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Tens of Thousands Could Lose Coverage Under Georgia's 1332 Waiver Proposal

By Tara Straw

About 500,000 Georgians enroll in private health plans or Medicaid through the federal marketplace, HealthCare.gov. Georgia is seeking federal permission to dismantle this pathway to health insurance, endangering coverage and access to care for tens of thousands of people. Through a waiver under Section 1332 of the Affordable Care Act (ACA), Georgia proposes to exit HealthCare.gov without creating a state-based marketplace to replace it. Instead, 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, likely decreasing enrollment, raising premiums, and leading more Georgians to enroll in substandard plans instead of comprehensive coverage.

Georgia claims its privatization plan would increase coverage by giving consumers more choices to enroll through health insurers or web-brokers. But that's not what the proposal does. Georgians who choose to can already enroll in coverage through insurers and web-brokers, and the proposal itself documents that these options are already widely available. What the waiver would do is *eliminate* consumers' option to use the one-stop-shop HealthCare.gov platform. This likely would sharply reduce the number of Georgians with comprehensive coverage, for several reasons:

- Fragmenting the insurance market would confuse and discourage consumers, hindering enrollment.
- Insurers and brokers would likely provide less information and assistance to people eligible for Medicaid than HealthCare.gov does.
- Evidence from past, far simpler transitions between federal and state marketplaces suggests that tens of thousands of Georgians might lose coverage simply because of the disruption from the state's transition away from HealthCare.gov. That's especially likely given that Georgia has allocated minimal funding for the transition — about one-third of the already low amount the state itself previously estimated would be needed.
- 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.

Because it would harm consumers, Georgia’s proposal is not approvable under federal law. 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 those 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. It also would likely leave many Georgians with less affordable or less comprehensive coverage than they would otherwise have.

Unfortunately, the Centers for Medicare & Medicaid Services (CMS) moved quickly to deem Georgia’s proposal complete, starting the clock for public comments and federal review, despite significant gaps in Georgia’s application.¹ The Administration may intend to fast-track the proposal, since it has encouraged states to use Section 1332 waivers to radically alter ACA coverage programs, and Georgia would be the first to do so. Even so, the Administration should recognize that Georgia’s waiver would almost certainly reduce the number of people with health coverage, which clearly violates the statutory requirements for a Section 1332 waiver — and even the Administration’s watered-down interpretation of those requirements.

Waiver Would Upend Health Insurance Enrollment

On July 31 Georgia Governor Brian Kemp submitted a federal waiver proposal under Section 1332 of the ACA; CMS deemed the waiver complete on August 17, opening a 30-day public comment period.² Section 1332 allows a state to obtain permission to waive parts of the ACA 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.”)

Georgia’s 1332 waiver would implement a reinsurance program, as many other states have done. Reinsurance programs reimburse insurers for part of their costs for covering high-cost enrollees, enabling them to charge lower premiums. Georgia estimates that its program, which would take effect in 2022, would lower premiums by about 10 percent and increase the number of people in the individual market by 0.4 percent, entirely among residents with income above 400 percent of the federal poverty line (the ACA’s income limit for premium tax credits).³

¹ For a discussion of the waiver’s legal deficiencies, see 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/>. Public comments on the waiver are due September 16.

² 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). This waiver is a pared-down version of earlier drafts. For a discussion of the version previously submitted to CMS, see Aviva Aron-Dine, Tara Straw, and Sarah Lueck, “Georgia’s 1332 Waiver Proposal Puts Coverage at Risk for Tens of Thousands,” CBPP, January 23, 2020, <https://www.cbpp.org/research/health/georgias-1332-waiver-proposal-puts-coverage-at-risk-for-tens-of-thousands;> and Christen Linke Young and Jason Levitis, “Georgia’s 1332 waiver violates the ACA and cannot lawfully be approved,” Brookings Institution, January 23, 2020, <https://www.brookings.edu/research/georgias-1332-waiver-violates-the-aca-and-cannot-be-lawfully-approved/>.

³ Waiver, *op. cit.*, p. 3.

The second section of the waiver, which the state calls the Georgia Access Model, requests unprecedented authority to end use of HealthCare.gov without creating a comparable state substitute, as 13 states have done. Instead, Georgia would decentralize marketplace functions among a plethora of brokers and health insurers. The proposal projects a modest increase in enrollment, and slightly lower premiums, due to the Georgia Access Model.

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 standards related to:

- **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 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 qualify for, relative to what they would have received without the waiver, 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.

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>.

