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Georgia's 1332 Waiver Proposal Puts Coverage at Risk for Tens of Thousands

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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 cap the total amount of assistance available to help low- and moderate-income people pay premiums; make subsidies available for plans that have higher deductibles and other out-of-pocket costs than the ACA allows; and eliminate the ACA marketplace in the state, instead requiring consumers to enroll in coverage through private web-brokers or insurers.

Overhauling financial assistance would put coverage at risk for tens of thousands of Georgians, with no offsetting benefit. Today, the federal government provides premium tax credits that help cover the cost of individual market coverage to all eligible Georgians who apply for them. Under Georgia's proposal to replace these federal subsidies with an alternative state program, the state would instead receive a set amount of federal funding for subsidies, based on Treasury Department estimates of what the federal government would have spent absent the waiver. Since Georgia is unwilling to assume the financial risk of guaranteeing subsidies for all eligible Georgians if costs end up exceeding these estimates, it proposes to ration subsidies on a first-come, first-served basis if state costs would otherwise exceed a specified cap.

Georgia claims costs would reach this cap only if its waiver led to large coverage gains. But in reality, Georgia would also ration subsidies if other features of its waiver caused premiums to rise, for reasons explained below, or if Treasury underestimated what premiums or enrollment would have been absent the waiver. Modest premium increases or forecast errors could result in significant rationing. Even under optimistic assumptions, the budget cap would be triggered if premiums increased by just 6 percent as a result of the waiver, or if Treasury underestimated without-waiver premiums or enrollment by similar amounts. If premiums rose, or Treasury underestimated without-waiver premiums or enrollment, by 10 percent, Georgia would deny subsidies to about 15,000 people who would otherwise have received them.

Georgia's primary goal in substituting its own, capped subsidy program for the existing, uncapped federal program is to make subsidies available for plans that do not meet ACA standards. Most notably, Georgia is proposing to let consumers use subsidies to buy newly created "copper plans,"

which could have individual deductibles of at least $13,500 (potentially as high as $17,000), compared to a maximum of $8,150 this year under the ACA.

Georgia claims that these plans will attract otherwise-uninsured consumers not eligible for subsidies. But that's unlikely, since low-premium, high-deductible plans not eligible for subsidies can already be sold in Georgia. The difference, under the proposal, is that these plans would become eligible for subsidies. By the state's own estimates, that would cause about 13,000 lower-income Georgians to enroll in them who would otherwise have had more protective coverage.

Privatizing Georgia's marketplace would also endanger consumers. Georgia claims its privatization plan will increase coverage by giving consumers more choices. But Georgians already can enroll in ACA plans through private web-brokers and insurers, in the existing direct enrollment program. Rather than giving consumers new options, privatizing the marketplace would eliminate their option to access coverage through the neutral platform offered by HealthCare.gov.

Moreover, 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. Limiting enrollment to such entities while eliminating centralized outreach and consumer assistance would likely cause some Georgians to lose coverage altogether and would give web-brokers and insurers more opportunity to steer healthier consumers to substandard plans, resulting in adverse selection that could increase premiums for comprehensive coverage. In addition, evidence from past, far simpler transitions between federal and state marketplaces suggests that thousands of Georgians might lose coverage simply because of the disruption caused by the transition away from HealthCare.gov.

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. The version of the waiver Georgia submitted for federal review in December drops certain harmful proposals from the version released for state comment (although the application suggests Georgia may return to these ideas in the future). But even so, it fails the Section 1332 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 would likely also leave many Georgians with less affordable or less comprehensive coverage than they would otherwise have.

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 and fail the statutory tests for 1332 waivers. While the Trump Administration has sought to weaken these tests through legally questionable guidance, Georgia's waiver cannot meet even the Administration's watered-down standards.

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 avoids discussing the simplest solution: adopting the ACA's expansion of Medicaid to low-income adults. Instead, Georgia released the proposal along with a Medicaid waiver that would cover only about 1 in 10 of those who would gain coverage through expansion. By its own estimates, Georgia's combined cost for the two waivers would equal or exceed 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] Georgia submitted the waivers for federal review on December 23.

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

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 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 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 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. Georgia estimates that its program, which would take effect in 2021, would lower 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, through the portion of its waiver it calls the Georgia Access Model. Using that

[1] Both applications are available at https://medicaid.georgia.gov/patientsfirst.

authority, Georgia is proposing to administer its own roughly $2.5 billion subsidy program in place of the ACA's. This program would diverge from the existing subsidy structure in two ways:[2]

- **Enrollment in subsidies would be capped to meet budget targets.** Currently, subsidies are available to all low- and moderate-income consumers eligible for them.[3] Under the waiver, Georgia would receive federal pass-through 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.[4]
- **Subsidies could be used for plans not meeting certain ACA standards.** Georgia is proposing to approve two categories of subsidy-eligible plans that are not Qualified Health Plans (QHPs) meeting ACA standards: copper plans and disease management plans. Copper plans would have lower actuarial values than plans currently eligible for subsidies: 50 percent, versus 60 percent for bronze plans; these plans could also set higher limits on out-of-pocket costs than the ACA maximum of $8,150 per individual.[5] In practice, a plan with a 50 percent actuarial value could have an individual deductible of about $13,500 in 2020.[6] If actuarial values are allowed to vary from 46 percent to 52 percent, consistent with current standards for bronze plans, copper plans could have deductibles of about $17,000 per year for an individual.[7]

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[2] 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. 23).

