DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

November 1, 2020

VIA ELECTRONIC MAIL: ryan.loke@georgia.gov

The Honorable Brian P. Kemp
Governor, State of Georgia
115 State Capitol
Atlanta, Georgia 30334

Dear Governor Kemp:

Thank you for your December 23, 2019, submission and modified submission on July 31, 2020 of Georgia's application for a State Innovation Waiver, as well as the updates provided on October 9, 2020 in response to public comments. I am pleased to send this letter from the Centers for Medicare & Medicaid Services (CMS) within the Department of Health & Human Services (HHS) as well as on behalf of the Department of the Treasury (collectively, the Departments).

This letter is to inform you that the Departments, having completed their review of the application, approve Georgia's State Innovation Waiver under section 1332 of the Patient Protection and Affordable Care Act (PPACA) as described below and conditioned upon the state's written acceptance within 30 days of the specific terms and conditions (STCs) that are enclosed with this letter. This approval is effective for a waiver period of January 1, 2022 through December 31, 2026.

Georgia's waiver plan consists of two parts, Part I and Part II. In Part I, Georgia has requested a waiver of the PPACA requirement for the single risk pool in order to implement a Reinsurance Program for up to five years beginning with plan year (PY) 2022. Part I of Georgia's waiver plan requests to waive the single risk pool requirement in the individual market under section 1312(c)(1) of the PPACA to the extent it would otherwise require excluding total expected State reinsurance payments when establishing the market-wide index rate for the purposes described in the state's application. In Part II, Georgia has requested a waiver of certain PPACA requirements for Exchanges in order to implement and operate the Georgia Access Model. Part II of Georgia's waiver plan requests to waive section 1311 of PPACA to the extent it is inconsistent with the operation of the Georgia Access Model. As outlined in the waiver application updates provided on October 9, 2020, in response to federal comments received and to allow for a smooth transition, Georgia will implement the Georgia Access Model beginning with PY 2023 rather than PY 2022. Collectively, both parts of Georgia's State Innovation Waiver are referred to as the Georgia waiver plan (or "waiver plan") throughout this approval letter and enclosed STCs.

The Departments have determined that this waiver plan satisfies the statutory guardrails as set forth in section 1332(b)(1)(A)-(D) of the PPACA, and have also determined that implementation

of the Reinsurance Program and the Georgia Access Model will lower individual market premiums in the state and the premium tax credits (PTC) to which Georgia residents would have been entitled absent the waiver. These PTC savings will be passed through to the state to be used for implementation of the waiver plan; this pass-through funding will be made available once the state has secured its share of the Reinsurance Program funding. The Departments have considered public comments in making this determination, as discussed below.

The enclosed STCs further define the state's and the Departments' responsibilities with respect to implementation of the waiver, the state's use of pass-through funding during the waiver period, and the nature, character, and extent of federal oversight of the project. The state is encouraged to engage with the Departments early in the process if it is interested in amending or extending its waiver plan. The required information and process for a proposed change to or extension of the waiver plan may vary based on the complexity of such proposed change or extension. A material breach of any of the STCs by the state may lead to termination of Georgia's State Innovation Waiver. As outlined in the STCs, Georgia will submit a budget report and remain in frequent contact with the Departments during the state budget process to ensure sufficient state funding is available in order to operate and implement the Georgia waiver plan consistent with the STCs and as described in the approved waiver application. In addition, the STCs require Georgia to submit an implementation plan outlining its outreach and communications strategy to support a smooth transition to the Georgia Access Model, as well as an operational report detailing the project timeline for implementation of the Georgia Access Model and associated milestones.

Objectives of the Section 1332 Waiver Program

Section 1332 of the PPACA provides the Secretary of Health and Human Services and the Secretary of the Treasury (collectively, the Secretaries) with the discretion to approve a state's proposal to waive specific provisions of the PPACA provided the section 1332 state waiver plan meets certain requirements. One of the primary goals of the section 1332 statute and waiver program is to expand state flexibility, thereby empowering states to address problems with their individual health insurance markets and to increase coverage options for their residents, while at the same time encouraging states to adopt innovative strategies to reduce future overall health care spending. Section 1332 of the PPACA permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to higher value, more affordable health coverage. The overarching goal of section 1332 waivers is to give all Americans the opportunity to gain high value and affordable health coverage regardless of income, geography, age, gender, or health status, while empowering states to develop tailored health coverage strategies that best meet the needs of their residents. Section 1332 waivers provide states an opportunity to promote a stable health insurance market that offers more choice and affordability to state residents, including through expanded competition.

Under section 1332 of the PPACA, the Secretaries may exercise their discretion to approve a request for a section 1332 waiver only if the Secretaries determine that the proposal for the section 1332 waiver meets the following four requirements (referred to as the statutory guardrails): (1) the proposal will provide coverage that is at least as comprehensive as coverage defined in PPACA's section 1302(b) and offered through Exchanges established by title I of

PPACA, as certified by the Office of the Actuary (OACT) of the Centers for Medicare & Medicaid Services based on reviewing sufficient data from the state and from comparable states about their experience with programs created by the PPACA and the provisions of the PPACA that would be waived; (2) the proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided under title I of PPACA; (3) the proposal will provide coverage to at least a comparable number of the state's residents as title I of PPACA would provide; and (4) the proposal will not increase the federal deficit. Final regulations at 31 CFR part 33 and 45 CFR part 155, subpart N, require a state to provide actuarial analyses and actuarial certifications, economic analyses, data and assumptions, targets, an implementation timeline, and other necessary information to support the state's estimates that the proposed waiver will comply with section 1332 statutory guardrails.

Georgia's Individual Health Insurance Market

Nationally, one of the challenges with Exchanges is that many who are eligible for individual qualified health plan (QHP) coverage and premium subsidies remain uninsured, and people who do not qualify for subsidies continue to be priced out of the individual market. In 2013, Georgia began participating on the Federally-facilitated Exchange (FFE).[1] While initial enrollment numbers were promising, between 2016 and 2019, total enrollment in individual market plans on the FFE in Georgia declined by 22%, translating to over 129,000 fewer consumers on the Georgia FFE at the end of this period (based on non-cancelled plan selections and auto-reenrollments during Open Enrollment for each year).[2] On a year-by-year basis, approximately 94,000 Georgians dropped FFE coverage from 2016 to 2017. An additional 13,000 consumers left the Georgia FFE from 2017 to 2018, and another 22,000 left from 2018 to 2019. Looking at effectuated enrollment across the state's entire individual market, including off-Exchange plans, shows people who do not qualify for subsidies on the Exchange have been struggling to afford and maintain coverage. Unsubsidized enrollment dropped by 72% (approximately 150,000 individuals) between 2016 and 2019 in Georgia.[3] This substantial decline in enrollment occurred at the same time average monthly premiums increased by 58% in Georgia.[4] According to the U.S. Census Bureau American Community Survey (ACS) five-year estimates, Georgia also has one of the highest uninsured rates in the country at 13.7%, or 1.38 million people uninsured across the state.[5] Over half of the uninsured (795,000 people) in Georgia have household income

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[1] American Health Benefit Exchanges, or "Exchanges," are entities established under the PPACA through which qualified individuals and qualified employers can purchase health insurance coverage in qualified health plans (QHPs).

[2] CMS Marketplace Reports, Consumers Selecting and Enrolling in Plans 2015 – 2019, available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html

[3] CMS Marketplace Reports, Trends in Subsidized and Unsubsidized Enrollment, available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY18-19.pdf

[4] CMS Marketplace Reports, Trends in Subsidized and Unsubsidized Enrollment, available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY18-19.pdf

[5] U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates, Table S2701.

between 100 – 400% of the Federal Poverty Level (FPL) and may be currently eligible for federal subsidies; however, these consumers are not enrolling in subsidized coverage through the Georgia FFE.[6] The state's high uninsured rate is attributed to a variety of factors including high premiums and out-of-pocket expenses and low carrier participation in the individual market in certain parts of the state.

Georgia's section 1332 waiver application highlights a variety of factors driving high insurance premiums, including lack of competition in the individual market and high provider service costs.

In Georgia, the average second lowest cost silver plan individual market premium rate (also known as the benchmark rate) increased 84% for a family of four between 2016 and 2019[7], a jump from $856 to $1,573 per month. However, in recent years Georgia's individual health insurance market has begun to improve. Between 2019 and 2020, consumers benefited from an 8% decrease in average benchmark premiums and enrollment fell by 1.2%, or about 5,500 enrollees, which is lower than previous years on the Exchange in Georgia. Premium reductions coincided with an increase in competition among insurers in Georgia's individual market Exchange. In 2020, 70% of Georgia consumers have access to coverage offered by three or more QHP issuers on the Exchange in Georgia. By comparison, in 2018, no Georgians had more than two QHP issuers offering coverage in their area.[8] The aforementioned data points show that while there have been improvements resulting in some additional issuers entering or re-entering the market, Georgia's individual health insurance market still faces significant challenges and coverage remains unaffordable for millions of Georgians, especially in the rural areas of the state. The majority of carriers participating in Georgia's individual market operate in more densely populated urban areas, keeping premiums relatively more affordable in those areas whereas rural counties have fewer options.

Based on the above data and continued high uninsured rates in Georgia, the state asserts in its waiver application that the FFE and current applicable requirements are not providing accessible and affordable coverage to all residents. The challenges evident in Georgia's individual market are complex and cannot be solved by a single, one-size-fits-all approach. As such, Georgia submitted a two-part Section 1332 State Innovation Waiver application that crafts a tailored program unique to Georgia that aims to tackle the state's specific needs. The Departments agree that, even with the recent emerging positive trends, average premiums are still too high and affordability remains a substantial challenge for people who do not qualify for PTC and must pay the entire premium themselves. The high number of consumers eligible for subsidies who continue to not sign-up for individual market coverage through the Georgia FFE also remains a significant challenge.

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[6] U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates, Table S2701.

[7] Based on state average second lowest cost silver plan premium available for a family of four. Please see https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020QHPPremiumsChoiceAppendix.xlsx for more information.

[8] Based on state average second lowest cost silver plan premium available for a family of four. Please see https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020QHPPremiumsChoiceAppendix.xlsx for more information.

Overview and Background on Georgia's Waiver Plan

Georgia's section 1332 waiver plan includes two parts. Part I seeks to implement a five-year Reinsurance Program starting in PY 2022. The Georgia Reinsurance Program is a claims-based reinsurance program which, for PY 2022, will reimburse individual health plan carriers in the individual market with an attachment point of $20,000, up to a cap of $500,000, and an average coinsurance rate of 27%. Georgia's Reinsurance Program will reimburse at higher coinsurance for high-cost regions based upon a three-tiered geographic structure (15%, 45%, or 80%) designed to provide greater premium relief (4.8%, 14.4%, or 25.5%) to encourage more carriers to participate in parts of the state where there is currently less carrier participation. The program parameters may be updated annually by the state as outlined in the STCs.

Part II seeks to transition the state's individual market from the FFE to the Georgia Access Model starting in PY 2023, moving the current hybrid model of public (made up primarily of the FFE/HealthCare.gov and Navigators) and private (made up of issuers, web brokers, and individual agents and brokers) distribution channels to a model under which private sector entities would provide all of the front-end consumer shopping experience and enrollment operations with the state providing back-end operations to handle eligibility determinations and enrollment reconciliation. Through the Georgia Access Model, consumers in Georgia will be able to shop for and enroll in the metal level QHPs and catastrophic plans that are available today and receive the same PTC and cost-sharing reductions (CSRs) they would receive absent the waiver, if otherwise eligible. Georgians will be able to shop for and enroll in coverage through private entities including web-brokers, issuers, and agents and brokers. The state will validate eligibility information and determine if an applicant is eligible for QHPs, advance payments of the PTC (APTC) and CSRs. The state will send that information to CMS, which will continue to issue the applicable APTC to carriers on behalf of qualified individuals, and to the IRS, which will continue to administer the reconciliation of APTC on individual tax returns. As described in the state's waiver plan, the Georgia Access Model will be integrated with the state's Medicaid and Children's Health Insurance Program (CHIP) eligibility system, maintaining the single streamlined application and enhancing the referral and determination process for consumers. Furthermore, the Georgia Access Model will streamline the Medicaid referral process for consumers in Georgia because the same system that will perform eligibility determinations for Exchange coverage and Exchange federal subsidies (APTC and CSRs) will also determine eligibility for Medicaid.[9] As outlined in Georgia's waiver plan, when an individual applies through an enrollment platform in the Georgia Access Model, the state's eligibility system will always first perform a check for the consumer's Medicaid eligibility. If the consumer is eligible for Medicaid, the state's system will take the information provided in the single streamlined application and auto-create a Medicaid application for the individual.