Privatizing Marketplace Would Reduce Enrollment, Not Increase It

Georgia claims that privatizing its marketplace would increase enrollment in the individual market by about 25,000 people by giving consumers new options to shop for and enroll in plans.⁴ (In addition, Georgia projects that about 2,000 people would gain coverage due to the reinsurance program.) 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 — under policies called direct enrollment and enhanced direct enrollment, which CMS heavily promotes. Under direct enrollment, consumers select plans from brokers or insurers but complete an application on the HealthCare.gov platform to get an official eligibility determination; under enhanced direct enrollment, consumers complete the entire process on the private platform with eligibility determined by HealthCare.gov behind the

⁴ Waiver, *op. cit.*, p. 53.

scenes. In the 2020 plan year, at least 16 insurers and web-brokers offered these services in Georgia;⁵ the waiver itself notes these options are widely available and have “been promoted by [federal] guidance as an enrollment pathway.”

Meanwhile, the waiver analysis entirely ignores countervailing threats to enrollment posed by dismantling the enrollment and consumer support system that roughly 400,000 people use.⁶ As the waiver notes, only 21 percent of marketplace enrollees opted for direct enrollment or enhanced direct enrollment in 2020.⁷ Abandoning HealthCare.gov would leave the other 79 percent of enrollees without their platform of choice, almost certainly reducing enrollment significantly. 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 lastly, 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.

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

Under Georgia’s proposal, enrollment would likely fall because buying insurance would become harder. Purchasing health insurance is a complicated, expensive, and consequential undertaking. Eliminating the enrollment platform for the 79 percent of enrollees who complete the process directly through HealthCare.gov could not only confuse many consumers, it could paralyze them.

It’s well documented that having too many choices can stymie consumers.⁸ 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.⁹ 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.¹⁰ Confusion could be even greater under a system that requires consumers to choose among legions

⁵ CBPP analysis of enrollment partners on HealthCare.gov in January 2020. Certified entities’ subsidiaries that do business under different names fall under the parent group’s certification, so there could be more than 16 pathways for direct enrollment or enhanced direct enrollment.

⁶ In 2020, nearly 464,000 Georgians selected a plan in HealthCare.gov and another 38,000 enrolled in Medicaid via HealthCare.gov. CMS, 2020 Marketplace Open Enrollment Period Public Use Files, last modified April 2, 2020, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files>. Of those enrolled, about 88,000 enrolled through HealthCare.gov with the help of a broker or insurer. Waiver, *op. cit.*, p. 70.

⁷ Waiver, *op. cit.*, p. 70.

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 Consumers Union, *op. cit.*

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.

HealthCare.gov was created to simplify this complex decision. 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 by brokers and insurers. The waiver says that Georgia will set standards for how brokers and insurers can display plans, using existing federal guidelines for enhanced direct enrollment for reference, but these rules leave critical gaps. For instance, insurers show only their own plans, and web-brokers can preference plans that pay commissions and display scant information about other plans, even omitting their premiums. Also, individual agents and brokers have no such rules and can market any plan, including those that don't meet ACA rules for individual market coverage, and web-brokers may newly be permitted to do the same. Indeed, displaying additional categories of options, including those that aren't comprehensive coverage, is a stated goal of the waiver.¹¹ This would make shopping for health insurance much more complicated.

In addition, the proposal would give up the consumer outreach and marketing that HealthCare.gov provides. While the Trump Administration has drastically reduced spending for those services, they're still crucial to generating enrollment. Instead, the proposal relies on the outreach and marketing efforts of web-brokers and insurers to maintain and generate new enrollment, but there's no guarantee those efforts, if any, would increase enrollment. Consumers would also lose access to navigators and possibly to other impartial assisters that help people apply for and enroll in coverage.

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 2020, at least 38,000 Georgians enrolled in Medicaid via HealthCare.gov.¹²

Since Medicaid (including Medicaid managed care organizations) generally doesn't pay commissions, 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. For example, a search on HealthCare.gov displays more than 1,100 agents and brokers that enroll people in individual or family coverage in

¹¹ Waiver, *op. cit.*, p. 23.

¹² CMS, *op. cit.*

one Atlanta ZIP code but *zero* agents and brokers that say they'll assist with Medicaid or CHIP enrollment.¹³

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 and instead displays a menu of full-price marketplace, short-term, and accident plans.¹⁴ Eliminating HealthCare.gov as an unbiased eligibility and enrollment option could significantly decrease enrollment among some of the most vulnerable Georgians.