[3] 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 United States. 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.

[4] The waiver states that Georgia will grant subsidies "on a first in, first out basis until the projected funding cap is reached." In that case, additional enrollees would have the option of enrolling in plans without subsidies and would be placed on a wait list for subsidies and notified "if and when funding is available" (p. 24).

[5] A plan's actuarial value refers to the share of a typical population's costs that are covered by the plan premium versus cost sharing (deductibles, copays, and coinsurance). Georgia is seeking a waiver of the ACA's limit on out-of-pocket costs.

[6] Deductible calculations are CBPP's based on the Centers for Medicare & Medicaid Services 2020 Actuarial Value calculator; we disabled the feature of the calculator that requires the deductible and out-of-pocket maximum to be less than the ACA statutory limit. The calculator can be downloaded at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2020-AV-Calculator.xlsm. Figures in the main text are for plans that have maximum out-of-pocket limits equal to their deductibles; alternatively, plans could have lower deductibles and additional copayment and coinsurance requirements, up to an even higher out-of-pocket limit.

[7] Georgia's application says the copper plans would have a 50 percent actuarial value (AV) "with de minimis rules," a reference to the federal rules that permit a range of AVs to qualify for the other metal levels authorized under the ACA. Applying these rules to the proposed copper plans would result in AVs that range from 46 percent to 52 percent. (See page 61 of Georgia's application and 45 CFR § 156.140(c).) A plan with a 46 percent AV could have a $16,800 deductible.

It's less clear what the proposed disease management plans would look like. Georgia says that these plans would be designed to serve people with particular chronic conditions and their networks and cost-sharing designs would differ from other plans. But these are features for which states can generally set their own standards without a federal waiver. It is possible that Georgia would seek to use these plans as a vehicle to make larger changes (see textbox, "Proposal Leaves the Door Open to Additional Harmful Changes," below).

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 or insurers, which would also be responsible for most other marketplace functions, including outreach and customer service. As part of the privatization proposal, Georgia is also seeking to waive many marketplace standards, including the requirement that participating insurers offer at least one gold (80 percent actuarial value) and one silver (70 percent actuarial value) plan in all areas of the state.

Web-brokers and insurers could offer multiple types of coverage: QHPs that meet all ACA standards; copper plans, disease management plans, and any other subsidy-eligible non-QHPs licensed by the state; and non-subsidy-eligible, non-QHPs, such as short-term, limited-duration plans, which can medically underwrite (vary premiums based on health status), impose annual and lifetime limits, exclude any category of essential health benefits, and set unlimited deductibles and other cost-sharing requirements.

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]

Proposed Overhaul of Financial Assistance Puts Consumers at Risk

By converting health insurance subsidies from a program that adjusts to meet need to one that is rationed to meet an arbitrary cap, Georgia's proposal puts coverage for tens of thousands of low- and moderate-income consumers at risk. And its primary reason for establishing its own subsidy program — to make subsidies available for plans not meeting ACA standards — is more likely to harm consumers than to benefit them.

Budget Cap Could Result in Large Coverage Losses

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] Under the waiver, these

[8] Georgia 1115 Waiver Application, p. 10 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.

[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.

low- and moderate-income Georgians would be at risk of being denied subsidies, depending on whether the total state cost for the program exceeds Georgia's budget target.

Georgia argues that its proposal to ration subsidies would not harm consumers because it is a contingency plan that would take effect only if the waiver were far more successful than anticipated in reducing the state's uninsured rate. But the state could easily reach the cap for other reasons and end up denying subsidies to thousands or tens of thousands of Georgians who would otherwise have received them.

Rationing Could Occur Due to Premium Increases

Georgia's waiver could increase premiums for comprehensive coverage, thereby increasing per-person subsidy costs. This could occur because:

- **The introduction of copper plans could create adverse selection in other metal levels.** Copper plans, with their very high deductibles and other out-of-pocket costs, are likely to differentially attract healthier consumers. If consumers shift into these plans from gold, silver, or bronze plans, that could lead premiums to rise for these other metal-level plans, to account for the increase in their average enrollee costs.[10] An increase in silver plan premiums would increase per-person subsidy costs, since subsidies are based on premiums for the second-lowest cost silver ("benchmark") plan.

  Georgia's actuarial analysis acknowledges this possibility, but it concludes that adverse selection would be small and more than offset by increased enrollment among healthier consumers. But adverse selection could be greater if more people shift into copper plans than Georgia assumes. And, as discussed below, it's implausible that Georgia's proposals will meaningfully increase enrollment.

- **The privatization proposal could create adverse selection.** Non-ACA plans that can medically underwrite and exclude essential health benefits are already available in Georgia, and many healthy Georgians with incomes too high to qualify for subsidies likely already buy them. But eliminating the centralized marketplace would create new opportunities for web-brokers and insurers to steer healthy, unsubsidized consumers toward these plans, as explained below. That adverse selection would increase premiums in Georgia's ACA market and, since per-person subsidies depend on the level of premiums, it would increase subsidy costs as well. Georgia's actuarial analysis does not acknowledge this risk.[11]

- **The privatization proposal could reduce competition.** While Georgia says a goal of its plan is to make its market more competitive, privatization could instead reduce competition in two ways, as explained further below. First, smaller insurers might choose not to offer coverage if doing so required them to make major investments to set up their own enrollment platform and take on other functions currently performed by HealthCare.gov. Second, by

[10] Copper plans would be subject to risk adjustment, which transfers resources between plans that enroll healthier-than-average enrollees to those enrolling sicker-than-average enrollees. But the risk adjustment program may not fully adjust for the differences in enrollee health status across metal levels, leading insurers to incorporate some of those differences into premiums.

