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Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Room 120F  
Washington, DC 20201

Secretary Janet Yellen  
Department of the Treasury  
1500 Pennsylvania Avenue NW  
Room 3330  
Washington, DC 20220

Administrator Chiquita Brooks-LaSure  
Centers for Medicare & Medicaid Services  
200 Independence Avenue SW  
Washington, DC 20201

Re: Request for Comment on the Georgia Access Model

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

Thank you for the invitation to comment on the Georgia Access Model.<sup>1</sup> The Georgia Access Model is a component of a Section 1332 waiver submitted by the state of Georgia that would change how people enroll in health insurance in Georgia.<sup>2</sup> The model would eliminate the use of the HealthCare.gov enrollment platform in Georgia and the associated federal outreach activities. Instead, enrollment in individual-market plans would occur exclusively through private insurer agents and brokers, and Medicaid enrollment would occur exclusively through the state.

The comment solicitation from the Department of Health and Human Services and the Department of the Treasury (henceforth “the departments”) asks whether developments since the departments approved Georgia’s Section 1332 waiver should change the departments’ assessment of whether the Georgia Access Model meets the statutory requirements for Section 1332 waivers, including the requirement that waivers cannot reduce the number of people with insurance coverage.<sup>3</sup> The departments asked specifically about

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<sup>1</sup> The views expressed in this letter are our own and do not necessarily reflect the views of the Brookings Institution, the Urban Institute, their funders, or anyone affiliated with either organization other than ourselves.

<sup>2</sup> Georgia’s waiver also established a reinsurance program in Georgia starting in 2022. Throughout, we focus exclusively on the Georgia Access Model, as the departments’ comment solicitation indicates this is the only part of the waiver they are currently reevaluating.

<sup>3</sup> “Request for Comment on the Georgia Access Model,” Department of Health and Human Services and Department of the Treasury, November 9, 2021, <https://www.cms.gov/files/document/1332-ga-access-public-comment-request.pdf>.

changes in federal law and policy and newly available evidence or experience that would influence assessments of how various factors affect enrollment in health insurance coverage.

In this letter, we discuss two developments since approval of Georgia's waiver in November 2020 that have increased the likelihood that the Georgia Access Model will reduce coverage:

- During 2021, the Centers for Medicare & Medicaid Services (CMS) announced substantial new spending on outreach activities related to the Marketplaces and Medicaid, including an increased marketing budget and new grants for individual enrollment assistance under the Navigator program. These policy changes have increased the number of people expected to obtain insurance coverage if the Georgia Access Model is not implemented. Because these activities will not occur in Georgia if the state's proposal is implemented, these policy changes do not change the number of people expected to obtain insurance coverage if the Georgia model is implemented. Thus, these policy changes have increased the likelihood that implementing the model would reduce coverage.
- Research released in parallel with or after the departments' review of Georgia's waiver (and thus likely too late to be fully incorporated in that review) has provided evidence that (1) the outreach activities currently conducted by the federal government increase insurance enrollment, (2) private marketing activities are less effective in increasing insurance enrollment than comparable public activities per dollar spent and are more likely to steer people into plans that do not meet Affordable Care Act (ACA) benefit standards, and (3) curtailing public outreach efforts is unlikely to increase private outreach efforts. These findings strengthen the case that eliminating current federal outreach activities will reduce insurance enrollment in Georgia while making it less plausible that increases in private outreach efforts would be large enough to offset that decline, as Georgia officials had suggested in waiver application materials.<sup>4</sup>

The new evidence described above joins prior evidence, which we review and cite below, that raised questions about whether increases in private outreach and enrollment efforts would adequately substitute for the loss of HealthCare.gov and associated federal efforts. The loss of the HealthCare.gov enrollment portal in Georgia will likely increase the difficulty of navigating the enrollment process, which prior research conducted in various contexts suggests would significantly decrease enrollment. Earlier evidence also shows that private insurance brokers are less likely than navigators to engage in outreach and education efforts, and that brokers are less likely to provide assistance for people with low incomes, racial and ethnic minorities, and people who are not proficient in English.

