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Georgia's Unprecedented 1332 Waiver Would Endanger Consumers and Violate Federal Law

Tens of Thousands of Low- and Moderate-Income Georgians Would Likely Lose Subsidies and Become Uninsured

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Georgia has proposed sweeping changes to its private health insurance market that would endanger coverage for about 400,000 Georgians who purchase comprehensive health insurance through the state's individual market. Through a waiver under Section 1332 of the Affordable Care Act (ACA), Georgia seeks to make subsidies available for plans that lack benefits needed by people with serious health needs, while also capping the total amount of assistance available through subsidies to help low- and moderate-income people pay premiums. Georgia also seeks to eliminate the ACA marketplace in the state, with consumers enrolling in coverage only through private web-brokers and insurers.

Georgia's proposed subsidy changes would likely cause tens of thousands of people to lose coverage. Because Georgia's waiver would let consumers use subsidies to buy substandard plans that exclude various essential health benefits, healthier people would likely buy these lower-benefit, lower-premium plans, while less-healthy people would use their subsidies to enroll in comprehensive coverage. This phenomenon, known as adverse selection, would increase premiums for comprehensive plans. Since subsidy amounts under the waiver would continue to be based on the cost of these plans, per-person subsidy costs would rise. As a result, providing subsidies to all eligible people would cost more than Georgia is budgeting, triggering the provision of the waiver that would ration subsidies on a first-come, first-served basis.

Georgia would likely end up denying subsidies to a sizable share of those who would benefit from them absent the waiver. For example, under a scenario in which Georgia allowed subsidy-eligible plans to exclude only maternity coverage (and no other benefits), about 110,000 Georgians could lose subsidies — one-third of those who would otherwise receive them. Rationing would likely be even more severe if Georgia allowed plans to exclude different or additional benefit categories, such as prescription drugs, mental health, or substance use treatment.

Most of the low- and moderate-income Georgians losing subsidies would likely end up uninsured or severely underinsured. The same would be true for some middle-income people with serious

health needs, for whom comprehensive coverage would become unaffordable because of the premium increases under the waiver.

Privatizing the marketplace would also endanger consumers. Georgia's privatization plan is a more extreme version of the existing direct enrollment system, which lets consumers in states that use the federal HealthCare.gov marketplace enroll in ACA plans through web-brokers and insurers. Even under the current system, direct enrollment entities have a track record of steering consumers toward substandard plans that expose them to catastrophic costs if they get sick; failing to alert them when they are eligible for Medicaid; and making it difficult to compare plans.

Georgia's proposal would leave consumers with no way to enroll in coverage except through these web-brokers and insurers and would also put them in charge of outreach, customer service, and other marketplace functions. The transition from HealthCare.gov to the new system would create further risks for consumers, especially with Georgia budgeting little for administrative costs.

Because it would harm consumers, Georgia's proposal isn't approvable under federal law. The ACA requires 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. But the structure of Georgia's proposal would likely cause tens of thousands of Georgians to lose coverage, while making coverage worse or less affordable for many more.

Georgia's waiver is the first to incorporate recommendations for 1332 waivers that the Trump Administration released last year. By fleshing out these proposals, the waiver shows how they endanger consumers — especially lower-income people and those with pre-existing conditions — and fail the statutory tests for 1332 waivers. While the Trump Administration has sought to weaken these standards through legally questionable guidance, Georgia's waiver could not meet even the Administration's watered-down tests. If the Administration were to approve the waiver despite these flaws, it would almost certainly be challenged in court.

Georgia's waiver application rightly highlights the problem of the state's high uninsured rate: 13.7 percent, compared to the national uninsured rate of 8.9 percent. But it omits any mention of the simplest solution: adopting the ACA's expansion of Medicaid to low-income adults. Instead, Georgia released the 1332 waiver along with a Medicaid waiver that would cover only about 1 in 10 of those who would gain Medicaid through expansion. By its own estimates, Georgia's combined cost for the two waivers equals or exceeds the cost of expansion, which would cover hundreds of thousands more people without upending Georgia's insurance market.

Georgia's Proposed Waiver Would Overhaul Its Insurance Market

On November 4, Georgia Governor Brian Kemp released two waiver proposals: an ACA 1332 waiver and a Medicaid 1115 waiver.[1]

Under Section 1332 of the ACA, a state can obtain permission to waive portions of the federal law and design its own health coverage program, as long as the proposal meets certain statutory

[1] Both applications were posted on November 4, 2019 and are available at https://medicaid.georgia.gov/patientsfirst.

guardrails. If the waiver reduces federal subsidy costs, the state can receive federal funds equal to those savings. (See textbox, "Standards for 1332 Waivers.")

Georgia's 1332 waiver would start by implementing a reinsurance program, as many other states have done. Reinsurance programs reimburse insurers for a portion of their costs for high-cost enrollees, enabling them to charge lower premiums.[2] Georgia estimates that its program, which would take effect in 2021, would bring down premiums by about 10 percent and modestly increase the number of people buying marketplace coverage.

But Georgia is also requesting unprecedented authority, beginning in 2022, to overhaul its individual market for health insurance. First, Georgia is proposing to administer its own roughly $2.5 billion subsidy program in place of the ACA's. This program would immediately diverge from the existing subsidy structure in two key ways:[3]

- **Subsidies could be used for non-QHPs.** Currently, marketplace subsidies can only be used for plans — known as Qualified Health Plans (QHPs) — that meet all ACA standards, including covering all categories of essential health benefits, not engaging in medical underwriting (denying coverage or charging higher premiums based on pre-existing conditions), and not imposing annual or lifetime limits.[4] Georgia's waiver would create a new category of subsidy-eligible non-QHPs.

  The waiver provides limited information about these plans: Georgia is proposing to establish minimum standards for them, through state regulation, only *after* the waiver is approved. But the waiver does specify that the plans would be allowed to exclude at least some categories of essential health benefits. They would not be permitted to medically underwrite, and it is unclear whether the state would let them impose annual and lifetime limits.[5]

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[2] Sarah Lueck, "Reinsurance Basics: Considerations as States Look to Reduce Private Market Premiums," Center on Budget and Policy Priorities, April 3, 2019, https://www.cbpp.org/research/health/reinsurance-basics-considerations-as-states-look-to-reduce-private-market-premiums.

[3] Georgia's waiver states that, after 2022, it might make additional, unspecified changes to subsidies, although it says that it would seek federal approval before making these changes (p. 19).

[4] Essential health benefits are the ten broad benefit categories all individual and small-group market health plans are required to cover under the ACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

[5] While the waiver application is not explicit, Georgia could structure the subsidy-eligible non-QHPs as short-term, limited-duration plans. Because such plans are not considered individual market health insurance, they can exclude essential health benefits, engage in medical underwriting, impose annual and lifetime limits, and violate other ACA standards. Under this interpretation, the key authority Georgia is seeking is the ability to provide subsidies for a subset of these plans that meet yet-to-be-determined state-specified standards. The waiver application says the subsidy-eligible non-QHPs must "maintain pre-existing conditions protections, cannot medically underwrite, and must be a major medical health plan" (p. 23). But beyond prohibiting medical underwriting, the application does not specify what pre-existing condition protections would be maintained, creating ambiguity around annual and lifetime limits and potentially other market rules.

- **Enrollment in subsidies would be capped to meet budget targets.** Currently, subsidies are available to all low- and moderate-income consumers eligible for them.[6] Under the waiver, Georgia would receive federal funding based on projected current-law federal subsidies for its residents and would contribute a small amount of additional state funds. If total subsidy costs were on pace to exceed the total funding available in a given year, Georgia would ration subsidies on a first-come, first-served basis.[7]

The second component of Georgia's individual market overhaul, also in 2022, would be to exit the HealthCare.gov enrollment platform without creating its own state-based marketplace. Instead, consumers could enroll in coverage only through private web-brokers and insurers, which would also be responsible for most other marketplace functions, including outreach and customer service.

