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ANDERSON ECONOMIC GROUP

Healthcare Innovations in Georgia: Two Recommendations

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Preamble

This plan, specifically designed for Georgia, will decrease the number of uninsured, decrease healthcare costs for millions, and improve quality in a patient-centered system.

These reforms will allow Georgia to lead the nation in healthcare innovation.

I. Executive Summary

Goal of the Project. The goal of our project is to investigate whether the State of Georgia could implement market innovations under a Section 1332 waiver that would achieve one or more of the following goals:

1. Increase access to affordable health insurance coverage and expand access to healthcare services in rural areas.
2. Lower the cost of individual health insurance, particularly for under served populations.
3. Make health insurance access uncomplicated for small employers.
4. Promote an active patient-physician relationship grounded in responsibility and engagement.'

In March 2019, the Governor of Georgia signed Senate Bill 106, which authorized the administration to submit a Section 1332 waiver application. The bill also authorizes the state to implement the waivers upon approval by the U.S. Secretary of Health and Human Services and Treasury.

In this report, we look at how two policy innovations would affect individuals' decisions to seek insurance, employers' decisions to offer insurance, and state and federal government finances. We assess the recommended innovations against the requirements of Section 1332 of the Affordable Care Act, and the goals listed above.

The Continuing Problems of the Healthcare System in Georgia. Georgia continues to face a health insurance system that places many barriers and imposes high costs on workers and families. In particular:

- Over one million Georgia residents remain uninsured, even after the Affordable Care Act went into effect in January 2014.
- Many Georgians find dealing with the medical services covered by insurance products mandated under the ACA to be inadequate, unduly expensive, or both.
- Some Georgians are stuck in a coverage gap—they earn too little to get financial help to buy health insurance on the Marketplace, earn too much to qualify for Medicaid, and have sparse options for affordable health insurance.
- Meanwhile, employers—especially small employers—continue to face high costs and compliance risks when they desire to hire employees, make part-time workers full-time employees, or hire those previously classified as contractors.
- Even for those with employer-sponsored insurance, conventional insurance plans often provide them little opportunity to have a substantive direct engagement with their doctor.

- For doctors, the structures of the conventional fee-for-service model make it unattractive to locate in rural areas, and discourage them from spending time with their patients.

Opportunity for Reform. We believe the opportunity exists to help Georgians struggling with high insurance costs and limited choices. An overview of important demographic and health market information supports our assessment:

- Figure 1 on page 8 shows that only 21% of firms with less than 50 employees offer health insurance to their employees.
- Figure 3 on page 10 shows the population segments we believe will be most affected by the policy change: employees working in small firms and low-income individuals.
- Figure 3 also shows that more than 40% of low-income individuals in Georgia are uninsured, compared to less than 5% of middle-income individuals.
- Map 1 on page 6 shows how low rates of insured individuals cluster together throughout the state, particularly in rural areas.

Recommended Innovations

We recommend that the State of Georgia consider adopting the following two market innovations. Both of these recommendations directly address the problems of high costs and limited access that disproportionately affect small employers, rural residents, and low-income families.

Georgia Reinsurance Program. The Georgia Reinsurance Program entails the creation of a fund, managed by the program, to reimburse accumulated claim costs that exceed a set threshold within a given year. Georgia statute would require all large health insurers to take part in the reinsurance program.

The goal of the Georgia Reinsurance Program is to stabilize rates for individual health insurance plans and provide greater financial certainty to health insurers and health insurance consumers. As a result, we expect significant reductions in the cost of health insurance for individuals purchasing plans on the exchange, as well as more price stability in the future. We estimate that the savings for the segment of the market with the highest costs—individuals on the healthcare exchange—will exceed $500 per year, meaning that Georgia residents will save hundreds of millions of dollars each year in reduced premiums.

An important element of this plan is the state recapture of premium tax credit payments paid. We estimate that these savings—approximately $200 million in the first year—will cover the majority of the cost to the state of administering the program.

- See “Benefits of Georgia Reinsurance Program” on page 4.
- See “Policy 1: The Georgia Reinsurance Program” on page 14.

Georgia Primary Care Access Option. The Georgia Primary Care Access Option will require large insurers to offer at least one comprehensive health insurance plan that replaces the traditional fee-for-service payment model for primary care with a direct primary care model. The direct primary care model requires members to establish a relationship with a primary care doctor that will be provided for a fixed monthly fee. The cost associated with the delivery of direct primary care will be incorporated into a member’s health insurance premium.

We expect that this innovation will expand healthcare coverage to rural and other underserved communities. It will do this by providing insurance companies and doctors with the ability to account for state and regional differences in care and provide the means to make a reasonable profit

for both. Finally, we anticipate that direct primary care will produce savings for consumers in terms of efficiency, productivity, and satisfaction with their health.

- See "Benefits of Georgia Primary Care Access Option" on page 4.
- See "Policy 2: The Georgia Primary Care Access Option" on page 21.

Monitoring Recommendation: Association Health Plans. Association Health Plans (AHP) are group plans that small businesses and other organizations can join. The intention of association health plans is to give smaller organizations improved efficiency and better bargaining power through membership in larger groups. At this time, we recommend that Georgia monitor the ongoing judicial interpretation and executive branch regulation covering AHPs.

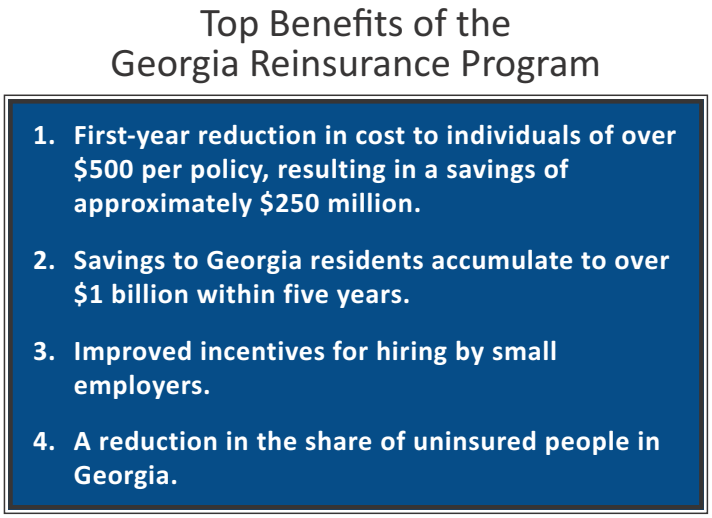
- See "Policy 3: Association Health Plans" on page 26.

Independent Actuarial Review. We retained an independent actuary to review the underwriting assumptions and analysis associated with each innovation. The actuary determined that

> "(1) the modeling assumptions are reasonable for this type of analysis and (2) the illustrative projections and savings are reasonable outcomes based on the modeling assumptions and data inputs selected."

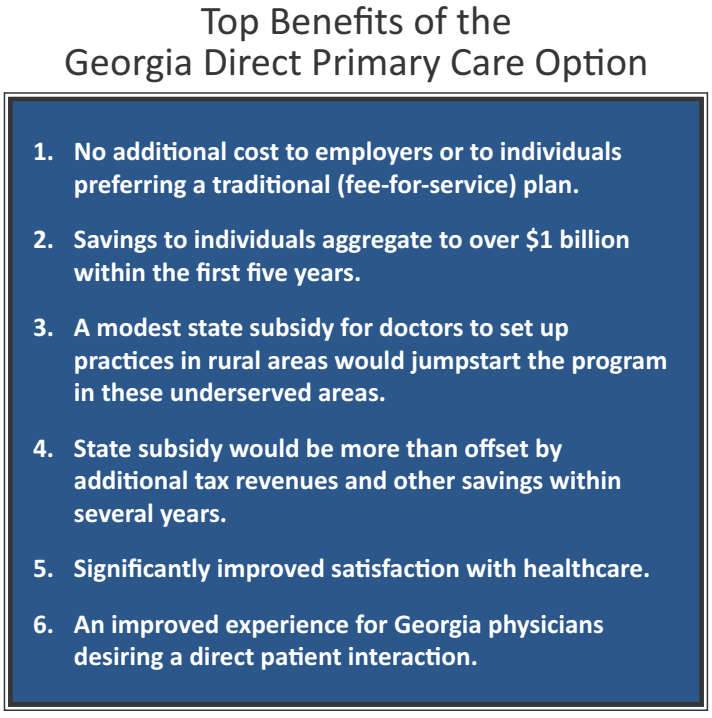
- See "Appendix E: Actuarial Review" on page E-1 for the full statement, including limitations

Exhibit 1. Benefits of Georgia Reinsurance Program



The State of Georgia must establish a reinsurance program for which an amount of approximately $250 million will be required in the first year. The State can expect approximately $200 million of that to be covered by federal premium tax credit savings passed through to the State government.

Exhibit 2. Benefits of Georgia Primary Care Access Option



About 1332 Waivers

Section 1332 of the Affordable Care Act authorizes the Department of Health and Human Services and the Treasury Department to waive certain ACA provisions for states that propose alternative approaches to increase health insurance coverage and affordability.

1332 Requirements. In order for any policy to be implemented under a 1332 waiver, it must comply with certain statutory guardrails. Specifically it must:

- Provide coverage at least as comprehensive as that required in ACA health insurance exchanges;
- Provide coverage and cost-sharing protections that are at least as affordable as what would be provided in ACA health insurance exchanges;
- Provide coverage to at least a comparable number of residents; and
- Not increase the federal deficit.

A number of states, including Alaska, Hawaii, and New Jersey, have already been approved for 1332 waiver programs developed for their states. See "Appendix A: State 1332 Waiver Applications" on page A-1.

These Innovations. Our assessment finds that both of these programs require federal approval of a 1332 waiver of certain federal requirements. In addition, both require state action and state support in some fashion, as described in this document.

We are confident that both of these healthcare innovations are consistent with the intention of Section 1332, including the beneficial effects of increasing health insurance coverage and health outcomes, producing additional savings in terms of tax revenues derived from more people working, and reducing federal premium tax credits.

About the Authors

The principal authors of the report are Patrick L. Anderson, Brandon Betz, and Sarah Mixon of Anderson Economic Group. AEG's contributions to this report include a summary of current healthcare coverage in Georgia, an economic analysis of the expected effects on Georgia residents of the policy innovations, a summary of the premium costs by sector, an analysis of household and employer business decisions, and a fiscal analysis of premium tax credit savings.

The policy innovations were prepared by David Wilson, Nate Lundsten, and Matthew Schoeppe of Wilson Partners. The underwriting projections for those innovations are a key part of this report.

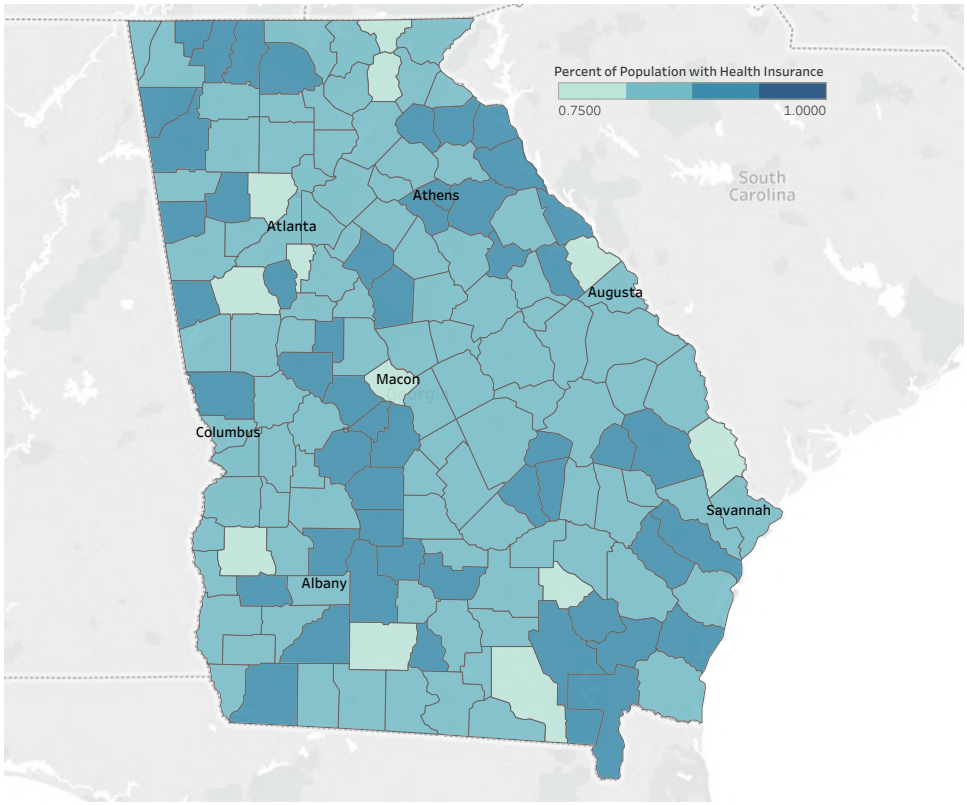
See "About the Authors" on page 37.

II. About Healthcare in Georgia

Historically, Georgia has had high percentages of uninsured residents. However, since the ACA went into full effect in January 2014, the state has seen an increase in the number of insured individuals. One of the main goals of the ACA was to extend health coverage to many of the non-elderly uninsured individuals across the country. Since 2014, many previously uninsured Georgians have enrolled in health coverage through the Health Insurance Marketplace. Georgia has not, however, expanded Medicaid. A significant portion, about 13% of the population, remains uninsured. The uninsured population includes many rural and low-income households in the state.

Map 1 below shows the percent of Georgia's population with health insurance by county.[1] There are a handful of counties still with low rates of insured individuals, and most counties still have rates below the national average of 90%.

MAP 1. Percent of Population with Health Insurance by County in Georgia, 2017



Source: Anderson Economic Group spatial analysis using base data from U.S. Census Bureau American Community Survey 2013-2017 5-year estimates

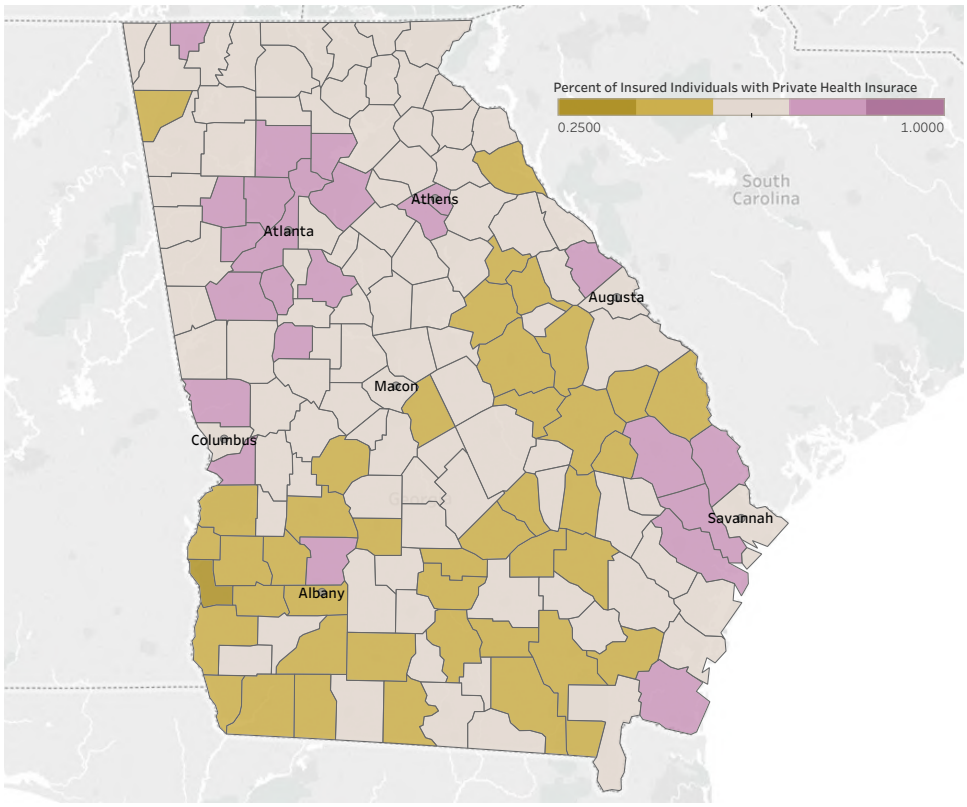
1. In our analysis, we use the most recent five-year estimates from the American Community Survey (ACS). We acknowledge that uninsured rates dropped after the implementation of the ACA in 2014 and that the inclusion of data from 2013 may distort the 5-year estimates; however, we found that the ACS offers the most comprehensive data on health insurance coverage in Georgia, and ACS data is often the basis of analysis in other 1332 waiver applications.

Map 2 below shows the percentage of the state's population who have private insurance. There is a cluster of counties in the central and southern part of the state where less than 50% of residents are insured through private insurance. Here, individuals are more likely to have public health insurance.

For our analysis we define private and public health insurance as follows:

- Private health insurance is a plan provided through an employer or union, including the Georgia State Health Benefit Plan (SHBP); a plan purchased by an individual from an insurance company; and TRICARE or other military health coverage.
- Public health insurance includes Medicare, Medicaid, and other federal medical assistance programs; VA Healthcare; and CHIP.

MAP 2. Percent of Insured Individuals with Private Health Insurance by County in Georgia, 2017

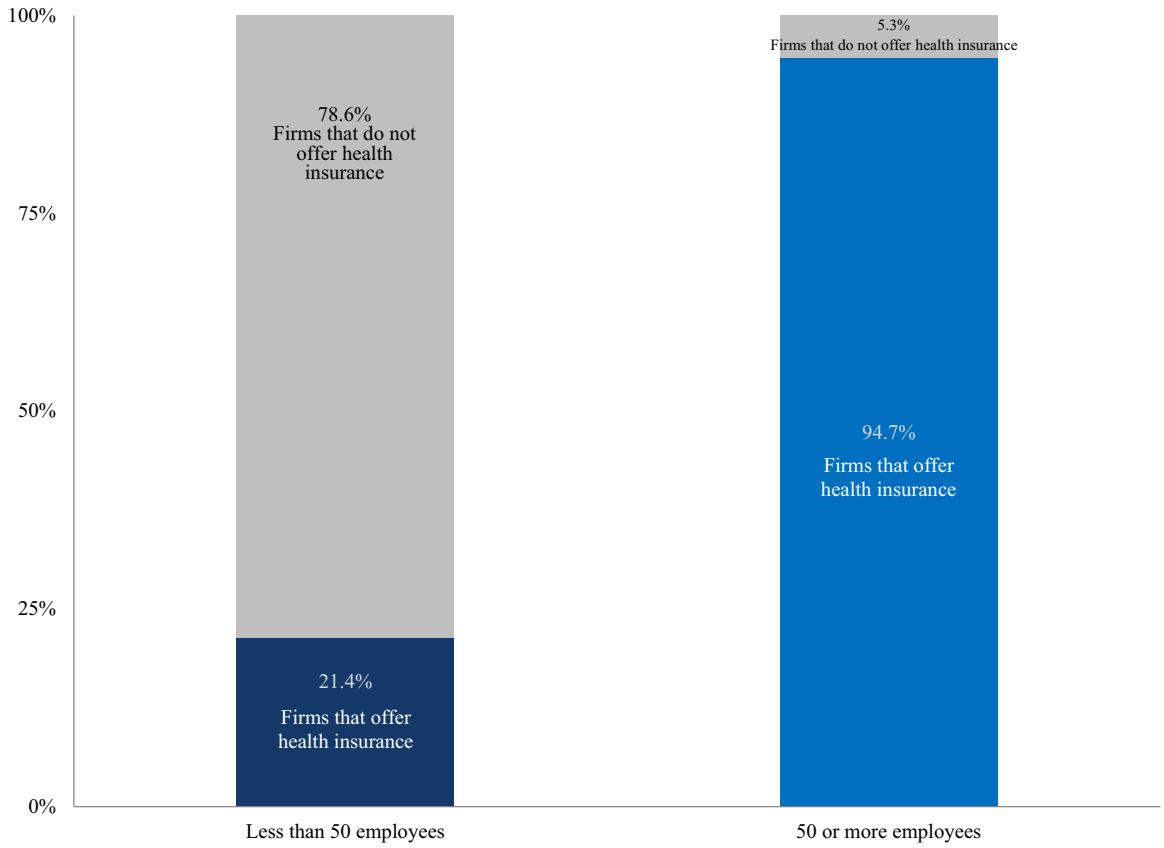


Source: Anderson Economic Group spatial analysis using base data from U.S. Census Bureau American Community Survey 2013-2017 five-year estimates

The majority of Georgians have insurance through their employers; therefore, it is important to consider how policy changes will affect employer decisions to offer insurance to their employees.

