-age/>.

³ Kaiser Family Foundation, Estimated Total Premium Tax Credits Received by Marketplace Enrollees, www.kff.org/health-reform/state-indicator/average-monthly-advance-premium-tax-credit-aptc.

⁴ Kaiser Family Foundation, Distribution of Eligibility for ACA Health Coverage Among those Remaining Uninsured as of 2021, <https://www.kff.org/health-reform/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/>.

inform consumers of Medicaid eligibility, denying those low-income individuals access to the best coverage available to them and saddling them with insurance costs they would not have to pay in Medicaid.⁵

Finally, we have seen recent examples of people signing up for non-QHP coverage and being left with huge medical bills or having to forgo care because their plan does not cover it.⁶ This waiver would amplify this dangerous trend by making inadequate plans even less expensive, eliminating the platform (HealthCare.gov) that presents unbiased information about QHPs, and allowing self-interested insurers and brokers to aggressively market and sell non-QHPs.

The Waiver Conflicts with Recent Changes in Federal Policy

CMS identifies enactment of the American Rescue Plan Act of 2021 and the adoption of Executive Order 13985 and Executive Order 14009 as changes that raise serious questions as to whether the Georgia Access Model complies with federal law and policy. We agree that these policy changes provide further reason to rescind approval.

First, the model does not account for changes under the American Rescue Plan that greatly increase enrollment and affordability of ACA Marketplace insurance. Georgia's model could not match the enhanced premium tax credits for Marketplace coverage currently available, nor the longer enrollment periods now available through HealthCare.gov and continuous enrollment for those with incomes at or below 150% of FPL. Second, the analysis Georgia based its model on does not account for increases in enrollment due to the pandemic, including the end of the public health emergency when some people currently enrolled in Medicaid are likely to transition to Marketplace coverage. Third, CMS has significantly increased financial support for Marketplace outreach and enrollment in the last year. If Georgia moved forward with its model, it would not be able to leverage this support to get Georgians enrolled. We are concerned that Georgia's decision to prohibit having federally funded navigators providing unbiased enrollment assistance will particularly harm underserved communities, including older adults who are limited English proficient or have barriers to online enrollment.

Georgia did not analyze the impact of its model on equity, therefore CMS would need to require such an assessment under EO 13985. However, it is clear from the application that Georgia's waiver would violate EO 14009 by undermining the Marketplace and protections for people with pre-existing conditions, reducing affordability of coverage, and making enrollment more difficult. These flaws would indicate that the waiver does not advance equity for marginalized and historically underserved communities.

⁵ Ctr. on Budget and Policy Priorities, Direct Enrollment in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm (Mar. 15, 2019), www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes.

⁶ Commonwealth Fund, Health Plans That Don't Comply with the ACA Put Consumers at Risk (Nov. 2019), www.commonwealthfund.org/blog/2019/health-plans-that-dont-comply-with-aca-put-consumers-at-risk.

Conclusion

For these reasons, we urge CMS to rescind approval of Part II of Georgia's 1332 waiver. If any questions arise concerning this submission, please contact Natalie Kean, Senior Staff Attorney, at nkean@justiceinaging.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Amber Christ". The signature is fluid and cursive, with the first name "Amber" and last name "Christ" clearly visible.

Amber Christ
Directing Attorney



Submitted electronically via email to stateinnovationwaivers@cms.hhs.gov

January 7, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Re: Request for Comment on the Georgia Access Model

Dear Secretary Becerra and Secretary Yellen:

Thank you for the opportunity to submit comments on the impact that recent changes in federal law and policy will have on the Georgia Access Model.

The Leukemia & Lymphoma Society's (LLS) mission is to cure leukemia, lymphoma, Hodgkin's disease, and myeloma, and to improve the quality of life of patients and their families. We advance that mission by advocating that blood cancer patients have sustainable access to quality, affordable, coordinated health care, regardless of the source of their coverage. In service of this mission, we write to again express our concerns with Georgia Access Model portion of the state's 1332 waiver and ask that you revoke the approval issued by the previous administration for the reasons detailed below.

LLS evaluates all health care policy proposals through the lens of our Principles for Meaningful Coverage. These principles give us an objective and constructive means of evaluating health care policies impacting the patients we serve.¹ LLS commented in December of 2019 and September of 2020 voicing our concerns with the state's proposal to eliminate access to Healthcare.gov as likely to jeopardize access to quality health coverage for blood cancer patients. Due to the enactment of the American Rescue Plan Act, the COVID-19 Special Enrollment Period (SEP), and new federal investments in outreach and enrollment activities, the situation has changed dramatically, and the assumptions Georgia made when formulating this plan have been fundamentally altered. These changes make the Georgia Access Model even more harmful to patients, further jeopardizing quality and affordable health care

¹ The Leukemia & Lymphoma Society, *Principles for Meaningful Coverage* <https://www.lls.org/cancercost/principles>

coverage for Georgians with acute and chronic health conditions. As such, the Georgia Access Model does not comply with federal law and should be revoked.

Impact on Coverage

If allowed to proceed, the Georgia Access Model will reduce enrollment in comprehensive coverage and jeopardize quality and affordable health care coverage for patients with blood cancer. Today, Healthcare.gov is the most commonly used pathway for Georgians to access high-quality individual market health insurance coverage. If implemented, the Georgia Access Model is likely to fragment the market and it is likely that over 650,000 Georgians who currently purchase comprehensive coverage through the marketplace could lose access to coverage and consumer protections.²

Loss of coverage would have a profound impact on the health of patients in the middle of treatment that rely on regular access to health care. More than 1.5 million people in the United States live with a blood cancer today, and over 5,400 people were projected to be newly diagnosed in Georgia in 2021.³ Blood cancer patients are uniquely dependent on steady access to health insurance coverage for treatment of their cancer. In many patients, their blood cancer is treated with a strict regimen of prescription drugs, often requiring daily prescription adherence. Without uninterrupted health insurance coverage, patients risk a relapse of their cancer which would otherwise respond to treatment.

Georgia previously asserted that the Georgia Access Model would increase coverage by projecting a dismal marketplace enrollment figure and declaring that the waiver was necessary to curb enrollment decline. However, the state's projections, based on the 2018 plan year, have proven to be grossly inaccurate. Georgia's marketplace enrollment was more than 280,000 higher in December 2021 than in 2018 – a roughly 75% increase.⁴ Even Georgia's own goals—to reach enrollment of 392,000 in 2023—cannot compete with the enrollment levels seen through Healthcare.gov of over 650,000 Georgians today. As such, in no case can the Georgia Access Model satisfy the statutory requirement⁵ that a 1332 demonstration provides coverage to at least a comparable number of state residents absent the demonstration.

Allowing Georgia to eliminate Healthcare.gov would have additional effects on the number of individuals with comprehensive health insurance. Healthcare.gov can automatically re-enroll

² Centers for Medicare & Medicaid Services, *Marketplace Weekly Enrollment Snapshot: Week 6*, December 22, 2021. <https://www.cms.gov/newsroom/fact-sheets/marketplace-weekly-enrollment-snapshot-week-6>.

³ The Leukemia & Lymphoma Society. *Facts 2020-2021*. https://www.lls.org/sites/default/files/2021-08/PS80%20FactsBook_2020_2021_FINAL.pdf

⁴ Georgia's baseline 2018 enrollment in marketplace coverage was 367,562. In December 2021, enrollment in the marketplace was 653,990. Georgia's final application (dated October 9, 2020), approval letter, all agency correspondence, and request for public comments are at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-#please_visit_the_Georgia_waiver_section_of_this_webpage_below. Department of Health and Human Services, *All-Time High: 13.6 Million People Signed Up for Health Coverage on the ACA Insurance Marketplaces With a Month of Open Enrollment Left to Go*, December 22, 2021. <https://www.hhs.gov/about/news/2021/12/22/all-time-high-13-million-people-signed-up-for-health-coverage.html>.

⁵ 42 USC § 18052(b)(1)(C).

individuals who signed up for coverage last year but do not select and new plan for the following year, ensuring continuity of coverage. However, transitioning away from Healthcare.gov would prevent this functionality, likely causing continuing coverage attrition each year.

Healthcare.gov also facilitates Medicaid enrollment with a “no-wrong-door” application that directs individuals to the program for which they’re eligible. In many cases, this prevents someone from needing to complete multiple applications to connect with the correct program. In the open enrollment period for 2021, about 35,000 Georgians who started the process at HealthCare.gov were assessed as eligible for Medicaid.⁶ Because brokers and agents have no incentive to similarly ensure that individuals are connected with programs like Medicaid, the Georgia Access Model threatens to negatively impact Georgians who are eligible for Medicaid at the time of their insurance search, likely decreasing the state’s Medicaid enrollment.

In addition to eliminating Healthcare.gov, the Georgia Access Model would remove Georgian’s ability to get trusted, unbiased help shopping for coverage through health insurance navigators. Especially for patients with chronic and serious illnesses like blood cancer, shopping for and enrolling in insurance can be both complicated and frustrating. Making sure that coverage includes the right specialists, prescriptions, and services is an overwhelming process. Georgia would completely opt out of the \$2.5 million⁷ it receives today from the federal government to provide impartial help, meaning that vulnerable uninsured individuals will be less likely to find coverage. Navigators integrate themselves into communities and are more likely to focus on underserved and vulnerable populations than private brokers and insurance agents. If Georgia is allowed to implement these changes, it will deepen the existing inequities in access to health coverage the state already faces.

Impact on Comprehensiveness

Today, patients who shop on Healthcare.gov can trust that they are purchasing a health insurance plan that meets the threshold of comprehensiveness set by the ACA. However, under the Georgia Access Model, consumers would lose access to a central location showing only qualified health plans and will only be able to purchase from agents and brokers that sell qualified health plans alongside other types of plans that discriminate against people with pre-existing conditions and will not cover enrollees’ medical expenses if they get sick. This is almost certain to create confusion for patients by obscuring eligibility for premium tax credits and Medicaid, as well as relying solely on insurers and brokers with financial incentives to sell plans that may not cover essential care.

⁶ Centers for Medicare & Medicaid Services, *2021 Marketplace Open Enrollment Period Public Use Files*, April 21, 2021. <https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files>.

⁷ Karen Pollitz, Jennifer Tolbert, and Kendal Orgera, *Navigator Funding Restored in Federal Marketplace States for 2022*, Kaiser Family Foundation, September 29, 2021. <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>.

Since the Georgia Access Model was approved, there has been mounting evidence of misleading marketing related to short-term and other skimpy plans leading individuals to unwittingly enroll in coverage that lacks key patient protections and services.⁸ A secret shopper study conducted by Georgetown's Center on Health Insurance Reforms during the recent COVID-19 special enrollment period documented misleading and deceptive marketing practices that lure patients into enrolling in sub-standard non-ACA-compliant plans.⁹ This study found that just 5 of 20 sales representatives recommended a marketplace plan despite the fact that their client would have qualified for a \$0 premium plan, instead steering patients towards short-term plans, healthcare sharing ministries, and other products that do not offer comprehensive coverage.

The Georgia Access Model is sure to exacerbate these trends if implemented. Healthcare.gov shows consumers all qualified health plans available in their area and cannot favor certain plans over others. In contrast, brokers helping individuals find coverage under Georgia's plan would not have to show individuals all their options and may receive larger commissions for certain plans over others. Increasing reliance on insurers and private brokers will limit the ability of patients with chronic and acute health conditions to find comprehensive coverage in an unbiased manner, exposing them to being inadvertently enrolled in a substandard plan that does not meet their needs. This failure to shield patients with pre-existing conditions from risk is unacceptable. In consideration of the facts above, LLS believes that these new trends have made the Georgia Access Model unable to comply with the statutory requirement that section 1332 demonstrations provide coverage that is at least as comprehensive under the Affordable Care Act (ACA).¹⁰

Impact on Affordability

Georgia previously claimed that the Georgia Access Model would reduce premiums by significantly increasing enrollment above projected levels. As discussed above, this is demonstrably false and could not have accounted for changes such as the American Rescue Plan Act, the recent COVID-19 SEP, and increased federal funding for enrollment outreach and support. If any enrollment will increase under the Georgia Access Model, it will likely be an increase in non-ACA-compliant coverage, weakening the individual risk pool. For example, a study commissioned by The Leukemia & Lymphoma Society found that 2020 premiums for ACA plans increased as much as 4.3% in states that chose not to regulate STLD plans and forecasted that marketplace enrollment would also drop. In contrast, states that have taken regulatory action to restrict or prohibit the sale of these substandard insurance options saw premiums drop by as much as 1.2%.¹¹ This means that comprehensive coverage for

⁸ *Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed*. March 2021.

https://www.lls.org/sites/default/files/National/undercovered_report.pdf.

⁹ Palanker, D. and Volk, J., *Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period*. Georgetown Center on Health Insurance Reforms, October 2021. <http://chirblog.org/misleading-marketing-non-aca-health-plans-continued-covid-19-special-enrollment-period/>

¹⁰ 42 USC § 18052(b)(1)(A).

¹¹ Hansen, D., & Dieguez, G., *The impact of short-term limited-duration policy expansion on patients and the ACA individual market: An analysis of the STLD policy expansion and other regulatory actions on patient spending, premiums, and enrollment in*

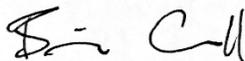
individuals will be even further out of reach financially under the Georgia Access Model than before.

For 2021 and 2022, the American Rescue Plan boosted the premium tax credit to reduce marketplace premiums across the board and extended eligibility to people with incomes above 400 percent of the poverty line. While the enhancements are currently set to end in 2022, the Congressional Budget Office predicts an enrollment “tail” as more people stay enrolled in 2023, the year the Georgia Access Model would begin.¹² Even if subsidies return to pre-Rescue Plan levels in 2023, as many as 80 percent of Georgia’s enrollees could still be eligible for zero- or low-cost plans.¹³ The elimination of healthcare.gov and help from navigators would cause individuals to leave the full value of these subsidies unused if steered towards non-ACA-compliant plans. Given the changes that have occurred since the approval of the Georgia Access Model, LLS believes that the Georgia Access Model does not satisfy the statutory requirement that a 1332 demonstration provide coverage that is at least as affordable absent a waiver.¹⁴ In fact, premiums in the individual market are likely to be higher than they would be in the absence of the waiver.

Conclusion

We thank you again for the opportunity to submit comments on the impact that recent changes in federal law and policy will have on the Georgia Access Model. For the reasons described above, LLS strongly opposes the Georgia Access Model and urges the Departments to revoke the previously granted approval. While LLS did not believe that the proposal met statutory requirements at the time of its approval, changes since then have exacerbated our concerns and made the Georgia Access Model worse for patients and even further out of compliance with statutory requirements. If you have any questions regarding LLS’ comments, please contact Phil Waters, Director of Federal Public Policy at Phil.Waters@lls.org.

Sincerely,



Brian Connell
Executive Director of Federal Affairs

the ACA individual market, Milliman Actuarial, February 2020. <https://www.lls.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>

¹²Congressional Budget Office, *Reconciliation Recommendations of the House Committee on Ways and Means*, February 15, 2021. <https://www.cbo.gov/publication/57005>.

¹³ D. Keith Branham *et al.*, *Access to Marketplace Plans with Low Premiums of the Federal Platform, Part I: Availability Among Uninsured Non-Elderly Adults and HealthCare.gov Enrollees Prior to the American Rescue Plan*, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, March 29, 2021. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/199686/low-premium-plans-issue-brief.pdf.

¹⁴ 42 USC § 18502(b)(1)(B).



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**BEATING
CANCER
IS IN
OUR BLOOD.**



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VIA ELECTRONIC SUBMISSION

January 7, 2022

Re: Georgia section 1332 waiver

Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Becerra:

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the Georgia section 1332 waiver. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

On November 1, 2020, the Trump Administration approved a section 1332 waiver allowing Georgia to exit HealthCare.gov starting in 2023. Today, we urge the Biden Administration to reverse this unwise decision before the waiver goes into effect.

In 2020, most (79%) of Georgia's individual marketplace enrollees used HealthCare.gov to sign up for coverage. Georgia's planned waiver will eliminate this one-stop shop, robbing consumers of their only option for a guaranteed, central source of unbiased information about the comprehensive coverage available to them. Instead, Georgians would be forced to rely on a jumble of private insurance companies and brokers to compare plans, apply for financial assistance, and enroll in coverage.

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Georgia asserts that this will increase enrollment and improve customer service but does not identify how.¹ Based on our experience, it is far more likely that the change will instead heighten confusion about where and how to access good-quality health coverage, thus hindering enrollment. Rather than increasing coverage rates, such a shift will likely result in many Georgians losing coverage entirely or being enrolled into non-ACA-compliant plans that will underinsure them, putting them at extreme financial risk if they become sick or injured.² Contrary to the promise of expanded choices, this waiver reduces options. Currently, Georgians have the option of using HealthCare.gov or private brokers and they overwhelmingly prefer HealthCare.gov. In 2023, they will be losing their preferred choice, not gaining a new one.

Moreover, private brokers and insurers have a track record of failing to alert consumers of Medicaid eligibility and picking and choosing the plans they offer, often based on the size of plan commissions.³ Indeed, in the new Georgia system, people who are eligible for Medicaid will have a much harder time finding help with enrollment because Medicaid generally does not pay broker or plan commissions. Agents and brokers will have no financial incentive to fill these gaps.

Statutory guardrails require 1332 waivers to cover as many people, with coverage as affordable and comprehensive, as without the waiver.⁴ Georgia has not provided a plausible explanation of how its waiver will accomplish this. Instead, coverage is likely to decline and to be less comprehensive, less available, and more expensive. The waiver therefore does not meet the federal standard for approval.

In its application, Georgia claimed the waiver was necessary to stem enrollment losses. Current statistics clearly demonstrate the flaws in Georgia's ACA enrollment assumptions. The state's post-waiver projected enrollment—392,000 in 2023—is lower than the 549,000 actually enrolled as of August 2021. These data reveal missing pieces in Georgia's analysis. At a minimum, the state must revise its analysis to account for significant changes that have increased enrollment, including statutory boosts in tax

¹ State of Georgia, "Modified Section 1332 State Relief and Empowerment Waiver," p 17 (July 31, 2020), <https://medicaid.georgia.gov/patientsfirst> ("The goal of the Georgia Access Model is to increase affordability and spur innovation in the individual market while maintaining access to QHPs and ensuring consumer protections for individuals with pre-existing conditions. The Georgia Access Model will create a competitive private insurance marketplace that provides Georgia's residents with better access, improved customer service, and expanded choice of affordable coverage options.")

² Tara Straw, "Tens of Thousands Could Lose Coverage Under Georgia's 1332 Proposal," Center on Budget and Policy Priorities (September 1, 2020), <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>.

³ Tara Straw, "'Direct Enrollment' in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm," Center on Budget and Policy Priorities (March 15, 2019), <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

⁴ Patient Protection and Affordable Care Act, Pub. L. 111-148, Sec. 1332(b) ("(1) IN GENERAL—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived; (B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide; (C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and (D) will not increase the Federal deficit.")

credits, extended open enrollment periods, wider availability of special enrollment periods, and federal investments in marketing and navigators.

In addition, agencies must review the waiver for conflicts with Executive Orders on equity and health coverage. These Executive Orders require federal agencies to review new and existing policies to assess whether they advance equity for marginalized and historically underserved communities⁵ and whether they undermine protections for people with pre-existing conditions, create barriers to coverage, reduce coverage, or reduce the affordability of coverage.⁶

As the current COVID-19 public health emergency reveals, the need for health care can arise at any moment and may be the difference between life and death. People without health coverage may avoid care or face extreme financial hardship when they obtain it. The interdependence of the major health insurance systems in the United States as well as public health makes an individual's access to coverage a national concern. For example, the Medicare program benefits when incoming beneficiaries have insurance coverage. As individuals approach Medicare eligibility, their health is often compromised, and this is especially true for those who have unmet health care needs from being un- or underinsured. This absence of quality coverage can lead to reduced well-being for entire families;⁷ poorer health;⁸ lack of access to care;⁹ economic devastation;¹⁰ and higher Medicare costs when they are ultimately eligible.¹¹

In addition to our concerns about the impact of the waiver on Georgians, on public health, and on Medicare finances, and our position that the waiver is not legally sound, we are deeply concerned about the precedent that would be set by approving a waiver that is expected to result in more people being uninsured and more people being enrolled in plans that do not provide comprehensive coverage. The ACA must not be undercut by rules or waivers that limit its effectiveness.

For these reasons, Medicare Rights urges the Biden Administration to revoke approval of Georgia's waiver and stop these harmful changes before they start. The state should be encouraged instead to

⁵ Executive Order 13985 calls on federal agencies to review new and existing policies to assess whether they advance equity for marginalized and historically underserved communities.

⁶ Executive Order 14009, on strengthening Medicaid and the Affordable Care Act, calls for an immediate review of all federal agency actions, with the goal of making coverage accessible and affordable to everyone. This includes policies that undermine protections for people with pre-existing conditions; waivers that may reduce coverage under Medicaid or the ACA; policies that undermine the marketplace; policies that create unnecessary barriers to families attempting to access ACA coverage; and policies that may reduce the affordability of coverage.

⁷ Committee on the Consequences of Uninsurance, Board on Health Care Services, "Health Insurance is a Family Matter," INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, Chapter 5 (2002), https://www.ncbi.nlm.nih.gov/books/NBK221016/pdf/Bookshelf_NBK221016.pdf.

⁸ David W Baker, et al., "Changes in Health for the Uninsured After Reaching Age-eligibility for Medicare," J GEN INTERN MED. 2006 Nov; 21(11): 1144–1149 (2006), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831646/>.

⁹ Committee on the Consequences of Uninsurance, Board on Health Care Services, "Health Insurance is a Family Matter," INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, pp 91-106 (2002), https://www.ncbi.nlm.nih.gov/books/NBK221016/pdf/Bookshelf_NBK221016.pdf.

¹⁰ Rohan Khera, et al., "Burden of Catastrophic Health Expenditures for Acute Myocardial Infarction and Stroke Among Uninsured in the United States," CIRCULATION, 2018;137:00–00 (2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5780190/>.

¹¹ David W Baker, et al., "Changes in Health for the Uninsured After Reaching Age-eligibility for Medicare," J Gen Intern Med. 2006 Nov; 21(11): 1144–1149 (2006), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831646/>.

maintain HealthCare.gov access and to adopt the ACA's Medicaid expansion, a proven strategy to improve health care coverage and well-being that has the added benefit of support for rural hospitals.¹²

Thank you again for this opportunity to provide comment. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,



Fred Riccardi
President
Medicare Rights Center

¹² Hailey Mensik, "Medicaid expansion key indicator for rural hospitals' financial viability" (June 2, 2020), <https://www.healthcarediver.com/news/medicaid-expansion-rural-hospitals-health-affairs/579005/>.

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January 7, 2022

Submitted by email to: stateinnovationwaivers@cms.hhs.gov

Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services

Honorable Janet Yellen, Secretary
Department of Treasury

Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services

RE: Georgia Section 1332 Waiver
Comments

Dear Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure:

The William E. Morris Institute for Justice (“Institute”) is a non-profit organization dedicated to protecting the most basic civil and human rights of low-income Arizonans. The Institute’s work focuses its advocacy on systemic issues in several areas involving public benefit programs, including Medicaid. Proposed changes to Medicaid programs through the waiver process across the country are of great interest to the Institute because Arizona’s whole Medicaid program, the Arizona Health Care Cost Containment System (“AHCCCS”), operates under a waiver.

We appreciate the opportunity to comment on the Georgia Affordable Care Act (“ACA”) Section 1332 Demonstration Waiver. We write to express deep concern about the Georgia waiver and to urge you to rescind its initial approval.

Under the waiver, Georgia would exit the centralized federal health insurance marketplace, HealthCare.gov. Instead, people would enroll directly with insurers or through online enrollment vendors, agents, or brokers, similar to the insurance market prior to the ACA. This would eliminate the central source of help for Georgians who enroll in private health plans or Medicaid through HealthCare.gov.

The Institute submitted comments in opposition to Georgia’s waiver proposal in September 2020. On November 1, 2020, the Trump Administration approved the waiver for what the state calls the Georgia Access Model, slated for implementation in Plan Year 2023 of the waiver period from January 1, 2022, through December 31, 2026.¹ States’ 1332 waiver proposals must satisfy federal statutory requirements, or “guardrails.”² Notably, section 1332(b)(1)(A)-(C) of the ACA (42 U.S.C. § 18052(b)(1)(A)-(C)) requires that ACA waivers cover as many people, with coverage as affordable and comprehensive, as without the waiver. However, under the Georgia Access Model, more people would be left without coverage. The coverage accessible to Georgians would be less comprehensive, and more people would find themselves with less affordable coverage and more out-of-pocket costs than would be the case without the waiver. In short, the Georgia Access Model violates the core requirements of applicable federal law, not to mention the overarching goal of ensuring health care access to people without the means to afford it.

The Institute once again submits comments opposing the waiver and asks that the new administration revoke approval of Georgia’s 1332 waiver to exit the federal medical insurance marketplace.

Our comments are detailed below.

I. The Waiver Would Reduce the Number of Georgians Enrolled in Health Insurance

Under the waiver, fewer Georgians would have health coverage. In its application, Georgia painted a bleak view of the future of the marketplace and claimed that the waiver was necessary to stem enrollment losses. But the state’s baseline projections, based on the 2018 plan year, have proven to be wildly inaccurate. In reality, Georgia’s marketplace enrollment is more than 180,000 higher in August 2021 than it was in 2018 — a roughly 50 percent increase over the last three years. In its application, however, the state projected its waiver plan would increase marketplace enrollment from

¹ U.S. Dept. of Health and Human Services, Georgia 1332 Waiver Approval Letter, Nov. 1, 2020, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Approval-Letter-STCs.pdf. A second portion of the waiver establishing a reinsurance program was also approved but is not open for public comment and is proceeding in 2022.

² ACA § 1332(b)(1)(A)-(D), 42 U.S.C. § 18052(b)(1)(A)-(D).

about 366,000 in 2018 to 392,000 in 2023.³ Even if Georgia's waiver could generate those coverage gains over 2018, it would fall well short of the over 549,000 people actually enrolled as of August 2021.

Georgia's analysis also does not account for significant changes in the law that increase enrollment. For 2021 and 2022, the American Rescue Plan boosted the premium tax credit to reduce marketplace premiums across the board and extended eligibility to people with incomes above 400 percent of the poverty line.⁴ While the enhancements are currently set to end in 2022, the Congressional Budget Office (CBO) predicts an enrollment "tail" as more people stay enrolled in 2023, the year the Georgia Access Model would begin.⁵ Even if subsidies return to pre-Rescue Plan levels in 2023, as many as 80 percent of Georgia's enrollees could still be eligible for zero- or low-cost plans, likely boosting enrollment beyond Georgia's expectations.⁶ The Families First Coronavirus Response Act included a provision under which states, to get a higher

³ In 2018, Georgia's baseline enrollment (its starting point for enrollment over the course of the waiver) in marketplace coverage was 367,562. In August 2021, enrollment in the marketplace was 549,066. Georgia's final application (dated October 9, 2020), approval letter, all agency correspondence, and request for public comments are at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-#please_visit_the_Georgia_waiver_section_of_this_webpage_below. Department of Health and Human Services, *Biden-Harris Administration Announces Record-Breaking 12.2 Million People Are Enrolled in Coverage Through the Health Care Marketplaces*, press release, Sept. 15, 2021, <https://www.hhs.gov/about/news/2021/09/15/biden-harris-administration-announces-2-8-million-people-gained-affordable-health-coverage-during-2021-special-enrollment.html>.

⁴ U.S. Dept. of Health and Human Services, *2021 Final Marketplace Special Enrollment Period Report*, Oct. 20, 2021, <https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf>.

⁵ CBO, *Reconciliation Recommendations of the House Committee on Ways and Means*, Feb. 15, 2021, <https://www.cbo.gov/publication/57005>.

⁶ D. Keith Branham *et al.*, *Access to Marketplace Plans with Low Premiums of the Federal Platform, Part I: Availability Among Uninsured Non-Elderly Adults and HealthCare.gov Enrollees Prior to the American Rescue Plan*, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Mar. 29, 2021, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//199686/low-premium-plans-issue-brief.pdf.

federal matching percentage for Medicaid costs, must keep Medicaid-eligible people enrolled for the duration of the COVID-19 public health emergency.⁷ As public health emergency winds down, some people with income too high for Medicaid may qualify for a premium tax credit in the marketplace and, if the system works well, enroll in marketplace coverage. Georgia's analysis does not account for this.

In addition, Georgia would opt out of important federal investments that raise enrollment. The federal government devotes resources to market plans through HealthCare.gov to promote enrollment. The Biden Administration made a historic \$100 million investment in nationwide marketing to increase public awareness of affordable health coverage in the marketplace during the Special Enrollment Period during the COVID-19 pandemic.⁸ Marketing is a powerful tool to drive enrollment.⁹ In 2016, the Centers for Medicare & Medicaid Services ("CMS") determined that 1.8 million of the marketplace's 9.6 million enrollees enrolled due to advertising, and by 2017, an estimated 37 percent of enrollments were attributed to advertising.¹⁰

Not using HealthCare.gov means Georgia would no longer benefit from the federal investments made to increase public awareness; forgoing government-funded advertising means Georgia can expect lower enrollment under its waiver. Further, in

⁷ See 42 U.S.C. § 1396d note (Temporary Increase of Medicaid FMAP) (Families First Coronavirus Response Act ("FFCRA"), Pub. L. No. 116-127, § 6008).

⁸ U.S. Dept. of Health and Human Services, *HHS Secretary Becerra Announces Reduced Costs and Expanded Access Available for Marketplace Health Coverage Under the American Rescue Plan*, press release, April 1, 2021, <https://www.hhs.gov/about/news/2021/04/01/hhs-secretary-becerra-announces-reduced-costs-and-expanded-access-available-marketplace-health-coverage-under-american-rescue-plan.html>.

⁹ Tara Straw, *Marketplaces Poised for Further Gains as Open Enrollment Begins*, CBPP, Oct. 29, 2021, <https://www.cbpp.org/research/health/marketplaces-poised-for-further-gains-as-open-enrollment-begins>.

¹⁰ This included a combination of television, radio, direct response (text messaging, email, and autodial), internet search buys, and paid digital ads, and reflected the results of a partial open enrollment period. Centers for Medicare & Medicaid Services, *Preliminary OE4 Lessons Learned*, <https://downloads.cms.gov/files/359411146-preliminary-oe4-lessons-learned.pdf>

2021, HealthCare.gov navigators received a \$70 million funding increase.¹¹ Assistors are more likely than agents and brokers to report that their clients were previously uninsured, help with Medicaid or CHIP enrollment, perform public education and outreach activities, or to help Latino clients, people who have limited English proficiency, or people who lack internet at home.¹² Georgia would opt out of this federal investment and would not establish any form of impartial, unbiased help, which means that vulnerable, uninsured people would be less likely to find coverage. In essence, Georgia is electing to ignore known inequities in health care access and to implement a foundationally less inclusive system.

Because the waiver would decrease health insurance enrollment in Georgia and exacerbate inequity in health care access, its approval should be rescinded.

II. Privatization of Georgia's Health Insurance Market Would Cause Greater Enrollment in Substandard Plans.

All ACA marketplace plans meet a consistent set of standards: they cover a core set of benefits, cannot set premiums based on health status or gender, and are displayed in an impartial way to simplify consumer decision-making.

The Georgia Access Model would increase enrollment in substandard plans, such as short-term plans, to be presented alongside comprehensive insurance. Even now, brokers sometimes steer people into such plans, which often come with higher commissions, a tactic that has continued during the pandemic.¹³ People enrolled in substandard plans are subject to punitive exclusions of their pre-existing conditions, benefit limitations, and caps on plan reimbursements that expose them to potentially high

¹¹ Karen Pollitz, Jennifer Tolbert, and Kendal Orgera, *Navigator Funding Restored in Federal Marketplace States for 2022*, Kaiser Family Foundation, Sept. 29, 2021, <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>.

¹² Rebecca Myerson and Honglin Li, *Information Gaps and Health Insurance Enrollment: Evidence from the Affordable Care Act Navigator Programs*, posted at SSRN, Nov. 11, 2021, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3966511.

¹³ Christen Linke Young and Kathleen Hannick, *Misleading Marketing of Short-Term Health Plans Amid COVID-19*, Brookings Institution, Mar. 24, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

out-of-pocket costs. A study of short-term plans in Atlanta in 2020 showed that even though people would pay lower premiums up-front, they could be responsible for out-of-pocket costs several times higher for common or serious conditions, such as diabetes or a heart attack. The most popular plan in Atlanta refused to cover prescription drugs, mental health services, or maternity services, had pre-existing condition exclusions, and had a deductible three times as high as an ACA-compliant plan.¹⁴

Short-term health insurance plans have been promoted in Arizona in recent years, even though legislators have stressed concern these plans take advantage of consumers with their low costs and inadequate coverage.¹⁵

The Georgia Access Model would result in people getting less comprehensive coverage that is more expensive and with more out-of-pocket costs. Because the Georgia Access Model decreases the affordability and comprehensiveness of health care access available to Georgians, we ask that the Secretary rescind the waiver's approval.

III. Georgia's Waiver Conflicts with Recent Executive Orders on Equity and Health Coverage

Executive Order 13985 calls on federal agencies to review new and existing policies to assess whether they advance equity for marginalized and historically underserved communities.¹⁶ Georgia did not analyze the waiver's impact on equity, which should raise the Departments' level of scrutiny.

¹⁴ Dane Hansen and Gabriela Dieguez, *The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market*, Milliman, Feb. 2020, <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>; Kelsey Waddill, *Do Short-Term Limited Duration Plans Deserve Industry Skepticism?* HealthPayerIntelligence, Mar. 4, 2020, <https://healthpayerintelligence.com/news/do-short-term-limited-duration-plans-deserve-industry-skepticism/>.

¹⁵ Stephanie Innes, *New Arizona Law Will Expand So-Called "Junk" Health Insurance Plans*, The Republic, Mar. 12, 2019, <https://www.azcentral.com/story/news/politics/legislature/2019/03/12/new-arizona-law-expand-so-called-junk-health-insurance-plans-gov-doug-ducey/3131533002/>.

¹⁶ Executive Order 13095, *Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, Jan. 20, 2021, <https://www.whitehouse.gov/briefing-room/presidential->

Executive Order 14009, on strengthening Medicaid and the Affordable Care Act, calls for an immediate review of all federal agency actions, with the goal of making coverage accessible and affordable to everyone. This includes policies that undermine protections for people with pre-existing conditions; waivers that may reduce coverage under Medicaid or the ACA; policies that undermine the marketplace; policies that create unnecessary barriers to families attempting to access ACA coverage; and policies that may reduce the affordability of coverage.¹⁷ Georgia's waiver conflicts with each of these goals and its approval should be rescinded.

IV. Conclusion

We believe that health care is a fundamental human right, not a privilege. Quality affordable health care should not be elusive to people based on their means and life circumstances. We abhor models of health coverage administration that sustain broken systems, retreat from goals of accessibility and inclusion, and fail to deliver affordable, comprehensive, and equitable health care system access to people.

The Institute is deeply concerned that the waiver advanced by the State of Georgia would leave tens of thousands of people uninsured during the most devastating health crisis in modern history. Because this waiver would likely decrease the number of persons covered and would increase use of substandard plans for those with coverage it does not meet the statutory requirements under the ACA and approval must be rescinded. The waiver also conflicts with recent Executive Orders on Equity and Health Coverage.

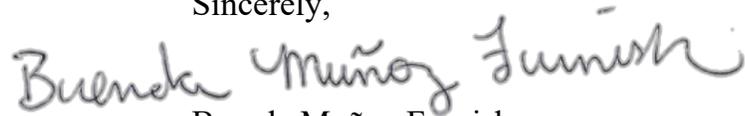
Thank you for your consideration of our comments. Please let us know if you have any questions or if we can provide any additional information.

actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.

¹⁷ Executive Order 14009, *Strengthening Medicaid and the Affordable Care Act*, Jan. 28, 2021, <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/>.

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January 7, 2022
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Sincerely,


Brenda Muñoz Furnish



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EME AUGUSTINI
National Association
of Dental Plans

January 7, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Center for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Request for Comment on Georgia Section 1332 Waiver

Dear Administrator Brooks-LaSure,

The National Association of Dental Plans (NADP) appreciates the opportunity to comment on the Georgia Access Model (GAM) portion of the Georgia Section 1332 waiver originally approved on November 1, 2020. If implemented, the GAM would eliminate the use of the Federal Facilitated Exchange (FFE) in the state and shift responsibility for marketing, enrollment, and education to brokers and plans through direct enrollment. As we stated in our letter on September 14, 2020¹ NADP is deeply concerned that the GAM would reduce the availability of dental benefits for individuals who are currently enrolled in coverage through the FFE in Georgia and for those who could potentially seek coverage. The elimination of the FFE creates an uncertain environment for medical and dental plan enrollment that is not adequately addressed in the Georgia waiver application.

- **Recommendation:** The Centers for Medicare and Medicaid (CMS) must reject the Georgia Access Model portion of the Section 1332 waiver which, as proposed, would reduce access to and enrollment in Exchange qualified health and dental plans in Georgia. Furthermore, increased medical and dental enrollment on the FFE since the waiver was developed highlights the functionality of the existing exchange platform.

Loss of Coverage

Section 1332 of the ACA establishes guardrails for the approval of state waivers which include a requirement that the waiver “provide coverage to at least a comparable

¹ Center for Medicare & Medicaid Services (CMS). 2020. Public comments from organizations on July 2020 waiver during Federal Comment Period from August 17 through September 23, 2020. Page 1953. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Federal-Comments-Organization-Letters.pdf>

National Association of Dental Plans

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number of its residents as the provisions of [the ACA] would provide.”² Maintenance of coverage is critical to the mission and effect of the waiver. **Any waiver that could be reasonably expected to reduce enrollment cannot be approved.** Analysis of the GAM shows that Georgia’s projected coverage would not match the existing growth of the state’s FFE, which has beaten Georgia’s original growth projections for the waiver.³

Since the GAM was originally submitted to CMS, Georgia’s FFE enrollment has outperformed the state’s projections multiple years in a row and enrollment has consistently increased. This is in part a result of changes in federal policy to increase tax credits for QHPs, as well as increased funding for navigators and marketing.⁴ Before the end of open enrollment for PY2022, the over 650,000 Georgians selected a marketplace plan, up from 517,000 in PY2021 and 463,000 in PY2020.⁵

NADP is concerned that the GAM would put these enrollment gains at risk in several ways. First, consumer confusion directly resulting from the loss of the exchange and its marketplace comparison features. While marketing efforts from brokers and plans will no doubt increase to try and bridge the knowledge gap, the lack of federal and/or state outreach could lead to substantial uncertainty for consumers about their coverage options, particularly for enrollees who are less responsive to enrollment campaigns or are not communicated with in their native language. Second, automatic re-enrollment has consistently proven critical to maintaining coverage year-over-year for Exchange enrollees.⁶ Congress reaffirmed its commitment to the value of automatic re-enrollment in the 2019 budget language, noting that CMS may not suspend the practice on the FFE.⁷ The resulting loss of coverage would directly effect dental plans, which are also eligible for auto-reenrollment on the FFE.

