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September 23, 2020

VIA ELECTRONIC SUBMISSION

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

The Honorable Steven Mnuchin, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Re: Georgia Section 1332 State Empowerment and Relief Waiver Application

Dear Secretaries Azar and Mnuchin:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide these comments on Georgia's Section 1332 State Empowerment and Relief Waiver Application (Georgia § 1332 Application).

NHeLP recommends that the Department of Health & Human Services (HHS) reject the Georgia § 1332 Application, because it would impose a number of unlawful conditions on coverage and access to care for the exchange and Medicaid populations. In addition, there are a number of procedural defects with Georgia's application that make it unapprovable.

I. Procedural Problems

Georgia's application suffers from several procedural defects that make it unapprovable and require the State to take specific actions before it is a proper and approvable application.

Inadequate State Comment Period

Georgia allowed only a 15-day comment period at the state level for public stakeholder input. Regulations require states to “provide a public notice and comment period sufficient to ensure a meaningful level of public input for the application for a section 1332 waiver.”¹ HHS did not set a minimum comment period in the regulation, but in the preamble stated that “[t]o the extent that a proposal is particularly wide-ranging, the proposed regulations will support a longer State public notice and comment period.”² At the same time, HHS noted that commenters to the proposed regulation had recommended comment periods “ranging from 45 to 90 days.”³ Medicaid section 1115 demonstrations have a minimum 30-day state comment period.⁴

Georgia’s 15-day comment period is woefully inadequate. Georgia is proposing to dismantle the entire system for exchange enrollment for over 400,000 individuals, replacing it with a complex matrix of insurance brokers, while at the same time allowing them to sell new types of substandard plans alongside the exchange plans, and also implementing a new and complex reinsurance program. Fifteen days is not sufficient time to provide meaningful comments in any case, but that is particularly true here as this is the type of broad proposal that HHS identified as requiring *longer* comment periods. Instead, Georgia provided a period that is half of the § 1115 comment period minimum and one-third of the low end of the recommendations from commenters to the 1332 regulations. HHS should return the application to Georgia until the State implements a state comment period for this proposal that is sufficient.

The State comment period was also insufficient because the application lacked specificity, including information required by regulation to be complete (discussed below). State commenters did not have sufficient information to provide meaningful input.

Incomplete Federal Application

Georgia’s § 1332 application is incomplete under the law for at least three reasons, and thus is not approvable.

First, federal regulations require “written evidence of the State’s compliance with the public notice requirements.”⁵ As described above, Georgia’s state comment period was insufficient.

Second, federal regulations also require that all § 1332 applications include “[a] list of the provisions of law that the State seeks to waive including a description of the reason for the

¹ 45 C.F.R. §155.1312(a)(1).

² Application, Review, and Reporting Process for Waivers for State Innovation, 77 Fed. Reg. 11700, 11706 (Feb 27, 2012) (finalizing regulations for § 1332 waiver processes, including transparency requirements).

³ *Id.*

⁴ 42 C.F.R. § 431.408(a).

⁵ 45 C.F.R. § 155.1308(f)(2).



specific request.”⁶ However, to implement its Georgia Access Model the State lists only a “partial” waiver of ACA § 1311 – a massive section that includes a wide-range of requirements.⁷ The application goes on to say that “[s]ection 1331 would be waived only to the extent that it is inconsistent with the operation of the Georgia Access Model.”⁸ With this language, Georgia’s application essentially acknowledges that the § 1311 waiver request is extremely overbroad and passes the responsibility onto the reader to determine what the State is requesting, and based on that, what provisions of law the State is ostensibly seeking to waive. However, meaningful public comment and compliance with the regulations require the State to make “specific requests” *and* provide the reasons for them.

Third, federal regulations require the application to include sufficient data, including economic and actuarial analyses, to determine whether it complies with the four statutory guardrails for § 1332 waivers.⁹ Georgia’s data and analysis in the application are wholly inadequate to make these determinations. Even where Georgia does provide calculations, they are useless. For example, the State’s analysis supporting its compliance with the “scope of coverage” requirement essentially credits the waiver for enrollment gains calculated by simply relying on the *current* enrollment trend (while at the same time ignoring numerous reasons enrollment will decrease). To allow such baseless estimating to stand for analysis would be to eviscerate the regulations.

II. Georgia’s § 1332 Application Exceeds Statutory Authority

Waiver authority under § 1332 is circumscribed to the specific provisions of law listed at 42 U.S.C. § 18052(a)(2). However, Georgia’s § 1332 application effectively seeks to waive many additional laws that cannot be waived through § 1332. For example, Georgia’s proposal ignores § 1321 of the ACA (42 U.S.C. § 18041). This provision, which is not waivable, requires HHS to set standards for exchanges and affirmatively operate a federal exchange in states that do not operate compliant exchanges. The requirement to have an exchange is reflected throughout the statute cannot be eviscerated using § 1332’s circumscribed authority. Ultimately, this is a reflection of the inappropriate nature of Georgia’s request: while Congress envisioned and created waiver authority enabling states to *innovate* in the operation of their exchanges, it did not intend or create authority for states to *entirely abandon* exchanges and the ACA unless the federal government steps in and operates the exchange. If approved, Georgia’s end run around § 1321 would do just this.

III. Georgia’s § 1332 Waiver Worsens Coverage in Violation of Statutory Guardrails

⁶ 45 C.F.R. § 155.1308(f)(3)(iii).

⁷ *Georgia Section 1332 State Empowerment and Relief Waiver Application 4* (July 31, 2020), <https://medicaid.georgia.gov/document/document/georgia1332waiverapplicationfinal07312020vfpdf/download> (hereinafter “Application”).

⁸ *Id.*

⁹ 45 C.F.R. § 155.1308(f)(3)(iv).



A. Georgia's § 1332 Waiver Will Decrease Enrollment

Section 1332 waivers are required, by statute, to “provide coverage to at least a comparable number” of state residents. Although Georgia estimates that its proposal will increase enrollment, the evidence shows it do the opposite.

Georgia's § 1332 Application Will Not Increase Enrollment

According to Georgia's analysis in its application, about 25,000 people will gain coverage, based on roughly 33,000 new people gaining coverage and only roughly 8,000 people losing coverage.

However, Georgia's assumption that 33,000 people will gain coverage is not perceivably different than the status quo. Georgia's application itself states that “[t]he baseline scenario assumes the *continued* growth and success of private sector vendors will bring in roughly 33,000 new individuals via outreach.”¹⁰ (Emphasis added) The fundamental problem with Georgia's calculation is that the State would like to credit private market vendors used under the waiver with growth in enrollment, but the State *already* uses the private vendors. In 2020 there were “at least 16 insurers and web-brokers” offering coverage in Georgia.¹¹ There is no explanation as to why or how the waiver would lead to any change. Georgia's application merely references “market incentives” – which also *already* exist.¹²

Furthermore, the trend line Georgia uses is not probative. Georgia essentially trends forward the proportion of individuals being enrolled through brokers. There is no evidence this trend will continue, much less be applicable to or continue under a new model. But more importantly, this trend is not the equivalent of an overall enrollment trend. Whether brokers are an increasing or decreasing as a subset of the total enrollment does not tell us whether total enrollment is increasing. In fact, Georgia's data may cut the other way: at the same time that the State became more reliant on brokers, overall enrollment has – by the State's admission – begun to decrease.¹³ The conclusion that more brokers will result in more enrollment is, if anything, the opposite of what the State's data shows.