The share of establishments that offer health insurance to eligible employees, or the "offer rate," is shown in Figure 1. There is a significant difference between firms with fewer than 50 employees and firms with more than 50 employees. Almost all large firms offer health insurance coverage. However, offer rates among small firms are much lower, indicating that smaller firms find health insurance costs and compliance burdens to be a significant barrier. [2]

FIGURE 1. Share of Firms that Offer Health Insurance by Firm Size in Georgia, 2017



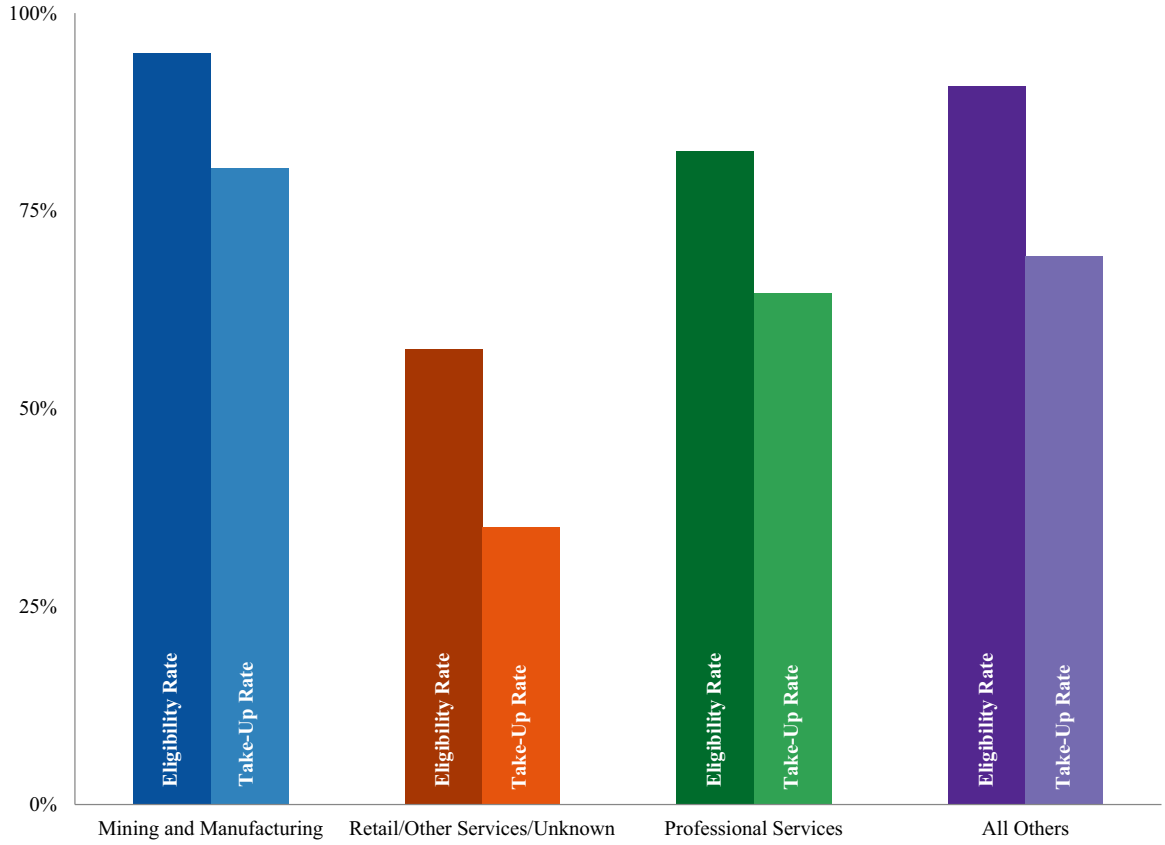
Source: Anderson Economic Group analysis using base data from U.S. Department of Health & Human Services, Medical Expenditure Panel Survey 2017

2. This is consistent with prior research on the impact of policy cost uncertainty on employer decisions. See the discussion and references cited in "Employer Decision Model" on page 28 for more information.

Figure 2 below shows the percent of employees who are eligible for health insurance (the "eligibility rate") and the percent of employees who are enrolled in health insurance (the "take-up rate") among establishments that offer insurance in Georgia.

In Georgia, the eligibility and take-up rates in the retail industry are well below those in any other industry. This may be due to the high share of part-time employees common to this industry.

FIGURE 2. Employee Eligibility and Take-Up by Industry in Georgia, 2017

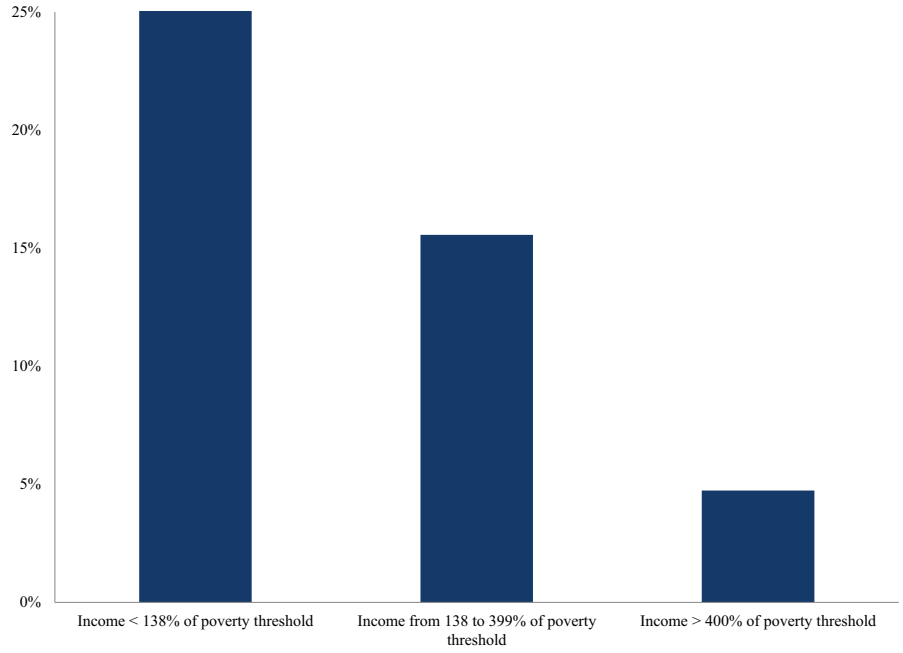


Source: Anderson Economic Group analysis using base data from U.S. Department of Health & Human Services, Medical Expenditure Panel Survey 2017

The percent of uninsured individuals with incomes less than 400% of the federal poverty level (FPL)[3] is significantly greater than those with incomes greater than 400% FPL, as shown in Figure 3 below. In Georgia, there are significant disparities in rates of uninsured individuals between income levels.

These income thresholds help to determine eligibility for reduced-cost health coverage. For instance, most individuals with income less than 100% of FPL in Georgia are ineligible for Medicaid and also ineligible for financial assistance in the form of credits with a Marketplace plan. Georgia has not expanded Medicaid. The state's Medicaid program is relatively more restrictive than in other states.[4] This creates a "coverage gap". Individuals make too much to be eligible for Medicaid but too little to qualify for lower premiums in the marketplace. Individuals with incomes between 100% and 400% of FPL qualify for a Marketplace plan with lower premiums, but those with incomes greater than 400% are not eligible to save on any Marketplace plan.[5]

FIGURE 3. Uninsured Individuals by Income Level in Georgia, 2017



Source: Anderson Economic Group analysis using base data from the U.S. Census Bureau, American Community Survey 2013-2017 five-year estimates

3. The federal poverty line is a commonly used reference point. It is only based on cash earnings. In 2018, the FPL was $12,140 for single individuals.
4. Access to Medicaid is limited to only a few specific low-income groups, including low-income households with children under the age 18, low-income pregnant women, and elderly or disabled individuals.
5. A recent CBO report estimates that the number of uninsured individuals in the U.S. has increased by about 1.4 million since 2016. This appears to be driven by a decrease in the number of individuals who purchase non-group coverage outside of the marketplaces. https://www.cbo.gov/system/files/2019-04/55094-CoverageUnder65_0.pdf.

Additional Underwriting Data

For additional information we used to outline the policy innovations described in this document, see "Appendix B: Underwriting Assumptions."

Note the limitation stated in that appendix regarding data from different sources.

III. Healthcare Innovation Policies

In January 2019 Anderson Economic Group was commissioned to perform a study on the economic and fiscal effects of several policies that could be implemented in Georgia under an Affordable Care Act 1332 waiver. To produce this report, we undertook the following tasks:

1. Reviewed the demographics of Georgia, the health insurance marketplace in Georgia, and the costs and availability of health insurance throughout the state;
2. Identified two specific innovative reforms that could improve health insurance coverage and affordability;
3. Conducted the required economic and underwriting analyses to understand whether these specific innovations would be likely to improve health outcomes, health insurance coverage, and cost burdens imposed on families and employers in the state;
4. Undertook a fiscal and actuarial analysis to estimate the effects on the state and federal governments, as well as on insurance companies operating in the state;
5. Analyzed the effects on employer decisions and individual decisions, particularly those involving hiring workers, offering employer-sponsored insurance, and purchasing insurance when previously uninsured; and
6. Assessed whether these reforms are likely to satisfy the requirements set forth in law for a Section 1332 waiver.

The following sections of this report and the corresponding appendices detail the results of our analyses.

In this section, we outline, describe, and evaluate three policy innovations. The goals of these policies are to:

1. Increase access to affordable health insurance coverage and expand access to healthcare services.
2. Lower the cost of individual health insurance, particularly for underserved populations, so that they are more likely to purchase health insurance and make use of primary care services.
3. Make health insurance easier to offer for small employers, encouraging them to offer health insurance coverage or benefits that support health insurance to their employees.
4. Promote an active patient-physician relationship grounded in responsibility and engagement, and
5. Improve patient health.

For this study, we present results for two policy innovations that require a 1332 waiver to implement in Georgia.

Recommendations. We recommend that Georgia consider the following two health insurance market reform innovations:

1. The Georgia Reinsurance Program; and
2. The Georgia Primary Care Access Option.

We also recommend that Georgia monitor closely the legal status of a third reform option: Association Health Plans. For reasons listed below, we suggest that the state delay including this innovation in a waiver application until the legal uncertainty regarding their regulation is at least partially resolved.

Statutory Guardrails. Our assessment of these innovations is subject to the limitations noted in this report. Among these limitations are the fact that state implementation, state support, certain underwriting factors, and specific regulatory decisions (such as the degree to which the state's insurance regulations require large insurers to participate in these innovations) will be critical to their success.

Given these limitations, we believe that with proper state implementation and appropriate regulation, these innovations would align with the guardrails set forth by statute under Section 1332 of the Affordable Care Act.

See "About 1332 Waivers" on page 5.

Limitations of this Assessment. There are limitations to our analysis, including the following:

- We include illustrations of policies that are dependent on numerous factors, only some of which we can explicitly define here. In particular, we fully expect both federal tax policy and federal healthcare policy to change in the future.
- The state must propose to the federal government a specific manner of implementing the waiver program. The state may decide to modify, delay, or change the policies we recommend here.
- Section 1332 waivers must be granted by the federal government. The Centers for Medicare Services (CMS) or the IRS may require modifications to conform with policies or administrative decisions that are not now in written form. In addition, these approvals involve political and bureaucratic factors that are outside our control.
- While our project plan involves an actuarial review, this review is necessarily incomplete as it involves a proposed policy for which some information is not available.
- We recommend changes in policies that would affect both employers and households. We have adopted an underwriting convention that, while common, understates the effects of these behavioral changes, and captures only some of those changes in our economic analyses.
- We assume unchanging enrollment for the purposes of the underwriting analysis because this is a convention in the health insurance industry and because we want to illustrate how these programs work internally. However, we fully expect there to be societal benefits from policy changes that result in lower costs and larger enrollment in health insurance. Our economic analysis assumes there are changes in enrollment, due to economic trends and policy-induced changes. See "Enrollment Assumptions: Underwriting Convention and Economic Analysis" on page C-1 for more details.
- We use recent trends in costs to forecast future trends. Of course, actual events will produce changes in costs that are irregular and, in some cases, unexpected.

Policy 1: The Georgia Reinsurance Program

The Georgia Reinsurance Program will provide for the statewide sharing of financial risk associated with large health insurance claimants. The structure of the reinsurance fund will incorporate Georgia's fully-insured employer markets, including both small and large employer groups, and the individual health insurance markets, inclusive of exchange-based coverage.

We expect the successful deployment and management of this innovation will yield substantive benefits, including:

- Significant reductions in health insurance premiums in the individual insurance market, including for ACA-compliant comprehensive plans.
- Premium stability in Georgia's fully-insured marketplace (comprising large and small group employer markets).
- No direct effect on the self-insured employer market, which includes very large employers that generally already offer extensive benefits and already have large risk pools.
- Premium tax credit savings from the federal government could be applied to the cost to the state of establishing the fund and cover the majority of first-year costs.

Two additional features of this innovation include:

1. The requirement that large insurers offer at least one qualified wellness program that actively engages patients in wellness education, programs, and activities; and
2. A statewide, reference-based pricing schedule for reimbursements from a fund managed by the program.

Summary. The Georgia Reinsurance Program will entail the creation of a fund, managed by the program, that will reimburse claims of Georgia residents that exceed a set threshold within a given year. The program will cover Georgia residents. Georgia statute would require all large health insurers appointed to conduct business in Georgia to take part in the reinsurance program. This will require these insurers to pay reinsurance premiums in return for relief from some claims. Self-insured employers (and large claimant expenses originating from self-insured employer plans) are not incorporated into this reinsurance program.

Under this insurance policy, Georgia statute or regulation will define a threshold requiring the reinsurance fund to cover large claimant expenses. After a claimant passes the threshold, the reinsurance fund will be responsible for 100% of those aggregate claims that exceed the threshold.

The reinsurance fund focuses solely on accumulated paid claims per insured person. Accumulated claims will be measured across insurers using a statewide reference-based pricing schedule. This reference-based pricing is not intended to regulate provider prices.

The insurer will be fully responsible for paid medical and pharmacy expenses up to the threshold, taking into account member responsibilities (such as co-pays and deductibles). All claims exceeding the threshold will be the responsibility of the reinsurance program. For our analysis, we assume that the threshold is set at $50,000 per year per insured person.

Implementation by other States. Of the eight approved 1332 waivers, seven states proposed a reinsurance policy. These states at least partially funded their program through federal pass-through funding related to premium tax credit savings.

See "Appendix A: State 1332 Waiver Applications."

In contrast to other state reinsurance programs, the Georgia reinsurance program defined in this innovation extends across the fully-insured marketplace and is not condition specific. It covers all large claimants, further increasing market stability.

1332 Waiver Applicability. As noted above, several states have successfully received 1332 waivers to implement a reinsurance program. The successful deployment of the Georgia Reinsurance Program would require Sections 1312(c)(1)[6] and 1312(c)(2)[7] to be waived in order to allow for the inclusion of the individual and employer/group markets in the reinsurance fund.

Furthermore, recent guidance document from the Centers for Medicare Services (CMS) explicitly describes two concepts that are part of this innovation:

1. State-specific premium assistance, including the use of direct state subsidies to cover certain risks, and Premium Tax Credit (PTC) payment pass-throughs to states. As stated by CMS, "States may receive federal pass-through assistance funding by waiving the PTC under section 36B of the IRC to help fund the state subsidy program."
2. Risk stabilization strategies, including the use of reinsurance, which CMS states have "lowered premiums for consumers, improved market stability, and increased consumer choice."[8]

Financing the Reinsurance Program. As a result of the reduction in premiums paid by Georgia residents under the reinsurance program, the federal government will realize savings from reduced PTC payments. These payments are used to offset the cost of insurance premiums for low-income individuals in the United States. As of February 2017, approximately 8.7 million individuals in the U.S. were eligible for such credits, representing approximately 87% of participants in exchange health insurance plans. It appears this figure could be as much as 90% in the State of Georgia.[9] PTC totaled over $20 billion nationwide in 2015.[10]

The estimated savings from these tax credits have been utilized in other Section 1332 innovations as federal pass through funds to ensure the long-term stabilization of states' individual health insurance markets.

For the purpose of our analysis, we assume that Georgia will follow the practice of most other states and request pass-through money from the federal government as part of their 1332 waiver

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6. Section 1312(c)(1) states, "a health insurance issuer shall consider all enrollees in all health plans (other than grand fathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the exchange, to be members of a single risk pool."
7. Section 1312(c)(2) states, "a health insurance issuer shall consider all enrollees in all health plans (other than grand fathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the exchange, to be members of a single risk pool."
8. Center for Medicare & Medicaid Services, "Fact Sheet: State Empowerment and Relief Waiver Concepts," November 29, 2018.
9. Congressional Research Service, "Health Insurance Credits and Subsidies," April 2018.
The CMS report on "effectuated enrollment" in Georgia for March 2017, cited in the CRS document, indicates Georgia had 90% of its "effectuated" enrollment receiving premium tax credits.
10. Data on the total PTC was estimated in the CRS document cited above.
We note in this report there are significant discrepancies in the federal government data from different agencies that underlie PTC payments in the state. See the discussion in the appendix on this matter, and "Premium Tax Credit Calculations" on page D-7.

application. However, we recognize that establishing the program will involve the state accepting some risk and that a state subsidy may be required.

See "Premium Tax Credit Calculations" on page D-7.