As detailed in the state's waiver plan, under the Georgia Access Model, web-brokers, issuers, and agents and brokers will have access to a significantly larger addressable (or obtainable) market than under the current hybrid FFE/private sector model, and will therefore have greater incentive to invest in marketing and outreach in order to retain existing enrollees and attract new

[9] Currently, the Georgia FFE handles eligibility determinations for QHPs and Exchange federal subsidies while Georgia Medicaid handles eligibility determinations for Medicaid and CHIP coverage.

consumers to the individual market. This incentive is likely to be intensified in rural areas of Georgia, which will receive increased reinsurance funding under the state's Reinsurance Program to drive more affordable premiums and increased carrier participation.

Without the waiver, Georgia anticipates that enrollment in individual health coverage will remain flat across the State. The total number of consumers electing to enroll in a plan through the FFE in Georgia has declined more than 22% since 2016. The state asserts that these individuals will not return and the state's uninsured rate will not decline until it takes steps to align market incentives in order to increase participation and attract more residents to enroll in coverage.

Georgia's Enabling Legislation

On March 27, 2019, Governor Brian P. Kemp signed Senate Bill 106, the Patients First Act (Act), into law.[10] The Act grants the State of Georgia broad authority to submit and implement a section 1332 waiver in a manner consistent with state and federal law.[11] Furthermore, the Act includes language noting the General Assembly found that "such waivers may be narrowly tailored to address specific problems and may address, among other things, the creation of state reinsurance programs..."[12] It also repeals all laws or parts of law in conflict with the Act.[13]

On April 25, 2019, Governor Brian P. Kemp signed House Bill 186 into law.[14] Part II of the legislation, The Health Act, establishes the Office of Health Strategy and Coordination (Office) within the Office of the Governor. The objective of this Office is to strengthen and support the healthcare infrastructure of the state through interconnecting health functions, sharing resources across multiple state agencies, and overcoming the barriers to the coordination of health functions. The powers and duties of the Office include facilitating collaboration and coordination between state agencies, coordinating state health functions and programs, serving as a forum for identifying Georgia's specific health issues of greatest concern, and promoting cooperation from both public and private agencies to test new and innovative ideas. As noted in Georgia's waiver plan, this Office will be responsible for implementing the state's Section 1332 waiver.

Procedural History of Georgia's Waiver Plan

To increase transparency and provide for meaningful public input on section 1332 waivers, section 1332(a)(4)(B)(i) of the PPACA requires the Secretaries to issue regulations that provide a process for public notice and comment at the state level, including public hearings. Implementing regulations at 31 C.F.R. § 33.112 and 45 C.F.R. § 155.1312 require states to

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[10] http://www.legis.ga.gov/legislation/en-US/Display/20192020/SB/106

[11] See Section 3-2 of Senate Bill 106. Also see O.C.G.A. § 33-1-26, available at: https://law.justia.com/codes/georgia/2019/title-33/chapter-1/section-33-1-26/.

[12] See Section 3-1 of Senate Bill 106.

[13] See Section 4-2 of Senate Bill 106. In 2014 Georgia enacted a state law which prohibited the state from establishing any program to implement an Exchange and from establishing, creating, implementing or operating a Navigator program or its equivalent. See O.C.G.A. § 33-1-23, available at: https://law.justia.com/codes/georgia/2019/title-33/chapter-1/section-33-1-23.

[14] http://www.legis.ga.gov/Legislation/en-US/display/20192020/HB/186

provide a public notice and comment period for a waiver application sufficient to ensure a meaningful level of public input prior to submitting an application. Because State Innovation Waiver applications may vary significantly in their complexity and breadth, the regulations provide states with some flexibility in determining the length of the state comment period and processes to allow for meaningful and robust public engagement.

Section 1332 of the PPACA and its implementing regulations also require the Federal Government to provide a public notice and comment period, once the Secretaries receive an application.[15] A submitted application will not be deemed received until the Secretaries have made the preliminary determination that the application is complete.[16] Additionally, pursuant to 45 C.F.R. § 155.1308(g) and 31 C.F.R. § 33.108(g), during the federal review process, the Departments "may request additional supporting information from the State…as needed to address public comments or to address issues that arise in reviewing the application."

The Departments have determined that Georgia's application meets the applicable public notice and comment requirements. What follows is an overview of the procedural history for Georgia's waiver plan, which highlights how the state went above and beyond to satisfy these requirements.

Georgia submitted a waiver application to the Departments on December 23, 2019. Prior to submitting the waiver application, Georgia conducted a 30-day state public comment period for the Reinsurance Program and the Georgia Access Model 1332 Waiver from November 4, 2019 through December 3, 2019. Georgia also conducted six public hearings in geographically dispersed regions of the state prior to submitting their application in 2019. In the cover note accompanying the December 2019 submission, Governor Kemp requested the Departments consider review and approval of each of the phases of Georgia's waiver application separately, and further requested the review and approval of the Reinsurance Program be accelerated.

The Departments also received a February 5, 2020, letter from the Governor reiterating the state's request for separate review of the Reinsurance Program part of Georgia's application and asking the Departments pause the preliminary review of the Georgia Access Model portion of the waiver application pending submission of additional supporting information.

On February 6, 2020, the Departments completed their preliminary review of the reinsurance portion of the December 2019 submission and made a preliminary determination that Georgia's application with respect to Part I was complete.[17] February 6, 2020, also marked the start of the 30-day federal comment period for the Reinsurance Program, which ran through March 7, 2020. The major themes of these comments are summarized and responded to below. In response to the state's request, the February 6, 2020 letter from the Departments also paused the preliminary review of the Georgia Access Model portion of the waiver. The Departments' letter also requested additional supporting information from Georgia regarding the Georgia Access Model.

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[15] See section 1332(a)(4)(B)(iii) of the PPACA, 31 C.F.R. § 33.116 and 45 C.F.R. § 155.1316.
[16] See 31 C.F.R. § 33.108(c) and 45 C.F.R. § 155.1308(c).
[17] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Completeness-Letter.pdf

Over the next few months, Georgia worked diligently with the Departments to address the questions raised and provide the information requested in the February 6, 2020, letter.

The Departments received a letter from Governor Kemp dated July 8, 2020, requesting the Departments pause review of Georgia's section 1332 waiver application that was submitted on December 23, 2019.[18] The letter indicated the state was modifying its original waiver application to begin the state-based Reinsurance Program on January 1, 2022 (rather than January 1, 2021). The letter further noted that the state was modifying components of the Georgia Access Model and maintaining the original implementation for Plan Year 2022.

On July 31, 2020, Georgia submitted a modified application which also included a cover note from Governor Kemp citing the July 8, 2020 letter and explaining that, as a result of the coronavirus disease 2019 (COVID-19) pandemic, Georgia had unanticipated budget constraints and that the state was modifying its original waiver application to address these unanticipated challenges. The modified application updated the implementation date for reinsurance to PY 2022 through 2026, but otherwise kept the proposed structure for the Reinsurance Program intact. In addition, the modified application changed some aspects of the Georgia Access Model. For example, the proposal to provide a state subsidy was removed along with the proposal to create copper-level and disease management plans. As such, the plans that would be offered under the modified Georgia Access Model would include all individual health plans offered by issuers licensed and in good standing with the state, including metal level QHPs and catastrophic plans that are available today. In addition, eligible Georgia residents will continue to receive, if eligible, APTC/PTC and CSRs under the Georgia Access Model, as they do today through the Georgia FFE. Similar to the original December 2019 submission, the modified application includes transitioning the individual market from the FFE to the private sector for the front-end consumer shopping experience and enrollment operations. Although Georgia submitted a modified application in July 2020, the submission sought to address concerns raised by commenters and the Departments and merely removed elements of the original proposal, rather than adding new proposals to the waiver plan. Prior to resubmission of its modified waiver application, the state held an additional 15-day state public comment period, which ran from July 9, 2020 to July 23, 2020, and conducted 2 additional public hearings.

On August 17, 2020, the Departments completed their preliminary review of the July 2020 modified application and made a preliminary determination that it was complete.[19] August 17, 2020 also marked the start of the 30-day federal comment period, which ran through September 23, 2020. The major themes of these comments are summarized and responded to below.

During the federal review period, the Departments requested additional information from Georgia, as needed, to address specific public comments submitted during the federal comment period regarding the Georgia Access Model.[20] On October 9, 2020, Georgia provided additional details and clarifications to its application that respond to public comments. This further

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[18] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Governor-July8-Letter.pdf

[19] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Completeness-Letter-Modified-Application.pdf

[20] See 31 C.F.R. § 31.108(g) and 45 C.F.R. § 155.1308(g).

demonstrates the state's consideration of public comments and their goal to implement an effective program to enroll more Georgians in health care coverage. Georgia's updated waiver provided additional detail and clarifications to the Georgia Access Model to address concerns and questions that arose during the federal comment period, including with respect to coverage and auto-reenrollment, implementation timeline, and assisting vulnerable populations. In response to the COVID-19 public health emergency, the state shifted the implementation of the Georgia Access Model to begin in PY 2023. No new proposals were added and the general revised framework outlined in the July 2020 modified application remains intact (e.g., consumers will be able to purchase the same coverage options available today and federal subsidies will be available as they are today, if the consumer is otherwise eligible).

Approval of Georgia's Waiver Plan

Under section 1332 of the PPACA, the Secretaries have discretion to approve a State Innovation Waiver if it provides access to quality health coverage that is at least as comprehensive and affordable as would be provided absent the waiver, provides coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and does not increase the federal deficit. In any section 1332 waiver application, for each of the guardrails, the state must clearly explain its estimates with and without the waiver. The actuarial and economic analyses must compare comprehensiveness, affordability, coverage, and net federal spending and revenues under the waiver to those measures absent the waiver (the baseline) for each year of the waiver. For reasons discussed below, the Departments have determined that the Georgia waiver plan satisfies the statutory guardrails and will promote the objectives of the section 1332 waiver program. The Departments are therefore approving Georgia's State Innovation Waiver for a waiver period of January 1, 2022 through December 31, 2026.

The Georgia waiver plan satisfies the statutory guardrails as set forth in section 1332(b)(1)(A)-(D) of the PPACA

Coverage Guardrail

State Analysis. The state projects that the waiver will provide coverage to at least a comparable number of residents as would have been in place without the waiver and that the waiver will not reduce coverage. This is largely due to increased incentives for web-brokers and carriers to bring new and former consumers to the market, the state's continuation of auto re-enrollment, their new public awareness efforts under the waiver, and their newly streamlined eligibility and determination process. The state's analysis indicates that enrollment in the individual market is estimated to increase 0.4% in PY 2022 due to the Reinsurance Program, driven by the estimated 10.2% premium rate reduction from the reinsurance reimbursements. Enrollment in the individual market is estimated to increase 0.4% in PY 2023 due to the Reinsurance Program and an additional 6.8% in PY 2023 due to the impact of the Georgia Access Model, compared to the without-waiver baseline. The state estimates total enrollment will increase by 0.4% in PY 2022, 7.2% in PY 2023, 7.2% in PY 2026, and 7.3% in PY 2031. No coverage changes are estimated to occur in other forms of public and private coverage as a result of the waiver. The state therefore asserts its waiver plan meets this guardrail as the waiver provides coverage to at least a comparable number of individuals as would have been in place without the waiver. Furthermore,

the state projects that the number of individuals covered is estimated to increase due to the implementation of the waiver.

Regarding the Georgia Access model, the state's analysis notes that, with an expanded available customer base, issuers, web-brokers, and individual agents and brokers will have an increased incentive to invest in marketing and outreach to attract new consumers. Additionally, the state's updated actuarial analysis included in its October 9, 2020 updates reflects that the state currently conducts no consumer outreach and, with the conversion to the Georgia Access Model, the state will implement a comprehensive, state-wide public awareness campaign through various media channels in coordination with other stakeholders.

Departments' Determination. The Departments have determined that the waiver satisfies the coverage guardrail, meeting the statutory requirement that the waiver will provide coverage to at least a comparable number of its residents as would receive it without the waiver. OACT[21] observed that the estimated aggregate premium reduction due to reinsurance estimated by the state, $331 million in PY 2022, is similar in magnitude to the expected reinsurance reimbursements, $398 million in PY 2022, and similarly, the estimated magnitude of enrollment increase is consistent with observed changes in enrollment that results from similar rate changes in other states that have implemented reinsurance waivers. The Departments further note that the state's estimates of the impact of the Reinsurance Program on enrollment are consistent with the Departments' experience with section 1332 reinsurance waivers implemented by other states.[22] The Departments also note that the new consumer outreach under the waiver will guard against coverage losses.

OACT also considered the state's projected enrollment increase attributable to the transition to the Georgia Access Model to be reasonable. We note that the state could still meet the statutory guardrail even if the actual enrollment impact was somewhat lower than the state estimates, since state waiver plans are not required to increase enrollment, but rather must provide coverage to a comparable number of people as would receive it absent the waiver in order to meet this statutory guardrail.