[11] If web-brokers and insurers steer subsidy-eligible consumers to substandard plans, that would mitigate cost increases due to steering but add to the waiver's violations of the Section 1332 affordability and comprehensiveness guardrails, since these consumers would otherwise have had more comprehensive and affordable coverage.

making it harder for consumers to compare premiums across insurers, eliminating the centralized marketplace could reduce competitive pressure to keep prices down. Georgia's actuarial analysis does not acknowledge this risk.

Rationing Could Occur Due to Forecast Errors

At least equally important, simple forecast errors in Treasury estimates of what premiums and enrollment would have been absent the waiver could trigger rationing. If the federal government approved Georgia's waiver, the Treasury Department would calculate Georgia's pass-through funding based on its estimates of what the federal government would have spent on subsidies for Georgia marketplace consumers absent the waiver. Georgia would receive an estimate of its pass-through funding each fall and actual payments in the spring.[12]

Since Georgia is proposing to ration subsidies at the point of initial enrollment, rather than take away subsidies from people mid-year, it would presumably impose rationing during or after open enrollment based on the comparison of actual costs to the estimate of federal funding it would obtain from Treasury in the fall. Treasury bases its pass-through estimates on prior-year enrollment levels and on premium projections formulated by states and the Centers for Medicare & Medicaid Services (CMS).[13]

As one example of how such estimates are subject to uncertainty and error, the actuarial analysis submitted with Georgia's 1332 waiver application projects a roughly 3 percent increase in benchmark premiums between 2019 and 2020 (before the waiver would take effect).[14] In fact, benchmark premiums *fell* by an average of 8 percent.[15] As another indication of uncertainty, changes in year-over-year enrollment between 2019 and 2020 ranged from an 11 percent decrease to a 12 percent increase across HealthCare.gov states.[16]

These examples show the challenges inherent in accurately predicting without-waiver premiums, enrollment, and subsidy costs. Further confirming the uncertainty in these forecasts, a number of

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[12] Centers for Medicare & Medicaid Services, "Section 1332 State Relief and Empowerment Waiver Pass-Through Funding Frequently Asked Questions (FAQ)," February 28, 2019, https://www.cms.gov/files/document/section1332-pass-through-funding-faq.pdf.

[13] Treasury Office of Tax Analysis, "Method for Calculation of Section 1332 Waiver Premium Tax Credit Pass-Through Amounts," January 2020, https://www.cms.gov/files/document/ota-methodology-2020-reinsurance-1332-waivers.pdf.

[14] Waiver pp. 70, 71.

[15] Centers for Medicare & Medicaid Services, "Plan Year 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States," October 22, 2019, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020QHPPremiumsChoiceReport.pdf.

[16] This calculation excludes Maine and Virginia, states for which significant drops in enrollment were expected due to expanding Medicaid; for other states, even the direction of year-over-year changes would have been challenging to predict *ex ante*. CBPP calculations from Centers for Medicare & Medicaid Services, "2020 Federal Health Insurance Exchange Enrollment Period Final Weekly Enrollment Snapshot," January 8, 2020, https://www.cms.gov/newsroom/fact-sheets/2020-federal-health-insurance-exchange-enrollment-period-final-weekly-enrollment-snapshot; and Centers for Medicare & Medicaid Services, "2019 Marketplace Open Enrollment Public Use Files," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.

states have been surprised by Treasury's estimates of their federal pass-through funding under existing 1332 reinsurance waivers.[17]

Remarkably, the sensitivity analysis included in Georgia's proposal — the basis for its conclusion that it will not deny subsidies to Georgians who would have received them absent the waiver — does not contemplate the risk of forecast errors in without-waiver projections.

Modest Discrepancies Could Lead to Substantial Rationing

Premium increases due to the waiver or discrepancies between actual and projected without-waiver premiums or enrollment would not have to be large to trigger the cap. While Georgia is proposing to contribute some state funds toward its subsidy program, these funds amount to only about 6 percent of expected costs, leaving little room for error.

Any premium increase exceeding about 6 percent would lead Georgia to deny subsidies to people who would otherwise have received them, as would a roughly 6 percent underestimate of what premiums or subsidized enrollment would have been absent the waiver. A 10 percent increase in or underestimate of premiums — roughly the same magnitude as the discrepancy between the benchmark premium estimates for 2020 included in Georgia's actuarial analysis and actual 2020 premiums — would cause Georgia to deny subsidies to about 15,000 people who would otherwise have received them. A 15 percent premium increase would cause it to deny subsidies to almost 30,000 people. (See Table 1; also see the Appendix for more details on these calculations.)