Wellness Plan. The Georgia Reinsurance Program will require that large insurers make available a comprehensive wellness management program that addresses the personalized needs of all members. These programs provide the ability to improve the risk-cost classification of every member.

This plan will use the results of health risk assessments and claims data to determine a personalized and incentivized health and well-being curriculum for each member. The curriculum would include education, health coaching support, and activity goal-setting and tracking. A modest cash incentive could encourage individuals to enter into a wellness plan.[11] This reward for participation would not affect premiums.

Illustration. We provide the following illustration of the costs and benefits of this program, based on current underwriting assumptions and demographic data.

- If the federal pass-through dollars from PTC savings are dedicated to the reinsurance fund, the overall savings to individual participants in the form of lower premiums will be considerable. We estimate annual savings for each healthcare exchange participant to exceed $550, and savings across the segment would exceed $250 million in the first year for Georgia residents.
- With the proper application of PTC pass-through funds, only a fraction of the cost of setting up the reinsurance fund would be a state responsibility in the first year, and no additional cost would be imposed on employers.
- With a $50,000 threshold, we estimate that the cost for the reinsurance program in 2020 would be $1,517 annually per member. Insurers would incur this additional cost per policy in return for relief from claims above the threshold. These costs would be offset by the reduction in claims costs.
- Employers will be incentivized to provide coverage to younger people, and individuals will be incentivized to purchase insurance because of lower prices. Expanding the insured population to include these individuals should lower premiums.

See Table 1 on page 19 for a summary of the costs and benefits.

See also "Appendix C: Underwriting Assumptions for the Reinsurance Option" on page C-1 for a detailed analysis of the Georgia Reinsurance Program.

11. For example, a monthly reward of $15 per member per month funded by employers should substantially improve participation. Insurers could also fund a reward for individuals. We note that the exchange market already demonstrates approximately a 90% participation in premium tax credit application (including Advanced Premium Tax Credits [APTC] paid before the person incurs the premium costs), demonstrating conclusively the effect of cash incentives in this segment.

Additional Considerations. There are a number of additional considerations we note below:

1. Attachment Point. We assume a threshold of $50,000 for an individual claimant to enter the reinsurance fund. This threshold could be adjusted higher or lower. A higher threshold would decrease payments by insurers to the reinsurance program, but results in a smaller reduction in claims costs and premiums.
   Other states have adopted reinsurance programs with "corridors," in which the reinsurance program covers the majority of or all of the claims expenses between an attachment point and an upper limit.[12] Georgia may wish to adopt a modification of the innovation outlined here, in which an upper limit and co-insurance rate is included. As an illustration, the reinsurance program could cover 90% of the allowed expenses between $50,000 and $250,000. Adopting such a modification would require modest changes in the underwriting assumptions and premium tax credit calculations, and may affect the total savings to the marketplace, but would be consistent with the design and goals of this innovation.
2. Statewide Reference-based Pricing. For the purpose of our analysis, we assume the statewide reference will be 110% to 115% above Medicare pricing for facilities, and 150% to 180% above Medicare pricing for providers. The reference used and the manner of adjusting it and taking into account regional variations will be part of implementing the Georgia Reinsurance Policy. As noted above, the reference-based pricing schedule is not intended as a regulated pricing mechanism for services other than those reimbursed from the reinsurance fund. Georgia will also need to consider reference-based methods for prescription drugs and how they will be used to determine eligibility for the reinsurance fund.
3. Reinsurance Fund Management. For the Georgia Reinsurance Program, each insurer will remain responsible for the management of their respective claimant costs above the threshold. Following the first year of the program, the state could select a single insurer as the manager of high-cost claimants, depending on their performance in managing the cost and efficacy of care for their high-cost claimants.
4. Premium Tax Credits Savings. As noted, most states that have established a reinsurance plan under Section 1332 have funded it with PTC pass-through savings. We assume Georgia would also use this mechanism but note that such dedication of funds is not required. See "Premium Tax Credit Calculations" on page C-7.
5. Definition of Large Insurers. The plan requirements described are for large insurers that provide comprehensive medical coverage. The exact definition of should be set out in statute as the state deems reasonable.
6. Wellness Plan Requirement for Large Insurers. The wellness plan requirement is described here as applying to a large subset of insurers. We do not specify here the mechanism that enforces this participation.

12. See "Appendix A: State 1332 Waiver Applications."

7. Uncertainty Regarding Behavioral Changes. As noted by a recent CBO report, the changing landscape of the healthcare market—including the removal of the individual mandate—makes projecting the results of innovations difficult:

   > Substantial uncertainty continues to exist about federal policies affecting the non group market and about the effects of eliminating the penalty related to the individual mandate. That uncertainty may affect insurers' decisions to participate in the non group market in future years, and such withdrawals could threaten market stability in some areas of the country.[13]

   For this reason, we note that estimates in this analysis—and in every other analysis of changes in healthcare policies—will have a significant margin of error.
8. Use of Trend Underwriting Factors. The underwriting projections make use of trend factors that smooth expected year-to-year variations in premiums, costs, and market adoption. Both past and future data will vary significantly around the underlying trend.

13. Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028," May 2018, https://www.cbo.gov/ as report file 53826-healthinsurancecoverage.pdf.

TABLE 1. Georgia Reinsurance Program Underwriting Summary

Per-insured (member), per year amounts	Uninsured	Individual (Including Exchange)	Large Group ESI	Small Group ESI	Self-Insured ESI
First Year					
Baseline Premium	$ -	$ 8,829	$ 5,845	$ 6,668	$ -
Less: Reinsurance Savings	$ -	$ 513	$ (192)	$ (79)	$ -
Less: Wellness Plan Savings	$ -	$ 42	$ 31	$ 34	$ -
Premium with Reinsurance and Wellness Plan Savings	**$ -**	**$ 8,273**	**$ 6,007**	**$ 6,713**	**$ -**
Savings Per Insured Person Per Year	$ -	$ 556	$ (161) *before subsidy*	$ (44) *before subsidy*	$ -
Aggregate Amounts					
Enrollment	1,370,455	516,089	1,202,191	247,293	3,593,523
Participation Rate	-	90%	95%	95%	-
Aggregate Savings (Costs)	$ -	$ 258,045,886	$ (184,274,450)	$ (10,416,614)	$ -
Presumed PTC Pass-through and State Subsidy	$ -	$ -	$ 184,274,450	$ 10,416,614	$ -
Net Savings (Cost) to Market Segment	**$ -**	**$ 258,045,886**	**$ -**	**$ -**	**$ -**
Presumed PTC Pass-through and State Subsidy	$ 194,691,063				
Fifth Year					
Baseline Premium	$ -	$ 12,883	$ 7,520	$ 8,579	$ -
Less: Reinsurance Savings	$ -	$ 749	$ (247)	$ (81)	$ -
Less: Wellness Plan Savings	$ -	$ 309	$ 168	$ 177	$ -
Premium with Reinsurance and Wellness Plan Savings	**$ -**	**$ 11,825**	**$ 7,599**	**$ 8,483**	**$ -**
Savings Per Insured Person Per Year	$ -	$ 1,058	$ (79)	$ 96	$ -
Aggregate Amounts					
Enrollment	1,370,455	516,089	1,202,191	247,293	3,593,523
Participation Rate	-	90%	95%	95%	-
Aggregate Savings (Costs)	$ -	$ 491,536,066	$ (90,041,702)	$ 22,581,313	$ -
Presumed PTC Pass-through and State subsidy	$ -	$ -	$ 90,041,702	$ -	$ -
Net Savings (Cost) to Market Segment	**$ -**	**$ 491,536,066**	**$ -**	**$ 22,581,313**	**$ -**
Presumed PTC Pass-through and State Subsidy	$ 90,041,702				

convention: costs are negative, savings are positive amounts
enrollment assumed to be stable in this illustration

Table 1 (continued)

Reinsurance Savings, First Year	Uninsured	Individual (Including Exchange)	Large Group ESI	Small Group ESI	Self-Insured ESI
Baseline Premium for Claims Greater than $50,000	$ -	$ 2,419	$ 1,602	$ 1,827	$ -
Reinsurance Premium Per Insured	$ -	$ (1,906)	$ (1,794)	$ (1,906)	$ -
Premium Savings from Reinsurance	**$ -**	**$ 513**	**$ (192)** *before subsidy*	**$ (79)** *before subsidy*	**$ -**
Wellness Plan Savings, First Year					
Baseline Premium with Savings from Reinsurance	$ -	$ 8,315	$ 6,038	$ 6,747	$ -
Fractional Savings fom Wellness Migration	0.0051	0.0051	0.0051	0.0051	0.0051
Premium Savings from Wellness Migration	**$ -**	**$ 42**	**$ 31**	**$ 34**	**$ -**

Assumptions and Variables	
Reinsurance Premium	$ 127
Fractional Savings from Wellness Migration	0.0051

Note: No changes in premiums or costs are projected for the self-insured ESI segment
Sources: Insurance underwriting assumptions, Wilson Partners
PTC and State subsidy assumptions, Anderson Economic Group
Analysis: Anderson Economic Group

Policy 2: The Georgia Primary Care Access Option

Under current healthcare plans, patients and their primary care physicians have the expectation that they will spend little time together until the patient is sick. Many Georgians, however, consider their health extremely important. Many take the necessary steps to protect and preserve their health, including purchasing insurance and visiting their primary care doctor for regular checkups, no matter how short or rushed. Many others, however, lack a relationship with a primary care physician. Establishing a relationship with a doctor for a fixed monthly fee can induce and empower many patients to see their primary care physician regularly, which results in decreased healthcare expenses and reduced health insurance premiums for Georgia residents.

Summary. The Georgia Primary Care Access Option provides a choice for individuals to purchase a fully-insured healthcare policy with a provision for a direct primary care model that replaces the traditional fee-for-service payment model. Under this policy, all large insurers will be required to offer at least one comprehensive health insurance plan, as defined by the ACA, that includes direct primary care. The direct primary care model requires members to establish a relationship with a primary care doctor that would cost a fixed monthly fee.

The cost associated with the delivery of direct primary care (the fee) will be incorporated into a member's health insurance premium and is considered to be payment in full for all care received within the direct primary care practice. Due to improved patient access, increased patient-physician time, and the proper financing of primary care, this model is expected to positively impact the utilization of healthcare services, including specialist care, emergency room and urgent care visits, and pharmacy services. Specialist visits would also decline as primary care physicians will be able to spend more time with their patients. These improvements will decrease the cost of insurance.

We expect rural communities and rural patients to be specifically advantaged by this model and insurance plan option. An optimal direct primary care physician panel size is between 500 and 800 patients. In comparison, a sustainable panel size for a traditional fee-for-service physician is between 2,000 and 3,000 patients.[14]

The successful deployment and management of this innovation is expected to reduce health insurance costs throughout the insurance market, while yielding increased patient access to high-quality primary care throughout the state.

Funding Mechanism. Direct primary care will be financed through a fixed monthly fee per patient as opposed to the traditional fee-for-service payment model. The fee associated with this model is considered a payment in full for all care delivered within a primary care practice. Services provided within the direct primary care model will include preventative care, acute care, chronic care, health coaching, population health management, behavioral health, and 24-hour access and care coordination.

Currently, about 7% of insurance premiums are allocated to primary care.[15] The Georgia Primary Care Access Option will reallocate $70 per member per month to pay for direct primary care. Savings from this plan accrue from the amount of time a patient spends with their primary care

14. Estimates by Wilson Partners. See "Appendix D: Underwriting Assumptions for the Primary Care Access Option."
15. Estimates by Wilson Partners. See "Appendix D: Underwriting Assumptions for the Primary Care Access Option."

doctor. More time with a primary care physician implies less time spent with specialists and better attention to care.

Wellness Plan. This program requires that large insurers make available a comprehensive, wellness-demand management program that is managed by the primary care physician. It uses the results of health risk assessments and claims data to determine a personalized health and well-being curriculum for each member. The curriculum would include education, health coaching support, and activity goal-setting and tracking.

The reward vehicle for participation in the wellness plan would be in the form of a Health Reimbursement Arrangement for members enrolled through employer or group coverage, or a Georgia Healthcare Premium Account for members enrolled through individual coverage. A modest cash incentive could be substituted to encourage particularly reluctant individuals to enter into a wellness plan. This reward for participation would not affect premiums.

Illustration. We provide an illustration of the costs and savings of the program, subject to the limitations expressed in this document, in Table 2 on page 24.

In accordance with our analysis, we have illustrated the annual premium savings per member by year over a five-year period; 2020 to 2025 for the Georgia marketplace. We have also illustrated the reduced monthly premiums in the fully insured market in Georgia on a market-wide basis.

We truncated the migration to the Primary Care Access Option at 20% over the five-year period. It is likely that enrollment in the option will continue after 2025, so our estimate that 20% of insured individuals in the state will enroll in the option is conservative. Based on the limitations we have already outlined, forecasting enrollment past five years becomes difficult.

See "Appendix D: Underwriting Assumptions for the Primary Care Access Option" on page D-1 for a detailed analysis of the Georgia Primary Care Access Option.

Implementation by other States. No state has submitted a waiver that includes direct primary care, as of March 2019.

We recognize that Georgia would be a pioneer in this area, should it decide to seek a waiver for the purpose of establishing this option. However, it fits squarely into the purpose of 1332 waivers, and the recent CMS guidance encourages "adjusted plan options" that could result in "increasing consumer choice and making coverage more affordable to individuals."[16] Moreover, the introduction of direct primary care would also be consistent with the federal government's goal for 1332 waivers, as stated in the recent rule to "promote consumer-driven healthcare," and in particular to "focus on providing people with the resources and information they need to afford and purchase the private insurance coverage that best meets their needs."[17]

1332 Waiver Applicability. The successful deployment of the Georgia Primary Care Access Option may require a waiver of Section 1302(b)(1) in order to allow the inclusion of the individual and small group markets.[18]

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16. Center for Medicare & Medicaid Services, "Fact Sheet: State Empowerment and Relief Waiver Concepts," November 29, 2018, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Fact-Sheet.pdf.
17. State Relief and Empowerment Waivers Rule, published at 83 FR 53575 (October 24, 2018).

Additional Considerations. There are a number of additional considerations we note below:

1. Definition of Wellness Plan. The benefits of a wellness plan depend on broad participation and effective encouragement. The manner of defining wellness services, and the mechanisms for encouraging participation, are largely left to state regulation, insurance policy plans, and implementation by employers.
2. Definition of Large Insurers. The plan requirements described are for large insurers that provide comprehensive medical coverage. The exact definition of should be set out in statute as the state deems reasonable.
3. Wellness Plan Requirement for Large Insurers. The wellness plan requirement is described here as applying to a large subset of insurers. We do not specify here the mechanism that enforces this participation.
4. Support in Rural Areas. We recommend the state support the establishment of primary care networks and physicians providing services under this model in rural areas. While not outlined specifically in this document, we believe a subsidy for the establishment of such services could be partially funded by federal pass-through monies from PTC savings. See the note under "1332 Waiver Applicability" on page 15.
5. Inclusion in State Health Plan. An obvious candidate to pioneer the implementation of this option is the health plan operated by the state government.
6. Use of Trend Underwriting Factors. The underwriting projections make use of trend factors that smooth expected year-to-year variations in premiums, costs, and market adoption. Both past and future data will vary significantly around the underlying trend.
7. DPC concept and regulations. The direct primary care concept was included in the ACA.[19] However, the Department of Health and Human Services has not yet specifically defined direct primary care services.[20]

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18. Section 1302(b)(1) states, "essential health benefits shall include at least the following general categories and the items and services covered within the categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative services and devices, laboratory services, preventative and wellness services and chronic disease management, and pediatric services (including oral and vision care)."
As noted above, DPC services are now available in many states. Furthermore, both statute (e.g. 42 USC 18021) and regulation (45 CFR 156.245, related to direct primary care medical homes) explicitly provide for health plan coverage for certain forms of direct primary care.
Arguably, current law and regulation do not preclude Georgia from requiring certain health insurers to offer a product that includes DPC features. In addition, our economic and underwriting analyses do not rely upon any federal financial support for a DPC model, including any PTC pass-through savings. However, we have included a full outline of the DPC innovation to allow the state to consider the policy, as well as the applicability of the waiver requirement.
19.Public law 111-148. (124 Stat. 162; Date: March 23, 2010). Text from: United States Public Laws. https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf.
20. There is a federal rule on the treatment of direct primary care medical homes, 45 CFR § 156.245 (2018). CMS also recently announced a Primary Care Initiative. https://revcycleintelligence.com/news/hhs-launching-direct-contracting-payment-models-for-primary-care.

TABLE 2. Georgia Primary Care Access Option Underwriting Summary

	Individual (Including Exchange)	Large Company ESI	Small Company ESI	Self Insured ESI	Total
Aggregate Amounts					
Weighted Net Savings (Cost) Per Insured, First Year (2020)	$ 42	$ 13	$ 19	$ -	
Enrollment	516,089	1,202,191	247,293	3,593,523	5,559,096
Aggregate Savings Per Year (2020)	$ 21,528,562	$ 15,589,436	$ 4,615,047	$ -	$ 41,733,045
Weighted Premium Calculations per Insured, First Year					
Premium without Direct Primary Care (DPC)	$ 736	$ 487	$ 556	$ -	
Less: Weighted Average Premium with & w/o DPC	732	486	554	-	
Weighted Net Savings on Premium, Per Month	$ 3.33	$ 1.05	$ 1.45	$ -	
Wellness Migration Savings per Month	$ 0.14	$ 0.03	$ 0.11		
Total Savings Per Month	$ 3.48	$ 1.08	$ 1.56		
<Months>	12	12	12	-	
Weighted Net Savings on Premiums Per Year	$ 42	$ 13	$ 19	$ -	
Consolidated Premium Calculations per Insured					
Premiums without DPC (95% weight)	$ 736	$ 487	$ 556		
Premiums with DPC (5% weight)	$ 669	$ 466	$ 527		
Weighted Average Premiums	$ 732	$ 486	$ 554		

Underwriting Assumptions: Assuming that 5% of all enrollees move to DPC in 2020, 3% of the population will improve their overall health risk each year. This will result in a per member, per year claims savings of 0.17% for each 1% of migration toward a better health services model.

Note: No changes in premiums or costs projected for the self-insured ESI segment.
Source: Insurance underwriting assumptions, Wilson Partners.
Analysis: Anderson Economic Group LLC

Table 2 (continued)

	Individual (Including Exchange)	Large Company ESI	Small Company ESI	Self Insured ESI	Total
Aggregate Amounts					
Weighted Net Savings (Cost) Per Insured, Fifth Year (2024)	$ 409	$ 154	$ 193	$ -	
Enrollment	516,089	1,202,191	247,293	3,593,523	5,559,096
Aggregate Savings Per Year (2024)	$ 210,853,708	$ 184,628,301	$ 47,654,473	$ -	$ 443,136,482
Weighted Premium Calculations per Insured, Fifth Year					
Premium without DPC	$ 1,074	$ 627	$ 715	$ -	
Less: Weighted Average Premium with & w/o DPC	1,042	616	701	-	
Weighted Net Savings on Premium, Per Month	$ 31.09	$ 11.07	$ 14.09	$ -	
Wellness Migration Savings per Month	$ 2.96	$ 1.73	$ 1.97		
Total Savings Per Month	$ 34.05	$ 12.80	$ 16.06		
<Months>	12	12	12	-	
Weighted Net Savings on Premiums Per Year	$ 409	$ 154	$ 193	$ -	
Consolidated Premium Calculations per Insured					
Premiums without DPC (77.4% weight)	$ 1,074	$ 627	$ 715		
Premiums with DPC (22.6% weight)	$ 936	$ 578	$ 653		
Weighted Average Premiums	$ 1,042	$ 616	$ 701		

Underwriting Assumptions: Assuming that 5% of all enrollees move to DPC in 2020, 3% of the population will improve their overall health risk each year. This will result in a per member, per year claims savings of 0.17% for each 1% of migration toward a better health services model.