**In sum, accounting for the current policy landscape and both recent and prior evidence, we believe implementing the Georgia Access Model would meaningfully reduce insurance coverage in Georgia. We believe this reduction in insurance coverage would be even larger if coverage provisions similar to those in the Build Back Better Act, passed by the House, were to become law. The remainder of this letter examines these points in greater detail.**

## **Background on the Georgia Access Model**

The Georgia Access Model would eliminate state residents' ability to enroll in health insurance via HealthCare.gov, and the portal would not be replaced with a state website like those used in other states that do not use HealthCare.gov. Instead, people eligible for Medicaid would apply directly with the state Medicaid agency, and applicants eligible for premium tax credits and others interested in individual-market

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<sup>4</sup> "Georgia Section 1332 State Empowerment and Relief Waiver Application," State of Georgia, October 9, 2020, <https://medicaid.georgia.gov/document/document/modified-1332-waiver/download>.

health insurance would enroll through private insurer agents and brokers. This approach would not provide access to any new enrollment avenues, because private agents and brokers and the Medicaid agency are already available in Georgia under current policy. Notably, CMS reports that, during the 2020 open enrollment period, approximately half of all Marketplace plan selections in Georgia did not involve an agent or broker.<sup>5</sup>

Eliminating access to HealthCare.gov would also have implications for the types of outreach activities that occur in Georgia. Many outreach activities currently supported by the federal government—including radio, television, and digital advertising; targeted consumer-level outreach like emails, phone calls, and texts; and funding for individualized assistance via the Navigator program—occur only (or, at least, primarily) in states that use the HealthCare.gov platform. Accordingly, those activities would either be ceased or greatly reduced under Georgia’s proposal.

By law, the secretaries may approve a Section 1332 waiver request only if the proposal meets the statutory “guardrails.” Specifically, the proposal must not reduce the number of state residents with insurance coverage, reduce the affordability or comprehensiveness of that coverage, or increase the federal deficit. Thus, a key question is how the Georgia Access Model would affect insurance coverage. On its own, eliminating the channel that many individual-market enrollees (and many Medicaid enrollees) in Georgia use to enroll in coverage and associated federal outreach activities would be expected to reduce insurance coverage. Georgia officials have argued, however, that increases in private outreach and enrollment efforts would more than offset this decline.<sup>6</sup>

## Recent Changes in Federal Policy Related to Outreach

The Georgia Access Model’s effect on coverage depends in part on the extent of the federally supported outreach activities that would occur without the model. More robust federal outreach efforts will likely increase the expected level of coverage without the Georgia model, making it more likely that the model will reduce coverage.

Recent policy actions taken by CMS have substantially expanded federal support for outreach activities. CMS announced \$100 million in funding for marketing and outreach activities to support the HealthCare.gov special enrollment period that occurred during plan year 2021, and the departments’ solicitation for comments on Georgia’s waiver indicates that they intend to maintain funding for these types of HealthCare.gov outreach activities at a similar or higher level in future years.<sup>7</sup> This is a major departure

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<sup>5</sup> “Agents and Brokers in the Marketplace,” Centers for Medicare & Medicaid Services, October 30, 2020, <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Agents-and-Brokers-in-the-Marketplace.pdf>.

<sup>6</sup> Georgia, “Section 1332 State Empowerment and Relief Waiver Application.”

<sup>7</sup> Centers for Medicare & Medicaid Services, “2021 Special Enrollment Period in Response to the COVID-19 Emergency,” news release, January 28, 2021, <https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency>; Centers for Medicare & Medicaid Services, “HHS Secretary Becerra Announces Reduced Costs and Expanded Access Available for Marketplace Health Coverage under the American Rescue Plan,” news release, April 1, 2021, <https://www.cms.gov/newsroom/press-releases/hhs-secretary-becerra-announces-reduced-costs-and-expanded-access-available-marketplace-health>; and Departments of Health and Human Services and the Treasury, “Request for Comment on the Georgia Access Model.”

from CMS's policy at the time of waiver approval. For plan year 2020, CMS's total annual budget for these types of outreach activities was only \$10 million.<sup>8</sup>