Web-brokers and insurers could offer multiple types of coverage:

- QHPs that meet all ACA standards;
- Subsidy-eligible non-QHPs, with benefits ranging from the state's (to-be-determined) minimum standard to plans that nearly meet ACA standards; and
- Non-subsidy eligible, non-QHPs, such as short-term, limited-duration plans, which could medically underwrite, impose annual and lifetime limits, and exclude any category of essential health benefits.

Georgia's accompanying Medicaid waiver would provide Medicaid to uninsured adults with incomes below the poverty line who meet work requirements and pay premiums. (See textbox, "Medicaid Waiver Falls Far Short of Expansion," below.) The state estimates the Medicaid waiver would cover about 50,000 people, compared to an estimated 487,000 to 598,000 who would gain Medicaid if the state took up the ACA expansion.[8]

[6] People are eligible for premium tax credits if they have household income between the federal poverty line and 400 percent of the poverty line (or about $12,500 to $50,000 a year for an individual), buy a plan through the marketplace in their state, and are lawfully present in the U.S. People with incomes up to 250 percent of the poverty line can also get "cost-sharing reductions," another type of assistance that reduces their deductibles and other cost-sharing if they enroll in a silver marketplace plan. People are not eligible for subsidies if they are eligible for other "minimum essential coverage," such as Medicare, Medicaid, or employer-sponsored coverage that is considered adequate and affordable.

[7] The waiver states that Georgia will grant subsidies "on a first in, first out basis until the funding cap is reached. Additional enrollees will still be able to enroll in plans and will be placed on a wait list, should additional State funds become available" (p. 20).

[8] Georgia Draft 1115 Waiver Application, p. 27 and Georgia Department of Audits and Accounts, 'Fiscal Note: House Bill (LC 46 0015)," January 18, 2019, https://opb.georgia.gov/sites/opb.georgia.gov/files/related_files/site_page/LC%2046%200015.pdf.

Standards for 1332 Waivers

States' 1332 waiver proposals must satisfy four statutory requirements, or "guardrails," to obtain federal approval. The 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 standards related to:

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

If a state's 1332 waiver reduces the federal premium tax credits, cost-sharing reductions, or small business tax credits a state's residents qualify for, relative to what they would have received without the waiver, the state may receive funding from the federal government equaling the financial assistance its residents would have received (subject to the limitations imposed by the deficit neutrality guardrails). States can use this funding to provide financial assistance or other benefits to consumers different from those available under the ACA.

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

Georgia's Revamp of Subsidies Would Cause Many People to Lose Coverage

Georgia's proposed subsidy changes would cause large numbers of low- and moderate-income Georgians to lose subsidies and become uninsured. They would also raise premiums for already unsubsidized consumers, putting comprehensive coverage out of reach for many middle-income people with serious health needs. As a result, the waiver fails the comprehensiveness, affordability, and coverage tests that apply to 1332 waivers.

Appendix 1 explains why these problems with Georgia's waiver cannot be fixed with modest changes to the proposed subsidy structure, as well as why these problems are not solved by the ACA risk adjustment program or single risk pool requirements.

Waiver Would Lead Georgia to Ration Subsidies

Over 300,000 low- and moderate-income Georgians currently receive subsidies that help them afford individual market premiums, a major reason Georgia's non-elderly uninsured rate has fallen by 26 percent under the ACA, despite its rejection of Medicaid expansion.[9] By allowing subsidies to be used for non-QHPs and rationing subsidies to hit a state-established budget target, the waiver could cause many low- and moderate-income Georgians to lose financial help.

[9] The waiver estimates that monthly enrollment in subsidized marketplace coverage averaged 333,584 in 2018. Census American Community Survey data show a 26 percent drop in Georgia's non-elderly uninsured rate from 2013 to 2018, from 21.2 percent to 15.7 percent, as the ACA's major coverage reforms took effect.

As noted above, the waiver gives little information about what non-QHPs could be purchased with subsidies, and Georgia says it will issue specific minimum standards for these plans only after the waiver is approved. But the waiver does specify that subsidy-eligible, non-QHPs will be allowed to exclude at least some categories of essential health benefits, and the waiver's actuarial analysis assumes that allowable exclusions will amount to at least 10 percent of the cost of the standard QHP benefit package.[10]

Most likely, plans will be permitted to exclude some of the essential health benefits most commonly left out of individual market coverage before the ACA, such as maternity and newborn care, mental health and substance use disorder services, prescription drugs, and rehabilitative and habilitative services and devices. Importantly, if insurers are allowed to offer plans that completely exclude some category of essential health benefits, such as prescription drugs, they would almost certainly also be allowed to offer plans that cover some but not all benefits in that category, for example, prescription drugs other than high-cost specialty drugs.

Plans excluding various categories of essential health benefits are already available in Georgia's market. But most subsidy-eligible healthy people likely still enroll in QHPs to take advantage of subsidies. Under the waiver, those who don't need expensive, excludable services could instead use subsidies to purchase eligible non-QHPs, which would offer lower premiums by excluding these services.

QHPs, therefore, would likely be purchased mostly by people who need the set of services the subsidy-eligible non-QHPs would be allowed to exclude. That would cause QHP premiums to increase substantially, since the cost of these services would be spread over a dwindling pool comprising mostly people who use them, rather than over the broader pool of users and non-users.

These premium increases would make coverage much less affordable for people who need the excludable services but have incomes too high to qualify for subsidies. But the consequences would go well beyond that. Under the proposal, subsidies would still be calculated as they are today, based on what it would cost an enrollee to purchase a QHP.[11] So as QHP premiums rose, per-person subsidy costs would rise as well. That would cause the total cost of providing subsidies to everyone eligible for them to exceed Georgia's budget limit, triggering the provision of the waiver under which Georgia would ration subsidies among eligible people.

If Subsidy-Eligible Non-QHPs Were Allowed to Exclude Even Just Maternity Coverage, More Than 100,000 Georgians Could Lose Subsidies

How much rationing would occur would depend on the size of the premium increases. The following illustrative scenario shows how Georgia could easily wind up denying subsidies to about 110,000 people, a third of those who would otherwise benefit from them.

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[10] The actuarial analysis "assumes that the average value of benefits covered of an eligible non-QHP plan will be on average 90 percent of the average value of benefits covered for a standard QHP," (p. 53) which implies that allowable exclusions must equal or exceed 10 percent of the average QHP benefit package.

[11] The waiver's actuarial analysis makes clear that subsidies would still be calculated based on premiums for the second-lowest cost silver plan (SLCSP) and states "the SLCSP premium will continue to be tied to plans covering all ten EHBs [essential health benefits]" (p. 53).

Suppose that subsidy-eligible non-QHPs were allowed to exclude *only* maternity and newborn coverage and were otherwise identical to QHPs.

In 2017, individual market insurers spent an average of about $14,000 on maternity and newborn care for the roughly 2 percent of enrollees using these services. With that spending spread over the entire pool, it accounted for only about 6 percent of QHP premiums, or about $280 per person.[12]

But if subsidy-eligible, lower-price plans were available, people not expecting to get pregnant would presumably buy them. Anticipating that, insurers offering QHPs would have to price them based on the assumption that they would mostly enroll pregnant people. Even if insurers assumed that just a quarter of those enrolling in QHPs would in fact use maternity and newborn care, they would need to raise premiums by *more than 50 percent* to cover their cost for the now-segmented market. Using Georgia's estimates of premiums absent the waiver, this would amount to a nearly $4,000 increase in average annual premiums in 2022, the first year non-QHPs would be eligible for subsidies under the waiver.[13]

As noted above, Georgia would maintain the ACA's structure under which subsidies increase roughly dollar-for-dollar with QHP premiums. That means the average subsidy under this scenario would also rise by nearly $4,000. That could increase Georgia's cost to provide subsidies to everyone eligible for them by more than $1.3 billion, requiring the state to deny subsidies to about 110,000 people who would receive them absent the waiver in order to stay within its budget cap.[14] (For a detailed explanation of these calculations, see Appendix 2.)