Note: No changes in premiums or costs projected for the self-insured ESI segment.
Source: Insurance underwriting assumptions, Wilson Partners.
Analysis: Anderson Economic Group LLC

Policy 3: Association Health Plans

Recommendation. We recommend that Georgia carefully monitor the ongoing judicial interpretation and executive branch regulation of the rules and statutes covering Association Health Plans (AHP). While AHPs have sufficient benefits to warrant inclusion in future health policy for the State of Georgia, given the current legal uncertainty we recommend delaying including them in a section 1332 waiver application.

Description of Association Health Plans. Association Health Plans are group plans that can be joined by small businesses and other organizations. The intention of AHPs is to give smaller organizations improved efficiency and better bargaining power by including them in larger groups. AHPs are explicitly contemplated in the Executive Order of the President dated November 2017.[21] Some are in place and operating in states that have not applied for 1332 waivers. However, more aggressive use of AHPs—including their availability to very small businesses such as sole proprietorships with no other employees—could be facilitated by explicitly including an AHP plan into a state 1332 innovation waiver.

As described by the Department of Labor:

> AHPs are an innovative option for expanding access to employer-sponsored coverage (especially for small businesses). Through AHPs, employers band together to purchase health coverage. By participating in AHPs, employees of small employers and working owners are able to obtain coverage that is not subject to the regulatory complexity and burden that currently characterizes the market for individual and small group health coverage and, therefore, can enjoy flexibility with respect to benefit package design comparable to that enjoyed by large employers. AHPs may also help reduce the cost of health coverage to participating employer members by giving groups of employers increased bargaining power vis-à-vis hospitals, doctors, and pharmacy benefit providers, and creating new economies of scale, administrative efficiencies, and a more efficient allocation of plan responsibilities (as the day-to-day administration of the benefit program is transferred from participating employers, who may have little expertise in these matters, to the AHP sponsor).
>
> The Department expects that a substantial number of uninsured people will enroll in AHPs because the Department expects the coverage will be more affordable than what would otherwise be available to them, and other people who currently have coverage will replace it with AHP coverage because the AHP coverage will be more affordable or better meet their needs. The Department also notes the U.S. Congressional Budget Office (CBO) predicted that 400,000 people who would have been uninsured will enroll in AHPs and 3.6 million people will enroll in AHPs who would have had other coverage, resulting in 4 million additional people enrolling in AHPs.[22]

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21. Exec. Order No. 13813, 82 FR 48385 (2017), https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/.
22. DOL rule, "background," at 83 Fed. Reg. at 28,912 (June 21, 2018). The citation in the rule is to U.S. Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028," https://www.cbo.gov/ as report file 53826-healthinsurancecoverage.pdf.

Department of Labor Rule. In 2018, the Department of Labor adopted a new rule for AHPs.[23] This rule defined the scope of businesses included as AHP-eligible, and included sole proprietorship with no other employees and other small businesses. The DOL rule, however, maintained consumer protections, such as the prohibition against using pre-existing conditions as an underwriting criteria justifying higher premiums. It also maintained state oversight.[24]

However, because AHPs have been included as an employment benefit under the federal ERISA law, there is some ambiguity regarding the status of the insurance coverage provided under AHPs. This ambiguity has allowed for legal uncertainties regarding such policies.

This uncertainty has increased recently with the March 2019 memorandum opinion in *State of New York v. US Dept of Labor,* in which a federal court enjoined the rule. The court asserted that the DOL Final Rule "stretches the definition of 'employer' beyond what ERISA's text and purpose will bear."[25] The court also noted "DOL has always permitted some AHPs meeting stringent criteria to qualify as a single ERISA employee benefit plan, as if the plan was sponsored by a single employer for its employees."

Implementation by other States. Association Health Plans already operate in multiple states. However, our review did not discover any state that has included a specific AHP proposal in a waiver application.

23. The DOL website describing AHPs is: https://www.dol.gov/general/topic/association-health-plans. The rule is reprinted in the federal register at 83 Fed. Reg. at 28,912, June 21, 2018.
24. See, e.g., DOL website listed above.
25. *State of New York v. US Dept of Labor,* no. 18-747, memorandum opinion, March 28, 2019.

IV. Expected Effects on Georgia Residents

We discuss the effects of these innovations on employers and households below.

Methodology for Estimating Employer Decisions

One of the main avenues by which individuals are enrolled in health insurance is through employer-sponsored insurance. However, many individuals are not able to access insurance through their employer. These employees work for companies that do not offer insurance or are ineligible due to their status as part-time workers, contractors, or other complications. When the price of covering employee health insurance declines, businesses will be more likely to offer insurance. Additionally, those businesses that already offer insurance will be able to hire employees and extend health coverage to current and newly-hired employees. Our analysis of employer decisions is an innovation to the 1332 waiver process because it takes into account these effects.

Employer Decision Model

Businesses make forward-looking decisions when hiring employees and when determining their level of compensation. Below, we describe our sector-based decision model, which takes into account the specific costs faced by companies in different industries and of various sizes. This model has been demonstrated in other applications (including healthcare insurance costs) to show how businesses will anticipate and respond to changes in present and future costs over time. This model will be used to estimate the extent to which changes in healthcare premiums or other healthcare insurance characteristics will affect firms' willingness to provide healthcare and to hire or lay off employees.

Model Description. We utilize a business decision model, created by Rapid Recursive® technology, to estimate changes in business hiring behavior and behavior in regard to offering employer-sponsored insurance under different health insurance regimes. The model assumes that policy cost uncertainty affects employers' decisions to hire or lay off employees. In particular, it assumes employers consider both current, and expected future, government policies and related costs when they make employment or investment decisions The model has been used to estimate these decisions for businesses facing this kind of risk. We make use of an improved and extended approach based on Patrick L. Anderson's 2014 publication regarding business decisions under policy uncertainty.[26]

The decision model employs industry and firm-size specific data to compose and solve the sequential decision problem that businesses face of whether to lay off employees, maintain current employment levels, or hire employees. Calibrated using current employment data and employee healthcare costs, this model estimates how many employees would be hired or laid off as a a result of changing healthcare regimes. The model estimates the effects of these policies on employer decisions. If a particular innovation encourages a firm to hire and give employees employer-sponsored insurance, then unemployed workers, workers who are not working full time, or workers who do not have employer-sponsored health insurance, will be hired and be given employer-sponsored insurance.

We estimated employer effects on multiple industries in Georgia, using the approximate changes in cost we project for the GRP innovation, and the employer decision model described above. We

26. Patrick L. Anderson, "Persistent Unemployment and Policy Uncertainty: Numerical Evidence from a New Approach," *Business Economics* 49:1, 2014.

found that certain industries, listed below, were likely to have small but significant increases in employment, which would cumulate over time. This includes improvements in the number of workers currently categorized as "contractors" that would become "employees." These improvements were concentrated in industries where smaller businesses were the dominant employers. This is consistent with the analysis of the Georgia market in "About Healthcare in Georgia" on page 6 and in the previous research cited above.

Below is a listing of the industries in which our analysis suggests improved hiring would result from innovations reducing the costs of health insurance to employers.

- Educational Services
- Healthcare and Social Assistance
- Accommodation and Food Service
- Other Services (Except Public Administration)

We did not, however, include quantitative estimates of new employment in either our underwriting or fiscal analyses. This renders our assessment of the benefits of these innovations quite conservative.

Methodology for Estimating Household Decisions

There are two ways in which households will be impacted by these policy changes. First, premiums and options for coverage in the individual market will be affected by the new policies. Second, business decisions may affect their employment or the household's ability to receive coverage through their employer. We examine both cases separately below.

Individual Market. We estimate how a change in premium costs in the individual market will affect the population insured. We reviewed previous analyses (see "Comparison with Other Models" on page 34) to determine various populations' responses to these changes in costs. We estimate that 5% of the uninsured population would migrate from the uninsured population to the insured population each year, given the reduction in price. Of the 5% migration, we estimate that 80% would enter the individual market and 20% would obtain employer sponsored insurance each year. We estimate this migration only for the subset of the uninsured population that would be offered ACA insurance and is potentially able to exercise that decision, or about 50% of the 1.4 million uninsured residents.

We expect that our estimates of increased enrollment and migration are conservative, as they reflect a response to policy and price changes that have been calculated in comparable recent analysis.[27]

Employer-Group Markets. We do not expect that individuals will switch from purchasing employer sponsored insurance to the individual market. The price of employer sponsored health insurance is significantly lower than that of the individual market, even after the decline in premiums due to the implementation of the reinsurance program.[28] Additionally, there are compliance and transition costs associated with switching from employer sponsored insurance to the individual market; typically, employers pay a portion of an employee's premium. It is also challenging to navigate the individual healthcare exchanges to enroll in the individual market.

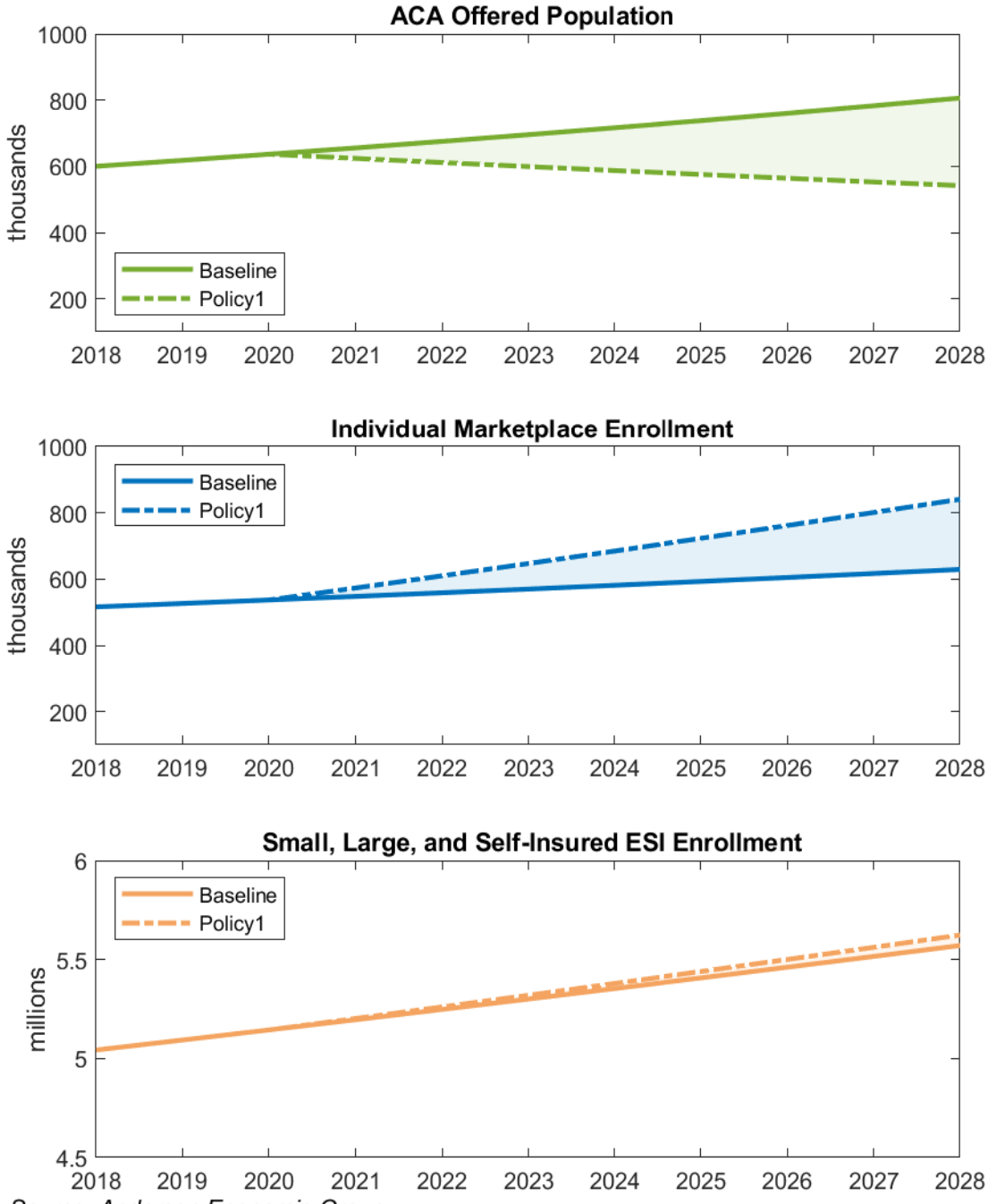
27.See "Recognizing Sensitivity to Price Changes" on page 35 for more details.

28. Comparison of the premium per member per year (PMPY) in the individual market and in the small and large group markets. See Exhibit 1 on page C-2.

Change in Enrollment. We estimate the change in insured individuals due to the implementation of the Georgia Reinsurance Program as follows. From 2020 to 2029, there is a significant increase in enrollment in the individual market due to the policy innovation relative to the baseline scenario in which there is no Georgia Reinsurance Program. The projected change in enrollment is shown in Figure 4 on page 31.

We look at the household response separately from the underwriting analysis of the policy innovation, meaning that we estimate behavioral changes as a response to the implementation of the program. The underwriting analysis uses a convention of stable enrollment, typical in the health insurance industry. Here, however, we use a dynamic analysis to project enrollment changes.

FIGURE 4. Projected Change in Enrollment due to Reinsurance Policy, 2020 to 2029



Source: Anderson Economic Group
See assumptions and limitations stated in text.

Net Fiscal Impact

A key statutory guardrail associated with the 1332 waiver is that an innovation cannot increase the federal deficit.[29] There are a number of avenues by which the innovations described in "Healthcare Innovation Policies" on page 12 would affect the federal deficit. In order to estimate the magnitude of the fiscal effects, we utilize the output of the employer and household decision models.

Direct Effects. The largest and most direct fiscal effect of these innovations would be a reduction in premium tax credit payments by the federal government. See "Premium Tax Credit Calculations" on page C-7 for more details.

Indirect Effects. The indirect fiscal impacts of implementing a new insurance regime include implementation and administrative costs, which would increase the federal deficit.

Some of the indirect effects of the innovations would increase the federal deficit, including increased spending on some tax credits that are not directly associated with the policy change. On the other hand, some of the indirect effects would serve to offset deficit increases, including decreases in spending on some tax credits and reductions in spending on some programs.

The direct and indirect effects of implementing the innovations are illustrated in:

- Table 3, "Anticipated Fiscal Effects from the Employer-based Insurance Market" on page 33, and
- Table 4, "Anticipated Fiscal Effects from the Individual Insurance Market" on page 33.

The tables include the budget item affected, the anticipated direction of effect, and an effect description.

29.See "1332 Requirements" on page 5 for a summary of all statutory guardrails.

TABLE 3. Anticipated Fiscal Effects from the Employer-based Insurance Market

Budget Item	Effects	Channel of Influence
Small Business Tax Credits (SBTC)	Increase in spending on premium tax credits	Policy innovations induce more small businesses to offer more insurance; hence, more businesses become SBTC-eligible
Payroll Taxes	Increase in tax revenue	Lower premiums lead to more workers hired and receiving income. Since payroll taxes are applied to taxable income, tax collections increase
State Unemployment Insurance	Decrease in spending on unemployment insurance	Lower premiums lead to more workers getting hired and fewer workers eligible for state unemployment insurance
Cadillac Tax (starts 2022)	Loss in tax revenue	Lower premiums lead to fewer workers having their insurance premiums in excess of the threshold for the tax; hence, the tax applies to fewer insurance buyers and collections fall
Employer-shared Responsibility Payments	Loss in tax revenue	Policy innovations induce more businesses to offer insurance; hence, fewer businesses owe employer-shared responsibility payments for not providing their workers with insurance

Source: Anderson Economic Group

TABLE 4. Anticipated Fiscal Effects from the Individual Insurance Market

Budget Item	Effects	Channel of Influence
State Program Funding, Federal Administrative Costs	Increase in spending	Direct spending
Advanced Premium Tax Credits (APTC) and Premium Tax Credits (PTC)	Decrease in spending on tax credits	Lower premiums lead to lower premium tax credits
Advanced Premium Tax Credits (APTC) and Premium Tax Credits (PTC)	Increase in spending on tax credits	Lower premiums induce the previously uninsured to buy individual insurance. Some of the new buyers become eligible for APTC
Health Insurance Providers Fee	Loss in tax revenue	The fees are based on collections on premiums as a share of nationwide aggregate net premiums and year-to-year premium growth; lower premiums lead to lower collections
Federal Exchange User Fees	Loss in tax revenue	The fees are based on collections on premiums; lower premiums lead to lower collections
Risk Adjustment Administration Fee	Increase in tax revenue	The fees are based on the number of individual insurance buyers; higher number of individual insurance buyers

Source: Anderson Economic Group

Comparison with Other Models

As noted in "Appendix A: State 1332 Waiver Applications" on page A-1, we reviewed the 1332 waivers applications of multiple states. One aspect of this comparison involved the methodology for analyzing individual choices in the insurance marketplace. In this section, we compare the specific methods we used with the methods used in other states and by federal government agencies. We also discuss some of the problems that arise from ignoring or under counting the incentives and choices that face consumers, employers, and insurers.

Focus on micro-level decisions. Our review of other state applications and federal government analyses confirms that the best practices in analysis involve a focus on choices by subgroups within the general population and specific segments of the insurance market. While differing in many aspects, the most effective models attempt to examine the choices in terms of costs of different options in specific segments of the market.

This focus on micro-level analysis allows for differences in costs and benefits that are strong in some segments of the market to be properly recognized, rather than absorbed into a large and diffuse "average" for the country.

Our approach is firmly in line with the practice of focusing on micro-level decisions, in that we attempt to model the decisions of individuals and households separately from those of employees, for whom employer-based insurance is available. Similarly, we attempt to analyze the decisions of households at different income levels, and in some cases, regions of the state. Finally, we undertake a serious effort to model the decisions of employers at different scales of operation and in different industries.

"Microsimulation" Models. Multiple states and the federal government have employed what they term a "microsimulation model" to project choices by individuals in specific sub-markets. The degree to which these models are documented varies widely, making it difficult to directly compare them. However, they do attempt to understand different segments of the market.

There is a set of weaknesses that have been noted in the traditional microsimulation models, which we discuss briefly below.