CMS has also expanded funding for individualized enrollment assistance via the Navigator program. In August 2021, CMS announced \$80 million in funding for navigators in states using the HealthCare.gov platform for plan year 2022 and indicated that it intends to continue that funding level through at least plan year 2024.<sup>9</sup> For comparison, annual navigator funding was previously only \$10 million.<sup>10</sup> For Georgia specifically, CMS is now allocating \$2.5 million per year in navigator funding, compared with \$0.7 million under prior policy.<sup>11</sup>

Notably, the number of Marketplace plan selections for the 2022 plan year is higher than that for the 2021 plan year, including a 26 percent increase in Marketplace plan selections in Georgia.<sup>12</sup> Much of this increase likely reflects the expansion of the premium tax credits included in the American Rescue Plan Act (which we discuss further at the close of this letter). However, particularly in light of the research on the effectiveness of federal outreach activities we discuss in the next section, expanded federal outreach efforts have likely contributed to this increase as well.

## Recent Research on the Effectiveness of Public and Private Outreach Activities

The effect of the Georgia Access Model on insurance coverage also depends on the effectiveness of the public outreach activities that would be eliminated and the private activities that might replace them. Multiple recent studies have provided evidence relevant to this question; they find that (1) outreach activities similar to those now conducted by the federal government increase enrollment, (2) private marketing is less effective in increasing overall insurance enrollment than comparable federal activities on a dollar-for-dollar basis and is more likely to steer people into plans that do not meet ACA standards, and (3) curtailing public outreach efforts is unlikely to increase private efforts. These findings strengthen the case that eliminating federal outreach efforts will reduce insurance enrollment in Georgia and make it less plausible that private efforts will offset that decline.

Given the recency of these studies, it is unlikely that they were fully incorporated in the departments' prior assessment of Georgia's waiver. None of these studies were publicly posted before August 2019.

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<sup>8</sup> Centers for Medicare & Medicaid Services, "Federal Health Insurance Exchange 2020 Open Enrollment," news release, October 25, 2019, <https://www.cms.gov/newsroom/fact-sheets/federal-health-insurance-exchange-2020-open-enrollment>.

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

<sup>10</sup> Centers for Medicare & Medicaid Services, "CMS Announces New Funding Opportunity Announcement for the Federally-Facilitated Exchange Navigator Program," news release, July 10, 2018, <https://www.cms.gov/newsroom/press-releases/cms-announces-new-funding-opportunity-announcement-federally-facilitated-exchange-navigator-program>.

<sup>11</sup> Karen Pollitz, Jennifer Tolbert, and Kendal Orgera, "Navigator Funding Restored in Federal Marketplace States for 2022" (San Francisco: Kaiser Family Foundation, 2021).

<sup>12</sup> Centers for Medicare & Medicaid Services, "Marketplace Weekly Enrollment Snapshot: Week 6," news release, December 22, 2021, <https://www.cms.gov/newsroom/fact-sheets/marketplace-weekly-enrollment-snapshot-week-6>; and Centers for Medicare & Medicaid Services, "2021 Federal Health Insurance Exchange Weekly Enrollment Snapshot: Final Snapshot," news release, January 12, 2021, <https://www.cms.gov/newsroom/fact-sheets/2021-federal-health-insurance-exchange-weekly-enrollment-snapshot-final-snapshot>.

Further, only two became available in their final forms, in August and September 2020, before the departments approved Georgia's waiver in November 2020. We summarize the findings of these studies and their relevance for Georgia's waiver proposal below.

### *Public Outreach Activities Have Been Shown to Be Effective; Eliminating Them Will Likely Significantly Decrease Insurance Coverage*

Domurat, Menashe, and Yin studied the effect of sending letters that reminded consumers of the deadline for enrolling in coverage via Covered California, California's state Marketplace.<sup>13</sup> These reminders targeted people who had started but not finished an application for coverage and people referred by the state Medicaid program. These letters are similar in many respects to the email, text, and phone reminders that CMS has historically sent to consumers shopping for coverage on HealthCare.gov.<sup>14</sup> This suggests the authors' results are highly relevant to assessing ongoing federal outreach activities.