To summarize, while the actual enrollment increase could be lower than the state estimates, as evidenced by the state's continuation of auto re-enrollment for existing Exchange consumers, its plan to conduct a statewide public awareness campaign, and its plan to implement a streamlined eligibility determination process, the waiver plan includes safeguards aimed to ensure it will not result in a decrease in enrollment.[23] The Departments therefore find that the waiver plan meets the coverage guardrail, as it will provide coverage to at least a comparable number of Georgia residents as it would without the waiver.

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[21] OACT conducts and directs the actuarial program for CMS and directs the development of and methodologies for macroeconomic analysis of health care financing issues. In addition, OACT reviews actuarial, economic and demographic studies to estimate CMS program expenditures under current law and under proposed modifications to current law. See more: https://www.cms.gov/About-CMS/Agency-Information/CMSLeadership/Office_OACT

[22] See Table 3, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-June2020.pdf.

[23] As noted by the state in its final October application, carriers also have strong incentives to conduct marketing and outreach to retain their current consumers.

Affordability Guardrail

State Analysis. The state's analysis indicates that for PY 2022, reinsurance is expected to reduce non-group individual market premiums by an average of 10.2% statewide. For PY 2023, the state has estimated average individual market premium reductions of 13.8 % statewide as a result of implementation of the state's waiver plan (10.4% due to the Reinsurance Program and an additional 3.4% reduction for metal level QHP premiums due to morbidity improvements associated with the Georgia Access Model). The estimated average annual premium decrease compared to the without waiver baseline over the 5-year waiver period and 10-year period is 13.4% and 14.2%, respectively. Further, there are no changes to the criteria to determine consumer eligibility for APTC/PTCs and CSRs, as well as no change for benefit design parameters established under the PPACA as part of the Georgia Access Model, thereby maintaining affordability for subsidy-eligible individuals. The anticipated reduction in individual market premiums will also help bring coverage into reach for individuals and families not eligible for the federal subsidies. Under the waiver, the state has acknowledged that total commission payments to web-brokers, agents and brokers may increase slightly, but it does not expect increased commissions to increase premiums by more than 0.25 percentage points on average.

The waiver plan also includes several safeguards as part of the Georgia Access Model to protect against inappropriate steering of applicants (e.g., making coverage recommendations based on commissions rather than the consumer's needs), including restrictions on web-brokers modeled after federal requirements, such as requiring the provision of unbiased information as a condition of participating in Georgia Access.[24] The state therefore asserts its waiver plan meets this guardrail because coverage and cost sharing protection against excessive out-of-pocket spending will be the same as the without waiver baseline scenario.

Departments' Determination. The Departments have determined that the waiver plan will provide coverage and cost sharing protection against excessive out-of-pocket spending that are at least as affordable as would have been in place without the waiver. The state's estimate of the premiums reductions attributable to reinsurance is consistent with other approved waivers to implement state-based reinsurance programs.[25] OACT found that the state's expected premium reduction resulting from the Reinsurance Program is reasonable when looking at the assumptions used to estimate the impact of the waiver. More specifically, as evidenced by the analysis of the state's Reinsurance Program, which, by itself, is estimated to lower annual premiums by an average 10% statewide, Georgia's waiver plan will increase affordability as compared to the without waiver baseline scenario. The state's estimates of the impact of its Reinsurance Program are also consistent with the Departments' experience with section 1332 reinsurance waivers implemented by other states.[26] When combined with the introduction of the Georgia Access

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[24] For example, to participate in Georgia Access, the state will require compliance the following standards by private sector partners: (1) provide consumers with correct information, without omission; (2) refrain from marketing or conduct that is misleading; (3) display all available QHPs (applicable to web-brokers); (4) a prohibition on providing financial incentives, such as rebates or giveaways; and (5) a prohibition on displaying plan recommendations based on compensation from the issuer.

[25] See Table 3, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-June2020.pdf.

[26] Ibid.

Model in PY 2023, annual individual market premiums are estimated to decrease by an average 13% statewide. The Georgia Access Model maintains the same APTC/PTC framework, cost-sharing requirements and other benefit design parameters established under PPACA. The Departments therefore find that the waiver plan meets the affordability guardrail as it will provide at least the same coverage and cost sharing protection against excessive out-of-pocket spending as the without waiver baseline scenario.

The Departments agree that total commission payments to web brokers, agents and brokers may increase slightly and estimate those impacts to be modest. In addition, OACT considered the state's assumptions about commissions and whether broker commissions would be structured to steer healthy new enrollees to short-term, limited duration (STLD) plans, which could have the adverse effect of increasing premiums in the individual market by increasing the morbidity of the risk pool. The state's revised actuarial analysis provides a comparison of current average broker commissions for STLD plans and Exchange plans, and shows that STLD plan commissions are only $8.42 per member / per month PMPM on average compared to $6.88 PMPM for QHPs. As long as there is not a major change in commission structure, OACT would not expect broker behavior to change drastically. Neither the state nor the Departments expect PMPM commission payments to change. The state's analysis also points to the fact that web brokers will provide training to agents and brokers use their respective enrollment platforms that emphasizes the obligation to provide objective information to applicants about eligibility for APTC, CSRs and QHP coverage and to not steer applicants to plans based on commissions. As such, the state's assumptions were found to be reasonable.

Further, the Departments do not expect morbidity to increase in the state's individual market risk pool under the waiver, so there would not be negative impact on premiums from morbidity changes in the market. Finally, while the state plans to implement a state user fee, it would be no more than the FFE user fee in 2023, so the introduction of a state user fee is not expected to result in an increase in premiums relative to premiums without the waiver. The state also indicated it intends to reduce this fee in the future, which could lead to a further slight reduction in individual market premiums.

Comprehensiveness Guardrail

State Analysis. The state's analysis indicates no impact to the comprehensiveness of coverage for this guardrail as it is not seeking to waive and no changes are being made to the Essential Health Benefits (EHB) requirements established under section 1302(b) of PPACA. Consumers will continue to have access to coverage that is at least as comprehensive as coverage offered through the Georgia FFE without the waiver and will have increased access to all individual market products offered by issuers who are licensed and in good standing within the state. The state therefore asserts its waiver plan meets this guardrail.

Departments' Determination. The Departments have determined that the waiver will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) of the PPACA and offered through Exchanges without the waiver. Georgia is not seeking to waive or otherwise change the EHB or other benefit design requirements applicable to coverage offered through Exchanges. As evidenced by the fact that consumers will have access under the state's waiver plan to the same metal level plans and catastrophic plans that are available today and

include EHB benefits, consumers will have access to coverage that is at least as comprehensive as the without waiver baseline scenario. The Departments therefore find that the waiver plan meets this guardrail as it will provide coverage that it at least as comprehensive as the coverage defined in section 1302(b) of PPACA and offered through Exchanges.

Deficit Neutrality Guardrail

State Analysis. The state projects that its waiver plan will decrease federal spending on APTC by $306 million in PY 2022 and reduce federal user fee revenue by $10 million. In PY 2023, the state has projected that, with a 13.8% premium reduction due to the waiver and attracting an additional 21,250 subsidized enrollees to purchase coverage, net federal APTC spending will decrease by $288 million. The state also estimates that the federal government will experience a $101 million reduction in user fee revenue in PY 2023 as the federal government will no longer collect the fee because the state will not be using any FFE functions funded by the fee. The state therefore asserts its waiver plan meets this guardrail.

Departments' Analysis. The Departments have determined that Georgia's waiver plan is not projected to increase the federal deficit. To assess the impact on the deficit, the Departments considered PY 2022, when Georgia will be operating only its reinsurance program, separately from PYs 2023 through 2026, when Georgia will be operating both reinsurance and the Georgia Access Model.

For PY 2022, the only change to the individual market in Georgia will be the introduction of a state-based reinsurance program, which is expected to reduce premiums and increase unsubsidized enrollment in the state but have no impact on subsidized enrollment. The state's estimates of the impact of its Reinsurance Program on the federal deficit are consistent with the Departments' experience with section 1332 reinsurance waivers implemented by other states.[27] The premium reduction is expected, in turn, to reduce federal spending on the PTC, which is pegged to the premium of the Second-Lowest Cost Silver Plan, and reduce federal revenue yielded by the FFE user fee, which is assessed as a percent of premiums. The Departments have found the state's projection that the waiver will decrease federal spending on APTC by $306 million in PY 2022 and reduce federal user fee revenue by $10 million in PY 2022 to be reasonable. Taking into account PTC reconciliation, based on Georgia's historic reconciliation factor of approximately 96%, the waiver would be expected to reduce net federal spending by approximately $285 million in PY 2022 prior to payment of pass-through.

Starting in PY 2023, with the introduction of the Georgia Access Model in addition to the state's reinsurance program, the waiver is expected to continue to reduce premiums and increase unsubsidized enrollment. In addition, the introduction of the Georgia Access Model is expected to increase subsidized enrollment (as described in the coverage guardrail discussion), eliminate the federal user fee for plans sold in Georgia, and reduce federal spending with respect to administering the FFE. Increased subsidized enrollment would increase federal PTC spending, offsetting some of the PTC savings attributable to premium reductions under the waiver. The Departments have again found the state's projection to be reasonable that, with a 13.8% average

[27] See Table 3, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-June2020.pdf.

premium reduction due to the waiver in PY 2023 and an additional 21,250 subsidized enrollees, net federal APTC spending will decrease by $288 million. After accounting for reconciliation, federal PTC savings are expected to amount to approximately $277 million.

In addition to considering the waiver's expected impact on federal PTC spending, the Departments also assessed whether the waiver's impact on federal user fee revenue and on federal costs associated with administering the FFE will increase the federal deficit. As part of this analysis, the Departments considered the impact of the transition from a traditional FFE to the Georgia Access Model and the federal savings attributable to the Georgia Access Model taking over administrative functions from the FFE. Beginning with PY 2023, Georgia QHP issuers will no longer be assessed a user fee by the FFE. As a result, federal user fee revenue from Georgia QHP issuers will drop to zero.

This reduction in user fee revenue from the state will have no impact on the federal deficit. Consistent with OMB Circular No. A25, federal policy requires the user fee to be set to recover the full cost of the special benefits provided to issuers.[28] Federal regulations further provide for the user fee rate to be set through the annual HHS Notice of Benefit and Payment Parameters,[29] allowing adjustments to be made to the user fee to compensate for any changes in projected spending or user fee collections from year to year. The Departments therefore determine that, absent the waiver, CMS's administrative cost for providing Exchange-related services would equal the amount of user fee revenue, and that discontinuation of the services and associated fees will therefore have no net effect on the deficit beginning with PY 2023 through the five-year term of the waiver. To the extent Georgia wants or requires more limited technical or specialized services or support from the Departments in addition to those services the Departments provides to every state in connection with supporting Exchange functions, and as federal law requires and permits, the state and CMS will enter a written agreement under which Georgia must cover the costs for those services.[30]

The Departments therefore find that the waiver plan meets the deficit neutrality guardrail as it will not increase the federal deficit.

The Georgia waiver plan promotes the objectives of the section 1332 waiver program.

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[28] OMB Circular No. A-25; and 85 FR 29164, at 29216, https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf

[29] 45 CFR § 156.50.

[30] CMS, for example, may provide specialized and technical services in support of the state's section 1332 waiver plan, including eligibility determinations or specialized consumer assistance services to support eligibility determinations for participation in State waiver programs under the Intergovernmental Cooperation Act (ICA), 31 USC 6501, *et seq*. Under the ICA, a federal agency generally may provide certain technical and specialized services to state governments, so long as the state covers the full costs of those services. *See* 31 USC 6505. Accordingly, where a state intends to rely on CMS for services, the state must cover CMS's costs. For this reason, the Departments will not consider costs for CMS services covered under the ICA as an increase in federal spending resulting from the state's waiver plan for purposes of the deficit neutrality analysis. *See*, State Relief and Empowerment Waivers; Guidance, 83 FR 53575, 53581 (October 24, 2018).

In updates made to the application submitted on October 9, 2020, Georgia explains how the waiver plan advances several of the objectives of the section 1332 waiver program, including increasing access to affordable private market coverage, encouraging sustainable spending growth, fostering state innovation, and promoting consumer-driven healthcare.[31] The Departments agree that Georgia's waiver plan meets these objectives. The Departments applaud Georgia for developing a unique and innovative waiver plan that addresses problems with its individual health insurance market and increases affordable coverage options for its residents.

Consideration of Public Comments

To increase the transparency of section 1332 waivers, section 1332(a)(4)(B) of the PPACA requires the Secretaries to issue regulations that provide a process for public notice and comment on a state's application for a section 1332 waiver that is sufficient to ensure a meaningful level of public input. This includes a state-level public comment period, as well as a federal public comment period. Requirements for the state comment period are codified at 31 C.F.R. § 33.112(a)(1) and 45 C.F.R. § 155.1312(a)(1), while federal public comment period requirements are codified at 31 C.F.R. § 33.116 and 45 C.F.R. § 155.1316. Under these regulations, the initial comment period, which includes public hearings, generally occurs at the state level prior to submission of a waiver application, while the federal comment period generally occurs after the state's application is received and deemed complete by the Secretaries.