Need to Understand Employer Decisions. Traditional models of this type are limited in their ability to capture the choices facing employers. As noted by the Council of Economic Advisors (CEA) in their recent analysis:

> First, it is difficult for microsimulation models like those used by the CBO to capture dynamic responses on the supply side of the health insurance market. Setting the mandate tax penalty to zero combined with the expansion of options through the AHP and STLDI rules create incentives for insurers to develop new insurance products to better meet consumers' preferences. Additional AHP and STLDI plans might also drive down premiums and profit margins for other insurance products. The possibility that the deregulatory reforms will spur further expansion of insurance options means that our analysis understates the net benefits of the reforms.[30]

30. CEA, "Deregulating Health Insurance Markets," February 2019, page 23.

Need to Recognize Value as Understood by Consumer. The CEA clearly notes the problems that arise when federal government subsidies are much more costly to taxpayers than the benefit that is perceived by consumers.[31]

The CEA also notes that the dollar value to consumers of ACA premium subsidies is far less than their cost to the Treasury because the subsidies significantly distort labor supply by imposing marginal tax rates of about 40 percent on income (on top of all other income and payroll taxes):

> The CBO's analysis of the deficit effects of repealing the individual mandate is informative (CBO 2017b). CBO projections imply that enrollees on the margin of ACA-compliant individual market insurance plans and no insurance are receiving a large subsidy: at least $3,800 per year. If the CBO is correct, many subsidized consumers are unhappy with ACA-compliant individual plans—so unhappy that they leave these plans to become uninsured.[32]

Avoiding the Implausible Zero-Sum Assumption. There are other difficulties with traditional analyses of healthcare options that have resulted in underestimates of the effects of policy changes. One is the "zero sum" assumption embedded in many models, which treats any change in premiums paid by one person as an added burden on others:

> Many health insurance simulation models treat consumer choice as a negative- or zero-sum game. A person who reduces his or her net premium spending by $1,000 when he or she forgoes unwanted coverage merely increases by $1,000 the premiums that must be collected from those who retain this coverage. This assumption is unrealistic because of moral hazard, administrative costs, and the fact that the exchanges cap and means-test premiums. For example, this person's gross premium for the forgone coverage may have been $1,500 (he or she receives premium subsidies on the exchange), $300 of which goes to administrative costs, and with another $1,200 going to the person's own claims that were of little value but are made as long as they are forced to have the coverage. This person's enhanced choice saves taxpayers $500, and imposes no cost on the risk pool. As demonstrated in this report, a broader and more realistic range of insurance market frictions, and thereby more reliable conclusions, are possible without unduly complicating the analysis.

Recognizing Sensitivity to Price Changes. One of the striking conclusions from studying health insurance choices in a complicated market is the strong sensitivity to net costs that is displayed by consumers. One econometric study cited by the Council of Economic Advisors estimated the own-premium price elasticity of demand at -2.9.[33] This careful analysis, using post-ACA data in California and Washington, clearly illustrates the peril of ignoring incentives facing consumers.

This magnitude implies over twice the price sensitivity of many durable consumer goods (such as automobiles), and four times or more the price sensitivity to many nondurable goods.

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31. The CEA report discusses this extensively in the section "Cost-Benefit Analysis of Deregulatory Reform," including on pages 13-16.
32. CEA, "Deregulating Health Insurance Markets," February 2019, pages 36-37, quoting Mulligan, "Side Effects and Complications: the Economic Consequences of Healthcare Reform," University Chicago Press, 2015.
33. CEA, "Deregulating Health Insurance Markets," February 2019, page 24, citing Saltzman (2017).

The magnitude of the price sensitivity is even higher when considered at the insurer level, with subsidies included in the cost. The same analysis indicates a price elasticity of demand of -6.79 in the less-sensitive state, if subsidies are ignored.[34]

34. Saltzman, E. (2017). Demand for Health Insurance: Evidence from the California and Washington ACA Marketplaces. *Wharton Healthcare Management,* https://repository.upenn.edu/hcmg_papers/11/.

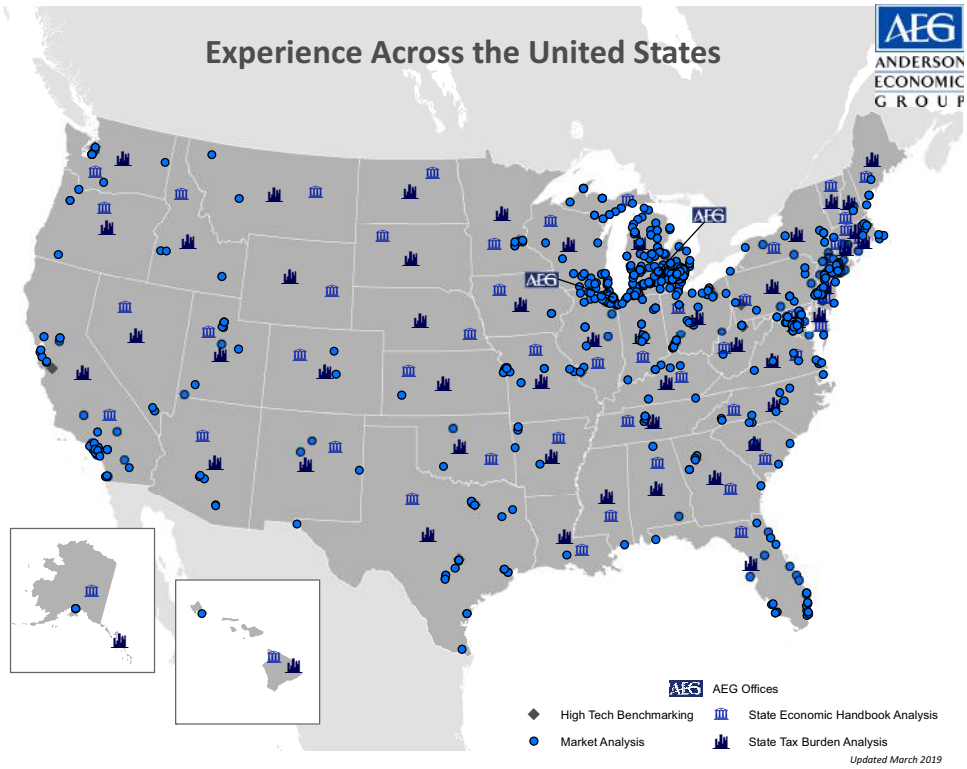
V. About the Authors

Anderson Economic Group

Founded in 1996, Anderson Economic Group is a boutique research and consulting firm, with offices in East Lansing, Michigan, and Chicago, Illinois. The experts at AEG have particular expertise in public policy and economic analysis. Relevant publications from our firm include:

- "The Economic Impact of the Barack Obama Presidential Library in Chicago," commissioned by the University of Chicago in 2014.
- The Anderson Economic Group "HQ2 Index," a ranking of 50 different cities competing for the Amazon HQ2 facility, and an interactive data presentation, released in October 2017 and updated in January 2018.
- Annual State Business Tax Burden Rankings, published regularly since 2007.
- "The Economic Impact of Business Tax Credits in Tennessee," commissioned by the Tennessee Department of Economic and Community Development and the Department of Revenue in 2016.
- "The Cost of Dental-related Emergency Room Visits in Michigan," May 2014.
- "Analysis of 2014 Proposal 1: Personal Property Tax Reform and the Michigan Economy," published in 2014.
- "Personal Property Tax Reform in Michigan," published in 2012.
- "Economic Benefits of the Earned Income Tax Credit in Michigan," published in 2009.

For more information about Anderson Economic Group, please visit www.AndersonEconomicGroup.com.



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Patrick L. Anderson. Mr. Anderson founded Anderson Economic Group in 1996, and serves as the company's Principal and Chief Executive Officer.

Mr. Anderson has written over 100 published works, including *Economics of Business Valuation* from Stanford University Press. Three of his journal articles, "Pocketbook Issues and the Presidency," "The Value of Private Businesses in the United States," and "Policy Uncertainty and Persistent Unemployment," have been recognized for outstanding writing by the National Association of Business Economics.

Mr. Anderson has taken a leading role in several major public policy initiatives in his home state. He was the author of the 1992 Term Limit Amendment to the Michigan Constitution, and also the author of the 2006 initiated law that repealed the state's four-decade-old Single Business Tax. His firm's work resulted in a wage increase for home help workers in 2006, the creation of a Michigan earned income tax credit in 2008, and the repeal of the item pricing law in 2011. Before founding Anderson Economic Group, Mr. Anderson was Deputy Budget Director for the State of Michigan, and Chief of Staff for the Michigan Department of State.

Mr. Anderson is a graduate of the University of Michigan, where he earned a Master of Public Policy degree and a Bachelor of Arts degree in political science. He is a member of the National Association for Business Economics and the National Association of Forensic Economists. The Michigan Chamber of Commerce awarded Mr. Anderson its 2006 Leadership Michigan Distinguished Alumni award for his civic and professional accomplishments. The University of Michigan Ford School of Public Policy awarded him its Neil Staebler Award for civic participation in 2014.

Brandon Betz. Brandon Betz is a Senior Analyst with Anderson Economic Group, working in the Public Policy and Economic Analysis practice area. His work focuses on cost-benefit, economic impact, and fiscal impact analysis.

Mr. Betz comes from the public sector, where he worked as a labor economist; his background includes research on workforce programs in Michigan. He also operated as a regional economist, where he interfaced with regional economic partners regarding workforce development. Additionally, he has previous experience in experimental economics and tax policy.

Mr. Betz holds a master's degree in economics with a specialization in public economics from Syracuse University and a bachelor's degree in economics with a minor in mathematics from Brigham Young University.

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Prior to joining AEG, Ms. Mixon served as Director of a small non-profit operating after school ESL classes in the refugee camps in northern Palestine. She managed the organization's transition to an all-girls program, raised funds to open a new teaching site, and partnered with community leaders to garner program support.

Ms. Mixon holds a master's degree in public policy from the Harris School of Public Policy at the University of Chicago and a Bachelor of Arts in economics from Oklahoma State University.

Wilson Partners

This report features healthcare innovation policies designed by Wilson Partners.

Wilson Partners is an innovative, mission-focused healthcare consulting practice dedicated to the successful management of market reform, healthcare access, costs, increased healthcare value, improved health and health outcomes and the fully engaged patient-physician relationship. Wilson Partners is focused on these objectives with the goal of empowering the improved health and wellbeing of each individual we serve. We accomplish this mission through strategic consulting and analysis, and the creation of intellectual property, strategies, assets, companies, resources, technologies and market partnerships. The clients of Wilson Partners include large employers, hospitals, health systems, physician practices, municipal risk pools, associations, insurance companies, foundations, and technology providers.

For more information about Wilson Partners, please visit www.wilsonpartners.com.

David Wilson. Mr. Wilson is recognized as a visionary and accomplished public policy market leader in the innovation, design, and implementation of patient health and healthcare management solutions. He is a founder of the employee-patient centered health and healthcare movement today; focused on the improved health and well-being of the whole person, reduced healthcare costs, the active patient-physician relationship, and the formation of increased business, market, and consumer value. Mr. Wilson has been a dynamic entrepreneur for over 38 years; developing, growing and capitalizing five successful businesses that actively invest in the requirements of improved individual health and greater well-being.

Mr. Wilson is the CEO of Asset Health, a national leader in integrated health and wellness management technologies. He is President of Wilson Partners, the national healthcare and benefits management consulting firm. Mr. Wilson is the founder of the One Nation Health Coalition and is an active leader in the definition of federal healthcare policy. He has worked with the American Enterprise Institute (AEI), Ethics and Public Policy, Health and Human Services, CMS, The White House, Senate and House Leadership, the committees of jurisdiction, and the healthcare policy community. Today, Mr. Wilson is a leading proponent of effective healthcare reform and the promotion of expanded access, benefits, choices and health savings for all Americans. His efforts in the marketplace and in public policy beginning in the early 1980s have been significant and continuous, improving the lives of people. His contributions are inclusive of, but not limited to, the definition of comprehensive Flexible Benefit Plans, Flexible Spending Accounts, Health Reimbursement Arrangements, and Health Savings Accounts.

Mr. Wilson is a graduate of Ohio Wesleyan University. He is engaged in many community activities and reforms; inclusive of the revitalization of Detroit. He has served as President of Legatus-Detroit. He is a Knight of Malta and a Patron of the Vatican Arts. Mr. Wilson is also a founding member of Emmaus Health and SALTA Direct Primary Care.

Nate Lundsten. Mr. Lundsten serves as Managing Consultant for Wilson Partners, the national healthcare and benefits management consulting firm. Mr. Lundsten is recognized for his broad, market-wide experience, consultation, detailed analytics, and financial forecasting. In this role, Mr. Lundsten is responsible for client relationship management, strategic planning, scope of work management, quality assurance, and staffing management and development.

During his time with Wilson Partners, Mr. Lundsten has been heavily engaged in underwriting, account management, communication development, project management, data analysis, program implementation, ongoing compliance, reporting, and strategic plan design.

Mr. Lundsten is a graduate of Saginaw Valley State University. He currently serves on the board of the Gift of Adoption Fund (Michigan Chapter). Mr. Lundsten actively holds accident, life, and health insurance licenses in states throughout the U.S.

Matthew Schoeppe. Mr. Schoeppe serves as the Client Director for Wilson Partners. Mr. Schoeppe is responsible for the day-to-day activity associated with the Wilson Partners book of business and for the financial and underwriting analysis that is performed for clients on a regular basis. Mr. Schoeppe has seven years of underwriting and consulting experience in the insurance industry. His experience spans consulting services for clients, financial analysis, development of analytical tools and models, account and vendor management, compliance consulting, and benefit, health, and wellness education.

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Appendix A: State 1332 Waiver Applications

As part of our work plan, we reviewed each of the 14 Section 1332 applications submitted by other states as of March 2019. Below, we describe the innovations of each of the applications that were approved, deemed incomplete, or withdrawn from consideration.[1]

Approved applications. Eight of the 14 applications were approved, including those for Alaska, Hawaii, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin. Each of the approved applications proposed the creation of reinsurance programs that would be financed by federal pass-through funding, with the exception of Hawaii. For some of the states, the high risk pool consists of individuals with specific qualifying conditions. Others reinsure high risk individuals based on their total accumulated claims.

See Table 4 on page A-2 for a summary of selected approved waivers.

Hawaii proposed to waive federal requirements on the provision of healthcare insurance by small businesses to eliminate the conflict with the state's more generous requirements, as well as to facilitate the process of obtaining small business tax credits.

Applications deemed incomplete. Three states had incomplete applications—Massachusetts, Ohio, and Vermont. Each of these states proposed policy innovations that are not applicable under current healthcare law. Ohio proposed to waive the individual mandate requirement, which was reduced to zero in 2019. Vermont proposed to allow small businesses to enroll directly with health insurance carriers instead of requiring the use of the online Small Business Health Options Program portal—a requirement that was eliminated, effective 2019. Massachusetts proposed a nullification of cost-sharing reduction payments to insurers. Nullification of these payments, use of federal pass-through funding, and savings on tax credits from lower premiums would be used to fund a reinsurance program in the state—the federal cost-sharing reduction payments were eliminated as of 2019.

Applications withdrawn. Three states withdrew their applications—California, Iowa, and Oklahoma. California proposed to provide special health plans to individuals who were not eligible to use the state's marketplace due to their immigration status. Oklahoma proposed a reinsurance program similar to the waivers proposed by accepted applicants. Iowa proposed to establish a reinsurance program and create a single plan analogous to the standard "silver" plan. They also proposed to replace the existing Advance Premium Tax Credit program with flat subsidies that would be distributed based on income and age.

Previous Applications' Consideration of Employment Effects. In their waiver applications, the eight states whose applications were approved did not estimate the changes in employment that would occur because of the implementation of the 1332 waiver.[2] These states either expected that there would be no change in the number of employers that would offer coverage or that the innovation would not impact the employers' decision to offer coverage to employees.[3]

1. The Georgia Health Policy Center and the National Conference of State Legislatures provide an overview of 1332 waivers and information on state 1332 waiver applications. These can be found at https://ghpc.gsu.edu/download/policy-brief-1332-state-innovation-waivers/ and http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx, respectively.
2. For example, Minnesota did not complete an analysis of the group markets because it is not expected that the reinsurance program will impact the small group, large group, or other health programs in the state.

TABLE 4. Selected Approved 1332 Waivers

State	Date Approved	Description
Alaska	July 2017	Allow federal pass-through funding to partially finance the Alaska reinsurance program. The program would fully or partially reimburse insurers from incurred claims for high-risk enrollees diagnosed with certain health conditions.
Maine	July 2018	Allow federal pass-through funding to partially finance reinstatement of the Guaranteed Access Reinsurance Association. The program will reimburse insurers 90% of claims paid between $47,000 and $77,000 and 100% of claims in excess of $77,000 for high-risk enrollees diagnosed with certain health conditions or who are referred by the insurer's underwriting judgement.
Wisconsin	July 2018	Allow federal pass-through funding to partially finance Wisconsin's Healthcare Stability Plan. The program will reimburse insurers 50%-80% of claims between $50,000 and $250,000.
New Jersey	August 2018	Allow federal pass-through funding to partially finance the New Jersey's Health Insurance Premium Security Plan. The plan will reimburse insurers 60% of claims between $40,000 and $215,000.

Source: Anderson Economic Group review of State 1332 waiver applications

3. Alaska did not expect any changes in the insurance market for small and large employer groups that comply with the ACA after the implementation of the 1332 waiver.

All but one of the approved 1332 waiver applications estimate an increase in enrollment in the individual market. Below, we show the estimated change in enrollment for the seven approved waivers.

TABLE 5. State Estimated Change in Individual Market Enrollment in Year Following Approval of 1332 Waivers

State	Baseline	After Waiver	Change	Percent Change
Alaska	21,253	22,894	1,641	7.7%
Maine	61,000	62,100	1,100	1.8%
Maryland	171,526	181,522	9,996	5.8%
Oregon	200,793	204,162	3,369	1.7%
Wisconsin	201,251	202,957	1,706	0.8%
New Jersey	322,000	331,000	9,000	2.7%
Hawaii	54,599	54,599	-	-

Source: State 1332 waiver applications as summarized by Anderson Economic Group

Appendix B: Underwriting Assumptions

Basic Demographics

For the purposes of outlining the healthcare market and the policy innovations we discuss in this document, we assembled a baseline data on the market. We consider these to the be most relevant underwriting assumptions for the policy innovations.

- Number of Georgia residents: Approximately 10.3 million
- Georgia residents who reside in rural communities: 25%
- Median age: 36.5
- Number of residents age 65 and older: 1,354,662
- Median household income: $53,559
- Number of uninsured residents: 1,366,843
- Number of residents per one primary care provider: 1,519
- Percent of residents with ACA subsidy: 4.0%

Note on Data Sources. The data listed above come from Country Health Rankings, with the exception of ACA subsidy data, which comes from the Centers for Medicare & Medicaid Services.