In practice, allowing subsidy-eligible plans to exclude maternity and newborn care might lead to either more or fewer subsidy denials than this calculation implies. On the one hand, the assumption that only 1 in 4 people purchasing QHPs need maternity coverage is likely conservative, at least in the long run. Prior to the ACA, when maternity coverage was generally sold as an a la carte rider to individual market coverage, these riders were priced on the assumption that virtually everyone buying them would use maternity and newborn care.[15] If this were the case under Georgia's waiver, the state would need to deny subsidies to about 230,000 people.

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[12] Linda J. Blumberg and John Holahan, "The Implications of Cutting Essential Health Benefits: An Analysis of Nongroup Insurance Premiums Under the ACA," Urban Institute, July 2017, https://www.urban.org/sites/default/files/publication/91711/2001398_the_implications_of_cutting_essential_benefits_0.pdf.

[13] Estimates are presented for 2022 for simplicity; in practice, it might take several years for the market to fully segment. The $4,000 increase in average premiums is greater than one-quarter of the $14,000 cost of maternity and newborn coverage in 2017 because of increases in medical costs through 2022. See Appendix 2 for details of these calculations.

[14] This estimate takes into account the $149 million in state funds Georgia would contribute toward subsidies in 2022, on top of the federal funding.

[15] See for example, National Women's Law Center, "Nowhere to Turn: How the Individual Health Insurance Market Fails Women," 2008, https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2015/08/NWLCReport-NowhereToTurn-81309w.pdf; Julie Rovner, "Families To Pay Price If Maternity Coverage Is Cut By GOP," Kaiser Health News, March 14, 2017, https://khn.org/news/families-to-pay-price-if-maternity-care-coverage-meets-gop-knife/; and Blumberg and Holahan.

On the other hand, consumers cannot receive subsidies that exceed their premiums. That means that some consumers using subsidies to purchase non-QHPs might not use the entire subsidy they are eligible for, reducing the extent of rationing needed to meet the state's budget target.

It is unlikely that consumers will leave large amounts of subsidy dollars on the table, at least in the long run. That's because subsidized consumers will be price insensitive up to the amount of the subsidy, and it will be in insurers' strong interest to design plans that induce them to use up the entire amount. To see why, consider a simplified example where QHPs cost $16,000 per year, and subsidized consumers are eligible for subsidies of $15,000 but are mostly purchasing the typical non-QHP at a cost of only $10,000. If an insurer offers a plan that adds benefits worth an average of $2,500 to the typical non-QHP (for example, reduced cost sharing, a broader network, concierge services, or other benefits) and charges a premium of $15,000, the plan will be attractive to most subsidized consumers (whose out-of-pocket costs are the same for all plans with premiums up to $15,000), but will be unattractive to unsubsidized consumers, limiting the scope for adverse selection.[16] Thus, the insurer would pocket profits averaging $2,500 per sale. Even if insurers could not realize profits this large (for example, due to regulatory constraints), the example illustrates that they will benefit from finding ways to design plans to soak up available subsidy dollars.

Appendix 2 shows, however, that even if consumers did leave substantial subsidy dollars unused, Georgia would still have to deny coverage to tens of thousands of people. If subsidized consumers spend $1,000 less than the available subsidy, on average, Georgia would deny coverage to about 85,000 people who would otherwise have received them. Even if consumers spend only half the total increase in available subsidies (leaving about $2,500 unused, on average), Georgia would still deny subsidies to about 60,000 people. (Appendix 2 also discusses other simplifying assumptions built into the above calculations and explains why they are unlikely to change the qualitative results.)

Allowing Other Benefit Exclusions Would Likely Cause More People to Lose Subsidies

The maternity coverage scenario outlined above may seem extreme, but many alternative or additional benefit exclusions would likely cause even *more* people to lose subsidies.

As noted above, the waiver does not specify what categories of essential health benefits subsidy-eligible non-QHPs could exclude, but its actuarial analysis assumes these exclusions will amount to at least 10 percent of the standard QHP benefit package. A plan leaving out just maternity and newborn care would cover only about 6 percent less than a full QHP, on average, meaning that Georgia anticipates allowing plans to exclude additional or costlier benefits.[17]

In general, allowing plans to exclude additional services would lead to even more market segmentation and greater premium increases for QHPs. For example, if subsidy-eligible non-QHPs

[16] As a point of reference for insurers' ability to develop plan variants that soak up extra subsidies, the cost differential for a 45-year-old between the lowest-cost and highest-cost silver plan offered in Atlanta for 2020 is $2,308, and the cost differential between the second-lowest cost silver plan and the highest-cost gold plan is $3,253. (Platinum plans are not currently available in Atlanta)

[17] Blumberg and Holahan.

could exclude both maternity care and substance use treatment, QHPs would end up disproportionately serving people who expect to use both sets of services.[18]

But on top of that, maternity coverage differs from other categories of essential health benefits in ways that tend to *reduce* the amount of rationing that would result from making it an a la carte service. The key difference is that people generally have limited ability to predict whether they will have a higher- or lower-than-average cost pregnancy and delivery. Even a woman with few risk factors, for example, still faces a significant chance of a Cesarean delivery or a baby needing a stay in a neonatal intensive care unit. In contrast, for many other categories of essential health benefits, it is more straightforward to design a benefit package attracting only the healthiest subset of those needing services. As a result, while QHP premiums in the maternity coverage scenario increase by the *average* spending of people using the excluded benefit category, for other benefit categories, premiums may increase by the spending of the *highest-cost users*.

For example, suppose subsidy-eligible non-QHPs could exclude prescription drugs. An insurer offering QHPs could be undercut not only by plans that exclude all prescription drugs, but also by plans that exclude only specialty drugs, plans that exclude only drugs to treat HIV, plans that exclude only cancer treatments, and many other variations. In the end, QHPs could end up priced to cover the costs of the very highest-cost patients in the market. That would lead to very large increases in per-person subsidy costs, and substantially more rationing than in the maternity coverage scenario. It is also possible that the market would become so chaotic that some or all insurers might choose not to participate, at least for a time.

Many Unsubsidized Enrollees Would End up Uninsured or Severely Underinsured

Lucky enrollees retaining subsidies could still purchase comprehensive, affordable coverage under Georgia's waiver. In fact, healthy people who were able to keep their subsidies might pay lower out-of-pocket premiums than they do now. For example, men could use subsidies, calculated based on QHP premiums, to purchase a subsidy-eligible non-QHP that leaves out maternity coverage.

But almost no low- and moderate-income people, and few people at higher income levels, would be able to afford QHP premiums without a subsidy. The consequences would vary for different groups of Georgians.

- **Lower-income people losing subsidies.** Most of the lower-income Georgians losing subsidies as a result of the waiver would likely become uninsured. Even for relatively healthy low-income adults, expected health care costs are high as a share of income, putting even medically underwritten coverage that covers catastrophic costs out of reach.[19] Consistent with

[18] To see why, suppose that a significant number of people who need maternity care and not substance use treatment were purchasing QHPs. It would be in any insurer's interest to offer a plan that excludes substance use treatment and has a premium just a little below the QHP premium, which would attract most of these much lower-cost enrollees.

[19] For example, Idaho is currently allowing sales of short-term plans that can engage in medical underwriting but must cover a set of benefits only slightly narrower than a QHP, although they can have much higher out-of-pocket costs; they are not eligible for subsidies. One insurer's lowest available premium for these plans is reportedly $207 per month for a 39-year-old. That premium, which is only available to people with no pre-existing health conditions (who are also non-smokers), is still about 20 percent of income for someone at the poverty line and about 10 percent of income for someone earning 200 percent of the poverty line. See Shelby Livingston, "Blue Cross of Idaho Unveils Souped-Up

that, before the ACA introduced subsidies for individual market coverage, a large majority of Georgia adults without employer plans and with incomes between 100 and 400 percent of the poverty line were uninsured.[20]

- **People with serious health needs and incomes too high to qualify for subsidies.** Many middle-income Georgians with pre-existing conditions or other serious health needs would also likely become uninsured or severely underinsured. While some have claimed that the ACA market is already unaffordable for unsubsidized people, the reality is that over 50,000 Georgians not receiving subsidies purchased comprehensive ACA plans in 2018.[21] Currently, this group benefits from the fact that healthy low- and moderate-income people also enroll in these plans because subsidies are only available for these plans.