And Georgia may have considerably less headroom than these estimates suggest. Georgia assumes that its federal pass-through funding would be nearly the full amount of what the federal government would have spent on subsidies for Georgians absent the waiver. But Treasury would offset against that amount any costs it estimates Georgia's waiver would impose on the federal government. Such costs could include the loss of up to about $150 million of federal employer mandate penalty revenue and up to about $100 million in federal marketplace user fees each year.[18]

Unexpected reductions to federal pass-through funding could easily offset Georgia's limited state contribution (capped at about $145 million in 2022).[19] In that case, *any* increase in premiums as a result of the waiver or *any* underestimate of without-waiver premiums or enrollment would result in

[17] See for example Katie Keith, "CMS Releases New Info on State Reinsurance Funding," *Health Affairs* Blog, March 4, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190304.112399/full/.

[18] The federal employer mandate penalty is calculated in part based on whether employees receive federal premium tax credits, which would no longer be available to Georgians under the waiver. Meanwhile, by privatizing its marketplace, Georgia would eliminate about $100 million per year in federal marketplace user fee revenue (waiver, p. 72); Treasury might offset some or all of that revenue against pass-through funding. For further discussion of these costs and an explanation of the estimates of lost employer mandate penalty revenue, see 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/.

[19] Georgia proposes to cap its total contribution to reinsurance and subsidies at $255 million in 2022 (p. 23). While the waiver does not explicitly specify the breakdown of the contribution between the two programs, it estimates that the state would contribute $111 million toward the reinsurance program (p. 10). Georgia has not appropriated funding for its state contribution, raising the question of whether it would actually provide the full amount on a consistent basis.

rationing, and a 10 percent increase in premiums would require denying subsidies to about 34,000 people. (See Table 1.)

Georgia could also hit the cap and have to ration subsidies due to a combination of factors: premium increases as a result of the waiver, errors in premium projections, errors in enrollment projections, and unanticipated reductions in pass-through funding to offset federal costs. In contrast, without the waiver, *every eligible Georgian is guaranteed subsidies, regardless of premium and enrollment levels.*

TABLE 1

Rationing Required Under Various Scenarios

Increase in Benchmark Premiums as a Result of the Waiver	Number of Georgians Denied Subsidies Who Would Have Received Them Absent the Waiver	
	Under Georgia's Financing Assumptions	If Unaccounted-for Federal Costs Offset Georgia's Contribution Toward Subsidies
1 percent	0	4,000
6 percent	2,000	21,000
10 percent	15,000	34,000
15 percent	30,000	48,000
20 percent	43,000	61,000
25 percent	56,000	72,000

Source: CBPP calculations based on waiver actuarial analysis; see Appendix for details

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.[20] Consistent with that, before the ACA introduced subsidies for individual market coverage, most Georgia adults without employer plans and with incomes between 100 and 400 percent of the poverty line were uninsured.[21]

Copper Plans Would Expose Lower-Income Georgians to High Out-of-Pocket Costs

Georgia is proposing to expose its residents to the risk of losing financial assistance and coverage so that it can run its own subsidy program. And it seeks to run its own subsidy program primarily to

[20] 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 non-smokers with no pre-existing health conditions, 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 Short-Term Health Plans," Modern Healthcare, November 27, 2019, https://www.modernhealthcare.com/insurance/blue-cross-idaho-unveils-souped-up-short-term-health-plans.

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

make subsidies available for plans that do not meet ACA standards — most notably, copper plans. But the introduction of subsidy-eligible copper plans is more likely to harm than to benefit Georgia consumers. (Introducing a broader array of subsidy-eligible, non-QHPs, the approach Georgia initially proposed and appears to still be considering for the future, would cause even more harm; see textbox, "Proposal Leaves the Door Open to Additional Harmful Changes," below.)

Copper plans, as noted, would have lower actuarial values and higher out-of-pocket costs than are now permitted in subsidized ACA plans. With an actuarial value of 50 percent, copper plans could have individual deductibles of about $13,500. Alternatively, plans could have lower deductibles, but even higher limits on total out-of-pocket costs; for example, a plan could have a deductible of $8,000, a 30 percent coinsurance rate above the deductible, and a maximum out-of-pocket limit of about $20,000. If actuarial values are allowed to vary from 46 percent to 52 percent, as Georgia's waiver application suggests, these plans could have individual deductibles of almost $17,000, more than twice the current law limit of $8,150, or lower deductibles and even higher out-of-pocket limits.[22] The plans would have to cover all essential health benefits and would have to meet other ACA standards, including the prohibitions against medical underwriting and annual and lifetime benefit limits. The state estimates that unsubsidized premiums for copper plans would be about 17 percent lower on average than for bronze plans.[23]

Georgia's rationale for certifying copper plans is to "provide residents with expanded access to more affordable and consumer-focused health coverage."[24] But healthy Georgians who want to pay a low premium for a plan with high out-of-pocket costs can already do so, by purchasing one of the many so-called short-term health plans that are now available for a year or more in the states, including Georgia, that allow them. In fact, a healthy person not eligible for subsidies would likely find the premiums available for short-term plans, which can medically underwrite, to be substantially lower than those for copper plans, which would be barred from doing so. Copper plans would offer protections that short-term plans do not. But it's implausible that large numbers of Georgians are willing to pay a much higher premium (compared to short-term plans) for a plan that offers additional protections but cannot offer them a discount based on their health status, and yet are not willing to pay the premium for currently available bronze plans.[25]

It is, therefore, highly unlikely that introducing copper plans would lead to substantial new enrollment. At the same time, it would have other harmful effects. Some subsidy-eligible people — about 13,000, Georgia estimates — are expected to "buy down" to copper plans, meaning they would forgo coverage that would have provided significantly more protection against high out-of-

[22] CBPP calculations from CMS Actuarial Value Calculator.