Transition Itself Poses Additional Risks to Consumers

To transition away from HealthCare.gov in 2022, Georgia is proposing daunting technological changes on a tight timeline. Within about a year, the state must build a system to reliably query and receive information from the federal marketplace data services hub, a rules engine for calculating advance premium tax credits and transmitting this information to CMS and the IRS, secure interfaces with brokers and insurers, and an appeals apparatus. Georgia must also expand the capacity of the existing state systems it would rely on to determine eligibility.¹⁵

For these tasks and ongoing oversight of the program, the waiver budgets only about \$6 million in upfront costs and \$1 million in ongoing annual administrative costs — far less than the already-low \$18.5 million and \$5 million, respectively, the state budgeted for similar functions in the version of the waiver it submitted to CMS in December 2019.¹⁶ The budgeted amounts would likely fall far short of covering even the limited functions the state will perform.¹⁷ The waiver provides no direct explanation for the reduced administrative funding, but it may reflect the fact that, like many states, Georgia faces a serious budget deficit, which could reach \$4 billion in the next 15 months.¹⁸ In fact, the state cites “unanticipated budget constraints that emerged and will continue to develop as a result of the COVID-19 pandemic” as a reason for delaying its reinsurance program, which was previously slated to start in 2021 pending federal approval.¹⁹ Given the budget crisis, it's unclear

¹³ CBPP analysis. HealthCare.gov search conducted on August 14, 2020, using the 30310 ZIP code.

¹⁴ CBPP analysis, as of August 25, 2020.

¹⁵ Waiver, *op. cit.*, p. 36.

¹⁶ Waiver, *op. cit.*, p. 82. The state's prior waiver is available at <https://medicaid.georgia.gov/patientsfirst>, p. 106.

¹⁷ For comparison, Georgia paid a consultant \$2 million just to draft the initial versions of the state's 1332 and Medicaid waivers in 2019. Andy Miller, “Georgia Picks Deloitte To Craft Waiver Plan On Health Coverage,” Georgia Health News, June 4, 2019, <https://www.wabe.org/georgia-picks-deloitte-to-craft-waiver-plan-on-health-coverage/>.

¹⁸ Danny Kanso, “Georgia Can't Afford Another Lost Decade: Options to Increase State Revenues to Decrease Budget Shortfalls,” Georgia Budget & Policy Institute, May 11, 2020, <https://gbpi.org/georgia-cant-afford-another-lost-decade-options-to-increase-state-revenues-to-close-budget-shortfalls>.

¹⁹ Waiver, *op. cit.*, cover letter.

whether Georgia will provide even the limited resources it now says it will dedicate to implementing new eligibility and enrollment systems.²⁰

As evidence that it can accomplish the required tasks, Georgia notes that it will leverage its current integrated eligibility system, Georgia Gateway. But that system has been plagued with problems, including mistakenly canceling Medicaid coverage for thousands of Georgians in 2019.²¹

Failure to successfully build a robust, reliable technology system could prevent consumers from enrolling in coverage or receiving subsidies, leading to massive coverage losses in 2022, 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 (8,000 people, offset by a supposed 33,000 new enrollees), but other states' experiences show this figure is unrealistic.²² 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.²³ Similar percentage declines in Georgia would translate into a drop of 25,000-46,000 people in marketplace enrollment.²⁴

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.²⁵

Other Factors Could Raise Premiums, Lead to Less Comprehensive Coverage

The waiver estimates premiums would fall 3.4 percent due to the Georgia Access Model. Not only is that estimate based on the flawed premise of increased enrollment, but it fails to account for

²⁰ Waiver, *op. cit.*, p. 36.

²¹ Andy Miller, "Enrollment Drops, Eligibility Snags, Cyber-Errors in Ga. Benefit Programs Cause Concern," WABE, June 25, 2019, <https://www.wabe.org/enrollment-drops-eligibility-snags-cyber-errors-in-ga-benefit-programs-spark-concern/>; and Ariel Hart, "Georgia Is Cutting Off Medicaid for 17,000 Patients," *Atlanta Journal-Constitution*, June 6, 2019, <https://www.ajc.com/news/state--regional-govt--politics/lawyers-georgia-may-medicaid-for-000-elderly-disabled-clients/BVxukL3aenklu1FZN93VJ/>.

²² Waiver, *op. cit.*, p. 71.

²³ 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; and 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>.

²⁴ 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).