For the reasons described above, the waiver's design would cause the cost of full QHPs to skyrocket, harming those Georgians who need whichever benefits subsidy-eligible non-QHP plans were allowed to exclude. But on top of that, rationing subsidies would shrink the pool of healthy low- and moderate-income people purchasing even the subsidy-eligible non-QHP plans. Depending on the extent of rationing, premiums for even these limited benefit plans might rise quite high. Georgians with serious health needs could face a choice between subsidy-eligible non-QHPs that are prohibited from engaging in medical underwriting but are still very expensive due to adverse selection or non-QHPs not eligible for subsidies that are allowed to engage in medical underwriting and could therefore deny them coverage or charge high premiums based on pre-existing conditions.

- **People without serious health needs and with incomes too high to qualify for subsidies.** Many of these consumers are likely already purchasing short-term plans, which can offer them lower premiums by engaging in medical underwriting and excluding essential health benefits. But premium increases for subsidy-eligible plans under the waiver would lead even more of these consumers to exit comprehensive coverage for plans that often have large coverage gaps. For example, most short-term, limited-duration health plans offered by major online brokers in Atlanta in 2018 excluded coverage for prescription drugs and substance use treatment, and about half excluded coverage for mental health services.[22]

Short-Term Health Plans," Modern Healthcare, November 27, 2019, https://www.modernhealthcare.com/insurance/blue-cross-idaho-unveils-souped-up-short-term-health-plans.

[20] Census data show that almost two-thirds of Georgians in this group were uninsured in 2013.

[21] The Centers for Medicare & Medicaid Services reports that 63,000 Georgians were enrolled in ACA-compliant coverage without subsidies in the average month in 2018, the latest year for which data are available. Centers for Medicare & Medicaid Services, "Trends in Subsidized and Unsubsidized Enrollment," August 12, 2019, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY17-18.pdf.

[22] Karen Pollitz *et al.*, "Understanding Short-Term Limited Duration Health Insurance," Kaiser Family Foundation, April 23, 2018, https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

Georgia's Actuarial Analysis Reaches Different Conclusions by Making Unfounded and Highly Implausible Assumptions

In contrast to the analysis above, Georgia's waiver concludes that the state would not ration subsidies at all and that comprehensive coverage would remain affordable for middle-income people who currently purchase it. It reaches these conclusions based on an actuarial analysis that estimates QHP premiums would increase just 1.1 percent due to adverse selection under the waiver. That estimate in turn hinges on an assumption that just 10 percent of consumers would opt to purchase subsidy-eligible non-QHPs.

This critical assumption is only stated, not explained.[23] It implies an additional assumption: that large numbers of subsidized consumers would continue to purchase plans that include services they do not expect to need, even though the waiver allows them to use their subsidies to purchase lower-premium plans excluding these services. This outcome is implied almost regardless of what specific benefits Georgia allows plans to exclude, since even widely used benefit categories include some expensive services that most people can be quite confident they will not need in a given year. For example, far more than 10 percent of the population can confidently expect not to need: maternity and newborn care, substance use disorder treatment, various high-cost specialty drugs, certain laboratory services, certain rehabilitative services, and pediatric services.

But there cannot be a market equilibrium in which subsidy-eligible QHPs are allowed to exclude various expensive services and yet large numbers of people purchase QHPs that cover expensive, excludable services that they do not expect to need. In that situation, any insurer could realize large profits by offering a subsidy-eligible non-QHP with a premium slightly below the prevailing QHP premium and excluding just the one expensive service. Even supposing some consumer inertia, the insurer using this tactic would profit, as the non-QHP's lower premium would attract many or most of the enrollees not needing the service. Yet those enrollees' costs would be less than the premium the insurer set, since that premium is just slightly below the prevailing QHP premium, which incorporates costs for the expensive, excludable services.

As described above, plausible levels of market segmentation under Georgia's waiver would result in very large premium increases. But even much smaller premium increases would lead to significant rationing. For example, even a 10 percent increase in QHP premiums would lead Georgia to deny subsidies to almost 20,000 people who would otherwise receive them, as shown in Appendix 2. A 20 percent increase would result in more than 45,000 people losing subsidies.

Notably, Georgia's argument for how it meets the Section 1332 statutory guardrails *depends on avoiding rationing altogether*: it asserts that people will have access to coverage as affordable as without the waiver because they will maintain access to the same subsidies.[24]

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[23] The actuarial analysis states, "the modeling assumes that 10% of current QHP enrolled individuals will buy-down to Eligible non-QHPs, with most of those still maintaining the same level of claims costs" (p. 54). It offers no justification for this assumption, only noting that since no other state has pursued a waiver like Georgia's, "the magnitude of these enrollment impacts is uncertain."

[24] For example, the state argues that its waiver meets the affordability guardrail because "affordability is estimated to improve for members not receiving a subsidy *and to be unchanged for members receiving a subsidy absent the waiver*" (p. 23; emphasis added).

Georgia Would Privatize the Marketplace With No Backstop for Consumers

Georgia is also proposing to exit the HealthCare.gov platform, and instead of creating an equivalent state substitute, would decentralize its functions among web-brokers and health insurers. Allowing these entities to operate without the marketplace as a backstop, while erasing the federal regulations governing these entities (with no apparent state plan to recreate them), would invite malfeasance and create new barriers to enrollment for consumers. The likely result is that fewer people would get coverage, coverage would be less comprehensive, and plans would be less affordable. As with Georgia's subsidy proposal, the likely harm to consumers means the privatization scheme violates the statutory 1332 guardrails.

Elimination of the Marketplace

The marketplace is a central part of the ACA's improved consumer experience. It allows people to navigate one website to get an unbiased view of all plans eligible for a tax credit and has tools to compare plans by premium, deductible, out-of-pocket cost, in-network status of preferred providers, and prescription drug costs, among others. All plans are guaranteed to meet the ACA's insurance market standards, like covering the ten essential health benefits and having no lifetime or annual limits on benefits. The marketplace also facilitates Medicaid enrollment, determines eligibility for premium tax credits and cost-sharing reductions, spearheads consumer outreach for open enrollment, and funds navigators to offer impartial help applying for coverage and choosing the health plan that best meets the consumer's needs. Some states have decided to establish their own marketplace to perform these functions instead of using HealthCare.gov.

Instead of the one-stop shopping experience of the marketplace, Georgia's waiver proposes a free-for-all run by web-brokers and insurers. There would be no central source of information or assistance, and other resources, such as unbiased assistance from navigators, would be eliminated, leaving consumers with no unbiased source of insurance information.

The waiver would also put web-brokers and insurers in charge of important marketplace functions such as outreach and customer service: there would be no other way for consumers to get help. This opens the possibility of blatant steering of the healthiest consumers from QHPs to subsidy-eligible non-QHPs or to subsidy-ineligible plans that vary premiums based on health status, which would exacerbate the market segmentation described above. Even if the state were to adopt regulations akin to the federal direct enrollment regulations that protect consumers who buy coverage through web-brokers and insurers, steering could still occur through aggressive marketing and through web-brokers selling consumers' personal information to entities that don't have to comply with those rules.

The waiver gives no indication of what oversight the state would undertake to police these actors. Georgia's insurance department would likely need a large infusion of resources to regulate a more complex insurance market, handle consumer complaints, and oversee the enlarged role brokers would play, while the state says it expects to spend only $5 million per year in ongoing increased administrative costs spread across all functions. If state health and revenue agencies undertook the current marketplace responsibilities, they would need to determine eligibility for subsidies, handle year-round plan and subsidy issues that web-brokers and insurers can't or won't resolve, calculate cost-sharing reductions, administer subsidy payments to insurers, and create a system to reconcile the credit — none of which they do now. The state will either neglect important consumer and

oversight services or spend more than budgeted on administration which might reduce the number of people that can be enrolled in premium tax credits under the state spending cap.