Georgia's § 1332 Application Will Result in Significant Net Disenrollment

While Georgia provides no clear evidence that this waiver application will result in enrollment increases, it ignores clear evidence that there will be significant enrollment disruptions and decreases.

¹⁰ Application at 70.

¹¹ Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia's 1332 Waiver Proposal*, CENTER ON BUDGET & POLICY PRIORITIES (Sept. 1, 2020), <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>.

¹² Application at 69.

¹³ Compare growth in broker usage in recent years with reduction in FFE enrollment. Application at 70.



To begin with, the State's estimate that only about 8,000 individuals will end up losing coverage is not a good-faith estimate. Georgia purports to rely on data showing that only 2 percent of enrollees will lose coverage, "based on experience seen in other states when transitioning from the FFE."¹⁴ However, "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."¹⁵ The Center on Budget and Policy Priorities calculates that "[s]imilar percentage declines in Georgia would translate into a drop of 25,000-46,000 people in marketplace enrollment."¹⁶

Also, the 8,000/2 percent estimates derive from state transitions from a federal exchange to a state-based exchange with comparable functionality and supports, not states transitioning from a federal exchange to no exchange. In the first situation, the average consumer is not even aware of a change in who is running the enrollment call center or website, while they would not even *have* a centralized call center or website in the latter transition. The State's suggestion that only 8,000 will lose coverage is not credible.

Other reliable evidence further demonstrates the inaccuracy of the State's estimates and the significant reductions in coverage the Georgia § 1332 application would lead to. First, elimination of the FFE would require enrollees and applicants to proactively shop an unfamiliar fragmented market; this will surely lead to large failure rates. In 2020, a whopping 79 percent of Georgia enrollees (about 330,000 enrollees) chose to enroll through the FFE instead of using an option to enroll directly with plans. Georgia residents apparently *prefer* the FFE option. This also means that if just 10 percent of the FFE enrolling population failed to successfully switch enrollment methods, it would wipe out all of the unsupported enrollment gains that Georgia has predicted. As detailed earlier, Kentucky and Nevada saw 13 percent and 7 percent declines (respectively) with much simpler transitions from federal to state exchanges.

Second and even worse, disruption to the current exchange automatic re-enrollment system would directly result in large and predictable numbers of individuals being terminated. According to CMS, in 2020 in Georgia, 80,000 consumers (about 25 percent of total re-enrollment) relied on this pathway.¹⁷ This is *ten* times the number (8,000) that Georgia assumes will lose coverage. Georgia is making the untenable assumption that no more than 10 percent of the individuals who were *nonresponsive* in the long-standing one stop shop (FFE) will proactively engage in a totally new fragmented system. Evidence shows how unreasonable that assumption is. For example, a California study found that

¹⁴ Application at 70.

¹⁵ Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia's 1332 Waiver Proposal*, CENTER ON BUDGET & POLICY PRIORITIES (Sept. 1, 2020), <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>.

¹⁶ *Id.*

¹⁷ 2020 Marketplace Open Enrollment Period Public Use Files, Center for Medicaid and Medicare Services, 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>.



loss of automatic re-enrollment was associated with a 58 percent reduction in re-enrollment among the *full* population.¹⁸ This is consistent with behavioral economics research finding that, to preserve current enrollment, the “simplest evidence-based approach would be to create automatic, annual renewal of health insurance for those currently covered by ACA plans.”¹⁹

When considering these two enrollment factors, analysis from the by USC-Brookings Schaeffer Initiative for Health Policy, using conservative numbers, concludes that at least 52,000 people will lose coverage under Georgia’s § 1332 Application (this would be well over 10 percent of the exchange population).²⁰ Even if the State’s illusory 33,000-person coverage gains somehow materialized, they would be dwarfed by the coverage losses. Furthermore, all of the above factors, such as consumer confusion and technological systems problems, are particularly likely to lead to heavy enrollment losses in the first transition year. This raises an insurmountable problem for the State, as current guidance requires that § 1332 waivers must comply with the coverage guardrail “each year the waiver is in effect.”²¹

Predictions are not necessary to understand the impact of eliminating the exchange; history provides clear evidence of the result. The ACA was passed to address the long-standing enrollment problems for consumers using fragmented health insurance markets. A survey conducted before the ACA exchanges were implemented found that 43 percent of adults who shopped for insurance on the individual market had difficulty finding plans they could afford and many were denied coverage altogether because of a preexisting condition.²² Fewer than half of people who tried to buy a plan on the individual market ended up purchasing one.²³ As the ACA market rules and premium subsidies went into effect in 2014, it became easier for consumers to find and purchase health insurance. As a

¹⁸ Coleman Drake & David M. Anderson, *Association Between Having an Automatic Reenrollment Option and Reenrollment in the Health Insurance Marketplaces*, 179 JAMA Intern. Med. 1725, 1725-1726 (Sept. 23, 2019), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2751516> (attached).

¹⁹ Jonathan S. Skinner and Kevin G. Volpp, *Replacing the Affordable Care Act: Lessons From Behavioral Economics*, 317 JAMA 1951-1952 (Mar. 16, 2017), <https://jamanetwork.com/journals/jama/article-abstract/2616408> (attached).

²⁰ Christen Linke Young and Jason Levitis, *Georgia’s Latest 1332 Proposal Continues to Violate the ACA*, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY (Sept. 1, 2020), <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>.

²¹ State Relief and Empowerment Waivers, 83 Fed. Reg. 53575, 53579 (Oct. 24, 2018) (guidance setting standards for § 1332 guardrails).

²² Sara R. Collins et. al, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief*, THE COMMONWEALTH FUND (Mar. 16, 2011), <https://www.commonwealthfund.org/publications/fund-reports/2011/mar/help-horizon-how-recession-has-left-millions-workers-without>.

²³ Sara R. Collins et. al, *How the Affordable Care Act Has Improved Americans’ Ability to Buy Health Insurance on Their Own*, THE COMMONWEALTH FUND (FEB. 1, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/how-affordable-care-act-has-improved-americans-ability-buy>.



result, there was significant growth in enrollment on the individual market.²⁴ By 2016, more than two-thirds of people ended up purchasing a health plan.²⁵ Eliminating the exchanges threatens to undermine this progress.