[23] Waiver, p. 22.

[24] Waiver, p. 20.

[25] For example, a cursory search shows that a healthy 35-year-old man in Atlanta can purchase a one-year "short-term medical plus select A" plan from United Healthcare, with an individual deductible of $12,500 and an out-of-pocket maximum of $22,500, for about $120 per month. For comparison, if the waiver were in effect in 2020, the same consumer could purchase a copper plan for about $240 per month or a bronze plan for about $290 per month. The short-term plan has a lifetime limit and does not guarantee coverage for all categories of essential health benefits, but it does include hospital, physician, and prescription drug coverage unrelated to a pre-existing condition. Plan information was accessed on January 21, 2020. Additional information about United's short-term plans is available at https://www.uhone.com/filehandler.ashx/?FileName=45071P-G201904.pdf.

Proposal Leaves the Door Open to Additional Harmful Changes

The version of its waiver Georgia submitted to the federal government in December differs in an important way from the version it released for state comment in November. The earlier version proposed to make subsidies available for plans that could exclude various essential health benefits. That would result in severe adverse selection, since healthier people would likely buy these lower-benefit, lower-premium plans, while less-healthy people would use their subsidies to enroll in comprehensive coverage.

While Georgia was not specific about what categories of benefits plans could exclude, under a scenario in which Georgia allowed these 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.[a]

Georgia has dropped this proposal for now, but it notes that it may seek future federal approval to introduce additional categories of subsidy-eligible non-QHPs, and its application still seeks a waiver of federal essential health benefit standards.

Moreover, Georgia's proposal to create disease management plans could end up being a vehicle to allow plans that exclude or limit certain benefit categories. Georgia says that these plans would be required, at least initially, to cover all categories of essential health benefits, but they would "have the flexibility within each category to define benefits to best serve members."[b] If, in the future, Georgia decided to let these plans substitute benefits between categories (for example, offer better coverage for prescription drugs but less or no coverage for maternity care), that could create similar selection pressures as under Georgia's original proposal, resulting in premium increases, increases in total subsidy costs, and substantial rationing of subsidies.

Georgia also notes that it might seek to modify the subsidy structure in future years, which could entail cutting assistance for lower-income Georgians.

[a] Aviva Aron-Dine, Tara Straw, and Sarah Lueck, "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," Center on Budget and Policy Priorities, December 17, 2019, https://www.cbpp.org/research/health/georgias-unprecedented-1332-waiver-would-endanger-consumers-and-violate-federal-law.

[b] Waiver, p. 28.

pocket costs.[26] And the migration of likely healthier people from higher metal levels to the copper plans could also raise premiums, at least somewhat, for these more protective plans, as discussed above.

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. Eliminating the marketplace would cause consumer confusion, create new barriers to enrollment, increase opportunities for web-brokers to shift healthy consumers toward underwritten substandard insurance products and out of the marketplace risk pool, and reduce competition among individual

[26] Georgia estimates that 23,287 subsidized consumers would buy copper plans, of whom 10,363 would be new enrollees. Waiver pp. 84, 127.

market plans. The likely result is that thousands of Georgians would lose coverage, and many others would enroll in less comprehensive coverage.

Eliminating the Marketplace Would Likely Reduce, Not Increase, Enrollment

Georgia claims that privatizing its marketplace will increase the number of Georgians with health coverage by giving consumers new options to shop for and enroll in plans. However, it greatly overstates the extent to which the waiver will add new options. In addition to HealthCare.gov, Georgia consumers already can enroll in subsidy-eligible coverage directly through an insurer or web-broker under programs called direct enrollment and enhanced direct enrollment, which are heavily promoted by the federal marketplace. Under direct enrollment, consumers select plans on web-broker or insurer websites and 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. In the 2020 plan year, at least 16 insurers and web-brokers offered these services in Georgia.[27]

Meanwhile, the waiver proposal fails to consider how privatization could *reduce* enrollment. Purchasing health insurance is a complicated, expensive, and consequential undertaking. HealthCare.gov was created to help consumers make these complex decisions. It allows people to navigate one website to get an unbiased view of all plans eligible for subsidies 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 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 web-brokers and insurers. There would be no central source of information or assistance, and other resources, such as impartial assistance from navigators, would be eliminated.

Eliminating a centralized enrollment platform could lead not just to consumer confusion, but to consumer paralysis. It's well documented that consumers can be stymied by having too many choices.[28] For example, one study of Medicare Part D plans found that having fewer than 15 options increased enrollment, whereas having 15 to 30 options did not, and having more than 30 options actually decreased enrollment.[29] And overwhelmed by choice, consumers are more likely to delegate their choice to others, regret their selection, and be less confident in the choices they make.[30]

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[27] CBPP analysis of enrollment partners on HealthCare.gov. Certified entities' subsidiaries that do business under different names fall under the parent group's certification so, in reality, there could be many more direct enrollment/enhanced direct enrollment pathways.

[28] 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.

[29] 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.

[30] Consumers Union.

Confusion could be even greater under a system where consumers have to choose not only their plan but their platform and have no single platform on which to see and compare all choices.