As detailed above, prior to submitting its initial application to the Departments on December 23, 2019, Georgia conducted a 30-day state public comment period and hosted six formal in-person public hearings in geographically dispersed regions of the state. Before resubmitting its modified waiver application on July 31, 2020, the state provided the public with notice and opportunity to comment on the modifications through an additional 15-day state public comment period and two more public hearings. Taken together, these procedures provided the public with a meaningful opportunity to provide input on all aspects of the application and its modifications. Georgia received 946 comments during the first comment period and 611 comments during the second comment period, which are summarized in the state's application.

As detailed above, the Departments conducted a 30-day federal comment period on the Reinsurance Program of the December 2019 application from February 6, 2020, through March 7, 2020. The Departments received a total of 24 comments during this federal comment period.[32] Of those comments, 9 were supportive of the reinsurance program, 3 generally opposed reinsurance, and 12 expressed concerns about the Georgia Access Model. A second federal comment period was conducted that focused on the July 2020 modified application from August 17, 2020 through September 23, 2020. In total, the Departments received approximately 1,826 comments during the second federal comment period on Georgia's modified waiver application; the majority of which (approximately 1,160) were part of letter writing campaigns. The state's updated October application also includes responses to comments received during the second federal comment period. In terms of organizations, a total of 75 letters were received, some of

[31] See *Alignment with Principles* section in Georgia Waiver application.

[32] While comments were only solicited on the Reinsurance Program, some comments were also submitted during the first federal comment period on the Georgia Access Model proposal in the state's December 2019 application.

which had multiple organizations co-signing letters.[33] Nearly all 75 organizational letters expressed support for the Reinsurance Program; 72 organizational letters opposed the Georgia Access Model and 3 were in support. In terms of individual comments, approximately 1,751 were received during the second federal public comment period, of which 951 expressed support of the Reinsurance Program and 6 were opposed to it; and of which 1,746 opposed the Georgia Access Model and 5 supported it (note that not every individual commenter commented on both the Reinsurance Program and Georgia Access Model). The Departments fully considered all relevant comments.[34] A summary of the public comments and responses to their major themes appears below.

The Departments shared all comments received during the federal comment periods with the state for their review and consideration, and also posted them on the CMS section 1332 waiver website.[35]

General Comments on Reinsurance Program

Almost all commenters supported the Reinsurance Program. Some of the commenters expressed support for the Reinsurance Program as an important tool to stabilize health insurance markets, and to help patients with pre-existing conditions obtain affordable, comprehensive coverage. Commenters who supported the Reinsurance Program also noted that a well-designed program can help to lower premiums, mitigate plan risk associated with high-cost enrollees, and maintain or increase plan competition. Some of these commenters further noted that these premium savings could help cancer patients and survivors afford health insurance coverage and may allow some individuals to enroll who previously could not afford coverage. The Departments agree with these comments. As the experience with the existing section 1332 reinsurance waivers show, reinsurance programs offer states an important tool to reduce premiums and represent the first step in stabilizing the individual market and bringing down premiums.

A few commenters opposed reinsurance in general and expressed concerns that it would only benefit individuals who already have above-average incomes, as well as skepticism that the program would lead to insurance companies lowering premiums. As noted earlier, the Departments are of the view that reinsurance programs are an important tool to stabilize health insurance markets, and help patients with pre-existing conditions obtain affordable, comprehensive coverage. Because heavily subsidized, Exchange consumers, are largely insulated from changes in premiums due to the structure of the federal premium tax credit, reinsurance programs typically do not induce changes in enrollment in the subsidized eligible population. Instead reinsurance programs are more likely to impact or increase enrollment for

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[33] Of these organizational letters, 10 letters represented provider groups/associations, 19 disease/health advocacy groups (note: 33 organizations were represented in those 19 letters), 4 consumer advocacy groups, 17 legal/civil rights/social services advocacy groups, 9 women's advocacy groups, 4 children/family advocacy groups, 3 religious advocacy groups, 1 small business group, 5 think tanks/policy research groups, 2 web-broker/agent groups, and 1 Congressional group.

[34] The Departments received 166 comments that included suggestions that were out-of-scope and these suggestions are not summarized or responded to below. The majority of out-of-scope comments recommended the state expand Medicaid instead of pursuing the Georgia Access Model, which is outside the purview of section 1332 waivers.

[35] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-

unsubsidized consumers who are paying the full premium out of pocket costs for plans, and as such are more price sensitive. The Departments are of the view that average premiums are still too high and affordability remains a substantial challenge for people who do not qualify for PTC and must pay the entire premium themselves. Reinsurance programs have real impacts on real consumers and their ability to afford health care. The Departments' experience with section 1332 reinsurance waivers implemented by other states clearly shows that well-designed and operated reinsurance programs lead to lower premiums – state-based reinsurance programs have led issuers to lower premiums by 3.8%-40% (depending on the parameters of the program).[36] Georgia estimates a similar impact for its Reinsurance Program (e.g., lower annual individual market premiums by an average 10% statewide and enrollment in the individual market is estimated to increase 0.4% in PY 2022 due to the Reinsurance Program).

Another commenter noted that if the reinsurance program is not accounted for in federal risk adjustment payments that may result in double compensation of costs for high-risk members. In response, the Departments note that the state performed an actuarial analysis to assess the need and impact of the intersection with risk adjustment and the reinsurance program and determined that it would have limited impact and as such would not need to be addressed at this time. Other states with approved reinsurance waivers have conducted similar analyses to determine whether and how to address this issue. As of today, only Maryland has decided to implement a factor to address this concern by implementing a "dampening factor" in their reinsurance program to account for what it identified could be double compensation of costs for high-risk members.[37] CMS encourages states considering a state-based reinsurance program to consider the interplay between the high-cost risk pool adjustment in the HHS operated risk adjustment program and any state-based reinsurance program, and has provided and can provide technical guidance to states considering such an adjustment.[38] The Departments do not require this for a state's reinsurance program and generally defer to states to design their reinsurance programs to meet their state's needs.

Another commenter stated that the Reinsurance Program should apply a uniform coinsurance rate to ensure equitable premium reductions statewide, and that Georgia should continue to fund the Reinsurance Program using independent, sustainable funding sources. The Departments acknowledge that the state's tiered coinsurance rates are based upon rating region, in which higher coinsurance rates are applied to high-cost regions. This is intended to help bring premiums in high-cost regions closer to the statewide average, and to encourage carrier participation in areas where there are currently fewer carriers. The Departments encourage states to develop state specific approaches tailored to address their residents' unique needs. As detailed

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[36] See table 3, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-June2020.pdf

[37] In Maryland, the "dampening factor" is a coefficient that modifies payments under the State Reinsurance Program to account for Risk Adjustment and Reinsurance program interaction to the extent that the medical loss ratio between payers and receivers under the risk adjustment is normalized. See: https://www.marylandhbe.com/wp-content/uploads/2018/09/State-Reinsurance-Program-Regulations.pdf; and https://www.marylandhbe.com/wp-content/uploads/2018/11/MHBE-Board-Resolution-Interaction-Between-Risk-Adjustment-and-Reinsurance_Programs.pdf

[38] See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020: https://www.govinfo.gov/content/pkg/FR-2019-04-25/pdf/2019-08017.pdf

above and in the state's waiver plan, Georgia is facing unique challenges related to cost and competition in rural parts of the state. The state's approach to address premium increases in rural areas with a tiered coinsurance structure in its Reinsurance Program is an innovative and reasonable approach to address these challenges. In response to the comments on funding for the Reinsurance Program, consistent with STC 4, the Departments note that the state must ensure sufficient funds on an annual or other appropriate basis for the operation of the Reinsurance Program. The Departments understand that the state will consider and evaluate other funding options during the implementation process and that the state is committed to working with other state officials to secure the necessary state funding during the budget process.[39] Moreover, consistent with other section 1332 reinsurance waivers, financing subsequent years of the Reinsurance Program will be determined on a yearly basis, as the Departments understand that state budgets may change from year to year.

Another commenter expressed concern that the Reinsurance Program would increase premiums for those with pre-existing conditions, alleging that the program would put high-risk individuals in a separate risk pool with higher premiums. The Departments appreciate commenters' concerns, however, Georgia's Reinsurance Program will lower individual market premiums by reimbursing insurers for the claims of high-cost individuals based on the state's parameters. Further, the Georgia Reinsurance Program does not create a separate risk pool for high-cost individuals.

General Comments on Georgia Access Model

The majority of the comments the Departments received opposed either the Georgia Access Model as a whole or certain features of it. Some of those comments expressed general concerns about the elimination of access to the HealthCare.gov website and the benefit it provides consumers to be able to compare health coverage options. In particular, some commenters expressed concerns that the Georgia Access Model eliminates an enrollment pathway without creating any new enrollment pathways. Relatedly, some commenters raised concerns that the Georgia Access Model will impose a burden on consumers by making shopping for health insurance more time-consuming. Other commenters noted that they like shopping on HealthCare.gov and expressed concern that more states would adopt a similar proposal if the Georgia waiver is approved. The Departments agree with commenters that it is important for consumers to have access to tools and resources to compare their coverage options. Under the Georgia Access Model consumers will be able to compare plans using the platform of their choice. Furthermore, the state will provide consumers with a single source of information on health care coverage options available in Georgia and how to access and enroll in coverage. Through the state's website, the state will provide consumers a list of approved carriers and web-brokers participating in the Georgia Access Model. In addition, the state plans to implement a web-based consumer support tool to provide answers to questions and connect consumers with additional support and resources. As reflected in the state's final October application, the

[39] The Departments acknowledge that Georgia's state laws and budget cycle prohibit the state from committing funds for future years' budgets outside of its present budget cycle (which runs from July 1 through June 30 of the following year). The enclosed STCs include additional requirements and safeguards in recognition of these budget realities. The state has also clarified, that working with the General Assembly, the Governor intends to pursue authority to collect a user fee starting in PY 2023. The Departments intend to monitor the funding and budget process with the state as outlined in the enclosed STCs.

adoption of standards for web brokers, agents and brokers modeled after federal requirements will also help ensure consumers have access to the same comparative plan information they receive today. The state also notes that the Georgia Access Model will spur growth and innovation in the private market to increase consumer tools and information. The Departments also share commenters' concerns about the burdensome nature of shopping for health insurance and believe that this waiver will spur the private sector to make consumer-centric investments that will improve consumers' shopping experiences, as these private entities are incentivized to provide the best possible consumer experience to retain their customer base year over year and to attract new consumers each year.

Comments Addressing Coverage Losses

Commenters opposed to the Georgia Access Model raised concerns that many individuals are likely to lose coverage because there would be no automatic re-enrollment for existing Exchange consumers. Commenters also expressed concerns that the transition from HealthCare.gov to the Georgia Access Model would generally result in coverage losses as consumers may be confused when navigating a new system. These commenters noted that both the transition itself and the new shopping experience would result in less overall enrollment. Some commenters also raised related concerns about the impact that coverage losses or underinsurance resulting from the waiver might have on safety net providers, such as Indian Health Service clinics.

After considering these comments, the state updated its application on October 9, 2020 to clarify the state would include automatic re-enrollment for current Georgia FFE enrollees during the transition year to the Georgia Access Model, and that this process would mirror the one currently provided through the FFE. The state's final October application also clarifies consumers will similarly be able to auto-re-enroll each year in the Georgia Access Model. CMS is committed to partnering with Georgia to ensure that the appropriate steps are taken to minimize coverage loss during the transition year. As reflected in STC 3, CMS will also be providing notice to Georgia FFE enrollees about the transition to the Georgia Access Model and will also provide the state with any necessary technical assistance to effectuate a smooth transition from HealthCare.gov. Additionally, the Departments have incorporated safeguards into the attached STCs that are intended to minimize coverage loss during the transition year. For example, as described in STC 3, the state must develop a comprehensive outreach and communications plan detailing, with milestones, all of the steps the state will take to ensure a smooth transition and share its plan with the Departments at least 12 months prior to implementation of the Georgia Access Model. The state will also be required to share information with consumers about the state's automatic re-enrollment process, where to find information on the partners approved to participate in the Georgia Access Model, and other important details regarding the upcoming plan year. As detailed elsewhere in this letter, the state's waiver plan includes other additional safeguards aimed to ensure it will not result in a decrease in enrollment, while allowing the state to pursue innovative market-driven strategies to target the state's large uninsured population.

Several commenters raised concerns about the impact of the transition from the FFE to the Georgia Access Model on Medicaid-eligible individuals. Some commenters asked how agents and brokers will be incentivized under the Georgia Access Model to support these individuals.