Domurat, Menashe, and Yin used a high-quality research design in which consumers were randomized to receive one of several types of reminder letters or no reminder letter. They estimated that receipt of a letter increased the share of people who enrolled in coverage through Covered California by 1.3 percentage points, an increase of 16 percent relative to not receiving a letter. They also found that the expected claims spending of people induced to enroll by the receipt of a letter was 37 percent lower than the claims risk of existing enrollees. This latter finding suggests that the reminder letters ultimately reduced premiums and thereby increased enrollment among unsubsidized enrollees.

Goldin, Lurie, and McCubbin evaluated the effect of letters sent by the Internal Revenue Service to almost 4 million households that paid a tax penalty because they lacked health insurance.<sup>15</sup> Relative to the letters studied by Domurat, Menashe, and Yin, these letters are less similar in content and target population to the individualized outreach currently conducted by CMS. However, they still provide useful information on how public outreach affects enrollment.

Like Domurat, Menashe, and Yin, these authors also used a high-quality research design in which people were randomized to receive one of a few types of letters or no letter. The authors estimate that receipt of a letter increased insurance enrollment by 0.7 percentage points, an increase of 1 percent relative to those who did not receive a letter. (Notably, the authors also find that the increase in enrollment spurred by the

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<sup>13</sup> Richard Domurat, Isaac Menashe, and Wesley Yin, "The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk: Evidence from a Field Experiment," *American Economic Review* 111, no. 5 (May 2021): 1549–74, <https://doi.org/10.1257/aer.20190823>; for the working paper version, see Richard Domurat, Isaac Menashe, and Wesley Yin, "The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk: Evidence from a Field Experiment" (Rochester, NY: Social Science Research Network, 2019).

<sup>14</sup> Randy Pate, "Policies Related to the Navigator Program and Enrollment Education for the Upcoming Enrollment Period," Centers for Medicare & Medicaid Services, August 31, 2017, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Policies-Related-Navigator-Program-Enrollment-Education-8-31-2017.pdf>; US Government Accountability Office, *Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance* (Washington, DC: US Government Accountability Office, 2018); and Joshua Peck, "Why Marketing Matters for HealthCare.gov," Medium, February 7, 2018, <https://medium.com/get-america-covered/why-marketing-matters-for-healthcare-gov-46d19534a287>.

<sup>15</sup> Jacob Goldin, Ithai Z. Lurie, and Janet McCubbin, "Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach," *Quarterly Journal of Economics* 136, no. 1 (December 2020): 1–49, <https://doi.org/10.1093/qje/qjaa029>; for the working paper version, see Jacob Goldin, Ithai Lurie, and Janet McCubbin, "Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach" (Rochester, NY: Social Science Research Network, 2019).

letters reduced mortality, though this finding is not directly relevant to whether Georgia’s waiver satisfies the coverage guardrail.)

Aizawa and Kim studied the effect of federal television advertising on Marketplace enrollment.<sup>16</sup> Their study took advantage of the fact that television advertising is purchased at the local market level. Local television markets are defined as collections of counties, and thus advertising exposure can change sharply at county boundaries. The authors estimated that federal advertising for HealthCare.gov meaningfully increases enrollment. Their estimates imply that eliminating federal television advertising would have reduced HealthCare.gov enrollment by approximately 5 percent in the years they studied (2014–17).

We are unaware of research that provides comparable direct evidence on the causal effect of the Navigator program on insurance enrollment. However, recent survey research by the Kaiser Family Foundation examined the use of enrollment assistance among nonelderly adults with Marketplace plans, with Medicaid, and without health insurance when the Navigator program was funded at the low levels that prevailed during the Trump administration.<sup>17</sup> The survey results showed that 12 percent of respondents (including 17 percent of Black respondents and 18 percent of Hispanic respondents), or 5 million people, tried but were unable to find assistance to enroll in health insurance coverage. Additionally, among the 18 percent of consumers who received assistance, 40 percent reported that they would have been unlikely to find coverage without the help they received. These findings suggest there is substantial latent demand for enrollment assistance for the federal Navigator program to seek to meet. They also suggest decreasing the availability of navigators (Georgia’s waiver envisions eliminating them entirely) could create a larger shortfall of assistance than would otherwise be the case, thereby decreasing insurance coverage below levels that might otherwise be realized.