²⁵ Waiver, *op. cit.*, pp. 19, 169.

significant factors that could raise premiums. The waiver ignores the potential for greater enrollment in substandard plans, which could raise premiums (and greatly increase consumers' exposure to catastrophic medical expenses) by pulling healthy people out of comprehensive coverage. And despite the waiver's goal of expanding consumer choice, insurers' participation could decrease, putting further upward pressure on premiums by reducing competition.

Privatization Could Steer Healthier Consumers to Non-ACA Plans

An explicit goal of the waiver is to increase access to coverage that doesn't meet ACA standards. The waiver proposal 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.²⁶ 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 2018.²⁷ 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 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.²⁸

Brokers have an incentive to steer consumers toward short-term plans because they tend to pay higher commissions — up to ten times as much as ACA-compliant plans (an average of 23 percent compared to 2 percent).²⁹ Commissions for ACA plans have declined, and some pay no commissions at all.³⁰ Insurers also profit on short-term plans, which aren't required to meet the

²⁶ Waiver, *op. cit.*, p. 23.

²⁷ 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/>.

²⁸ 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>. The Democratic staff of the House Energy and Commerce Committee produced 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.) In addition, 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>.

²⁹ 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>.

³⁰ Virgil Dickson, "Thousands of brokers exit HealthCare.gov as plan commissions go unpaid," Modern Healthcare, April 5, 2017, <https://www.modernhealthcare.com/article/20170405/NEWS/170409972/thousands-of-brokers-exit-healthcare-gov-as-plan-commissions-go-unpaid>.

medical loss ratio standards for ACA-compliant plans: short-term plans spend only about 48 percent of premium revenue on medical care, compared to at least 80 percent for ACA plans.³¹

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.³² 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.³³ 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.³⁴ And consumers are often subjected to aggressive or even fraudulent marketing tactics.³⁵ 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.³⁶ 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 a policy’s 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.³⁷ The waiver doesn’t account for short-term plan enrollment, its impact on ACA-compliant coverage enrollment, the risk profiles

³¹ House report, *op. cit.*, p. 48.

³² 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>.

³³ 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>.

³⁴ 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/>.

³⁵ House report, *op. cit.*, p. 29; Corlette, *et al.*, “The Marketing of Short-Term Health Plans.”

³⁶ 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/>.

³⁷ Hansen and Dieguez, *op. cit.*, p. 3.

of enrollees in short-term or ACA-compliant plans, or the likelihood of premium increases in the ACA-compliant market.

Waiver Could Reduce Competition Among Marketplace Insurers

Georgia's waiver could also raise premiums by reducing head-to-head competition between insurers.³⁸ For one, the state might have overestimated insurers' willingness and ability to perform enhanced direct enrollment functions for marketplace consumers. Entities that have opted not to offer enhanced direct enrollment to date might not be able to meet the basic requirements related to security, privacy, and plan display standards, or might simply not want to assume that role. Taking away the option for insurers and brokers to use HealthCare.gov could cause them to stop working with subsidy-eligible consumers altogether and only sell non-compliant coverage. It could also deter smaller insurers from entering Georgia's market in the future if they can't afford to build such a system themselves or contract with an outside vendor to run it.

Similarly, requiring insurers to do all their own outreach and marketing could reduce, not increase, competition. Insurer television marketing, for example, tends to rob other insurers of customers, not increase overall enrollment.³⁹ Absent HealthCare.gov's leveling of the playing field, smaller insurers or insurers with low marketplace enrollment may not be able to compete with dominant insurers with greater brand recognition, a higher marketing budget, or a more generous commission structure. They might choose to exit, or new insurers might decline to enter, if the cost of competing in the market is prohibitive.

The lack of a single, unbiased source of comparative plan data could also directly reduce competition.⁴⁰ The waiver says web-brokers will be required to show all plans, as under current federal regulations.⁴¹ However, insurers that participate in enhanced direct enrollment never display their competitors' plans, leaving consumers with an incomplete list of their options. And even web-brokers are permitted to give preference to the plans that pay commissions by showing them with full-color logos at the top of the page and burying other plans at the bottom without displaying premiums, deductibles, or other information.

Without a centralized marketplace, Georgia consumers would thus have no way to effectively compare plans or premiums without visiting numerous websites or call centers. That would reduce competitive pressure to keep prices down, especially in areas of the state with a dominant insurer. If insurers believed they could keep most of their current customers despite having considerably higher

³⁸ Unmentioned in the waiver, the number of insurers offering comprehensive coverage in the state rose from four to six in 2020.