Web-Brokers Have an Uneven Track Record

While Georgia's waiver states that it "expands consumer access by allowing individuals to shop for and compare available plans using the platform of their choice," Georgians already have the option to purchase subsidy-eligible coverage directly through web-brokers or insurers, through processes known as direct enrollment and enhanced direct enrollment.[25]

Under direct enrollment, consumers select plans on web-broker or insurer websites but are routed to HealthCare.gov to apply and get an official eligibility determination; under enhanced direct enrollment, consumers stay on the web-broker or insurer's site during the entire process with eligibility determined by HealthCare.gov behind the scenes. Federal regulations set rules requiring web-brokers and insurers to be certified by the marketplace, meet security standards, and display plans based on certain parameters. And consumers can always go to HealthCare.gov if they encounter problems.

Georgia's proposal offers no details on how it would recreate, revise, or eliminate current federal regulations on web-broker and insurer conduct, marketing practices, or privacy of consumer information. And even with federal protections in place, direct enrollment can be problematic.[26] Some direct enrollment entities have a track record of steering consumers away from comprehensive health plans. Web-brokers screen applicants before sending them down the official enrollment pathway and sometimes divert applicants toward substandard plans that pay higher commissions but leave enrollees exposed to catastrophic costs if they get sick.[27] In other cases, web-brokers' screening tools fail to alert low-income people about their eligibility for Medicaid.[28]

Federal regulations require web-brokers to show all plans, but not on the same terms. They often preference the plans that pay commissions by showing them with full-color logos at the top of the page and as "recommended" plans, while plans that don't pay commissions may be buried at the bottom of the list with no premium, deductible, or other information. And insurers that participate in direct enrollment never display their competitors' plans, leaving consumers with an incomplete list of their options. This means that consumers can't compare plans on equal footing without visiting numerous websites and call centers. This is precisely the type of legwork the marketplace was designed to avoid and that Georgia's waiver would reinstate.

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[25] p. 17.

[26] 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.

[27] 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.

[28] Straw.

Privatization of Marketplace Functions Violates Statutory Guardrails

Because it puts consumers at risk, Georgia's plan to disperse marketplace functions among web-brokers and insurers violates the statutory guardrails in a few ways. First, as described above, web-brokers and insurers will likely divert more Georgians into non-QHPs, meaning that people will be enrolled in less comprehensive coverage than without the waiver.

Second, by reducing competition, privatization could increase premiums and worsen affordability. People would have less means by which to effectively compare prices, reducing competitive pressure to keep prices down. For example, if each insurer now believes it can keep most of its current customers even if its premiums are slightly higher than its competitors' (because most consumers won't bother shopping across multiple platforms), then all insurers will set higher premiums than they otherwise would.

Finally, while the waiver asserts, without evidence, that privatization will cause more consumers to sign up for coverage, it could just as easily reduce coverage if consumers find it harder to enroll without a centralized platform.

Georgia's Waiver Fails Even Watered-Down Tests for Waiver Approval

As explained above, Georgia's waiver fails the statutory tests for 1332 waivers, because it would result in fewer people covered, and with less comprehensive and affordable insurance. The Trump Administration issued guidance that attempts to weaken the statutory guardrails, in ways that are likely inconsistent with federal law.[29] But Georgia's proposal doesn't meet even these watered-down tests. Under the Administration's 1332 waiver guidance:

1. People must have *access* to plans that are both as *comprehensive* and as *affordable* as ACA marketplace plans, even if they do not enroll in such plans.
2. A *comparable number* of state residents must have health coverage, including through substandard plans.
3. And the waiver must not increase the *federal deficit*.[30]

Georgia claims that it meets these requirements because consumers will continue to have access to the same ACA plans, with the same subsidies, as they do today. But as explained above, this is not the case, since the waiver would increase the cost of comprehensive coverage for unsubsidized consumers and would ration subsidies, leaving far fewer people with "access to" affordable coverage than would be the case without the waiver.

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[29] Joel McElvain, "The Administration's Recent Guidance on State Innovation Waivers under the Affordable Care Act Likely Violates the Act's Statutory Guardrails," Notice & Comment, December 11, 2018, http://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/.

[30] The guidance is available at https://www.govinfo.gov/content/pkg/FR-2018-10-24/pdf/2018-23182.pdf. See also Centers for Medicare & Medicaid Services, "Section 1332 State Relief and Empowerment Waiver Concepts Discussion Paper," November 29, 2018, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF.

Waiver Also Fails Regulatory Completeness Requirements

Under federal regulations (which the current Administration has not modified), a complete waiver application must provide "an explanation of the key assumptions used to develop the estimates of the effect of the waiver," as well as detailed data on the assumed composition of the market. To be approvable, a waiver application must first be determined complete.

In addition to its substantive flaws, Georgia's waiver fails these procedural standards, for example because:

- It fails to specify what categories of essential health benefits subsidy-eligible non-QHPs could exclude. As shown in the main text, any plausible set of exclusions would lead to premium increases and rationing of subsidies that would cause the waiver to fail the section 1332 guardrails. But which categories of benefits plans were allowed to exclude would have a significant impact on the extent of premium increases and the stability of the market. It is impossible to appropriately analyze the waiver without this information.
- It assumes without justification that only 10 percent of consumers would purchase subsidy-eligible non-QHPs, as discussed in the main text.
- It assumes without justification that QHPs would continue to be offered in every county in the state, an assumption that could easily break down in some counties in some years under some of the more chaotic scenarios.[a]
- It fails to include detailed data specifically required by regulation, for example cross-tabulations of the age, income, health expenses, and current health insurance status of the relevant state population.[b]

[a] The analysis states that the actuarial modeling was conducted based on an assumption "that currently available QHPs will continue to be available in all rating areas" (p. 53).

[b] 31 CFR § 33.108

The Administration, under the 2018 guidance, also claimed it could approve waivers that reduce affordability of comprehensive coverage for some people, as long as the overall number of people with access to affordable, comprehensive coverage is roughly the same. But here, too, Georgia falls short. The guidance said: "A waiver that makes coverage slightly more affordable for some people but much less affordable for a comparable number of people would be less likely to be granted than a waiver that makes coverage substantially more affordable for some people without making others substantially worse off." Georgia's waiver would make comprehensive coverage *much* less affordable for many people, while making it more affordable for a select few — those lucky enough to receive full subsidies before the state's funding cap is reached.

Georgia's waiver also fails to meet the regulatory standards for a complete 1332 waiver application; see textbox, "Waiver Also Fails Regulatory Completeness Requirements."

Proposal Poses Major Additional Risks

The analysis above assumes that Georgia can successfully execute the enormously complex administrative, operational, and regulatory project the waiver outlines, and can do so by 2022. If not, the waiver could result in even larger coverage losses, at least in the near term. Risks include:

- **Lack of specificity around market rules and consumer protections.** As written, Georgia's waiver only scratches the surface of the regulatory and administrative complexity the state is proposing. (See Appendix 3.) It's missing key details about what statutory and regulatory provisions it will waive under the broad authority it seeks, what state laws (if any) will fill in the breach, and what protections consumers will lose. The waiver doesn't contemplate the regulatory gaps that would emerge if federal regulations are waived, leaving the fine details of administering such a program in doubt. If the state were unprepared to set benefit standards for subsidy-eligible, non-QHP plans, the resulting uncertainty could lead insurers to set even higher prices for QHPs.
- **Incomplete analysis around how subsidies would operate.** The waiver also leaves out many details of how the proposed state-run subsidies would be distributed, monitored, and reconciled and, notably, whether the ACA's cost-sharing reductions would still be in place and how they would operate. In particular, there is no mention of the state revenue agency's role in routing subsidies to insurers, setting up an administrative tracking system for funds, reconciling subsidies and cost-sharing reductions with insurers on monthly and annual bases, reporting relevant information to the Internal Revenue Service (IRS) for enforcement of the employer mandate, reporting subsidy information to consumers to facilitate reconciliation of the subsidies, or additional work processing tax returns that reconcile billions of dollars of subsidies on state tax returns. In the waiver, the state doesn't demonstrate that it understands the full scale of what this process would entail.
- **Insufficient funding.** While Georgia's waiver would turn over many marketplace functions to health plans, the state would remain in charge of determining subsidy eligibility, and it would need to oversee health plans to make sure they abide by at least the limited standards for subsidy-eligible coverage. But the waiver budgets less than $20 million for the upfront transition and only $5 million for ongoing annual administrative costs and doesn't describe how the funds would be used. The budgeted amounts are likely much less than would be needed to cover verification of identity, eligibility determinations, state revenue agency functions, and oversight of web-brokers and insurers, among other state responsibilities.
- **Unprecedented responsibilities for health plans and web-brokers.** The waiver also assigns complex new tasks to web-brokers and insurers. They'd be responsible for all marketing and consumer call centers. They'd also presumably play the central role in auto-reenrollment, which enrolled roughly 16 percent of the state's marketplace population for 2019.[31] If insurers and web-brokers were unprepared for any of these responsibilities in 2022, thousands of consumers could be lost in the shuffle.