In sum, these studies strongly suggest that many of the main types of outreach activities currently conducted by the federal government increase Marketplace enrollment (and may improve risk mix as well). Therefore, the studies imply that enrollment in health insurance would be expected to fall substantially if those activities were eliminated.

### *Private Outreach Activities Are Less Likely Than Public Outreach Activities to Increase Insurance Enrollment*

Notably, Aizawa and Kim’s study on television advertising described above examined such advertising by private insurers in addition to public advertising. Though the authors’ estimates of the effect of advertising by private insurers are somewhat imprecise, their best estimate is that a 1 percent increase in advertising spending by insurers is less than half as effective in increasing Marketplace enrollment as a 1 percent increase in federal advertising spending. Because insurers spent more on advertising than the federal government during the study period, insurer advertising was likely even less effective than federal advertising when evaluated on a dollar-for-dollar basis. On the other hand, Aizawa and Kim found that private advertising is highly effective in causing enrollees to select an insurer’s own plan instead of a competing insurer’s plan (whereas federal advertising had little effect on which plans consumers selected).

The different effects of federal and insurer advertising likely reflect their differing content. The researchers found that federal advertising focused on the availability of coverage (and, in particular,

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<sup>16</sup> Naoki Aizawa and You Suk Kim, “Public and Private Provision of Information in Market-Based Public Programs: Evidence from Advertising in Health Insurance Marketplaces” (Cambridge, MA: National Bureau of Economic Research, 2020).

<sup>17</sup> Karen Pollitz, Jennifer Tolbert, Liz Hamel, and Audrey Kearney, “Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need” (San Francisco: Kaiser Family Foundation, 2020).

subsidized coverage) through the Marketplace and on providing information on how to enroll in coverage and obtain help with enrollment. In contrast, more than 60 percent of private advertisements focused on promoting a particular private insurer's brand. In addition, private advertising was targeted specifically to markets that insurers find to be more profitable, whereas government advertising was targeted to a broader set of markets.

A likely explanation for these differences in advertising approaches and outcomes, as noted by Aizawa and Kim, is that the federal government and private insurers have different objectives. Whereas the federal government was likely primarily interested in increasing aggregate insurance enrollment, private insurers were likely motivated by increasing their profits. Advertising aimed at increasing aggregate enrollment may generate weak returns for an individual private insurer, because much of any increase in enrollment may accrue to the insurer's competitors, particularly in competitive markets. Consequently, insurers may invest little in advertising efforts aimed at increasing overall enrollment and instead focus their advertising efforts on luring enrollees away from competitors.

Insurers face similar incentives when making any marketing decision, not just when deciding on television advertising. Thus, Aizawa and Kim's finding that federal television advertising is more effective in increasing enrollment than private advertising per dollar spent may extend to other outreach activities as well. If so, this suggests the Georgia Access Model would need to spur a very large increase in private outreach spending to offset the reduction in federal outreach spending that the implementation of Georgia's proposal would cause.

Recent evidence also suggests that even when private outreach efforts successfully encourage people to enroll in coverage, they may tend to push people toward less comprehensive forms of insurance coverage. A recent Kaiser Family Foundation survey found that 22 percent of consumers using private health insurance brokers or representatives of private insurance plans to explore their health insurance options were offered policies other than qualified health plans.<sup>18</sup> Thus, with only brokers and insurance company representatives available to provide enrollment assistance, more Georgia consumers will likely be exposed to sales efforts related to these types of non-ACA-compliant plans.

Shifting into these plans is often not in a consumer's best interest. These alternative policies, notably short-term limited-duration plans, typically exclude coverage for preexisting conditions, do not cover all benefits included in Marketplace plans or place significant limits on them (e.g., prescription drugs, mental health care, substance use disorder treatment, maternity care), are not required to comply with medical loss ratio requirements, are not subject to the ACA's modified community rating rules, and cannot be purchased using premium tax credits. For most people, except some healthy consumers ineligible for significant subsidies, these plans likely offer a worse combination of premiums and coverage than ACA-compliant plans. And even consumers who rationally opt for these plans may nevertheless face very high costs in the event of a serious illness or injury.