Enrollment by Market Segment

Below we outline total enrollment by type of market. Non-ACA individual coverage data is from the first quarter of 2018. We applied a factor to employer insured coverage due to the difference in time period between the insured employer coverage and individual coverage. ACA marketplace data comes from the Centers for Medicaid and Medicare Services.

- Employer group coverage ("fully insured"): 1,449,484
- Self-Insured ESI: 3,593,523
- ACA Marketplace: 480,911
- Non-ACA individual coverage: 35,178
- Medicaid: 1,779,449
- Medicare:1,591,000

Note on Data Sources. Non-ACA individual coverage data comes from the Mark Farrah County Coverage Level Database, as of the first quarter of 2018.

Enrollment Assumptions: Underwriting Convention and Economic Analysis

The underwriting analyses rely upon a specific convention, which is not generally applied in economic analysis. We explain this difference as follows:

1. The underwriting analysis assumes stable enrollment in all markets.

   See Exhibit 1, "Underwriting Assumptions for the Georgia Reinsurance Program," on page C-2.

   We assume unchanging enrollment for the purposes of the underwriting analysis because this is a convention in the health insurance industry, and because we want to illustrate how these programs work internally. Of course, enrollment does changes over time. Using this convention involves the presumption that changes in enrollment produce changes in both costs

and premiums that are approximately proportional to that of the rest of the underwriting population.

2. The economic analysis assumes there are changes in enrollment, due to economic trends and policy-induced changes.

   We fully expect there to be societal benefits from policy changes that result in lower costs and larger enrollment in health insurance. Part of these changes are considered in our PTC and employer analysis. See, for example:

   - Exhibit 2, "Average Georgia APTC Costs and Savings Due to Implementation of Waiver," on page C-11 and
   - See "Method 2: Econometric Analysis" on page 8 for more details.

Enrollment by Age and Income

Below we break down enrollment by market according to age groups and income, respectively.

TABLE 1. Enrollment by Age Group

Age Bands	ESI (Large and Small Group and Self-Insured)	Individual Market	Medicaid
0-18	30%	7%	58%
19-26	10%	12%	10%
27-44	32%	34%	12%
46-64	26%	46%	10%
65+	2%	1%	10%

Source: Wilson Partners analysis using base data from Centers for Medicaid & Medicare Services, Kaiser Family Foundation, Optum Benefits Modeler

TABLE 2. Enrollment by Income, as a Percent of Federal Poverty Line

FPL%	ESI (Large and Small Group and Self-Insured)	Individual Market	Medicaid	Medicare
< 100%	3%	4%	38%	12%
100-150%	11%	47%	33%	23%
150-200%		19%		
200-250%	33%	10%	21%	30%
250-300%		6%		
300-400%		7%		
> 400%	53%	7%	8%	35%

Source: Wilson Partners analysis using base data from Centers for Medicaid & Medicare Services, Kaiser Family Foundation

Appendix C: Underwriting Assumptions for the Reinsurance Option

Market Pricing Stability. The impact of the Georgia Reinsurance Program on the market, specific to premium stability, is significant for all fully insured market segments realizing an across the board savings in the fully insured market for all segments against the baseline analysis. This increased stability in year-over-year costs represents significant savings to employers, employees, and to individual coverage participants. These savings are based on the existing population enrolled in the fully-insured market. Additional per-member annual and cumulative savings are achieved for each new member entering the fully-insured market.

In accordance with our analysis, we have illustrated the annual premium savings per member by year over a five-year period: 2020 to 2025 for the Georgia marketplace. We have also illustrated the reduced monthly premiums in the fully insured market in Georgia on a market-wide basis.

See Exhibit 1, "Underwriting Assumptions for the Georgia Reinsurance Program," on page C-2 for a detailed look at the methodology and assumptions that we used in our analysis.

Stable Enrollment Convention. This illustration follows the convention stated in "Enrollment Assumptions: Underwriting Convention and Economic Analysis" on page B-1.

Exhibit 1. Underwriting Assumptions for the Georgia Reinsurance Program

Innovation #1: Premium Impact Summary Table

Individual Market	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline										
Headcount	516,089	516,089	516,089	516,089	516,089	516,089	516,089	516,089	516,089	516,089
PMPY: premium	$8,829	$9,703	$10,665	$11,721	$12,883	$14,159	$15,562	$17,104	$18,799	$20,661
Annual premium	$4,556,353,450	$5,007,796,950	$5,503,969,472	$6,049,302,767	$6,648,667,685	$7,307,417,680	$8,031,436,623	$8,827,191,364	$9,701,789,484	$10,663,042,786
Adjusted: Innovation #1										
PMPY: premium	$8,273	$9,046	$9,891	$10,815	$11,825	$12,928	$14,134	$15,453	$16,893	$18,468
Annual premium	$4,269,625,565	$4,668,604,818	$5,104,731,541	$5,581,450,159	$6,102,522,974	$6,672,059,338	$7,294,547,497	$7,974,889,329	$8,718,438,245	$9,531,040,552
Impact (baseline less adjusted)										
PMPY: difference	$555.58	$657.24	$773.58	$906.53	$1,058.24	$1,231.10	$1,427.83	$1,651.46	$1,905.39	$2,193.42
Annual difference	$286,727,885	$339,192,132	$399,237,931	$467,852,608	$546,144,712	$635,358,342	$736,889,126	$852,302,035	$983,351,239	$1,132,002,235
% difference	6.3%	6.8%	7.3%	7.7%	8.2%	8.7%	9.2%	9.7%	10.1%	10.6%

Sources: **Headcounts (individual ACA Exchange)** - Center for Medicare & Medicaid Services, 2018 Marketplace Open Enrollment Period Public Use Files, '2018 OEP County-Level Public Use File', https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html. 04/04/2018.

Headcounts (individual non-ACA Exchange) - Mark Farrah Health Coverage Portal Database, 'Enrollment by Segment', State of Georgia, https://www.mfamarketdata.com/portal/hcp/expanded/EnrollmentBySegmentParentView.aspx. 1Q 2018.

Premiums (per member per month) - Center for Medicare & Medicaid Services, 2018 Marketplace Open Enrollment Period Public Use Files, '2018 OEP County-Level Public Use File', https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html. 04/04/2018.

Claims Trend (claims included as part of premium totals) - Center for Medicare & Medicaid Services, 2018 Marketplace Open Enrollment Period Public Use Files, '2018 OEP County-Level Public Use File', https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html. 04/04/2018.

Percentage of paid claims in excess of Georgia Reinsurance Pool Attachment Point ($50,000) - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/28/2019.

Wellness Migration Factor - Asset Health ROI^2 reporting book of business as of 2/28/19**.**

Assumptions and methodology: **Headcounts** - Added ACA Exchange and non-ACA Exchange headcounts from sources listed above for the state of Georgia.

Premiums - Filtered for the state of Georgia only. Multiplied per member per month premium totals from source above by 12 to get per member per year totals.

Trend - Adjusted trend of 19.9%, as indicated by source above, by 50% due to higher than normal increases as the result of CSR reductions (utilized 9.9%). Utilized this percentage for all proceeding years.

Adjusted Premiums (Georgia Reinsurance Pool) - First, the total paid claims per member per month in excess of $50,000 (Georgia Reinsurance Pool attachment point) annually are calculated by taking the premium totals from the baseline and multiplying them by the % of paid claims in excess of $50,000, which totals $161.27 per member per month ($1,935 per year) in the individual market in 2020 (as determined by the source noted above). Then, those per member per month claims totals are weighted to get a composite total across all market segments (individual, small group, large group), which comes to $126.41 ($1,517 per year). That composite total is then applied to each market segment so that they are all equal, thus leading to a reduction in premiums for the individual market and an increase for the small and large group markets initially. The wellness migration impact is then applied, which is described below.

Adjusted Premiums (Wellness Migration Impact) - Once the adjusted premiums are calculated for the Georgia Reinsurance Pool, a wellness migration factor is applied which will reduce the total per member per year premiums in all markets. Through the source described above, it is determined that 3% of the population will improve their overall health risk each year. This will result in a per member per year claims savings of 0.17% for each 1% of migration toward a better health risk factor. Both this wellness migration factor and the adjustment caused by the Georgia Reinsurance Pool lead to the premium reflected below for innovation #1.

Small Employer Market	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline										
Headcount	247,293	247,293	247,293	247,293	247,293	247,293	247,293	247,293	247,293	247,293
PMPY: premium	$6,668	$7,102	$7,563	$8,055	$8,579	$9,136	$9,730	$10,363	$11,036	$11,754
Annual premium	$1,649,054,949	$1,756,243,521	$1,870,399,350	$1,991,975,307	$2,121,453,702	$2,259,348,193	$2,406,205,825	$2,562,609,204	$2,729,178,802	$2,906,575,424
Adjusted: Innovation #1										
PMPY: premium	$6,713	$7,112	$7,536	$7,984	$8,459	$8,961	$9,494	$10,057	$10,654	$11,286
Annual premium	$1,660,010,307	$1,758,848,412	$1,863,521,927	$1,974,371,865	$2,091,758,914	$2,216,064,558	$2,347,692,255	$2,487,068,680	$2,634,645,040	$2,790,898,461
Impact (baseline less adjusted)										
PMPY: difference	($44.30)	($10.53)	$27.81	$71.18	$120.08	$175.03	$236.62	$305.47	$382.27	$467.77
Annual difference	($10,955,358)	($2,604,892)	$6,877,422	$17,603,443	$29,694,788	$43,283,635	$58,513,570	$75,540,524	$94,533,763	$115,676,963
% difference	-0.7%	-0.1%	0.4%	0.9%	1.4%	1.9%	2.4%	2.9%	3.5%	4.0%

Sources: **Headcounts** - Center for Medicare & Medicaid Service, Rate Review Data, 'Worksheet I and II Data for 2018 Single Risk Pool Filings', 2017 Experience Period. https://www.cms.gov/cciio/resources/data-resources/ratereview.html. 1/2/2018.

Premiums (per member per month) - Center for Medicare & Medicaid Services, Rate Review Data, 'Worksheet I and II Data for 2018 Single Risk Pool Filings', 2017 Experience Period. https://www.cms.gov/cciio/resources/data-resources/ratereview.html. 1/2/2018.

Claims Trend (claims included as part of premium totals) - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/15/2019.

Percentage of paid claims in excess of Georgia Reinsurance Pool Attachment Point ($50,000) - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/28/2019.

Wellness Migration Factor - Asset Health ROI[2] reporting book of business as of 2/28/19**.**

Assumptions and methodology: **Headcounts** - Counted experience period enrollment for the state of Georgia only using the source referenced above.

Premiums - Filtered for the state of Georgia during the 2017 experience period. Multiplied per member per month premium totals from source above by 12 to get per member per year totals.

Trend - Utilized the group trend percentage from the source noted above (same for large and small group) of 6.5%. Utilized this trend for all proceeding years.

Adjusted Premiums (Georgia Reinsurance Pool) - First, the total paid claims per member per month in excess of $50,000 (Georgia Reinsurance Pool attachment point) annually are calculated by taking the premium totals from the baseline and multiplying them by the % of paid claims in excess of $50,000, which totals $121.81 per member per month ($1,462 per year) in the small group market (as determined by the source noted above). Then, those per member per month claims totals are weighted to get a composite total across all market segments (individual, small group, large group), which comes to $126.41 ($1,517 per year). That composite total is then applied to each market segment so that they are all equal, thus leading to a reduction in premiums for the individual market and an increase for the small and large group markets initially. The wellness migration impact is then applied, which is described below.

Adjusted Premiums (Wellness Migration Impact) - Once the adjusted premiums are calculated for the Georgia Reinsurance Pool, a wellness migration factor is applied which will reduce the total per member per year premiums in all markets. Through the source described above, it is determined that 3% of the population will improve their overall health risk each year. This will result in a per member per year claims savings of 0.17% for each 1% of migration toward a better health risk factor. Both this wellness migration factor and the adjustment caused by the Georgia Reinsurance Pool lead to the premium reflected below for innovation #1.

Large Employer Market	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline										
Headcount	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191
PMPY: premium	$5,845	$6,225	$6,630	$7,061	$7,520	$8,009	$8,529	$9,084	$9,674	$10,303
Annual premium	$7,027,282,626	$7,484,055,997	$7,970,519,637	$8,488,603,413	$9,040,362,635	$9,627,986,206	$10,253,805,309	$10,920,302,654	$11,630,122,327	$12,386,080,278
Adjusted: Innovation #1										
PMPY: premium	$6,007	$6,364	$6,743	$7,144	$7,569	$8,019	$8,495	$8,999	$9,533	$10,099
Annual premium	$7,221,208,125	$7,651,163,604	$8,106,503,690	$8,588,711,822	$9,099,357,032	$9,640,098,813	$10,212,692,241	$10,818,993,398	$11,460,965,081	$12,140,682,834
Impact (baseline less adjusted)										
PMPY: difference	($161.31)	($139.00)	($113.11)	($83.27)	($49.07)	($10.08)	$34.20	$84.27	$140.71	$204.13
Annual difference	($193,925,499)	($167,107,607)	($135,984,054)	($100,108,409)	($58,994,398)	($12,112,607)	$41,113,068	$101,309,256	$169,157,247	$245,397,444
% difference	-2.8%	-2.2%	-1.7%	-1.2%	-0.7%	-0.1%	0.4%	0.9%	1.5%	2.0%

Sources: **Headcounts (small and large group insured group coverage)** - Mark Farrah Health Coverage Portal Database, 'Enrollment by Segment', State of Georgia. https://www.mfamarketdata.com/portal/hcp/expanded/EnrollmentBySegmentParentView.aspx. 3Q 2018.

Paid Claims per member per month - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/15/2019.

Claims Trend (claims included as part of premium totals) - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/15/2019.

Average Actuarial Value (Small Group only) - Center for Medicare & Medicaid Services, Rate Review Data, 'Worksheet I and II Data for 2018 Single Risk Pool Filings', 2017 Experience Period. https://www.cms.gov/cciio/resources/data-resources/ratereview.html. 1/2/2018.

Average Actuarial Value (Small Group/Large Group differential) - Henry J Kaiser Family Foundation, 2018 Employer Health Benefits Survey, Section 7 – Employee Cost Sharing. http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018. 10/3/2018.

Average administrative fee - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/15/2019.

Claims Charged Amount, Discounts, and Admin Fees - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/15/2019.

Percentage of paid claims in excess of Georgia Reinsurance Pool Attachment Point ($50,000) - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/28/2019.

Assumptions and methodology: **Headcounts** - Combined large and small group employer total was derived from the source noted above. In order to get a specific count for the large group market only, the combined headcount total was subtracted from the small group headcount total for the state of GA.

Average Actuarial Value - The average actuarial value for the Small Group market is derived from the source noted above (74.35%) by taking the average actuarial value for all GA small group plans. Then, that number is increased by 4.7% as the Large Group market has a 4.7% higher average actuarial value than the Small Group market, leading to the average actuarial value for the Large Group market being calculated as 79.05%. The average actuarial value for small and large groups was calculated by taking the average deductible, coinsurance and out-of-pocket maximums for each segment, which allowed for the calculation of the actuarial value. The difference between large and small group was determined to be 4.7%.

Premiums - In order to calculate premiums, the Optum Comprehensive Benefits Modeler was setup with a plan design matching the 79.05% actuarial value for large groups. Once the plan design was put in place, the modeler was able to pull from it's 2017 claims database to determine the paid claims for the state of Georgia. This is inclusive of a 15% admin fee. Totals were multiplied by 12 to get a per member per year total (PMPY).

Trend - Utilized the group trend percentage from the source noted above (same for large and small group) of 6.5%. Utilized this trend for all proceeding years.

Adjusted Premiums (Georgia Reinsurance Pool) - First, the total paid claims per member per month in excess of $50,000 (Georgia Reinsurance Pool attachment point) annually are calculated by taking the premium totals from the baseline and multiplying them by the % of paid claims in excess of $50,000, which totals $113.45 ($1,361 per year) per member per month in the large group market (as determined by the source noted above). Then, those per member per month claims totals are weighted to get a composite total across all market segments (individual, small group, large group), which comes to $126.41 ($1,517 per year). That composite total is then applied to each market segment so that they are all equal, thus leading to a reduction in premiums for the individual market and an increase for the small and large group markets initially. The wellness migration impact is then applied, which is described below.

Adjusted Premiums (Wellness Migration Impact) - Once the adjusted premiums are calculated for the Georgia Reinsurance Pool, a wellness migration factor is applied which will reduce the total per member per year premiums in all markets. Through the source described above, it is determined that 3% of the population will improve their overall health risk each year. This will result in a per member per year claims savings of 0.17% for each 1% of migration toward a better health risk factor. Both this wellness migration factor and the adjustment caused by the Georgia Reinsurance Pool lead to the premium reflected below for innovation #1.

Markets Combined	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline										
Headcount	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573
PMPY: premium	$6,732	$7,249	$7,807	$8,410	$9,061	$9,765	$10,527	$11,350	$12,241	$13,205
Annual premium	$13,232,691,025	$14,248,096,467	$15,344,888,458	$16,529,881,487	$17,810,484,022	$19,194,752,078	$20,691,447,758	$22,310,103,222	$24,061,090,614	$25,955,698,489
Adjusted: Innovation #1										
PMPY: premium	$6,691	$7,163	$7,669	$8,214	$8,798	$9,426	$10,101	$10,827	$11,607	$12,446
Annual premium	$13,150,843,997	$14,078,616,834	$15,074,757,158	$16,144,533,846	$17,293,638,920	$18,528,222,709	$19,854,931,994	$21,280,951,407	$22,814,048,365	$24,462,621,847
Impact (baseline less adjusted)										
PMPY: difference	$41.64	$86.22	$137.43	$196.05	$262.95	$339.10	$425.58	$523.59	$634.44	$759.61
Annual difference	$81,847,028	$169,479,634	$270,131,299	$385,347,642	$516,845,103	$666,529,369	$836,515,764	$1,029,151,816	$1,247,042,248	$1,493,076,642
% difference	0.6%	1.2%	1.8%	2.3%	2.9%	3.5%	4.0%	4.6%	5.2%	5.8%
Cumulative difference	$81,847,028	$251,326,662	$521,457,961	$906,805,603	$1,423,650,705	$2,090,180,075	$2,926,695,839	$3,955,847,655	$5,202,889,903	$6,695,966,545

Premium Tax Credit Calculations

We estimated the Premium Tax Credit (PTC) pass-through payments for which the state may be eligible, if it were to apply and be granted a 1332 waiver for the reinsurance option identified in this report. We used two methods to perform this estimation:

1. A share-of-premium-change analysis, which relies upon the aggregate data for the state's participating population in the current individual market; and
2. An econometric analysis that presumes consumers adjust to the changed prices of exchange plans, and which uses a more involved interpretation of the available tax and health marketplace data.

Both of these methods have advantages and disadvantages. However, using both can provide a good deal of confidence if the results are similar or approximately the same.