While the re-insurance portion of the waiver may lower premiums for some plans, the threat of adverse selection and loss of coverage without the FFE or an adequate state-based replacement is substantial. Previous rollouts of state-based Exchanges have identified continuity of auto re-enrollment as critical for preserving coverage⁸, and without a smooth transition there can be declines in coverage. Georgia has not provided an adequate safety net for enrollees to ensure their coverage is maintained, and has placed a substantial administrative, marketing, and financial burden on plans and brokers.

² Patient Protection and Affordable Care Act, 42 U.S.C § 18052. (2010).

³ Levitis, J. and Straw, T. 2021. Georgia’s Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked. CBPP. <https://www.cbpp.org/sites/default/files/12-17-21health.pdf>

⁴ Linke Young, C. and Levitis, J., 2020. *Georgia’s Latest 1332 Proposal Continues To Violate The ACA*. Brookings. <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>

⁵ Center for Medicare and Medicaid Services. 2022. Marketplace Open Enrollment Period Public Use Files. <https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files>

⁶ Drake C, Anderson DM. Association Between Having an Automatic Reenrollment Option and Reenrollment in the Health Insurance Marketplaces. *JAMA Intern Med.* 2019;179(12). p.1725–1726.

⁷ Explanatory Statement Submitted by Mrs. Lowey, Chairwoman of The House Committee On Appropriations Regarding H.R.1865. 2019. <https://www.appropriations.senate.gov/imo/media/doc/HR%201865%20-%20SOM%20FY20.pdf>

⁸ Livingston, S. 2019. *Fewer People Maintain Obamacare Coverage Without Auto-Enrollment*. Modern Healthcare. <https://www.modernhealthcare.com/insurance/fewer-people-maintain-obamacare-coverage-without-auto-enrollment>.

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When combined with the past three years of enrollment gains, these factors indicate that the GAM would not meet the standards for maintenance of coverage required by the ACA. NADP believes that Georgia has not thoroughly addressed these concerns in its responses to CMS' inquiries and would suggest the state provide clarity on how the GAM would improve upon the existing FFE framework given the enrollment increases since its original projections.

Dental Effects

On the FFE, an enrollee cannot purchase a stand-alone dental plan (SADP) without first purchasing a medical plan. Therefore, a potential decline in medical coverage described in the previous section could have similar effects on dental coverage.

NADP member plans actively participate in the private individual market for dental coverage, but the centralized FFE for individuals is critical as it provides coverage for those who qualify for subsidized medical plans and for those seeking a central marketplace to purchase coverage. Likewise, the FFE functions as a hub for directing individuals or families who are eligible for Medicaid and CHIP to those respective programs. Instead of fostering an increase in available options for enrollees, the GAM removes a critical piece of the coverage puzzle.

While brokers may offer a variety of dental benefits options, there is no guarantee that their selection will reflect the diverse coverage of SADPs on the Exchange. Furthermore, a broker may not offer SADPs if their medical plans meet the pediatric dental essential health benefit requirement. This would result in a significant reduction in dental benefit choice for those accustomed to purchasing dental coverage on the Georgia FFE, which has had multiple SADP options available every year since its inception. In Plan Year 2021, 11 carriers offered 40 unique SADPs on the Georgia FFE covering over 65,000 Georgians.⁹

Dental coverage is critical to ensuring oral health. Without dental treatment individuals with chronic conditions like diabetes and heart disease may be at increased risk of hospitalization for oral health issues.¹⁰ Dental benefits increase utilization of preventive and extensive dental care and prevent costly emergency room visits that strain hospitals, which is of particular importance during the COVID-19 pandemic. The GAM is unique among 1332 waiver applications in that it does not have a clear place for SADPs to continue to offer benefits to the widest possible set of potential enrollees. This could reduce overall dental benefits penetration and jeopardize public health.

Alternative Approaches

⁹ Center for Medicare and Medicaid Services. 2022. Marketplace Open Enrollment Period Public Use Files. <https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files>

¹⁰ Singhal et al. "Eliminating Medicaid Adult Dental Coverage In California Led To Increased Dental Emergency Visits And Associated Costs." Health Affairs. Project HOPE—The People-to-People Health Foundation, Inc., May 1, 2015. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1358>.



While the GAM does not meet the guardrails and requirements for a 1332 waiver, NADP recommends that Georgia consider other policy options in its pursuit of increased dental coverage:

1. **Independent Purchase of SADPs:** Currently, the FFE does not allow dental plans to be purchased independently of medical plans, blocking access to an avenue of dental coverage for Georgians who already have medical coverage from their employer, Medicare, or other programs. If dental plans were available for purchase independent of medical, the Exchange would provide a central, trusted marketplace for individuals to purchase dental coverage regardless of the source of their medical coverage. In creating their own Exchanges, states including Nevada, Pennsylvania, Idaho, and the District of Columbia have all opted to allow the independent purchase of dental. NADP would be happy to discuss this proposal in further detail with either CCIIO or Georgia.
2. **Medicaid Expansion:** Full expansion of the Medicaid program would give over 219,000 Georgians¹¹ health coverage and reduce spending on emergency room visits. Medicaid in Georgia provides an emergency dental benefit to its enrollees, meaning patients may be diverted away from hospitals for oral health treatment. Further expansion of the benefit would help improve the oral health of low-income Georgians.

Given these concerns and considerations, NADP strongly encourages CMS to reconsider the approval of the Georgia waiver. If you have any questions, please feel free to contact our Director of Government Relations, Owen Urech at 972-458-6998 x108 or ourech@nadp.org.

Sincerely,



Eme Augustini
Executive Director

NADP Description:

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental Indemnity and discount dental products to 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

¹¹ Garfield, R., Orgera, K. and Damico, A., 2020. *The Coverage Gap: Uninsured Poor Adults In States That Do Not Expand Medicaid*. KFF. <http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid>





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Seattle, Washington

January 7, 2022

U.S. Department of Health and Human Services (HHS)
U.S. Department of the Treasury
Sent via electronic mail: stateinnovationwaivers@cms.hhs.gov

Re: Georgia section 1332 waiver comments

To whom it may concern,

I write to you today on behalf of the National Council on Independent Living (NCIL). NCIL is the longest-running national cross-disability, grassroots organization run by and for people with disabilities. Founded in 1982, NCIL represents thousands of individuals with disabilities and organizations including Centers for Independent Living (CILs), Statewide Independent Living Councils (SILCs), and other organizations that advocate for the human and civil rights of people with disabilities throughout the United States.

Thank you for the opportunity to provide comments on Part II of Georgia's Section 1332 State Innovation Waiver, the "Georgia Access Model." We were deeply concerned when the Trump Administration approved Georgia's original waiver allowing them to exit HealthCare.gov, which always violated the 1332 guardrails. We are grateful to the current Administration for requiring an updated analysis from the State for compliance with updated federal law and policies and for requesting public comment. We strongly urge the Biden Administration to listen to the concerns expressed by the disability community and countless others, and to revoke approval of Georgia's waiver.

Having a single, centralized, unbiased place to enroll in health coverage is one critical component to ensuring equitable access to healthcare. The "Georgia Access Model" – which would eliminate Georgians' access to HealthCare.gov and require people shop for coverage among scattered web brokers and insurers – would make health coverage significantly less accessible for half a million people across the state. This change would make enrollment more fragmented, confusing, and would result in the following:

(202) 207-0334 (Voice)
(202) 207-0341 (Fax)
(844) 778-7961 (Toll-Free)

2013 H Street NW; 6th Floor
Washington, DC 20006
Email: ncil@ncil.org

- Lower enrollment:*

Georgia’s application was based on the premise that, without state intervention, marketplace enrollment would decline from its 2018 level. The reality has been starkly different. Enrollment in August 2021 reached 549,000 – more than 180,000 higher than in 2018 (an approximately 50% increase) – significantly higher than even the Georgia Access Model’s goals for 2023. Any updated analysis of Georgia’s waiver – particularly in light of new federal statutes and regulations that have helped increase coverage – would show that it simply cannot match today’s enrollment numbers. Rather than increasing coverage, the Georgia Access Model risks losing coverage for tens of thousands of Georgians.
- Reduced Medicaid assistance and coverage:*

For many people, HealthCare.gov facilitates Medicaid enrollment. In the 2021 open enrollment period alone, approximately 35,000 Georgians who started the process at HealthCare.gov were assessed as eligible for Medicaid. Brokers and insurers (who people would have to rely on if HealthCare.gov and Navigators are eliminated) have no incentive – and may not have the knowledge or skills – to provide information to people who are eligible for Medicaid. They do, however, have incentive – in the form of commissions or other profits – to steer low-income consumers toward private coverage. A Center for Budget and Policy Priorities analysis¹ of agents and brokers listed on HealthCare.gov found over 1,500 in one Atlanta zip code, none who said they’d assist with Medicaid or Children’s Health Insurance Program (CHIP) enrollment. Eliminating HealthCare.gov would eliminate this unbiased information source and enrollment option, likely resulting in many Georgians losing Medicaid coverage.
- Less effective assistance:*

The Affordable Care Act (ACA) created Navigators to help people enroll in coverage. The Georgia Access Model would opt Georgia out of this federal investment without establishing a similar program; in fact, the state made it illegal to use state funds on such programs.² Navigators provide consumers with general information, help them understand what type of coverage and financial assistance is available, and assist with enrollment. They do not direct consumers toward specific policies, and they are not compensated by insurance companies, which ensures consumers are provided with unbiased information. This is in stark contrast to brokers and insurance companies, who have clear incentives to steer people toward specific companies or policies; the Government Accountability Office (GAO) published a report in 2016³ which

¹ Tara Straw and Jason Levitas, “Georgia’s Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked,” CBPP, December 17, 2021, <https://www.cbpp.org/research/health/georgias-plan-to-exit-marketplace-will-leave-more-people-uninsured-should-be>.

² GA Code § 33-1-23 (2020). “Neither the state nor any department, agency, bureau, authority, office, or other unit of the state, including the University System of Georgia and its member institutions, nor any political subdivision of the state shall establish, create, implement, or operate a navigator program or its equivalent.”

³ GAO, “Private Health Coverage: Results of Covert Testing for Selected Offerings,” August 24, 2020, <https://www.gao.gov/products/gao-20-634r>.

found more than a quarter of health insurance sales representatives engaging in “potentially deceptive marketing practices,” including falsely claiming drugs were covered or offering a plan that didn’t cover preexisting conditions.

Moreover, Navigators are trained and skilled in reaching underserved groups. According to a 2016 Kaiser Family Foundation survey⁴, Navigators are five times more likely than agents and brokers to report their clients were previously uninsured, and nine in ten programs helped eligible individuals enroll in Medicaid or CHIP (compared to fewer than half of brokers). A study⁵ from 2021 found that cuts to the Navigator program led to declines in coverage for: people with incomes between 150 and 200 percent of poverty; consumers under age 45; consumers who identified as Hispanic; and consumers who spoke a language other than English at home. Eliminating Navigators would cause the greatest harm to people who already face significant barriers to coverage.

Figuring out the health coverage system is complex, and many people are unaware of their options, including the financial help that is available to them. Navigators provide critical, unbiased assistance. By eliminating Navigators, the Georgia Access Model would exacerbate barriers to information and coverage, further driving down enrollment.

- *More people steered to substandard plans that don’t meet their needs:* Kaiser Health News reported⁶ in 2016 about a man who discovered his healthcare plan was not ACA-compliant only after being diagnosed with cancer. He had been steered into his sub-par, short-term plan by a broker and had assumed he was buying a plan that would cover him in the case of serious illness; he found out too late that his chemo, radiation, and other treatments would not be covered. This is one story of many, and under the Georgia Access Plan, it will undoubtedly happen to many more in Georgia.

A 2020 report⁷ from the Urban Institute found that compensation for selling short-term and other products that do not comply with the ACA is significantly more generous than for selling ACA-compliant plans. The Georgia Access Plan specifically creates opportunities for brokers and insurers to steer people toward these non-ACA-compliant plans. These substandard plans are not

⁴ Karen Pollitz, Jennifer Tolbert, and Kendal Orgera, “Navigator Funding Restored in Federal Marketplace States for 2022,” Kaiser Family Foundation, September 29, 2021, <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>.

⁵ Rebecca Myerson and Honglin Li, “Information Gaps and Health Insurance Enrollment: Evidence from the Affordable Care Act Navigator Programs,” SSRN, November 22, 2021, <https://ssrn.com/abstract=3966511>

⁶ Michelle Andrews, “Think Your Health Care Is Covered? Beware of the ‘Junk’ Insurance Plan,” Kaiser Health News, December 4, 2020, <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>.

⁷ Sabrina Corlette *et al.*, “Perspectives From Brokers: The Individual Market Stabilizes While Short-Term and Other Alternative Products Pose Risks,” Urban Institute, April 1, 2020, <https://www.rwjf.org/en/library/research/2020/04/perspectives-from-brokers-the-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks.html>.

comprehensive and will result in potentially catastrophic costs in the case of an accident or illness. Under the Georgia Access Plan is it a near certainty that more Georgians would end up with these plans. By and large the people steered toward these plans will be low-income, will not be fully informed of the details and risks involved, and will be vulnerable to significant financial risk as a result.

- *Higher costs:*
While the Georgia Access Model projected a 3.4 percent premium reduction, this was based on an assumption of increased marketplace enrollment resulting from the waiver. Increased enrollment as a result of this waiver is very unlikely; if approved, it is more likely that there will be a significant decrease in marketplace enrollment. As a result, there is far greater potential for the Georgia Access Model to increase premiums than for premiums to decrease.

States must satisfy four guardrails to obtain approval for a 1332 waiver. The state's plan must: provide coverage that is at least as comprehensive in covered benefits; provide coverage that is at least as affordable; provide coverage to at least a comparable number of state residents; and not increase the federal deficit. Based on our review, the Georgia Access Model fails the comprehensiveness, affordability, and comparability guardrails.

The potential for harm from the Georgia Access Model is significant. Tens of thousands of people are at risk of losing coverage as a result, and the people at the greatest risk are people who already face the greatest coverage barriers and the highest uninsured rates: racially marginalized people, people living in poverty, disabled people, people with limited English proficiency, and other marginalized people and groups. Now, as even more people have lost access to employer-sponsored insurance during the COVID-19 pandemic and are turning to subsidized Marketplace plans and Medicaid for coverage, the urgency is greater than ever. If the Georgia Access Model moves forward, people across the state of Georgia will have a much harder time finding and enrolling in the coverage they need. The Biden Administration must revoke approval of Georgia's waiver.

Thank you for the opportunity to provide feedback on this proposal. If you have any questions or would like to discuss our comments further, please feel free to contact our Policy Director, Lindsay Baran, at lindsay@ncil.org or (202) 207-0334 x 1108.

Sincerely,

Reyma McCoy Hyten



Elizabeth G. Taylor
Executive Director

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January 9, 2022

VIA ELECTRONIC SUBMISSION

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, D.C. 20201

The Honorable Janet Yellen, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington D.C. 20220

RE: Georgia Section 1332 State Innovation Waiver

Dear Secretaries Becerra and Yellen:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide these comments on Georgia's Section 1332 State Innovation Waiver (Georgia § 1332 Application).

NHeLP recommends that the Department of Health & Human Services (HHS) withdraw its approval of Georgia § 1332 waiver, because it would impose a number of unlawful conditions on coverage and access to care for the marketplace and Medicaid populations.

We submitted comments during an earlier federal comment period that we wish to incorporate by reference. Those comments are available [here](#). Rather than reiterate those prior comments, we are focusing only on providing new information in these comments.

We believe the Administration can terminate the waiver not just for its violation of statutory protections but also based on administrative and procedural grounds. The Department of Health and Human Services and Department of the Treasury (“Departments”) have the authority to ask Georgia for further analysis under the relevant statute, federal regulations, and the waiver approval agreement the state signed. Letters requesting additional information were sent to Georgia on June 3 and July 30, 2021. Since Georgia has refused to provide updated information, HHS has the authority to terminate the agreement. Both the 1332 regulations and the terms of the waiver itself expressly list termination as a possible consequence.

Some of the current reasons additional information is critical before Georgia proceeds are outlined below.

Georgia’s model will not enroll as many individuals as compared to enrollment without the waiver. Fewer Georgians would have health coverage if the “Georgia Access Model” takes effect. Thus, the waiver fails the “coverage guardrail” that 1332 waivers are required by law to meet.

In its application, Georgia painted a bleak view of the future of the marketplace and claimed that the waiver was necessary to stem enrollment losses. But the state’s 2018 baseline projections are significantly lower than current enrollment. Georgia’s marketplace enrollment is more than 180,000 higher in August 2021 than in 2018 — a roughly 50 percent increase. Further, with additional provisions enacted in the American Relief Plan Act (ARPA), more individuals are receiving greater assistance in obtaining marketplace coverage, further undermining Georgia’s projections.

The state projected its plan would increase marketplace enrollment from about 366,000 in 2018 to 392,000 in 2023. Even if Georgia’s waiver did generate those coverage gains, it would fall well short of the 549,000 individuals enrolled as of August 2021.



Georgia’s analysis does not account for significant changes in federal law that increase enrollment. For 2021 and 2022, ARPA boosted the premium tax credit to reduce marketplace premiums across the board and extended eligibility to people with incomes above 400% FPL (Federal Poverty Line). While the enhancements are currently set to end in 2022, the Congressional Budget Office (CBO) predicts more people will stay enrolled in 2023, the year the Georgia Access Model would begin. Even if subsidies return to pre-ARPA levels in 2023, as many as 80% of Georgia’s enrollees could still be eligible for zero- or low-cost plans. As noted by researchers, the presence of zero-premium plans substantially increases re-enrollment.¹ Thus recent federal policies would likely boost enrollment beyond Georgia’s predictions and if the waiver were to proceed, many more people would be impacted by the loss of HealthCare.gov.

Further, the Families First Coronavirus Response Act included a “maintenance-of-effort” provision under which states, to get a higher federal matching percentage for Medicaid costs, must keep Medicaid-eligible people enrolled for the duration of the COVID-19 public health emergency. CBO anticipates the provision will begin to unwind in July 2022. As it does, some people with income now too high for Medicaid would likely qualify for assistance in the marketplace. Assuming the transfers between Medicaid and the marketplace works as it should, enrollment in marketplace coverage will again increase. Georgia’s analysis does not account for this.

Georgia’s analysis does not account for changes in federal rules that increase enrollment. CMS recently changed the length of the marketplace open enrollment period, providing additional time for individuals to enroll. A longer open enrollment period for HealthCare.gov gives people more time to enroll each year and has already contributed to a surge in marketplace enrollment.

Further, a recent rule change allows people with incomes at or below 150% FPL to enroll in marketplace coverage in any month starting in 2022, rather than needing to have a separate life event to qualify for a special enrollment period (SEP). In Georgia, about 160,000 uninsured adults have incomes between 100-150% FPL. Again, Georgia’s projections do not account for these rule changes and are thus out-of-date.

¹ McIntyre AL, Shepard M, Wagner M. Can Automatic Retention Improve Health Insurance Market Outcomes? [Internet]. National Bureau of Economic Research; 2021 Apr [cited 2021 Jun 21]. Report No.: w28630. Available from: <https://www.nber.org/papers/w28630>.



In addition to not addressing recent statutory and rule changes making it easier for individuals to enroll in marketplace coverage, Georgia would opt out of important federal investments that raise enrollment. The Biden Administration made a historic \$100 million investment in nationwide marketing during the six-month emergency enrollment period in 2021, a contrast to the Trump Administration’s \$10 million in annual funding in prior years. The Biden administration has demonstrated its commitment to making people aware of affordable coverage in the marketplace. Delinking from HealthCare.gov means Georgia would no longer benefit from this investment. Forgoing government-funded advertising means Georgia can expect lower enrollment under its waiver as private advertising likely will not be of the same amount and scope.

Further, in 2021, HealthCare.gov navigators received a \$70 million funding increase plus an additional \$10 million to assist with the longer open enrollment period. Assistors are more likely than agents and brokers to report that their clients were previously uninsured, help with Medicaid or CHIP enrollment, perform public education and outreach activities, and help clients of color, people who have limited English proficiency, or people who lack internet at home. The Georgia Access Model opts out of this federal investment and does not establish any form of impartial, unbiased help. The result is that uninsured and underserved people would be less likely to find coverage.

Unlike brokers and insurers, navigators must – pursuant to federal regulation – focus on reaching hard-to-reach and underserved populations. They must also provide fair, accurate and unbiased information to consumers. In Georgia in particular, the Georgia Association for Primary Health Care targeted rural consumers, veterans, Latino consumers and other minority racial or ethnic groups, the self-employed, and women with children while the Georgia Refugee Health and Mental Health targeted refugee and international/limited English speaking populations.² A recent study examined changes in coverage before versus after the 80% cut in funding for the navigator program under the Trump administration, comparing across counties in federally facilitated marketplace states that had more versus fewer navigator programs prior to the cuts. Cuts to the navigator program were associated with drops in the coverage rate among lower-income adults, adults under

² Centers for Medicare and Medicaid Services. In-Person Assistance in the Health Insurance Marketplaces: Navigator Grant Recipients, 2019. Available from: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance>.



age 45, Hispanic adults, and adults who speak a language other than English at home.³ Thus the Georgia Access Model would not only result in large scale coverage losses generally but likely would disproportionately impact people of color, limited English proficient individuals, and underserved individuals.

We are also concerned that eliminating HealthCare.gov and navigators will result in people enrolling in plans that do not provide comprehensive coverage. Private vendors and insurers are not subject to the same rules as HealthCare.gov navigators and often lure people into plans that earn companies higher profits but provide little care or contain expensive premiums and deductibles.

And the waiver could also have a detrimental impact on children and families. HealthCare.gov is designed to automatically let parents know if their children qualify for Medicaid or CHIP (PeachCare for Kids). As experience has shown throughout the past open enrollment periods, applying through HealthCare.gov identifies potential eligibility of adults in Medicaid and helps them enroll. HealthCare.gov is also essential in making sure that parents are covered. Healthy parents are better able to work and take care of their families and parents with health insurance are more likely to keep their kids enrolled in health coverage. Agents and brokers likely will not provide the same information, especially because they do not benefit financially from enrolling people in Medicaid and CHIP.

Georgia’s waiver conflicts with recent Executive Orders on equity and health coverage. The Biden-Harris Administration has taken strong stands on enrolling eligible individuals into health coverage and advancing health equity. The Georgia Access Model would undermine both of these stated aims. [Executive Order 13985](#) calls on federal agencies to review new and existing policies to assess whether they advance equity for marginalized and historically underserved communities. Georgia did not analyze the waiver’s impact on equity, which should raise the Departments’ level of scrutiny.

[Executive Order 14009](#), on strengthening Medicaid and the Affordable Care Act, calls for an immediate review of all federal agency actions, with the goal of making coverage accessible and affordable to everyone. This includes policies that undermine protections for people with pre-existing conditions; waivers that may reduce coverage under Medicaid or

³ Myerson R, Li H. Information Gaps and Health Insurance Enrollment: Evidence from the Affordable Care Act Navigator Programs [Internet]. Social Sciences Research Network; 2021 Nov. Available from: <http://dx.doi.org/10.2139/ssrn.3966511>.



the ACA; policies that undermine the marketplace; policies that create unnecessary barriers to families attempting to access ACA coverage; and policies that may reduce the affordability of coverage. Georgia's waiver conflicts with each of these goals.

Conclusion

We appreciate the new comment period as the Departments assess whether to allow Georgia to continue forward with its Section 1332 waiver. As noted above as well as in our prior comments, we oppose the Georgia Access Model. Recent developments as well as Georgia's failure to respond to requests for additional analysis lead us to recommend the Departments withdraw their approval of Georgia's Section 1332 waiver.

Our comments include citations to supporting research, including direct links to the research. We direct Treasury and HHS to each of the studies we have cited and made available through active links, and we request that the full text of each of the studies cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If Treasury and HHS are not planning to consider these citations part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies into the record.

Thank you for the opportunity to provide our input on this proposed rule. If you have any questions please contact Mara Youdelman (youdelman@healthlaw.org).

Sincerely,



Elizabeth G. Taylor
Executive Director





**National
Multiple Sclerosis
Society**

January 7, 2022

The Honorable Xavier Becerra
Secretary, U.S. Department of Health and
Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary, U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20200

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare &
Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Request for Comment on the Georgia Access Model

Submitted via stateinnovationwaivers@cms.hhs.gov

Dear Secretary Becerra, Secretary Yellen & Administrator Brooks-LaSure:

Thank you for the opportunity to comment on Georgia's proposal to waive federal rules under the Affordable Care Act (ACA). I am writing on behalf of the National MS Society to express our organization's ongoing concerns about Georgia's ACA Section 1332 Waiver.

The National MS Society's vision is a world free of MS. Our mission is to ensure that people affected by MS can live their best lives as we stop MS in its tracks, restore what has been lost and end MS forever. MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms vary from person to person and range from numbness and tingling, to walking difficulties, fatigue, dizziness, pain, depression, blindness, and paralysis. The progress, severity, and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to a better understanding and moving us closer to a world free of MS.

Nearly one million people are living with MS in the United States. Given that the average age of an MS diagnosis is between the ages of 20 and 50, this is a disease that often hits Georgians during their prime employment years, and too often it is financially devastating. Access to needed health care services and early and consistent control of disease activity appears to play key roles in preventing accumulation of disability, prolonging the ability of people with MS to remain active and protecting quality of life.

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**National
Multiple Sclerosis
Society**

We have significant concerns that current waiver proposals will not reduce costs, enhance access, and improve quality of care. Ideally, the “Georgia Access Model” would give many more Georgians a pathway to affordable, high-quality insurance. The proposed Georgia Access Model will put individuals living with MS at greater risk of becoming uninsured or under-insured. Georgians with little or no experience buying or using health insurance, those with limited English proficiency, Georgians with low health literacy skills, and individuals living with certain disabilities could experience adverse consequences from the outlined plan.

Georgia’s individual health insurance landscape has drastically changed since the waiver was approved

When Georgia’s 1332 waiver was approved in November 2020, 463,910 Georgians were enrolled in coverage through healthcare.gov.¹ In 2021, over 550,000 Georgians are enrolled, a difference of about 86,000 new enrollments.² Many of these new enrollments came during the COVID Special Enrollment Period, which ran from February 12 to August 15, 2021.

A major driver of the enrollment increase was the more generous Advanced Premium Tax Credits (APTCs) created through the American Rescue Plan. Along with these increased APTCs, enrollees above 400% FPL received an 8.5% income cushion for repaying subsidies and enrollees between 100-150% FPL were guaranteed access to a \$0 silver-level plan and increased cost-sharing reductions to significantly lower deductibles for this group.³ We have every expectation that Georgians will continue to benefit from this supplemental financial assistance as Congress works to extend the help in the proposed Build Back Better Act.

The Biden Administration also dramatically increased funding for outreach and enrollment assistance. Georgia navigator organizations received \$1,945,303 beginning in August 2021, compared to \$700,000 the year prior—a 177% increase.^{4,5} The increase in navigators and

¹ Georgia Health News, “Exchange Enrollment Hits Record Level in State,” September 22, 2021, <https://www.georgiahealthnews.com/2021/09/georgia-exchange-enrollment-hits-record-level/>

² Kaiser Family Foundation, Marketplace Enrollment 2014 – 2021, <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22georgia%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

³ Kaiser Family Foundation, “Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID 19 Relief on Marketplace Premiums,” March 15, 2020. <https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/>

⁴Centers for Medicaid & Medicare Services, “2021 CMS Navigator Cooperative Agreement Awardees,” August 27, 2021. <https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf>

⁵Centers for Medicaid & Medicare Services, “2020 CMS Navigator Cooperative Agreement Recipients,” August 30, 2020. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2020-Navigator-Grant-Recipients.pdf>

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outreach efforts will help more Georgians find more affordable plans by spreading awareness of the increased APTCs.

Finally, five new insurers have joined Georgia's health insurance marketplace. Georgia has 11 insurers offering plans on the Marketplace for the 2022 plan year, up from four in 2019 and six in 2021.⁶ An increase in insurers demonstrates that Georgia's insurance marketplace has stabilized and matured and is benefiting as expected from the state's reinsurance program.

The recent advances in Georgia's health insurance marketplace all trend in positive directions that benefit consumers and meaningfully resolve the shortcomings that the Georgia Access model was purported to address. Implementation of the Georgia Access proposal would only serve to undercut the progress our state has experienced since it was first put forward. We urge the Departments to withdraw their previous approval of this waiver proposal.

The steering of healthier consumers towards substandard plans would make comprehensive coverage more expensive for individuals living with MS.

The proposal would give insurers and brokers new opportunities to steer healthier consumers toward substandard plans that expose them to catastrophic costs if they get sick. The resulting adverse selection could make comprehensive coverage more expensive for individuals living with MS, reducing their enrollment as well.

Brokers have an incentive to steer consumers toward substandard plans (e.g., short-term and single-disease plans), which normally cannot be sold alongside ACA plans, because they tend to pay higher commissions. Short-term plans in particular pay up to ten times higher commissions than ACA-compliant plans.⁷ Insurers also profit on short-term plans, which aren't required to meet the medical loss ratio standards for ACA-compliant plans.⁸

Healthier and younger Georgians' would be more likely to choose short-term plans, since less healthy people —like those who the National MS Society represents— are less likely to qualify for such a policy and face higher premiums when they do. If healthier consumers leave the

⁶ Kaiser Family Foundation, Navigator Funding Restored in Federal Marketplace States for 2022, September 29, 2021. <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>

⁷ House report, *op. cit.*, p. 43. Due to the time it takes to assist marketplace consumers, some brokers report that they lose money on each marketplace enrollment, and so have stopped marketing their services or operate only through referrals. Others say they are uneasy about selling short-term plans despite the higher commissions, given the plans' risks for people with pre-existing conditions. See Sabrina Corlette *et al.*, "Perspective from Brokers: The Individual Market Stabilizes While Short-Term and Other Alternative Products Pose Risks," Urban Institute, April 2020, <https://www.urban.org/research/publication/perspective-brokers-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks>.

⁸ House report, *op. cit.*, p. 48.

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ACA-compliant market, its risk pool would become less healthy and would cause premiums to rise. (Similarly, the recent expansion of short-term plans nationally caused premiums for comprehensive coverage to go up by an average of 0.5 to 4 percent.⁹) The waiver does not account for these likely outcomes.

The enrollment of individuals living with MS in substandard plans would threaten their health and economic well-being.

Experience with enhanced direct enrollment programs shows that some brokers and agents screen applicants before sending them down the official enrollment pathway and divert some toward substandard plans that pay higher commissions but leave enrollees with existing health needs, like MS exposed to catastrophic costs.¹⁰ Even in less egregious circumstances, these companies are allowed to show substandard plans alongside comprehensive plans, thus encouraging Georgia consumers to enroll in substandard plans.

Substandard plans are not required to cover all essential health benefits, leaving people with chronic illness or disability potentially without access to necessary health services unless they are able to pay out of pocket. More than one-third of substandard plans do not cover most MS prescription drugs, for example.¹¹ The median price for one year of a disease modifying therapy (DMT) for MS continues to increase—in 2019 it was \$88,853. A recent study showed that MS DMT costs nearly tripled over the last 7 years. The \$88,853 number is just for a disease modifying therapy and does not consider the costs of other often used medications to control and treat MS symptoms and comorbidities. Disease modifying treatments (DMTs) are approximately 75% of the cost of treating MS. On top of that, substandard plans can exclude coverage for pre-existing conditions altogether and charge more for people with pre-existing conditions like MS. That leaves individuals living with MS vulnerable to catastrophic costs, limited access to care, and other negative consequences.

Georgians eligible for Medicaid are unlikely to receive assistance from insurers, agents, or brokers.

HealthCare.gov facilitates Medicaid enrollment with a “no-wrong-door” application that routes Georgians to the program for which they’re eligible based on their family size, income, and other factors. In 2020, at least 38,000 Georgians enrolled in Medicaid via HealthCare.gov. Medicaid enrollment ability is especially important for individuals living with MS because failure to treat

⁹ Hansen and Dieguez, *op. cit.*, p. 3.

¹⁰ Tara Straw, “‘Direct Enrollment’ in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm,” CBPP, March 15, 2019, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

¹¹ Kaiser Family Foundation, <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>

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MS can result in a rapid, debilitating progression of the disease, which affects the brain and central nervous system.

Brokers and insurers have no incentive to provide information and assistance to consumers who turn out to be eligible for Medicaid. For example, a search on HealthCare.gov shows more than 1100 agents and brokers that enroll people in coverage in one Atlanta zip code but zero agents and brokers that say they will assist with Medicaid/CHIP enrollment. Brokers and agents not assisting in Medicaid enrollment is problematic for individuals living with MS because the physical and financial challenges of an MS diagnosis can result in significant negative changes to a household's income in a short amount of time.

The Georgia Access waiver violates the statutory guardrails set forth in Section 1332 of the Affordable Care Act.

Georgia's proposal is not approvable under federal law because it would harm consumers, including individuals living with MS. The ACA requires that Section 1332 waivers cover as many people, with coverage as affordable and comprehensive, as would be covered absent the waiver, without increasing the federal deficit. Georgia's waiver fails these tests. There is a high chance that the waiver would cause thousands of Georgians to lose coverage, and no reason to expect it would meaningfully increase coverage. Georgia's proposed plan would likely leave many Georgians with less affordable or less comprehensive coverage than they would otherwise have.

Although we have concerns about the Georgia Access portion of the state's waiver application, the National MS Society is supportive of the state's reinsurance program. Like those approved in other states, the reinsurance portion of Georgia's proposal has reduced premiums and provided market stability. In its earliest stage, it has been a positive move forward for Georgia consumers.

Thank you for your consideration of our comments on Georgia's Section 1332 waiver application.

Sincerely,

Heather Breeden
Sr. Manager of Advocacy
National MS Society

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**National
Urban League**

January 9, 2022

CMS Administrator Chiquita Brooks-Lasure
7500 Security Boulevard
Baltimore, MD 21244

Via electronic mail: stateinnovationwaivers@cms.hhs.gov

Dear Administrator Brooks-Lasure,

On behalf of the National Urban League, with 91 affiliates in 36 states and the District of Columbia, including the Urban League of Greater Atlanta and the Urban League of Greater Columbus, we write to share our belief that Georgia's 1332 waiver and "Georgia Access Model" do not comply with federal requirements for the following reasons.

The "Georgia Access Model" would eliminate Georgians' access to HealthCare.gov — a centralized platform that displays and allows enrollment in all marketplace health plans. Instead, beginning in 2023, Georgia would scatter marketplace functions for more than half a million enrollees among a multitude of private brokers and health insurers. This would create mass confusion and result in even fewer Georgians successfully gaining access to affordable health insurance.

Georgia's model can't produce enrollment comparable to enrollment that would happen absent the waiver. Therefore, it fails the "coverage guardrail" that 1332 waivers are required by law to meet. In its application, Georgia painted a bleak view of the future of the marketplace and claimed that the waiver was necessary to stem enrollment losses. But the state's baseline projections, based on the 2018 plan year, are incorrect.

Consider these carefully researched statistics: Georgia's marketplace enrollment is more than 180,000 higher in August 2021 than in 2018 — a roughly 50 percent increase. The state projected its plan would increase marketplace enrollment from about 366,000 in 2018 to 392,000 in 2023. Even if Georgia's waiver could generate those coverage gains over 2018, it would fall well short of the 549,000 enrolled as of August 2021.

Georgia's waiver conflicts with recent Executive Orders on equity and health coverage. First, Executive Order 13985 calls on federal agencies to review new and existing policies to assess whether they advance equity for marginalized and historically underserved communities. Georgia did not analyze the waiver's impact on equity, which should raise the Department's

level of scrutiny. Second, Executive Order 14009, on strengthening Medicaid and the Affordable Care Act, calls for an immediate review of all federal agency actions, with the goal of making coverage accessible and affordable to everyone. This includes policies that undermine protections for people with pre-existing conditions; waivers that may reduce coverage under Medicaid or the ACA; policies that undermine the marketplace; policies that create unnecessary barriers to families attempting to access ACA coverage; and policies that may reduce the affordability of coverage. ***Georgia’s waiver conflicts with each of these goals.***

Georgia’s analysis doesn’t account for significant changes in law that increase enrollment.

For 2021 and 2022, the *American Rescue Plan Act* boosted the premium tax credit to reduce marketplace premiums across the board and extended eligibility to people with incomes above 400 percent of the poverty line. While the enhancements are currently set to end in 2022, the Congressional Budget Office (CBO) predicts an enrollment “tail” as more people stay enrolled in 2023, the year the Georgia Access Model would begin. Even if subsidies return to pre-Rescue Plan levels in 2023, as many as 80 percent of Georgia’s enrollees could still be eligible for zero- or low-cost plans, likely boosting enrollment beyond Georgia’s expectations. Additionally, the *Families First Coronavirus Response Act* included a provision under which states must keep Medicaid-eligible people enrolled for the duration of the COVID-19 public health emergency to get a higher federal matching percentage for Medicaid costs. The CBO anticipates the provision will begin to unwind in July 2022. As it does, some people with income too high for Medicaid might qualify for a premium tax credit in the marketplace and, if the system works well, enroll in marketplace coverage. ***Georgia’s analysis does not account for this.***

Georgia’s analysis doesn’t account for changes in federal rules that increase enrollment.

First, a longer open enrollment period for HealthCare.gov gives people more time to enroll each year and has already contributed to a surge in marketplace enrollment. Second, a rule change allows people with incomes at or below 150 percent of the poverty line to enter the marketplace in any month starting in 2022, rather than needing to have a separate life event to qualify for a special enrollment period (SEP). In Georgia, about 160,000 uninsured adults have incomes between 100 and 150 percent of poverty.

Georgia would opt out of important federal investments that raise enrollment. The Biden Administration made a historic \$100 million investment in nationwide marketing during the six-month emergency enrollment period in 2021. This contrasts with the Trump Administration’s \$10 million in annual funding in prior years, and it is a demonstration of the current administration’s commitment to making people aware of affordable coverage in the marketplace. Leaving HealthCare.gov means Georgia would no longer benefit from such investment; and foregoing government-funded advertising means Georgia can expect lower enrollment under its waiver.

In 2021, HealthCare.gov navigators received a \$70 million funding increase. Assistants are more likely than agents and brokers to report that their clients were previously uninsured, help with Medicaid or CHIP enrollment, perform public education and outreach activities, or to help

Latino clients, people who have limited English proficiency, or people who lack internet at home. ***However, Georgia made it illegal to use state funds on navigators.*** Meanwhile, brokers can enroll people in plans that will not benefit them and can lead to increased inequities in health. The Georgia Access Model would opt out of this federal investment and wouldn't establish any form of impartial, unbiased help. This means that vulnerable, uninsured people would be less likely to find coverage. We work with these populations and know firsthand their circumstances and the depth of their need.

Thank you for your consideration of these points. Please reach out to Morgan Polk (mpolk@nul.org) on National Urban League's staff with any follow up questions.

Sincerely,



Marc H. Morial
President and CEO, National Urban League



Nancy A. Flake Johnson
President and CEO, Urban League of Greater Atlanta



Tracey R. Mosley
President and CEO, Urban League of Greater Columbus



SUBMITTED VIA EMAIL TO stateinnovationwaivers@cms.hhs.gov

January 9, 2022

State Innovation Waiver Team
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Georgia section 1332 waiver comments

To whom it may concern:

Planned Parenthood Southeast, Inc., and the Feminist Women's Health Center appreciate the opportunity to comment in response to the recent request by the Department of Health and Human Services and the Department of the Treasury regarding Part II of the State of Georgia's Section 1332 waiver, colloquially referred to as the "Georgia Access Model."¹ We strongly oppose the Georgia Access Model because it was unlawfully approved and threatens access to quality health insurance coverage for Georgia residents—a fact which has only become more apparent in the year since the waiver was approved. We urge the Departments to promptly rescind their approval for Georgia's plan.