Georgia's § 1332 Application is also likely to result in net disenrollment because it will be poorly implemented. The State has a short timeline to implement a complex system, heavily dependent on technological systems, and has underfunded that transition. The State 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," less than one year ago.²⁶ A reduction in costs of more than two-thirds is as unexplained as it is implausible. The predictable poor systems implementation in Georgia will result in many people losing coverage, as is evidenced by the fact that Georgia's "Gateway" eligibility system has already improperly led to thousands of individuals losing Medicaid coverage.²⁷

Finally, Georgia's § 1332 Application may also result in decreased enrollment due to reductions in FFE outreach and consumer assistance.²⁸

B. Georgia's § 1332 Waiver Will Decrease Comprehensiveness of Coverage

Section 1332 waivers are required, by statute, to "provide coverage that is at least as comprehensive as the coverage" provided in the Essential Health Benefits (EHB) package. Georgia's application would lead to many consumers enrolling in plans failing to meet this standard and is thus not approvable.

In eliminating a federal or state exchange, Georgia proposes to allow vendors to sell plans that are not compliant with numerous ACA requirements. Such plans may be allowed to reject or charge higher premiums to people with pre-existing conditions, charge more

²⁴ Rachel Fehr et. al, *Data Note: Changes in Enrollment in the Individual Health Insurance Market through Early 2019*, KAISER FAMILY FOUNDATION (Aug. 21, 2019), <https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/>.

²⁵ Sara R. Collins et. al, *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own*, THE COMMONWEALTH FUND (FEB. 1, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/how-affordable-care-act-has-improved-americans-ability-buy>.

²⁶ Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia's 1332 Waiver Proposal*, CENTER ON BUDGET & POLICY PRIORITIES (Sept. 1, 2020), <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>.

²⁷ 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/BVxkukL3aenklu1FZN93VJ>; 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/>.

²⁸ See *infra*, notes 40-45.



based on age, gender, or other factors, and place lifetime and annual benefit limits.²⁹ These are all serious harms to consumers.

Additionally, many non-ACA plans exclude coverage of all EHB services, in direct violation of the comprehensiveness of coverage guardrail. Georgia's proposal would allow such plans to be sold next to and instead of ACA-compliant plans.³⁰ Such a policy would violate the letter and intent of the ACA. First, Congress set a strict requirement that, as a *mandatory minimum*, exchange plans must cover the full EHB. Congress's goal was to create *one* exchange where consumers could be certain that *all* plans covered comprehensive benefits. Second, Congress went even further by explicitly requiring that any waiver flexibility under § 1332 must still comply with the comprehensive benefits requirement. Georgia's § 1332 application (like HHS's 2018 § 1332 guidance), instead, is premised on the fiction that individuals only need the *option* of a comprehensive plan under the law. But Congress's statute – both in the EHB requirement and the § 1332 comprehensiveness guardrail – leaves no room for this interpretation and makes it plain that Congress wanted to eliminate the *existence* of such plans on the exchange, not create options.

A 2018 survey of short-term plans available through two major online brokers found that 43 percent of plans did not cover mental health services, 62 percent lacked coverage for substance use disorder treatment, 71 percent did not cover outpatient prescription drugs, and none covered maternity care.³¹ Even when these services are covered in non-ACA plans, they can be severely limited. For example, four of the ten products offered by two major health insurance brokers “cover at least some substance abuse and mental health services, [but] an enrollee suffering from a dual diagnosis may only be covered for care received up to a maximum of \$3,000.”³²

The ACA was designed to solve these historic problems. For example, before the ACA, only 12 states required pregnancy-related services to be covered by individual market plans, and many health insurance plans did not include coverage for maternity care.³³ Instead, plans offered optional maternity “riders” that had to be purchased before a person

²⁹ Tara Straw, “Direct Enrollment” in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm, THE COMMONWEALTH FUND (MAR. 15, 2019),

<https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

³⁰ Application at 4.

³¹ Karen Pollitz et. al, *Understanding Short-Term Limited Duration Health Insurance*, KAISER FAMILY FOUNDATION (Apr. 23, 2010), <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

³² Karen Pollitz et. al, *Understanding Short-Term Limited Duration Health Insurance*, KAISER FAMILY FOUNDATION (Apr. 23, 2010), <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

³³ Dania Palanker et. al, *Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers*, THE COMMONWEALTH FUND (Mar. 24, 2017), <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.



became pregnant; otherwise, pregnancy would be considered a pre-existing condition.³⁴ If a person planned a pregnancy far enough in advance to purchase one of these riders, it could cost an additional \$1,000 per month, along with separate deductibles and higher cost sharing than regular insurance.³⁵ As another example, 20 percent of people enrolled in the individual market had no prescription drug coverage.³⁶

The Center on Budget and Policy Priorities notes that, “[s]hort-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. 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” – all required EHB services.³⁷ Under Georgia’s § 1332 Application, numerous types of such plans violating the EHB requirement – including short-term and indemnity plans – would be sold alongside and frequently *in replacement of* ACA-compliant plans. Many individuals (many of them unsuspecting) would end up in a non-compliant plan instead of an EHB-compliant plan, and this would violate the comprehensiveness guardrail (this would be true even for individuals who choose a noncompliant plan).

Consumers are particularly likely to end up in short-term plans because brokers receive up to ten times the compensation for short-term plans as compared to ACA-compliant plans.³⁸ One report found that 22 percent of exchange enrollees enrolled by brokers were

³⁴ Julie Rovner, *Families To Pay Price If Maternity Care Coverage Is Cut By GOP*, KAISER HEALTH NEWS (Mar. 14, 2017), <https://khn.org/news/families-to-pay-price-if-maternity-care-coverage-meets-gop-knife/>.

³⁵ *Id.*

³⁶ Dania Palanker et. al, *Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers*, THE COMMONWEALTH FUND (Mar. 24, 2017), <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

³⁷ Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia’s 1332 Waiver Proposal*, CENTER ON BUDGET & POLICY PRIORITIES (Sept. 1, 2020), <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>, citing to Dane Hansen & Gabriela Dieguez, *The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market*, MILLMAN RESEARCH REPORT (Feb. 2020), <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>; 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>. See also Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers*, CENTER ON BUDGET & POLICY PRIORITIES (September 20, 2018), <https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers>.