Though shifting into these plans will often not be in consumers' best interests, this may occur often under the Georgia Access Model. As Baicker and colleagues noted,<sup>19</sup> wide-ranging empirical and theoretical work in behavioral economics demonstrates that the greater the complexity and number of insurance options presented, the less likely people will enroll in coverage or choose their optimal option. Additionally,

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<sup>18</sup> Pollitz, Tolbert, Hamel, and Kearney, "Consumer Assistance in Health Insurance."

<sup>19</sup> Katherine Baicker, William J. Congdon, and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *Millbank Quarterly* 90, no. 1 (2012): 107–34, <https://doi.org/10.1111/j.1468-0009.2011.00656.x>.

because brokers have historically received higher commissions for non-ACA-compliant plans than ACA-compliant plans,<sup>20</sup> they may be particularly likely to steer consumers toward non-ACA-compliant plans.

Non-ACA-compliant plans generally do not qualify as coverage for the purposes of the Section 1332 coverage guardrail (under the departments' current interpretation of the coverage guardrail, though not under the interpretation that the departments had adopted at the time of waiver approval).<sup>21</sup> Thus, a substantial shift into these plans would likely cause Georgia's waiver to reduce insurance enrollment as measured for the purposes of the coverage guardrail. (Further, even if these plans were counted as coverage under the coverage guardrail, a shift into these plans would likely cause Georgia's waiver to violate the affordability or comprehensiveness guardrails.)

Finally, because short-term limited-duration plans can deny coverage to people with health problems or set such people's premiums at much higher levels, they tend to pull largely healthy consumers out of the ACA-compliant nongroup health insurance market. Consequently, increased sales of short-term plans can alter the average health care risk of enrollees in the ACA-compliant plans, increasing health insurance premiums.<sup>22</sup> This can lead to higher premiums for unsubsidized enrollees in comprehensive coverage and, thereby, reduced enrollment.

### *Curtailing Public Outreach Will Not Necessarily Increase Private Outreach*

Recent research also provides some evidence on whether curtailing public outreach efforts should be expected to increase private outreach efforts. Myerson and colleagues examined reductions in federal funding for the Navigator program that started in 2018 and found that areas that saw larger reductions in Navigator funding did not see larger increases in private outreach efforts, at least as measured by the intensity of private insurers' television advertising.<sup>23</sup>

Aizawa and Kim also provided indirect evidence on this question. They found that the effectiveness of private television advertising (in increasing an insurer's own enrollment) does not depend on the level of federal television advertising. This implies that the returns to private outreach efforts may not change when public outreach efforts are cut, so cuts to public outreach are unlikely to cause private insurers to compensate with increased outreach efforts.

These two studies do not speak to all of the possible mechanisms by which the Georgia Access Model could spur increases in private outreach efforts. For example, if eliminating HealthCare.gov made comparison shopping harder, that could increase insurers' incentives to do outreach to the uninsured by increasing the likelihood that a person induced to obtain coverage would enroll in an insurer's own plan rather than a competitor's plan. (On the other hand, making comparison shopping harder could also have direct negative effects on insurance enrollment, as described in the next section.) These studies cannot

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<sup>20</sup> Lisa L. Gill, "The High Cost of Cheap Health Insurance," Consumer Reports, February 13, 2021, <https://www.consumerreports.org/health-insurance/the-high-cost-of-cheap-health-insurance-a1062352816/>; and US House of Representatives, Committee on Energy and Commerce, *Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans Is Putting Americans at Risk* (Washington, DC: US House of Representatives, 2020).

<sup>21</sup> Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Fed. Reg. 53469 (Sept. 27, 2021).

<sup>22</sup> Linda J. Blumberg, Matthew Buettgens, and Robin Wang, "Updated Estimates of the Potential Impact of Short-Term Limited Duration Policies" (Washington, DC: Urban Institute, 2018).