HealthCare.gov also facilitates Medicaid enrollment. Since Medicaid agencies and managed care organizations generally don't pay commissions, web-brokers and insurers may have an incentive to steer low-income consumers toward low-premium, low-benefit substandard plans, without explaining their Medicaid eligibility. 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 direct enrollment web-brokers already neglect to identify certain Medicaid-eligible children. For example, with the web-broker GoHealth, a parent and child with household income of $15,000 — which in Georgia puts the parent in the Medicaid coverage gap and the child in Medicaid — fails to identify that the child is likely eligible for Medicaid and instead displays a menu of full-price marketplace, short-term, accident, and fixed-benefit coverage plans.[31] Eliminating HealthCare.gov as an unbiased eligibility and enrollment option could significantly increase the number of people affected by such discrepancies, putting some of the most vulnerable Georgians at risk of losing coverage.

Privatization Could Steer Healthier Consumers to Non-ACA Plans

As with steering consumers away from Medicaid, web-brokers often have an incentive to steer consumers toward substandard plans. Despite their serious drawbacks for consumers, non-ACA plans tend to pay higher commissions.[32] Short-term plans pay commissions of close to 20 percent, compared to 5 percent for a typical ACA-compliant plan, according to eHealth.[33] Commissions for ACA plans have declined, and many pay no commissions at all.[34]

Experience with the existing direct enrollment program shows that these incentives sometimes give rise to steering. Federally regulated web-brokers often 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.[35] 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

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[31] CBPP analysis, as of December 13, 2019.

[32] Kevin Lucia *et al.,* "Views From the Market: Insurance Brokers' Perspectives on Changes to Individual Health Insurance," Urban Institute, August 2018, https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2018/rwjf447745.

[33] Margot Sanger-Katz, "What to Know Before You Buy Short-Term Health Insurance," *New York Times*, August 1, 2018, https://www.nytimes.com/2018/08/01/upshot/buying-short-term-health-insurance-what-to-know.html.

[34] 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.

[35] 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.

rules prohibiting certain types of steering appear not to apply.[36] 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, is presumably 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.

While some marketing and steering is already occurring in Georgia under current law, it's likely to increase significantly in a wholly decentralized health insurance marketplace. In fact, creating more opportunities to market non-ACA plans alongside comprehensive insurance is an explicit goal of the waiver.[37] As discussed above, increased steering of healthier consumers to substandard plans would raise ACA plan premiums.

Privatization Could Raise Premiums Due to Reduced Competition

Georgia's waiver could also raise premiums by reducing head-to-head competition between insurers. For one, the state might be overestimating insurers' willingness and ability to perform direct enrollment functions for marketplace consumers. Entities that have opted not to offer direct enrollment today might be unable to meet the basic requirements — related to security, privacy, plan display standards, and state licensure — or are simply uninterested in assuming 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. It could also deter smaller insurers from entering Georgia's market in the future.

Likewise, requiring insurers to do all their own outreach and marketing could disadvantage certain insurers. Smaller insurers or insurers with low QHP enrollment may find themselves unable to compete with dominant insurers with greater brand recognition, a higher marketing budget, or a more generous commission structure, absent HealthCare.gov's leveling of the playing field. 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. The waiver says web-brokers will be required to show all plans, as under current federal regulations.[38] However, insurers that participate in 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, while plans that don't pay commissions may be buried at the bottom of

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[36] 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.

[37] The waiver cites one consumer impact as the ability to visit web-brokers "to view a wide range of health insurance products offered by carriers that are licensed and in good standing with the state … such as eligible non-QHPs, accident supplemental plans, critical illness plans, limited-benefit plans, short-term limited duration plans, vision, and dental" (p. 29). This would be a departure from current federal web-broker regulations, which require web-brokers to display only marketplace-eligible plans after the consumer indicates they'd like to shop for those plans.

[38] Waiver, p. 37.

the list without displaying a premium, deductible, 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 believe they can keep most of their current customers even if their premiums are considerably higher than their competitors' (because most consumers won't bother shopping across multiple enrollment platforms), then all insurers will likely set higher premiums than they otherwise would, increasing the risk of hitting the funding cap.

Transition Poses Additional Risks to Consumers

To transition away from HealthCare.gov in 2022, Georgia is proposing a daunting technology build on a tight timeline. Prior to November 1, 2021, the state must create a rules engine for the individual market subsidies, develop secure interfaces with web-brokers and insurers, develop client correspondence templates, develop a means to generate reports, and create case management functionality, in addition to expanding the capacity of the existing state systems it would rely on to determine eligibility.[39]

Despite this workload, the waiver budgets less than $20 million for the upfront transition and only $5 million for ongoing annual administrative costs, and it doesn't describe how the state would use the funds. 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.

As evidence that it can accomplish the required tasks, Georgia notes that it will leverage its "new and modern Integrated Eligibility system," Georgia Gateway. But that system has been plagued with problems, including mistakenly canceling Medicaid coverage for thousands of Georgians. In addition, at least as of 2019, the system accepted new applications for assistance only between 8 a.m. and 4 p.m., which would be a huge departure from HealthCare.gov's 24-hour availability.[40]

Failure to successfully build a robust technology system could prevent consumers from enrolling in coverage or prevent them from receiving subsidies, leading to widespread coverage losses in 2022, the first year of the new system. But even if the state stands up the new system mostly successfully, enrollment may fall as a result of the transition. Kentucky and Nevada, the two states that have transitioned to or away from HealthCare.gov in recent years, both saw enrollment declines compared to other states in the year they transitioned. Kentucky's marketplace enrollment fell 13 percent when it transitioned to the federal marketplace in 2017, compared to a national 4 percent decline that year. Nevada's enrollment fell 7 percent for the 2020 plan year after its transition to a

[39] Waiver p. 25.