³⁸ 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://degette.house.gov/sites/degette.house.gov/files/STLDI%20Report%2006%2025%2020%20FINAL_.pdf.



offered plans that are not ACA-compliant.³⁹ Evidence shows that brokers often provide consumers with unclear or false information about what short-term plans actually cover or exclude from coverage, and they engage in marketing tactics to pressure consumers to purchase plans without providing written information about the benefits covered, among other things.⁴⁰ This will result in consumers lacking needed coverage – a fact even brokers acknowledge. In one report, brokers raised concerns about selling short-term plans that may, for example, leave an individual without adequate coverage if they develop cancer.⁴¹

At the same time that consumers may get false information from brokers under Georgia's § 1332 Application, they may go without the valuable and *unbiased* consumer assistance provided by the exchange. By law, exchanges must establish Navigator programs that work year-round to help consumers apply for coverage and financial assistance through the marketplace. About 20 percent of enrollees (including exchange and Medicaid applicants) who actively sought coverage got help in 2020, and 20 percent of those who did not get help had gotten help when they first signed up.⁴² Consumers who got help reported that they needed help to understand their options and various steps of the process.⁴³ Forty percent of the consumers who got help said they would not have gotten coverage without assistance.⁴⁴ Under Georgia's model many consumers will end up without coverage, or in plans that do not meet their needs, because they will not have the same high-quality assistance. Evidence shows there is a meaningful difference between Navigators and brokers. Navigators tend to be more trained and more likely to help

³⁹ 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/>.

⁴⁰ 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*, 29 (June 2020), https://degette.house.gov/sites/degette.house.gov/files/STLID1%20Report%2006%2025%2020%20FINAL_.pdf; Sabrina Corlette *et al.*, *The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses*, URBAN INSTITUTE (Jan. 31, 2019), <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>; Christen Linke Young and Kathleen Hannick, *Misleading Marketing of Short-Term Health Plans Amid COVID-19*, BROOKINGS INSTITUTION (Mar. 24, 2020), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

⁴¹ Sabrina Corlette *et al.*, *Perspective from Brokers: The Individual Market Stabilizes While Short-Term and Other Alternative Products Pose Risks*, URBAN INSTITUTE, 10 (Apr. 2020), <https://www.urban.org/research/publication/perspective-brokers-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks>.

⁴² 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/>.

⁴³ *Id.*

⁴⁴ *Id.*



consumers with complex applications, while brokers are *less* likely to help consumers who are uninsured, need help in another language, or apply for Medicaid.⁴⁵

C. Georgia’s § 1332 Waiver Will Decrease Affordability of Coverage

Section 1332 waivers are required by statute to “provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable” as the ACA normally requires. Georgia’s application would lead to many consumers enrolling in plans that result in increases in costs and cannot be approved under the law.

The cost of health care and health insurance are complex topics that most consumers are ill-positioned to understand. One of the reasons that the ACA standardized minimum benefits and affordability protections was to protect consumers from being duped into low-value plans. Consumers are at risk for enrollment into plans that do not cover all of the services they need or plans which appear to have a low costs (such as a low premium), but in fact wind up being expensive when deductibles, cost-sharing, and copays are factored in.

While some consumers may end up in a cheaper plan through Georgia’s § 1332 Application (*i.e.*, a lower premium plan), there are at least three reasons that many consumers will end up with less affordable coverage – a result prohibited by the comparable affordability guardrail.

First, many consumers will pay a low premium for a “junk” plan, but then end up paying large deductibles, cost-sharing, copays, or run into maximum coverage limits. Relative to the coverage minimums required by the ACA, these consumers will save a small amount on their premiums, but get gouged on the overall cost of coverage. For example, analysis of a short-term plan in Pennsylvania found that although the plan premium seemed cheap (about \$128 a month), the plan could cover \$0 for an average hospitalization – leaving the enrollee with a bill over \$25,000.⁴⁶ Other consumers may enroll in low deductible plans, even if the plans are designed to always lead to higher out of pocket spending.⁴⁷ Another study found that in the six-month period following diagnosis, a newly diagnosed lymphoma patient enrolled in a short-term plan could pay \$16,800 more in out-of-pocket expenses than they would pay while enrolled in an ACA plan.⁴⁸

⁴⁵ 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/>.

⁴⁶ Jackson Williams, *Short-Term Health Insurance Coverage is Almost Worthless*, PHILADELPHIA INQUIRER (July 30, 2018), <https://www.inquirer.com/philly/health/health-cents/short-term-health-insurance-coverage-is-almost-worthless-20180730.html>.

⁴⁷ Richard H. Thaler, *Why So Many People Choose the Wrong Health Plans*, N.Y. TIMES (Nov. 4, 2017), <https://www.nytimes.com/2017/11/04/business/why-choose-wrong-health-plan.html>.

⁴⁸ Dane Hansen & Gabriela Dieguez, *The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market*, MILLMAN RESEARCH REPORT (Feb. 2020), <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>.



Second, many consumers will end up in a low premium plan that does not cover essential health benefits that they need and that are *required* by the ACA. Consider the example of a young woman needing maternity care or mental health services that enrolls in a short-term plan that does not cover either of these services. She will “save” some money on her premiums, but spend far more paying out of pocket for childbirth or a mental health crisis.

The junk value of these plans is confirmed by medical loss ratio data. The average short-term plan in 2017 spent less than 65 percent of premium dollars on patient care, compared to at least 80 percent for qualified health plans.⁴⁹ The three largest short-term plans spent even less, at 44, 34, and 52 percent.⁵⁰ HHS should not further open the door to such wasteful, low-value health insurance.

Third, there are in fact reasons to believe that premiums themselves will increase under Georgia's § 1332 Application. As many individuals transition into plans that are not compliant with the ACA, there will be a smaller pool of individuals in the ACA-compliant plans, meaning premiums will increase. The individuals who qualify for short-term plans, and are willing to enroll in such plans, will be healthier on average, leaving a riskier and more expensive pool in the ACA-compliant plans, also increasing premiums.⁵¹ As noted earlier, brokers have strong incentives to steer enrollees towards short-term plans.⁵² Individuals choosing the same ACA-compliant plans will have less affordable coverage. Georgia also fails to adequately consider several other factors that could increase premiums, such as the large increase in broker commissions in the proposed model as consumers transition into the model.⁵³

In short, there is no reasonable way for HHS and Treasury to conclude that Georgia's § 1332 application will comply with the statutory affordability guardrail that prohibits a § 1332 that decreases affordability. As discussed earlier, this violation is not cured by the fact that consumers have the *option* of choosing an ACA-compliant plan. Congress, in the ACA

⁴⁹ Katie Keith, *The Short-Term, Limited-Duration Coverage Final Rule: The Background, The Content, And What Could Come Next*, HEALTH AFFAIRS BLOG (Aug. 1, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180801.169759/full/>.

⁵⁰ Katie Keith, *The Short-Term, Limited-Duration Coverage Final Rule: The Background, The Content, And What Could Come Next*, HEALTH AFFAIRS BLOG (Aug. 1, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180801.169759/full/>.

⁵¹ Dane Hansen & Gabriela Dieguez, *The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market*, MILLMAN RESEARCH REPORT (Feb. 2020), <https://www.lls.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>.

⁵² 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*, 29 (June 2020), https://degette.house.gov/sites/degette.house.gov/files/STLDI%20Report%2006%2025%2020%20FINAL_.pdf.