Our organizations, which are both headquartered in Georgia, provide reproductive and complementary health care to thousands of Georgia residents. We also advocate for public policies that guarantee access to such services, including policies that assist individuals in obtaining health insurance coverage for themselves and their families. To that end, we routinely comment on federal rulemakings and decisions regarding these subjects. Both of our organizations submitted comments urging the Departments not to grant Part II of Georgia's waiver,² and we have continued to oppose that waiver since it was granted. Our organizations are also the plaintiffs in a federal lawsuit filed in the U.S. District Court for the District of Columbia challenging the Departments' decision, which is stayed pending their evaluation process.³

¹ *Request for Comment on the Georgia Access Model*, Ctrs. for Medicare & Medicaid Servs. (Oct. 27, 2021), <https://www.cms.gov/files/document/1332-ga-access-public-comment-request.pdf>.

² The comment letters of Planned Parenthood Southeast, Inc. and Feminist Women's Health Center are located at pages 986-93 and 1088-91 of the online compilation of organizational comment letters, which can be found at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Federal-Comments-Organization-Letters.pdf> (last visited Jan. 9, 2022).

³ *See Planned Parenthood Se. v. HHS*, No. 1:21-cv-00117 (D.D.C. filed Jan. 14, 2021); *Planned Parenthood Southeast et al. v. HHS, CMS, Treasury et al.*, Democracy Forward, <https://democracyforward.org/lawsuits/planned-parenthood-southeast-et-al-v-hhs-cms-aca-section-1332/> (last visited Jan. 9, 2022).

We have long been strong supporters of the Patient Protection and Affordable Care Act (the “ACA”), which has provided affordable, high-quality health insurance to millions of Americans over the last decade, including many in Georgia.⁴ As a result, health coverage for women of reproductive age is at an all-time high. The ACA’s guarantee of preventive services without cost-sharing has accounted for massive gains in access to lifesaving care⁵ and cost savings, particularly for women of color.⁶

A critical part of the ACA’s reforms is its Exchanges: one-stop marketplaces where consumers can go to compare qualified health plans, obtain information about public programs for which they may be eligible, and, ultimately, enroll in the coverage that’s right for them. Prior to the ACA, consumers had to go to individual insurers or brokers to survey their offerings and to purchase a plan—a confusing, arduous, and time-consuming process. Now, consumers can go to a single Exchange established by their state, or, in states that have not established Exchanges, to healthcare.gov, which is administered by the federal government. Enrollment on the Exchanges remains robust: in just the first month and a half of 2022 open enrollment, over 9.7 million consumers purchased insurance on healthcare.gov, with nearly 654,000 in Georgia.⁷

Georgia’s Section 1332 waiver threatens to tear a hole in the ACA—overriding Congress’s considered legislative judgments and eviscerating the ACA’s substantial achievements. By doing away with healthcare.gov, the euphemistically named Georgia Access Model will force consumers to shop through multiple private insurance companies, agents, and brokers, rather than through a single, consolidated marketplace. In this respect, the Georgia Access Model will essentially return the health insurance shopping experience for Georgia consumers to how it stood before the ACA was enacted.

As explained further in the lawsuit filed by our organizations (attached as Exhibit A), the Departments’ decision to allow Georgia’s extraordinary and unprecedented plan was unlawful in multiple respects:

- Most importantly, the Georgia Access Model will drastically underperform the ACA and therefore violates Section 1332’s so-called “guardrails.” As the record before the agency demonstrated, the waiver will decrease health insurance enrollment in Georgia by up to 100,000 consumers, violating the coverage guardrail; shift consumers to non-ACA-compliant junk plans that provide inadequate coverage, violating the comprehensiveness

⁴ See, e.g., Jennifer Tolbert et al., *Key Facts about the Uninsured Population*, Kaiser Family Found. (Nov. 6, 2020), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>; Off. of the Ass’t Sec’y for Planning & Evaluation, *Compilation of State Data on the Affordable Care Act*, HHS, <https://aspe.hhs.gov/compilation-state-data-affordable-care-act> (last visited Jan. 9, 2022) (“Compilation of State Data on the Affordable Care Act” spreadsheet).

⁵ Usha Ranji et al., *Overview: 2017 Kaiser Women’s Health Survey*, Kaiser Family Found., (Mar. 13, 2018), <https://www.kff.org/report-section/executive-summary-2017-kaiser-womens-health-survey/>.

⁶ Marcela Howell & Ann M. Starrs, *For Women of Color, Access to Vital Health Services Is Threatened*, The Hill (July 26, 2017), <https://thehill.com/blogs/pundits-blog/healthcare/343996-for-women-of-color-access-to-vital-health-services-is>.

⁷ *Marketplace Weekly Enrollment Snapshot: Week 6*, CMS (Dec. 22, 2021), <https://www.cms.gov/newsroom/fact-sheets/marketplace-weekly-enrollment-snapshot-week-6>.

guardrail; and result in increased premiums, violating the affordability and deficit neutrality guardrails.

- The Departments’ decision to approve Part II of Georgia’s waiver was itself based on an erroneous, since-revoked guidance document from 2018 that weakened the standards for approving waivers under Section 1332 (the “2018 Guidance”). *See State Relief and Empowerment Waivers*, 83 Fed. Reg. 53,575 (Oct. 24, 2018). Specifically, the 2018 Guidance unlawfully encouraged state plans—like Georgia’s—that are intended to drive consumers toward junk plans that are anathema to the ACA. Because Georgia’s waiver cannot meet the statutory guardrails without the lenient standards of the 2018 Guidance, the waiver is unlawful as well.
- The Departments also lacked the authority to approve Georgia’s extraordinary waiver because, by allowing Georgia to terminate its reliance on healthcare.gov without creating a state Exchange in its place, the Departments’ decision grossly exceeded their authority under Section 1332. That provision allows the waiver of a discrete list of statutory requirements. *See* 42 U.S.C. § 18052(a)(2). The Departments cannot, and did not, waive regulations requiring the establishment of a federal Exchange if no state Exchange is present, *see id.* § 18041(c)(1), nor numerous other statutes and regulations presupposing the existence of an Exchange.
- Finally, both Georgia and the agency rushed Georgia’s application through the approval process amidst a global pandemic placing extraordinary strain on health system stakeholders. They therefore deprived the public of adequate time to comment on Georgia’s radical changes. Georgia’s application alone was deficient in numerous respects, failing to explain core elements of the state’s plan and reasoning.

Each of these flaws provides ample cause for rescinding Georgia’s waiver, and should the agency properly choose to do so, our organizations would encourage the agency to explicitly rely on the waiver’s unlawfulness as one ground for decision.

The waiver’s deficiencies have only become clearer in the last year. At the beginning of his Administration, President Biden committed to increasing equity and building upon the ACA’s gains in enrollment. He has matched word with deed, implementing a number of statutory and regulatory changes that have increased enrollment among Georgia consumers and among the populations that our organizations serve. Those changes have improved the baseline such that Georgia’s plan cannot possibly match the ACA’s approach in terms of coverage, comprehensiveness, and affordability, as Section 1332 requires. Moreover, Georgia has refused to provide the Departments with updated actuarial and economic analysis to support its waiver in light of these changed conditions. These legal and policy changes, coupled with Georgia’s unlawful refusal to provide the requested information, provide still more reason to rescind Part II of Georgia’s waiver.

The Departments can and should rescind the waiver promptly. The governing regulations and the terms and conditions of Georgia’s waiver provide that the Departments may rescind the waiver if it fails to comply with Section 1332 or with the waiver’s other terms. That is the case here, where Georgia’s waiver did not and does not comply with Section 1332’s guardrails,

properly construed; where the Departments exceeded their statutory authority in granting the waiver; where the Departments violated procedural requirements in granting the waiver; and where Georgia has repeatedly refused to provide the information required by CMS as permitted by the waiver's terms. Nor is there any reliance interest that would justify a different result. Any interest Georgia might have in implementing an unlawful waiver pales in comparison to the dramatic consequences the waiver will have for thousands of Georgia consumers if allowed to stand. The Departments should therefore act swiftly to guarantee that Georgia consumers will continue to have access to the federal Exchange.

I. Part II of Georgia's Section 1332 waiver was unlawfully granted.

The Departments' decision to permit the Georgia Access Model was unlawful in several ways.

First, the Georgia Access Model violates Section 1332's statutory guardrails, which are critical safeguards designed to ensure that a state's plan does not undermine the ACA's goals.

Second, the Departments' decision to approve Georgia's plan was predicated in large part on the 2018 Guidance, which badly misinterpreted Section 1332 and has since been revoked.

Third, Georgia's attempt to eliminate the state's healthcare marketplace is so radical and sweeping that it conflicts with provisions of the ACA that cannot be waived under Section 1332.

And *fourth*, Georgia's incomplete plan was rushed through the process without adequate time for public comment and without adequate clarification of how the state intends to approach key issues, as required by the Administrative Procedure Act and Section 1332.

We summarize these shortcomings below.⁸

A. The Departments' decision violated the Section 1332 guardrails.

The Departments' decision violated all four of Section 1332's statutory guardrails. *See* Compl., Exhibit A, ¶¶ 98-131. Specifically, the Georgia Access Model will result in fewer Georgians with insurance coverage, *see* 42 U.S.C. § 18052(b)(1)(C); fewer Georgians with comprehensive coverage, as opposed to non-ACA-compliant junk plans, *see id.* § 18052(b)(1)(A); and more expensive coverage, which will also potentially expand the federal deficit, *see id.* § 18052(b)(1)(B), (D). The Departments' decision was therefore contrary to law under the Administrative Procedure Act. *See* 5 U.S.C. § 706(2)(A). The Departments also failed to adequately consider these matters and other significant comments and concerns—including alternatives like expanding Medicaid or adopting a reinsurance-only model—and its decision

⁸ For ease of reference, we cite to two informative publications regarding Georgia's waiver: Christen Linke Young & Jason Levitis, *Georgia's Latest 1332 Proposal Continues to Violate the ACA*, Brookings (Sept. 1, 2020), <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>, and Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia's 1332 Waiver Proposal*, Ctr. on Budget & Pol'y Priorities (Sept. 1, 2020), <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>.

was therefore arbitrary and capricious and unsupported by substantial evidence. *See id.* § 706(2)(A), (E), (F).

1. Coverage

The Georgia Access Model will result in fewer Georgians with insurance coverage. 42 U.S.C. § 18052(b)(1)(C). Although Georgia estimated that the Georgia Access Model will increase enrollment by 33,000, with approximately 8,000 consumers losing coverage, thereby yielding net enrollment growth of 25,000,⁹ those figures rested on fatally flawed assumptions and modeling.

According to the state, “[t]he Georgia Access Model expands consumer access by allowing individuals to shop for and compare available plans using the platform of their choice.”¹⁰ But insurance companies, as well as agents and brokers, are *already* allowed to sell plans directly to consumers, through a process called direct enrollment.¹¹ In the year before the waiver was approved, “at least 16 insurers and web-brokers offered these services in Georgia,” and even Georgia’s application itself “notes these options are widely available.”¹² Despite the wide availability of direct enrollment options in Georgia, 79 percent of Georgians who enroll on the individual market choose to find and purchase their health coverage using *healthcare.gov*, with only 21 percent opting for direct enrollment.¹³ Rather than expanding consumer access, Georgia’s plan would *eliminate* the easiest and most common way for consumers to shop for insurance plans—*healthcare.gov*.

As a fallback, the state argued that “[c]arriers have an additional incentive to invest in marketing to attract new business and retain their current FFE consumers.”¹⁴ Again, however, “to the extent private entities face ‘market incentives’ to drum up new enrollment, those incentives *already exist*, and nothing in the application creates new incentives that could plausibly bring in new business.”¹⁵

In support of its numbers, Georgia’s application notes that the share of enrollments that happen through private vendors has grown by “an average of 4 percentage points ... over the past two years.”¹⁶ Thus, “[a]ssuming this trend continues,” private enrollment will “increase by 33,658.”¹⁷ But there are two flaws in this analysis. First, it conflates the share of enrollment and the total amount of enrollment; obviously, if *healthcare.gov* is eliminated, the share of private enrollment will be 100%, regardless of how much enrollment there is. And second, if the private

⁹ *Georgia Section 1332 State Empowerment and Relief Waiver Application*, Ga. Off. of the Gov. 56 (dated July 31, 2020, revised Oct. 9, 2020), <https://medicaid.georgia.gov/document/document/modified-1332-waiver/download> (“Georgia’s Application”).

¹⁰ *Id.* at 17.

¹¹ Young & Levitis, *supra* note 8.

¹² Straw, *supra* note 8.

¹³ *Id.*

¹⁴ Georgia’s Application, *supra* note 9, at 18.

¹⁵ Young & Levitis, *supra* note 8.

¹⁶ Georgia’s Application, *supra* note 9, at 77.

¹⁷ *Id.*

share of enrollment is *already* increasing by 4% each year, then those increases in enrollment cannot be attributed to the waiver.¹⁸

On the other side of the ledger, Georgia’s enrollment losses from eliminating healthcare.gov will be far higher than the 8,000 estimated by the state. The state’s “analysis entirely ignores countervailing threats to enrollment posed by dismantling the enrollment and consumer support system that roughly 400,000 people use.”¹⁹ Given that “only 21 percent of marketplace enrollees opted for direct enrollment or enhanced direct enrollment in 2020,” “[a]bandoning HealthCare.gov would leave the other 79 percent of enrollees without their platform of choice, almost certainly reducing enrollment significantly.”²⁰

Specifically, abolishing healthcare.gov in the state would require customers to identify private vendors, shop through them, and complete new enrollment processes, resulting in enrollment losses in at least several ways. New enrollees and active re-enrollees would need to navigate new administrative barriers that would likely cause some of them to drop out of the enrollment process, or to lose coverage later as a result of such barriers.²¹ Consumers would have to navigate multiple private vendors and additional types of insurance plans on their own, rather than shopping for plans on one, consolidated website. “Fragmenting the insurance market would confuse and discourage consumers, hindering enrollment.”²² Indeed, studies show that administrative barriers are one of the most common reasons people decline to participate in health and other programs.²³ Purchasing health insurance is a complicated and expensive undertaking, especially for marginalized communities, people with low incomes, those with limited English proficiency or education, or those who lack the knowledge necessary to navigate our country’s complicated insurance system.

Moreover, more than 80,000 Georgia enrollees have opted to automatically reenroll in coverage—meaning that they were automatically re-enrolled in the same or a comparable plan

¹⁸ Young & Levitis, *supra* note 8.

¹⁹ Straw, *supra* note 8.

²⁰ *Id.*

²¹ Young & Levitis, *supra* note 8.

²² Straw, *supra* note 8.

²³ See, e.g., Samantha Artiga & Olivia Pham, *Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage*, Kaiser Family Found. (Sept. 24, 2019), <https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/>; Pamela Herd, *How Administrative Burdens Are Preventing Access to Critical Income Supports for Older Adults: The Case of the Supplemental Nutrition Assistance Program*, 25 Pub. Pol’y & Aging Rep. 52 (June 20, 2015), <https://academic.oup.com/ppar/article/25/2/52/1501759>; Sheila Hoag et al., *CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings*, Mathematica Pol’y Rsch. (Dec. 2013), <https://www.mathematica.org/our-publications-and-findings/publications/chipra-mandated-evaluation-of-express-lane-eligibility-final-findings>; Jennifer Maier Snow, *Overcoming Barriers to Enrollment: A 50-State Assessment of Outreach and Enrollment Simplification Strategies for the State Children’s Health Insurance Program (SCHIP)*, 9 J. of Pub. Affs. Educ. 63 (Aug. 27, 2018), <https://www.tandfonline.com/doi/abs/10.1080/15236803.2003.12023574>. See generally Pamela Herd & Donald P. Moynihan, *Administrative Burden: Policymaking by Other Means* (2018); Eldar Shafir & Sendhil Mullainathan, *Scarcity: Why Having Too Little Means So Much* (2013).

and did not make an active choice during open enrollment.²⁴ Because an insurer may no longer offer a consumer’s specific plan, the auto-reenrollment process sometimes involves “mapping” or “crosswalking” enrollees to similar plans offered by the insurer.²⁵ However, the latest version of Georgia’s waiver was the first to provide even an abbreviated account of how the state will carry out and fund auto-reenrollment. And because the public was not permitted to comment on those revisions, they were not permitted to articulate the significant challenges Georgia will face in designing a system for auto-reenrollment while simultaneously shifting all enrollment to private vendors. In the past, states transitioning to state-based marketplaces have experienced substantial difficulty in porting over and using previous enrollment information to facilitate auto-reenrollment. In approving Georgia’s waiver, the Departments uncritically rubberstamped its assertions about auto-reenrollment.

Georgia’s waiver would also allow private vendors to direct Medicaid-eligible consumers to less affordable insurance. Under the “no wrong door” requirement, healthcare.gov automatically redirects individuals who may be Medicaid-eligible to the state Medicaid agency.²⁶ However, private vendors, who are incentivized by commissions and profits, have no incentive to direct consumers to Medicaid, and may actively mislead consumers to deter them and their families from enrolling in Medicaid.²⁷ For example, a 2019 report revealed that, in exchange for commissions, some direct enrollment entities were deliberately steering consumers away from Medicaid and instead promoting plans that cost hundreds of dollars more per month than Medicaid, and that many entities were not presenting information about the Medicaid enrollment process.²⁸ Medicaid access is especially important for Black cisgender women, trans men, and nonbinary people with uteruses. Georgia has one of the highest maternal mortality rates in the country, and the rate is significantly higher for Black birthing people than for any other group.²⁹ Because more than half of all births in Georgia are covered by Medicaid,³⁰ creating an environment where more consumers who qualify for Medicaid are unable to access it is likely to increase Georgia’s maternal mortality rates.

Additionally, following the initial transition, Georgia will not be assuming any of healthcare.gov’s extensive outreach and support functions to assist consumers in navigating the

²⁴ Young & Levitis, *supra* note 8; see also Coleman Drake et al., *Sources of Consumer Inertia in the Individual Health Insurance Market, Ctr. for Growth & Opportunity* (Nov. 2019), <https://www.thecgo.org/wp-content/uploads/2020/04/working-paper-2019.015-1.pdf>.

²⁵ Louise Norris, *How to Avoid the Surprise of Health Plan ‘Mapping,’* Healthinsurance.org (Jan. 9, 2021), <https://www.healthinsurance.org/obamacare/how-to-avoid-the-surprise-of-health-plan-mapping/>.

²⁶ Straw, *supra* note 8.

²⁷ Young & Levitis, *supra* note 8.

²⁸ Tara Straw, “Direct Enrollment” in *Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm*, *Ctr. on Budget & Pol’y Priorities* (Mar. 15, 2019), <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

²⁹ Stacey Eidson, *Racial Disparities in Health Care: Maternal, Infant Mortality Remains High in Georgia*, *Augusta Univ.*, <https://jagwire.augusta.edu/racial-disparities-in-health-care-maternal-infant-mortality-remains-high-in-georgia/> (last visited Jan. 9, 2022).

³⁰ Liza Lucas, *Medicaid Extension for Georgia Moms Gets Green Light*, *11Alive* (Apr. 27, 2021), <https://www.11alive.com/article/news/health/medicaid-extension-for-georgia-new-moms/85-cd2bc434-c6e5-4a9d-93f3-d040224bc8d7>.

enrollment process. There is little reason to assume that private vendors will pick up the slack.³¹ And Georgia will be required to construct a new administrative apparatus to provide all of the “back-end” functions it has never before provided, which it appears to have inadequately funded.³² Thus, the Georgia Access Model may lead to still more enrollment losses.

Experts therefore calculated that the Georgia Access Model is likely to lead to significant net enrollment losses, the scale of which will depend on the extent of these effects, as displayed below.³³

Figure 1: Coverage losses from Georgia waiver under various assumptions

Scenario	Active Re-Enrollee Loss	Automatic Re-enrollee Loss	Medicaid Enrollee Loss	Total Coverage Loss
Minimal coverage losses: retain 97% active re-enrollees, 70% automatic re-enrollees, 90% Medicaid enrollees	7,243	24,029	3,807	35,078
Moderate coverage losses: retain 95% active re-enrollees, 50% automatic re-enrollees, 75% Medicaid enrollees	12,072	40,048	9,517	61,636
Large coverage losses: retain 90% active re-enrollees, 30% automatic re-enrollees, 50% Medicaid enrollees	24,144	56,067	19,034	99,244

Source: Authors' calculations based on CMS 2020 Marketplace Open Enrollment Period Public Use Files

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Finally, even if Georgia’s estimates of coverage gains and losses were in the ballpark, it makes errors in the timing of the enrollment effects. To satisfy the coverage guardrail, a state’s plan must not result in fewer individuals with coverage in any given year. 83 Fed. Reg. at 53,579. The state assumes that enrollment will rise on net by 25,000 in the first year of the Georgia Access Model, while remaining relatively constant moving forward.³⁴ But any gains are likely to phase in over time, as Georgia estimates that web-brokers enroll a slightly larger fraction of the market each year, while any losses are likely to occur immediately for the reasons

³¹ Straw, *supra* note 8; *see also, e.g.*, Naoki Aizawa & You Suk Kim, *Public and Private Provision of Information in Market-Based Public Programs: Evidence from Advertising in Health Insurance Marketplaces*, Nat’l Bureau of Econ. Rsch., Working Paper No. 27,695 (2021), https://www.nber.org/system/files/working_papers/w27695/w27695.pdf; Rebecca Myerson et al., *Cuts to Navigator Funding Were Not Associated With Changes to Private Sector Advertising in the ACA Marketplaces* (Dec. 9, 2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3981909; Paul R. Shafer et al., *Competing Public and Private Television Advertising Campaigns and Marketplace Enrollment for 2015 to 2018*, 6 Russell Sage Found. J. of the Soc. Scis. 85 (2020), https://www.rsfsjournal.org/content/rsfjss/6/2/85_full.pdf; Paul R. Shafer et al., *Television Advertising and Health Insurance Marketplace Consumer Engagement in Kentucky: A Natural Experiment*, 20 J. Med. Internet Rsch. (Oct. 25, 2018), <https://www.jmir.org/2018/10/e10872/>.

³² Young & Levitis, *supra* note 8; Straw, *supra* note 8.

³³ *Id.*

³⁴ Georgia’s Application, *supra* note 9, at 56.

explained above.³⁵ Thus, if one instead assumes that the 33,000 gain phases in linearly over the first five years of the waiver, then losses will actually exceed gains in the first year of the waiver—violating the coverage guardrail.³⁶

For these reasons, the Georgia Access Model will decrease, rather than increase, overall enrollment, violating the coverage guardrail even under the standards of the 2018 Guidance. In nonetheless concluding that “the waiver plan meets the coverage guardrail,”³⁷ the Departments simply adopted Georgia’s wildly unrealistic assumptions and estimates in a manner that is unreasoned, contrary to the record, and contrary to the ACA’s legal requirements.

2. Comprehensiveness

To approve a state waiver, the Office of the Actuary of the Centers for Medicare and Medicaid Services must certify, “based on sufficient data from the State and from comparable States,” that the waiver will provide coverage at least as comprehensive as the coverage offered through Exchanges. 42 U.S.C. § 18052. The Departments referenced no such certification, and in fact, the Georgia Access Model will result in consumers enrolling in less comprehensive, non-ACA-compliant insurance products, to the extent they are able to enroll at all. Georgia’s plan therefore flunks the comprehensiveness guardrail as well.

Non-ACA-compliant plans, including short-term, limited-duration insurance plans, association health plans, and others, generally represent a bad deal for the consumer. They often have discriminatory gaps that can leave consumers (or providers) exposed to high costs,³⁸ especially as compared to the affordable, comprehensive, and non-discriminatory coverage of the ACA. Some individuals may be turned down by insurers based on their prior health status, while others will face benefit exclusions based on prior health care needs.³⁹ These plans are also generally subject to other conditions that limit their value, like large amounts of cost-sharing, annual or lifetime limits on coverage, limitations on services, or limitations on the amount the plan will pay per medical visit.⁴⁰ For example, “[o]ne review of the most popular short-term plan in Atlanta found that although it had lower premiums, its deductible and maximum out-of-pocket costs were nearly three times higher than the most popular bronze ACA plan, and it offered no coverage of prescription drugs, mental health services, or maternity care.”⁴¹

³⁵ Young & Levitis, *supra* note 8.

³⁶ *Id.*; see also Straw, *supra* note 8.

³⁷ Letter from CMS Admin. Seema Verma to Ga. Gov. Brian P. Kemp at 10 (Nov. 1, 2020), [https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section 1332 State Innovation Waivers-/1332-GA-Approval-Letter-STCs.pdf](https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section%201332%20State%20Innovation%20Waivers-/1332-GA-Approval-Letter-STCs.pdf) (the “Approval Letter”).

³⁸ See Christen Linke Young, *Taking a Broader View of “Junk Insurance”*, Brookings (July 6, 2020), <https://www.brookings.edu/research/taking-a-broader-view-of-junk-insurance/>.

³⁹ See Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Found. (Apr. 23, 2018), <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

⁴⁰ See Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers*, Ctr. on Budget & Pol’y Priorities (Sept. 20, 2018), <https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers>.

⁴¹ Straw, *supra* note 8.

This issue is of particular concern to our organizations. Non-ACA-compliant plans frequently have blanket exclusions for basic health care services that women, transgender people, and nonbinary people rely on, such as birth control, maternity services, and gender transition-related services.⁴² Similarly, short-term plans do not have to cover the ACA’s essential health benefits, including maternity care. Women of reproductive age would be among the most harmed if coverage of these benefits is undermined; before the ACA, only 12 percent of plans in the individual market covered maternity coverage.⁴³ Without coverage for important services that enrollees need, they may find themselves paying a monthly insurance premium and still having to pay out-of-pocket for needed services such as maternity care, which can cost \$30,000 on average for a birth, or for their preferred birth control method, which can cost up to \$1,300.⁴⁴

As Georgia itself has stated, “[a]n explicit goal of the waiver is to increase access to coverage that doesn’t meet ACA standards”⁴⁵ by allowing consumers to access “the full range of health plans licensed and in good standing in the State that are available to them today but sold through channels outside the FFE.”⁴⁶ It does so by shifting all enrollment to private vendors who, unlike healthcare.gov, can offer non-ACA-compliant plans next to ACA-compliant plans.

Moreover, those private vendors have an incentive to steer consumers toward non-ACA-compliant products. For brokers, such products generally pay higher commissions—up to ten times as much as ACA-compliant plans.⁴⁷ For insurers, such products generally have better margins because they are not required to meet medical loss ratio standards.⁴⁸ “Experience with enhanced direct enrollment programs shows that these incentives sometimes give rise to ‘steering,’ in which web-brokers screen applicants before sending them down the official enrollment pathway and divert some toward substandard plans that pay higher commissions but leave enrollees exposed to catastrophic costs if they get sick.”⁴⁹ Studies have repeatedly shown that private vendors tend to redirect consumers toward such plans.⁵⁰ Even under current law, “[r]oughly one in four marketplace enrollees who were helped by a broker or commercial health

⁴² See Janel George, *How Short-Term Limited Duration Insurance Plans Being Pushed by the Trump Administration Shortchange Women*, Nat’l Women’s Law Ctr. (Mar. 1, 2018), <https://nwlc.org/blog/how-short-term-limited-duration-insurance-plans-being-pushed-by-the-trump-administration-shortchange-women/>.

⁴³ *Women and the Health Care Law in the United States*, Nat’l Women’s Law Ctr. (May 2013), https://nwlc.org/wp-content/uploads/2015/08/us_healthstateprofiles.pdf.

⁴⁴ *The Cost of Having a Baby in the United States*, Truven Health Analytics et al. (Jan. 2013), <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/archive/the-cost-of-having-a-baby-in-the-us.pdf>; *How Can I Get an IUD?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/iud/how-can-i-get-an-iud> (last visited Jan. 9, 2022).

⁴⁵ Straw, *supra* note 8.

⁴⁶ Georgia’s Application, *supra* note 9, at 4; *see also id.* at 26, 31.

⁴⁷ *Shortchanged: How the Trump Administration’s Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk*, H.R. Comm. on Energy & Com. 43 (June 2020), https://degette.house.gov/sites/degette.house.gov/files/STLDI%20Report%2006%2025%2020%20FINAL_.pdf.

⁴⁸ Straw, *supra* note 8.

⁴⁹ *Id.*

⁵⁰ *See, e.g.,* Straw, *supra* note 28; *Shortchanged*, *supra* note 47.

plan representative said they were offered a non-ACA-compliant policy as an alternative or supplement to a marketplace policy.”⁵¹

Georgia’s plan would also allow additional room for deceptive or aggressive marketing tactics that healthcare.gov does not permit. “One recent study, for example, showed that most brokers gave ambiguous, misleading, or demonstrably false information regarding short-term plan coverage for COVID-related illnesses.”⁵²

For all these reasons, the Georgia Access Model is likely to shift individuals from ACA-compliant plans to less comprehensive, non-ACA-compliant junk plans. Perhaps that is why, in the letter approving Georgia’s waiver, the Departments did not refer to the requisite certification of comprehensiveness by the Office of the Actuary of CMS. 42 U.S.C. § 18052. For that reason alone, the Departments failed to comply with the comprehensiveness guardrail.

As explained further below, *see infra* Section I.B., the Departments’ decision relied on the erroneous 2018 Guidance and is unlawful for that reason as well. But even if that 2018 Guidance were lawful, Part II of Georgia’s waiver fails even under its lenient standards. The 2018 Guidance evaluates whether consumers have “access to coverage that is as affordable and comprehensive as coverage” that would have been available prior to the waiver. 83 Fed. Reg. at 53,578 (emphasis added). But given the Georgia Access Model’s failure to include protections against inappropriate steering and marketing of non-ACA-compliant plans, it would not leave consumers with meaningful access to ACA-compliant plans. Section 1332 requires more than comprehensive coverage being theoretically available somewhere in the marketplace. Here too, the Departments failed to ensure that Georgia’s plan meets the comprehensiveness guardrail, acting in an unreasoned manner to reach a decision contrary to the agency record.

3. Affordability and deficit neutrality

For many of the same reasons and others, the Georgia Access Model will also increase premiums, violating the affordability guardrail. Indeed, Georgia’s affordability estimates are, in substantial measure, premised on its incorrect assumption of increased enrollment.⁵³

Even leaving that flawed assumption aside, the Georgia Access Model will also decrease affordability by baking additional costs into the premiums that consumers pay. Insurers generally pay private agents and brokers a commission for directing consumers to their health plans. “Transitioning all enrollment to private vendors (most of whom are commission-supported) is

⁵¹ Karen Pollitz et al., *Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need*, Kaiser Family Found. (Aug. 7, 2020), <https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/>.

⁵² Straw, *supra* note 8; *see also, e.g.*, Dania Palanker & JoAnn Volk, *Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period*, Georgetown Univ. Health Pol’y Inst. Ctr. on Health Ins. Reforms (October 2021), <https://georgetown.app.box.com/s/mn7kgnhibn4kapb46tqmv6i7putry9gt>; U.S. Gov’t Accountability Off., GAO-20-634R, *Private Health Coverage: Results of Covert Testing for Selected Offerings* (Aug. 24, 2020), <https://www.gao.gov/products/gao-20-634r>; U.S. Gov’t Accountability Off., GAO-21-568R, *Private Health Coverage: Results of Covert Testing for Selected Sales Representatives Listed on Healthcare.gov* (Aug. 10, 2021), <https://www.gao.gov/products/gao-21-568r>.

⁵³ Straw, *supra* note 8.

likely to meaningfully increase the total volume of broker commissions paid in Georgia, which will in turn increase premiums.”⁵⁴ Alternatively, if consumers transition to enrolling directly through insurers, those insurers will have increased costs from building their enrollment infrastructure. Those costs will be incorporated into the premiums that consumers pay.⁵⁵ Georgia’s application did not adequately account for either of these dynamics, instead offering only that the state “does not expect increased commissions to increase premiums by more than 0.25 percentage points on average.”⁵⁶

Additionally, as explained above, Georgia’s waiver will also lead to greater enrollment in non-ACA-compliant plans, which typically involve higher cost-sharing. Because premiums for those plans are generally cheaper for young, healthy enrollees, these consumers will tend to select them—distorting the risk pool and thereby increasing premiums for comprehensive, ACA-compliant insurance products.⁵⁷ “It is not possible to promote underwritten and non-compliant plans that the state believes some consumers will prefer without ‘eroding’ the regulated market—if healthy enrollees can receive lower premiums from underwritten plans, that will, axiomatically, worsen the ACA risk pool and increase premiums.”⁵⁸ That conclusion is also backed by the evidence: “in states that took advantage of the Administration’s expansion of short-term plans—like Georgia, which has few restrictions—premiums for comprehensive coverage went up by about 4 percent.”⁵⁹ By making it even easier for insurers and brokers to push relatively healthier and cheaper consumers on to short-term plans, Georgia’s plan will exacerbate these effects.

Georgia’s analysis also makes assumptions that are not supported by the record about the risk profile of those who will lose coverage due to the elimination of healthcare.gov. In general, young, healthy people are less likely than older people to attempt to overcome administrative barriers, meaning that young people are proportionally more likely to lose coverage.⁶⁰ That shift will further weaken the ACA-compliant risk pool in the state and drive up premiums.⁶¹ By the same token, Georgia makes unfounded and unsupported assumptions about those who will *gain* coverage, assuming that they will tend to be the sort of young, healthy consumers who are, in fact, most likely to drop out of the enrollment process.⁶²

⁵⁴ Young & Levitis, *supra* note 8.

⁵⁵ *Id.*

⁵⁶ Approval Letter, *supra* note 37, at 11.

⁵⁷ Young, *supra* note 38.

⁵⁸ Young & Levitis, *supra* note 8.

⁵⁹ Straw, *supra* note 8 (citing Dane Hansen & Gabriela Dieguez, *The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market*, Milliman (Feb. 2020), <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>).

⁶⁰ See, e.g., Stan Dorn, *Helping Special Enrollment Periods Work Under the Affordable Care Act*, Urban Inst. 5-8 (June 2016), <https://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf>; *Strengthening the Marketplace – Actions to Improve the Risk Pool*, CMS (June 8, 2016), <https://www.cms.gov/newsroom/fact-sheets/strengthening-marketplace-actions-improve-risk-pool>.

⁶¹ Young & Levitis, *supra* note 8.

⁶² See sources cited *supra* note 60.

Finally, Georgia’s plan will reduce competition by causing insurers, particularly smaller insurers, to exit the market rather than devote additional resources to creating enrollment infrastructure.⁶³ Even where such insurers remain in the market, they may not be able to compete with larger insurers in the absence of healthcare.gov. And “[t]he lack of a single, unbiased source of comparative plan data could also directly reduce competition.”⁶⁴

These effects also violate the deficit neutrality guardrail because advance premium tax credits are pegged to the premiums in a given market, putting the federal government on the hook for higher payments, depending on the size of the coverage losses that Georgia’s plan will cause. Separately, Georgia’s plan also threatens to expand the deficit because Georgia miscalculates the impact of the state losing user fees for healthcare.gov. “Some HealthCare.gov functions entail fixed costs, and so the absence of HealthCare.gov user fees from Georgia will not be fully offset by reduced operating costs. The federal government is clear that such costs must be accounted for in deficit neutrality calculations, and the state fails to do so.”⁶⁵ Thus, the Departments’ decision violated the affordability guardrail and, by extension, potentially the deficit neutrality guardrail, and is unreasoned and contrary to the record.

B. The Departments’ decision was predicated on an erroneous, since-revoked understanding of Section 1332.

By considering only whether affordable, comprehensive coverage would still be available on the market, the Departments based their decision on the interpretation of the statutory guardrails contained in the 2018 Guidance. But that guidance, which deviated from previous interpretations of Section 1332, was itself fatally flawed. *See* Compl., Exhibit A, ¶¶ 69-76.

In 2015, HHS and Treasury issued guidance clarifying how they would apply Section 1332’s statutory guardrails (the “2015 Guidance”). In accord with the ACA’s fundamental purpose, the agencies correctly explained that they would “take[] into account the effects” of any state plan “across different groups of state residents, and, in particular, vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues.” *Waivers for State Innovation*, 80 Fed. Reg. 78,131, 78,132 (Dec. 16, 2015).

Nevertheless, the Departments revoked the 2015 Guidance and replaced it with the 2018 Guidance. *See* 83 Fed. Reg. 53,575. One commentator noted that, “[a]s the name change from ‘Innovation’ to ‘Relief and Empowerment’ implies, the administration views the waiver as a way to ‘relieve’ states from the statute’s requirements, and shifts the aim from novel experiments to simply giving states greater authority to work around the federal regulations.”⁶⁶ In announcing the Guidance, then-Administrator Verma made plain that its purpose was to restore “a state’s

⁶³ Straw, *supra* note 8.

⁶⁴ *Id.*

⁶⁵ Young & Levitis, *supra* note 8.

⁶⁶ Elizabeth Y. McCuskey, *Big Waiver Under Statutory Sabotage*, 45 Ohio N.U. L. Rev. 213, 235 (2019).

traditional regulatory role over health insurance,” and to address the ACA’s purported “negative impact on state insurance markets.”⁶⁷

In relevant part, the 2018 Guidance interpreted Section 1332 to permit waivers that would promote non-ACA-compliant coverage, including short-term, limited-duration insurance plans and association health plans. *See, e.g., id.* at 53,576-77. To that end, the 2018 Guidance interpreted the “comprehensiveness” and “affordability” guardrails to focus only on the “nature of coverage that is made available to state residents” by a proposed state plan, “rather than on the coverage that residents actually purchase.” *Id.* at 53,576. Under the 2018 Guidance, a proposed state plan still had to cover the same number of state residents, but it could allow those residents to have less affordable or less comprehensive coverage, so long as they could purchase comparably affordable or comprehensive coverage on the market.⁶⁸ In other words, a proposed state plan would meet the statutory guardrails under this interpretation even if it had the effect of pushing 100% of the state’s residents on to non-ACA-compliant insurance products.

That interpretation violated the Affordable Care Act for several reasons. Much like Section 1332 requires that a state’s waiver “*provide* coverage to at least a comparable number of its residents,” the waiver must also “*provide* coverage that is at least as comprehensive” and “affordable” to the state’s residents. 42 U.S.C. § 18052(b)(1) (emphasis added). Thus, a state waiver may be approved only “where the state shows that at least as many of its residents would actually have coverage—not merely have access to coverage—that is as affordable and comprehensive as what those residents would have under the ACA.”⁶⁹ The 2018 Guidance’s contrary interpretation also rendered meaningless the statute’s requirement that the state provide “an actuarial analysis, based on real data, comparing the scope of coverage that state residents would receive under the waiver to that they would receive without a waiver.”⁷⁰ And finally, it was predicated on an expansive definition of coverage that includes short-term, limited-duration insurance plans not found in the ACA itself.⁷¹

The Departments properly rescinded the 2018 Guidance in rulemaking earlier this year. In doing so, it noted that “rescinding the 2018 Guidance, repealing the previous codification of its guardrail interpretations in part 1 of the 2022 Payment Notice final rule, and finalizing new policies and interpretations will align with the Administration’s goals to strengthen the ACA and

⁶⁷ Letter from CMS Admin. Seema Verma to State Governors at 1 (Oct. 22, 2018), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/SignedSREWaiverDearGovLetter.pdf>.