[40] 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/exclusive-georgia-cutting-off-medicaid-for-000-patients/BVkxukL3aenklu1FZN93VJ/.

state-based marketplace, compared to flat enrollment nationally.[41] In Georgia, a 7 percent drop in marketplace enrollment would amount to about 25,000 people.

Challenges during transitions away from HealthCare.gov include maintaining communication with existing enrollees, conducting strong outreach to potential new consumers, and transferring account information and conducting automatic re-enrollment for existing enrollees. Each of these challenges is likely to be more severe in Georgia, where there will be no centralized system for HealthCare.gov to transfer consumer information to.

Georgia's Proposal Fails Tests for Waiver Approval

Georgia's 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 in coverage and minimal chance it would increase it. Thus, the expected effect of the waiver is to reduce coverage, failing the statutory test.

As discussed above, Georgia's waiver has a high chance of reducing coverage because of its proposals to ration subsidies based on budget targets and privatize the marketplace, making 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.

Meanwhile, Georgia's claims that the waiver would increase coverage rest on the flawed premise that its proposal is introducing important new options. But, as discussed above, neither introducing copper plans nor privatizing the marketplace would give consumers meaningful new options, and the privatization proposal would *eliminate* the option to compare plans and enroll in coverage through a neutral platform.

Affordability. The proposal to ration subsidies risks making coverage far less affordable for low- and moderate-income Georgians, who would no longer be guaranteed subsidies as they are today.

The proposal to introduce copper plans also violates the statutory affordability test for 1332 waivers, which requires that a waiver provide "coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable" as without the waiver. By the state's own analysis, thousands of people would enroll in copper plans under the waiver who would otherwise have had coverage offering them greater protection against out-of-pocket costs.

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[41] CBPP calculations from Centers for Medicare & Medicaid Services public use files and 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.

[42] This discussion refers to the Georgia Access module of Georgia's waiver. 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 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/.

Comprehensiveness. The statutory comprehensiveness test requires that a 1332 waiver provide coverage at least as comprehensive as offered by plans meeting ACA standards. But, as discussed above, Georgia's privatization proposal creates new opportunities for web-brokers and insurers to steer healthy people toward substandard plans that do not meet ACA requirements. The waiver is thus likely to 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

The Trump Administration issued guidance that attempts to weaken the statutory guardrails, in ways that are likely inconsistent with federal law.[43] But Georgia's proposal doesn't meet even these watered-down tests. Under the Administration's 1332 waiver guidance:

1. A *comparable number* of state residents 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. The waiver must not increase the *federal deficit*.[44]

Georgia's proposal to cap enrollment in subsidies violates the first of these tests. Currently, all eligible Georgians have access to subsidized health coverage. Under the proposal, by Georgia's own estimates, at most 26,000 additional people could sign up for subsidized coverage, a small subset of the more than 700,000 people Georgia estimates are eligible for subsidies and not enrolled.[45]

In addition, Georgia is seeking to waive the ACA provision that requires marketplace insurers to offer at least one gold plan (a plan with an 80 percent actuarial value) in all areas of a state where they operate.[46] Georgia's (and other states') experience with platinum plans (plans with a 90 percent actuarial value) provides a guide to what would likely happen as a result. The ACA allows, but does not require, insurers to offer platinum plans, and such plans are unavailable in 128 of Georgia's 159 counties, including most of the Atlanta metropolitan area, presumably because insurers are wary of offering generous plans that would likely attract higher-cost enrollees. Georgia's actuarial analysis assumes that insurers would continue to offer the same plans they do now, but the waiver provides

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[43] 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/.

[44] 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," November 29, 2018, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF.

[45] Waiver, pp. 24, 18.

[46] Georgia 1332 application, p. 27. The provision in question is found in section 1301(a) of the ACA, which Georgia proposes to waive in its entirety.

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 with incomes up to 100 percent of the federal poverty line who report working or engaging in work-related activities 80 hours per month would be eligible for coverage. There would be no categorical 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 didn't comply with the work requirement or missed 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.

no analysis of why insurers would continue to offer gold plans if not required to do so.[47] If gold plan offerings were reduced or eliminated, this would curtail *access* to plans with lower out-of-pocket costs, violating even the Administration's watered-down version of the affordability guardrail.

Finally, as discussed above, there is a high chance the waiver would reduce enrollment in comprehensive plans and minimal chance it would increase it. While privatization could increase the number of healthy Georgians steered to substandard plans, the additional enrollment in substandard plans is likely to come mostly at the expense of further drops in enrollment in comprehensive ACA plans. Thus, the expected effect of the waiver is to reduce coverage, even including substandard plans, failing the Administration's watered-down version of the coverage guardrail.

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 could worsen both problems. But better approaches exist that would not require the state to upend its insurance market.

[47] Waiver, p. 61. "This actuarial analysis assumes these plans [standard metal levels and catastrophic plans] will be available at the same rates they are under the baseline scenario."

First, Georgia could extend health insurance coverage to almost 500,000 people by taking up the ACA Medicaid expansion.[48] 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.[49] (See textbox, "Medicaid Waiver Falls Far Short of Expansion.")