⁵³ Christen Linke Young and Jason Levis, *Georgia's Latest 1332 Proposal Continues to Violate the ACA*, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY (Sept. 1, 2020), <https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/>.



provisions on affordability *and* in the § 1332 guardrails, established and bulletproofed a legal minimum.

IV. Georgia’s § 1332 Application Violates Medicaid Law and Would Decrease Medicaid Enrollment

Section 1332 does not authorize waivers of the Medicaid Act. However, Georgia’s § 1332 Application would require waiver of numerous Medicaid provisions.⁵⁴ For example, Georgia’s § 1332 Application ignores Medicaid “no wrong door” requirements operating between Medicaid and exchanges. Georgia cannot waive these and other policies through § 1332, and as such this application is not sufficient to implement the policies requested.

CMS also should not approve Georgia’s § 1332 Application because it will result in large reductions in Medicaid enrollment. This is because the exchange eligibility system is an important vehicle for Medicaid applications in Georgia. About 38,000 Medicaid enrollees came through healthcare.gov in 2020.⁵⁵

In contrast, evidence shows that brokers do not faithfully enroll clients in Medicaid. For example, data shows that, “[f]ourteen percent of marketplace enrollees overall reported receiving assistance from brokers compared to just 2% of Medicaid enrollees,” but “[n]avigators helped consumers at about the same rate whether they were uninsured or enrolling in marketplace coverage or Medicaid.”⁵⁶

This is not a surprising outcome given that brokers receive commissions for private plan enrollments but generally do not for Medicaid enrollments.⁵⁷ One report found numerous instances of broker eligibility systems failing to notify individuals that they or their family members were eligible for Medicaid and instead diverted them to private plans, including plans that are not ACA-complaint, or even relied on a deceptive practice to trick consumers.⁵⁸ Analysis from the Center on Budget and Policy Priorities finds that “a search

⁵⁴ See 42 U.S.C. § 1396w-3 and 42 C.F.R. § 435.1200.

⁵⁵ 2020 Marketplace Open Enrollment Period Public Use Files, Center for Medicaid and Medicare Services, 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>.

⁵⁶ 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/>.

⁵⁷ Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia’s 1332 Waiver Proposal*, CENTER ON BUDGET & POLICY PRIORITIES (Sept. 1, 2020), <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>.

⁵⁸ Tara Straw, *“Direct Enrollment” in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm*, THE COMMONWEALTH FUND (MAR. 15, 2019), <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>. See also Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia’s 1332 Waiver Proposal*, CENTER ON BUDGET & POLICY PRIORITIES, note 14 (Sept. 1, 2020), <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>.



on HealthCare.gov displays more than 1,100 agents and brokers that enroll people in individual or family coverage in one Atlanta ZIP code but zero agents and brokers that say they'll assist with Medicaid or CHIP enrollment.”⁵⁹ CMS should not approve this section § 1332 waiver as the evidence shows it will reduce Medicaid enrollment.

V. Reduced Coverage Under Georgia’s Proposal Will Result in Serious Harms

As described above, Georgia’s § 1332 Application will result in increased uninsurance, reduced access to EHB and Medicaid services, and reduced affordability protections – all problems that the ACA was designed to solve. By proposing to eliminate the exchange, Georgia wants to turn back the clock to a time when consumers faced significant harms associated with a lack of affordable, comprehensive, and streamlined coverage.

Georgians Who End Up Uninsured Will Be Harmed

As the number of uninsured individuals and families rises, more Georgians will face the adverse health and financial consequences associated with going uninsured. Those without insurance frequently face medical debt or forgo necessary medical care.⁶⁰ One study found that uninsured adults with low and moderate incomes were much less likely to have a regular source of health care than people with similar incomes who were insured.⁶¹ And the consequences can be dire. Prior to the ACA, in 2010 alone, more than 25,000 non-elderly adults died prematurely due to a lack of health coverage.⁶²

Georgians Who Are Denied Comprehensive Coverage Will Be Harmed

Georgia’s § 1332 Application explicitly undermines the ACA’s EHB standard by unleashing authority and incentives for individuals to be enrolled in plans that are not ACA-compliant. Before the ACA’s requirement that health plans in the individual and small-group market cover essential health benefits, many people faced barriers to obtaining comprehensive health insurance. Insurers aggressively marketed other limited forms of coverage at

⁵⁹ Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia’s 1332 Waiver Proposal*, CENTER ON BUDGET & POLICY PRIORITIES (Sept. 1, 2020), <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>.

⁶⁰ Families USA, *Dying for Coverage: The Deadly Consequences of Being Uninsured* (Jun. 2012), <https://familiesusa.org/wp-content/uploads/2019/09/Dying-for-Coverage.pdf>.

⁶¹ Sara R. Collins et. al, *The Income Divide in Health Care: How the Affordable Care Act Will Help Restore Fairness to the U.S. Health System*, THE COMMONWEALTH FUND (Feb. 7, 2012), <https://www.commonwealthfund.org/publications/issue-briefs/2012/feb/income-divide-health-care-how-affordable-care-act-will-help>.

⁶² Kim Bailey, *Dying for Coverage: The Deadly Consequences of Being Uninsured*, FAMILIES USA (Jun. 2012), <https://familiesusa.org/wp-content/uploads/2019/09/Dying-for-Coverage.pdf>.



discount prices.⁶³ However, these plans often left consumers exposed to high out-of-pocket costs and uncovered treatments.⁶⁴

Before the Affordable Care Act went into effect, in 2010, 43 percent of people buying plans on their own said they found it very difficult or impossible to find the coverage they needed.⁶⁵ Among those with health problems, 53 percent reported difficulty finding a plan that met their needs.⁶⁶ Furthermore, prior to the ACA, 62 percent of individual market plans lacked maternity coverage, 34 percent lacked coverage for substance use disorder, 18 percent lacked mental health services, and 9 percent did not cover prescription drugs.⁶⁷ As a result, one in five people enrolled in the individual market had no prescription drug coverage and six in ten people had no maternity benefits.⁶⁸

Without comprehensive coverage of necessary services, individuals will face negative health outcomes and financial harm. For example, prenatal, labor and delivery, and postpartum care can help address the considerable risks associated with having a child, including hemorrhaging, high blood pressure, blood clots, gestational diabetes, and postpartum depression.⁶⁹ At the same time, prenatal and postpartum care can be cost-prohibitive without maternity coverage; without insurance, the total price charged for pregnancy and newborn care can cost between \$30,000 and \$50,000.⁷⁰ Thus, if a pregnant person's health plan excludes maternity care, they could be cut off from the array of beneficial prenatal and postpartum services.⁷¹ Some individuals will suffer harm forgoing care. Others will suffer financial harm, some by going deep in debt for services that would have been covered in an ACA-compliant plan, while a lucky few with resources will also suffer harm by paying out of pocket for those same services that should have

⁶³ Dania Palanker et. al, *Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers*, THE COMMONWEALTH FUND (Mar. 24, 2017), <https://www.commonwealthfund.org/blog/2017/eliminating-essential-health-benefits-will-shift-financial-risk-back-consumers>.