⁶⁸ Individuals tend to choose plans based on multiple factors, including the individual’s health status. Young, healthy individuals are more likely to purchase a cheaper, non-ACA-compliant plan, believing that they are unlikely to use the plan in the near future. In contrast, an older individual with preexisting conditions is likely to choose a more expensive plan that guarantees full coverage. As explained further below, however, this sorting effect means that the risk pool for ACA-compliant insurance becomes filled with higher risk individuals, driving up the cost for ACA-compliant coverage.

⁶⁹ Joel McElvain, *The Administration’s Recent Guidance on State Innovation Waivers under the Affordable Care Act Likely Violates the Act’s Statutory Guardrails*, Yale J. on Regul.: Notice & Comment (Dec. 11, 2018), <https://www.yalejreg.com/nc/the-administrations-recent-guidance-on-state-innovation-waivers-under-the-affordable-care-act-likely-violates-the-acts-statutory-guardrails-by-joel-mcelvain/>.

⁷⁰ *Id.*

⁷¹ *Id.*

increase enrollment in comprehensive, affordable health coverage among the remaining underinsured and uninsured.” *Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond*, 86 Fed. Reg. 53,412, 53,459 (Sept. 27, 2021). The rescission of the 2018 Guidance constitutes a change in federal law or regulations with which Georgia must comply under both federal regulations, *see id.*; 45 C.F.R. § 155.1320(a), and the terms and conditions of its waiver.⁷² But even if the Departments had not rescinded the 2018 Guidance, the Guidance distorts and misconstrues Section 1332 itself, with which Georgia’s waiver must always comply despite any guidance to the contrary.

Any waiver predicated on the 2018 Guidance, including Georgia’s waiver, must be rescinded as well. Because the Departments and Georgia did not, and cannot, show that the Georgia Access Model would actually provide state residents with equally comprehensive coverage, the Departments’ approval of Georgia’s plan is necessarily predicated on the 2018 Guidance that a plan complies with the comprehensiveness guardrail so long as equally comprehensive coverage remains available on the market. That much is clear from the Departments’ approval letter: in approving Georgia’s waiver, the Departments concluded that “consumers will have *access* under the state’s waiver plan to the same metal level plans and catastrophic plans that are available today and include EHB benefits,” and so “consumers will have *access* to coverage that is at least as comprehensive as the without waiver baseline scenario.”⁷³

Put simply, the Departments did not conclude, and Georgia did not show, that an equal number of consumers would *possess* comprehensive insurance coverage as a result of the Georgia Access Model—only that equally comprehensive coverage would remain theoretically available on the market. That was unlawful under Section 1332.

C. The Departments’ decision exceeded their authority.

Even if the Departments’ decision had complied with the statutory guardrails, they exceeded their statutory authority by waiving provisions that cannot be waived under Section 1332. *See* Compl., Exhibit A, ¶¶ 132-38. Section 1332 does not allow the Departments to nullify any and all ACA provisions; it limits its authority to specific, enumerated statutory requirements. *See* 42 U.S.C. § 18052. To that end, Georgia’s application was limited to waiving provisions of 42 U.S.C. § 18031, and the state recognizes that it must “remain in full compliance with sections of [the ACA] not waived.”⁷⁴ By ending the state’s reliance on healthcare.gov without creating a state Exchange or a hybrid model in its place, however, Part II of Georgia’s waiver is so radical

⁷² *See* Approval Letter, *supra* note 37, STC 7 at 31 (“The state must, within the applicable timeframes, come into compliance with any changes in federal law, or regulations promulgated in response to a change in federal law affecting Section 1332 waivers.”). In rescinding the 2018 Guidance, the Departments referenced “the Administration’s efforts to build on the ACA by meeting the health care needs created by the COVID-19 PHE,” 86 Fed. Reg. at 53,459, several of which have taken the form of statutory enactments, like the American Rescue Plan Act of 2021.

⁷³ Approval Letter, *supra* note 37, at 12-13 (emphasis added).

⁷⁴ Georgia’s Application, *supra* note 9, at 29.

that it rips a hole in the ACA—grossly exceeding the scope of authority provided by Section 1332.

Most importantly, Section 1321, which is not in the list of provisions that are waivable under Section 1332, mandates that, if a state does not create an Exchange, “the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.” 42 U.S.C. § 18041(c)(1). If the state does create an Exchange, it must meet the standards established by the Secretary. *Id.* § 18041(e). Federal regulations further define an Exchange as “a governmental agency or non-profit entity that meets the applicable standards of this part and makes QHPs available to qualified individuals and/or qualified employers.” 45 C.F.R. § 155.20. Georgia’s plan obviously does not create an Exchange; instead, it leaves the state’s consumers without a central, impartial marketplace for purchasing insurance plans, as was the case prior to the existence of the ACA. The Departments therefore could not approve Georgia’s plan to withdraw from healthcare.gov without creating an Exchange in its place.

The ACA also contains many provisions that presuppose the existence of an Exchange, but that are not included within the provisions that may be waived under Section 1332.⁷⁵ Even if the Departments could waive these requirements, Georgia’s application is limited to provisions of 42 U.S.C. § 18031, and thus both expressly disavows any request for a waiver of other statutory provisions and promises that the state will comply with all non-waived provisions. By eliminating the exchange in Georgia entirely, Part II of Georgia’s waiver prevents these other, non-waivable statutory provisions from operating, in violation of Section 1332. To take just one example, an Exchange cannot provide information or determine eligibility if there is no Exchange in the first place. In permitting Georgia to violate these requirements, the Departments again exceeded their statutory authority.

Of course, states retain the flexibility to experiment with different models of Exchange management. But deciding to eliminate the Exchange entirely—one of the ACA’s signature achievements and statutory cornerstones—is not a choice that Section 1332 permits.

D. The Departments’ decision was procedurally deficient.

Finally, the Departments’ decision to approve Georgia’s waiver was procedurally deficient in several important ways, including the manner in which the Departments and the state allowed for notice and comment and the contents of the state’s application. *See* Compl., Exhibit A, ¶¶ 139-45.

⁷⁵ *See, e.g.*, 42 U.S.C. §§ 300u-12 (public health campaign to explain preventive services offered by Exchange plans), 300gg-94(b)(1)(B) (state to make recommendations to Exchange to exclude insurers from participation), 1396a(e)(14)(K) (notify lottery winners who lose Medicaid eligibility of opportunity to enroll in Exchange), 1396w-3 (Medicaid’s version of the “no wrong door” provision), 1397ee(a)(1) (Exchange coverage to cover shortfalls in CHIP funding), 1397gg (incorporating “no wrong door” for CHIP), 18081(b) (Exchange collects and transmits information on eligibility), 18082(a) (Exchange determines eligibility for advance premium tax credits), 18083 (the Exchange version of the “no wrong door” provision), 18092 (notification of non-enrollment includes information on services offered in Exchanges).

Before granting a waiver under Section 1332, both the state and federal governments must provide “a process for public notice and comment . . . sufficient to ensure a meaningful level of public input.” 42 U.S.C. § 18052(a)(4)(B)(i), (iii). The Departments have noted that, “[t]o the extent that a proposal is particularly wide-ranging, the proposed regulations will support a longer State public notice and comment period.” *Application, Review, and Reporting Process for Waivers for State Innovation*, 77 Fed. Reg. 11,700-1, 11,706 (Feb. 27, 2012); *see also id.* at 11,708 (same for the federal notice and comment period).

The Departments and Georgia violated these requirements multiple times. Georgia offered only 15 days for comment on the third version of its proposal—the final version made public before approval. That was wholly inadequate given the scale of the changes Georgia’s waiver makes to the state’s insurance market and the ongoing global pandemic. Every other state to seek a waiver has allowed at least 29 days for comment, and those waivers were generally far less significant than what Georgia has proposed.⁷⁶ In this regard, Georgia cannot rely on its comment period for the second version, which involved an “entirely different proposal that affected [essential health benefits] and financial assistance, and would not be reflective of stakeholder concerns or feedback on the current set of ideas.”⁷⁷

The Departments themselves offered thirty days for notice and comment, with a seven-day extension because of issues with its website portal.⁷⁸ But that amount of time is nonetheless insufficient for the public to fully comment on a waiver of this scope. “When substantial rule changes are proposed, a 30-day comment period is generally the *shortest* time period sufficient for interested persons to meaningfully review a proposed rule and provide informed comment.” *Nat’l Lifeline Ass’n v. FCC*, 921 F.3d 1102, 1117 (D.C. Cir. 2019) (emphasis added). “[B]ecause 30 days is ordinarily seen as the minimally acceptable period, two Executive Orders state that agencies should ‘generally’ or ‘in most cases’ provide at least 60 days for comments.” *Cath. Legal Immigr. Network, Inc. v. Exec. Off. for Immigr. Rev.*, 2021 WL 3609986, at *3 (D.D.C. 2021). Here, the gravity and complexity of Part II of Georgia’s waiver merited a longer federal notice and comment period. Georgia’s waiver is the first waiver to ever dispense with a state’s Exchange entirely—a matter far more significant than the plethora of reinsurance waivers and other minor adjustments approved by the Departments in the past.

Even more troubling, neither the state nor the Departments offered *any* opportunity for notice and comment following the state’s October 9, 2020 revisions to its application, including revisions regarding important subjects like auto-reenrollment and inappropriate steering. To the extent the state claims that those changes addressed critical shortcomings in the waiver, they merited full public scrutiny to test those assertions.

⁷⁶ The length of notice and comment periods is referenced in the states’ initial application letters. *See Section 1332: State Innovation Waivers*, CMS, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section-1332-State-Innovation-Waivers-> (last visited Jan. 9, 2021).

⁷⁷ Young & Levitis, *supra* note 8.

⁷⁸ *See* Ariel Hart, *Public Comment Function Broken on Kemp Proposal to Block ACA Website*, Atlanta J.-Const. (Sept. 8, 2020), <https://www.ajc.com/news/public-comment-function-broken-on-kemp-proposal-to-block-aca-website/ZJZARXW4KNESLIHFQMHKV6ARAI/>.

Finally, Part II of Georgia’s waiver was incomplete and vague, in violation of Section 1332 and its implementing regulations. The incompleteness of the state’s application further exacerbated the public’s inability to fully weigh in on the state’s proposal.

- The application failed to provide “[a] comprehensive description of the State legislation and program to implement a plan,” 45 C.F.R. § 155.1308(f)(3)(i); *see also* 42 U.S.C. § 18052(a)(4)(B)(ii)(II), because it said little about how the program would operate, how the state will fund or conduct functions previously performed by the federal exchange, or how the state intends to transition over to the new plan.
- Georgia has not enacted “State legislation that provides the State with authority to implement the proposed waiver,” 45 C.F.R. § 155.1308(f)(3)(ii), because it has only enacted legislation allowing the state to apply for a waiver rather than legislation authorizing Georgia’s intended approach.
- The application failed to provide an adequate “list of the provisions of law that the State seeks to waive,” *id.* § 155.1308(f)(3)(iii); *see also* 42 U.S.C. § 18052(a)(4)(B)(ii)(I). It says only that the state would waive relevant subsections of Section 1311, which is “a massive and multifaceted provision with over 100 subsections, paragraphs, and clauses,” ranging from “extensive standards for Marketplaces” to “rules on CMS responsibilities, plan certification, navigators, quality improvement, and mental health parity.”⁷⁹
- The application lacked “analyses, actuarial certifications, data, assumptions, targets and other information ... sufficient to provide ... the necessary data to determine that the State’s proposed waiver” meets the statutory guardrails. 45 C.F.R. § 155.1308(f)(3)(iv). As explained above, “the state makes entirely unsupported (and unsupported) claims about coverage gains and losses, neglects to consider important and obvious factors that will raise premiums in the state and makes other related errors.”⁸⁰

In sum, Part II of Georgia’s waiver was both procedurally and substantively deficient—a reflection of the haste with which the state and the Departments rammed through the application and the lack of any basis for it. It cannot be allowed to stand.

II. Recent events and policy changes have made Part II of Georgia’s waiver even more unsustainable.

The legal flaws outlined above provide more than enough reason to rescind Part II of Georgia’s waiver and require the state to come up with a new proposal that satisfies Section 1332 should it wish to engage in market reforms. However, in the time since Georgia’s waiver has been granted, multiple developments have taken place that strengthen the case for rescinding the waiver.

To start, the waiver is inconsistent with the Administration’s overarching approach toward policymaking and the ACA. Two of the President’s initial Executive Orders underscore

⁷⁹ Young & Levitis, *supra* note 8.

⁸⁰ *Id.*

that approach. The President issued Executive Order 13,095 on the day of his inauguration to emphasize that “the Federal Government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.”⁸¹ A week later, he issued Executive Order 14,009, directing federal agencies to “protect and strengthen Medicaid and the ACA and to make high-quality healthcare accessible and affordable for every American.”⁸² Our organizations, which provide health care to many people of color and other historically underserved communities, strongly agree with both of those goals, and urge the Departments to consider them in evaluating Georgia’s waiver.

While these broad policy shifts may not themselves invalidate Georgia’s waiver, they have been met with specific regulatory action that changes the assumptions and modeling underpinning Georgia’s proposed approach. Accompanying changes in federal law and policy have increased enrollment on Georgia’s Exchange, showing that the Exchange remains stable and that Georgia consumers continue to rely on the Exchange. The American Rescue Plan boosted premium tax credits and increased eligibility for those credits, thereby making enrollment cheaper for many Americans—and by 54% for Georgia enrollees.⁸³ The Families First Coronavirus Response Act provided incentives for states to keep Medicaid-eligible people enrolled for the duration of the COVID-19 pandemic.⁸⁴ CMS has also created new opportunities to enroll through executive action, including by extending the duration of open enrollment and creating a SEP for low-income individuals.⁸⁵ Finally, CMS has dramatically increased funding for outreach, marketing, and assistance, increasing awareness of Exchange coverage and making it easier for consumers to purchase coverage on the Exchange.⁸⁶

These policy changes have, in turn, achieved their intended effect. As of August 2021, Georgia’s Exchange had 549,000 enrollees—a figure that far outstrips Georgia’s estimate of 392,000 enrollees once its waiver is fully implemented in 2023.⁸⁷ But 2022 enrollment has blown through even that figure entirely. In just the first month and a half of 2022 open enrollment, over 9.7 million consumers purchased insurance on healthcare.gov, with nearly 654,000 in Georgia—

⁸¹ *Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, The White House (Jan. 20, 2021), <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.

⁸² *Executive Order on Strengthening Medicaid and the Affordable Care Act*, The White House (Jan. 28, 2021), <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/>.

⁸³ See *2021 Final Marketplace Special Enrollment Period Report*, CMS, <https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf> (last visited Jan. 9, 2022); Tara Straw & Jason Levitis, *Georgia’s Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked*, Ctr. on Budget & Pol’y Priorities (Dec. 17, 2021), <https://www.cbpp.org/research/health/georgias-plan-to-exit-marketplace-will-leave-more-people-uninsured-should-be>.

⁸⁴ Straw & Levitis, *supra* note 83.

⁸⁵ *Id.*; Katherine Swartz & John A. Graves, *Shifting the Open Enrollment Period for ACA Marketplaces Could Increase Enrollment and Improve Plan Choices*, 33 Health Affs. 1286 (July 2014), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.0007>.

⁸⁶ Straw & Levitis, *supra* note 83.

⁸⁷ *Id.*

a 27% increase over the same time period for 2021 open enrollment, and a 40% increase over 2020.⁸⁸ Including state-based Exchanges, the overall number rises to 13.6 million, an all-time high.⁸⁹ Updated projections from the Congressional Budget Office also support this higher enrollment baseline: in 2020 it predicted 2030 marketplace enrollment of 8 million people, but in 2021, it boosted this estimate to 10 million.⁹⁰ Finally, enrollment in Medicaid remains high nationwide in the wake of the pandemic.⁹¹ By changing the statutory baseline, these new developments have raised the bar that Georgia's waiver must meet to pass muster under the guardrails. Allowing Georgia's waiver to stand would undercut these substantial gains.

Maintaining Georgia's waiver would also lessen the benefits that our organizations have derived from these changes. We have been heartened by the Administration's focus on equity and increasing coverage and by the many steps the Administration has taken to increase coverage among the communities that we serve. Many people of color, women, trans- and nonbinary individuals, people with special health needs, and others have benefited from increased access to Marketplace coverage and to Medicaid. But if Georgia's waiver remains in place, many Georgia consumers would be shunted from their existing coverage options and into more expensive or less comprehensive, non-ACA compliant plans. Many would end up uninsured, or with plans that do not cover the reproductive health services offered by our organizations. The Administration should not allow the effects of its major initiatives to be canceled out in Georgia.

Despite these legal and policy changes, which further call into question the validity and soundness of Georgia's waiver, the state has repeatedly and unlawfully refused to provide the Departments with updated actuarial and economic analyses about its waiver.⁹² Section 1332, federal regulations, and the terms and conditions of its waiver require Georgia to, among other things: comply with Section 1332 throughout the lifespan of its waiver;⁹³ comply with pertinent

⁸⁸ See *Marketplace 2022 Open Enrollment Period Report*, *supra* note 7; *Federal Health Insurance Exchange Weekly Enrollment Snapshot: Week Six*, CMS (Dec. 18, 2020), <https://www.cms.gov/newsroom/fact-sheets/federal-health-insurance-exchange-weekly-enrollment-snapshot-week-six>; *Federal Health Insurance Exchange Weekly Enrollment Snapshot: Week 7*, CMS (Dec. 20, 2019), <https://www.cms.gov/newsroom/fact-sheets/federal-health-insurance-exchange-weekly-enrollment-snapshot-week-7>.

⁸⁹ *All-Time High: 13.6 Million People Signed Up for Health Coverage on the ACA Insurance Marketplaces With a Month of Open Enrollment Left to Go*, CMS (Dec. 22, 2021), <https://www.cms.gov/newsroom/press-releases/all-time-high-136-million-people-signed-health-coverage-aca-insurance-marketplaces-month-open>.

⁹⁰ *Compare Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT's September 2020 Projections*, Cong. Budget Off. (Aug. 29, 2020), <https://www.cbo.gov/system/files/2020-10/51298-2020-09-healthinsurance.pdf>, with *Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT's July 2021 Projections*, Cong. Budget Off. (July 2021), <https://www.cbo.gov/system/files/2021-08/51298-2021-07-healthinsurance.pdf>.

⁹¹ *CMS Releases Latest Enrollment Figures for Medicare, Medicaid, and Children's Health Insurance Program (CHIP)*, CMS (Dec. 21, 2021), <https://www.cms.gov/newsroom/news-alert/cms-releases-latest-enrollment-figures-medicare-medicicaid-and-childrens-health-insurance-program-chip>.

⁹² Letter from Grant Thomas, Dir., Georgia Gov.'s Office of Health Strategy & Coordination, to Chiquita Brooks-LaSure, Admin., CMS (July 2, 2021), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Response-1332-GA-request-Updated-GA-Analysis-Letter.pdf>; Letter from Grant Thomas, Dir., Georgia Gov.'s Office of Health Strategy & Coordination, to Chiquita Brooks-LaSure, Admin., CMS (Aug. 26, 2021), <https://www.cms.gov/files/document/1332-georgia-letter-cms-82621.pdf>; see generally Straw & Levitis, *supra* note 79.

⁹³ See, e.g., 45 C.F.R. § 155.1320(a)(1); *Approval Letter*, *supra* note 37, at STC 6 at 30-31.

changes in federal law and policy;⁹⁴ and provide the Departments with data and information about its waiver upon request.⁹⁵ By refusing to provide the Departments with updated information about how its waiver complies with federal law, Georgia has flatly violated these requirements and suggested that it does not intend to comply with federal law moving forward. Georgia's ongoing recalcitrance, coupled with the changes in federal law and policy outlined above, therefore provides sufficient reason by itself to rescind Part II of Georgia's waiver.

III. The Departments can and should rescind Part II of Georgia's 1332 waiver.

These concerns provide the Departments with ample reason to rescind Georgia's waiver, and it has the authority to do so. Under the governing regulations,

The Secretary and the Secretary of the Treasury, as applicable, reserve the right to suspend or terminate a section 1332 waiver in whole or in part, at any time before the date of expiration, whenever the Secretary or the Secretary of the Treasury, as applicable, determines that a State has materially failed to comply with the terms of a section 1332 waiver.

45 C.F.R. § 155.1320(d). The terms and conditions of Georgia's waiver reiterate that

[t]he Departments reserve the right to amend, suspend, or terminate, the waiver (in whole or in part) at any time before the date of expiration, only if the Departments determine that the state has materially failed to comply with these STCs, or if the state fails to meet the specific statutory requirements or 'guardrails' related to coverage, affordability, comprehensiveness, or deficit neutrality.⁹⁶

The legal flaws described above, coupled with the mounting evidence against Georgia's waiver, have triggered these provisions. Indeed, if the agency chooses not to rescind the waiver in the face of these violations, our organizations will be forced to maintain our existing legal challenge and seek a ruling vacating the waiver.

To start, Georgia's waiver plainly fails to meet Section 1332's statutory guardrails, especially in light of subsequent legal and policy changes which have improved the statutory baseline. *See supra* Part II. Whether or not Georgia's waiver was sustainable at the time it was approved, these changed conditions mean that the waiver no longer passes muster under Section 1332. And Georgia's non-compliance with the guardrails plainly provides sufficient cause under the regulations for termination.⁹⁷ Were it otherwise, the Departments would have to stand idly by while a state's residents lose the benefits and protections of the ACA.

⁹⁴ *See, e.g.*, 45 C.F.R. § 155.1320(a)(1); *Approval Letter, supra* note 37, STC 7 at 31.

⁹⁵ *See, e.g.*, 42 U.S.C. § 18052(a)(4)(B)(iv), (v); 45 C.F.R. § 155.1320(a)(2), (b), (f); *Approval Letter, supra* note 37, STC 12, 14, 15, 16 at 34-39.

⁹⁶ *Approval Letter, supra* note 37, STC 17 at 39.

⁹⁷ *Id.*

But Georgia’s waiver also could not have been lawfully approved in 2020. For the reasons explained above, the Departments’ and the state’s analysis was so deficient as to violate Section 1332 and to constitute arbitrary and capricious decision-making under the Administrative Procedure Act. *See supra* Sections I.A., I.B. It is no defense that Georgia’s waiver purported to comply with the 2018 Guidance: that guidance conflicted with the governing statute, *see id.* Section I.B., and has since been revoked, requiring Georgia to conform to the changed regulations, *see id.*; and besides, Georgia’s waiver failed to comply even with the lenient standards of the 2018 Guidance, *see supra* page 11. For that reason, a reviewing court would be justified in vacating the Departments’ decision as it stood in 2020. Instead, the Departments should voluntarily correct their own error and rescind Georgia’s waiver.

The Departments’ decision to grant Georgia’s waiver also exceeded their statutory authority, and so that decision is null and void. *See supra* Section I.C. “Agency actions beyond delegated authority are ‘ultra vires,’ and courts must invalidate them.” *Transohio Sav. Bank v. Dir., Off. of Thrift Supervision*, 967 F.2d 598, 621 (D.C. Cir. 1992), *abrogated on other grounds as recognized in Perry Cap. LLC v. Mnuchin*, 864 F.3d 591, 620 (D.C. Cir. 2017). That principle applies even where an agency exceeds its authority in contracting with another party: “anyone entering into an arrangement with the Government takes the risk of having accurately ascertained that he who purports to act for the Government stays within the bounds of his authority.” *Id.* at 623 (quoting *Federal Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 384 (1947)); *see also FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 125 (2000) (“Regardless of how serious the problem an administrative agency seeks to address ... it may not exercise its authority ‘in a manner that is inconsistent with the administrative structure that Congress enacted into law.’”) (quoting *ETSI Pipeline Project v. Missouri*, 484 U.S. 495, 517 (1988)).

Similarly, both the regulations and the terms of Georgia’s waiver make plain that the Departments’ authority under Section 1332 is limited.

Per ... 45 C.F.R. § 155.1320(a), the state must comply with all applicable federal laws and regulations, unless a law or regulation has been specifically waived. The Departments’ state innovation waiver authority is limited to requirements described in section 1332(a)(2) of the [ACA]. Further, section 1332(c) of the [ACA] states that, while the Departments have broad discretion to determine the scope of a waiver, no federal laws or requirements may be waived that are not within the Secretaries’ authority.⁹⁸

Georgia was therefore on notice that the Departments lacked the authority to waive certain provisions, and that it would still be required to comply with provisions that the Departments did not and could not have lawfully waived. Georgia’s waiver is therefore void to the extent it purports to confer authority to the contrary.

Even assuming that the Departments had the statutory authority to grant Georgia’s waiver, they failed to exercise that authority in a procedurally proper manner. *See supra* Section I.D. However, the Departments may correct that error by rescinding Georgia’s waiver. “Administrative tribunals, like courts, have the power to reopen and permit the correction of

⁹⁸ *Id.* STC 6 at 30-31.

procedural error.” *Liu v. Waters*, 55 F.3d 421, 425 (9th Cir. 1995); *see, e.g., Bookman v. United States*, 453 F.2d 1263, 1265 (Ct. Cl. 1972) (“[I]t is the general rule that ‘[e]very tribunal, judicial or administrative, has some power to correct its own errors or otherwise appropriately to modify its judgment, decree, or order.’”) (quoting 2 Davis, *Administrative Law Treatise* 606 (1958)); *Gun S., Inc. v. Brady*, 877 F.2d 858, 863 (11th Cir. 1989) (collecting cases).⁹⁹ “An agency, like a court, can undo what is wrongfully done by virtue of its order.” *United Gas Improvement Co. v. Callery Props., Inc.*, 382 U.S. 223, 229 (1965). The terms and conditions of Georgia’s waiver do not displace that power, nor could they. To the contrary, the terms reiterate that “no federal laws or requirements may be waived that are not within the Secretaries’ authority”¹⁰⁰—language that naturally assumes that the Secretaries’ authority must be properly exercised. Otherwise, the Departments would be powerless to correct even a blatant procedural error, like failing to provide notice and comment at all.

If more cause were needed, Georgia’s repeated refusal to provide updated analysis to the Departments would supply it. *See supra* Part II. It constitutes a breach of the express terms of the waiver.¹⁰¹ 45 C.F.R. § 155.1320(d). And that breach is material. There are serious questions about whether Georgia’s waiver can keep up with the tremendous growth in ACA enrollment over the last year—even assuming that it matched the ACA in the first place—and Georgia has been given multiple opportunities to supply the requested information. It has instead chosen obstinance and, indeed, belligerence. The Departments should not provide any more chances.

Georgia may argue that it would be unreasonable to rescind its waiver given that it has already expended resources in implementing the Georgia Access Model. But that argument would suffer from several serious flaws. Most importantly, Georgia’s responses—such as they are—to the Departments’ repeated requests for information provide virtually no concrete details about the pace of its implementation or resources expended by the state.¹⁰² That failure calls into question whether Georgia has any reliance interests whatsoever. Indeed, the state has apparently not even appropriated funds for Part I of its waiver, pertaining to its proposed reinsurance program, which was supposed to take effect on January 1, 2022.

The presence of serious legal challenges to Georgia’s waiver also undermines any claim the state might have to reasonable reliance. As the D.C. Circuit has explained, where an agency’s policy has been subject to “persistent legal challenges,” “[a]ny reliance ... would not have been reasonable unless tempered by substantial concerns for legal or political jeopardy.” *Mozilla Corp. v. FCC*, 940 F.3d 1, 64 (D.C. Cir. 2019).¹⁰³ But even where a party’s “reliance interests

⁹⁹ As *Gun South* notes, several cases have also applied this principle to orders like licenses which confer authority to engage in conduct that would otherwise be prohibited.

¹⁰⁰ *Approval Letter*, *supra* note 37, STC 6 at 30-31.

¹⁰¹ *See supra* notes 91-94.

¹⁰² *See* sources cited *supra* note 92.

¹⁰³ Similarly, the D.C. Circuit in *Bell Atlantic Telephone Companies v. FCC* held that a new policy did not “upset petitioners’ reasonable reliance interests” because “the state of the law has never been clear, and the issue has been disputed since it first arose.” 79 F.3d 1195, 1207 (D.C. Cir. 1996); *see also California v. Wheeler*, 2020 WL 3403072, at *8 (N.D. Cal. 2020) (“[G]iven the long uncertainty about the permissible scope of federal regulation under the [Clean Water Act], it is difficult to see how significant cognizable reliance interests would have arisen.”); *Amgen Inc. v. Hargan*, 285 F. Supp. 3d 351, 367 (D.D.C. 2018) (finding weaker reliance interests where “[t]he

rank as serious, they are but one factor to consider”; the agency “may determine, in the particular context before it, that other interests and policy concerns outweigh any reliance interests.” *DHS v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1914 (2020). Here, any interests created by Georgia’s unreasonable reliance on its waiver are outweighed by the need to prevent up to 100,000 Georgia consumers from losing high-quality, ACA-compliant coverage.¹⁰⁴

If the Departments choose to rescind Georgia’s waiver, we would encourage the Departments to expressly rely on that waiver’s unlawfulness, in addition to explaining why circumstances have changed since the waiver was approved and/or relying on Georgia’s failure to provide requested information. Doing so would send a strong signal that the Departments intend to abide by the law in issuing Section 1332 waivers. That approach is also more likely to be upheld by a reviewing court: “[w]here ... an agency has set out multiple independent grounds for a decision,” a court “will affirm the agency so long as any one of the grounds is valid, unless it is demonstrated that the agency would not have acted on that basis if the alternative grounds were unavailable.” *Fogo De Chao (Holdings) Inc. v. DHS*, 769 F.3d 1127, 1149 (D.C. Cir. 2014) (quotation omitted). The waiver’s legal flaws also underscore why rescission is the only reasonable alternative, and why any purported reliance interests are unavailing.

In any event, the Departments should rescind Georgia’s waiver expeditiously. Georgia consumers deserve to know whether their access to the Exchange will be maintained, and organizations that provide health services, like ours, need to understand what the marketplace will look like moving forward. Rescinding Georgia’s waiver quickly would also further defuse any argument from the state that it has already sunk costs in implementing the Georgia Access Model. Georgia should not be permitted a third chance to supply the information it has refused to provide, nor to further delay the Departments’ review process in any way.

* * *

We encourage the Departments to promptly rescind Georgia’s 1332 waiver. If you have any questions or would like to discuss the information contained in this comment, please contact our counsel at the Democracy Forward Foundation, John Lewis, jlewis@democracyforward.org.

Respectfully submitted,

Planned Parenthood Southeast, Inc.
Feminist Women’s Health Center

[Food and Drug Administration]’s change in position ... hardly came out of the blue; it followed a judicial decision” holding that its prior policy was inconsistent with the governing statute); *cf. Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2127 (2016) (dealing with the elimination of a “longstanding” exemption).

¹⁰⁴ By the same token, any reliance interests by private parties should not compel the Departments to maintain Georgia’s waiver. Even assuming such reliance is both documented by evidence and reasonable in light of the waiver’s illegality, the interests of consumers must be given paramount consideration.

EXHIBIT A

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

PLANNED PARENTHOOD SOUTHEAST,
INC.

241 Peachtree St. NE, Suite 400
Atlanta, GA 30303; and

FEMINIST WOMEN'S HEALTH CENTER

1924 Cliff Valley Way NE
Atlanta, GA 30329;

Plaintiffs,

v.

Case No.

ALEX M. AZAR, II, in his official capacity
as Secretary of Health and Human
Services,

200 Independence Ave. SW
Washington, DC 20201;

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES

200 Independence Ave. SW
Washington, DC 20201;

SEEMA VERMA, in her official capacity as
Administrator of the Centers for Medicare
and Medicaid Services,

7500 Security Blvd.
Baltimore, MD 21244;

CENTERS FOR MEDICARE AND
MEDICAID SERVICES

7500 Security Blvd.
Baltimore, MD 21244;

STEVEN T. MNUCHIN, in his official
capacity as Secretary of the Treasury,

1500 Pennsylvania Ave. NW
Washington, DC 20220;

DAVID KAUTTER, in his official capacity
as Assistant Secretary for Tax Policy,
United States Department of the Treasury,
1500 Pennsylvania Ave. NW
Washington, DC 20220; and the

UNITED STATES DEPARTMENT OF THE
TREASURY
1500 Pennsylvania Ave. NW
Washington, DC 20220,

Defendants.

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

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Plaintiffs Planned Parenthood Southeast, Inc. and Feminist Women’s Health Center hereby sue Alex M. Azar, II, in his official capacity as Secretary of Health and Human Services, the United States Department of Health and Human Services, Seema Verma, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services, the Centers for Medicare and Medicaid Services, Steven T. Mnuchin, in his official capacity as Secretary of the Treasury, David Kautter, in his official capacity as Assistant Secretary for Tax Policy, United States Department of the Treasury, and the United States Department of the Treasury, and allege as follows:

1. The Patient Protection and Affordable Care Act (the “ACA”), enacted in 2010, has provided affordable, high-quality health insurance to millions of Americans over the last decade, including to millions of Americans who could not previously purchase health insurance because of preexisting health conditions or inadequate financial support. A critical part of the ACA’s reforms is its Exchanges: online marketplaces where consumers can go to compare qualified health plans, obtain information about public programs for which they may be eligible, and, ultimately, enroll in the coverage that’s right for them. Prior to the ACA, consumers had to go to individual insurers or brokers to survey their offerings and to purchase a plan—an arduous and time-consuming process. Now, consumers can go to an Exchange established by their state, or in states that have not established Exchanges, to healthcare.gov, which is administered by the federal government.

2. A recent decision by Defendants—amidst the COVID-19 pandemic—threatens to reverse this considerable progress in the State of Georgia. Over the course of 2019 and 2020, Georgia submitted several versions of an application for a State Innovation Waiver under Section 1332 of the ACA. *See* 42 U.S.C. § 18052. Section 1332 is intended to give states flexibility to

innovate in providing coverage to their residents. To that end, Section 1332 allows states to waive certain ACA requirements, so long as they can show that their proposed alternative would match the ACA with respect to coverage, comprehensiveness, affordability, and deficit neutrality—criteria referred to as Section 1332’s “statutory guardrails.” *Id.* § 18052(b)(1).

3. Georgia’s plan, however, would tear a hole in the ACA—overriding Congress’s considered legislative judgments and eviscerating the ACA’s substantial achievements. Georgia’s proposal, the euphemistically named “Georgia Access Model,” does away with Georgia consumers’ access to healthcare.gov. It forces them to shop through private insurance companies, agents, and brokers, rather than through a single, consolidated marketplace. In this respect, the Georgia Access Model essentially returns the health insurance shopping experience for Georgia consumers to how it stood before the ACA was enacted. Despite overwhelming public opposition to Georgia’s plan, Defendants approved the final version of Georgia’s application on November 1, 2020.

4. Defendants’ decision is unlawful for several reasons. Most importantly, the Georgia Access Model will drastically underperform the ACA and therefore violates the statutory guardrails. As the record before Defendants demonstrated, it will decrease enrollment in Georgia by up to 100,000 consumers, violating the coverage guardrail; shift consumers to non-ACA-compliant junk plans that provide inadequate coverage, violating the comprehensiveness guardrail; and result in increased premiums that consumers must pay to receive coverage, violating the affordability and deficit neutrality guardrails. In nonetheless approving the Georgia Access Model, Defendants violated Section 1332, as well as the Administrative Procedure Act’s requirements for reasoned agency decisionmaking.

5. Defendants’ decision was itself based in substantial measure on a guidance document from 2018 that weakened the standards for approving waivers under Section 1332 (the “2018 Guidance”). *See State Relief and Empowerment Waivers*, 83 Fed. Reg. 53,575 (Oct. 24, 2018). The 2018 Guidance interprets Section 1332 to permit waivers that would promote non-ACA-compliant coverage, including short-term, limited-duration insurance plans and association health plans. *See, e.g., id.* at 53,576-77. To that end, the 2018 Guidance interprets the “comprehensiveness” and “affordability” guardrails of Section 1332 to focus only on the “nature of coverage that is made available to state residents” by a proposed state plan, “rather than on the coverage that residents actually purchase.” *Id.* at 53,576. The 2018 Guidance therefore unlawfully encourages state plans—like Georgia’s—intended to drive consumers toward junk plans that are anathema to the ACA. Even under the 2018 Guidance, however, Georgia’s plan still violates the coverage guardrail and is therefore unlawful.

6. Georgia’s plan also suffers from several other flaws. By allowing Georgia to terminate its reliance on healthcare.gov without creating a state Exchange in its place, Defendants’ decision grossly exceeds their authority under Section 1332, which allows the waiver of a discrete list of statutory requirements. Even if Defendants had the authority to grant Georgia’s waiver, both Georgia and Defendants rushed Georgia’s application through the approval process—again, amidst a global pandemic placing extraordinary strain on health system stakeholders—and deprived the public of adequate time to comment on Georgia’s radical changes. And Georgia’s application itself was deficient in numerous respects, failing to explain core elements of the state’s plan and reasoning.

7. If allowed to stand, Defendants’ decision to approve Georgia’s waiver will harm Georgia consumers and those who serve them, including Plaintiffs. Plaintiffs Planned

Parenthood Southeast and the Feminist Women’s Health Center are healthcare providers that offer reproductive health services to thousands of otherwise-underserved patients in Georgia. By dismantling Georgia’s Exchange, the Georgia Access Model will make obtaining health insurance—particularly insurance that covers Plaintiffs’ services—more expensive and difficult for Plaintiffs’ patients. That result will strain Plaintiffs’ resources by increasing demand for them to provide uncompensated care to their patient populations, by making their patients less healthy and therefore more resource-intensive to care for, and by making it more complicated for them to assist their patients in obtaining insurance coverage for their services. In each of these ways, Georgia’s waiver inflicts significant, tangible injuries on Plaintiffs.

8. For these reasons, and as described more fully below, the Court should declare that Defendants’ issuance of a waiver to Georgia under Section 1332 is unlawful and that the related 2018 Guidance is unlawful, set both the waiver and the Guidance aside, and enjoin Defendants from issuing the proposed waiver to Georgia or processing future waivers under the terms of the 2018 Guidance.

JURISDICTION AND VENUE

9. The Court has subject matter jurisdiction over this action under 28 U.S.C. § 1331 because this action arises under federal law.

10. Venue is proper in this district under 28 U.S.C. § 1391(e), because Defendants are officers and agencies of the United States and Defendants Alex M. Azar, II, the United States Department of Health and Human Services, Steven T. Mnuchin, David Kautter, and the United States Department of the Treasury are located in Washington, DC.

PARTIES

11. Plaintiff Planned Parenthood Southeast, Inc. (“PPSE”) is a not-for-profit corporation registered in Georgia. PPSE “believes in the fundamental right of each individual,

throughout our service area, to manage his or her fertility.”¹ “Based on these beliefs, and reflecting the diverse communities within which [it] operate[s], the mission of Planned Parenthood Southeast is:”

- a. “to provide comprehensive reproductive and complementary health care services in settings which preserve and protect the essential privacy and rights of each individual”;
- b. “to advocate for public policies which guarantee these rights and ensure access to such services”;
- c. “to provide educational programs which enhance understanding of individual and societal implications of human sexuality”; and
- d. “to participate in research that supports the advancement of reproductive health care and encourages understanding of their inherent bioethical, behavioral, and social implications.”²

12. PPSE and its corporate predecessors have provided care in Georgia for over 50 years. PPSE operates four health centers in Georgia, located in DeKalb, Gwinnett, Cobb, and Chatham counties, and an additional three health centers in Alabama and Mississippi. PPSE provides comprehensive reproductive health care, including family planning services, testing and treatment for sexually transmitted infections (“STIs”), cancer screening and treatment, pregnancy testing, all options counseling, and abortion.