Second, Georgia could simplify its 1332 waiver and move forward with just its proposed reinsurance program. At 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 or middle-income people with pre-existing health conditions.

[48] 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.

[49] 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. Cost estimates for the versions of the waivers submitted to the federal government are only slightly different and do not change the conclusion.

Appendix: Rationing of Subsidies Under Georgia's Proposal

In the main text, we estimate the number of Georgians who would be denied subsidies under various premium and enrollment increase scenarios. This appendix provides the details of those calculations. All estimates are for 2022, the first year of the Georgia Access Model.

Premiums, subsidies, and subsidized enrollment under the waiver. We start from the estimates provided in Georgia's actuarial analysis, excluding the enrollment increases and associated premium reductions that Georgia claims would result from the Georgia Access Model (but taking into account the premium reductions under the reinsurance program). Specifically:

- Setting aside enrollment increases attributed to the Georgia Access Model, Georgia estimates subsidized enrollment of 333,584.[50]
- Based on the 2019 average silver plan premiums and premium growth assumptions reported in the waiver, we calculate an average silver plan premium of $7,577 (taking into account the 10.2 percent reduction in premiums Georgia estimates would result from the reinsurance program).[51]
- Georgia's analysis assumes an average annualized subsidy (per subsidized enrollee) of $6,744 under the Georgia Access Model.[52] Since we do not have data on the full distribution of premiums and subsidies in Georgia's market, we make the simplifying assumption (discussed further below) that changes in average premiums translate one-for-one into changes in average subsidies. So removing the effect of the 1.9 percent premium reduction that Georgia assumes would result from the Georgia Access Model gives an average subsidy of $6,888 ($6,744 + 1.9%*$7,577).
- Subsidy costs in this baseline scenario thus total $2.297 billion ($6,888 x 333,584). This compares to costs of $2.399 billion in Georgia's baseline scenario, which assumes a 22,050 increase in subsidized enrollment and a 1.9 percent reduction in premiums.

Determining when the subsidy cap would trigger. Georgia proposes to cap its state contribution toward reinsurance and subsidies at $255 million. Of that amount, $144 million would be available for subsidies, resulting in a total subsidy budget of $2.438 billion, under Georgia's pass-through assumptions.[53] So with estimated subsidy costs of $2.297 billion, Georgia would be left with about $140 million in extra funding (roughly equal to its state contribution) to cover unanticipated discrepancies between projected and actual premiums and enrollment.

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[50] Waiver, p. 121.

[51] Specifically, based on the estimates provided in the waiver, we inflate the 2019 average silver plan premium of $7,464 (p. 2) by 2.73 percent for 2020 (p. 70) and 4.9 percent for subsequent years (p. 2), and then lower it by 10.2 percent to reflect the reinsurance program (p. 10).

[52] Waiver, p. 93.

[53] Georgia estimates that it would contribute $111 million toward the reinsurance program in 2022 (p. 10). The estimated subsidy budget equals the $2.399 billion in estimated costs under Georgia's baseline scenario, plus the $39 million in headroom under the cap under the scenario (p. 99).

Extent of rationing due to enrollment discrepancies. If Treasury underestimated subsidized enrollment absent the waiver, Georgia would receive less federal funding than expected, and so the budget cap could trigger even if the waiver itself had no effect on premiums or enrollment.

With $140 million in extra funding available, Georgia would have to ration subsidies if Treasury underestimated subsidized enrollment by about 20,000 (6.1 percent) or more.

Extent of rationing due to premium discrepancies. To determine the amount of rationing that would occur if the waiver increased premiums, or if Treasury underestimated what premiums would be absent the waiver, we compute the increase in average and total subsidies that would result from various premium increases. We then determine the excess costs that would result (compared to the $2.438 billion available in 2022) and compute the number of people who would have to be denied subsidies to meet Georgia's budget target.

For example, with a 10 percent premium increase, the average subsidy would increase by $758 (to $7,646), total subsidy costs would increase by $253 million, and excess costs would equal $112 million. With an average subsidy amount of $7,646, Georgia would have to deny subsidies to about 15,000 people ($112 million/$7,646) to remain within the budget cap. Similar calculations show that the rationing would be triggered for any premium increase exceeding 5.6 percent.

Alternative scenario. As discussed in the main text, the above calculations take as given Georgia's estimate of its federal pass-through funding (conditional on premiums and enrollment). We use the same approach to estimate rationing under a scenario in which Treasury reduces Georgia's pass-through funding by $144 million (the amount of Georgia's state contribution toward subsidies) to offset unaccounted-for federal costs.

Limitations of the analysis. There are a number of limitations that could lead to either more or less rationing than we predict for a given premium increase, although it is unlikely that these factors would change the conclusion that modest premium increases could result in significant rationing.

- As noted, we assume that premium increases would increase the average subsidy by the same amount as the average premium. While this is a simplification, in general, subsidies under the ACA increase dollar-for-dollar with increases in benchmark silver plan premiums, since the amount enrollees are required to pay is held constant. And in practice, changes in average subsidies have closely tracked changes in average premiums over the past several years.[54]
- We assume that people denied subsidies would have costs roughly equal to the average. While costs could be greater or less, there is no reason to expect they would diverge sharply from the average with subsidies rationed on a first-come, first-served basis.

[54] 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. CBPP calculations from CMS public use files.