Raising further questions, the waiver application makes no mention of a reported plan to increase use of health reimbursement arrangements (HRAs), despite an op-ed from Georgia Governor Brian Kemp that suggests such a proposal is at the core of the proposal. The governor wrote, "Under current law, employers cannot offset the cost of an employee's health insurance plan purchased through the federal exchange. Georgia Access waives that provision and allows employers to invest

[31] Centers for Medicare & Medicaid Services, 2019 Marketplace Open Enrollment Period Public Use Files, March 25, 2019, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.

Medicaid Waiver Falls Far Short of Expansion

Alongside its 1332 waiver, Georgia is proposing a Medicaid 1115 waiver that would expand coverage to a limited number of low-income adults, rather than expanding coverage to all adults with incomes below 138 percent of the federal poverty line by adopting the ACA Medicaid expansion.

Under the proposed waiver, only adults who report working or engaging in work-related activities 80 hours per month would be eligible for coverage. There would be no exemptions, meaning no path to coverage for people with health conditions that make it hard or impossible for them to work or for people taking care of children, aging parents, or family members with disabilities. Those who could meet the 80-hour threshold would face another hurdle: individuals with incomes above 50 percent of the federal poverty line would have to pay premiums to get coverage and copays for certain services. If an individual doesn't comply with the work requirement or misses a premium payment, they would be disenrolled after a three-month grace period.

Under the state's own projections, only 25,000 Georgians would enroll in the first year and only about 50,000 total in later years, leaving out more than 400,000 people who would be eligible for Medicaid under full expansion. And Georgia would pay substantially more per enrollee than it would under full expansion. The Trump Administration recently announced that it will only approve partial Medicaid expansions at a state's regular matching rate, not at the enhanced matching rate available for full expansion, meaning that Georgia would cover 33 percent, rather than only 10 percent, of per-enrollee costs.[a]

[a] Centers for Medicare & Medicaid Services, "CMS Statement on Partial Medicaid Expansion Policy," July 29, 2019, https://www.cms.gov/newsroom/press-releases/cms-statement-partial-medicaid-expansion-policy.

in the health and wellbeing of their employees."[32] However, small businesses already have the ability to contribute to their employees' plans through the Qualified Small Employer HRA — one of the statutory provisions the state seeks to waive.[33] And in June, the departments of Treasury, Labor, and Health and Human Services finalized regulations to further allow employers of any size to contribute to employee HRAs tax free.[34]

The waiver proposal doesn't mention any changes affecting employer plans, include the term HRA, discuss what promotion, revision, or expansion of current HRA rules the state would undertake, or account for any resulting change in individual market enrollment.

Georgia Has Better Options to Solve the Problems Its Waiver Highlights

Georgia frames its waiver as a response to two problems: a high uninsured rate and high premiums for ACA plans. As explained above, its waiver would worsen both problems. But better approaches exist that would not require the state to upend its insurance market.

[32] Governor Brian P. Kemp, "Op-Ed: Our Plan to Make Health Insurance Accessible, Affordable in Georgia," Press Release, November 18, 2019, https://gov.georgia.gov/press-releases/2019-11-18/op-ed-our-plan-make-health-insurance-accessible-affordable-georgia.

[33] 26 U.S.C. 36B(c)(3).

[34] Departments of the Treasury, Labor, and Health and Human Services, "Health Reimbursement Arrangements and Other Account-Based Group Health Plans," Federal Register, Vol. 84, No. 119, June 20, 2019, https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf.

First, Georgia could extend health insurance coverage to almost 500,000 people by taking up the ACA Medicaid expansion.[35] By its own estimates, the state's cost for doing so would roughly equal its costs for the 1332 waiver plus its accompanying Medicaid waiver, which would cover roughly 50,000 people.[36]

Second, Georgia could simplify its 1332 waiver and move forward with just its proposed reinsurance program. At modest state cost (a little over $100 million per year), that would cut premiums by about 10 percent and make coverage more affordable for middle-income consumers, without harming lower-income consumers or middle-income people with pre-existing health conditions.

[35] Matthew Buettgens, "The Implications of Medicaid Expansion in the Remaining States: 2018 Update," Urban Institute, May 2018, https://www.urban.org/sites/default/files/publication/98467/the_implications_of_medicaid_expansion_2001838_2.pdf.

[36] Kyle Hayes, "Georgia Waivers: At Least as Costly to Cover Far Fewer People Than Medicaid Expansion," Center on Budget and Policy Priorities, November 14, 2019, https://www.cbpp.org/blog/georgia-waivers-at-least-as-costly-to-cover-far-fewer-people-than-medicaid-expansion.

Appendix 1: Could the Problems With Georgia's Waiver Be Fixed?

It might seem like the problems with Georgia's waiver could be fixed with modest tweaks to the subsidy structure. But in fact, variants on Georgia's approach would still cause severe harm and run afoul of the statutory guardrails for 1332 waivers.

Eliminating the Subsidy Cap

Without the cap on total subsidies, Georgia's waiver would either expose the state to unlimited — and likely very high — costs, which Georgia taxpayers would have to cover, or it would violate the deficit neutrality guardrail for 1332 waivers, by requiring the federal government to spend substantially more than it would without the waiver.

Changing How Subsidies Are Calculated

The increase in per-person subsidy costs under Georgia's proposal occurs because subsidies remain tied to QHP premiums. So it might seem that delinking them could solve the problem. But under that approach, comprehensive health plans would become extremely expensive. And, unlike under the current proposal, they might even disappear from Georgia's market altogether, if insurers could not profitably offer them at any price.

To see what could occur, suppose subsidy-eligible non-QHPs were allowed to exclude prescription drug coverage. An insurer offering such coverage would expect to enroll mostly people needing prescription drugs. But if the insurer priced the plan based on the average per-enrollee cost of prescription drugs for those needing them, it would mostly attract enrollees with higher-than-average drug costs, since many of those with lower costs would be better off just paying for drugs out of pocket. Likewise, if the insurer priced the plan based on the average cost of specialty drugs, it would mostly attract enrollees using the most expensive of these drugs, forcing further premium increases, and so on — a true adverse selection death spiral for whichever categories of essential health benefits were no longer mandated for subsidy-eligible plans.[37]

Under the 2017 House-passed ACA repeal bill, states would have been able to waive essential health benefits requirements, limited-benefit plans would have been eligible for subsidies, and subsidies would not have been linked to the value of comprehensive coverage. Analyzing the legislation, the Congressional Budget Office found that, if medical underwriting were still prohibited (as would be the case for subsidy-eligible plans under Georgia's waiver):

> *[I]nsurers generally would not want to sell policies that included benefits that were not required by state law.* Plans with additional benefits that were not mandated would tend to attract enrollees who would use them and thus increase insurers' costs. However, if insurers raised premiums to pay for those costs, they would tend to lose enrollees who did not expect to use those additional benefits. To avoid that outcome, *insurers would probably offer plans that excluded such*

[37] As discussed above, maternity coverage is a somewhat special case, and insurers might be able to sell maternity coverage riders priced based on the average cost of maternity care. However, if subsidies were not sufficiently large and sufficiently widely available, most women with low-risk pregnancies would purchase cheaper coverage through the non-subsidy eligible, medically underwritten market, in which case non-medically underwritten riders would either become very expensive or disappear altogether.