The Departments agree that everyone who needs and is eligible for Medicaid should have access to the program and note the state updated its application in response to these comments. As detailed in its updates to its application on October 9, 2020, the state has taken steps to enhance and streamline the Medicaid referral and eligibility determination process under the Georgia Access Model. For example, the use of the same system to perform eligibility determinations for Exchange coverage (including Exchange federal subsidies) and Medicaid will improve and further streamline the referral process for all stakeholders. The state's application explains that when an individual applies through an enrollment platform in the Georgia Access Model, the state's eligibility system will always first perform a check for the consumer's Medicaid eligibility. If the consumer is eligible for Medicaid, the state's system will take the information provided in the single streamlined application and auto-create a Medicaid application for the individual. The current bifurcated approach – whereby the Georgia FFE handles eligibility determinations for Exchange coverage (including Exchange federal subsidies) while Georgia Medicaid, through the Georgia Gateway system, handles Medicaid eligibility determinations creates inefficiencies in the process. For example, under the Georgia Access Model, the state will leverage existing Georgia Gateway infrastructure to develop a new process to validate income using more recent employment data, rather than solely using prior year federal tax return information used by the FFE. This will not only result in a more accurate APTC calculation, but will also more effectively manage the eligibility process across Medicaid and the individual market. Furthermore, today, the FFE only checks for Modified Adjusted Gross Income (MAGI) Medicaid, which does not include all of the Medicaid eligibility categories within the state of Georgia. Under the Georgia Access Model, the state will be able to use one system to assess whether an individual is eligible for QHP coverage and federal subsidies in the individual market, income-based Medicaid, or other eligible categories of Medicaid (such as Aged, Blind, and Disabled). In addition, existing, comprehensive state licensing requirements for agents and brokers and the new requirements the state would impose (such as working with partners to develop a curriculum and offer Continuing Education credits for agents and brokers regarding the Georgia Access Model, Medicaid, and the transition to and from Medicaid and individual market coverage to better inform and serve the public) will help retain enrollment in Medicaid as agents and brokers will have to meet new requirements for training necessary for licensure.

State Innovation Waivers, as provided in statute, must be approved before being implemented, and the Departments must determine that the waiver will not reduce coverage. The Departments undertake extensive analysis and reviews of research and program evaluation as part of these determinations. As a part of this analysis, the Departments have determined that the Georgia waiver plan meets the coverage guardrail. However, as all policy changes can have a range of impact due to the specifics of the state, such as, the time the policy was implemented, the specific operational choices, and other market factors, the Departments set up strict safeguards and monitoring protocols to ensure that the waiver continues to meet the guardrails, including the coverage guardrail, for the duration of the waiver period. Finally, recognizing the unique nature of Georgia's waiver plan, the attached STCs include robust reporting requirements to enable the Departments to closely monitor the impacts of the state's innovative strategies to target the uninsured population both on individual market enrollment and on Medicaid enrollment. This will be part of the oversight to monitor the waiver plan's compliance with the statutory guardrails and the Departments will conduct evaluation to determine the impact of the waiver, including the impact on enrollment.

Comments Addressing the Comprehensiveness and Affordability Guardrails
Commenters opposed to the Georgia Access Model questioned whether it could meet the comprehensiveness and affordability guardrails set forth at section 1332(b)(1)(A) and (B) of PPACA. Some were concerned consumers with pre-existing conditions or mental health concerns would be worse off, with less comprehensive and affordable coverage under the waiver. Many were concerned that the proposal would result in agents and brokers steering healthy people towards less comprehensive and affordable plans, such as short term limited duration (STLD) plans and plans without EHB, rather than to QHPs or other individual market metal-level coverage options. Other commenters argued that Georgia's actuarial analysis failed to appropriately model the impact this type of steering could have on enrollment and affordability for individual market single risk pool coverage. Some commenters noted that Georgia also failed to adequately consider several other factors that could increase premiums, such as the large increases in broker commissions these commenters believed would occur under the Georgia Access Model. Relatedly, some commenters were concerned that the state does not and will not sufficiently regulate agents and brokers.

As discussed above, the Departments determined that Georgia's waiver plan satisfies these guardrails. Most importantly, Georgia is not seeking to waive or otherwise change the EHB or other PPACA benefit design requirements applicable to coverage offered through Exchanges or in the outside individual market. As such, Georgia residents will have access under the state's waiver plan to the same metal level plans and catastrophic plans that are available today and include EHB. Consumers will therefore have access to at least the same coverage and cost sharing protection against excessive out-of-pocket spending as without the waiver. The innovative strategies that the state is pursuing to attract the state's uninsured population to the individual market will provide access to all of these comprehensive and affordable coverage options, while also informing consumers about other available coverage options. The Departments are of the view that consumers are best suited to determine what coverage best suits their individual or family's needs, whether that is a QHP, a major medical non-QHP, a STLD plan or another available coverage option. With respect to affordability, consistent with other state reinsurance waivers, Georgia's Reinsurance Program is estimated to lower annual individual market premiums by an average of 10% statewide. When combined with the introduction of the Georgia Access Model in PY 2023, annual individual market premiums are estimated to decrease by an average of 13% statewide.

In response to federal public comments and at the Departments' request, the state did a further analysis in response to the concerns about the potential steering of consumers to STLD plans. As reflected in updates to its application on October 9, 2020, the state's analysis of available data shows that there is not substantial evidence of inappropriate steering to such products. More specifically, the state looked at various data sources and determined that the average commission paid in Georgia for QHPs is $6.88 PMPM compared to $8.42 PMPM for STLD plans. While the state acknowledged this difference in commission could provide a slight incentive for brokers and agents to steer consumers towards STLD plans, it found no evidence that this has, in fact, influenced consumer and agent/broker behavior in the State of Georgia. In addition, the Departments further note that the existing federal consumer disclosure notice that informs

consumers about the limitations of STLD plans will continue to apply,[40] as will state marketing and other insurance consumer protection laws. Taken together, these measures mitigate the potential for inappropriate steering and ensure consumers have the information they need to make an informed purchasing decision. Nonetheless, the state has incorporated several safeguards to further mitigate the potential under the Georgia Access Model for inappropriate steering and ensure private sector partners and individual agents and brokers participating in the Georgia Access Model educate consumers about all of the available coverage options. For example, the state will require individual agents and brokers to complete training before participating in the Georgia Access Model and will implement other consumer protections based on the standards the FFE has adopted for its Enhanced Direct Enrollment (EDE) pathway that private sector partners offering enrollment pathways in the Georgia Access Model will have to follow.[41]

Commenters also raised concerns that, by eliminating access to the HealthCare.gov platform, the waiver proposal would reduce competition and result in higher premiums. These commenters alleged the lack of a single, unbiased source of comparative plan data could also directly reduce competition because some issuers that are not able to compete with larger issuers may leave or not enter the market. Some of these commenters expressed concern there would be an additional burden on issuers because they would have to do all their own outreach and marketing. In addition, commenters expressed concerns that consumers would have to visit numerous websites under the Georgia Access Model to shop for coverage, and thus the waiver could actually reduce the competitive pressure to keep prices down, especially in areas of the state with a dominant insurer.

The Departments disagree that the waiver will reduce competition. One of Georgia's main goals in pursuing its waiver plan is to promote a more competitive individual health insurance market and attract its large uninsured population to purchase coverage. As previously discussed, the state will provide consumers with a single source of information on health care coverage options available in Georgia and how to access and enroll in that overage. The existing FFE and Navigator program has simply had limited impact on reducing the overall uninsured rate in Georgia, suggesting there may be a more effective way to reach and engage consumers. In fact, one of the key criticisms of HealthCare.gov and the implementation of the Navigator program is that it has squeezed local agents and brokers out of the market with government-funded competition.[42,43] There are an estimated 1.38 million Georgia residents without healthcare coverage and over half of these individuals are eligible for subsidies. Over 150,000 of uninsured adults 19 to 64 years old are between 100 – 138% of the FPL, effectively making them eligible for free Bronze Plans after APTCs. This is a target-rich market for the agents and brokers that, when combined with fact that enrollment won't be occurring on HealthCare.gov, creates

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[40] See, e.g., 45 C.F.R. § 144.103.
[41] See, e.g., 45 C.F.R. §§ 155.220, 155.221 and 156.1230. Also see supra 24.
[42] Pipes. The Gardner News. "Obamacare's Unnecessary 'Navigators' a Colossal Waste of Taxpayer Money." (2013). Available at https://gardnernews.com/obamacares-unnecessary-navigators-a-colossal-waste-of-taxpayer-money/
[43] Letter to CMS Administrator. https://republicans-energycommerce.house.gov/wp-content/uploads/2019/10/102219-Letter-to-CMS-on-Navigators-Program.pdf

significant market incentives to invest in marketing and outreach in the state. Today, in Georgia, approximately 80% of consumers enroll in the FFE through HealthCare.gov website, with the remaining 20% enrolling through the FFE Direct Enrollment (DE) Pathways.[44] This limits the available market for agents and brokers, as the FFE (HealthCare.gov) is a formidable competitor with private sector entities in the individual market. Once the transition from the FFE occurs, the available market for issuers, web-brokers agents, and brokers increases substantially as the portion that currently enrolls through the FFE would begin enrolling through approved private entity pathways. These private entities will then compete in the market to enroll those consumers. The amount of an entity's marketing and outreach investment is largely dependent on the size of the available market. When there is a relatively smaller available market, there is limited return on investment and therefore limited market incentives to pursue a larger footprint in the state. When there is a large available market, private entities can anticipate a higher return on investment because there are a large population of potential new customers. With the added incentive of having access to the entire individual market, private sector partners will have the critical mass and accompanying incentives to invest in new Georgia-focused resources to target the high uninsured population in the state.

Comments on Vulnerable Populations
Commenters opposed to the Georgia Access Model expressed concerns that it will disproportionately impact vulnerable populations[45], who are already at greater risk of being underinsured or uninsured and may not receive the outreach and assistance needed. These commenters also were concerned that agents and brokers lack the appropriate background and training to work effectively with vulnerable populations and several commenters suggested that agents and brokers would be less likely to assist these individuals under the Georgia Access Model.

The Departments agree it is important that vulnerable populations have the support they need to obtain affordable and comprehensive coverage that meets their individual or family's needs. In addition, states are not able to waive the federal non-discrimination statutes under section 1332 of PPACA and STC 5 affirms that the state must comply with all applicable federal statutes related to non-discrimination, such as the Americans with Disabilities Act of 1990. Similarly, STC 6 requires the state to comply with all applicable federal laws and regulations, except to the extent an otherwise applicable law or regulation has been specifically waived. Recognizing the unique nature of Georgia's waiver plan, the enclosed STCs include more robust reporting requirements to allow the Departments to closely monitor the waiver, including the potential impact on vulnerable populations and health disparities, if any. In addition, the Departments have emphasized to the state the importance of working to ensure that during the transition year and beyond, the agent and broker community and private sector partners participating in Georgia Access are closely engaging with local community organizations, advocacy groups, and other stakeholders who work directly with vulnerable populations to provide the necessary support to

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[44] This includes enrollments through both the FFE EDE and Classic DE pathways. See, e.g., 45 C.F.R. §§ 155.220(c)(3)(i) and (ii), for Classic DE and EDE web-broker requirements, respectively.
[45] Vulnerable populations include people with low health literacy, people with limited English proficiency, people with disabilities, people with pre-existing conditions (e.g., mental illness, substance use disorders, HIV, cancer, other chronic health issues), people of color, queer and trans people, pregnant and postpartum women, and rural residents.

these individuals. Furthermore, the Departments also have encouraged the state to provide agents and brokers with specialized trainings and certifications enabling them to better support individuals from vulnerable populations, thereby further incentivizing agents and brokers to compete in providing the best possible services to a wide array of individuals. The state noted that health literacy continues to be a challenge for some Georgia consumers. In its application, the state noted that agents and brokers are part of local communities throughout the state and therefore have the understanding of local dynamics needed to reach consumers, and that they have built careers helping consumers manage the complexities of the nation's health care system. The state further noted that it will implement a dynamic, web-based consumer support tool to provide answers to frequently asked questions and connect consumers with additional support or services.

Comments on COVID-19
A number of commenters stated that Georgia should not seek to transition from the individual market FFE to the Georgia Access Model during the COVID-19 public health emergency. These commenters expressed concerns that during a pandemic, people need clear access to enrollment channels that are not confusing, costly, and decentralized and that a trusted source of healthcare information (the FFE) should not be eliminated at this time.

After considering the comments received during the federal comment period, including those expressing concern regarding the impact of the COVID-19 public health emergency, the state moved the implementation start date for the Georgia Access Model to PY 2023. This change is reflected in the state's updated October 9, 2020 application. This shift also will allow for additional time for the state to further engage with stakeholders and communicate with the public to support the successful transition to the Georgia Access Model.