13. Plaintiff Feminist Women’s Health Center (“FWHC”) is a non-profit reproductive health care facility registered in the state of Georgia and located in DeKalb County. FWHC has

¹ *Who We Are*, Planned Parenthood Southeast, <https://www.plannedparenthood.org/planned-parenthood-southeast/who-we-are> (last visited Jan. 13, 2021).

² *Id.*

been providing reproductive health care in the state since 1976. It currently provides a range of services, including abortion up to 21 weeks and 6 days from the first day of a woman's last menstrual period, contraception, annual gynecological examinations, miscarriage management, STI testing and treatment, and transgender health care, such as hormone replacement therapy. FWHC also engages in community education, grassroots organizing, public affairs, and advocacy programs to advance reproductive health, rights, and justice for all Georgians.

14. Defendant Alex M. Azar, II, is sued in his official capacity as Secretary of Health and Human Services.

15. Defendant the United States Department of Health and Human Services ("HHS") is a federal agency headquartered in Washington, DC, at 200 Independence Avenue SW, Washington, DC, 20201.

16. Defendant Seema Verma is sued in her official capacity as Administrator of the Centers for Medicare and Medicaid Services.

17. Defendant the Centers for Medicare and Medicaid Services ("CMS") is a component of Defendant HHS and is headquartered in Baltimore, Maryland, at 7500 Security Boulevard, Baltimore, MD, 21244.

18. Defendant Steven T. Mnuchin is sued in his official capacity as Secretary of the Treasury.

19. Defendant David Kautter is sued in his official capacity as Assistant Secretary for Tax Policy, United States Department of the Treasury.

20. Defendant the United States Department of the Treasury ("Treasury") is a federal agency headquartered in Washington, DC, at 1500 Pennsylvania Avenue NW, Washington, DC 20220.

FACTUAL ALLEGATIONS

I. The Affordable Care Act

A. The ACA's reforms

21. In 2010, Congress passed, and President Obama signed into law, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010)).

22. One of the primary objectives of the ACA is “to expand coverage in the individual health insurance market.” *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015); *see also Maine Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1315 (2020) (explaining that the Act seeks “to improve national health-insurance markets and extend coverage to millions of people without adequate (or any) health insurance”); *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012) (“The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care.”); *Doe #1 v. Trump*, 957 F.3d 1050, 1063 (9th Cir. 2020) (explaining that Congress aimed “[t]o incentivize the purchase of insurance plans through ACA marketplaces”).

23. In enacting the ACA, Congress concluded that high uninsured and underinsured rates harm both individuals who lack adequate insurance and society as a whole. Specifically, Congress found that the uninsured suffer from “poorer health and shorter lifespan”; that the “cost of providing uncompensated care to the uninsured” is high; that “health care providers pass on the cost to private insurers, which pass on the cost to families” by “increas[ing] family premiums”; and that, because many “personal bankruptcies are caused in part by medical expenses,” “significantly increasing health insurance coverage ... will improve financial security for families.” 42 U.S.C. § 18091(2)(E)-(G).

24. Prior to the enactment of the ACA, individual health insurance markets were dysfunctional: “premiums for these policies were increasing more than 10% a year, on average, while the policies themselves had major deficiencies,” including that they “often excluded pre-existing conditions” and “charged higher premiums for people with health risks.”³

25. As the Supreme Court has explained, many state efforts to reform the individual health insurance market in the 1990s were unsuccessful. *King*, 135 S. Ct. at 2485-86. The ACA “grew out of [this] long history of failed health insurance reform,” *id.* at 2485, and aims to achieve systemic improvements in the individual health insurance market by means of certain key reforms, including:

- a. ***Nondiscrimination on the basis of health status and health history.*** The ACA requires “each health insurance issuer that offers health insurance coverage in the individual ... market in a State [to] accept every ... individual in the State that applies for such coverage,” 42 U.S.C. § 300gg-1(a), and bars insurers from charging higher premiums on the basis of a person’s health, *id.* § 300gg(a).
- b. ***Coverage for essential health benefits.*** Insurance for individuals and families sold on ACA Exchanges must cover “essential health benefits,” *id.* § 300gg-6(a), and so-called “cost-sharing” payments—for example, deductibles and copayments—for such coverage are limited, *see id.* §§ 300gg-6(b), 18022(a)(2), (c).

³ David Blumenthal & Sara Collins, *Where Both the ACA and AHCA Fall Short, and What the Health Insurance Market Really Needs*, Harv. Bus. Rev. (Mar. 21, 2017), <https://hbr.org/2017/03/where-both-the-aca-and-ahca-fall-short-and-what-the-health-insurance-market-really-needs>.

- c. ***Subsidized coverage.*** The ACA “seeks to make insurance more affordable by giving refundable tax credits to individuals with household incomes between 100 percent and 400 percent of the federal poverty line.” *King*, 135 S. Ct. at 2487 (citing 26 U.S.C. § 36B; 42 U.S.C. §§ 18081, 18082).

26. Through these reforms, the ACA aims to increase enrollment in affordable, high-quality health coverage. But increasing enrollment in quality health insurance coverage is not only the ACA’s immediate goal; it is also key to the ACA’s long-term success. “At the overall market level, enrollment must be high enough to reduce random fluctuations in claims from year to year.”⁴ In addition, “[b]ecause the ACA prohibits health plans from denying coverage or charging higher premiums based on pre-existing health conditions, having affordable premiums depends on enrolling enough healthy individuals over which the costs of the less-healthy individuals can be spread. Enrollment of only individuals with high health care needs ... can produce unsustainable upward premium spirals.”⁵

B. The ACA’s Exchanges

27. To help individuals learn about and enroll in the health coverage options that are available to them, the ACA requires each State to “establish” an “Exchange” that “facilitates the purchase of qualified health plans” (“QHPs”). 42 U.S.C. § 18031(b)(1); *see also Maine Cmty. Health Options*, 140 S. Ct. at 1315 (explaining that the ACA “called for the creation of virtual health-insurance markets, or ‘Health Benefit Exchanges,’ in each State,” to serve the “end” of increased coverage); *King*, 135 S. Ct. at 2487 (explaining that the ACA “requires the creation of

⁴ *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*, Am. Academy of Actuaries 5 (Jan. 2017), https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

⁵ *Id.*

an ‘Exchange’ in each State where people can shop for insurance, usually online”). “ACA exchanges are virtual marketplaces in which consumers and small businesses can shop for and purchase private health insurance coverage and, where applicable, be connected to public health insurance programs.”⁶

28. Prior to the enactment of the ACA, individuals generally had to purchase insurance through private insurers, agents, and brokers, rather than through a consolidated marketplace. Those “individual and small group health insurance markets ... suffered from adverse selection and high administrative costs, resulting in low value for consumers.”⁷ In 2006, however, Massachusetts created the first successful health insurance marketplace—an exchange referred to as the “Connector”—which then served as a model for the ACA’s Exchanges.⁸

29. The Exchanges have therefore been described as the “centerpiece,”⁹ a “central feature,”¹⁰ and “the major national innovation”¹¹ of the ACA’s reforms. As President Obama explained in signing the ACA, “Once this reform is implemented, health insurance exchanges

⁶ Vanessa C. Forsberg, Cong. Res. Serv., R44065, *Overview of Health Insurance Exchanges* 1 (June 20, 2018), <https://fas.org/sgp/crs/misc/R44065.pdf>.

⁷ *Initial Guidance to States on Exchanges*, CMS, [https://www.cms.gov/CCIIO/Resources/Files/guidance to states on exchanges](https://www.cms.gov/CCIIO/Resources/Files/guidance%20to%20states%20on%20exchanges) (last visited Jan. 13, 2021).

⁸ William P. Brandon & Keith Carnes, *Federal Health Insurance Reform and “Exchanges”*: *Recent History*, 25 *J. of Health Care for the Poor & Underserved*, at xxxii, xli (Feb. 2014), [https://www.researchgate.net/publication/260130007 Federal Health Insurance Reform and Exchanges Recent History](https://www.researchgate.net/publication/260130007_Federal_Health_Insurance_Reform_and_Exchanges_Recent_History).

⁹ Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, The Commonwealth Fund, at v (July 2010), https://www.commonwealthfund.org/sites/default/files/documents/_media_files_publications_fund_report_2010_jul_1426_jost_hlt_insurance_exchanges_aca.pdf.

¹⁰ Sharon Silow-Carroll et al., *Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection*, The Commonwealth Fund, <https://www.commonwealthfund.org/publications/newsletter-article/health-insurance-exchanges-state-roles-selecting-health-plans-and> (last visited Jan. 13, 2021).

¹¹ Brandon & Carnes, *supra* note 8, at xxxii.

will be created, a competitive marketplace where uninsured people and small businesses will finally be able to purchase affordable, quality insurance.”¹²

30. The Exchanges “are intended to provide a seamless, single point of access for individuals to enroll into private health plans, apply for income-based financial subsidies established under the law, and, as applicable, obtain an eligibility determination for other health coverage programs, such as Medicaid or the State Children’s Health Insurance Program (CHIP).”¹³ The ACA’s Exchanges are grounded in substantial scholarship from health economists and policy scholars finding that competitive, well-managed marketplaces “reward quality, efficiency, and value among insurers and plans.”¹⁴

31. To that end, the ACA’s Exchanges “are designed to streamline enrollment and help ensure affordability for a range of consumers. Exchanges must offer centralized, online mechanisms for plan enrollment[,] ... are responsible for determining purchasers’ eligibility for plans and subsidies,” and “must coordinate with other federal institutions, including [CMS] and [Treasury], to ensure that consumers receive the maximum possible assistance in the form of tax credits and/or cost-sharing subsidies.”¹⁵

32. Exchanges must also play an active role in helping consumers obtain coverage. Specifically, “Exchanges have a number of responsibilities related to assisting consumers in accessing and obtaining coverage, including providing tools to help consumers access the

¹² *Statement by President of the United States; Statement by President Barack Obama Upon Signing H.R. 3590*, 2010 U.S.C.C.A.N. S6.

¹³ U.S. Gov’t Accountability Off., GAO-13-601, *Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges 2* (June 2013), <https://www.gao.gov/assets/660/655291.pdf>.

¹⁴ Margo M. Hoyler et al., *Insurance Exchanges Under the Affordable Care Act: How Will They Affect Surgical Care?*, Bull. of the Am. Coll. of Surgeons (May 1, 2013), <https://bulletin.facs.org/2013/05/insurance-exchanges/>.

¹⁵ *Id.*

exchange, helping consumers determine which plan or program to enroll in, and helping consumers determine their potential financial responsibility for a QHP offered through an exchange.”¹⁶

33. As CMS put it in its first Exchange-related rule, the Exchanges “will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs, and Exchanges will give individuals and small businesses the same purchasing clout as big businesses.”¹⁷

34. Indeed, CMS again recognized just over a month ago that

[o]ne of the primary advantages of th[e] [Exchange] design is that consumers can access one-stop shopping for all QHPs offered through an Exchange and can access relevant details on such plans in a standardized format. Before Exchanges existed, consumers shopping for individual market health insurance who tried to search for this information would have to contact multiple issuers or visit multiple websites, and the information would often be presented inconsistently, preventing true apples-to-apples comparison shopping. Exchange-run application and enrollment websites also help to manage churn between private health insurance coverage and public programs such as Medicaid and CHIP by offering connections to those public programs for individuals who may qualify for participation.

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates To State Innovation Waiver (Section 1332 Waiver) Implementing Regulations, 85 Fed. Reg. 78,572, 78,618 (Dec. 4, 2020).

35. Exchanges may offer only quality health insurance plans, referred to as “qualified health plans” or “QHPs” under the Act. 42 U.S.C. § 18031(b)(1), (c); *see id.* § 18021(a). QHPs

¹⁶ Bernadette Fernandez & Annie L. Mach, Cong. Res. Serv., R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)* 14 (Aug. 15, 2012), <https://www.ncsl.org/documents/health/CRS-ExchgRpt81512.pdf>.

¹⁷ *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers*, 77 Fed. Reg. 18,310, 18,311 (Mar. 27, 2012).

must cover preexisting conditions and essential health benefits and cannot impose annual or lifetime-dollar limits on core coverage. *See, e.g., id.* §§ 300gg-3(a), -6(a), -11, 18022. For ease of comparison, the ACA differentiates plans along four standard metallic tiers—Bronze, Silver, Gold, and Platinum, from least to most generous—according to how they apportion costs between individuals and issuers. *Id.* § 18022(d).

36. An Exchange may be established by the state in which it operates or, in states that have elected not to establish Exchanges, by the federal government. *See King*, 135 S. Ct. at 2487 (citing 42 U.S.C. §§ 18031(b)(1), 18041(c)(1)); 45 C.F.R. § 155.105(f).¹⁸ As of 2021, fifteen states operated “state-based exchanges” or “SBEs” (operating their own websites rather than using the federally run healthcare.gov), thirty states relied principally on the federal government to run their “federally facilitated exchanges” or “FEEs” using healthcare.gov, and six states had hybrid exchanges that assume some, but not all, exchange functions.¹⁹

37. Since the effective date of the ACA’s Exchange provisions and, as of the filing of this lawsuit, Georgia has had a federally facilitated Exchange.²⁰

C. The ACA’s substantial achievements

38. When faithfully implemented, the ACA’s reforms, including the Exchanges, successfully met Congress’s goal of enabling more individuals—specifically, 20 million more individuals—to enroll in health insurance coverage. At the time the ACA was adopted, 46.5

¹⁸ *See Forsberg, supra* note 6, at 2.

¹⁹ *State Health Insurance Marketplace Types, 2021*, Kaiser Family Found., <https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/> (last visited Jan. 13, 2021).

²⁰ *See Louise Norris, Georgia Health Insurance Marketplace: History and News of the State’s Exchange*, Healthinsurance.org (Dec. 16, 2020), <https://www.healthinsurance.org/georgia-state-health-insurance-exchange/>.

million non-elderly Americans, 17.8% of the population, lacked health coverage.²¹ By 2016, the ACA had driven the uninsured rate down dramatically, to 26.7 million and 10%.²² Millions of those individuals obtained health insurance through the ACA's Exchanges. These coverage gains have also been witnessed in Georgia, where the uninsured rate declined by 5.8 percentage points from 2010 to 2015, a coverage gain of 581,000 people.²³

39. These national coverage gains have been “widely shared”:

As the ACA took effect, uninsured rates fell by a third or more for low-income households (mostly due to Medicaid expansion), moderate-income households (mostly due to subsidies), and middle- and upper-income households (mostly due to market reforms, including the individual mandate). They fell for people of all ages (especially sharply for young adults), of all racial/ethnic backgrounds, and at all education levels. Other data show uninsured rates also fell dramatically for both urban and rural households and for both healthy and sick people.²⁴

40. The ACA's individual market reforms were particularly successful in reducing the uninsured rate among individuals with preexisting conditions.²⁵ That is because the ACA “put in place crucial protections for the more than 50 million non-elderly Americans with pre-existing health conditions,” preventing health insurers from continuing to “deny coverage or charge exorbitant premiums based on health status.”²⁶

²¹ Jennifer Tolbert et al., *Key Facts about the Uninsured Population*, Kaiser Family Found. (Nov. 6, 2020), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>.

²² *Id.*

²³ Off. of the Ass't Sec'y for Planning & Evaluation, *Compilation of State Data on the Affordable Care Act*, HHS, <https://aspe.hhs.gov/compilation-state-data-affordable-care-act> (last visited Jan. 13, 2021) (“Compilation of State Data on the Affordable Care Act” spreadsheet).

²⁴ *Chart Book: Accomplishments of Affordable Care Act*, Ctr. for Budget & Pol'y Priorities (Mar. 19, 2019), <https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act>.

²⁵ Off. of the Ass't Sec'y for Planning & Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act*, HHS 1 (Jan. 5, 2017), <https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf>.

²⁶ See *Chart Book*, *supra* note 24.

41. These coverage expansions are generally understood to have improved access to care, health outcomes, and financial security, and reduced the level of income inequality in the United States.²⁷

42. Moreover, health coverage for women of reproductive age is at an all-time high. The ACA's guarantee of preventive services without cost-sharing has accounted for massive gains²⁸ in access to lifesaving care and cost savings, particularly for women of color.²⁹ Since the ACA was passed, the proportion of Black and Hispanic women of reproductive age without health insurance fell by 36 percent and 31 percent, respectively.³⁰

43. Enrollment on the Exchanges remains robust. During 2020 open enrollment, preliminary numbers show that over 8.2 million consumers purchased insurance on healthcare.gov, an increase of 6.6% over 2019, with over 517,000 in Georgia, an increase of roughly 11%.³¹

²⁷ See, e.g., *id.*; *The Economic Record of the Obama Administration: Reforming the Health Care System*, Council of Econ. Advisers 27-36 (Dec. 2016), https://obamawhitehouse.archives.gov/sites/default/files/page/files/20161213_cea_record_health_care_reform.pdf.

²⁸ Usha Ranji et al., *Overview: 2017 Kaiser Women's Health Survey*, Kaiser Family Found., (March 2018), <https://www.kff.org/report-section/executive-summary-2017-kaiser-womens-health-survey/>.

²⁹ Marcela Howell & Ann M. Starrs, *For Women of Color, Access to Vital Health Services Is Threatened*, The Hill (July 26, 2017), <https://thehill.com/blogs/pundits-blog/healthcare/343996-for-women-of-color-access-to-vital-health-services-is>.

³⁰ *Id.*

³¹ *2021 Federal Health Insurance Exchange Weekly Enrollment Snapshot: Final Snapshot*, CMS (Jan. 12, 2021), <https://www.cms.gov/newsroom/fact-sheets/2021-federal-health-insurance-exchange-weekly-enrollment-snapshot-final-snapshot>; Joshua Peck, *Week 6: HealthCare.gov Enrollment Grows Due to COVID-19—Underscoring the ACA's Critical Role in the Safety Net*, Medium (Dec. 18, 2020), <https://medium.com/get-america-covered/week-6-healthcare-gov-6cb216b6a238>.

44. Indeed, as of 2020, Georgia’s Exchange appears to be functioning well. “After several years of insurer exits and fairly substantial rate increases, Georgia’s individual insurance market appears to be stabilizing. The average rate increase for 2019 was less than 4 percent, and average rates decreased slightly for 2020. ... For 2021, all six insurers are continuing to offer coverage, and average rates are increasing by less than 5 percent.”³²

II. Defendants’ efforts to undermine the ACA

45. The Affordable Care Act remains a binding, duly enacted law—one that, as explained above, has provided coverage to tens of millions of Americans.

46. Since the beginning of the Trump Administration, however, Defendants have “follow[ed] a long-established pattern ... to weaken and discourage enrollees to the ACA at nearly every turn possible” in an effort to sabotage the law.³³

47. President Trump and his advisors repeatedly promised to undermine the Affordable Care Act as a substitute for repealing it legislatively. To take just a few examples:

- a. On January 25, 2017, President Trump stated, “[T]he best thing we could do is nothing for two years, let [the ACA] explode. And then we’ll go in and we’ll do a new plan and—and the Democrats will vote for it. Believe me. ... So let it all come [due] because that’s what’s happening. It’s all coming [due] in ‘17. We’re gonna have an explosion. And to do it right,

³² Norris, *supra* note 20.

³³ Katelyn Burns, *Trump Could Have Reopened Enrollment for the Affordable Care Act for Coronavirus. He Chose Not to.*, Vox (Apr. 1, 2020), <https://www.vox.com/policy-and-politics/2020/4/1/21202841/trump-enrollment-affordable-care-act-coronavirus>.

sit back, let it explode and let the Democrats come begging us to help them because it's on them.”³⁴

- b. After Congress declined to repeal the Affordable Care Act on July 28, 2017, President Trump tweeted, “3 Republicans and 48 Democrats let the American people down. As I said from the beginning, let ObamaCare implode, then deal. Watch!”³⁵
- c. On October 13, 2017, President Trump stated, “We’re taking a little different route than we had hoped, because getting Congress—they forgot what their pledges were. ... So we’re going a little different route. But you know what? In the end, it’s going to be just as effective, and maybe it’ll even be better.”³⁶
- d. In late April 2018, at a rally in Michigan, President Trump bragged, “Essentially, we are getting rid of Obamacare[.] ... Some people would say, essentially, we have gotten rid of it.”³⁷
- e. In signing a bill unrelated to the ACA on May 30, 2018, President Trump stated: “For the most part, we will have gotten rid of a majority of

³⁴ *Transcript: ABC News Anchor David Muir Interviews President Trump*, ABC News (Jan. 25, 2017), <http://abcnews.go.com/Politics/transcript-abc-news-anchor-david-muir-interviews-president/story?id=45047602>.

³⁵ Donald J. Trump (@realDonaldTrump), Twitter (July 28, 2017, 2:25 AM), <https://twitter.com/realDonaldTrump/status/890820505330212864>. Now that President Trump has been suspended from Twitter, his account is no longer viewable; however, this tweet can be viewed at the “Trump Twitter Archive” at <https://www.thetrumparchive.com/?searchbox=%22%5C%223+Republicans+and+48+Democrat+s+let+the+American+people+down.%5C%22%22>.

³⁶ *President Trump Addresses Values Voters Summit*, CNN (Oct. 13, 2017), <http://www.cnn.com/TRANSCRIPTS/1710/13/cnr.04.html>.

³⁷ Alan Rappeport, *Trump Says He Got Rid of Obamacare. The I.R.S. Doesn't Agree.*, N.Y. Times (May 6, 2018), <https://www.nytimes.com/2018/05/06/business/trump-obamacare-irs.html>.

Obamacare.”³⁸ He went on to confirm that his Administration’s objective is to achieve by executive action alone what Congress has refused to do: “Could have had it done a little bit easier, but somebody decided not to vote for it, so it’s one of those things.”³⁹

- f. At a rally on June 23, 2018, according to an observer, President Trump complained about Congress’s decision not to repeal the ACA and told audience members that “it doesn’t matter. We gutted it anyway.”⁴⁰
- g. On August 1, 2018, President Trump returned to the same theme, stating that, even though Congress declined to repeal the ACA, “I have just about ended Obamacare,” but “we’re doing it a different way. We have to go a different route.”⁴¹

³⁸ *Remarks by President Trump at S.204, “Right to Try” Bill Signing*, The White House (May 30, 2018), <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-s-204-right-try-bill-signing/>.

³⁹ *Id.*

⁴⁰ Laura Litvan (@LauraLitvan), Twitter (June 23, 2018, 4:04 PM), <https://twitter.com/LauraLitvan/status/1010614472946352128>; *see also* Jake Sherman et al., *Overheard at the DSCC Retreat on Martha’s Vineyard*, Politico (June 24, 2018), <https://www.politico.com/newsletters/playbook/2018/06/24/overheard-at-the-dscc-retreat-on-marthas-vineyard-281247>.

⁴¹ *President Trump Calls the Show!*, The Rush Limbaugh Show (Aug. 1, 2018), <https://www.rushlimbaugh.com/daily/2018/08/01/president-trump-calls-the-show/amp/> (emphasis added).

- h. On November 2, 2018, President Trump boasted that his Administration is “decimating [the ACA] strike by strike”⁴²; “we’ve decimated Obamacare.”⁴³
- i. On May 6, 2020, during a press availability in the Oval Office, President Trump declared that his Administration would continue arguing to invalidate the ACA, stating that “Obamacare is a disaster,” that “[w]hat we want to do is terminate it,” and that his Administration had “already pretty much killed it.”⁴⁴
- j. On May 26, 2020, President Trump claimed that “essentially we got rid of Obamacare, if you want to know the truth. You can say that in the truest form.”⁴⁵

48. President Trump and his Administration have made good on their threats to undermine the ACA through executive action, although the ACA has continued to function and—again—remains the law of the land.

49. Hours after he was sworn in, President Trump signed Executive Order No. 13,765, *Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal*, 82 Fed. Reg. 8,351 (Jan. 20, 2017). The Order turned what had been candidate

⁴² *Speech: Donald Trump Holds a Political Rally in Huntington, West Virginia – November 2, 2018*, Factbase, <https://factba.se/transcript/donald-trump-speech-maga-rally-huntington-wv-november-2-2018>.

⁴³ Jim Acosta (@Acosta), Twitter (Nov. 2, 2018, 8:19 PM), <https://twitter.com/acosta/status/1058514065595777024?s=21>.

⁴⁴ Nikki Carvajal, *Trump Says Administration Will Continue Legal Fight to Eliminate Obamacare*, CNN (May 6, 2020), <https://www.cnn.com/2020/05/06/politics/trump-obamacare/index.html>.

⁴⁵ *Remarks by President Trump on Protecting Seniors with Diabetes*, The White House (May 26, 2020), <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-protecting-seniors-diabetes/>.

Trump’s promises to repeal the ACA into President Trump’s official policy. *Id.* § 1 (“It is the policy of my Administration to seek the prompt repeal of the Patient Protection and Affordable Care Act ...”). “[P]ending such repeal,” the Order directs Administration officials to “take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the Act.” *Id.*; *see id.* §§ 2-4.

50. In particular, the Trump Administration has taken steps to promote so-called “junk plans” that do not provide the coverage the ACA guarantees. On October 12, 2017, President Trump signed Executive Order No. 13,813, *Promoting Healthcare Choice and Competition Across the United States*, 82 Fed. Reg. 48,385 (Oct. 12, 2017). The Order directs the Administration to “prioritize three areas for improvement in the near term: association health plans (AHPs), short-term, limited-duration insurance (STLDI), and health reimbursement arrangements (HRAs).” *Id.* § 1(b). All three forms of coverage fail to comply with the ACA’s requirements. In keeping with Executive Order No. 13,813’s directive, the Administration has issued rules expanding access to AHPs,⁴⁶ STLDI,⁴⁷ and HRAs.⁴⁸

51. In an effort to further destabilize the ACA’s Exchanges, the Trump Administration shortened the period for open enrollment, cutting the open enrollment period for 2018 plans in half compared to prior years.⁴⁹ The Administration provided a similarly short

⁴⁶ See *Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans*, 83 Fed. Reg. 28,912 (June 21, 2018).

⁴⁷ See *Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 38,212 (Aug. 3, 2018).

⁴⁸ See *Health Reimbursement Arrangements and Other Account-Based Group Health Plans*, 84 Fed. Reg. 28,888 (June 20, 2019).

⁴⁹ *Patient Protection and Affordable Care Act; Market Stabilization*, 82 Fed. Reg. 18,346, 18,353-54 (Apr. 18, 2017); *see* 45 C.F.R. § 155.410(e).

period for open enrollment in 2019 and 2020.⁵⁰ The Administration has also repeatedly slashed funding for outreach and advertising for open enrollment,⁵¹ even though evidence known to HHS demonstrates that robust advertising is critical to fulfilling the ACA’s goal of increasing enrollment.⁵² And, finally, the Administration has slashed funding for navigators, groups which assist individuals in the enrollment process.⁵³

III. Defendants’ use of State Innovation Waivers

52. The Trump Administration has also sought to sabotage the ACA through its approach to waivers of the ACA’s requirements, including waivers under Section 1332 of the ACA—so-called “State Innovation Waivers.” 42 U.S.C. § 18052; *see also* 31 C.F.R. § 33.100 *et seq.*; 45 C.F.R. § 155.1300 *et seq.* (implementing regulations).

53. Section 1332 allows a state to apply “for the waiver” of certain individual market requirements “for plan years beginning on or after January 1, 2017.” 42 U.S.C. § 18052(a)(1). State Innovation Waivers are intended to allow states to “pursue innovative strategies for

⁵⁰ Clary Estes, *We Are Midway Through ACA’s 2020 Enrollment Period, but The Trump Administration Is Hoping You Won’t Notice*, Forbes (Nov. 23, 2019), <https://www.forbes.com/sites/claryestes/2019/11/23/we-are-midway-through-acas-2020-enrollment-period-but-the-trump-administration-is-hoping-you-wont-notice/#45ab958f6bb1>.

⁵¹ Paul Demko, *Trump White House Abruptly Halts Obamacare Ads*, Politico (Jan. 26, 2017), <http://www.politico.com/story/2017/01/trump-white-house-obamacare-ads-234245>; *Policies Related to the Navigator Program and Enrollment Education for the Upcoming Enrollment Period*, CMS 1 (Aug. 31, 2017), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Policies-Related-Navigator-Program-Enrollment-Education-8-31-2017.pdf>.

⁵² *See id.*

⁵³ U.S. Gov’t Accountability Off., GAO-18-567, *Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance* 24 (July 2018), <https://www.gao.gov/assets/700/693362.pdf>.

providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.”⁵⁴

54. Under Section 1332, a state may seek to waive requirements only under Part A of the ACA (the definition of “qualified health plans,” scope of “essential health benefits,” and limits on cost-sharing), Part B of the ACA (the establishment of Exchanges, risk pool requirements, and enrollment), Section 18071 of Title 42 (cost-sharing reductions), or Sections 36B (premium tax credits), 4980H (payments by employers who don’t offer coverage), or 5000A (the individual mandate) of Title 26. 42 U.S.C. § 18052(a)(2).

55. If the state seeks to waive requirements under Sections 36B, 4980H, or 5000A of Title 26, the Secretary of the Treasury must review the waiver; the others are reviewed by the HHS Secretary. *Id.* § 18052(a)(6)(B). In practice, however, HHS and Treasury generally collaborate in reviewing waivers.

56. Neither official may “waive under this section any Federal law or requirement that is not within [their] authority.” *Id.* § 18052(c)(2).

57. State Innovation Waivers also allow states to receive the amount of funding that would have otherwise been paid to participants in the state’s Exchange for the purpose of implementing the state’s plan. *Id.* § 18052(a)(3).

58. To ensure that State Innovation Waivers further, rather than undermine, the goals of the ACA, Section 1332 and its implementing regulations impose several significant requirements. Most importantly, the Secretaries must determine that the state plan will meet

⁵⁴ *Section 1332: State Innovation Waivers*, CMS, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers- (last visited Jan. 13, 2021).

Section 1332’s “statutory guardrails”—*i.e.*, that it will match or outperform the ACA in certain respects. The Secretaries must conclude that the plan:

(A) will provide coverage that is at least as comprehensive [with respect to essential health benefits] as certified by [the] Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States ... ;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and

(D) will not increase the Federal deficit.

Id. § 18052(b)(1). Section 1332’s implementing regulations provide further detail concerning the information and analyses that states must submit to demonstrate that their requests comply with the statutory guardrails. *See, e.g.*, 45 C.F.R. § 155.1308.

59. Section 1332 also imposes a variety of procedural requirements designed to ensure that both the state and federal governments thoroughly scrutinize the state’s plan and allow the public to comment on the plan.

60. ***Application Requirements.*** A state’s application “shall ... contain such information as the Secretary may require, including

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government.

42 U.S.C. § 18052(a)(1)(B). It must also “provide an assurance that the State has enacted” a law, *id.* § 18052(a)(1)(C), “that provides for State actions under a waiver under this section, including the implementation of the State plan,” *id.* § 18052(b)(2)(A).

61. After submission, “[e]ach application for a section 1332 waiver will be subject to a preliminary review by the Secretary and the Secretary of the Treasury, as applicable, who will make a preliminary determination that the application is complete.” 45 C.F.R. § 155.1308(b). However, “[t]he preliminary determination that an application is complete does not preclude a finding ... that a necessary element of the application is missing or insufficient.” *Id.* § 155.1308(c)(3).

62. ***Process for Approval.*** Prior to even being submitted, the proposed waiver must undergo “a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input” 45 U.S.C. § 18052(a)(4)(B)(i). Similarly, after submission, the waiver must undergo a federal “process for providing public notice and comment ... that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance.” *Id.* § 18052(a)(4)(B)(iii).

63. HHS and Treasury must promulgate, and have promulgated, regulations providing for state and federal notice and comment procedures. *See, e.g.*, 45 C.F.R. §§ 155.1312, .1316. In issuing those regulations, they opined that, “[t]o the extent that a proposal is particularly wide-ranging, the proposed regulations will support a longer State public notice and comment period.” *Application, Review, and Reporting Process for Waivers for State Innovation*, 77 Fed. Reg. 11,700, 11,706 (Feb. 27, 2012). The same is true of the federal notice and comment period. *Id.* at 11,708.

64. Ultimately, the Secretaries must make a decision on the application within 180 days from deeming the application complete and submitted. 42 U.S.C. § 18052(d)(1). If the

waiver is granted, the Secretaries “shall notify the State involved of such determination and the terms and effectiveness of such waiver.” *Id.* § 18052(d)(2)(A).

65. HHS and Treasury must also promulgate regulations providing a process for submitting “periodic reports by the State concerning the implementation of the program under the waiver”; and “for the periodic evaluation by the Secretary of the program under the waiver,” *id.* §§ 18052(a)(4)(B)(iv), (v), which they have, *see, e.g.*, 45 C.F.R. § 155.1320, .1324, 1328.

66. ***Term of Waiver.*** A waiver lasts no longer than five years unless the state applies for a continuance, which is deemed granted if HHS fails to respond in 90 days. 42 U.S.C. § 18052(e). However, Defendants have stated that the “Secretaries reserve the right to suspend or terminate a waiver, in whole or in part, any time before the date of expiration, if the Secretaries determine that the state materially failed to comply with the terms and conditions of the waiver.” 83 Fed. Reg. at 53,577.

67. Through these requirements, Section 1332 maintains a careful balance between offering states flexibility to manage their insurance markets while ensuring that the ACA’s protections remain in place.

68. Prior to Georgia’s application, twenty-two states had applied for State Innovation Waivers; fifteen of those applications had been approved.⁵⁵ Fourteen of those fifteen approvals, however, were for state reinsurance programs, which are relatively uncontroversial programs in which a third party acts as an insurer for the insurer, protecting them against high medical

⁵⁵ *Section 1332: State Innovation Waivers, supra* note 54.

claims.⁵⁶ Indeed, the ACA itself established a transitional reinsurance program during the first few years of its implementation.⁵⁷

69. In 2015, HHS and Treasury issued guidance clarifying how they would apply Section 1332’s statutory guardrails (the “2015 Guidance”). In accord with the ACA’s fundamental purpose, the agencies explained that they would “take[] into account the effects” of any state plan “across different groups of state residents, and, in particular, vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues.” *Waivers for State Innovation*, 80 Fed. Reg. 78,131, 78,132 (Dec. 16, 2015).

70. In 2018, Defendants revoked the 2015 Guidance concerning State Innovation Waivers and replaced it with the 2018 Guidance. *See* 83 Fed. Reg. 53,575. One commentator noted that, “[a]s the name change from ‘Innovation’ to ‘Relief and Empowerment’ implies, the administration views the waiver as a way to ‘relieve’ states from the statute’s requirements, and shifts the aim from novel experiments to simply giving states greater authority to work around the federal regulations.”⁵⁸

71. The 2018 Guidance expressly invokes President Trump’s 2017 Executive Order instructing agencies to waive the ACA’s requirements “to the maximum extent permitted by law.” *Id.* at 53,584. In announcing the Guidance, Administrator Verma made plain that its

⁵⁶ Jack Pitsor & Samantha Scotti, *State Roles Using 1332 Health Waivers*, Nat’l Conf. of St. Legislatures (Nov. 3, 2020), <https://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx>.

⁵⁷ *The Transitional Reinsurance Program - Reinsurance Contributions*, CMS, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions> (last visited Jan. 13, 2021).

⁵⁸ Elizabeth Y. McCuskey, *Big Waiver Under Statutory Sabotage*, 45 Ohio N.U. L. Rev. 213, 235 (2019).

purpose was to restore “a state’s traditional regulatory role over health insurance,” and to address the ACA’s purported “negative impact on state insurance markets.”⁵⁹

72. In relevant part, the 2018 Guidance interprets Section 1332 to permit waivers that would promote non-ACA-compliant coverage, including short-term, limited-duration insurance plans and association health plans. *See, e.g., id.* at 53,576-77.

73. To that end, the 2018 Guidance interprets the “comprehensiveness” and “affordability” guardrails to focus only on the “nature of coverage that is made available to state residents” by a proposed state plan, “rather than on the coverage that residents actually purchase.” *Id.* at 53,576. Under the 2018 Guidance, a proposed state plan must still cover the same number of state residents, but it can allow those residents to have less affordable or less comprehensive coverage, so long as comparably affordable or comprehensive coverage remains theoretically available on the market.⁶⁰ In other words, a proposed state plan would meet the statutory guardrails under this interpretation if it, for example, pushed 100% of the state’s residents on to non-ACA-compliant insurance products, so long as they could theoretically buy comprehensive ACA-compliant insurance on the market.

74. That interpretation violates the Affordable Care Act for several reasons. Much like Section 1332 requires that a state’s waiver “*provide* coverage to at least a comparable

⁵⁹ Letter from CMS Admin. Seema Verma to State Governors 1 (Oct. 22, 2018), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/SignedSREWaiverDearGovLetter.pdf>.

⁶⁰ Individuals tend to choose plans based on multiple factors, including the individual’s health status. Young, healthy individuals are more likely to purchase a cheaper, non-ACA-compliant plan, believing that they are unlikely to use the plan in the near future. In contrast, an older individual with preexisting conditions is likely to choose a more expensive plan that guarantees full coverage. As explained further below, however, this sorting effect means that the risk pool for ACA-compliant insurance becomes filled with higher risk individuals, driving up the cost for ACA-compliant coverage.

number of its residents,” the waiver must also “*provide* coverage that is at least as comprehensive” and “affordable” to the state’s residents. 42 U.S.C. § 18052(b)(1) (emphasis added). Thus, a state waiver may be approved only “where the state shows that at least as many of its residents would actually have coverage—not merely have access to coverage—that is as affordable and comprehensive as what those residents would have under the ACA.”⁶¹

Defendants’ contrary interpretation also renders meaningless the statute’s requirement that the state provide “an actuarial analysis, based on real data, comparing the scope of coverage that state residents would receive under the waiver to that they would receive without a waiver.”⁶²

And finally, it is predicated on an expansive definition of coverage that includes short-term, limited-duration insurance plans not found in the ACA itself.⁶³ Any waiver predicated on the 2018 Guidance, including Georgia’s waiver, therefore violates the ACA as well.