⁶⁴ *Id.*

⁶⁵ Sara R. Collins et. al, *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own*, THE COMMONWEALTH FUND (Feb. 1, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/how-affordable-care-act-has-improved-americans-ability-buy>

⁶⁶ *Id.*

⁶⁷ Timothy Jost, *Essential Health Benefits: What Could Their Elimination Mean*, HEALTH AFFAIRS BLOG (Mar. 23, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170323.059343/full/>.

⁶⁸ Dania Palanker et. al, *Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers*, THE COMMONWEALTH FUND (Mar. 24, 2017), <https://www.commonwealthfund.org/blog/2017/eliminating-essential-health-benefits-will-shift-financial-risk-back-consumers>.

⁶⁹ Adam Sonfield, *No One Benefits If Women Lose Coverage for Maternity Care*, GUTTMACHER INSTITUTE (Jun. 14, 2017), <https://www.guttmacher.org/gpr/2017/06/no-one-benefits-if-women-lose-coverage-maternity-care>.

⁷⁰ Julie Rovner, *Families To Pay Price If Maternity Care Coverage Is Cut By GOP*, Kaiser Health News (Mar. 17, 2017), <https://khn.org/news/families-to-pay-price-if-maternity-care-coverage-meets-gop-knife/>.

⁷¹ Adam Sonfield, *No One Benefits If Women Lose Coverage for Maternity Care*, GUTTMACHER INSTITUTE (Jun. 14, 2017), <https://www.guttmacher.org/gpr/2017/06/no-one-benefits-if-women-lose-coverage-maternity-care>.



been covered. In one report, even brokers raised concerns about selling Non-ACA plans that may, for example, leave an individual without adequate coverage if they develop cancer.⁷²

Georgians Who Lose Affordability Protections Will Be Harmed

Georgia's § 1332 Application also explicitly undermines the ACA's affordability standards by unleashing authority and incentives for individuals to be enrolled in plans that are not ACA-compliant. These plans often lure consumers with a low sticker-price, but have high-cost features such as high cost-sharing or deductibles that make the plans less affordable. Countless studies demonstrate the harm to lower-income consumers faced with cost-sharing and other affordability barriers.⁷³

As more Georgians become uninsured and underinsured, they will face negative consequences due to increased costs. In 2017, nonelderly uninsured adults were over twice as likely as those with insurance to have trouble paying medical bills.⁷⁴ As a result, uninsured adults are more likely to use up savings, have difficulty paying for necessities, borrow money, or have medical bills sent to collection.⁷⁵

Georgians who switch to a less comprehensive health plan will also be at risk for financial burdens due to high out-of-pocket costs. In fact, one study found that more than half of low-income individuals and over one-third of those with chronic conditions faced excessive financial burdens after switching from traditional coverage to high-deductible plans.⁷⁶

Conclusion

NHeLP recommends that the Departments of Treasury and Health and Human Services reject Georgia's § 1332 application because it has serious procedural flaws, violates statutory requirements for § 1332 waivers, exchanges, and Medicaid, and would result in serious harms to exchange and Medicaid enrollees.

⁷² Sabrina Corlette *et al.*, *Perspective from Brokers: The Individual Market Stabilizes While Short-Term and Other Alternative Products Pose Risks*, URBAN INSTITUTE, 10 (Apr. 2020), <https://www.urban.org/research/publication/perspective-brokers-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks>.

⁷³ David Machledt & Jane Perkins, *Medicaid Premiums and Cost Sharing*, NAT'L HEALTH LAW PROGRAM, 2-14 (Mar. 26, 2014), <https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/>.

⁷⁴ Rachel Garfield *et al.*, *The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act*, KAISER FAMILY FOUNDATION (Jan. 25, 2019), <https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-what-are-the-financial-implications-of-lacking-insu/>.

⁷⁵ *Id.*

⁷⁶ Emily Gersema, *High-Deductible Health Plans Raise Risk of Financial Ruin For Vulnerable Americans, Study Finds*, USC NEWS (Apr. 5, 2018), <https://news.usc.edu/140182/high-deductible-health-plans-raise-risk-of-financial-ruin-for-vulnerable-americans-study-finds/>.



We have included numerous citations to supporting research, including direct links to the research. We direct Treasury and HHS to each of the studies we have cited and made available through active links, and we request that the full text of each of the studies cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If Treasury and HHS are not planning to consider these citations part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies into the record.

We appreciate your consideration of our comments. If you have questions about these comments, please contact Leonardo Cuello (cuello@healthlaw.org) or me (perkins@healthlaw.org).

Sincerely,

A handwritten signature in cursive script that reads "Jane Perkins". The signature is written in black ink on a light-colored background.

Jane Perkins
Legal Director



Administrative, technical, or material support: Applebaum, Kneifati-Hayek, Carter, Adelman.

Supervision: Salmasian, Adelman.

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- Adelman JS, Berger MA, Rai A, et al. A national survey assessing the number of records allowed open in electronic health records at hospitals and ambulatory sites. *J Am Med Inform Assoc*. 2017;24(5):992-995. doi:10.1093/jamia/ocx034
- Office of the National Coordinator for Health Information Technology. Patient Identification SAFER Guide, 2016; http://www.healthit.gov/sites/default/files/safer/guides/safer_patient_identification.pdf. Published September 2016. Accessed February 24, 2017.
- Joint Commission. Safe use of health information technology. Sentinel Event Alert, Issue 54 2015; http://www.jointcommission.org/assets/1/18/SEA_54.pdf. Accessed July 27, 2018.
- Adelman JS, Applebaum JR, Schechter CB, et al. Effect of restriction of the number of concurrently open records in an electronic health record on wrong-patient order errors: a randomized clinical trial. *JAMA*. 2019;321(18):1780-1787. doi:10.1001/jama.2019.3698
- Zhang J, Walji MF. TURF: toward a unified framework of EHR usability. *J Biomed Inform*. 2011;44(6):1056-1067. doi:10.1016/j.jbi.2011.08.005
- Wachter RM, Murray SG, Adler-Milstein J. Restricting the number of open patient records in the electronic health record: is the record half open or half closed? *JAMA*. 2019;321(18):1771-1773. doi:10.1001/jama.2019.3835