Other Comments
Some commenters raised concerns about the shortage of rural healthcare providers in Georgia and the challenges in accessing quality, affordable coverage for rural residents. In response, the Departments note that the Reinsurance Program has tiered coinsurance rates targeting rural areas in the state in order to provide greater premium relief in these areas, and by leveraging private entities for consumer support, the Georgia Access Model will be able to better address the needs of the state's rural residents. Further, as noted above and detailed in the states' application, Georgia agents and brokers are part of their respective local communities and have a much greater reach and understanding of local dynamics to better reach local consumers (including those who live in rural communities).

Several commenters alleged that Georgia's waiver application did not meet the applicable procedural requirements and therefore should not be approved. For example, some commenters argued that the waiver application does not include sufficient detail on the timeline to implement and operationalize the waiver. Some commenters questioned the state government's capacity to implement the waiver. Others alleged that the waiver violates Medicaid rules, such as sections 1413 and 2201 of the PPACA.[46]

[46] Section 1413 requires that consumers can apply for Medicaid coverage using a "single, streamlined form that...may be filed with an Exchange...."; while section 2201 of PPACA, which requires states, as a condition of participation in the Medicaid program, to provide so-called "no wrong door" enrollment into Medicaid.

The Departments disagree with these commenters. As outlined above in the Procedural History of Georgia's Waiver Plan discussion, Georgia met the applicable public notice and comment requirements and went above and beyond to ensure there was a meaningful opportunity to comment on its waiver proposal. Prior to submitting its application on December 23, 2019, Georgia conducted a 30-day state public comment period, including holding six formal public hearings in geographically dispersed regions of the state during the state's initial public comment period. Before resubmitting the modified waiver application, the state conducted an additional 15-day state public comment period and hosted two additional public hearings. These further procedures provided the public a meaningful opportunity to provide input on the changes to the application, which were limited to the removal of certain elements and the postponement of the effective date for the state's Reinsurance Program. Of note, no new programs or elements were added in the modified submission. For the second federal comment period, stakeholders had 37 days to submit comments.[47] Consistent with 45 CFR § 155.1308(g) and 31 CFR § 33.108(g), during the federal review process, the Secretaries may request additional information from the state as needed to address public comments or to address issues that arise in reviewing the application. So it is not atypical that the Departments request additional information during the review process. Furthermore, it is expected that a state will take into consideration and update their waiver plan based on public comments or questions from the Departments as necessary.

Regarding an implementation plan, the state updated its application to include more details on its implementation plan in response to the public comments received during the second federal comment period. For example, the state's updated October 9, 2020 application notes that the state's implementation plan will include key activities, timelines, and milestones for detailed program design, IT implementation, communication with carriers and brokers, transition plan from HealthCare.gov, communications and outreach plan, budgeting, and reporting. The Departments understand the importance of operational planning and a smooth transition to the Georgia Access Model. The Departments further note that the STCs are another vehicle that further specify state responsibilities related to implementation of State Innovation Waivers. To address these concerns and ensure a smooth and successful implementation of the Georgia Access Model, the STCs include several requirements for the state to submit timely, detailed planning documents and to undergo operational readiness reviews. For example, the enclosed STCs require Georgia to develop and submit an implementation plan outlining its outreach and communications strategy to support a smooth transition to the Georgia Access Model, as well as an operational report detailing the project timeline for implementation of the Georgia Access Model and associated milestones. See, e.g., STCs 3 and 12.

The Departments also disagree that the state's waiver plan violates either section 1413 or section 2201 of the PPACA. Georgia residents will continue to apply for Medicaid and Exchange coverage using a single streamlined application. Once implemented, the Georgia Access Model will streamline the Medicaid eligibility and referral process for consumers because, for the first time, the same system that will perform eligibility determinations for Exchange coverage and Exchange federal subsidies (APTC and CSRs) also will determine eligibility for Medicaid. When an individual applies through any of the Georgia Access enrollment platforms, the state's

[47] Due to a technical glitch, the Departments held an extended second federal comment period for 37 days. This was in addition to the initial 30-day federal comment period on Part I of the state's December application.

eligibility system will always first perform a check for the consumer's Medicaid eligibility. If the consumer is eligible for Medicaid, the state's system will take the information provided in the single streamlined application and auto-create and process a Medicaid application for the individual.

Additionally, a number of commenters raised concerns during the second federal comment period based on misunderstandings of the changes that the Georgia Access Model would introduce. Some commenters expressed concerns related to components of the original waiver proposal submitted in December 2019 that have since been removed, including a state subsidy in place of the federal PTC for QHPs, the cap on state expenditures and the introduction of copper plans and disease management plans. Some commenters relatedly expressed concerns that, due to the waiver, certain PPACA provisions, such as dependent coverage up to age 26 and protections for individuals with pre-existing conditions, would no longer apply to Georgia residents. As detailed above and in the state's final October application, the Georgia Access Model no longer involves replacing the federal APTC/PTC structure with a state subsidy, so there is also no longer a need for a cap on state subsidy expenditures. The waiver plan also no longer introduces new plan types. Under the approved waiver plan, Georgia residents will continue to have access to the QHPs currently sold on the FFE as well as to APTC/PTC and to CSRs, along with the same other non-QHP offerings available today. The other PPACA provisions relating to dependent coverage and pre-existing conditions identified by commenters cannot be waived under section 1332 of PPACA and will continue to apply in Georgia.

Some commenters also noted concerns that the Georgia Access Model could introduce burdensome requirements for participating web-brokers and that some brokers, such as independent agents, might be at a disadvantage. The Departments appreciate commenters' concerns and recognize the need to mitigate the burden imposed on participating brokers while retaining key consumer protections. The Departments understand that the state has consulted industry stakeholders to ensure that the Georgia Access Model is feasible for brokers and agents.[48] In addition, as reflected in the state's final October application, the Georgia Access Model will adopt standards for web-brokers modeled after the FFE Enhanced Direct Enrollment (EDE) requirements. This approach should minimize the potential for introduction of any new burdens, as the FFE's EDE requirements currently apply in Georgia.

Finally, a number of commenters expressed concerns about the Georgia Access Model being antithetical to the idea of competition in a free market by replacing HealthCare.gov, and subsequently limiting consumer empowerment and choice. The Departments and Georgia understand that consumer freedom is an essential part of the experience of purchasing health insurance coverage, and indeed the impetus for the Georgia Access Model is to increase competition amongst private entities to improve existing enrollment pathways and the overall consumer experience. The Georgia Access Model is designed to create a competitive environment based on the consumer experience – fostering growth and innovation in the private market to increase consumer tools, information, and customer service. The state anticipates that Georgians will receive more direct and meaningful services at a lower cost under the Georgia

[48] See letter from E-health and Association of Web-Based Health Insurance Brokers (AWHIB) available here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Federal-Comments-Organization-Letters.pdf.

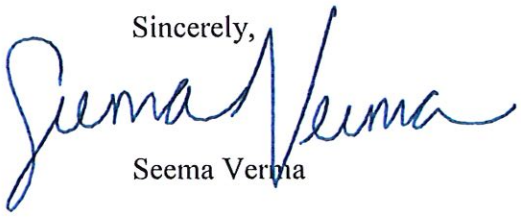
Access Model and that the state will be able to leverage private market innovation to attract more of the state's currently uninsured population to join the market.

Other Information

Please send your written acceptance and any communications and questions regarding program matters or official correspondence concerning the waiver to Lina Rashid at Lina.Rashid@cms.hhs.gov, Michelle Koltov at Michelle.Koltov@cms.hhs.gov, or stateinnovationwaivers@cms.hhs.gov.

Congratulations and we look forward to working with you and your staff. Please do not hesitate to contact us if you have any questions.

Sincerely,



Seema Verma

Enclosure

Cc: David Kautter, Assistant Secretary for Tax Policy, U.S. Department of the Treasury
Gen. John F. King, Commissioner, Georgia Office of the Commissioner of Insurance and Safety Fire
Ryan Loke, Special Projects, Office of Governor Brian Kemp

DEPARTMENT OF HEALTH & HUMAN SERVICES (HHS)
U.S. DEPARTMENT OF THE TREASURY
PATIENT PROTECTION AND AFFORDABLE CARE ACT SECTION 1332 STATE INNOVATION WAIVER
SPECIFIC TERMS AND CONDITIONS
TITLE: State of Georgia—Patient Protection and Affordable Care Act Section 1332 Waiver Approval
AWARDEE: The State of Georgia

I. PREFACE

The following are the specific terms and conditions (STCs) for the State of Georgia's ("the state") Patient Protection and Affordable Care Act (PPACA) section 1332 State Innovation Waiver ("the waiver"), which has been approved by the U.S. Department of Health & Human Services (HHS) and the U.S. Department of the Treasury (collectively, the Departments). These STCs govern the operation of the waiver by the state. The STCs set forth in detail the state's responsibilities to the Departments related to the waiver, as well as the Departments' responsibilities related to the waiver. These STCs are effective beginning January 1, 2022, through December 31, 2026, unless the waiver is extended or otherwise amended by the parties in accordance with the process set forth in and provided by these STCs. The state's final application to waive certain provisions of the PPACA, dated October 9, 2020, is specifically incorporated by reference into these STCs, except with regard to any proposal or text that is inconsistent with the Departments' approval of the waiver or these STCs. The Georgia Reinsurance Program is administered by the Office of Health Strategy and Coordination (OHSC), working in collaboration with the Georgia Office of Insurance and Safety Fire Commissioner (OCI). The Georgia Access Model will also be implemented by OHSC, working in coordination across state agencies including OCI and the Department of Community Health (DCH).

1. PPACA Provisions Waived under Section 1332 State Innovation Waiver. The Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) provides states with flexibility to tailor their health insurance markets to best meet the needs of their populations. Section 1312(c)(1) of the PPACA is waived to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate for the purposes described in the state's approved waiver. In addition, the Exchange requirements in sections 1311(b), (c), (d), (e) and (i) of the PPACA are waived to the extent they conflict with the Georgia Access Model as described in the state's approved waiver.

The Secretary of HHS has determined, after implementation of the waiver, that HHS along with the state or its designees will be able to carry out the applicable functions of section 1311 of the PPACA that have not been waived. HHS will continue to provide limited federal Exchange functions related to advance payments of the premium tax credit (APTC). The Internal Revenue Service (IRS) will continue to provide certain tax information required to determine APTC eligibility and amounts.

2. Changes in State Law and Technical Changes to the Georgia Reinsurance Program and Georgia Access Model. The state must inform the Departments of any change in Georgia state law or regulations that would directly impact the waiver, including changes to the requirements to the Georgia Reinsurance Program or Georgia Access Model.

The state must inform the Departments of any technical changes that alter the design or terms of the waiver occurring after the date of this approval letter within seven days of any such changes. Technical changes are changes that the Departments determine do not materially impact the number of individuals with coverage, comprehensiveness and affordability of the coverage provided, or the federal deficit. Technical changes may also include changes to any obligations of the state or the Departments, such as changes to the state-approved program funding level or program parameters (e.g., altering the attachment point, cap, coinsurance rate, or eligible conditions).

If the Departments determine that the change in state law or regulation or a technical change to the state Reinsurance Program or Georgia Access Model would be a change that is not a technical change as described above, the state must immediately suspend implementation of the change and submit an amendment as set forth in STC 10. However, the Departments will afford the state an opportunity to be heard and to challenge the Departments' determination that the change materially impacts the waiver's ability to satisfy the section 1332 statutory guardrails.

Consistent with the approved waiver, the state is responsible for any reconciliation of reinsurance payments that Georgia may wish to make to account for any duplicative reimbursement through the Georgia Reinsurance Program for the same high-cost claims reimbursed through the HHS-operated risk adjustment program, and such reconciliation would be considered a technical change to the state Reinsurance Program.