75. A month after issuing the 2018 Guidance, CMS issued a “discussion paper” “intended to foster discussion with states by illustrating how states might take advantage of new flexibilities provided in recently released guidance.” CMS reiterated its commitment to “empowering states to innovate” with Section 1332 waivers, and encouraged states to “reach out to the Departments promptly for assistance in formulating an approach that meets the requirements of section 1332.”⁶⁴ Among the options highlighted by CMS was an option for

⁶¹ Joel McElvain, *The Administration’s Recent Guidance on State Innovation Waivers under the Affordable Care Act Likely Violates the Act’s Statutory Guardrails*, Yale J. on Reg.: Notice & Comment (Dec. 11, 2018), <https://www.yalejreg.com/nc/the-administrations-recent-guidance-on-state-innovation-waivers-under-the-affordable-care-act-likely-violates-the-acts-statutory-guardrails-by-joel-mcelvain/>.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ Ctr. for Consumer Info. & Ins. Oversight, *Discussion Paper, Section 1332 State Relief and Empowerment Waiver Concepts*, CMS 3-4 (Nov. 29, 2018), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF>.

states to provide subsidies for consumers to enroll in non-ACA-compliant plans through mechanisms other than a consolidated Exchange platform.⁶⁵

76. More recently, Defendants issued an interim final rule that allows them to modify public notice and comment requirements to expedite decisions under Section 1332, and that modifies the post-award public participation requirements as well. *See Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency*, 85 Fed. Reg. 71,142, 71,144-45 (Nov. 6, 2020). Although these changes were published on November 6, 2020, and therefore did not affect the approval of Georgia’s waiver, which was granted on November 1, the interim final rule further illustrates Defendants’ intent to rush through State Innovation Waivers that would undermine the ACA’s fundamental goals.⁶⁶

IV. Georgia’s waiver applications

77. Georgia has prepared four separate iterations of the waiver application at issue here. Each time, it has consisted of two parts: “Part I,” involving an uncontroversial reinsurance program, and “Part II,” a program called the “Georgia Access Model” that would make sweeping changes to Georgia’s individual health market, including by eliminating Georgia’s reliance on healthcare.gov without creating an Exchange in its place. This case is concerned primarily with Part II of Georgia’s application.

78. The first two iterations of Part II—a draft prepared in November 2019, and a revised application submitted to HHS in December 2019—would have made even more drastic

⁶⁵ *Id.* at 13-15.

⁶⁶ Similarly, Defendants recently proposed to codify the 2018 Guidance as a formal rule and to allow states to request approval to pursue models similar to Georgia’s without seeking a waiver under Section 1332. *See* 85 Fed Reg. at 78,572. While these potential changes, if finalized, would also be unlawful, they again have no bearing on the manner in which Georgia’s waiver was approved.

changes to the state’s insurance market.⁶⁷ Those proposed waivers “would have converted the ACA’s open-ended premium tax credit into a capped, state-administered financial assistance program that would place consumers on a waitlist when funding ran out.”⁶⁸ The first iteration also “proposed allowing the sale of individual market health plans that did not offer all of the ACA’s mandated Essential Health Benefits,” while the second left benefit requirements unchanged but permitted the sale of plans that impose excessive cost-sharing.⁶⁹

79. After Georgia’s plan received substantial public criticism, and it became clear that it could not lawfully be approved,⁷⁰ Georgia asked CMS on February 5, 2020, to bifurcate its review of Parts I and II, and to pause its review of Part II pending the completion of CMS’s review of Part I.⁷¹ CMS agreed to do so the next day, and asked Georgia to provide additional data concerning Part II.⁷²

80. Georgia again asked CMS to pause its review of Part II on July 8 while the state solicited a new round of notice and comment, lasting only fifteen days, on a proposed third iteration of its Part II application.⁷³ That third iteration focuses solely on implementing the

⁶⁷ *Georgia Section 1332 State Empowerment and Relief Waiver Application*, Ga. Off. of the Gov. (Dec. 23, 2019), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.

⁶⁸ Christen Linke Young & Jason Levitis, *Georgia’s Latest 1332 Proposal Continues to Violate the ACA*, Brookings (Sept. 1, 2020), <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>.

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ Letter from Ga. Gov. Brian P. Kemp to CMS Admin. Seema Verma (Feb. 5, 2020), <https://www.cms.gov/files/document/25-cms-1332-letter-georgia.pdf>.

⁷² Letter from Randy Pate, Dir., Ctr. for Consumer Info. & Ins. Oversight, to Ga. Gov. Brian P. Kemp 1-2 (Feb. 6, 2020), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Completeness-Letter.pdf>.

⁷³ Letter from Ga. Gov. Brian P. Kemp to CMS Admin. Seema Verma (July 8, 2020), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Governor-July8-Letter.pdf>.

Georgia Access Model, as described above, eliminating the first and second iteration's changes to what plans may be sold.

81. Despite the unreasonably short period for comment, Georgia received over 600 detailed comments from the public.⁷⁴

82. Georgia formally submitted the third iteration of its Part II application to CMS on July 31, 2020.⁷⁵

83. CMS preliminarily declared Georgia's revised Part II application complete on August 17, initiating a thirty-day federal notice and comment period lasting until September 16.⁷⁶ That period was subsequently extended to September 23 because of a computer error that prevented individuals from commenting for an unknown amount of time during the original comment period.⁷⁷

84. During that comment period, Defendants received approximately 1,826 total comments. Those comments comprised 75 comments from organizations, of which 72 were opposed to the Georgia Access Model, and 1,751 comments from individuals, of which 1,746

⁷⁴ *Georgia Section 1332 State Empowerment and Relief Waiver Application*, Ga. Off. of the Gov. 29-30 (July 31, 2020), <https://medicaid.georgia.gov/document/document/georgia1332waiverapplicationfinal07312020vf/pdf/download>.

⁷⁵ *Id.*

⁷⁶ Letter from Randy Pate, Dir., Ctr. for Consumer Info. & Ins. Oversight, to Ga. Gov. Brian P. Kemp (Aug. 17, 2020), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Completeness-Letter-Modified-Application.pdf>.

⁷⁷ Ariel Hart, *Public Comment Window Extended on Kemp Plan to Block ACA Shopping Site*, Atlanta J.-Const. (Sept. 18, 2020), <https://www.ajc.com/news/georgia-news/public-comment-window-extended-on-kemp-plan-to-block-aca-shopping-site/LN3SMSGOSRBP HDRZAMB4P2GUGY/>.

were opposed.⁷⁸ In other words, only *eight* comments supported the model, or less than half of one percent of the total.

85. After the notice and comment period closed, Georgia submitted a fourth iteration of its waiver application on October 9, purportedly in response to comments it received during the federal comment period.⁷⁹ That application retains the essential features of the third iteration of Georgia’s plan, but includes additional details about how the state plans to approach certain subjects. According to the Internet Wayback Machine, that application was not made publicly available on the CMS website until November 1, the same day Georgia’s waiver was approved.⁸⁰ Nor did Defendants provide the public with any opportunity to comment on the October application.

86. While the July and October submissions abandon Georgia’s proposed changes to essential health benefits, cost-sharing, and financial assistance, the state continues to seek to “waive certain exchange requirements and ... transition its individual market from the FFE to the new Georgia Access Model.”⁸¹

⁷⁸ Letter from CMS Admin. Seema Verma to Ga. Gov. Brian P. Kemp 15-16 (Nov. 1, 2020), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Approval-Letter-STCs.pdf (the “Approval Letter”).

⁷⁹ *Georgia Section 1332 State Empowerment and Relief Waiver Application*, Ga. Off. of the Gov. 4 (dated July 31, 2020, revised Oct. 9, 2020), <https://medicaid.georgia.gov/document/document/modified-1332-waiver/download> (“Georgia’s Application”).

⁸⁰ *Section 1332: State Innovation Waivers*, Wayback Machine, https://web.archive.org/web/2020*/https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers- (last visited Jan. 13, 2021). To see the change, click the calendar entry for November 1. The application does not appear on prior calendar entries.

⁸¹ Georgia’s Application, *supra* note 79, at 4.

87. Specifically, Georgia requested a “five-year partial waiver” of 42 U.S.C. § 18031—a lengthy statutory provision containing dozens of subsections and requirements—but “only to the extent that it is inconsistent with the operation of the Georgia Access Model.”⁸² The state asserts that it “will remain in full compliance with sections of [the ACA] not waived.”⁸³

88. Under the Georgia Access Model, “the private sector provides the front-end consumer shopping experience and operations”—*i.e.*, the virtual store fronts at which individuals shop for plans—while the state performs functions like “validating eligibility information and determining if an applicant is eligible for [advance premium tax credits]; transmitting the eligibility determination to CMS ... ; sending information annually to enrollees ... ; and sending information to the IRS.”⁸⁴ “The State will transition responsibility for the front-end functions of consumer outreach, customer service, plan shopping, selection, and enrollment from the FFE to the commercial market.”⁸⁵ All that would remain of those functions is a website where “the State will provide a list of approved carriers and web-brokers that will participate in Georgia Access.”⁸⁶

89. As a practical matter, that means that, “[i]nstead of selecting and enrolling in plans through the FFE, consumers will enroll through private web-brokers or directly with carriers”⁸⁷—as they were essentially required to do prior to the enactment of the ACA.

⁸² *Id.*

⁸³ *Id.* at 29.

⁸⁴ *Id.* at 4.

⁸⁵ *Id.* at 17.

⁸⁶ *Id.* at 18-19.

⁸⁷ *Id.* at 25.

“Georgia’s unprecedented proposal would force consumers to navigate the type of fragmented insurance system of brokers and insurers the ACA was intended to remedy.”⁸⁸

90. The state nonetheless claims that “[t]he Georgia Access Model expands consumer access by allowing individuals to shop for and compare available plans using the platform of their choice.”⁸⁹ The state asserts that the Georgia Access Model will “increase affordability and spur innovation in the individual market while maintaining access to QHPs and ensuring consumer protections for individuals with pre-existing conditions.”⁹⁰

91. In its revised October application, the state “decided to move the implementation date for Georgia Access to [Plan Year] 2023” in response to concerns about “migrating during a national pandemic.”⁹¹ The state also provided additional details about how it will offer “auto-reenrollment” for current consumers; “streamline the referral process for Medicaid-eligible individuals and incentivize agents and brokers to provide support for consumers”; provide “consumer protections” against inappropriate steering to non-ACA-compliant plans; and assist “vulnerable individuals.”⁹²

92. Despite significant public resistance to Georgia’s extraordinary waiver, Defendants approved the waiver on November 1, 2020, just weeks after the federal notice and

⁸⁸ Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia’s 1332 Waiver Proposal*, Ctr. on Budget & Pol’y Priorities (Sept. 1, 2020), <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>.

⁸⁹ Georgia’s Application, *supra* note 79, at 17.

⁹⁰ *Id.*

⁹¹ *Id.* at 180.

⁹² *Id.* at 180-81.

comment period closed and Georgia submitted the governing version of its application.⁹³ That decision constitutes the final agency action regarding Defendants' review of Georgia's waiver.

93. Georgia's waiver was approved for a period lasting from January 1, 2022 to December 31, 2026.⁹⁴

94. In approving the waiver, Defendants concluded that it "satisfies the statutory guardrails" set forth in Section 1332, and that "implementation of ... the Georgia Access Model will lower individual market premiums in the state."⁹⁵

95. Although Defendants purported to assess whether Georgia's waiver, taken as a whole, complied with Section 1332's statutory guardrails, it is clear from Georgia's application that the two parts of the waiver were designed to operate independently. To that end, Georgia repeatedly requested that Defendants evaluate the two parts of the waiver separately, explained why it thought each part complied with the guardrails,⁹⁶ and structured its waiver so that the two parts take effect in the 2022 and 2023 plan years, respectively.⁹⁷ Moreover, Defendants separately considered the effects of Parts I and II on the statutory guardrails, assessing, for example, the coverage effects of the reinsurance program and the Georgia Access Model in isolation.⁹⁸ Regardless, Defendants' decision to approve Georgia's waiver is unlawful, both with respect to the waiver as a whole and as to Part II in particular.

⁹³ Approval Letter, *supra* note 78.

⁹⁴ *Id.* at 1.

⁹⁵ *Id.* at 1-2.

⁹⁶ Georgia's Application, *supra* note 79, at 8-9, 30-31.

⁹⁷ *Id.* at 1.

⁹⁸ Approval Letter, *supra* note 78, at 9-14.

V. Defendants' approval of Georgia's waiver is unlawful.

96. Defendants' hasty approval of Georgia's waiver will cause immense damage to Georgia's health insurance market, resulting in thousands of individuals losing coverage and thousands more losing coverage appropriate for them, including public programs like Medicaid and private health insurance plans adequate to their needs.

97. Defendants' decision is unlawful in three overarching ways. *First*, Georgia's waiver violates Section 1332's statutory guardrails, which are critical safeguards designed to ensure that a state's plan does not undermine the ACA's goals—and, for similar reasons, is arbitrary and capricious and unsupported by the record. Defendants' contrary conclusion is predicated in large part on the 2018 Guidance, which is unlawful as well. *Second*, Part II of Georgia's waiver is so radical and sweeping that it conflicts with provisions of the ACA that cannot be waived under Section 1332. And *third*, Georgia's incomplete plan was rushed through the process without adequate time for public comment and without adequate clarification of how the state intends to approach key issues, as required by the Administrative Procedure Act and Section 1332. Plaintiffs summarize these shortcomings below.⁹⁹

A. Defendants' decision violates Section 1332's guardrails.

98. To start, Defendants' decision violates all four of Section 1332's statutory guardrails: the Georgia Access Model will result in fewer Georgians with insurance coverage, *see* 42 U.S.C. § 18052(b)(1)(C); fewer Georgians with comprehensive coverage, as opposed to

⁹⁹ For ease of reference, Plaintiffs cite to two informative publications regarding Georgia's waiver: Young & Levitis, *supra* note 68, and Straw, *Tens of Thousands*, *supra* note 88. Many of the organizational comments on Georgia's waiver, including the comments submitted by PPSE and FWHC, echo these points. While an administrative record has not yet been produced in this matter, those comments are available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Federal-Comments-Organization-Letters.pdf>.

non-ACA-compliant junk plans, *see id.* § 18052(b)(1)(A); and more expensive coverage, which will also potentially expand the federal deficit, *see id.* § 18052(b)(1)(B), (D). It is therefore contrary to law. *See* 5 U.S.C. § 706(2)(A). Defendants also failed to adequately consider these matters and other significant comments and concerns—including alternatives like expanding Medicaid or adopting a reinsurance-only model—and their decision is therefore arbitrary and capricious and unsupported by substantial evidence. *See id.* § 706(2)(A), (E), (F).

I. Coverage

99. The Georgia Access Model will result in fewer Georgians with insurance coverage. 42 U.S.C. § 18052(b)(1)(C). Although Georgia estimates that the Georgia Access Model will increase enrollment by 33,000, with approximately 8,000 consumers losing coverage, thereby yielding net enrollment growth of 25,000,¹⁰⁰ these figures rest on fatally flawed assumptions and modeling.

100. According to the state, “[t]he Georgia Access Model expands consumer access by allowing individuals to shop for and compare available plans using the platform of their choice.”¹⁰¹ But insurance companies, as well as agents and brokers, are *already* allowed to sell plans directly to consumers, through a process called direct enrollment.¹⁰² In the past year, “at least 16 insurers and web-brokers offered these services in Georgia,” and even Georgia’s application itself “notes these options are widely available.”¹⁰³ Despite the wide availability of direct enrollment options in Georgia, 79 percent of Georgians who enroll on the individual market choose to find and purchase their health coverage using healthcare.gov, with only 21

¹⁰⁰ Georgia’s Application, *supra* note 79, at 56.

¹⁰¹ *Id.* at 17.

¹⁰² Young & Levitis, *supra* note 68.

¹⁰³ Straw, *Tens of Thousands*, *supra* note 88.

percent opting for direct enrollment.¹⁰⁴ Rather than expanding consumer access, Georgia’s plan thus *eliminates* the easiest and most common way for consumers to shop for insurance plans—healthcare.gov.

101. As a fallback, the state argues that “[c]arriers have an additional incentive to invest in marketing to attract new business and retain their current FFE consumers.”¹⁰⁵ Again, however, “to the extent private entities face ‘market incentives’ to drum up new enrollment, those incentives *already exist*, and nothing in the application creates new incentives that could plausibly bring in new business.”¹⁰⁶

102. In support of its numbers, Georgia’s application notes that the share of enrollments that happen through private vendors has grown by “an average of 4 percentage points ... over the past two years.”¹⁰⁷ Thus, “[a]ssuming this trend continues,” private enrollment will “increase by 33,658.”¹⁰⁸ But there are two flaws in this analysis. First, it conflates the share of enrollment and the total amount of enrollment; obviously, if healthcare.gov is eliminated, the share of private enrollment will be 100%, regardless of how much enrollment there is. And second, if the private share of enrollment is *already* increasing by 4% each year, then those increases in enrollment cannot be attributed to the waiver.¹⁰⁹

103. On the other side of the ledger, Georgia’s enrollment losses from eliminating healthcare.gov will be far higher than the 8,000 estimated by the state. The state’s “analysis entirely ignores countervailing threats to enrollment posed by dismantling the enrollment and

¹⁰⁴ Georgia’s Application, *supra* note 79, at 77.

¹⁰⁵ *Id.* at 18.

¹⁰⁶ Young & Levitis, *supra* note 68.

¹⁰⁷ Georgia’s Application, *supra* note 79, at 77.

¹⁰⁸ *Id.*

¹⁰⁹ Young & Levitis, *supra* note 68.

consumer support system that roughly 400,000 people use.”¹¹⁰ Given that “only 21 percent of marketplace enrollees opted for direct enrollment or enhanced direct enrollment in 2020,” “[a]bandoning HealthCare.gov would leave the other 79 percent of enrollees without their platform of choice, almost certainly reducing enrollment significantly.”¹¹¹

104. Specifically, abolishing healthcare.gov in the state would require customers to identify private vendors, shop through them, and complete new enrollment processes, resulting in enrollment losses in at least several ways.

105. New enrollees and active re-enrollees would need to navigate new administrative barriers that would likely cause some of them to drop out of the enrollment process, or to lose coverage later as a result of such barriers.¹¹² Consumers would have to navigate multiple private vendors and additional types of insurance plans on their own, rather than shopping for plans on one, consolidated website. “Fragmenting the insurance market would confuse and discourage consumers, hindering enrollment.”¹¹³ Indeed, studies show that administrative barriers are one of the most common reasons people decline to participate in health and other programs.¹¹⁴

¹¹⁰ Straw, *Tens of Thousands*, *supra* note 88.

¹¹¹ *Id.*

¹¹² Young & Levitis, *supra* note 68.

¹¹³ Straw, *Tens of Thousands*, *supra* note 88.

¹¹⁴ See, e.g., Samantha Artiga & Olivia Pham, *Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage*, Kaiser Family Found. (Sept. 24, 2019), <https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/>; Pamela Herd, *How Administrative Burdens Are Preventing Access to Critical Income Supports for Older Adults: The Case of the Supplemental Nutrition Assistance Program*, 25 Pub. Pol’y & Aging Rep. 52 (Spring 2015), <https://academic.oup.com/ppar/article/25/2/52/1501759>; Sheila Hoag et al., *CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings*, Mathematica Pol’y Res. (Dec. 2013), <https://www.mathematica.org/our-publications-and-findings/publications/chipra-mandated-evaluation-of-express-lane-eligibility-final-findings>; Jennifer Maier Snow, *Overcoming Barriers to Enrollment: A 50-State Assessment of Outreach and Enrollment Simplification Strategies for the State Children’s Health Insurance Program (CHIP)*, 9 J. of Pub. Aff. Educ. 63 (Jan. 2003),

106. Moreover, more than 80,000 Georgia enrollees opted to automatically reenroll in coverage—meaning that they were automatically re-enrolled in the same or a comparable plan and did not make an active choice during open enrollment.¹¹⁵ Because an insurer may no longer offer a consumer’s specific plan, the auto-reenrollment process sometimes involves “mapping” or “crosswalking” enrollees to similar plans offered by the insurer.¹¹⁶ However, the latest version of Georgia’s waiver was the first to provide even an abbreviated account of how the state will carry out and fund auto-reenrollment. And because the public was not permitted to comment on those revisions, they were not permitted to articulate the significant challenges Georgia will face in designing a system for auto-reenrollment while simultaneously shifting all enrollment to private vendors. In the past, states transitioning to state-based marketplaces have experienced substantial difficulty in porting over and using previous enrollment information to facilitate auto-reenrollment. In nonetheless approving Georgia’s waiver, Defendants simply rubberstamped its assertions about auto-reenrollment.

107. Georgia’s waiver will also allow private vendors to direct Medicaid-eligible consumers to less affordable insurance. Under the “no wrong door” requirement, [healthcare.gov](https://www.healthcare.gov) automatically redirects individuals who may be Medicaid-eligible to the state Medicaid agency.¹¹⁷ However, private vendors, who are incentivized by commissions and profits, have no incentive to direct consumers to Medicaid, and may actively mislead consumers to deter them

https://mpa.unc.edu/sites/default/files/MPA%20Capstone%20Paper%20Snow_0.pdf. See generally Eldar Shafir & Sendhil Mullainathan, *Scarcity: Why Having Too Little Means So Much* (2013).

¹¹⁵ Straw, *Tens of Thousands*, *supra* note 88.

¹¹⁶ Louise Norris, *How to Avoid the Surprise of Health Plan ‘Mapping,’* [Healthinsurance.org](https://www.healthinsurance.org) (Jan. 9, 2021), <https://www.healthinsurance.org/obamacare/how-to-avoid-the-surprise-of-health-plan-mapping/>.

¹¹⁷ Straw, *Tens of Thousands*, *supra* note 88.

and their families from enrolling in Medicaid.¹¹⁸ For example, a 2019 report revealed that, in exchange for commissions, some direct enrollment entities were deliberately steering consumers away from Medicaid and instead promoting plans which cost hundreds of dollars more per month than Medicaid, and that many were not presenting information about the Medicaid enrollment process.¹¹⁹

108. Additionally, following the initial transition, Georgia will not be assuming any of healthcare.gov's extensive outreach and support functions to assist consumers in navigating the enrollment process. There is little reason to assume that private vendors will pick up the slack.¹²⁰ And Georgia will be required to construct a new administrative apparatus to provide all of the "back-end" functions it has never before provided, which it appears to have inadequately funded.¹²¹ Thus, the Georgia Access Model may lead to still more enrollment losses.

109. Experts have therefore calculated that the Georgia Access Model is likely to lead to significant net enrollment losses, the scale of which will depend on the extent of these effects, as displayed below.¹²²

¹¹⁸ Young & Levitis, *supra* note 68.

¹¹⁹ Tara Straw, "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm, Ctr. on Budget & Pol'y Priorities (Mar. 15, 2019), <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

¹²⁰ Straw, *Tens of Thousands*, *supra* note 88.

¹²¹ Young & Levitis, *supra* note 68; Straw, *Tens of Thousands*, *supra* note 88.

¹²² *Id.*

Figure 1: Coverage losses from Georgia waiver under various assumptions

Scenario	Active Re-Enrollee Loss	Automatic Re-enrollee Loss	Medicaid Enrollee Loss	Total Coverage Loss
Minimal coverage losses: retain 97% active re-enrollees, 70% automatic re-enrollees, 90% Medicaid enrollees	7,243	24,029	3,807	35,078
Moderate coverage losses: retain 95% active re-enrollees, 50% automatic re-enrollees, 75% Medicaid enrollees	12,072	40,048	9,517	61,636
Large coverage losses: retain 90% active re-enrollees, 30% automatic re-enrollees, 50% Medicaid enrollees	24,144	56,067	19,034	99,244

Source: Authors' calculations based on CMS 2020 Marketplace Open Enrollment Period Public Use Files

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110. Finally, even if Georgia and Defendants were roughly in the ballpark on gains and losses, it makes errors in the timing of the enrollment effects. To satisfy the coverage guardrail, a state's plan must not result in fewer individuals with coverage in any given year. 83 Fed. Reg. at 53,579. The state assumes that enrollment will rise on net by 25,000 in the first year of the Georgia Access Model, while remaining relatively constant moving forward.¹²³ But any gains are likely to phase in over time, as Georgia estimates that web-brokers enroll a slightly larger fraction of the market each year, while any losses are likely to occur immediately for the reasons explained above.¹²⁴ Thus, if one instead assumes that the 33,000 gain phases in linearly over the first five years of the waiver, then losses will actually exceed gains in the first year of the waiver—violating the coverage guardrail.¹²⁵

111. For these reasons, the Georgia Access Model will decrease, rather than increase, overall enrollment, violating the coverage guardrail even under the standards of the 2018

¹²³ Georgia's Application, *supra* note 79, at 56.

¹²⁴ Young & Levitis, *supra* note 68.

¹²⁵ *Id.*; see also Straw, *Tens of Thousands*, *supra* note 88.

Guidance. In nonetheless concluding that “the waiver plan meets the coverage guardrail,”¹²⁶ Defendants simply rubberstamped Georgia’s wildly unrealistic assumptions and estimates in a manner that is unreasoned, contrary to the record, and contrary to the ACA’s legal requirements.

2. *Comprehensiveness*

112. The Georgia Access Model will also result in consumers enrolling in less comprehensive, non-ACA-compliant insurance products, to the extent they are able to enroll at all. Georgia’s plan therefore violates the comprehensiveness guardrail as well.

113. Non-ACA-compliant plans, including short-term, limited-duration insurance plans, association health plans, and others, generally represent a bad deal for the consumer. They often have discriminatory gaps that can leave consumers (or providers) exposed to high costs,¹²⁷ especially as compared to the affordable, comprehensive, and non-discriminatory coverage of the ACA. Some individuals may be turned down by insurers based on their prior health status, while others will face benefit exclusions based on prior health care needs.¹²⁸ These plans are also generally subject to other conditions that limit their value, like large amounts of cost-sharing, annual or lifetime limits on coverage, limitations on services, or limitations on the amount the plan will pay per medical visit.¹²⁹

114. For example, “[o]ne review of the most popular short-term plan in Atlanta found that although it had lower premiums, its deductible and maximum out-of-pocket costs were

¹²⁶ Approval Letter, *supra* note 78, at 10.

¹²⁷ See Christen Linke Young, *Taking a Broader View of “Junk Insurance”*, Brookings (July 6, 2020), <https://www.brookings.edu/research/taking-a-broader-view-of-junk-insurance/>.

¹²⁸ See Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Found. (Apr. 23, 2018), <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

¹²⁹ See Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers*, Ctr. on Budget & Pol’y Priorities (Sept. 20, 2018), <https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers>.

nearly three times higher than the most popular bronze ACA plan, and it offered no coverage of prescription drugs, mental health services, or maternity care.”¹³⁰

115. Nevertheless, “[a]n explicit goal of the waiver is to increase access to coverage that doesn’t meet ACA standards”¹³¹ by allowing consumers to access “the full range of health plans licensed and in good standing in the State that are available to them today but sold through channels outside the FFE.”¹³² It does so by shifting all enrollment to private vendors who, unlike healthcare.gov, can offer non-ACA-compliant plans next to ACA-compliant plans.

116. Moreover, private vendors have an incentive to steer consumers toward non-ACA-compliant products. For brokers, such products generally pay higher commissions—up to ten times as much as ACA-compliant plans.¹³³ For insurers, such products generally have better margins because they are not required to meet medical loss ratio standards.¹³⁴

117. “Experience with enhanced direct enrollment programs shows that these incentives sometimes give rise to ‘steering,’ in which web-brokers screen applicants before sending them down the official enrollment pathway and divert some toward substandard plans that pay higher commissions but leave enrollees exposed to catastrophic costs if they get sick.”¹³⁵ Studies have repeatedly shown that private vendors tend to redirect consumers toward

¹³⁰ Straw, *Tens of Thousands*, *supra* note 88.

¹³¹ *Id.*

¹³² Georgia’s Application, *supra* note 79, at 4; *see also id.* at 26, 31.

¹³³ *Shortchanged: How the Trump Administration’s Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk*, U.S. House of Reps. Comm. on Energy & Commerce 43 (June 2020), <https://degette.house.gov/sites/degette.house.gov/files/STLDI%20Report%2006%2025%2020%20FINAL.pdf>.

¹³⁴ Straw, *Tens of Thousands*, *supra* note 88.

¹³⁵ *Id.*

such plans.¹³⁶ Even under current law, “[r]oughly one in four marketplace enrollees who were helped by a broker or commercial health plan representative said they were offered a non-ACA-compliant policy as an alternative or supplement to a marketplace policy.”¹³⁷

118. Georgia’s plan would also allow additional room for deceptive or aggressive marketing tactics that healthcare.gov does not permit. “One recent study, for example, showed that most brokers gave ambiguous, misleading, or demonstrably false information regarding short-term plan coverage for COVID-related illnesses.”¹³⁸

119. Thus, the Georgia Access Model is likely to shift individuals from ACA-compliant plans to less comprehensive, non-ACA-compliant junk plans. Perhaps that is why, in the letter approving Georgia’s waiver, Defendants did not refer to the requisite certification of comprehensiveness by the “Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived.” 42 U.S.C. § 18052. For that reason alone, Defendants failed to comply with the comprehensiveness guardrail.

120. Because Defendants and Georgia did not, and cannot, show that the Georgia Access Model would actually provide state residents with equally comprehensive coverage, Defendants’ approval of Georgia’s plan is necessarily predicated on CMS’s 2018 Guidance that a plan complies with the comprehensiveness guardrail so long as equally comprehensive coverage remains available on the market. That much is clear from Defendants’ approval letter:

¹³⁶ See, e.g., Straw, “*Direct Enrollment*,” *supra* note 119; *Shortchanged*, *supra* note 133.

¹³⁷ Karen Pollitz et al., *Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need*, Kaiser Family Found. (Aug. 7, 2020), <https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/>.

¹³⁸ Straw, *Tens of Thousands*, *supra* note 88.

in approving Georgia’s waiver, Defendants concluded that “consumers will have *access* under the state’s waiver plan to the same metal level plans and catastrophic plans that are available today and include EHB benefits,” and so “consumers will have *access* to coverage that is at least as comprehensive as the without waiver baseline scenario.”¹³⁹

121. As noted above, however, the 2018 Guidance rests on an incorrect interpretation of Section 1332. *See supra* ¶¶ 71-75. These flaws in the Guidance therefore doom Georgia’s waiver as well. Put simply, Defendants did not conclude, and Georgia did not show, that an equal number of consumers would *possess* comprehensive insurance coverage as a result of the Georgia Access Model—only that equally comprehensive coverage would remain theoretically available on the market.

122. Moreover, Part II of Georgia’s waiver fails even under the lenient standards of the 2018 Guidance. The 2018 Guidance evaluates whether consumers have “*access* to coverage that is as affordable and comprehensive as coverage” that would have been available prior to the waiver. 83 Fed. Reg. at 53,578 (emphasis added). But given the Georgia Access Model’s failure to include protections against inappropriate steering and marketing of non-ACA-compliant plans, consumers do not have meaningful access to ACA-compliant plans. If the 2018 Guidance’s conception of “access” requires only that a plan be theoretically available somewhere in the marketplace, then that is simply another reason why the 2018 Guidance is inconsistent with the text and purpose of Section 1332.

123. Defendants therefore failed to ensure that Georgia’s plan meets the comprehensiveness guardrail and acted in an unreasoned manner and one that is contrary to the agency record.

¹³⁹ Approval Letter, *supra* note 78, at 12-13 (emphasis added).

3. *Affordability and deficit neutrality*

124. For many of the same reasons and others, the Georgia Access Model will also increase premiums, violating the affordability guardrail. Indeed, Georgia’s affordability estimates are, in substantial measure, premised on its incorrect assumption of increased enrollment.¹⁴⁰ *See supra* ¶¶ 100-12.

125. The Georgia Access Model will also decrease affordability by baking additional costs into the premiums that consumers pay. Insurers generally pay private agents and brokers a commission for directing consumers on to their health plans. “Transitioning all enrollment to private vendors (most of whom are commission-supported) is likely to meaningfully increase the total volume of broker commissions paid in Georgia, which will in turn increase premiums.”¹⁴¹ Alternatively, if consumers transition to enrolling directly through insurers, those insurers must pay to support the enrollment infrastructure. But those costs, too, are naturally incorporated into the premiums that consumers pay.¹⁴² Georgia’s application did not adequately account for either of these dynamics, instead offering only that the state “does not expect increased commissions to increase premiums by more than 0.25 percentage points on average.”¹⁴³

126. As explained above, Georgia’s waiver will also lead to greater enrollment in non-ACA-compliant plans, which typically involve higher cost-sharing. Because premiums for those plans are generally cheaper for young, healthy enrollees, these consumers will tend to select them—distorting the risk pool and thereby increasing premiums for comprehensive, ACA-compliant insurance products.¹⁴⁴ “It is not possible to promote underwritten and non-compliant

¹⁴⁰ Straw, *Tens of Thousands*, *supra* note 88.

¹⁴¹ Young & Levitis, *supra* note 68.

¹⁴² *Id.*

¹⁴³ Approval Letter, *supra* note 78, at 11.

¹⁴⁴ Young, *Taking a Broader View*, *supra* note 127.

plans that the state believes some consumers will prefer without ‘eroding’ the regulated market—if healthy enrollees can receive lower premiums from underwritten plans, that will, axiomatically, worsen the ACA risk pool and increase premiums.”¹⁴⁵ It is also backed by the evidence: “in states that took advantage of the Administration’s expansion of short-term plans—like Georgia, which has few restrictions—premiums for comprehensive coverage went up by about 4 percent.”¹⁴⁶ By making it even easier for insurers and brokers to push relatively healthier and cheaper consumers on to short-term plans, Georgia’s plan will only exacerbate these effects.

127. Georgia’s analysis also makes assumptions that are not supported by the record about the risk profile of those who will lose coverage due to the elimination of healthcare.gov. In general, young, healthy people are less likely than older people to attempt to overcome administrative barriers, meaning that young people are proportionally more likely to lose coverage.¹⁴⁷ That shift will further weaken the ACA-compliant risk pool in the state and drive up premiums.¹⁴⁸ By the same token, it makes unfounded and unsupported assumptions about those who will *gain* coverage, assuming that they will tend to be the sort of young, healthy consumers who are, in fact, most likely to drop out of the enrollment process.

128. Finally, Georgia’s plan will reduce competition by causing insurers, particularly smaller insurers, to exit the market rather than devote additional resources to creating enrollment

¹⁴⁵ Young & Levitis, *supra* note 68.

¹⁴⁶ Straw, *Tens of Thousands*, *supra* note 88.

¹⁴⁷ See, e.g., Stan Dorn, *Helping Special Enrollment Periods Work Under the Affordable Care Act*, Urban Inst. 5-8 (June 2016), <https://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf>; *Strengthening the Marketplace – Actions to Improve the Risk Pool*, CMS (June 8, 2016), <https://www.cms.gov/newsroom/fact-sheets/strengthening-marketplace-actions-improve-risk-pool>.

¹⁴⁸ Young & Levitis, *supra* note 68.

infrastructure.¹⁴⁹ Even where such insurers remain in the market, they may not be able to compete with larger insurers in the absence of healthcare.gov. And “[t]he lack of a single, unbiased source of comparative plan data could also directly reduce competition.”¹⁵⁰

129. These effects also potentially violate the deficit neutrality guardrail because advance premium tax credits are pegged to the premiums in a given market, putting the federal government on the hook for higher payments, depending on the size of the coverage losses that Georgia’s plan will cause.

130. Separately, Georgia’s plan also threatens to expand the deficit because Georgia miscalculates the impact of the state losing user fees for healthcare.gov. “Some HealthCare.gov functions entail fixed costs, and so the absence of HealthCare.gov user fees from Georgia will not be fully offset by reduced operating costs. The federal government is clear that such costs must be accounted for in deficit neutrality calculations, and the state fails to do so.”¹⁵¹

131. Thus, Defendants’ decision violates the affordability guardrail and, by extension, potentially the deficit neutrality guardrail, and is unreasoned and contrary to the record.

B. Defendants’ decision exceeds the scope of Section 1332.

132. Even if Defendants’ decision complied with the statutory guardrails, it exceeds their statutory authority by waiving provisions that cannot be waived under Section 1332.

133. Section 1332 does not allow Defendants to nullify any and all ACA provisions; it limits their authority to specific, enumerated statutory requirements. *See* 42 U.S.C. § 18052. To that end, Georgia’s application was limited to waiving provisions of 42 U.S.C. § 18031, and the

¹⁴⁹ Straw, *Tens of Thousands*, *supra* note 88.

¹⁵⁰ *Id.*

¹⁵¹ Young & Levitis, *supra* note 68.

state recognizes that it must “remain in full compliance with sections of [the ACA] not waived.”¹⁵²

134. By ending the state’s reliance on healthcare.gov without creating a state Exchange or a hybrid model in its place, however, Part II of Georgia’s waiver is so radical that it rips a hole in the ACA—grossly exceeding the scope of authority provided by Section 1332.

135. Most importantly, Section 1321, which is not in the list of provisions that are waivable under Section 1332, mandates that, if a state does not create an Exchange, “the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.” 42 U.S.C. § 18041(c)(1). If the state does create an Exchange, it must meet the standards established by the Secretary. *Id.* § 18041(e). Federal regulations further define an Exchange as “a governmental agency or non-profit entity that meets the applicable standards of this part and makes QHPs available to qualified individuals and/or qualified employers.” 45 C.F.R. § 155.20. Georgia’s plan obviously does not create an Exchange; instead, it leaves the state’s consumers without a central, impartial marketplace for purchasing insurance plans, as was the case prior to the existence of the ACA.

136. The ACA also contains many provisions that presuppose the existence of an Exchange, but that are not included within the provisions that may be waived under Section 1332. *See, e.g.*, 42 U.S.C. §§ 300u-12 (public health campaign to explain preventive services offered by Exchange plans), 300gg-94(b)(1)(B) (state to make recommendations to Exchange to exclude insurers from participation), 1396a(e)(14)(K) (notify lottery winners who lose Medicaid eligibility of opportunity to enroll in Exchange), 1396w-3 (Medicaid’s version of the “no wrong

¹⁵² Georgia’s Application, *supra* note 79, at 29.

door” provision), 1397ee(a)(1) (Exchange coverage to cover shortfalls in CHIP funding), 1397gg (incorporating “no wrong door” for CHIP), 18081(b) (Exchange collects and transmits information on eligibility), 18082(a) (Exchange determines eligibility for advance premium tax credits), 18083 (the Exchange version of the “no wrong door” provision), 18092 (notification of non-enrollment includes information on services offered in Exchanges).

137. Even if Defendants could waive these requirements, Georgia’s application is limited to provisions of 42 U.S.C. § 18031, and thus both expressly disavows any request for a waiver of other statutory provisions and promises that the state will comply with all non-waived provisions.

138. By eliminating the exchange in Georgia entirely, Part II of Georgia’s waiver prevents these other, non-waivable statutory provisions from operating, in violation of Section 1332. To take one example, an Exchange cannot provide information or determine eligibility if there is no Exchange in the first place. Of course, states retain the flexibility to experiment with different models of Exchange management. But deciding to eliminate the Exchange entirely—one of the ACA’s signature achievements and statutory cornerstones—is not a choice that Section 1332 permits.

C. Defendants’ decision was procedurally improper.

139. Finally, Defendants’ decision to approve Georgia’s waiver was procedurally deficient in several important ways, including the manner in which Defendants and the state allowed for notice and comment and the contents of the state’s application.

140. Before granting a waiver under Section 1332, both the state and federal governments “must provide a public notice and comment period sufficient to ensure a meaningful level of public input.” 42 U.S.C. § 18052(a)(4)(B)(i), (iii). Defendants have opined that, “[t]o the extent that a proposal is particularly wide-ranging, the proposed regulations will

support a longer State public notice and comment period.” 77 Fed. Reg. at 11,706; *see also id.* at 11,708 (same for the federal notice and comment period).

141. However, Georgia offered only 15 days for comment on the third version of its proposal—the final version made public before approval. That was wholly inadequate given the scale of the changes Georgia’s waiver makes to the state’s insurance market and that the comment period took place during a global pandemic. Every other state to seek a waiver has allowed at least 29 days for comment, and those waivers were generally far less significant than what Georgia has proposed. And Georgia cannot rely on its comment period for the second version, which involved an “entirely different proposal that affected [essential health benefits] and financial assistance, and would not be reflective of stakeholder concerns or feedback on the current set of ideas.”¹⁵³

142. Similarly, Defendants only offered thirty days for notice and comment, with a seven-day extension because of issues with its website portal. That amount of time is likewise insufficient for the public to fully comment on a waiver of this scope.