> *benefits entirely or limited the benefits substantially.* As a result of the narrow scope of benefits, enrollees who use the services no longer covered or for which coverage was limited would face increases in their out-of-pocket costs. [Emphasis added.][38]

Basing subsidies on QHP premiums (as the current proposal does) likely prevents the disappearance of comprehensive plans. If no QHPs were available, it would be in an insurer's interest to offer a QHP with a premium high enough to cover the costs of essentially any potential enrollee. In so doing, the insurer could make very large subsidies available to at least a small fraction of its potential enrollees, increasing its enrollment.

But if Georgia's waiver severed the link between QHP premiums and subsidies, it would leave people with certain medical needs with no option to purchase coverage for these conditions, forcing them to pay out of pocket for care. That would violate the ACA's comprehensiveness and affordability guardrails for 1332 waivers.

Restricting Cost-Sharing Assistance to QHPs

Under the ACA, subsidies are divided into two components: premium tax credits, available to consumers with incomes up to 400 percent of the poverty line, and cost-sharing reductions, available to those with incomes up to 250 percent of the poverty line. Some have suggested that Georgia could avoid the problems outlined above by making cost-sharing reductions available only in QHPs. The assumption is that this would lead the more than two-thirds of Georgia's subsidized consumers who are eligible for cost-sharing assistance to continue to enroll in these plans, regardless of health needs, preventing large premium increases from market segmentation.

But restricting cost-sharing reductions to QHPs likely would not prevent healthy lower-income people from exiting these plans. Consider again the illustrative scenario where subsidy-eligible non-QHPs exclude only maternity and newborn coverage. Consumers who didn't need maternity care and who were eligible for subsidies but not cost-sharing assistance would still exit QHPs, driving premium increases. But these premium increases would likely lead consumers who didn't need maternity services and who were eligible for the less generous tiers of cost-sharing assistance to also purchase subsidy-eligible non-QHPs. And as these people exited QHPs, premiums would increase further. Ultimately, even those people eligible for the most generous cost-sharing assistance would likely be able to purchase plans with lower premiums *and* zero cost sharing by using their subsidies to purchase subsidy-eligible non-QHPs.[39]

And even if this somehow did not occur, and consumers eligible for the more generous tiers of cost-sharing assistance continued to buy QHPs, the exit of other subsidized consumers would cause significant premium increases, leading to significant rationing.

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[38] Congressional Budget Office, "H.R. 1628: American Health Care Act of 2017," May 24, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.

[39] In more technical terms, the problem is that, in equilibrium, the premium difference between ACA plans and subsidy-eligible ACA plans, nearly $4,000 on average in this scenario, would exceed the value of even the most generous tier of cost-sharing assistance.

Risk Adjustment and "Single Risk Pool" Requirements

Risk adjustment programs transfer resources from insurers who enroll a healthier-than-average pool of enrollees to those enrolling a sicker pool. But while risk adjustment is designed to help protect against adverse selection problems, it cannot arrest the dynamic described above, at least not without rendering Georgia's proposal moot.

To avoid the large increase in premiums for QHPs, a risk adjustment program would have to make non-QHPs pay their share of the benefits they leave out. For example, it would need to require plans excluding maternity care and enrolling mainly people who do not get pregnant to pay a share of market-wide maternity costs equal to their share of total enrollees. But if that were the case, plans leaving out essential health benefits would not be able to charge meaningfully lower premiums.

The federal ACA risk adjustment program would presumably continue to operate for QHPs in Georgia if the waiver were approved (since risk adjustment cannot be waived under section 1332), but Georgia's waiver is silent on the question of whether subsidy-eligible non-QHPs would be subject to risk adjustment. As the waiver explains, however, the reason the state is proposing to let insurers offer subsidy-eligible plans that exclude essential health benefits is to "provide residents with expanded access to affordable health care coverage options."[40] So it presumably does not envision a risk adjustment program that would reverse the premium reductions resulting from covering fewer benefits.

The ACA's single risk pool requirement would also be ineffective in the context of Georgia's proposal. Under the single risk pool requirement, which Georgia says it would apply to all subsidy-eligible plans (both QHPs and non-QHPs), each insurer offering such plans would be required to set the premiums for its plans by considering all of its enrollees as part of a single pool. This normally helps to spread the costs of covering people across a broader group, by barring insurers from pricing each plan based on the expected health costs of the population likely to enroll in that plan.

But under Georgia's proposal, insurers could price all plans for a "single risk pool," but still set lower premiums for non-QHPs that reflect their reduced benefits.[41] Alternatively, insurers could simply specialize in either QHPs or non-QHPs, pricing each based on the distinct risk pools they attract, since the state does not say it would require each insurer to offer both types of plans.

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[40] p. 7.

[41] For example, an insurer could price all its plans for a population of pregnant women, which would not meaningfully alter the premium differential between plans covering and not covering maternity care. See Matthew Fiedler, "Requirement to Maintain a 'Single Risk Pool' Would Not Contain Adverse Effects of Cruz's Proposal," Brookings Institution, July 20, 2017, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/07/20/requirement-to-maintain-a-single-risk-pool-would-not-contain-effects-of-cruzs-proposal/.

Appendix 2: Rationing of Subsidies Under Georgia's Proposal

In the main text, we describe a scenario in which subsidy-eligible non-QHPs can exclude maternity and newborn coverage but must continue to provide all other categories of essential health benefits. We conclude that this scenario could result in Georgia denying subsidies to over 100,000 people who would otherwise receive them. This appendix provides the details of those calculations.

Estimating premium increases. To approximate the increase in QHP premiums that would result from allowing subsidy-eligible non-QHPs to exclude maternity and newborn care, we rely on an Urban Institute analysis of insurer costs for various essential health benefits in marketplace silver plans in 2017.[42] The Urban study finds that maternity and newborn care accounted for about $278 (6 percent) of the $4,700 average marketplace benchmark (second-lowest-cost silver) plan premium nationally, with a cost to insurers of $13,888 per enrollee using these services.

This implies that, if plans with and without maternity coverage were offered, and if only people needing maternity services enrolled in plans covering them, premiums for these plans would increase by $13,610 (the $13,888 full cost of maternity care less the $278 already built into premiums).

To apply these calculations to Georgia's waiver, we first inflate these 2017 costs to 2022 based on Center for Medicare & Medicaid Services projections for growth in per-enrollee costs for employer-sponsored health insurance.[43] We also subtract the 1.1 percent, or about $80, increase in average QHP premiums already assumed in the waiver's actuarial analysis. The result is an additional premium increase of $16,768 in the scenario where only people needing maternity services enroll in QHPs and an additional premium increase of $3,871 in the scenario we focus on in the main text, where only 1 in 4 people enrolled in QHPs need maternity and newborn care.

Based on the assumptions in the waiver, QHP premiums, taking into account the 10 percent premium reduction due to reinsurance and the 1.1 percent premium increase the waiver's actuarial analysis concludes would result from adverse selection, would average $7,660 in 2022.[44] The above increases thus amount to 219 percent and 51 percent respectively.

Impact of premium increases on subsidies. Since we do not have data on the full distribution of premiums and subsidies in Georgia's market, we make the simplifying assumption that the average subsidy would increase by the same amount as the average premium. (In general, subsidies under the ACA increase dollar for dollar with increases in second-lowest-cost silver QHP marketplace premiums, since the amount the enrollee is required to pay is held constant.) In the imperfect sorting scenario we focus on in the main text, this amounts to an increase in average subsidies of $3,871.

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[42] Blumberg and Holahan.

[43] These projections are available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected; see Table 17.

[44] Specifically, we use the waiver's estimate of the average 2019 silver QHP premium, $7,464, and increase it by 2.73 percent for 2019-2020 and by 4.9 percent per year for 2020-2022 consistent with the assumptions described in the actuarial analysis (pp. 50, 4).