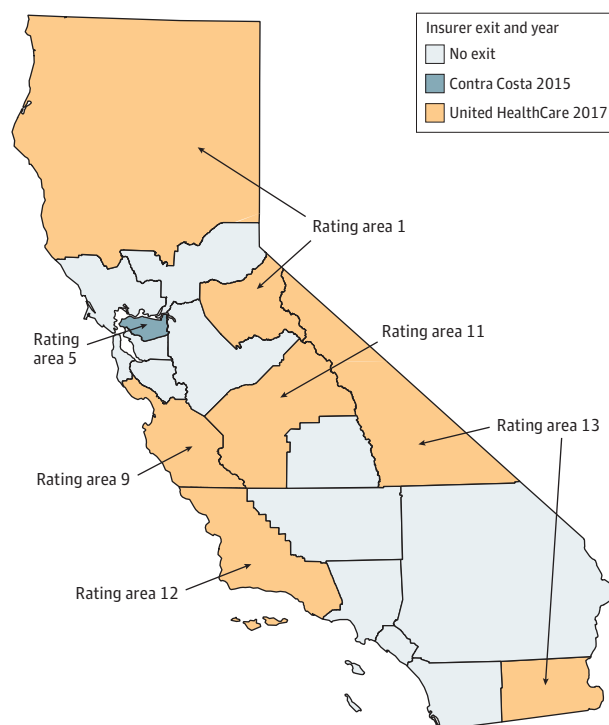
Association Between Having an Automatic Reenrollment Option and Reenrollment in the Health Insurance Marketplaces

Of the 11.4 million US health insurance marketplace enrollees in 2019, 3.4 million were automatically reenrolled based on their marketplace coverage in 2018.¹ Marketplace enrollees are automatically reenrolled in their current health plan the following year unless they actively change their enrollment status by discontinuing their coverage or selecting a new plan. Enrollees who actively select a plan have been reported to make better plan choices²; however, requiring enrollees to make a plan selection each year may be associated with their becoming uninsured.³ In January 2019, the Centers for Medicare & Medicaid Services requested public comments on eliminating automatic reenrollment for marketplace enrollees.⁴ While evidence suggests that administrative barriers to reenrollment are associated with reductions in Medicaid coverage,⁵ it is unknown whether elimination of automatic reenrollment is associated with decreases in reenrollment in the marketplaces.

Methods | We obtained 2014-2017 individual enrollment data from California's marketplace, Covered California, through a public records act request.⁶ These data identify whether households had the option to automatically reenroll in Covered California. Households enrolled as of December 31 in a given year were able to automatically reenroll in their plan or a similar plan in the following year unless their insurer exited Covered California. Two insurers exited Covered California during the study period. Contra Costa exited Contra Costa County in 2015. United HealthCare exited other counties in 2017 (Figure). These exits divided Covered California households into groups that could automatically reenroll and groups that could not automatically reenroll. Our sample consists of 123 244 households in geographic areas and years that experienced insurer exit (rating area 5 in 2015; rating areas 1, 9, and 11-13 in 2017). This study was deemed exempt from review and approval by the University of Pittsburgh institutional review board.

We used multivariate linear regression to examine the association between household reenrollment and whether the household could automatically reenroll and adjusted for household characteristics, including the age of the oldest household member, household size, whether the household received a premium tax credit subsidy, the postsubsidy premium of the lowest-cost available plan, and indicators for geographic areas and years. We clustered SEs by geographic areas using the wild cluster bootstrap method to address the small

Figure. Covered California Rating Areas Where Households Lost the Option to Automatically Reenroll Because of Insurer Exit



Covered California is divided into 19 separate rating areas in which several insurers offer health plans.

Table. Differences in Reenrollment Among Covered California Households With and Without an Automatic Reenrollment Option^a

Status	Automatic Reenrollment Option, % ^b		Difference (95% CI)	P Value
	Yes (n = 122 463)	No (n = 781)		
Unadjusted	51.2	21.4	29.8 (14.2-46.8)	<.001
Adjusted ^c	51.2	21.5	29.9 (9.4-52.0)	<.001

^a Data are from 2014-2017 Covered California enrollment records. Observations are households in rating areas that experienced insurer exits.

^b Households had the option to automatically reenroll in Covered California if they retained their coverage as of December 31 and their insurer did not exit Covered California. Households that discontinued their coverage are not included in the sample.

^c Adjusted reenrollment percentages were estimated using a multivariate linear

regression (ie, a linear probability model) adjusting for the age of the oldest household member, the postsubsidy premium of the lowest cost plan available to the household, household size, whether the household received a premium tax credit subsidy, the rating area in which the household resides, and year. The SEs were clustered at the rating area level. We used the wild cluster bootstrap method to address the small number of clusters (ie, 6 rating areas).

number of clusters. Analyses were conducted in Stata SE 15 statistical package (StataCorp LLC). Statistical significance was defined as a 2-sided $P < .05$.

Results | Of the 781 households (0.63%) that could not automatically reenroll in Covered California because of insurer exit, unadjusted and adjusted reenrollment rates were 21.4% and 21.5%, respectively (Table). Both the unadjusted and adjusted reenrollment rates among the 122 463 households with the option to automatically reenroll were 51.2%. Losing the option to automatically reenroll was associated with a 30-percentage point decrease in enrollment both with adjusting for household characteristics (95% CI, 9.4%-52.0%; $P < .001$) and without (95% CI, 14.2%-46.8%; $P < .001$).

Discussion | Elimination of automatic reenrollment would likely be associated with decreases in the number of enrollees who remain insured through the marketplaces. As an opt-out policy³ similar to that used in other health insurance markets such as Medicaid,² automatic reenrollment may be associated with increases in continuity of coverage in the marketplaces by reducing administrative barriers to reenrollment.

Although we found losing an automatic reenrollment option was associated with decreases in reenrollment, this association requires further study. The group that lost the automatic reenrollment option was relatively small. Households with different demographics or different experiences with insurers may have behaved differently if they had lost the option to automatically reenroll. Losing automatic reenrollment because of policy changes rather than insurer exit also may be associated with households behaving differently. Given the magnitude of our findings, it is critical that future studies continue investigating the association between automatic reenrollment and continuity of coverage.

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Drafting of the manuscript: Both authors.

Critical revision of the manuscript for important intellectual content: Both authors.

Statistical analysis: Drake.

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1. Centers for Medicare & Medicaid Services. Health insurance exchanges 2019 open enrollment report. cms.gov. <https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2019-open-enrollment-report>. Published 2019. Accessed March 26, 2019.

2. Handel B, Kolstad J. Getting the most from marketplaces: smart policies on health insurance choice. http://www.hamiltonproject.org/assets/files/smart_policies_on_health_insurance_choice_final_brief.pdf. Published 2015. Accessed March 26, 2019.

3. Skinner JS, Volpp KG. Replacing the affordable care act: lessons from behavioral economics. *JAMA*. 2017;317(19):1951-1952. doi:10.1001/jama.2017.4084

4. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020. *Fed Regist*. 2019;84(16):227-313.

5. Sommers BD, Goldman AL, Blendon RJ, Orav EJ, Epstein AM. Medicaid work requirements: results from the first year in Arkansas. [published online June 19, 2019]. *N Engl J Med*. 2019. doi:10.1056/NEJMs1901772

6. Guidelines for getting individual-level data through a public records act (PRA) are here: <https://www.coveredca.com/public-records-act-guidelines/>. Accessed October 1, 2018.