Summary of Estimates. The first-year comparison is most important, as this involves the amount of money that would be available to the state in the first year to partially fund the reinsurance pool. Our estimates are reasonably close:

- The first method produces available pass through funds of approximately $217 million for the state in the first year, shown in Table 3 on page 8 for the calculation.
- The second method produces available funds of approximately $185 million in the first year, assuming that the full amount of the Advanced Premium Tax Credit (APTC) payment reductions are passed through to the state. Estimates are shown in Exhibit 2, "Average Georgia APTC Costs and Savings Due to Implementation of Waiver," on page C-11 and Table 4 on page 12.

As noted in this report, there are discrepancies between the reported IRS and Centers for Medicare Services (CMS) data. The overlapping payments of APTC and PTC make it difficult to disentangle the likely net impact. However, given that these two methods produce similar results, we are confident that significant pass-through savings would be available to the state if it incorporated such a request into a successful 1332 waiver program.

Method 1: Share of Premium

The first method relies upon IRS data for APTC and PTC payments to residents in the years 2016 to 2018. These data show that a very high share of purchasers of exchange plans already make use of the ability to receive tax credits in the form of either APTC or PTC. Georgia's rate of 87% is higher than the national average of 83%.[4]

Given the structure of the PTC, which involves complicated calculations related to family income and the cost of a "second lowest silver plan," it is not possible to directly calculate the reduction in PTC that would occur if the innovation was adopted and reduced premiums in the exchange

4. CMS data for share participating "with financial assistance," for year 2016. Comparable figures from the same report indicate rates of 87.4% and 85.2% in 2017 and 2018, respectively; https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Effectuated_Quarterly_Snapshots.html.

marketplace. However, it provides a solid basis for an estimate. The estimate using this method for the first year is below:

TABLE 3. Share of Premium Method, Estimated APTC Savings, Change from Baseline to Waiver Scenario

Reductions in premiums in individual market		Share resulting in reduction in PTC and APTC				Pass-through share to State		Available to State
$286.70	*x*	0.8	=	$229.36	*x*	0.95	=	$217.89

Source: AEG analysis using base data from the Internal Revenue Service.
Note: Dollar amounts in millions.

Method 2: Econometric Analysis

Summary. The adoption of a statewide reinsurance program through the proposed 1332 waiver for Georgia is expected to lower the amount of Advanced Premium Tax Credits (APTC) and Premium Tax Credits (PTC) claimed by individuals in the state. This reduction will occur in two ways:

1. The effect of the policy would be to reduce the cost of insurance premiums in the individual market, including insurance products sold on the healthcare exchanges. Because the premium tax credit is calculated as a share of the premium paid, a reduction in premiums paid leads to a drop in premium tax credits.
2. The drop in price will induce some eligible individuals to purchase health insurance, because it will be both more affordable and less likely to increase cost in the future. This increased enrollment means more premiums paid to the insurance pool, a reduction in costly expenses for uncompensated care at hospitals, and an increase in positive health outcomes.

The direct effect of the reduced cost is much more straightforward to estimate than the second effect, as it involves behavioral changes. In this analysis, we estimate both the direct effect and modest behavioral changes.

Analysis. To construct our estimate we used historical enrollment and PTC data provided by the Centers for Medicare and Medicaid Services, Medical Expenditure Panel Survey (MEPS), and IRS data for information regarding APTCs and PTCs.

1. APTCs are claims that individuals make on their taxes and then are directly paid out by the government. It is the best metric to determine the savings during a fiscal year defined on the government calendar.
2. PTCs are defined as the final amount of credits provided by the government after they have been reimbursed for excess claims. They are typically rolled over from the previous year and used to adjust APTCs claimed in the following year. Although they are a good measure of long term savings, they provide little help in estimating yearly budgeting requirements.

We present the APTC savings as the potential savings to the federal government for the above reasons. However, in our analysis, we include both, as policy objectives may vary amongst state legislatures.

To estimate the impact of the 1332 waiver on the dollar value of the individual APTC and PTC, we used state level estimates from previous analyses and insurance enrollment data given by income, enrollment status, and type of insurance plan. We also looked at other states that had successfully

implemented these waivers, namely Alaska, New Jersey, Maine, Oregon, Wisconsin, and Hawaii. These states predicted that premiums per member would drop by the following amounts.[5]

- 18-20% in Alaska,
- 15% in New Jersey,
- 9% in Maine,
- 7.5% in Oregon, and
- 10.6% in Wisconsin.
- Hawaii predicted no effect on premiums or enrollment.

We calculated the average predicted decrease in premiums among these states to be 12.2%. We adjusted this by 2.8% to account for the large enrollment effect likely to occur in Georgia. This effect is due to the large number of employees who currently do not receive coverage.[6] Based on the available data, we estimate that a 15% decrease in premiums due to the waiver is conservative.

Assumptions. In order to estimate the 1332 waiver's effect on enrollment we relied on data from CMS and MEPS as well as a point price elasticity estimate of demand for the health insurance market constructed from historical data. Following are the assumptions we used in this estimate.

- The market would experience a 15% drop in average price of a standard silver plan on the exchange.
- Approximately 89% of Georgians are enrolled in silver plans.
- The growth in APTC would follow the pattern consistent with the compound annual growth rate from the historical data, which we estimate to be 10% per annum.
- We calculated an enrollment growth rate of 2.7%.
- We identified that 62% of the 907,220 employees at the establishments that qualify for reinsurance are uninsured. Of that group, 15% qualify for premium tax credits. For that group we assumed a take-up rate and coverage rates of 75% and 38%, respectively.
- We estimated a 0.5% increase in enrollment for every percent decrease in premium.

Cautions. For this analysis we note the following:

- We assume the effect on the PTC begins in 2019. The results would be only marginally different if the policy begins in 2020.
- This analysis makes simplifying assumptions regarding the effect of the policy innovation. It should be updated once the state applies for a specific policy waiver, and revisited periodically after that.
- This analysis is based on a 15% reduction in premiums. The actual policy innovation could result in a smaller or larger reduction in premiums. This means that PTC savings will be different than estimated here.[7]
- There are substantial differences in the data reported in the IRS Statistics of Income (SOI) and the CMS data on PTC payments to state residents. This discrepancy exceeds a billion dollars in the total reported PTC payments to Georgia residents.

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5. See See "Appendix A: State 1332 Waiver Applications" on page A-1 for a summary of 1332 state innovation waiver applications.
6.See Figure 1 on page 8 for more details. Note that expanding the number of people that are covered has a positive underwriting benefit of reducing premiums for individuals insured.

- We use the more conservative estimate of payments produced by the IRS. We recommend the state undertake an effort with federal government agencies to understand the discrepancy, and undertake a new estimate after doing so.

Estimates. Applying the aforementioned statistics to the eligibility pool, we determined how many eligible people would likely enroll under the 1332 provisions. The estimated growth in enrollment caused directly by the waiver was then supplemented by the entry of new enrollees due to the purchases in the individual market that are now viewed as affordable.

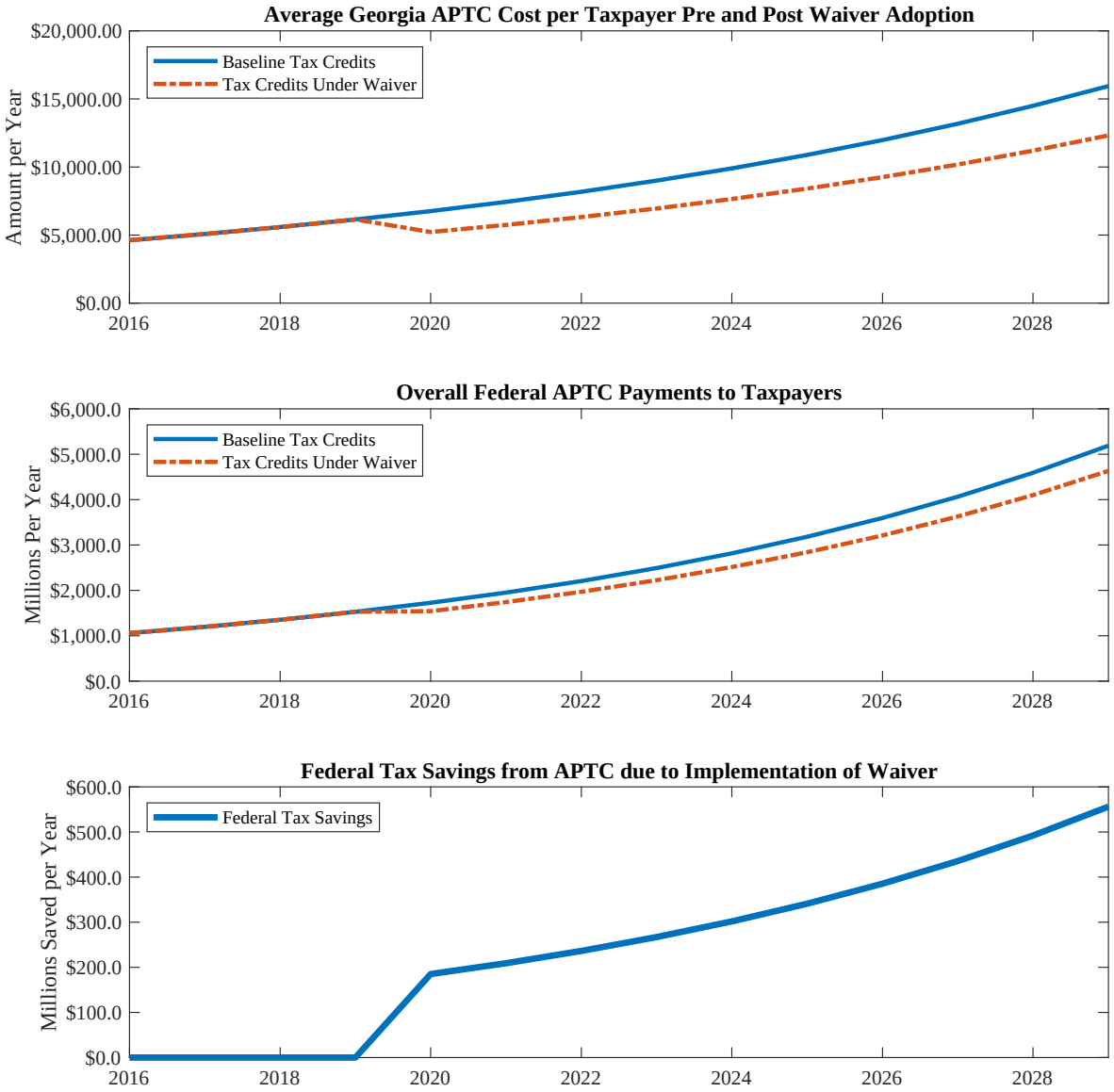
Using this method, we estimate the following:

- The total increase in enrollment, considering the combined effects, would be approximately 39,323 new enrollees qualifying for PTCs in 2019.
- Savings accrued in APTC savings to the federal government would be approximately $185 million in 2020. We calculated this as the difference between the APTCs realized in the baseline scenario, in which the statewide reinsurance program proposed in the 1332 waiver is implemented.

These estimates are shown in Exhibit 2, "Average Georgia APTC Costs and Savings Due to Implementation of Waiver," on page C-11 and Table 4 on page 12.

7.Our underwriting assumptions estimate a gradual change in premiums over time. See Exhibit 1, "Underwriting Assumptions for the Georgia Reinsurance Program," on page C-2 for more information.
However, we estimated an average change in premium to calculate the PTC pass-through payments. We explain this calculation on page C-8.

Exhibit 2. Average Georgia APTC Costs and Savings Due to Implementation of Waiver



Source: AEG estimates sourced from CMS, IRS data;
Assumes 1332 waiver plan reducing exchange premiums by 15%.
PTC payments also depend on federal tax policy and health care costs, which may change.

TABLE 4. Econometric Method, Estimated APTC Savings, Change from Baseline to Waiver Scenario

APTCs	2019	2020	2021	2022	2023	2024	2025
Baseline	$1,528	$1,727	$1,951	$2,205	$2,492	$2,816	$3,182
Waiver	$1,528	$1,541	$1,742	$1,968	$2,224	$2,514	$2,841
Change from Baseline to Waiver	$0	$185	$209	$236	$267	$301	$341

Source: AEG estimates sourced from CMS, IRS data
Notes:
1. Assumes 1332 waiver plan reduces exchange premiums by 15%.
2. PTC payments also depend on federal tax policy and healthcare costs, which may change.
3. Numbers have been rounded.
4. Dollar amounts in millions.

Appendix D: Underwriting Assumptions for the Primary Care Access Option

Member and Market-wide Financial Impact. The reduction in healthcare expenses achieved under the Georgia Primary Care Access Option is significant, both in the reduction of premiums per member and on a market-wide basis across the fully insured market. These savings would accrue from increased patient-physician time and decreased specialist care, emergency room and urgent care visits, and pharmacy services. Specialist visits would also decline as doctors would be able to spend more time with their patients.

See Exhibit 3, "Underwriting Assumptions for Primary Care Access Option," on page D-2 for a detailed look at the methodology and assumptions that we used in our analysis.

Exhibit 3. Underwriting Assumptions for Primary Care Access Option

Innovation #2: Premium Impact Summary Table

Individual Market	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline										
Headcount	516,089	516,089	516,089	516,089	516,089	516,089	516,089	516,089	516,089	516,089
PMPY: premium	$8,829	$9,703	$10,665	$11,721	$12,883	$14,159	$15,562	$17,104	$18,799	$20,661
Annual premium	$4,556,353,450	$5,007,796,950	$5,503,969,472	$6,049,302,767	$6,648,667,685	$7,307,417,680	$8,031,436,623	$8,827,191,364	$9,701,789,484	$10,663,042,786
Adjusted: Innovation #2										
PMPY: premium	$8,787	$9,602	$10,484	$11,439	$12,474	$13,598	$14,818	$16,143	$17,585	$19,153
Annual premium	$4,534,824,888	$4,955,437,801	$5,410,522,420	$5,903,430,398	$6,437,813,977	$7,017,654,230	$7,647,291,888	$8,331,460,981	$9,075,325,563	$9,884,519,793
Impact (baseline less adjusted)										
PMPY: difference	$41.71	$101.45	$181.07	$282.65	$408.56	$561.46	$744.34	$960.55	$1,213.87	$1,508.51
Annual difference	$21,528,562	$52,359,149	$93,447,052	$145,872,369	$210,853,708	$289,763,449	$384,144,735	$495,730,382	$626,463,922	$778,522,993
% difference	0.5%	1.0%	1.7%	2.4%	3.2%	4.0%	4.8%	5.6%	6.5%	7.3%

Sources: **Headcounts (individual ACA Exchange)** - Center for Medicare & Medicaid Services, 2018 Marketplace Open Enrollment Period Public Use Files, '2018 OEP County-Level Public Use File', https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html. 04/04/2018.
Headcounts (individual non-ACA Exchange) - Mark Farrah Health Coverage Portal Database, 'Enrollment by Segment', State of Georgia, https://www.mfamarketdata.com/portal/hcp/expanded/EnrollmentBySegmentParentView.aspx. 1Q 2018.
Premiums (per member per month) - Center for Medicare & Medicaid Services, 2018 Marketplace Open Enrollment Period Public Use Files, '2018 OEP County-Level Public Use File', https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html. 04/04/2018.
Claims Trend (claims included as part of premium totals) - Center for Medicare & Medicaid Services, 2018 Marketplace Open Enrollment Period Public Use Files, '2018 OEP County-Level Public Use File', https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html. 04/04/2018.

Direct Primary Care Adoption Rate & Fixed Fee - Industry-cited Direct Primary Care case studies.

Direct Primary Care Premium Adjustments - Wilson Partners case study analysis.

Wellness Migration Factor - Asset Health ROI[2] reporting book of business as of 2/28/19.

Assumptions and methodology: **Headcounts** - Added ACA Exchange and non-ACA Exchange headcounts from sources listed above for the state of Georgia.

Premiums - Filtered for the state of Georgia only. Multiplied per member per month premium totals from source above by 12 to get per member per year totals.

Trend - Adjusted trend of 19.9%, as indicated by source above, by 50% due to higher than normal increases as the result of CSR reductions (utilized 9.9%). Utilized this percentage for all proceeding years.

Direct Primary Care plan (Georgia Direct Primary Care Access Option) Headcounts - 5% of the population migrates to the Georgia Direct Primary Care Access Option annually. This factor applies to all market **segments.**

Total Claims Cost (Georgia Direct Primary Care Access Option Only) - Claims cost for those enrolled in the Georgia Direct Primary Care Access Option are adjusted first by applying a factor of 0.93 to the total claims cost, to bring the total per member month to $547.37 ($6,568 per year) for the individual market. This factor is derived from the sources noted above as the percentage of paid claims that are attributed to traditional primary care is 7%. Since Direct Primary Care would be paid through a fixed monthly fee, the cost for traditional primary care is removed, hence the 0.93 factor. Then, an additional adjustment is made for the impact direct primary care has on paid claims, which results in a factor 0f 0.85. Receiving care through a Direct Primary Care arrangement leads to an average savings of 15% per the sources noted above, which is why a factor of 0.85 is used. This reduces the per member per month claims cost to $465.27 ($5,583 per year).

Direct Primary Care fixed fee (Georgia Direct Primary Care Access Option Only) - Direct Primary Care fixed fee is $70 per member per month and remains $70 across all 10 years. This is added on to the $465.27 per member per month, resulting an adjusted per member per month claims total of $535.27 ($6,423 per year).

Total Claims Cost (non-Georgia Direct Primary Care Access Option) - Claims for those in a non-Georgia Direct Primary Care Access Option are trended by 9.9% annually for all years, meaning the claims cost for these members will match the baseline cost.

Adjusted Claims Cost (Georgia Direct Primary Care Access Option & non-Georgia Direct Primary Care Access Option) - The per member per month claims cost is calculated as a weighted average between the number enrolled in the Georgia Direct Primary Care Access Option and the non-Georgia Direct Primary Care Access Option. This cost is then further adjusted (for the Georgia Direct Primary Care Access Option population only) by the fixed fee and the impact of the wellness-demand management program, which is further explained below.

Adjusted Claims Cost (Wellness-Demand Management Program Impact - Georgia Direct Primary Care Access Option Only) - Once the adjusted premiums are calculated for the Georgia Direct Primary Care Access Option enrollees only, a wellness migration factor is applied which will reduce the total per member per year claims in all markets. Through the source described above, it is determined that 3% of the population will improve their overall health risk each year. This will result in a per member per year claims savings of 0.17% for each 1% of migration toward a better health risk factor. Both this wellness migration factor and the adjustment caused by the Georgia Direct Primary Care Access Option lead to the premium reflected below for innovation #2.

Conversion to Premiums - All claims cost as calculated above are divided by 20% to calculate the total premiums. This is due to the fact the administrative fees associated with individual insurance can be no more than 20% of the premiums. These numbers are then multiplied by 12 to obtain a per member per year premium total.