3. Transition from HealthCare.gov to Georgia Access Model for Plan Year 2023 Outreach: The state must notify the public and make good faith efforts to inform all Georgia consumers currently enrolled in coverage through the FFE that HealthCare.gov will discontinue serving Georgia residents seeking to shop for and enroll in QHPs, and, instead, the Georgia Access Model will provide individual market consumers with opportunities to enroll in coverage via agents, brokers, web-brokers and directly through insurance companies, and still be eligible to apply for APTC and cost-sharing reductions (CSRs) for plan years beginning on or after January 1, 2023 and through the duration of the waiver. At least 12 months prior to implementation of the Georgia Access Model, the state will share with the Departments an outreach and communications plan detailing information about actions the state will take to inform the public and to support a smooth transition of consumers currently enrolled in coverage through HealthCare.gov to the Georgia Access Model. This plan must also outline the communications strategy for open enrollment for plan year 2023 including consumer noticing and transitioning consumer messaging with HealthCare.gov. The state must also include details on how it will inform the public where to find the list of carriers and web-brokers approved by the state to participate in Georgia Access through which they will be able to apply for coverage and APTC. The state must notify the public that the open enrollment dates for plan year 2023 in the Georgia Access Model will be the same as those for the federal open enrollment period and that eligibility criteria for QHP coverage, APTCs, and CSRs remains unchanged. If the state were to seek to

modify the dates for open enrollment periods for plan years 2024 or later under its approved waiver, the state would need to discuss that change with the Departments and that program change would be considered, unless otherwise determined by the Departments, an amendment that would need to be submitted through the amendment process set forth in STC 10. Additionally, the state must make clear in a notice to each current enrollee whether that individual enrollee will be auto-reenrolled in their current health insurance coverage if they do not take action, as well as any actions that they must take to ensure that they are enrolled successfully. CMS will also provide ample notice to FFE enrollees in Georgia that HealthCare.gov will discontinue serving residents and that the Georgia Access Model will provide opportunities to enroll in coverage beginning on or after January 1, 2023. CMS notices will be provided timely to enrollees in both written and electronic format and shall include, at a minimum, the title, URL link, and description of the state's website listing carriers and web-brokers approved to participate in the Georgia Access Model. In addition, CMS will update HealthCare.gov to automatically direct Georgia consumers to the state website containing information on the Georgia Access Model and will also include information for consumers on how to access the website. CMS will also provide the state with technical assistance necessary to transition from HealthCare.gov to the new Georgia Access Model beginning with Plan Year 2023, including any handoff of enrollment data from the federal government to the state and any data connections required for such handoff.

4. Funds to Operate the Georgia Reinsurance Program and the Georgia Access Model. The Georgia Reinsurance Program and the Georgia Access Model will be funded through a combination of federal pass-through funding and state funding, including funds from the state general fund and/or a state user fee. The state must ensure sufficient funds are available on an annual basis for the Georgia Reinsurance Program and Georgia Access Model to operate as described in the state's approved waiver. The Departments acknowledge that Georgia's state laws and budget cycle prohibit the state from committing funds for future years' budgets outside of its present budget cycle (which runs from July 1 through June 30 of the following year). Therefore, the state must inform the Departments as to whether the state budget has met certain milestones as outlined in STC 12 in order to demonstrate the state's progress in securing the necessary state funding for the Georgia Reinsurance Program and the Georgia Access Model. The state will be considered to have secured funding for a given plan year once a state appropriations bill including funding for the Reinsurance Program and the Georgia Access Model has been enacted into law.

5. Compliance with Federal Non-Discrimination Statutes. The state must comply with all applicable federal statutes relating to non-discrimination. These include the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, title I and II of the Genetic Information Nondiscrimination Act of 2008 and section 1557 of the PPACA.

6. Compliance with Applicable Federal Laws. Per 31 C.F.R. § 33.120(a) and 45 C.F.R. § 155.1320(a), the state must comply with all applicable federal laws and regulations, unless a law or regulation has been specifically waived. The Departments' state innovation waiver authority is limited to requirements described in section 1332(a)(2) of the PPACA. Further, section 1332(c) of the PPACA states that, while the Departments have broad discretion to determine the

scope of a waiver, no federal laws or requirements may be waived that are not within the Secretaries' authority. *See* 77 Fed. Reg. 11700, 11711 (February 27, 2012). Therefore, for example, section 1332 of the PPACA does not grant the Departments authority to waive any provision of the Employee Retirement Income Security Act of 1974. The state must also comply with requirements of the Cash Management Improvement Act.

7. Changes to Applicable Federal Laws. The Departments reserve the right to amend, suspend, or terminate the waiver, these STCs, or the pass-through funding amount as necessary to bring the waiver, these STCs, or the pass-through funding amount into compliance with changes to existing applicable federal statutes enacted by Congress or applicable new statutes enacted by Congress. If practicable, the Departments will notify the state at least 90 days in advance of the expected effective date or implementation date of any amendment, suspension, or termination of the waiver, these STCs, or to the pass-through funding made pursuant to this STC to allow the state to discuss the changes necessary to ensure compliance with changes to existing applicable federal statutes enacted by Congress or applicable new statutes enacted by Congress, to allow the state adequate time to come into compliance with state and federal regulatory requirements (including rate review and consumer noticing requirements), and to provide comment, if applicable. Changes will be considered in force upon the Departments' issuance of amended STCs. The state must accept the changes in writing within 30 days of the Departments' notification for the waiver to continue to be in effect. The state must, within the applicable timeframes, come into compliance with any changes in federal law, or regulations promulgated in response to a change in federal law affecting section 1332 waivers, unless the provision being changed has been expressly waived for the waiver period. If any of the waived provision(s) are eliminated under federal law, the Departments would re-evaluate the waiver to see if it still meets all of the section 1332 waiver requirements. If the Departments determine that the waiver needs to be suspended or terminated as a result of a change to federal law, the Departments will provide further guidance to the state as to that process.

8. Finding of Non-Compliance. The Departments will review and, when appropriate, investigate documented complaints that the state is failing to materially comply with requirements specified in the approved waiver and these STCs. In addition, the Departments will promptly share with the state any complaint that they may receive and will notify the state of any applicable monitoring and compliance issues in good faith.

9. State Request for Suspension, Withdrawal, or Termination of a Waiver. The state may request to suspend, withdraw, or terminate all or portions of a waiver consistent with the following requirements:

(a) Request for suspension, withdrawal, or termination: If the state wishes the Departments to suspend, withdraw, or terminate all or any portion(s) of the waiver, the state must submit a request to the Departments in writing specifying: the reasons for the requested suspension, withdrawal, or termination; the effective date of the requested suspension, withdrawal or termination; and the proposed phase-out plan (with the summary of comments received, as described below). The state must submit its request and draft phase-out plan to the Departments no less than six (6) months before the proposed effective date of the waiver's suspension, withdrawal, or termination. Prior to submitting the request and draft phase-out plan to the

Departments, the state must publish on its website the draft phase-out plan for a 30-day public comment period and conduct Federal tribal consultation as applicable. The state must include with its request and proposed phase-out plan a summary of each public comment received, the state's response to the comment and whether or how the state incorporated measures into a revised phase-out plan to address the comment.

(b) Departments' approval: The state must obtain the Departments' approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must begin no sooner than 14 calendar days after the Departments' approval of the phase-out plan, unless otherwise directed by the Departments.

(c) Recovery of unused funding: Any unused pass-through funding will be recovered. The state will comply with all necessary steps to facilitate the recovery within a prompt timeframe.

10. State Request for Amendment.

(a) Definition: For purposes of these STCs, an amendment is a change to a waiver that is not otherwise allowable under these STCs or that the Departments determine could materially impact the number of individuals with coverage, comprehensiveness and affordability of the coverage provided, the federal deficit, or program design that either is approved or not approved. Such potential changes include, but are not limited to, changes to eligibility, coverage, benefits, premiums, out-of-pocket spending, and cost sharing.

(b) Amendment Process: To amend a waiver:

(1) The state must submit a letter to the Departments notifying them in writing of its intent to request an amendment to its waiver(s). The state must include a detailed description of all of the intended change(s) in the letter of intent. The state is encouraged to submit its letter of intent at least 15 months prior to the waiver amendment's proposed implementation date and to engage with the Departments early on in their amendment proposal process. The state may wish to submit this letter of intent earlier than 15 months prior to the waiver amendment's proposed implementation date, depending on the complexity of the amendment request.

(2) The Departments will review the state's letter of intent requesting changes to its waiver, and, within approximately 30 days of the Departments' receipt of the letter of intent, the Departments will confirm whether the change requested requires an amendment and to indicate the required information that the state would need to submit in its amendment request. This written response will also include whether or not the proposed waiver amendment(s) would be subject to any additional requirements outlined in STC 10(c)(6).

(3) The state should generally plan to submit its waiver amendment application, as outlined in STC 10(c), no later than the end of the first quarter of the year prior to the year the amendment would take effect in order to allow for sufficient time for

review of the application. Consistent with the regulations at 31 C.F.R. § 33.108(b) and 45 C.F.R. § 155.1308(b), the state is required to submit the waiver application sufficiently in advance of the requested waiver implementation date, particularly when the waiver impacts premium rates, to allow for an appropriate implementation timeframe. In developing the implementation timeframe for the state waiver amendment(s), the state must maintain uninterrupted operations of the Georgia Access Model in the state and provide adequate notice to affected stakeholders and any issuers of health insurance plans that would be (or may be) affected by the amendment to take necessary action based on approval of the waiver amendment.

(4) The Departments reserve the right to deny or withhold approval of a state waiver amendment based on non-compliance with these STCs or any additional direction and information requests from the Departments, pertinent to the submitted amendment.

(5) The state is not authorized to implement any aspect of the proposed amendment without prior approval by the Departments.

(c) Content of Amendment Application: All amendment applications are subject to approval at the discretion of the Secretaries in accordance with section 1332 of the PPACA. The state must furnish such information and analysis regarding the amendment as the Departments may request. An amendment application must include the following:

(1) A detailed description of the requested amendment, including the impact on the guardrails, and related changes to the waiver program elements as applicable, including sufficient supporting documentation;

(2) The state must conduct the state public notice process that is specified for new applications at 31 C.F.R. § 33.112 and 45 C.F.R. § 155.1312. The amendment request must include an explanation and evidence of the process used by the state to ensure meaningful public input. It may be permissible for a state to use its annual public forum for the dual purpose of public input on an amendment application request;

(3) Evidence of sufficient authority under state law(s) in order to meet the PPACA section 1332(b)(2)(A) requirement for purposes of pursuing the requested amendment(s);

(4) An updated actuarial and/or economic analysis demonstrating how the requested amended waiver will meet section 1332 statutory guardrails. Such analysis must identify the "with waiver" impact of the requested amendment on the statutory guardrails. Such analysis must include a "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using data from recent experience, as well as a summary of and detailed projections of the change in the "with waiver" scenario;

(5) An explanation of the impact, if any, of the proposed amendment on pass-through funding; and

(6) Any further requested information and/or analysis that is determined necessary by the Departments to evaluate the proposed amendment.

11. State Request for Waiver Extension. The state must inform the Departments if the state will apply for extension of its waiver at least one year prior to the waiver's end date. The Departments and the state will engage in further discussions regarding next steps for extension of its waiver. In addition to the periodic reports required by 31 C.F.R. § 33.124 and 45 C.F.R. § 155.1324, the Departments may require additional data and information to be submitted to review the extension request in accordance with 31 C.F.R. § 33.120(f)(2) and 45 C.F.R. § 155.1320(f)(2). An extension application must include information requested by the Departments, which may include the following, unless otherwise provided in these STCs:

(a) Updated economic or actuarial analyses for the extension period in a format and manner specified by the Departments;
(b) Preliminary evaluation data and analysis from the existing waiver program;
(c) Evidence of sufficient authority under state law(s) in order to meet the PPACA section 1332(b)(2)(A) requirement for purposes of pursuing the requested extension;
(d) An explanation of the process to ensure meaningful public input on the extension request. The state may use its annual public forum for the dual purpose of public input on an extension application request; and
(e) Other information as requested by the Departments to reach a decision on the requested extension.

The waiver extension request and approval process is separate from the amendment process described in STC 10, with separate timelines and requirements. An extension application under these STCs can only include an extension of the existing waiver terms, not other changes to the existing waiver. If a state also seeks to make changes to its existing waiver when submitting an extension request, the Departments will treat those changes as amendments and the requirements of STC 10 will also apply.

The Departments may extend an existing reinsurance program and the Georgia Access Model on a temporary basis for an additional year while a waiver extension request is under review, without regard to the date when the application was submitted.

If the state does not apply for an extension of the waiver, the Departments will provide guidance on wind-down of the state's waiver consistent with STC 9.

12. Reporting. The state must submit quarterly and annual reports as specified in 31 C.F.R. § 33.124 and 45 C.F.R. § 155.1324. Each such annual report must include:

(a) The progress of the section 1332 waiver;
(b) Data sufficient to show compliance with section 1332(b)(1)(A) through (D) of the PPACA;
(c) A summary of the annual post award public forum, held in accordance with 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155.1320(c), including all public comments received at such forum regarding the progress of the section 1332 waiver and action taken in response to such concerns or comments; and
(d) Other information the Departments determine is necessary to calculate pass-through amounts or to evaluate the waiver.

The state must submit a draft annual report to the Departments within 90 days after the end of the first waiver year and each subsequent year that the waiver is in effect. The state will publish the draft annual report on the state's public website within 30 days of submission to the Departments. Within 60 days of receipt of comments from the Departments on the report, the state must submit to the Departments the final annual report for the waiver year, summary of the comments, and all public comments received as part of the post-award forum process. The state must publish the final annual report on the state's public web site within 30 days of approval by the Departments.

Annual Reports: The annual reports must include the following:

(1) Metrics to assist evaluation of the waiver's compliance with the statutory requirements in section 1332(b)(1):
   a. Actual individual market enrollment in the state.
   b. Actual average individual market premium rate (i.e., total individual market premiums divided by total member months of all enrollees).
   c. The actual Second Lowest Cost Silver Plan (SLCSP) premium under the waiver and an estimate of the SLCSP premium as it would have been without the waiver, for a representative consumer (e.g., a 21-year old non-smoker) in each rating area.
   d. Actual Medicaid enrollments through the Georgia Access Model.