143. Even more troubling, neither the state nor Defendants offered any opportunity for notice and comment following the state’s October 9, 2020 revisions to its application, including revisions regarding important subjects like auto-reenrollment and inappropriate steering. *See supra* ¶¶ 92-93.

144. Finally, Part II of Georgia’s waiver was incomplete and vague, in violation of Section 1332 and its implementing regulations. The incompleteness of the state’s application also exacerbated the public’s inability to fully weigh in on the state’s proposal.

¹⁵³ Young & Levitis, *supra* note 68.

- a. The application fails to provide “[a] comprehensive description of the State legislation and program to implement a plan,” 45 C.F.R. § 155.1308(f)(3)(i); *see also* 42 U.S.C. § 18052(a)(4)(B)(ii)(II), because it says little about how the program would operate, how the state will fund or conduct functions previously performed by the federal exchange, or how the state intends to transition over to the new plan.
- b. Georgia has not enacted “State legislation that provides the State with authority to implement the proposed waiver,” 45 C.F.R. § 155.1308(f)(3)(ii), because it has only enacted legislation allowing the state to apply for a waiver in a general sense rather than authorizing the Georgia Access Model.
- c. The application fails to provide an adequate “list of the provisions of law that the State seeks to waive,” *id.* § 155.1308(f)(3)(iii); *see also* 42 U.S.C. § 18052(a)(4)(B)(ii)(I). It says only that the state would waive relevant subsections of Section 1311, which is “a massive and multifaceted provision with over 100 subsections, paragraphs, and clauses,” ranging from “extensive standards for Marketplaces” to “rules on CMS responsibilities, plan certification, navigators, quality improvement, and mental health parity.”¹⁵⁴
- d. The application lacks “analyses, actuarial certifications, data, assumptions, analysis, targets and other information ... sufficient to provide ... the necessary data to determine that the State’s proposed waiver” meets the

¹⁵⁴ *Id.*

statutory guardrails. 45 C.F.R. § 155.1308(f)(3)(iv). As explained above, “the state makes entirely unsupported (and unsupportable) claims about coverage gains and losses, neglects to consider important and obvious factors that will raise premiums in the state and makes other related errors.”¹⁵⁵

145. In sum, Part II of Georgia’s waiver is both procedurally and substantively deficient—a reflection of the haste with which the state and Defendants rammed through the application and the lack of any basis for it.

VI. Defendants’ unlawful decision will result in significant harm to Plaintiffs.

146. For many of the same reasons, Plaintiffs will be harmed by Defendants’ unlawful approval of Georgia’s waiver. Georgia’s waiver dramatically destabilizes the manner in which Georgians are able to obtain health insurance, harming, among others, providers of health care and organizations that assist with the insurance process. By the same token, Plaintiffs are injured by the 2018 Guidance, upon which Georgia’s waiver is predicated.

147. Planned Parenthood Southeast provides health care to people throughout Georgia through its four health centers and other service offerings that treated over 13,000 patients in 2020. Similarly, the Feminist Women’s Health Center provides health care to thousands of patients in Georgia, with a particular focus on underserved communities.

148. Both Plaintiffs serve Georgians with a wide variety of abilities to pay for care, including individuals with private insurance that covers some or all the range of health services offered by Plaintiffs; individuals who lack adequate insurance to pay for the services provided by

¹⁵⁵ *Id.*

Plaintiffs but can nonetheless “self-pay” to cover the costs of their care; and individuals who lack both insurance and the resources to self-pay.

149. Plaintiffs will face at least three forms of injury from Defendants’ decision to approve Georgia’s waiver: the waiver will strain Plaintiffs’ resources and force them to divert those limited resources from other critical aspects of their missions, including research, community outreach, and education, to continue to provide health care to its patients who need that care but are increasingly unable to afford it; it will make Plaintiffs’ patients less healthy, with more complex treatment needs; and it will require Plaintiffs to expend their already limited resources to assist its patients in managing a more complex insurance marketplace.

A. Defendants’ decision will strain Plaintiffs’ resources by making healthcare less affordable for their patients.

150. On the whole, Plaintiffs’ patient bases are less financially secure and more vulnerable than the average Georgian, with a disproportionate share of their patients relying on Medicaid or lacking adequate insurance entirely. For example, in 2019, over 80 percent of PPSE’s patients lived below 200% of the federal poverty line, as compared to 32 percent for Georgia as a whole.¹⁵⁶

151. Many of PPSE’s patients in Georgia are “self-pay” patients, who lack insurance coverage for PPSE’s services and pay for their care entirely out of pocket. PPSE provides these patients care at rates below market reimbursement rates for insured care. For some of these

¹⁵⁶ *Distribution of the Total Population by Federal Poverty Level (Above and Below 200% FPL)*, Kaiser Family Found. (2019), <https://www.kff.org/other/state-indicator/population-up-to-200-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

patients who are unable to pay PPSE's discounted rates, PPSE has some limited capacity to provide that care at a reduced rate, to the degree its budget allows.¹⁵⁷

152. Similarly, the majority of FWHC's patients seeking abortion-related services lack insurance coverage, while the majority of FWHC's patients seeking wellness services are able to take advantage of insurance coverage for at least some part of their care.

153. Both Plaintiffs can expect to pay more to provide care to their patient bases if Georgia's plan goes into effect. The waiver will increase the population of individuals who lack health insurance altogether, or whose insurance is insufficiently comprehensive to cover reproductive healthcare, likely increasing the number of patients seeking uncompensated (or partially compensated) care from Plaintiffs. Many of Plaintiffs' existing patients will have reduced ability to pay for their care, and as individual Georgians lose coverage, they may also choose to leave their existing reproductive healthcare providers and seek care through Plaintiffs instead.

154. Indeed, there is a close relationship between the amount of uncompensated or reduced-fee care provided by care providers and the uninsured and underinsured rates in a given area. For example, research has shown that as the ACA increased access to coverage, provider uncompensated care decreased. Between 2013 and 2015, total hospital charity care and bad debt decreased by \$8.6 billion nationwide.¹⁵⁸ In some states, uncompensated care dropped by as much

¹⁵⁷ *Payment and Insurance Information*, Planned Parenthood Southeast, <https://www.plannedparenthood.org/planned-parenthood-southeast/patient-resources/copy-payment-insurance-info> (last visited Jan. 13, 2021).

¹⁵⁸ *Report to Congress on Medicaid and CHIP*, Medicaid & CHIP Payment & Access Comm'n (Mar. 2018), <https://www.macpac.gov/wp-content/uploads/2018/03/Report-to-Congress-on-Medicaid-and-CHIP-March-2018.pdf>.

as 64%.¹⁵⁹ The share of hospital operating expenses consumed by uncompensated care dropped 30% nationally, from 4.4% in 2013 to 3.1% in 2015.¹⁶⁰

155. Thus, Plaintiffs expect the number of patients who lack the resources or coverage to compensate them for their care to increase substantially once Georgia implements the Georgia Access Model. Defendants' decision to approve Georgia's waiver will cause a predictable strain on Plaintiffs' resources and will require them to divert their limited resources from other needed programs into direct patient care as well as the fundraising necessary to increase available funds for that care. Defendants' decision therefore harms Plaintiffs' core missions of providing comprehensive reproductive care to their patient populations by either forcing them to turn away patients in need (endangering their ability to provide care to patients without regard to their ability to pay for them) or to instead redirect their resources to those patients, limiting their capacity to engage in other parts of their missions, including education.

B. Defendants' decision will lead to less healthy patients with more complex treatment needs.

156. Plaintiffs provide a range of reproductive health services to their communities, including contraception (including birth control pills, long-acting reversible contraceptives, and emergency contraception), sexually transmitted infection testing and treatment, pregnancy testing, breast and cervical cancer screening, and safe and legal abortion.

¹⁵⁹ *Id.* at 70.

¹⁶⁰ *Id.*; Jessica Schubel & Matt Broaddus, *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect*, Ctr. on Budget & Pol'y Priorities (May 23, 2018), <https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage>. Uncompensated care costs rose slightly in 2017 due to the Trump Administration's efforts to weaken the ACA, but remained much lower than they were before the enactment of the ACA. See Matt Broaddus, *Uncompensated Care Costs Well Down in ACA Medicaid Expansion States*, Ctr. on Budget & Pol'y Priorities (Oct. 21, 2020), <https://www.cbpp.org/blog/uncompensated-care-costs-well-down-in-aca-medicaid-expansion-states>.

157. Many of the services Plaintiffs provide are intended to be preventive, empowering and enabling patients to receive low-intervention care that can prevent the need for higher-intervention care later.

158. For example, patients with ready access to safe and effective contraception are less likely to face an unintended pregnancy. Even among patients with some access to contraception, patients' abilities to access the most-desired and effective forms of contraception for them (for example, patients who prefer to rely on a long-acting reversible contraceptive rather than condoms or birth control pills) can substantially affect the likelihood of an unintended pregnancy. Contraceptive services not only help to avoid unintended pregnancies and promote healthy birth spacing, resulting in improved maternal, child, and family health, but also provide preventive health benefits to some patients, such as reduced menstrual bleeding and pain and decreased risk of endometrial and ovarian cancer.

159. Similarly, widespread and regular sexually transmitted infection testing can help lower the chances of an outbreak in a community, reducing the likelihood that patients will ultimately need treatment. And availability of cancer screening is crucial to patient well-being and ensuring access to timely care if needed.

160. A large body of evidence, from both before and after implementation of the ACA, demonstrates that adequate health insurance coverage is associated with a greater likelihood that individuals will seek and receive needed care, like the preventive care described above. Significant research indicates that uninsured individuals are more likely to delay or forgo care because of costs and less likely to have reliable access to the health care system, as compared to those with comprehensive forms of health insurance coverage. Analysis of results from the

National Health Interview Survey¹⁶¹ administered by the Centers for Disease Control and Prevention (“CDC”) demonstrates that, in 2019, uninsured adults were over five times more likely to report that they had gone without health care “because of costs” in the previous twelve months (30.4% versus 5.4%).¹⁶² When including individuals who delayed care, and not just those who avoided it altogether, that figure rises to 36.5% of the uninsured (compared to only 7% of the insured).¹⁶³ That is, in the relatively recent past more than a quarter of uninsured adults reported that costs had affected their ability to seek care in a twelve month period.

161. Uninsured individuals are also far less likely to report having a usual source of care compared to insured people, meaning that treatable conditions may be detected later and when treatment is more expensive. National Health Interview Survey data reflect that in 2017, half (50%) of uninsured people reported that they did not have a place that they would “usually go to if [they were] sick and need health care,” compared to just 11% of the privately insured.¹⁶⁴ In the wake of the ACA’s implementation, researchers also found that 39% of the newly insured,

¹⁶¹ *National Health Interview Survey*, CDC, <https://www.cdc.gov/nchs/nhis/index.htm> (last updated Dec. 3, 2020).

¹⁶² Krutika Amin et al., *How Does Cost Affect Access to Care?*, Health System Tracker (Jan. 5, 2021), <https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care>. For survey question wording, see *NHIS Data, Questionnaires and Related Documentation*, CDC, <https://www.cdc.gov/nchs/nhis/data-questionnaires-documentation.htm> (last updated Sept. 22, 2020).

¹⁶³ Gary Claxton et al., *How Does Cost Affect Access to Care?*, Kaiser Family Found. (Jan. 22, 2019), <https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care>.

¹⁶⁴ Rachel Garfield et al., *The Uninsured and the ACA: A Primer*, Kaiser Family Found. (Jan. 25, 2019), <https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/>; *NHIS Data, Questionnaires and Related Documentation*, *supra* note 162; *see also, e.g.*, Claxton et al., *supra* note 163; Catherine Hoffman & Julia Paradise, *Health Insurance and Access to Health Care in the United States*, 1136 *Annals of the N.Y. Acad. of Scis.* 149 (2008), <https://nyaspubs.onlinelibrary.wiley.com/doi/full/10.1196/annals.1425.007>; *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2006*, CDC 12-13 (Dec. 2007), https://www.cdc.gov/nchs/data/series/sr_10/sr10_235.pdf.

compared to 57% of those who remained uninsured, did not have a regular source of health care services.¹⁶⁵

162. While Plaintiffs will continue to try to provide affordable care to all who need it, under Georgia's plan, many patients will have to pay more out of pocket for care. Some of these patients will have to ration care, delay care, or even go without it—allowing otherwise preventable conditions to worsen or become more difficult to treat or manage.

163. Specifically, research has shown that as the cost of family-planning services for patients increases, patients shift away from medium- and high-efficacy methods of contraception and toward less effective means (or no birth control at all).¹⁶⁶ This shift away from high- and medium-efficacy contraception leads to an increase in unwanted pregnancies.¹⁶⁷ For example, a study in California showed that two pregnancies were averted for every seven women who received contraceptives.¹⁶⁸ For these reasons, as Plaintiffs' patients lose healthcare coverage, the number of unintended pregnancies among Plaintiffs' patient bases will increase, resulting both in more risky pregnancies for Plaintiffs' patient bases as well as more abortions.

¹⁶⁵ Rachel Garfield et al., *Access to Care for the Insured and Remaining Uninsured: A Look at California During Year One of ACA Implementation*, Kaiser Family Found., at fig. 1 (May 28, 2015), <https://www.kff.org/report-section/access-to-care-for-the-insured-and-remaining-uninsured-issue-brief/>.

¹⁶⁶ M. Antonia Biggs et al., *Findings from the 2012 Family PACT Client Exit Interviews*, Bixby Ctr. for Global Reprod. Health, U. of Cal., S.F. 53-54 (2014), https://bixbycenter.ucsf.edu/sites/bixbycenter.ucsf.edu/files/3.%20CEI%20Report_ADA.pdf.

¹⁶⁷ See, e.g., *Unintended Pregnancies and Abortions Averted by Planned Parenthood, 2015*, Guttmacher Inst. (June 13, 2017), <https://www.guttmacher.org/infographic/2017/unintended-pregnancies-and-abortions-averted-planned-parenthood-2015#> (estimating that in 2015, Planned Parenthood's provision of contraceptive services averted approximately 430,000 unintended pregnancies nationwide).

¹⁶⁸ M. Antonia Biggs et al., *Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007*, Bixby Ctr. for Global Reprod. Health, U. of Cal., S.F. 16 (Apr. 2010), https://www.ansirh.org/sites/default/files/publications/files/familypactcost-benefitanalysis2007_2010apr_featured.pdf

164. Similarly, lost or diminished healthcare will lead some of Plaintiffs' patients to forgo or delay regular STI testing, ultimately only turning to Plaintiffs for treatment in the event they experience symptoms of an STI, at great risk to themselves and their partners. A decrease in regular testing will also cause an increase in community STI rates, and consequent demand for STI treatment.¹⁶⁹ And lost or diminished access to cancer screening will result in undiagnosed cancer or cancers diagnosed later, again at great risk to patient health.¹⁷⁰

165. By increasing the number of patients in Plaintiffs' communities that lack access to insurance coverage at all, or lack access to insurance coverage that covers Plaintiffs' preventive care, the Georgia Access Model is likely to make it more expensive for Plaintiffs to treat their patients. Georgia's plan will cause Plaintiffs' patients to forgo straightforward preventive care and turn to Plaintiffs for more complex treatment instead, while also likely increasing the number of patients with a need for STI testing and/or treatment in Plaintiffs' patient communities.

¹⁶⁹ See, e.g., Jennifer J. Frost et al., *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, 92 *Milbank Q.* 667, 696 (2014) (estimating that STI and HIV screening during family planning visits had saved public healthcare funds an estimated \$123 million in 2010 by avoiding complications from infections, avoiding care for patients who contracted HIV from partners who unknowingly transmitted it, and avoiding costs and complications from HPV treatment through early detection or vaccination).

¹⁷⁰ See, e.g., *id.* at 695 (estimating that in the absence of publicly-funded family planning services, an estimated 2.3 million women would have forgone or postponed cervical cancer testing in 2010; such testing identified 3,600 potential cancer cases before the cancer developed and averted 2,090 cervical cancer deaths).

166. Moreover, the consequences of the waiver will be disproportionately felt by Plaintiffs' low-income patients and patients of color—those who already face serious barriers to obtaining comprehensive, high-quality reproductive health care.¹⁷¹

C. Defendants' decision will require Plaintiffs to expend additional resources to manage a more complex insurance market for themselves and their patients.

167. Both Plaintiffs expend considerable resources to assist their patients in obtaining and/or using their insurance to access coverage.

168. PPSE provides a wide variety of services to ensure that as many members of its community have health coverage as possible, both to maximize the health of its community and to preserve its limited resources to serve patients who cannot otherwise access health coverage.

169. To that end, PPSE helps patients “enroll in programs like Medicaid or ... options under the Affordable Care Act.”¹⁷² PPSE trains its phone intake staff to discuss patients' financial needs and resources with them, including understanding the scope of their health insurance coverage (if any) and considering options for obtaining health insurance coverage that would cover the care that PPSE provides (including purchasing coverage on an ACA exchange).

170. Similarly, the staff on-site at PPSE's health centers are trained to discuss payment and insurance options with patients to ensure that they receive the broadest coverage possible. Health center staff also work with patients to ensure as far as possible that PPSE's outgoing referrals for ongoing care are to providers covered by patients' plans.

¹⁷¹ See generally *Healthy People 2020: An Opportunity to Address Societal Determinants of Health in the U.S.*, Sec'y's Advisory Comm. on Nat'l Health Promotion & Disease Prevention Objectives for 2020 (July 26, 2010), <https://www.healthypeople.gov/sites/default/files/SocietalDeterminantsHealth.pdf>.

¹⁷² *Payment and Insurance Information*, *supra* note 157.

171. PPSE also directs patients to resources provided by Planned Parenthood's nationwide entity, including a website which informs patients about how they can enroll in health insurance on [healthcare.gov](https://www.healthcare.gov).¹⁷³

172. In a similar vein, the staff of both Plaintiffs assist patients in ensuring that they are able to receive the reimbursements they are eligible for from their insurance providers. Plaintiffs file claims on patients' behalf for reimbursement of treatment and, in the event of denial, undertake the appeals process on their behalf, requiring significant staff time to be devoted to helping patients with insurance-related matters.

173. In order to maximize the insurance coverage its patients can receive for PPSE services, PPSE recently contracted with an expert health insurance consultant to manage its contracting efforts with insurers, to ensure as much as possible that PPSE is treated as an in-network provider of reproductive health services.

174. Finally, PPSE conducts broader outreach to its local community during open enrollment. Such efforts have in the past included paid door-to-door canvassing to discuss the ACA, as well as manning tables at public outreach events in order to discuss health coverage and PPSE's services with community members.

175. Similarly, FWHC undertakes substantial efforts to obtain the credentials needed to accept a variety of insurance plans, and to adjust to changing requirements and coverage by insurers.

176. Defendants' approval of Georgia's 1332 waiver application will force PPSE to divert resources from other programs to support its enrollment assistance efforts. Georgia's plan

¹⁷³ See *Health Insurance Questions and Answers*, Planned Parenthood, <https://www.plannedparenthood.org/get-care/health-insurance> (last visited Jan. 13, 2021).

will introduce a substantial overhaul to the consumer-facing process of choosing insurance plans, moving consumers from a centralized, regulated healthcare exchange to a fragmented series of interactions with individual insurers. This new process is likely to be far more complex and confusing for patients, and, in turn, PPSE staff assisting them. In order for PPSE staff to continue to assist its patients in this way, it will be forced to expend resources to understand the new, more fragmented insurance shopping experience, and train its staff to work through this shopping experience with patients. And because purchasing insurance will be more complex, PPSE will both have more people to assist and will need to devote additional time to each consumer interaction.

177. Similarly, Georgia's plan will force both Plaintiffs' staff to spend a larger portion of their time on efforts to obtain coverage on their patients' behalf when claims are denied by making the range of plans that their patients may carry more varied, complex, and likely to exclude coverage for the services they provide.

178. Georgia's approach is also likely to substantially alter the range of plans purchased by Georgians, particularly by facilitating insurers' promotion of non-ACA-compliant junk insurance plans with bare-bones coverage. Such plans are particularly unlikely to cover the reproductive services offered by Plaintiffs, among others. These plans often have blanket exclusions for basic health care services such as birth control, maternity services, and gender-transition related services, and frequently fail to provide coverage for preventive care such as birth control, cancer screenings, and well-woman exams without out-of-pocket costs to patients.

179. This overhaul in the state's insurance options is therefore likely to render far less useful the substantial resources PPSE already poured into rationalizing its relationships with payors, likely requiring that PPSE undertake another expensive effort to negotiate access to its

services from payors newly incentivized to encourage the purchase of a slew of new limited-coverage plans. FWHC will similarly need to undertake renewed and expanded efforts to negotiate insurers' changing credential requirements to make sure its patients can obtain covered care from FWHC as the mix of plans available in Georgia transforms as a result of Georgia's plan.

180. In sum, Georgia's plan will disrupt the manner in which Georgia consumers obtain coverage, and by extension, the manner in which Georgia providers offer care to their patients. It is both harmful and unlawful.

CLAIMS FOR RELIEF

Count One (Contrary to Law – Violates Section 1332's Guardrails, 5 U.S.C. § 706(2)(A), 42 U.S.C. § 18052)

181. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

182. Under the Administrative Procedure Act, a "reviewing court shall ... hold unlawful and set aside agency action ... found to be ... not in accordance with law." 5 U.S.C. § 706(2)(A).

183. Defendants' decision to grant Georgia's waiver is contrary to law because the waiver, evaluated both as a whole and with respect to Part II specifically, fails to meet Section 1332's statutory guardrails. Specifically, Georgia's plan will not provide coverage to a comparable number of state residents, it will not provide coverage that is at least as comprehensive or affordable to state residents, and it will increase the federal deficit. *See* 42 U.S.C. § 18052(b)(1).

184. Defendants' decision to approve Georgia's waiver in whole or in part is therefore unlawful and must be set aside.

Count Two

(Contrary to Law – The 2018 Guidance, 5 U.S.C. § 706(2)(A), 42 U.S.C. § 18052)

185. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

186. Under the Administrative Procedure Act, a “reviewing court shall ... hold unlawful and set aside agency action ... found to be ... not in accordance with law.” 5 U.S.C. § 706(2)(A).

187. Defendants’ decision to grant Georgia’s waiver is contrary to law because it was predicated on the 2018 Guidance, which is itself unlawful. Specifically, the 2018 Guidance erroneously interprets Section 1332 to mean that a state’s waiver request meets the statutory guardrails so long as equally comprehensive and affordable coverage would remain available under the state’s plan, even if fewer state residents obtain such coverage. *See* 83 Fed. Reg. at 53,578. Because Georgia’s waiver would result in fewer state residents with comprehensive and affordable coverage, even though such coverage would remain theoretically available on the market, Georgia’s waiver cannot be sustained if the 2018 Guidance is unlawful.

188. Both the 2018 Guidance and Defendants’ decision to approve Georgia’s waiver in whole or in part are therefore unlawful and must be set aside.

Count Three

(Contrary to Law / Exceeds Jurisdiction – Exceeds Scope of Authority Under Section 1332, 5 U.S.C. § 706(2)(A), (C), 42 U.S.C. § 18052)

189. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

190. Under the Administrative Procedure Act, a “reviewing court shall ... hold unlawful and set aside agency action ... found to be ... not in accordance with law.” 5 U.S.C. § 706(2)(A).

191. Defendants' decision to grant Georgia's waiver is contrary to law because it exceeds their authority under Section 1332. Georgia's plan is so radical and sweeping in character that it requires the waiver of provisions that are not waivable under Section 1332. By eliminating Georgia's reliance on the federal Exchange without establishing a state Exchange in its place, Georgia's plan fails to comply with numerous ACA requirements that mandate or presuppose the existence of an Exchange and that are not included among the provisions that Section 1332 allows Defendants to waive. *See* 42 U.S.C. § 18052(a)(2).

192. Defendants' decision to approve Georgia's waiver in whole or in part is therefore unlawful and must be set aside.

Count Four
(Arbitrary and Capricious, 5 U.S.C. § 706(2)(A))

193. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

194. Under the Administrative Procedure Act, a "reviewing court shall ... hold unlawful and set aside agency action ... found to be ... arbitrary [or] capricious." 5 U.S.C. § 706(2)(A).

195. In approving Georgia's waiver, Defendants "relied on factors which Congress has not intended [them] to consider, entirely failed to consider an important aspect of the problem, [and] offered an explanation for [their] decision that runs counter to the evidence before [them]," and their decision was "so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

196. Defendants' decision to approve Georgia's waiver in whole or in part is therefore arbitrary and capricious and must be set aside.

Count Five
(Insufficient Evidence, 5 U.S.C. § 706(2)(E), (F))

197. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

198. Under the Administrative Procedure Act, in certain circumstances, a “reviewing court shall ... hold unlawful and set aside agency action ... found to be ... unsupported by substantial evidence ... or unwarranted by the facts.” 5 U.S.C. § 706(2)(E), (F).

199. Defendants were obliged to, but did not, produce substantial evidence for their factual findings in approving Georgia’s waiver, and their decision was unwarranted by the facts.

200. Defendants’ decision to approve Georgia’s waiver in whole or in part is therefore backed by insufficient evidence and must be set aside.

Count Six
(Procedurally Deficient – State Notice and Comment, 5 U.S.C. § 706(2)(D))

201. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

202. Under the Administrative Procedure Act, a “reviewing court shall ... hold unlawful and set aside agency action ... found to be ... without observance of procedure required by law.” 5 U.S.C. § 706(2)(D).

203. Defendants’ decision to approve Georgia’s waiver was procedurally deficient because the state failed to “provide a public notice and comment period sufficient to ensure a meaningful level of public input for the application for a section 1332 waiver.” 45 C.F.R. § 155.1312(a)(1).

204. Defendants’ decision to approve Georgia’s waiver in whole or in part was therefore issued without observance of procedure required by law and must be set aside.

Count Seven
(Procedurally Deficient – Federal Notice and Comment, 5 U.S.C. § 706(2)(D))

205. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

206. Under the Administrative Procedure Act, a “reviewing court shall ... hold unlawful and set aside agency action ... found to be ... without observance of procedure required by law.” 5 U.S.C. § 706(2)(D).

207. Defendants’ decision to approve Georgia’s waiver was procedurally deficient because Defendants failed to provide a sufficient period for notice and comment. 45 C.F.R. § 155.1316(b); *see also* 42 U.S.C. § 18052(a)(4)(B)(iii).

208. Defendants’ decision to approve Georgia’s waiver in whole or in part was therefore issued without observance of procedure required by law and must be set aside.

Count Eight
(Procedurally Deficient – Incomplete Application, 5 U.S.C. § 706(2)(D))

209. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

210. Under the Administrative Procedure Act, a “reviewing court shall ... hold unlawful and set aside agency action ... found to be ... without observance of procedure required by law.” 5 U.S.C. § 706(2)(D).

211. Defendants’ decision to approve Georgia’s waiver was procedurally deficient because Part II of Georgia’s waiver application was incomplete and vague. Among other things, it lacked “[a] comprehensive description of the State legislation and program to implement a plan,” 45 C.F.R. § 155.1308(f)(3)(i); *see also* 42 U.S.C. § 18052(a)(4)(B)(ii)(II); failed to show that the State had enacted “legislation that provides the State with authority to implement the proposed waiver,” 45 C.F.R. § 155.1308(f)(3)(ii); failed to provide an adequate “list of the

provisions of law that the State seeks to waive,” *id.* § 155.1308(f)(3)(iii); *see also* 42 U.S.C. § 18052(a)(4)(B)(ii)(I); and lacked “analyses, actuarial certifications, data, assumptions, analysis, targets and other information ... sufficient to provide ... the necessary data to determine that the State’s proposed waiver” meets the statutory guardrails. 45 C.F.R. § 155.1308(f)(3)(iv).

212. Defendants’ decision to approve Georgia’s waiver in whole or in part was therefore issued without observance of procedure required by law and must be set aside.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs request that this Court:

1. declare that Defendants’ decision to approve Georgia’s waiver under Section 1332 is unlawful in whole or in part;
2. declare that the 2018 Guidance is unlawful;
3. vacate and set aside Defendants’ decision to approve Georgia’s waiver in whole or in part;
4. vacate and set aside the 2018 Guidance;
5. enjoin Defendants from issuing the proposed waiver to Georgia;
6. enjoin Defendants from processing future waivers under the terms of the 2018 Guidance;
7. award Plaintiffs their costs, attorneys’ fees, and other disbursements for this action; and
8. grant any other relief this Court deems appropriate.

Dated: January 14, 2021

Respectfully submitted,

/s/ John T. Lewis
John T. Lewis (DC Bar No. 1033826)
Aman George (DC Bar No. 1028446)
Sean A. Lev (DC Bar No. 449936)
Democracy Forward Foundation

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December 15, 2021

The Honorable Javier Becerra
Secretary, U.S. Department of Health and
Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary, U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20200

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid
Services
7500 Security Blvd.
Baltimore, MD 21244

The Honorable Lily Batchelder
Assistant Secretary for Tax Policy
1500 Pennsylvania Avenue NW
Washington, DC 20220

RE: Georgia's Section 1332 waiver

Dear Secretary Becerra, Secretary Yellen, Administrator Brooks-LaSure and Assistant Secretary Batchelder:

As a representative of America's 30 million small businesses and Georgia's 1.1 million small businesses, Small Business Majority writes to express our concern about Georgia's Section 1332 waiver for the proposed Georgia Access model, which would waive federal rules under the Affordable Care Act (ACA) and jeopardize the individual marketplace that small businesses and their employees rely on for access to quality and affordable coverage.

Small Business Majority is a national small business advocacy organization, founded and run by small business owners to ensure America's entrepreneurs are a key part of a thriving and equitable economy. With a network of more than 85,000 small businesses, we are actively engaging small business owners and policymakers in support of long- and short-term policies that will lead to a healthy recovery in the wake of COVID-19. We know from this work that healthcare coverage is an issue of top concern for small businesses in Georgia and across the country.

It's important to note that a majority of small business owners and their employees access their health coverage through the individual marketplace, and [our research](#) has found that more than half of all ACA marketplace enrollees are small business owners, self-employed individuals or small business employees.

In Georgia alone, more than 450,000 individuals bought affordable, comprehensive coverage through HealthCare.gov in 2020, with 9 in 20 Georgians receiving financial help to lower their premiums and out-of-pocket costs.

Leaving HealthCare.gov for the Georgia Access model would harm consumers, including small business owners and employees, which means Georgia's proposal is not approvable under federal law. Georgia's waiver fails the ACA's tests of coverage, comprehensiveness and affordability. There is a high chance that the waiver would cause thousands of Georgians to lose coverage and there is no reason to expect it would meaningfully increase coverage. It also would likely leave many in the small business community with less affordable or less comprehensive coverage than they would otherwise have, which is critically important during a pandemic.

Thank you for your consideration of our comments on Georgia's Section 1332 waiver application.

Sincerely,

Rachel Shanklin
Georgia Outreach Manager, Small Business Majority

January 7th, 2022

SUBMITTED VIA ONLINE PORTAL AND EMAIL to stateinnovationwaivers@cms.hhs.gov

The Honorable Xavier Becerra
Secretary, U.S. Department of Health and
Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary, U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20200

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare &
Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Georgia Section 1332 Waiver Comment

Dear Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure,

On behalf of the Southern Poverty Law Center (the SPLC or Center), we write to express our organization’s deep concern about Georgia’s Section 1332 waiver of federal rules under the Affordable Care Act (ACA) in light of the updated data the State has provided at the Centers for Medicare & Medicaid Services’ (CMS) request and changes in federal law to address the COVID-19 pandemic. Not only is the waiver illegal under federal law, but it would eliminate the central source of help for hundreds of thousands of Georgians—particularly Black, Brown, and rural residents—who use the federal marketplace to identify the best healthcare plans for themselves and their families—a need ever more important in the midst of the ongoing COVID-19 pandemic.

The SPLC is a non-profit legal organization with offices in Georgia and other states across the Deep South committed to eradicating poverty in the Deep South by dismantling exploitative economic systems that deprive people of wealth on account of their race and economic status. For five decades, the Center has sought justice for, and represented the needs of, the most vulnerable members of our society, particularly in communities of color, who are punished or penalized due to their economic status. Ensuring that no- and low-income people in the South have access to health coverage and care is a crucial part of this mission. For example, the SPLC, with co-counsel at the National Health Law Program and the Tennessee Justice Center, successfully obtained an injunction in *Wilson v. Gordon*, a class action lawsuit against the State of Tennessee for Medicaid practices that deprived thousands of eligible residents of health care coverage. The SPLC, alongside co-counsel, also successfully challenged the approval of Section 1115 Medicaid waivers sought by the States of

Arkansas and Kentucky in *Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019), and *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019), respectively. With this commitment to protecting healthcare rights of no- and low-income residents of the South, and for the reasons explained below, the SPLC respectfully urges the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, and Department of Treasury to **withdraw approval** of Georgia’s 1332 waiver application’s elimination of the federal marketplace and instead encourage Georgia to join 38 other states and the District of Columbia by adopting the ACA’s expansion of Medicaid to low-income adults. In sharp contrast to the effects of the proposed Section 1332 waiver, Medicaid expansion would sharply reduce the state’s uninsured rate, help respond to the ongoing pandemic, and bring billions in additional federal funding into Georgia, which has one of the highest uninsured rates in the nation.¹

We believe that the proposed Georgia Access model will put no- and low-income people, at risk of becoming un- or under-insured altogether. In addition, Georgians with little or no experience buying or using health insurance, those with limited English proficiency, Georgians with low health literacy skills, and low-income Georgians would be most at risk of experiencing adverse consequences from the outlined plan.

Instead of giving consumers more choices to enroll in comprehensive health coverage, as Georgia officials claim, the Georgia Access model would eliminate consumers’ option to use the one-stop-shop HealthCare.gov platform. Eliminating the use of the HealthCare.gov platform is likely to sharply reduce the number of Georgians with comprehensive coverage for four significant reasons:

- 1. Georgia’s individual health insurance landscape has drastically changed since the waiver was approved.**

When Georgia’s 1332 waiver was approved in November 2020, 463,910 Georgians were enrolled in coverage through HealthCare.gov.² In 2021, over 550,000 Georgians are enrolled, a difference of about 86,000 new enrollments.³ Many of these new enrollments came during the COVID Special Enrollment Period, which ran from February 12 to August 15, 2021.

A major driver of the enrollment increase was the more generous Advanced Premium Tax Credits (APTCs) created through the American Rescue Plan. Along with these increased APTCs, enrollees above 400% FPL received an 8.5% income cushion for repaying subsidies, and enrollees between 100-150% FPL were guaranteed access to a \$0 silver-level plan and increased cost-sharing reductions to significantly lower deductibles for this group.⁴ We have every expectation that

¹ Christen Linke Young and Jason Levitis, “Georgia’s latest 1332 proposal continues to violate the ACA,” Brookings Institute, Sept. 1, 2020, <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>

² Georgia Health News, “Exchange Enrollment Hits Record Level in State,” September 22, 2021, <https://www.georgiahealthnews.com/2021/09/georgia-exchange-enrollment-hits-record-level/>

³ Kaiser Family Foundation, Marketplace Enrollment 2014 – 2021, <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22georgia%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁴ Kaiser Family Foundation, “Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID 19 Relief on Marketplace Premiums,” March 15, 2020. <https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/>

Georgians will continue to benefit from this supplemental financial assistance as Congress works to extend the help in the proposed Build Back Better Act.

The Biden Administration also dramatically increased funding for outreach and enrollment assistance. Georgia navigator organizations received \$1,945,303 beginning in August 2021, compared to \$700,000 the year prior—a 177% increase.⁵ The increase in navigators and outreach efforts will help more Georgians find more affordable plans by spreading awareness of the increased APTCs.

Finally, five new insurers have joined Georgians health insurance marketplace. Georgia has 11 insurers offering plans on the Marketplace for the 2022 plan year, up from four in 2019 and six in 2021.⁶ An increase in insurers demonstrates that Georgia’s insurance marketplace has stabilized and matured and is benefiting as expected from the state’s reinsurance program.

The recent advances in Georgia’s health insurance marketplace all trend in positive directions that benefit consumers and meaningfully resolve the shortcomings that the Georgia Access model was purported to address. Implementation of the Georgia Access proposal would only serve to undercut the progress our state has experienced since it was first put forward. We urge the Departments to withdraw their previous approval of this waiver proposal. Under the proposed 1332 waiver, Georgia’s projected enrollment goals are drastically lower than the increase in coverage through HealthCare.gov. Under the waiver, the Georgia Access Model would, at best, have caused an increase from 366,000 in 2018 to 392,000 in 2023. Because the waiver intends to eliminate federal investments in marketing, out-reach, and in person assistance, the waiver will likely continue to fall short, let alone match, the current enrollment baseline as of August 2021.⁷

2. Fragmenting the insurance market would confuse and discourage consumers from enrollment.

Under this proposal, enrollment would likely fall because buying insurance would become harder for Georgia consumers. Purchasing health insurance is a complicated and expensive undertaking, especially for communities of color in Georgia. Seventy-nine percent of Georgia’s marketplace enrollees use HealthCare.gov to complete the enrollment process.⁸ Eliminating the preferred enrollment platform of most Georgia consumers could not only cause confusion but could also paralyze consumers, keeping them from making a decision altogether.

⁵Centers for Medicaid & Medicare Services, “2021 CMS Navigator Cooperative Agreement Awardees,” August 27, 2021. <https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf>

⁶ Kaiser Family Foundation, Navigator Funding Restored in Federal Marketplace States for 2022, September 29, 2021. <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>

⁷ Tara Straw and Jason Levitis, “Georgia’s Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked,” Center on budget and Policy Priorities, December 2021, <https://www.cbpp.org/research/health/georgias-plan-to-exit-marketplace-will-leave-more-people-uninsured-should-be>.

⁸ Georgia Section 1332 State Innovation Waiver as submitted to CMS on July 31, 2020; https://www.cms.gov/CCHIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers- (hereafter, Waiver).

Research shows that having too many choices makes it difficult for consumers to make a choice, much less a fitting choice.^{9,10} The system proposed in the waiver would require consumers to choose among legions of sellers before beginning the process of selecting a specific health plan and would not guarantee access to a single platform on which to see and compare all plan choices on equal terms. As a result, Georgians would be confused at the very least, find it challenging to make an informed choice, and, at the worst, not make a choice at all.