³⁹ Naoki Aizawa and You Suk Kim, "Government Advertising in Market-Based Public Programs: Evidence from the Health Insurance Marketplace," National Bureau of Economic Research, August 2020, <https://www.nber.org/papers/w27695>.

⁴⁰ California, for example, reduced plan variation even more than most marketplaces by standardizing plan design and making insurers compete on value in order to participate in its marketplace. This allows consumers to make a truer apples-to-apples plan comparison. Peter V. Lee, Elliott Fisher, and Kelly Green, "Lessons From Covered California's First Five Years For Marketplaces And The Employer Sector: Part 2," *Health Affairs* blog, April 21, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200413.283194/full/>.

⁴¹ Waiver, *op. cit.*, p. 18.

premiums (because most consumers wouldn't shop across multiple enrollment platforms), then all insurers would likely set higher premiums than they otherwise would.

Proposal Fails Federal Tests for Waiver Approval

The Georgia Access Model portion of the waiver fails the statutory tests for 1332 waivers. Specifically, 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.⁴²

Coverage. There is a high chance that Georgia's waiver would reduce enrollment, and minimal chance it would increase 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. While the reinsurance portion of the waiver could indeed reduce premiums, as it has in other states, the Georgia Access Model would likely *increase* premiums. 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. As discussed above, 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.

Waiver Also Fails Trump Administration's Watered-Down Tests

In 2018 the Trump Administration issued 1332 waiver guidance that attempts to weaken the ACA guardrails,⁴³ in ways that are likely inconsistent with federal law.⁴⁴ But Georgia's proposal doesn't

⁴² As noted above, the reinsurance program is similar to those in other states and meets the statutory tests. For a more detailed discussion of why Georgia's proposal is not approvable under federal law, see Linke Young and Levitis, *op. cit.*

⁴³ The guidance is available at <https://www.govinfo.gov/content/pkg/FR-2018-10-24/pdf/2018-23182.pdf>. See also CMS, "Section 1332 State Relief and Empowerment Waiver Concepts," November 29, 2018, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF>.

⁴⁴ Joel McElvain, "The Administration's Recent Guidance on State Innovation Waivers under the Affordable Care Act Likely Violates the Act's Statutory Guardrails," *Yale Journal on Regulation*, December 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/>.

pass muster even under that standard.⁴⁵ Under the Administration’s guidance, a waiver must provide coverage to a comparable number of people as the ACA, including people with substandard plans as well as those with comprehensive coverage. As discussed above, the waiver would likely reduce enrollment in comprehensive coverage, and since substandard plans are already available in Georgia, enrollment increases in these plans would likely come at the expense of further enrollment declines in comprehensive plans due to new opportunities for steering, not from enrollment by people who would otherwise go uninsured.

Moreover, the Administration’s guidance acknowledges that a waiver must meet its coverage test *in each plan year*. It is particularly implausible that the number of people with coverage would remain stable in the first year of the waiver, given the likelihood of large transition-related coverage losses.

Better Options Available

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 could worsen both problems. Moreover, better approaches exist that would not require the state to upend its insurance market. Most important, Georgia could cover more than 400,000 people by taking up the ACA Medicaid expansion, compared to its optimistic estimate of covering roughly 27,000 under the 1332 waiver.⁴⁶ Expanding Medicaid would also help address the state’s persistent racial disparities in health care access and outcomes.⁴⁷ Second, Georgia could simplify its 1332 waiver and move forward with just its proposed reinsurance program. At a modest state cost, that would cut premiums by about 10 percent and make coverage more affordable for middle-income consumers, without harming lower-income consumers.

⁴⁵ Linke Young and Levitis, *op. cit.*

⁴⁶ Michael Simpson, “The Implications of Medicaid Expansion in the Remaining States: 2020 Update,” Urban Institute, June 2020, https://www.urban.org/sites/default/files/publication/102359/the-implications-of-medicaid-expansion-in-the-remaining-states-2020-update_0.pdf. Instead of Medicaid expansion, Georgia is proposing a waiver that, by its own estimates, would cover hundreds of thousands fewer people. See Kyle Hayes, “Georgia Waivers: At Least as Costly to Cover Far Fewer People Than Medicaid Expansion,” CBPP, November 14, 2019, <https://www.cbpp.org/blog/georgia-waivers-at-least-as-costly-to-cover-far-fewer-people-than-medicaid-expansion>.

⁴⁷ Laura Harker, “Fast Facts on Medicaid Expansion,” Georgia Budget & Policy Institute, April 23, 2020, <https://gbpi.org/fast-facts-on-medicaid-expansion/>.