<sup>23</sup> Rebecca Myerson, David Anderson, Laura Baum, Erika Franklin Fowler, Sarah Gollust, and Paul Shafer, "Cuts to Navigator Funding Were Not Associated with Changes to Private Sector Advertising in the ACA Marketplaces" (Rochester, NY: Social Science Research Network, 2021).



capture these effect (if they exist). Nevertheless, this evidence suggests there is little reason to expect reductions in public outreach *per se* to spur compensating increases in private outreach.

## Research Available Well before Waiver Approval

The studies described in the previous section newly contributed to a significant body of literature relevant to assessing the potential ramifications of the Georgia Access Model that existed before waiver approval. These include findings from research on the likelihood of enrolling in benefit programs as a function of the personal “hassle” involved with enrolling<sup>24</sup> and research on differences between types of health insurance enrollment assisters.<sup>25</sup>

### *Eliminating HealthCare.gov Will Make It Harder to Navigate the Health Insurance Enrollment Process, and Research Indicates This Will Likely Depress Enrollment*

A recent book by Herd and Moynihan examined public policies that intentionally or unintentionally increase administrative burdens required to enroll in available programs and benefits.<sup>26</sup> The authors found that research in several areas, including health insurance, retirement savings, and welfare programs, shows that as the difficulty of navigating the enrollment process rises, program enrollment decreases. Herd and Moynihan specifically noted that community-based application assisters have been shown to decrease compliance costs and increase Medicaid participation (which, in turn, improves health outcomes) in certain populations, particularly those without English proficiency.<sup>27</sup>

Eliminating HealthCare.gov would make the health insurance enrollment process harder to navigate in two ways. First, HealthCare.gov provides and displays information on all qualified health plans offered through the Marketplace without any influence from a profit motive. Georgia’s waiver would, in principle, require web brokers to display all available qualified health plans and bar web brokers from preferentially displaying plans for which the web broker can earn higher commissions. However, brokers and agents other than web brokers would not be directly subject to similar standards. Moreover, web brokers likely have strong incentives to find ways around these restrictions, and it is unclear that the restrictions can be effectively enforced even where they apply. Consumers may thus (rationally) be less likely to trust information obtained via agents and brokers, forcing them to invest additional time and intellectual energy in identifying the plans that best meet their needs.

Second, Healthcare.gov is a well-known and well-publicized website that has been widely used by consumers in Georgia (and in most other states) since late 2013. The Georgia Access Model would require consumers to search out private agents and brokers on their own or collect information on participating insurers and web brokers from a new state website and then take the additional step to contact one of them to get enrolled in a plan. And because agents and many brokers work for particular insurers, any given agent or broker may not provide information on the plans a consumer prefers or provide enrollment services for those plans. The additional time-consuming steps necessary to collect objective information suitable for

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<sup>24</sup> Much of this work is summarized in Pamela Herd and Donald P. Moynihan, *Administrative Burden: Policymaking by Other Means* (New York: Russell Sage Foundation, 2018).

<sup>25</sup> Karen Pollitz, Jennifer Tolbert, and Ashley Semanskee, *2016 Survey of Health Insurance Marketplace Assister Programs and Brokers* (San Francisco: Kaiser Family Foundation, 2016).

<sup>26</sup> Herd and Moynihan, *Administrative Burden*.

<sup>27</sup> Anna Aizer, “Low Take-Up in Medicaid: Does Outreach Matter and for Whom?,” *American Economic Review* 93, no. 2 (May 2003): 238–41, <https://doi.org/10.1257/000282803321947119>.

weighing the advantages and disadvantages of different insurance options and getting enrolled would clearly make navigating the enrollment process more difficult relative to using HealthCare.gov.

Consumers' current enrollment behavior is consistent with the view that many consumers prefer enrolling through HealthCare.gov to enrolling through agents and brokers (whether for the reasons described in the preceding paragraphs or other reasons). Indeed, as noted earlier in this letter, CMS's data indicate that approximately half of Marketplace plan selections in Georgia during the 2020 open enrollment period occurred through HealthCare.gov without any involvement by an agent or broker.