3. Georgians eligible for Medicaid are unlikely to receive assistance from insurers, agents, or brokers.

HealthCare.gov facilitates Medicaid enrollment with a “no-wrong-door” application that routes Georgians to the program for which they are eligible based on their family size, income, and other factors. In 2020, at least 38,000 Georgians enrolled in Medicaid via HealthCare.gov.¹¹ Medicaid enrollment ability is especially important for low-income individuals, particularly in Black and Brown communities that the SPLC serves. Under the ACA, Black and Latinx families saw the greatest improvement in uninsured rates across the United States, especially in those states that expanded Medicaid, and the ACA’s implementation began to reduce the disparity in insurance coverage between Black and Brown families and white families.¹²

Brokers and insurers have no incentive to provide information and assistance to consumers who turn out to be eligible for Medicaid. For example, a search on HealthCare.gov shows more than 1100 agents and brokers that enroll people in coverage in one Atlanta zip code but zero agents and brokers that say they will assist with Medicaid/CHIP enrollment.¹³ Brokers and agents not assisting in Medicaid enrollment is problematic for Black and Brown families. Under the ACA, Black and Latinx families saw the greatest improvement in uninsured rates across the United States, especially in those states that expanded Medicaid,⁷ and the ACA’s implementation began to reduce the disparity in insurance coverage between Black and Brown families and white families. But in 2017, uninsured rates have risen and the disparity in health insurance coverage between Black and Brown families and white families also began increasing in Georgia and nationwide as the Trump Administration sought to repeal the ACA and undermine the stability of the private insurance market created under the ACA.¹⁴ The 1332 waiver’s lack of assistance from brokers, paired with the elimination of federal investment in enrollment outreach, will do nothing but increase these disparities in coverage.

⁹ Consumers Union, “The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making,” November 2012, https://advocacy.consumerreports.org/wp-content/uploads/2012/11/Too_Much_Choice_Nov_2012.pdf.

¹⁰ J. Michael McWilliams *et al.*, “Complex Medicare Advantage Choices May Overwhelm Seniors — Especially Those With Impaired Decision Making,” *Health Affairs*, September 2011, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.0132>.

¹¹ CMS, *op. cit.*

¹² Samantha Artiga, Kendal Orgera, and Anthony Damico “Changes in Health Coverage by Race and Ethnicity since the ACA, 2010-2018,” March 5, 2020, <https://www.kff.org/racial-equity-and-healthpolicy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/>.

¹³ Center on Budget and Policy Priorities analysis. HealthCare.gov search conducted on August 14, 2020, using the 30310-zip code.

¹⁴ *Id.*

Moreover, Georgia’s waiver will result in Georgians’ enrollment in substandard plans, such as short-term plans, into which brokers often steer people because they come with higher commissions—a tactic that has continued during the pandemic.¹⁵ In a national survey, one in four consumers who received assistance from a broker was offered an ACA non-compliant policy as an alternative or supplement to a compliant health insurance plan.¹⁶ People enrolled in subpar plans are subject to punitive exclusions of their pre-existing conditions, benefit limitations, and caps on plan reimbursements that expose them to potentially high out-of-pocket costs. A study of short-term plans in Atlanta in 2020 showed that even though people would pay lower premiums up-front, they could be responsible for out-of-pocket costs several times higher for common or serious conditions, such as diabetes or a heart attack. The most popular plan in Atlanta refused to cover prescription drugs, mental health services, or maternity services, had preexisting condition exclusions, and had a deductible three times as high as an ACA-compliant plan.

4. Georgians will lose coverage in the transition from HealthCare.gov to the Georgia Access system.

The disruption created by the state’s transition away from HealthCare.gov is likely to cause a decline in enrolment among Georgia consumers. Our state’s waiver predicts a loss of about 2 percent (8,000 people) of enrollees due to the change from one system to another. However, other states’ experiences show this figure is unrealistic.¹⁷ For example, Kentucky saw a reduction of 13 percent in its marketplace enrollment when the state transitioned to the federal marketplace in 2017, compared to a 4 percent decline nationally.¹⁸ More recently, Nevada’s 2020 marketplace enrollment dropped 7 percent after the state transitioned to a state-based marketplace, compared to flat enrollment nationally.¹⁹ Similar percentage declines in Georgia would translate into a drop of 25,000-46,000 people from marketplace enrollment.²⁰ Enrollment declines of this scope would likely exceed the increases anticipated by the waiver (27,000).

Enrollment declines are especially likely given that Georgia has only allotted one-third of the estimated cost of the waiver to the transition process. This funding seems solely dedicated to the

¹⁵ Christen Linke Young and Kathleen Hannick, “Misleading marketing of short-term health plans amid COVID-19,” Brookings Institution, March 24, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

¹⁶ Karen Pollitz, Jennifer Tolbert, Liz Hamel, and Audrey Kearney, “Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need” Aug 07, 2020, <https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need>

¹⁷ Waiver, *op. cit.*, p. 71.

¹⁸ Sarah Lueck, “Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges,” CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

¹⁹ CBPP calculations from CMS public use files. *See also*, Nevada Health Link, “Nevada’s State Based Exchange Announces Enrollment Figures for Plan Year 2020,” December 23, 2019, https://d1q4hslcl8rmbx.cloudfront.net/assets/uploads/2019/12/FINAL-2020-Nevada-Exchange-Prelim-Enrollment-Release_12.23.19.pdf; Sarah Lueck, “Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges,” CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

²⁰ As this calculation indicates, enrollment declines due to the Georgia Access Model would likely exceed the modest increases (about 2,000 people) Georgia projects from the reinsurance program and the total increase Georgia projects under the waiver (27,000).

technological transition. The state has not allocated specific funds to help consumers understand the transition, their options for enrollment, or how to access free, unbiased enrollment assistance.

5. The Georgia Access waiver violates the statutory guardrails set forth in Section 1332 of the Affordable Care Act.

Georgia's proposal is not legally viable under federal law because it would harm consumers, including Black and Brown families across the State, by increasing the number of uninsured Georgians and leave many others with worse coverage. The ACA requires that Section 1332 waivers cover as many people, with coverage as affordable and comprehensive, as would be covered absent the waiver, without increasing the federal deficit. Georgia's waiver fails these tests. There is a high chance that the waiver would cause thousands of Georgians to lose coverage, and there is no reason to expect it would meaningfully increase coverage. Georgia's plan would also likely leave many Georgians with less affordable or less comprehensive coverage than they would otherwise have. The waiver therefore does not meet the guardrails under federal law.

Thank you for this opportunity to comment on Georgia's Section 1332 waiver application and for your consideration of our comments. For these reasons, the SPLC urges the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, and Department of Treasury to rescind the approval of the Georgia Access model's plan to eliminate the federal marketplace after considering the numerous concerns expressed above and in public comments by other interested persons and organizations.

Sincerely,

Tom Jurgens
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Emily C. R. Early
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The Southern Poverty Law Center



Advocates for Families in Need

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January 7, 2022

VIA EMAIL (stateinnovationwaivers@cms.hhs.gov)

To: The Honorable Xavier Becerra, Secretary, Department of Health and Human Services
The Honorable Janet Yellen, Secretary, Department of the Treasury
The Honorable Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services

Re: Georgia Section 1332 Waiver Comments

Dear Secretary Becerra, Secretary Yellen, and Administrator Brooks-LaSure,

Thank you for the opportunity to comment on Georgia's proposal to waive federal rules under the Affordable Care Act (ACA) and the updated data provided by the state in response to CMS's request. I'm writing on behalf of the Tennessee Justice Center (TJC), a nonprofit organization founded in 1995 that uses the law, education, and advocacy to ensure that Tennesseans can meet their most basic needs and have a pathway to opportunity. Our mission is to advocate on behalf of low-income Tennesseans and to defend the programs that provide health care coverage and food security, not only in Tennessee but nationwide. TJC is deeply concerned that Georgia's exit from the federal marketplace (HealthCare.gov) and the proposed Georgia Access model would put Georgians at risk of becoming uninsured or underinsured and set a dangerous precedent for other states to follow.

In Tennessee, we know the importance of HealthCare.gov in helping people navigate the complex system of health plans. For years, the federal marketplace was the only online application portal for our state's Medicaid program ("TennCare"), which had a five-year delay in implementing its new computerized TennCare eligibility determination system (TEDS). Prior to the launch of TEDS, a good portion of the applicants on HealthCare.gov were determined eligible for Medicaid. The popularity of the ACA and the federal marketplace has raised public awareness about how to find health plans and has helped identify many individuals who were unaware of their eligibility for Medicaid.

Circumstances have changed since GA’s waiver was approved.

In 2021, over 550,000 Georgia residents were enrolled in coverage through healthcare.gov;¹ an increase of about 86,000 from the November 2020 enrollment number when the waiver was approved.² Many of these new enrollments happened between February 12 and August 15, 2021—the COVID Special Enrollment Period.

The enhanced Advanced Premium Tax Credits (APTCs) created under the American Rescue Plan was a significant factor in the enrollment increase. In addition to the enhanced APTCs, enrollees above 400% FPL received an 8.5% income cushion for repaying subsidies and enrollees between 100-150% FPL were guaranteed access to a \$0 silver-level plan and increased cost-sharing reductions to substantially lower deductibles for this group.³ Georgians are expected to continue to benefit from the extension of this supplemental financial assistance under the proposed Build Back Better Act, if passed.

The Biden Administration also significantly increased funding for outreach and enrollment assistance. Georgia navigator organizations received \$1,945,303 beginning in August 2021, compared to \$700,000 the previous year—a 177% increase.^{4,5} The increased outreach and enrollment assistance will help more Georgians find more affordable plans by spreading awareness of the increased APTCs.

Five additional insurers have entered the health insurance marketplace in Georgia. The state has 11 insurers offering plans on the marketplace for the 2022 plan year, up from four in 2019 and six in 2021.⁶ This increase proves that Georgia’s insurance marketplace is stable and well-developed and is benefiting as expected from the state’s reinsurance program.

The current status of Georgia’s health insurance marketplace indicates improvements that benefit consumers and address the issues that the Georgia Access model was supposed to resolve.

¹ Kaiser Family Foundation, Marketplace Enrollment 2014 – 2021, <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22georgia%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

² Georgia Health News, “Exchange Enrollment Hits Record Level in State,” September 22, 2021, <https://www.georgiahealthnews.com/2021/09/georgia-exchange-enrollment-hits-record-level/>

³ Kaiser Family Foundation, “Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID 19 Relief on Marketplace Premiums,” March 15, 2020. <https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/>

⁴Centers for Medicaid & Medicare Services, “2021 CMS Navigator Cooperative Agreement Awardees,” August 27, 2021. <https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf>

⁵ Centers for Medicaid & Medicare Services, “2020 CMS Navigator Cooperative Agreement Recipients,” August 30, 2020. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2020-Navigator-Grant-Recipients.pdf>

⁶ Kaiser Family Foundation, Navigator Funding Restored in Federal Marketplace States for 2022, September 29, 2021. <https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/>

Implementing the Georgia Access proposal now would only hinder the progress Georgia has seen since it was approved. The Departments should withdraw their previous approval of this waiver proposal.

Medicaid expansion is a better option to further the waiver’s stated goals.

Georgia is proposing to address the state’s high uninsured rate by exiting the federal marketplace. However, expanding Medicaid to low-income adults is a proven solution to increase insured rates, as shown in the 38 other states and D.C. that have adopted Medicaid expansion. Medicaid expansion offers Georgia the opportunity to expand coverage to hundreds of thousands of people. That would result in significant benefits to the state’s residents, including fewer premature deaths and improved access to care and financial security for people gaining coverage.^{7,8} The state should expand Medicaid instead of disrupting the state’s insurance market at great risk to consumers.

It is concerning that rather than expand coverage to more people, Georgia seeks to replace a centralized system with a fragmented one that could cause tens of thousands of Georgians not to receive application assistance and to lose coverage altogether, while other Georgians would likely be enrolled in skimpy plans that carry high out-of-pocket costs if they get sick.⁹ We strongly urge you to rescind the 1332 waiver approval and instead encourage Georgia to adopt Medicaid expansion, which would significantly increase the state’s insured rate, help with responding to the ongoing pandemic, and provide billions in additional federal funding for the state.

The proposal would negatively impact insured rates.

Georgia’s proposal would change where and how consumers purchase health insurance plans. In 2020, almost 80% of Georgia marketplace enrollees chose to use HealthCare.gov to sign up for coverage, rather than a private broker or insurer website, which were available options.¹⁰ Georgia’s waiver would eliminate the one-stop shop that helps people compare plans, apply for financial assistance, and enroll in plans. Instead, the state wants to *require* Georgians to use various private insurance companies and brokers to accomplish these tasks. Consumers would

⁷ Matt Broaddus and Aviva Aron-Dine, “Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds,” Center on Budget and Policy Priorities, November 6, 2019, <https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds>

⁸ Center on Budget and Policy Priorities, “Chart Book: The Far-Reaching Benefits of the Affordable Care Act’s Medicaid Expansion,” Updated November 6, 2019, <https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid>

⁹ Tara Straw, “Tens of Thousands Could Lose Coverage Under Georgia’s 1332 Proposal,” Center on Budget and Policy Priorities, September 1, 2020. <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>

¹⁰ Georgia Section 1332 State Innovation Waiver as submitted to CMS on July 31, 2020; [https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-\(hereafter,Waiver\)](https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-(hereafter,Waiver)).

have to visit several different websites or call centers if they want to compare plans or premiums, which would reduce competitive pricing among insurers who are likely to set higher premiums if they believe consumers will not bother to shop around. This de-centralization would lead to confusion and create enrollment barriers that will certainly cause many people to abandon their efforts and become uninsured. Contrary to the promise of expanded choices, this waiver would deprive consumers of their only option for a guaranteed, central source of impartial information about comprehensive coverage options.

The disruption created by the state's transition away from HealthCare.gov is likely to cause a decline in enrolment among Georgia consumers. The state's waiver predicts a loss of about 2 percent (8,000 people) of enrollees due to the change from one system to another. However, other states' experiences show this figure is unrealistic.¹¹ For example, Kentucky saw a reduction of 13 percent in its marketplace enrollment when the state transitioned to the federal marketplace in 2017, compared to a 4 percent decline nationally.¹² More recently, Nevada's 2020 marketplace enrollment dropped 7 percent after the state transitioned to a state-based marketplace, compared to flat enrollment nationally.¹³ Similar percentage declines in Georgia would translate into a drop of 25,000-46,000 people from marketplace enrollment. Enrollment declines of this scope would likely exceed the increases anticipated by the waiver (27,000).

Enrollment declines are especially likely given that Georgia has only allotted one-third of the estimated cost of the waiver to the transition process. This funding seems solely dedicated to the technological transition. The state has not allocated specific funds to help consumers understand the transition, their options for enrollment, or how to access free, unbiased enrollment assistance.

More people, particularly Medicaid eligibles, would be led into subpar plans or more expensive comprehensive plans.

In 2020, at least 38,000 Georgians enrolled in Medicaid via HealthCare.gov.¹⁴ Private brokers and insurers who operate through HealthCare.gov are notorious for not informing consumers of Medicaid eligibility and offering limited plan selections, often based on the amount of plan commissions.¹⁵ As a result, people who are eligible for Medicaid could have a much harder time

¹¹ Waiver, op. cit., p. 71.

¹² Sarah Lueck, "Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges," CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

¹³ CBPP calculations from CMS public use files. See also, Nevada Health Link, "Nevada's State Based Exchange Announces Enrollment Figures for Plan Year 2020," December 23, 2019, https://d1q4hslcl8rmbx.cloudfront.net/assets/uploads/2019/12/FINAL-2020-Nevada-Exchange-Prelim-Enrollment-Release_12.23.19.pdf; Sarah Lueck, "Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges," CBPP, February 6, 2020, <https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges>.

¹⁴ CMS, op. cit.

¹⁵ Tara Straw, "'Direct Enrollment' in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm," Center on Budget and Policy Priorities, March 15, 2019, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>

finding help with enrollment under Georgia’s proposed system because Medicaid generally doesn’t pay commissions, and agents and brokers have no incentive to fill the void that would arise from eliminating HealthCare.gov. Medicaid eligible people would end up in less comprehensive, more costly plans.

Georgia’s waiver proposes to have substandard, non-ACA compliant plans presented along with comprehensive insurance. Presently, brokers sometimes direct healthier people toward such plans, which often come with higher commissions. For example, short-term plans pay up to ten times as much as ACA-compliant plans.¹⁶ This tactic has continued during the pandemic.¹⁷ People enrolled in subpar plans are subject to punitive exclusions of their pre-existing conditions, benefit limitations, and caps on plan reimbursements that expose them to potentially high out-of-pocket costs. A study of short-term plans in Atlanta showed that even though people would pay lower premiums up-front, they could be responsible for out-of-pocket costs several times higher for common or serious conditions, such as diabetes or a heart attack. The most popular plan in Atlanta refused to cover prescription drugs, mental health services, or maternity services, had pre-existing condition exclusions, and had a deductible three times as high as an ACA-compliant plan.¹⁸ Directing healthier people to such non-ACA compliant plans would raise premiums in the ACA-compliant market by creating a less healthy risk pool.¹⁹

The waiver violates statutory requirements of Section 1332 of the Affordable Care Act.

There are statutory “guardrails” intended to ensure that people who live in states that implement an ACA waiver are not worse off than they would be without the waiver. Section 1332(b)(1) of the ACA requires that ACA waivers cover as many people, with coverage as affordable and comprehensive, as without the waiver. Georgia’s waiver fails to meet this requirement because it would likely increase the number of uninsured Georgians and leave many others with worse coverage. Many Georgians would end up with coverage that is less comprehensive, and more

¹⁶ House report, op. cit., p. 43. Due to the time it takes to assist marketplace consumers, some brokers report that they lose money on each marketplace enrollment, and so have stopped marketing their services or operate only through referrals. Others say they are uneasy about selling short-term plans despite the higher commissions, given the plans’ risks for people with pre-existing conditions. See Sabrina Corlette et al., “Perspective from Brokers: The Individual Market Stabilizes While Short-Term and Other Alternative Products Pose Risks,” Urban Institute, April 2020, <https://www.urban.org/research/publication/perspective-brokers-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks>.

¹⁷ Christen Linke Young and Kathleen Hannick, “Misleading marketing of short-term health plans amid COVID-19,” Brookings Institution, March 24, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

¹⁸ Dane Hansen and Gabriela Dieguez, “The impact of short-term limited-duration policy expansion on patients and the ACA individual market,” Milliman, February 2020, <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>; Kelsey Waddill, “Do Short-Term Limited Duration Plans Deserve Industry Skepticism?,” HealthPayerIntelligence, March 4, 2020, <https://healthpayerintelligence.com/news/do-short-term-limited-duration-plans-deserve-industry-skepticism>.

¹⁹ Tara Straw, “Tens of Thousands Could Lose Coverage Under Georgia’s 1332 Proposal,” Center on Budget and Policy Priorities, September 1, 2020. <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>

people would find themselves with less affordable coverage and higher out-of-pocket costs than would be the case without the waiver. Also, Georgia would likely see a reduction, rather than an increase, in coverage under the 1332 waiver. The waiver therefore does not meet the guardrails under federal law and should be rescinded.

In addition to our concerns about the impact of the waiver on Georgians, we are very concerned that a 1332 waiver like Georgia's that is expected to result in more people uninsured and more people enrolled in plans that do not provide comprehensive coverage than without the waiver, would set a dangerous precedent that other states could follow.

Although we have concerns about the Georgia Access portion of the state's waiver application, TJC is in favor of the state's reinsurance program. Like those approved in other states, the reinsurance portion of Georgia's proposal has reduced premiums and provided market stability. Thus far, it has been a positive advancement for Georgia consumers.

Thank you for your consideration of our comments. We ask that you include the full text of the materials cited through active hyperlinks in our comments in the formal administrative record for purposes of the Administrative Procedures Act. Please contact us if you have any questions or if we can be of further assistance.

Respectfully submitted,

/s/ Kinika L. Young
Senior Director of Health Policy and Equity
Tennessee Justice Center
kyoung@tnjustice.org

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January 9, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Brooks-LaSure:

The Georgia Chapter of the American Academy of Pediatrics (Georgia AAP) is the professional association representing pediatricians and pediatric subspecialists from across the state dedicated to the health, safety and well-being of all Georgia infants, children, adolescents, and young adults. Thank you for the opportunity to provide comments on the state's proposed Section 1332 waiver application.

As pediatricians, we know the importance of access to affordable, high-quality health insurance, both for children and their parents and caregivers. Meaningful health insurance coverage means preventive screenings and services that catch and treat disease earlier, before it becomes more acute, harmful, and costly to treat. It also means covering all benefits children are found to need, including those recommended by the AAP in its *Scope of Health Care Benefits for Children from Birth Through Age 26* policy statement. Affordable, high-quality health insurance is critically important for parents, caregivers, and ultimately all adults, as a healthy child starts with a healthy family.

To this end, we have significant concerns with the Georgia Access Model Section 1332 waiver proposal to eliminate Georgia families' access to HealthCare.gov, which serves as a centralized location for marketplace health insurance plans. Moving away from this central location toward commercial brokers, agents, and insurers has great potential to place families at risk. Over 500,000 Georgians, including almost 38,000 children and youth under the age of 18, obtained health coverage through the federal marketplace during the 2021 open enrollment period.¹ Leaving Georgia families to navigate a fragmented system of brokers, agents, and insurers will open the door to uncertainty and misinformation, and make it harder for families to obtain health plan information they can trust. Without the certainty of HealthCare.gov, families might then choose a substandard plan that does not meet their health needs, and/or leaves them with unaffordable deductibles or cost sharing. This problem may be particularly acute for those with limited experience with health insurance terms or enrollment procedures, which can be confusing for any family.

Importantly, HealthCare.gov is also designed to inform families if their children are eligible for Medicaid or PeachCare for Kids. By eliminating HealthCare.gov in our state, more Georgia children will therefore be at risk of falling into a coverage gap—this is a step we as a state cannot afford.

While we appreciate the state's intention to provide more open and easier access to health coverage, we believe this proposed change away from HealthCare.gov could have the unintended consequence of making it more difficult for families to obtain affordable, high-quality coverage. For these reasons, we ask that the CMS not approve this component of the state's Section 1332 waiver application.

Thank you for the opportunity to provide these comments; we appreciate CMS taking into consideration the thoughts of Georgia's pediatricians as you contemplate this waiver proposal. If you have questions about our comments, please contact me at rward@gaaap.org

Sincerely,

Richard Ward

Executive Director

¹ Centers for Medicare and Medicaid Services. 2021 Marketplace Open Enrollment Period State-Level Public Use File. Accessed January 6, 2022. Available at: <https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files>

[Note: The following comment was received after the GA comment period closed on January 9, 2022]

Hello,

Please see the attached comment letter on behalf of GetInsured from

Connel Fullenkamp, PhD
Professor of the Practice
Economics Department
Duke University

Thank you,

JS
Policy and Operations Lead
GetInsured

January 8, 2022

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight (CCIIO)
U.S. Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244
stateinnovationwaivers@cms.hhs.gov

Dear Director Montz:

I am writing this letter to support the Georgia Access Model approved by the Secretaries of Health and Human Services (HHS) and the Treasury as part of the State of Georgia's 1332 waiver on November 2, 2020.

I am an academic economist with 30 years of experience, studying and writing about financial markets and financial regulation development, structure, and design. I have published papers on financial market development, bank capital regulation, insurance disclosure, and other issues in financial economics and policy. I am deeply interested in finding ways to help financial markets develop and find the appropriate regulatory strategies for facilitating market development and consumer protection. In my research, I stress the importance of finding the right amount and type of regulation to promote financial markets' healthy and timely development. Georgia's 1332 waiver is especially interesting to me, since I believe it represents a significant opportunity to promote the next stage of development for an essentially important financial market (i.e., health insurance) that touches the lives of all Americans. *(Please note: this letter of support, expresses my own professional opinions and does not necessarily represent those of my employer, Duke University).*

In Part 1 of this letter, I lay out my support with accompanying rationale for Georgia Access based on my financial market development and regulation expertise. In Part 2, I discuss several of what I consider the most important criticisms of Georgia Access. I argue that while a few of these criticisms are valid, and should be addressed by the state authorities (as laid out in section 2.4), most of the criticisms are unsupported or inaccurate. More importantly, none of them appear to carry sufficient weight, either individually or collectively, to support revoking the waiver. Throughout the letter, I stress that the benefits of innovation within the well-regulated context of the ACA represent a very positive development opportunity for health insurance markets that should be implemented.

1. The Georgia Access Model Represents Beneficial Financial Market Development

The Georgia Access model represents a beneficial step forward in developing markets for health insurance. The past decade has seen major advances in the technology of online markets that

have brought significant benefits to consumers in virtually every retail market, particularly as it relates to personalized shopping needs. Because it enables competition among web platforms for market share, the Georgia Access model brings forth these advances and other innovations to come to the market for health insurance. Although the Administration has some legitimate concerns regarding this waiver, the continuing advancement in personalized shopping tools, particularly if applied to an inventory of standardized health insurance plans with little to no inventory differences, will lead to greater consumer empowerment and satisfaction.

1.1 Georgia Access Brings Ecommerce and Fintech Innovations to Health Insurance

We now live in an era of comparison shopping for nearly all goods and services facilitated by skilled web design. Almost every retailer's website will allow side-by-side comparisons of multiple products they offer, as well as different filters for comparison such as price, popularity, and features. Online travel services gather information from multiple websites and allow consumers to choose the most attractive offers. And in the insurance market, companies like Progressive have based their marketing strategy on showing comparisons across multiple providers. Technology companies have become experts at gathering information and using filters and screens to enable consumers to find products and services that best meet their needs. Thus it is only natural to avoid stifling the progress of consumer experiences based on a user interface paradigm conceived a decade ago and instead allow for the use of more modern technology in designing consumer health insurance purchases—subject, however, to important guardrails I describe in section 2.4.

In addition, artificial intelligence is increasingly being combined with vast repositories of consumer data to assist consumers in financial decision-making generally. For example, when a consumer purchases tax preparation software, the program simply asks a series of questions and prepares the appropriate tax returns based on the consumer's responses. Similarly, artificial intelligence is increasingly used to give investment advice to individuals. Investors can now choose among dozens of so-called robo-advisers whose advice mimics any number of successful professional money managers. Robo-advisers can also be used first to discern an investor's priorities—and their risk tolerance—and then recommend investment strategies as well as specific investments to their clients.

Both types of technology could help people make better health insurance decisions. While healthcare.gov and many EDE enabled marketplaces do have a modicum of guided shopping, Fintech innovation is a huge and ongoing phenomenon of our time and the competitive pressures of an open marketplace will mean that software-based intelligent assistants will get smarter at a pace much faster than a government based change order process will naturally allow. Then state-of-the-art information gathering and presenting tools will enable consumers to see a side-by-side comparison of the available plans that best meet their needs, given the information they put into the system. This will still allow consumers to modify their search, continue searching, or start over completely. Again, the revision process could be assisted by artificial intelligence that helps consumers discern their most important needs and desires and identifies the plans that best

meet them. The Georgia Access Model presents an opportunity to bring the same technological advances that have helped people make better financial choices to health insurance.

I believe that web-brokers will be keen to offer these advances in the context of Georgia Access because this has been the case in every other area of finance. Fintech is changing how people save, borrow, invest, make payments, and manage risk. To better provide what people need and want, personalization of services is at the heart of what fintech offers. The companies that provide this customization have been rewarded with higher market share, growth, and profits. Again, this is already taking place in other insurance products. For example, Liberty Mutual has utilized a successful strategy to allow consumers to customize their car insurance, and esurance's entire business plan is based on offering consumers greater convenience and customization through the mobile web. If we give health insurers a level playing field through an open-market approach like Georgia Access, I believe they will use the lessons from other fintech and e-commerce innovations, particularly in other insurance markets, to improve the consumers' experiences and satisfaction with ACA-compliant health insurance. In other words, I am arguing that modern fintech innovations can be intelligently used to align the interests of consumers, online brokers, and health insurance carriers.

1.2 Technology Can Help Improve Consumers' Health Insurance Choices

In addition, I believe that the innovations I described above will be sufficient to resolve any concerns or objections to the Georgia Access Model. The Administration is rightly concerned about the potential health insurance choices made by consumers and wishes to avoid the pitfalls in health insurance choices that have been described in the academic research. But suitable user interfaces—one of the main things that fintech focuses on—are a powerful tool for avoiding these pitfalls.

During the past decade, a large amount of research has been done into consumers' health insurance choices. A good summary of this research appeared several years ago in the *Handbook of Behavioral Economics*¹. Another good summary recently appeared in a paper on "vertical" choice in health insurance published in the *American Economic Review*². There are three main takeaways from this research that are directly relevant to the design of health insurance marketplaces:

1. **Consumers find shopping for insurance complex, and they have difficulty making tradeoffs between different plan features, such as premium costs and expected out-of-pocket costs of health insurance.** This means that they could make poor decisions if not provided with good assistance.

¹ Chandra, Amitabh, Benjamin Handel, and Joshua Schwartzstein, 2019, "Behavioral Economics and Health-Care Markets," Chapter 6 in *Handbook of Behavioral Economics: Foundations and Applications, vol. 2*. Douglas B. Bernheim, Stefano Della Vigna, and David Laibson, eds., Oxford: Elsevier Science and Technology.

² Marone, Victoria R., and Adrienne Sabety, 2022, "When Should There Be Vertical Choice in Health Insurance Markets?" *American Economic Review* 112:1, pp. 304–342.

2. **Consumer inertia is surprisingly costly.** Consumers have proven to be far too willing to remain with their default health insurance choices, and this can be costly since all plans change over time and in particular, a plan that is the best for a consumer one year often does not continue to be the best choice year after year.

3. **Consumers do learn and improve their choices over time.** This is very encouraging because it indicates that many consumers are interested in improving their health insurance choices, despite the force of inertia, and will take advantage of better information if given to them.

In my opinion, well-designed user interfaces can go a very long way toward mitigating the two potential problems with consumer choices while enhancing people's ability to learn and make better choices over time. My above discussion of e-commerce and fintech innovations in other financial markets included concrete innovations that could easily be applied to health insurance to achieve these outcomes. For example, intelligent digital assistants can help people better understand their own needs and priorities and help them identify suitable health plans that are fully ACA compliant. They can also automatically search for better plans at renewal time to reduce consumer inertia. And they can identify and exploit teachable moments, such as when a consumer's family status or healthcare needs change, which research in financial literacy suggests are the most effective times to provide practical financial education to consumers. Again, these strategies are well aligned with health insurers' incentives, especially given that these technologies already exist and would therefore be fairly inexpensive to adapt to the context of health insurance.

1.3 Two Important Lessons from the Development of Other Financial Markets

Allow me to close this section with two big-picture observations from my 30-year career studying and analyzing financial market development. First, in my opinion, **the most important driver of financial market development has been the application of technology in a competitive environment.** Technology has delivered vast improvements in information availability and decreased costs of providing services. These advances have allowed billions of people around the world to improve their lives through better access to financial products. We now have the opportunity to extend these benefits to an incredibly important financial market—health insurance. It would be a pity to forego this opportunity.

My second observation is that **financial regulators in the U.S. and throughout the world are successfully dealing with new technology through the creation of so-called regulatory sandboxes.** This term refers to a regulatory regime in which new financial technologies may be implemented on a small scale, under close monitoring and supervision by regulators. In this way, new and potentially beneficial fintech innovations may be tested under real-world conditions, but with sufficient backstops and consumer protections in place to protect the public. The Georgia Access model strikes me as a fintech innovation that should be given a chance to prove itself. The 1332 waiver process—with its close monitoring, supervision, and various terms and conditions imposed—strikes me not only as a regulatory sandbox in all but name but also a

pathway for states historically opposed to the ACA to embrace it through technology. I am confident enough in the quality of the ACA, and the administrative agencies administering the waiver process, to be fully supportive of allowing the Georgia Access model to enter the 1332 waiver's version of a regulatory sandbox. I hope you will agree with me and allow the waiver for the Georgia Access model to be implemented.

2. Criticisms of Georgia Access

In this part, I address several arguments against granting a 1332 waiver for Georgia Access.

2.1 One way of shopping for health insurance is better than many ways

One of the central negative claims made about the Georgia Access model is that it would deliver worse outcomes than the healthcare.gov site and marketplace. Most of these claims rest on the fact that the Georgia Access model is not trying to be a centralized market for ACA-compliant health plans, but rather a portal for connecting consumers with enrollment pathways. For example, the Georgia Access model is criticized as being a “fragmented” and “scattered” enrollment system by a recent Center for Budget and Policy Priorities report³, accompanied by assertions that consumers will “fall through the cracks” and that the Georgia approach will “subtract” enrollment pathways.

There is a vast difference between ensuring all consumers obtain health insurance that meets minimum quality standards and making everyone shop for this insurance in the same (one) way. This distinction seems to be lost on many of the critics of the Georgia Access model. There is no direct evidence that a single, government-administered shopping site would work better than a private market open to innovation. In market after market—including the markets for some types of insurance, as I indicated in Part I above—the private sector has found creative ways to attract, inform, and deliver value to customers.

The travel industry is an excellent example of this. Today there exists a plethora of sites that will help consumers find airline flights, rental cars, hotels, and other travel-related services. If a consumer wishes, they can simply go to a specific airline's or hotel's website and make a booking. But they can also use a service that aggregates information from multiple airlines or hotels and presents comparisons of available products and prices, or even custom-builds a trip or vacation. In the context of travel, it would be silly to assert that consumers would be better served if they all only used one shopping site because it's hard to imagine that one site could provide the best service for all people. Similarly, it's difficult to imagine that a single healthcare shopping site would also be best for everyone.

Therefore, as in the example of travel sites, it is reasonable to expect that Georgia Access would attract a variety of health insurance shopping sites offering a full complement of ACA health insurance plans and comparison tools to help consumers choose across those plans. The sites

³ Straw, Tara, and Jason Levitus, 2021. Georgia's Plan to Exit Marketplace Will Leave More People Uninsured, Should Be Revoked. Washington, D.C.: Center for Budget and Policy Priorities.

would compete by differentiating themselves both in terms of the consumer education and comparison tools they included and the health insurance policies themselves. Thus, it is difficult to understand how Georgia Access could reduce the number and variety of enrollment pathways when the pattern established in market after market increases the variety of ways to shop and purchase a good or service.

It is also difficult to understand how, subject to the guardrails I describe in section 2.4, Georgia Access would result in more people falling through the cracks. One significant advantage of any state-based model, whether Georgia Access or a state-based exchange, is that it would better integrate state Medicaid and the health insurance market and thus improve continuity of care. Improving the ACA enrollment rate of consumers who are denied Medicaid by their state Medicaid department by even a few percentage points would more than address any concerns about fragmentation of user experience.

In addition, the current situation where the needs of all consumers are met through one government run website means that the site needs to be all things to all people. Having multiple sites means that individual sites can focus marketing and compete for market segments (young people, gig workers, retirees, Spanish speakers etc.) Also, having multiple sites helps embed covered portals across the economic landscape so that they can reach consumers “where they are.”

Certainly, some concerns arise in connection with this approach to structuring the health insurance market, such as the concern that consumers could be steered to non-ACA compliant health insurance plans. Regulations need to be put in place to prevent this from happening. But as I discussed in Part 1 above, such regulations can be implemented through technical solutions that facilitate full disclosure about the compliance status of plans preventing non-compliant plans from being confused with ACA-compliant plans.

2.2 Marketing for Georgia Access may be insufficient

Marketing and outreach are also important concerns in the Georgia Access model, but these concerns are fundamentally no different than if Georgia were to use healthcare.gov. The success of either approach rests on its ability to attract consumers to shopping sites and then provide the information that will help them choose the best alternative for each person’s circumstances. In the healthcare.gov approach, marketing and outreach tend to be done at a national level. The State of Georgia is making marketing and outreach investments for Georgia Access both by itself and in conjunction with its private enrollment partners.

In addition, under Georgia Access, private providers will also have a strong incentive to market their services and insurance plans, particularly with the knowledge that they are furthering the Department’s mission rather than competing with it. The private sector will simply make less money if potential consumers are allowed to fall through the cracks or sold insurance that doesn’t suit their needs. This implies that the private sector will try to understand Georgians’ specific needs and concerns, and then base effective marketing campaigns on this knowledge. This will likely include significant outreach to disadvantaged communities of color, which can help service providers build or enhance their brand value. My understanding of the state’s plan

for outreach to these communities is to use “community partners” instead of the “navigators” who have had success in other states. Critics have a fair point that this may not be as successful. Furthermore, I understand that the state is working with local agents and brokers in underserved and rural communities that best understand the needs of their consumers to get them enrolled in plans through Georgia Access. The state may need to use additional tools, such as monetary incentives to insurance brokers, to reach its subscription goals among the lowest income consumers.

2.3 Georgia enrollment projections are inaccurate

Finally, some have tried to use Georgia’s enrollment projections under its original waiver as an additional reason to deny the state’s request for a 1332 waiver, arguing that Georgia’s projections of declining enrollment are inaccurate. Given that several major unexpected exogenous changes affecting enrollments took place during the past year, it would be unreasonable to use this argument as grounds to amend or terminate the waiver. First, the covid pandemic had a significant impact on household incomes due to the sharp lockdowns imposed in March of 2021. This, combined with the opening up of broad special enrollment periods, undoubtedly significantly impacted enrollments. These were further affected by the increase in federal subsidies for health insurance that were part of the American Rescue Plan Act. And finally, new rules that will allow people with incomes at or below 150 percent of the poverty level to enter the health insurance marketplace during any month of 2022 should also have noticeable impacts on enrollments. In short, the variables have changed in a manner that has increased enrollment. Still, these variables are neither influenced by nor do they influence the structure of the shopping experience in Georgia.

In other words, I believe that

- The effects of the pandemic and ARPA subsidies will certainly affect enrollment, but neutrally so when comparing their effects between a single website (healthcare.gov) and the Georgia Access model (where GA Access redirects consumers like Kayak to a choice of multiple shopping sites).
- The leading private market EDE vendors have a level of technology and operations such that the combination of technology, competition and sensible guardrails (described in section 2.4 below) will lead to superior enrollment outcomes.

Finally, new rules that will allow people with incomes at or below 150 percent of the poverty level to enter the health insurance marketplace during any month of 2022 should also have noticeable positive impact on enrollments.

2.4 Sensible Guardrails

Throughout this paper, I have argued for bringing the benefits of fintech innovation to the health insurance market. In this section, I lay out my view for the sensible regulation that would contribute to the positive functioning of the health insurance market:

- 1) Georgia Access must have a mechanism for “passive re-enrollment” – i.e., a tool to enroll consumers who simply choose to do nothing.

- 2) The private partners of Georgia Access must clearly and sharply distinguish non-ACA plans from ACA plans in any shopping experience; there must be safeguards with a heightened sense of regulation so that a consumer does not end up purchasing a non-ACA plan in an experience that would be reasonably considered to be an ACA shopping experience.
- 3) Outreach partners (who are not brokers) must have some readily available pathway to refer consumers effectively and quickly for enrollment.
- 4) The plan inventories of all Georgia's private enrollment partners (excepting carriers) must be full and identical so that consumers can always shop across a full inventory of plans regardless of the enrollment platform they use.
- 5) While Georgia Access is being set up, there needs to be a level of consumer support provided by the state as a back-stop to the private sector to support complex enrollments, families eligible for a mix of ACA plans and Medicaid and any customer support situation that is escalated by a broker.

Conclusion

The Georgia Access model will use technology-driven innovation to improve the health insurance shopping experience for Georgians and represents a positive step forward for health care and the development of health insurance markets. None of the objections to Georgia Access are serious enough to merit the rejection of their waiver application, especially given that the waiver essentially places the state in a regulatory sandbox with close supervision. I believe that the 1332 waiver for Georgia Access offers many significant benefits with very limited risks and should therefore be approved.

If you would like more information about any aspects of this letter, please contact me, Connel Fullenkamp, at cfullenk@duke.edu. Thank you again for being willing to provide the opportunity to comment on Part II of Georgia's Section 1332 waiver.

Sincerely Yours,

Connel Fullenkamp, PhD
Professor of the Practice
Economics Department
Duke University