(2) Technical changes to Georgia Reinsurance Program or Georgia Access Model, including the funding level the program will be operating at for the next plan year, or other program changes as specified in STC 2.

(3) Notification of changes to state law or regulations that may impact the waiver as specified in STC 2.

(4) Reporting of:
   a. Federal pass-through funding spent on reinsurance claim payments to issuers from Georgia Reinsurance Program and/or operation of the Reinsurance Program or Georgia Access Model.
   b. The unspent balance of federal pass-through funding for the reporting year, if applicable.

(5) The amount of state funding from the program fund, including but not limited to the general fund or state user fee, specifically any funds designated by the state to provide reinsurance to issuers that offer individual health benefit plans in the state or any other money from any other source accepted for the benefit of the fund to fully fund Georgia Reinsurance Program or Georgia Access Model for the reporting year.

(6) A description of any incentives for providers, enrollees, and issuers to continue managing health care cost and claims for individuals eligible for reinsurance.

(7) A report on the reconciliation (if any) of reinsurance payments that are duplicative of reimbursement through the HHS-operated risk adjustment program high-cost risk pooling mechanism. The report should include the Georgia reinsurance payment (before reconciliation) for high-cost claims to issuers who also receive payment through the HHS risk adjustment program under the high-cost risk pooling mechanism, the high-cost risk pool payment amount made by HHS for those claims, and the reinsurance true-up amount applied.

(8) Any other relevant data or information requested by the Departments.

Payment Schedule: The state will inform the Departments of the Georgia Reinsurance Program payment schedule by January 1, 2022.

Quarterly and Other Reports: Under 31 C.F.R. § 33.120(b), 31 C.F.R. § 33.124(a), 45 C.F.R. § 155.1320(b), and 45 C.F.R. § 155.1324(a), the state must conduct periodic reviews related to the implementation of the waiver. The state will submit a report to the Departments on the operation of Georgia Reinsurance Program, including the plan for processing claims, by February 28, 2022. Thereafter, the state must report on the operation of the waiver quarterly, including, but not limited to reports of any ongoing operational challenges and plans for and results of associated corrective actions, no later than 60 days following the end of each calendar quarter. The state must also include in its quarterly reports on the operation of the waiver metrics to assist evaluation of the waiver's compliance with the statutory requirements in section 1332(b)(1), including any other relevant data requested by the Departments. The state can submit its annual report in lieu of their fourth quarter report.

Budget Report: In addition, the state must inform the Departments as to whether the Reinsurance Program and Georgia Access Model has met certain milestones in the state budget process in order to demonstrate the state has secured funding as required under STC 4. The state must inform the Departments of any state budget update or milestone, occurring after the date of this approval letter, within seven days of any such update or milestone. In addition, as outlined in STC 16 the state must demonstrate the state has secured state funding in order to receive federal pass-through. These milestones must include, but are not limited to, whether state funding is included in:

a. The strategic priorities and guidelines issued to departments on budget development (e.g., development of the SFY 2022 Budget Report begins in August of 2020) released annually by the Governor and the Office of Planning and Budget (OPB);
b. The revenue forecast and budget recommendations in the Governor's Budget Report, which is presented to the General Assembly within 5 days of convening in January, released annually by the Governor.
c. The appropriations bill voted upon by the House and the Senate.
d. The appropriations bill passed by the House and the Senate.
e. The final enacted appropriations bill. Once the appropriations bill passes, the Governor has 40 days to sign it before it automatically becomes law. The Governor has the constitutional right to veto the entire budget and to strike out portions of the appropriations bill with a line-item veto.
f. Other budget information or milestones requested by the Departments.

Operational Report: In addition the state must submit a report to the Departments that details the project timeline for implementation of the Georgia Access Model and associated milestones, including but not limited to eligibility verifications and enrollment, at least 12 months prior to the first day of open enrollment for plan year 2023. The state must also comply with operational readiness reviews and open enrollment readiness reviews as required by the Departments.

13. Post Award Forum. Per 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155.1320(c), within six months of the waiver's effective date and annually thereafter, the state will afford the public an opportunity to provide meaningful comment on the progress of the waiver. The state is required to publish the date, time, and location of the public forum in a prominent location on the state's public web site at least 30 days prior to the date of the planned public forum. The state may request and submit a justification to do the post award forum virtually in certain circumstances, such as a natural disaster or public health emergency, as long as the other regulatory requirements for meaningful public input are met. The state must also include a summary of this forum as part of the quarterly report for the quarter in which the forum was held and the annual report as required under 31 C.F.R. § 33.124 and 45 C.F.R. § 155.1324 and as specified in STC 12.

14. Monitoring Calls. The state must participate in monitoring calls with the Departments that are deemed necessary by the Departments. The purpose of these monitoring calls is to discuss any significant actual or anticipated developments affecting the waiver. Areas to be addressed include the impact on the regulatory criteria discussed above and state legislative or policy changes. The Departments will update the state on any federal policies and issues that may affect any aspect of the waiver. The state and the Departments will jointly develop the agenda for the calls. It is anticipated that these calls will occur at least semi-annually.

15. Federal Evaluation. The Departments will evaluate the waiver using federal data, state reporting, and the application itself to ensure that the Departments can exercise appropriate oversight of the approved waiver. Per 31 C.F.R. § 33.120(f) and 45 C.F.R. § 155.1320(f), if requested by the Departments, the state must fully cooperate with the Departments or an independent evaluator selected by the Departments in consultation with the state, to undertake an independent evaluation of any component of the waiver. As part of this required cooperation, the state must submit all requested data and information to the Departments or the independent evaluator. As part of their ongoing oversight responsibilities to ensure the integrity of the Departments' programs, the Departments will fund the cost of any independent evaluation.

The state must generally meet the statutory requirements in each year that the waiver is in effect. However, the federal evaluation must also consider the longer-term impacts of the waiver and whether the statutory requirements will be met or exceeded over the course of the waiver term.

In the event a federal evaluation of the waiver determines the waiver is not meeting the statutory requirements in section 1332(b)(1), the Departments shall submit a report to the state that includes the findings of the evaluation and recommendations to bring the waiver into compliance with the statutory requirements.

16. Pass-through Funding. Under section 1332(a)(3) of the PPACA, pass-through funding is based on the amount of premium tax credits (PTC) that would have been provided to individuals under section 36B of the Internal Revenue Code in the State of Georgia absent the waiver, but that will not be provided under the waiver, reduced, if necessary, to ensure that the waiver does not increase the deficit as required by the section 1332(b)(1)(D). The state will receive pass-through funding for the purpose of implementing the approved waiver when the requirements described below are met. Pass-through amounts will not be made available annually until the state has demonstrated that they have secured the necessary funding as outlined in STC 4 for the applicable plan year.

Starting with the 2022 plan year and for each plan year thereafter, by September 15 of the preceding year or once a state has finalized rates for the applicable plan year, whichever is later, the state will provide the following information to the Departments:

(a) The final second lowest cost silver plan (SLCSP) rates for individual health insurance coverage for a representative individual (e.g., a 21-year-old non-smoker) in each rating area or service area (if premiums vary by geographies smaller than rating areas) for the plan year;

(b) The state's estimate of what the final SLCSP rates for individual health insurance coverage for a representative individual in each rating area or service area (if premiums vary by geographies smaller than rating areas) would have been absent approval of this waiver for the plan year;

(c) The total amount of all premiums expected to be paid for individual health insurance coverage for the plan year;

(d) What total premiums for individual health insurance coverage would have been for the plan year without the waiver;

(e) The amount of APTC paid by month and rating area for the current year to date;

(f) The number of APTC recipients by month and rating area for the current year to date. The state must include with this information the methods and assumptions the state used to estimate the final SLCSP rates for each rating area or service area absent approval of this waiver. In addition, the state should provide the state specific age curve premium variation for the current year and plan year;

(g) Reports of the estimated total reinsurance reimbursements for the reporting year;

(h) Reports of the total enrollment estimates for individual health insurance coverage, both with and without the waiver;

(i) An explanation of why the experience for the reporting year may vary from previous estimates and how assumptions used to estimate the impact have changed. This includes an explanation of changes in the estimated impact of the waiver on aggregate premiums,

the estimated impact to the SLCSP rates, and the estimated impact on enrollment. The state should also explain changes to the estimated reinsurance estimates relative to prior estimates; and

(j) Any other information or data requested by the Departments.

The estimated amount of pass-through funding for plan year 2022 will be communicated to the state as soon as practicable, conditional on receipt of items (a) through (j) in the paragraph above by the date specified above, and subject to a final administrative determination by the Department of the Treasury prior to payment. The pass-through amount for plan years 2022 through 2026 will be calculated by the Departments annually (per PPACA section 1332(a)(3)) and reported to the state on the earliest date practicable, conditional on the state securing funding as outlined in STC 4, on receipt of the budget reporting information outlined in STC 12, and on receipt of information identified in items (a) through (j) above by the applicable deadline. In calculating the pass-through amount, the Departments have determined that beginning with plan year 2023 through the remainder of the five-year term of the waiver, the loss in user fee revenue will be completely offset by the elimination of services provided by the FFE that provide special benefits to issuers in Georgia and will not impact the calculation of the pass-through amount.

While these STCs set forth certain conditions related to the payment of pass-through, the Departments' legal obligation to make such payments arises by operation of statute and not as a result of these STCs. Consistent with these STCs, pass-through funds will be determined annually by the Departments. The state agrees to use the full amount of pass-through funding for purposes of implementing the state's approved waiver plan, including implementing the Georgia Reinsurance Program for 2022 and future years and the Georgia Access Model for 2023 and future years. Moreover, to the extent pass-through funding exceeds the amount necessary for implementation of the Georgia Access Model and the Reinsurance Program to cover individual claim payments to issuers under the Georgia Reinsurance Program and/or operation of the Reinsurance Program, the remaining funds must be carried forward and used for purposes of implementing the state's approved waiver, such as making reinsurance payments in the next calendar year.

If the waiver is not extended, unused pass-through funds will be recovered by the Departments promptly following the end of the approved waiver period, December 31, 2026. The state will comply with all necessary steps to facilitate the recovery of such amounts by the Departments within a prompt timeframe.

17. The Departments' Right to Amend, Suspend, or Terminate. Under 31 C.F.R. § 33.120(d) and 45 C.F.R. § 155.1320(d), the Departments reserve the right to amend, suspend, or terminate, the waiver (in whole or in part) at any time before the date of expiration, only if the Departments determine that the state has materially failed to comply with these STCs, or if the state fails to meet the specific statutory requirements or "guardrails" related to coverage, affordability, comprehensiveness, or deficit neutrality.

(a) The Departments will promptly notify the state in writing of the determination and the reasons for the amendment, suspension, or termination, together with the effective

date.

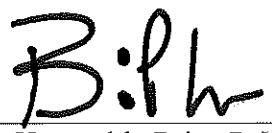
(b) The state will have 90 days from receipt of the Departments' notification to respond and, if applicable, provide a corrective action plan to bring the waiver into compliance with the STCs. The Departments must afford the state an opportunity to be heard and to challenge the Departments' determination prior to the effective date of the applicable amendment, suspension or termination.

(c) In the event that all of or a portion of the waiver is suspended or terminated by the Departments, federal funding available after the effective date of the suspension, or termination will be limited to normal closeout costs associated with an orderly suspension or termination including service costs during any approved transition period and administrative costs of transitioning participants, as described in 31 C.F.R. § 33.120(e) and 45 C.F.R. § 155.1320(e).

(d) Unused pass-through funding will be recovered. The state will comply with all necessary steps to facilitate the recovery within a prompt timeframe.

(e) Transition period. To avoid disruption and provide a reasonable transition period, the Departments will take all reasonable measures to align any termination or suspension of the waiver (in whole or in part) with the beginning of the following plan year and will take steps to mitigate any disruption to enrollees, the state, and other relevant stakeholders.

18. State's Recourse in Case of Breach of STCs by the Departments. The Departments and the state acknowledge that any final agency action taken by the Departments that is inconsistent with these STCs, including any suspension, modification, or termination of the waiver or these STCs on a basis not authorized under these STCs would constitute a material breach of these STCs. If the Departments suspend, modify, or terminate the waiver, except as provided in STC 17, the parties agree that damages at law for the breach of these STCs would not provide an adequate legal remedy and that the Departments' suspension, modification, or termination would constitute final agency action under the Administrative Procedure Act, 5 U.S.C. § 706.



The Honorable Brian P. Kemp
Governor
State of Georgia

Date: November 2, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services

Date: November 1, 2020

David Kautter
Assistant Secretary for Tax Policy
U.S. Department of the Treasury

Date: NOVEMBER 3, 2020