Gender Differences in Twitter Use and Influence Among Health Policy and Health Services Researchers

Ample research has documented the lower visibility and success of women compared with men in academic medicine. Against this setting, social media platforms such as Twitter offer academics opportunities to promote their research, network professionally, gain visibility, and, in turn, foster opportunities for career advancement.¹ These opportunities are particularly critical in health policy and health services research, in which dissemination of policy-relevant research and engagement with health care decision-makers impacts academic influence, recognition, and promotion. Herein, we describe gender differences in Twitter use and influence among health services researchers.

VIEWPOINT

Replacing the Affordable Care Act Lessons From Behavioral Economics

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Republican efforts to replace the Affordable Care Act (ACA) are not over, despite the failure of the American Health Care Act (AHCA) legislation. The major challenge facing the AHCA was the loss of insurance coverage for an estimated 24 million people.¹ Any subsequent reform, especially those less costly than the ACA, will have the same challenge of keeping currently insured individuals and households from discontinuing their insurance. In this Viewpoint, we draw on behavioral economics to propose 4 general principles for health insurance reform to help ensure that the currently insured will not lose their coverage.

Incentives for Healthy Individuals

In insurance markets, healthy people subsidize people with acute and chronic disease and other health conditions. Insurance is still valuable for healthy people, because they need not be concerned about the risk of no insurance coverage in the event of unexpected injuries or acute health events. However, there is often a tendency to minimize those future risks and use the money now for more pressing concerns rather than signing up

response as \$1 in penalties.² Furthermore, subsidies drain money from the federal treasury, whereas sticks bring in more revenue.

A second behavioral economics principle involves instant gratification; paying significant premiums means that something is received in return. Bare-bones or catastrophic plans, along with health savings accounts, do not do well from the perspective of instant gratification. Aside from the relatively few families who benefit from receiving catastrophic care, the vast majority of people do not experience any “immediate gratification” from paying those premiums, because they never reach the catastrophic cap. Even current enrollees in bronze high-deductible plans wonder why, after paying substantial premiums, they still are responsible for burdensome deductibles and co-pays.

People’s tendency to focus on immediate gratification also has important implications for the continuous coverage requirement in the AHCA. This requirement is a stick but is unlikely to work. Under this provision, if an individual who did not purchase insurance coverage now or who lets current insurance coverage lapse, would have been subject to a 30% penalty to sign up again. It is unlikely that young invincibles, young healthy people who see themselves as invulnerable who have been ignoring health insurance up until now, will suddenly become concerned about their ability to buy insurance many years down the road. Furthermore, the 30% stick would have discouraged uninsured people from buying insurance—precisely the opposite effect of the mandate.

The third principle is to use inertia to maintain enrollments. The simplest evidence-based approach would be to create automatic, annual renewal of health insurance for those currently covered by ACA plans, with the out-of-pocket premiums close to what they paid last year. People could opt out of the system but then would lose both the subsidy and their existing health insurance coverage. The bias toward holding on to a plan, combined with inertia and the sense of loss from giving up those federal subsidies, could work toward keeping people enrolled.²

The biggest challenge is a factor that even inertia cannot solve—that any proposal leading to higher out-of-pocket premium payments, especially among low-income and older people nearing retirement, can potentially lead to substantial disenrollment. Even for this seemingly intractable problem, behavioral economics can still provide some guidance.

Health insurance is an 80-20 proposition; 20% of enrollees account for 80% of costs. If the least healthy

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for expensive insurance. Once enough healthy people no longer elect to enroll in and purchase health insurance, a major challenge occurs, with rising premiums and the eventual collapse of insurance markets.

Incentives to encourage healthy individuals to sign up for health insurance can be described as either carrots or sticks. The ACA has both carrots (refundable tax credits) and a stick—the mandate—to ensure that healthy persons purchase insurance. Granted, the stick was not always effective; initially the amount was too small, and the penalty is too far in the future. But it was widely credited with increasing enrollment by overcoming “present bias,” the idea that potential future medical costs are discounted too much when compared with having to write a check for insurance premiums today. By contrast, current proposals rely almost entirely on carrots—tax credits for enrollees.

Behavioral Economics Principles

The first principle from behavioral economics research is that carrots do not work nearly as well as sticks; \$2 in subsidies induces approximately the same behavioral-

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patients can be moved off of the exchanges, this will allow for a substantial decline in premiums on the exchange for the 80% healthier people who remain. With inertia and automatic reenrollment, millions of individuals would likely be motivated to stay with their plans, despite shrinking subsidies. Congressional reformers understand this and have recommended moving high-cost patients into separate high-risk pools, but early experience with these pools has demonstrated their limitations that without a dedicated revenue source, they are perpetually underfunded.

So what can be done? The fourth principle relies on the salience of taxation—creating new taxes to pay for health insurance subsidies is far more painful politically and economically than simply shifting high-cost enrollees into an existing insurance plan that already enjoys wide political support.³ Most individuals with Social Security Disability Insurance (SSDI) already receive coverage under the Medicare program. The chronically ill individuals currently enrolled through the health insurance exchanges could be shifted into Medicare. There is already a mechanism for people older than 65 years who do not have Social Security to sign up for Medicare; the current price of enrolling is \$413 per month for Part A (hospital) cov-

erage, and \$134 for Part B coverage (for incomes under \$84 000). Combined with the currently proposed tax credits, out-of-pocket premiums could actually decline for many older people.

While placing additional pressures on the Medicare Trust Fund, this idea would yield a further cost-saving bonus for enrollees and the federal government: Because inpatient private insurance reimbursements are 75% higher than Medicare reimbursements,⁴ the overall health care spending would immediately decline. Most importantly, insurance premiums for everyone else also would decline immediately as the most expensive chronically ill patients are moved off private plans and into Medicare.

Conclusions

The behavioral economics approach cannot solve all of the problems facing US health care. But behavioral principles can inform approaches to help ensure that insurance markets do not unravel, which is the first and most important challenge of any “repeal and replace” efforts. Coupled with other approaches to reduce costs, behavioral reform could provide some needed optimism for 2017: Lower health insurance premiums for the first time in recent memory.

ARTICLE INFORMATION

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REFERENCES

1. Kahneman D, Tversky A. Prospect theory: an analysis of decision under risk. *Econometrica*. 1979; 47(2):263-292.
2. Madrian BCM, Shea DF. The power of suggestion: inertia in 401(k) participation and savings behavior. *Q J Econ*. 2001;66(4):1149-1187.

3. Chetty R, Looney A, Kroft K. Saliency and taxation: theory and evidence. *Am Econ Rev*. 2009; 99(4):1145-1177.

4. Selden TM, Karaca Z, Keenan P, White C, Kronick R. The growing difference between public and private payment rates for inpatient hospital care. *Health Aff (Millwood)*. 2015;34(12):2147-2150.