Total costs and required rationing. Georgia estimates that 349,584 people will enroll in subsidized coverage in 2022 under its waiver. Thus, a $3,871 increase in the average subsidy costs would increase total subsidy costs by about $1.35 billion. Georgia projects an average subsidy of $6,988 under the waiver, which would rise to $10,860 ($6,988 + $3,871) under our estimates of the impact of the bifurcated market. Since Georgia estimates that providing subsidies to 349,584 people would lead it to precisely reach its budget cap, it would need to deny subsidies to about 125,000 of these people to remain within the cap.[45]

Georgia estimates that subsidy take-up would increase by 16,000 under the waiver. So this calculation implies that Georgia would deny subsidies to about 109,000 people who would have received them absent the waiver.

Caveats and sensitivity analysis. These calculations are highly simplified, and there are a number of limitations that could lead to either more or less rationing than we estimate, although none would change the conclusion that Georgia would have to deny subsidies to tens of thousands of people.

- *Imperfect sorting.* The assumption that only 1 in 4 people purchasing QHPs would use maternity and newborn care is likely conservative, at least in the long run. As noted in the main text, maternity coverage riders sold prior to the ACA were priced on the assumption that nearly everyone purchasing them would use maternity services.[46] If 1 in 2 people purchasing QHPs used maternity and newborn care, Georgia would have to deny subsidies to about 172,000 people who would otherwise have received them. If everyone did, it would have to deny subsidies to about 231,000.
- *Unused subsidy amounts.* Consumers cannot receive subsidies that exceed their premiums, meaning that some consumers using subsidies to purchase non-QHPs might not use the entire subsidy they are eligible for. As explained in more detail in the main text, consumers are unlikely to leave large subsidy amounts unused; they would instead use them to purchase more generous coverage (for example, with less cost sharing). But it is plausible that consumers might not use the entire amount of their subsidies. If each subsidized consumer left an average of $1,000 in subsidies unused, Georgia would deny subsidies to about 86,000 (instead of 109,000) people who would otherwise have received them. Even if subsidized consumers used only about half the increase in available subsidies, Georgia would still have to deny subsidies to about 59,000 people.
- *Premium calculation.* The premium calculations above are based on Urban Institute estimates of the 2017 national average cost of maternity and newborn care, adjusted to 2022 based on projections for nationwide health care cost growth. Differences between nationwide and Georgia costs and between cost growth for maternity and newborn care versus other services could shift the estimates in either direction.

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[45] The waiver states, "The state-funded program cap is projected to be at $255M for PY [plan year] 2022, funded in part with a state user fee previously assessed [by the federal government]. The $255M is *equal to the estimated PY 2022 state funding requirement* using the methodology and assumptions described in this analysis" [emphasis added] (p. 41).

[46] See for example, National Women's Law Center, "Nowhere to Turn: How the Individual Health Insurance Market Fails Women," 2008, https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2015/08/NWLCReport-NowhereToTurn-81309w.pdf and Rovner.

- *Subsidy calculation.* As noted above, we assume that the average subsidy will increase by the same amount as the average QHP premium. While this is a simplification, in practice, changes in average subsidies have closely tracked changes in average premiums over the past several years.[47]
- *Health differences between QHP and non-QHP purchasers.* In addition to using maternity and newborn coverage, people continuing to purchase QHPs may differ from non-QHP purchasers in other ways. Overall, their non-maternity health costs might be lower (because they are younger than average) or higher (because pregnancy and delivery may be associated with other health needs). Our calculations ignore these other differences, which would not change the qualitative results.

As discussed in the main text, alternative scenarios, in which Georgia allows subsidy-eligible non-QHPs to exclude additional or alternative benefit categories, would generally result in larger premium increases and more rationing than the maternity coverage scenario. But since Georgia's argument for how it meets the Section 1332 guardrails hinges on avoiding rationing altogether, it is also important to note that even much smaller premium increases would result in significant rationing. Using the same approach outlined above, Appendix Table 1 shows how many people Georgia would need to deny subsidies under various premium increase assumptions.

APPENDIX TABLE 1

Rationing Required Under Various Premium Increase Scenarios

Assumed QHP Premium Increase*	Number of Georgians Denied Subsidies Who Would Receive Them Absent the Waiver
10 percent	19,000
20 percent	47,000
51 percent (base maternity coverage scenario)	109,000
100 percent	167,000
219 percent (maternity coverage scenario with full market segmentation)	231,000

* Amounts shown are premium increases in addition to the 1.1 percent increase assumed in the waiver.

[47] Average premiums rose by $145 in 2018 and fell by $9 in 2019; average subsidies rose by $167 in 2018 and fell by $11 in 2019. These calculations are based on CMS public use files for 2017, 2018, and 2019, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.

Appendix 3: Georgia Seeks to Waive a Wide Range of ACA Provisions

To implement the second phase of its waiver, the Georgia Access Model, the state wants to waive a sweeping array of ACA provisions beginning in 2022. Some of these requests are directly related to key features of the waiver, such as waiving the QHP definition in section 1301(a). In other cases, Georgia is seeking broad authority to set aside provisions of the ACA without explaining how the state might use this authority, whether consumers will get the same benefits under state authority, or how the waiver might affect access to affordable and comprehensive health plans. For example, the state proposes to waive section 1402, which requires insurers to reduce out-of-pocket costs for low-income consumers, but doesn't explain whether it would continue to ensure that reduced cost-sharing is delivered to eligible people, or the significant negative effect on consumers if it isn't.

Among the provisions Georgia wants to waive are:

ACA Section 1301(a)
Section 1301(a) defines qualified health plans (QHPs), the type of plan certified to be offered through an ACA marketplace. This provision requires QHPs to cover the essential health benefits package, which by cross-reference refers to both the ten categories of benefits and the metal levels that help define what deductibles and other cost sharing insurers can charge. This provision also requires insurers that offer a QHP to offer at least one silver plan and one gold plan.

ACA Section 1311
Section 1311 would be waived in its entirety beginning in 2022. This section requires states to either operate a state-based ACA marketplace or for the federal government to operate the marketplace in the state. The waiver proposal notes that waiving this entire section means that statutory language prohibiting the availability of plans that are not QHPs would no longer apply. But this section also includes many other requirements related to QHPs, such as:

- Certification of QHPs by the marketplace based on criteria including: not employing marketing tactics that discourage enrollment of people with significant health needs; ensuring sufficient choice of providers; including essential community providers in health plans; having a quality improvement strategy; using a uniform enrollment form; using a standardized form to present plan options; providing quality information; reporting pediatric quality measures.
- Developing a plan rating system;
- Developing an enrollee satisfaction system;
- Providing for open and special enrollment periods;
- Performing marketplace functions, including: certification and decertification of plans; providing a toll-free telephone hotline; maintaining a website with standardized comparative information on plans; assigning ratings to QHPs; utilizing a standardized format for presenting plan options; determining eligibility for and enrolling eligible people in Medicaid and the Children's Health Insurance Program; establishing an electronic calculator to determine the federal premium tax credit (PTC); providing information to the Secretary of the Treasury on the employer of PTC recipients; publication of marketplace administrative costs; requiring plans to justify premium increases; requiring plans to submit plain-language data on payment and claims policies; ensuring that plans' cost-sharing information is transparent; and

creating a navigator program to provide fair and impartial information and help consumers enroll in coverage; and

- Applying mental health parity to QHPs.

ACA Section 1402
This provision requires insurers to provide plans with reduced out-of-pocket limits and cost-sharing charges to people with low incomes who enroll in a silver QHP.

Internal Revenue Code Section 36B
This section of the Internal Revenue Code establishes the PTC; and:

- Determines the percentage of income a family must pay toward coverage, based on a sliding scale;
- Defines the applicable benchmark plan for calculation of the PTC;
- Defines who may receive a PTC;
- Permits lawfully present immigrants with income below the poverty line to receive PTCs if they are ineligible for Medicaid;
- Establishes the Qualified Small Employer Health Reimbursement Arrangements, which allow small employers to contribute toward their employees' coverage in the individual market;
- Establishes definitions of family size and household income relevant for PTC eligibility;
- Provides for the reconciliation of the PTC and caps potential repayment by income; and
- Requires reporting of the PTC and other pertinent information to the Treasury Department.