### *Brokers Are Less Likely Than Federal Assisters to Work with Certain Clients; Relying on Them Alone Will Likely Reduce Coverage and Increase Coverage Inequities*

The 2016 Kaiser Family Foundation Survey of Health Insurance Marketplace Assister Programs and Brokers explored differences in the populations served by private insurance brokers versus assisters (navigators, certified applications counselors, federally qualified health centers, and federal enrollment assistance programs).<sup>28</sup> The survey's findings indicated that brokers' clients were much less likely than assisters' clients to need language translation help (15 percent of brokers versus 46 percent of assister programs). In addition, 60 percent of brokers reported that few or none of their clients lacked internet access at home, compared with only 24 percent of assister programs. Fewer than half of brokers surveyed (48 percent) said they helped Latino clients, whereas more than three-quarters of assister programs (76 percent) served Latino clients. Brokers were also less likely than assister programs to report that most or nearly all of their clients were uninsured when they sought help (30 versus 56 percent).

Brokers' clientele generally had higher incomes than clients served by assister programs; eight percent of brokers said most or nearly all of their clients had incomes low enough to qualify for Medicaid, compared with 42 percent of assister programs. Brokers were also less likely to report that they helped when clients received notice of a data-match inconsistency from the Marketplace, a situation characteristic of consumers with lower incomes who have multiple jobs or other complex work histories. Plus, brokers were less likely to help people eligible for Medicaid or the Children's Health Insurance Program (47 versus 89 percent).

Taken together, these results provide compelling evidence that brokers are less likely than assisters to serve people who are currently uninsured, people needing language translation services, Latino clients, and people with very low incomes. The large differences in the populations currently served by brokers versus assister programs suggest brokers are poorly positioned to satisfy the unmet demand for enrollment assistance that would be caused by the Georgia Access Model's elimination of Georgia's Navigator program, leaving consumers without the assistance they need to enroll in insurance coverage.

Assister programs were also more likely to be involved in outreach and public education activities than brokers (76 versus 40 percent). Eliminating navigators could reduce people's awareness of the comprehensive, subsidized insurance available to them or the assistance available to help them enroll, compounding the challenges in identifying trusted information on program benefits and eligibility created by the loss of HealthCare.gov.

### **Implications If the Build Back Better Act Becomes Law**

Should the Build Back Better Act (BBBA) become law in something akin to its current form, the Georgia Access Model would likely cause larger reductions in insurance coverage in Georgia. The bill would offer

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<sup>28</sup> Pollitz, Tolbert, and Semanskee, *2016 Survey of Assister Programs and Brokers*.

Marketplace subsidies to people with incomes below the federal poverty level (who are generally ineligible today for any assistance) as a way of filling the Medicaid coverage gap created by the state's decision not to expand Medicaid eligibility under the ACA. In addition, the BBBA would extend the premium tax credits provided under the American Rescue Plan Act, which expanded subsidy eligibility to higher income levels and increased subsidy generosity across eligibility levels. These reforms have been projected to substantially increase insurance coverage—and Marketplace enrollment specifically—particularly among people with low incomes.<sup>29</sup> The sharp increase in Marketplace plan selections described earlier in this letter is consistent with the view that the American Rescue Plan Act subsidy expansions have increased coverage.

The increase in overall Marketplace enrollment under the BBBA will likely magnify the negative effects of the Georgia Access Model. Because more people would enroll in insurance coverage under the BBBA because of more generous subsidies and greater awareness of benefits, the effects of eliminating a preferred enrollment channel (HealthCare.gov) and curtailing federal outreach activities would likely depress insurance coverage to a greater extent. We believe private outreach efforts are unlikely to offset those effects even with the existing Marketplace population, and the influx of more enrollees with very low incomes would make that even less likely. As the analyses discussed above show, brokers are substantially less likely to work with certain clients, such as those with very low incomes, with data mismatches, who need language assistance, or are ethnic minorities. Thus, brokers are less likely than navigators to help newly eligible people obtain coverage, and they are less likely to do the outreach and consumer education necessary to inform these populations of the benefits and assistance newly available to them.

Thank you again for the opportunity to comment. We hope that this information is helpful to you. If we can provide any additional information, please do not hesitate to contact us.

Sincerely,

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<sup>29</sup> Jessica S. Banthin, Michael Simpson, and Andrew Green, “The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress” (New York: Commonwealth Fund, 2021).