Small Employer Market	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline										
Headcount	247,293	247,293	247,293	247,293	247,293	247,293	247,293	247,293	247,293	247,293
PMPY: premium	$6,668	$7,102	$7,563	$8,055	$8,579	$9,136	$9,730	$10,363	$11,036	$11,754
Annual premium	$1,649,054,949	$1,756,243,521	$1,870,399,350	$1,991,975,307	$2,121,453,702	$2,259,348,193	$2,406,205,825	$2,562,609,204	$2,729,178,802	$2,906,575,424
Adjusted: Innovation #2										
PMPY: premium	$6,650	$7,055	$7,479	$7,922	$8,386	$8,873	$9,383	$9,920	$10,484	$11,077
Annual premium	$1,644,439,902	$1,744,668,498	$1,849,412,734	$1,959,006,328	$2,073,799,229	$2,194,158,730	$2,320,470,624	$2,453,140,436	$2,592,594,702	$2,739,282,321
Impact (baseline less adjusted)										
PMPY: difference	$18.66	$46.81	$84.87	$133.32	$192.70	$263.61	$346.69	$442.67	$552.32	$676.50
Annual difference	$4,615,047	$11,575,023	$20,986,616	$32,968,980	$47,654,473	$65,189,463	$85,735,201	$109,468,768	$136,584,101	$167,293,104
% difference	0.3%	0.7%	1.1%	1.7%	2.2%	2.9%	3.6%	4.3%	5.0%	5.8%

Sources: **Headcounts** - Center for Medicare & Medicaid Services, Rate Review Data, 'Worksheet I and II Data for 2018 Single Risk Pool Filings', 2017 Experience Period. https://www.cms.gov/cciio/resources/data-resources/ratereview.html. 1/2/2018.

Premiums (per member per month) - Center for Medicare & Medicaid Services, Rate Review Data, 'Worksheet I and II Data for 2018 Single Risk Pool Filings', 2017 Experience Period. https://www.cms.gov/cciio/resources/data-resources/ratereview.html. 1/2/2018.

Claims Trend (claims included as part of premium totals) - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/15/2019.

Wellness Migration Factor - Asset Health ROI[2] reporting book of business as of 2/28/19**.**

Direct Primary Care Adoption Rate & Fixed Fee - Industry-cited Direct Primary Care case studies.

Direct Primary Care Premium Adjustments - Wilson Partners case study analysis.

Assumptions and methodology: **Headcounts** - Counted experience period enrollment for the state of GA only using the source referenced above.

Premiums - Filtered for the state of GA only during the 2017 experience period. Multiplied per member per month premium totals from source above by 12 to get per member per year totals

Trend - Utilized the group trend percentage from the source noted above (same for large and small group) of 6.5%. Utilized this trend for all proceeding years.

Direct Primary Care plan (Georgia Direct Primary Care Access Option) Headcounts - 5% of the population migrates to the Georgia Direct Primary Care Access Option annually. This factor applies to all market segments.

Total Claims Cost (Georgia Direct Primary Care Access Option Only) - Claims cost for those enrolled in the Georgia Direct Primary Care Access Option are adjusted first by applying a factor of 0.93 to the total claims cost, to bring the total per member month to $413.44 ($4,961 per year) for the Small Group market. This factor is derived from the sources noted above as the percentage of paid claims that are attributed to traditional primary care (7%). Since Direct Primary Care would be paid through a fixed monthly fee, the cost for traditional primary care is removed, hence the 0.93 factor. Then, an additional adjustment is made for the impact direct primary care has on paid claims, which results in a factor 0f 0.85. Receiving care through a Direct Primary Care arrangement leads to an average savings of 15% per the sources noted above, which is why a factor of 0.85 is used. This reduces the per member per month claims cost to $351.43 ($4,217 per year).

Direct Primary Care fixed fee (Georgia Direct Primary Care Access Option Only) - Direct Primary Care fixed fee is $70 per member per month and remains $70 across all 10 years. This is added on to the $351.43 per member per month, resulting an adjusted per member per month claims total of $421.43 ($5,057 per year).

Total Claims Cost (non-Georgia Direct Primary Care Access Option) - Claims for those in a non-Georgia Direct Primary Care Access Option are trended by 6.5% annually for all years, meaning the claims cost for these members will match the baseline cost.

Adjusted Claims Cost (Georgia Direct Primary Care Access Option & non-Georgia Direct Primary Care Access Option) - The per member per month claims cost is calculated as a weighted average between the number enrolled in the Georgia Direct Primary Care Access Option and the non-Georgia Direct Primary Care Access Option. This cost is then further adjusted by the fixed fee and the impact of the wellness-demand management program, which is further explained below.

Adjusted Claims Cost (Wellness-Demand Management Program Impact - Georgia Direct Primary Care Access Option Only) - Once the adjusted premiums are calculated for the Georgia Direct Primary Care Access Option enrollees only, a wellness migration factor is applied which will reduce the total per member per year claims in all markets. Through the source described above, it is determined that 3% of the population will improve their overall health risk each year. This will result in a per member per year claims savings of 0.17% for each 1% of migration toward a better health risk factor. Both this wellness migration factor and the adjustment caused by the Georgia Direct Primary Care Access Option lead to the premium reflected below for innovation #2.

Conversion to Premiums - All claims cost as calculated above are divided by 20% to calculate the total premiums. This is due to the fact the administrative fees associated with individual insurance can be no more than 20% of the premiums. These numbers are then multiplied by 12 to obtain a per member per year premium total.

Large Employer Market	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline										
Headcount	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191	1,202,191
PMPY: premium	$5,845	$6,225	$6,630	$7,061	$7,520	$8,009	$8,529	$9,084	$9,674	$10,303
Annual premium	$7,027,282,626	$7,484,055,997	$7,970,519,637	$8,488,603,413	$9,040,362,635	$9,627,986,206	$10,253,805,309	$10,920,302,654	$11,630,122,327	$12,386,080,278
Adjusted: Innovation #2										
PMPY: premium	$5,832	$6,191	$6,565	$6,957	$7,366	$7,796	$8,246	$8,718	$9,215	$9,737
Annual premium	$7,011,693,190	$7,442,680,589	$7,892,717,271	$8,363,235,028	$8,855,734,333	$9,371,789,100	$9,913,051,658	$10,481,257,992	$11,078,233,234	$11,705,897,448
Impact (baseline less adjusted)										
PMPY: difference	$12.97	$34.42	$64.72	$104.28	$153.58	$213.11	$283.44	$365.20	$459.07	$565.79
Annual difference	$15,589,436	$41,375,408	$77,802,365	$125,368,385	$184,628,301	$256,197,106	$340,753,651	$439,044,662	$551,889,093	$680,182,830
% difference	0.2%	0.6%	1.0%	1.5%	2.0%	2.7%	3.3%	4.0%	4.7%	5.5%

Sources: **Headcounts (small and large group insured group coverage)** - Mark Farrah Health Coverage Portal Database, 'Enrollment by Segment', State of Georgia. https://www.mfamarketdata.com/portal/hcp/expanded/EnrollmentBySegmentParentView.aspx. 3Q 2018.

Paid Claims per member per month - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/15/2019.

Claims Trend (claims included as part of premium totals) - Optum Comprehensive Benefits Modeler databas, 2017 Claims Database. Accessed 2/15/2019.

Average Actuarial Value (Small Group only) - Center for Medicare & Medicaid Services, Rate Review Data, 'Worksheet I and II Data for 2018 Single Risk Pool Filings', 2017 Experience Period. https://www.cms.gov/cciio/resources/data-resources/ratereview.html. 1/2/2018.

Average Actuarial Value (Small Group/Large Group differential) - Henry J Kaiser Family Foundation, 2018 Employer Health Benefits Survey, Section 7 – Employee Cost Sharing. http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018. 10/3/2018.

Average administrative fee - Optum Comprehensive Benefits Modeler database, 2017 claims database, Accessed 2/15/2019.

Claims Charged Amount, Discounts, and Admin Fees - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/15/2019.

Claims Trend (claims included as part of premium totals) - Optum Comprehensive Benefits Modeler database, 2017 Claims Database. Accessed 2/15/2019.

Wellness Migration Factor - Asset Health ROI^2 reporting book of business as of 2/28/19.

Direct Primary Care Adoption Rate & Fixed Fee - Industry-cited Direct Primary Care case studies.

Direct Primary Care Premium Adjustments - Wilson Partners case study analysis.

Assumptions and methodology: **Headcounts** - Combined large and small group employer total was derived from the source noted above. In order to get a specific count for the large group market only, the combined headcount total was subtracted from the small group headcount total for the state of GA.

Average Actuarial Value - The average actuarial value for the Small Group market is derived from the source noted above (74.35%) by taking the average actuarial value for all GA small group plans. Then, that number is increased by 4.7% as the Large Group market has a 4.7% higher average actuarial value than the Small Group market, leading to the average actuarial value for the Large Group market being calculated as 79.05%. The average actuarial value for small and large groups was calculated by taking the average deductible, coinsurance and out-of-pocket maximums for each segment, which allowed for the calculation of the actuarial value. The difference between large and small group was determined to be 4.7%.

Premiums - In order to calculate premiums, the Optum Comprehensive Benefits Modeler was setup with a plan design matching the 79.05% actuarial value for large groups. Once the plan design was put in place, the modeler was able to pull from it's 2017 claims database to determine the paid claims for the state of Georgia. This is inclusive of a 15% admin fee. Totals were multiplied by 12 to get a per member per year total (PMPY).

Trend - Utilized the group trend percentage from the source noted above (same for large and small group) of 6.5%. Utilized this trend for all proceeding years.

Direct Primary Care plan (Georgia Direct Primary Care Access Option) Headcounts - 5% of the population migrates to the Georgia Direct Primary Care Access Option annually. This factor applies to all market segments.

Total Claims Cost (Georgia Direct Primary Care Access Option Only) - Claims cost for those enrolled in the Georgia Direct Primary Care Access Option are adjusted first by applying a factor of 0.93 to the total claims cost, to bring the total per member month to $385.07 ($4,620 per year) for the Large Group market. This factor is derived from the sources noted above as the percentage of paid claims that are attributed to traditional primary care (7%). Since Direct Primary Care would be paid through a fixed monthly fee, the cost for traditional primary care is removed, hence the 0.93 factor. Then, an additional adjustment is made for the impact direct primary care has on paid claims, which results in a factor 0f 0.85. Receiving care through a Direct Primary Care arrangement leads to an average savings of 15% per the sources noted above, which is why a factor of 0.85 is used. This reduces the per member per month claims cost to $327.31 ($3,928 per year).

Direct Primary Care fixed fee (Georgia Direct Primary Care Access Option Only) - Direct Primary Care fixed fee is $70 per member per month and remains $70 across all 10 years. This is added on to the $351.43 per member per month, resulting an adjusted per member per month claims total of $397.31 ($4,768 per year).

Total Claims Cost (non-Georgia Direct Primary Care Access Option) - Claims for those in a non-Georgia Direct Primary Care Access Option are trended by 6.5% annually for all years, meaning the claims cost for these members will match the baseline cost.

Adjusted Claims Cost (Georgia Direct Primary Care Access Option & non-Georgia Direct Primary Care Access Option) - The per member per month claims cost is calculated as a weighted average between the number enrolled in the Georgia Direct Primary Care Access Option and the non-Georgia Direct Primary Care Access Option. This cost is then further adjusted by the fixed fee and the impact of the wellness-demand management program, which is further explained below.

Adjusted Claims Cost (Wellness-Demand Management Program Impact - Georgia Direct Primary Care Access Option Only) - Once the adjusted premiums are calculated for the Georgia Direct Primary Care Access Option enrollees only, a wellness migration factor is applied which will reduce the total per member per year claims in all markets. Through the source described above, it is determined that 3% of the population will improve their overall health risk each year. This will result in a per member per year claims savings of 0.17% for each 1% of migration toward a better health risk factor. Both this wellness migration factor and the adjustment caused by the Georgia Direct Primary Care Access Option lead to the premium reflected below for innovation #2.

Conversion to Premiums - All claims cost as calculated above are divided by 15% to calculate the total premiums. This is due to the fact the administrative fees associated with individual insurance can be no more than 15% of the premiums. These numbers are then multiplied by 12 to obtain a per member per year premium total.

Markets Combined	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline										
Headcount	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573	1,965,573
PMPY: premium	$6,732	$7,249	$7,807	$8,410	$9,061	$9,765	$10,527	$11,350	$12,241	$13,205
Annual premium	$13,232,691,025	$14,248,096,467	$15,344,888,458	$16,529,881,487	$17,810,484,022	$19,194,752,078	$20,691,447,758	$22,310,103,222	$24,061,090,614	$25,955,698,489
Adjusted: Innovation #2										
PMPY: premium	$6,711	$7,195	$7,709	$8,255	$8,836	$9,455	$10,115	$10,819	$11,572	$12,378
Annual premium	$13,190,957,980	$14,142,786,888	$15,152,652,425	$16,225,671,753	$17,367,347,540	$18,583,602,060	$19,880,814,171	$21,265,859,410	$22,746,153,499	$24,329,699,563
Impact (baseline less adjusted)										
PMPY: difference	$21.23	$53.58	$97.80	$154.77	$225.45	$310.93	$412.42	$531.27	$668.98	$827.24
Annual difference	$41,733,045	$105,309,580	$192,236,033	$304,209,734	$443,136,482	$611,150,018	$810,633,587	$1,044,243,813	$1,314,937,115	$1,625,998,926
% difference	0.3%	0.7%	1.3%	1.8%	2.5%	3.2%	3.9%	4.7%	5.5%	6.3%
Cumulative difference	$41,733,045	$147,042,624	$339,278,657	$643,488,391	$1,086,624,873	$1,697,774,891	$2,508,408,478	$3,552,652,291	$4,867,589,406	$6,493,588,332

Appendix E: Actuarial Review

This section includes an actuary's statement regarding the two proposed innovations.

Actuarial Review

The Nyhart Company was asked to review the analysis performed by Wilson Partners (WP) and Anderson Economic Group (AEG) in determining the feasibility of two innovation designs for the State of Georgia. The State may need to apply for a 1332 waiver under the Affordable Care Act if an application is ultimately made to CMS. The report titled *Healthcare Innovations in Georgia: Two Recommendations* contains the detailed innovation descriptions, data sources and supporting financial projections.

Our review concentrated on the claim cost reduction and resulting premium savings in the following insurance markets: individual market for policies sold on and off the federal marketplace, small group employers (<50 employees), and large group employers (> 50 employees).

Actuarial Conclusions

Nyhart relied on AEG and WP for the accuracy of the data provided to us and accepted it without audit. To the extent that the data provided is not accurate, the projections provided in this report would need to be modified to reflect revised information. Nyhart reviewed the underlying data inputs, assumptions, methodology and calculations prepared by Wilson Partners and AEG. In our opinion, (1) the modeling assumptions are reasonable for this type of analysis and (2) the illustrative projections and savings are reasonable outcomes based on the modeling assumptions and data inputs selected.

In the following pages are descriptions of the proposed innovations, key assumptions, actuarial qualification statement and objectivity statement.

Description of Innovation 1:

Creation of a reinsurance program to reimburse accumulated claim costs that exceed a $50,000 threshold within a given year, using a reference-based methodology. All insured medical products sold in the individual, small group, and large group markets would be required to participate. Self-insured plans would not participate in the program. Accumulated claims would be repriced using a reference-based methodology to determine when the excess threshold had been met. 100% of additional paid claims, after meeting the excess threshold, would be reimbursed using the carrier's existing provider contracts, meaning current market costs.

In addition, all insured markets would be required to offer a qualified wellness program that actively engages patients in wellness education, programs, and activities.

Description of Innovation 2:

All large insurers will be required to offer at least one comprehensive health insurance plan, as defined by the ACA, that includes direct primary care. The direct primary care model requires members to establish a relationship with a primary care doctor that would cost a fixed monthly fee. The fixed monthly fee would be considered payment in full for all primary care services.

As in Innovation 1, all insured markets would be required to offer a qualified wellness program.

Limitations

1. The analysis was prepared assuming all carriers would continue managing their provider contracts so as to control costs, while promoting quality and improved health outcomes. As an incentive to maintain efficient provider contracts, after a number of years, the state could choose a carrier to manage the reinsurance program if they demonstrate effective (reasonable cost and high quality) high-cost claimant management.

2. The long-term solvency for the reinsurance program should be evaluated annually and changes be made, if necessary, in key features such as: reinsurance threshold, reimbursement percentage, pricing methodology, state subsidy, definition of eligible costs, eligibility and employer group assessments.

3. Should carriers not decrease their premiums by the full modeled savings, then a smaller savings impact will result.

4. It is possible that utilization of reference-based pricing in the reinsurance program may cause future provider contracts to use similar methods. This possibility was not modeled in the analysis and may lead to additional premium savings

5. There is a certain amount of savings overlap if both innovations are approved. This overlap of savings has not been measured.

6. No recommendation is being made at this time for a reference-based method for prescription drugs when determining whether the $50,000 reinsurance deductible has been met. If the proposal moves forward, a recommendation should be made at that time.

7. It is our understanding that the federal pass-thru funds may be used to cover administrative expenses of the reinsurance pool and/or cover excess claims for any of the insured markets (individual, small group, and large group).

8. Any reader of this report must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

9. Due to the nature of health plan experience, actual results will vary from this analysis, perhaps significantly, due to variations in the assumptions, benefits provided, participant demographics, and actual experience for the different risk programs. Therefore, it is important to monitor experience as it emerges so that future projections may be modified as necessary.

10. The data and information used in the actuarial analysis may not be appropriate for any other purpose.

11. Nyhart makes no representations or warranties regarding the contents of this report to third parties. Other parties receiving this report must rely on their own experts in drawing conclusions about the premium rates, insurance market population estimates, trend rates, and other assumptions.

Key Assumptions

The key modeling assumptions used in the study are described below:

Healthcare Trend

Claims for small and large employer groups were projected using a level 6.5% annual trend and 9.9% for individual plans for the 10-year projection period.

Excess Claims

Different reinsurance deductibles, varying from $50,000 to $300,000, were considered during the analysis. The portion of excess claims at each level was determined using Optum's Comprehensive Benefits Modeler (2017 normative claims database). The following table documents the portion of claims in excess of the reinsurance deductible.

Reinsurance Deductible	% of Excess Claims
$ 50,000	27.4%
$ 75,000	20.4%
$ 100,000	16.0%
$ 150,000	10.9%
$ 200,000	7.9%
$ 250,000	5.9%
$ 300,000	4.6%

The above excess percentages were comparable to those using the Claros Actuarial Assistant normative database (version 5.2.0.2).

The selected $50,000 reinsurance deductible resulted in the largest savings impact on the individual market enrollees' premiums. The $50,000 reinsurance deductible is comparable to the lower limit that several states with approved 1332 waivers have elected for state reinsurance programs.

Initial Claims Per Member Per Month

The following claims per member per month (PMPM) for 2018 (Individual) and 2017 (Small Group and Large Group) were used as the starting point. They were then trended to 2020 to serve as the baseline year.

Product	Claims PMPM
Large Group	$342.77
Small Group	$368.03
Individual (on and off exchange)	$487.25

Enrollment by Product

Product	Modeled Enrollment
Large Group	1,202,191
Small Group	247,293
Individual (on and off exchange)	516,089
All Products	1,965,573

Impact of Wellness Program	Both Innovations 1 and 2 require offering in the insured markets at least one qualified wellness program. The anticipated claim reduction on total costs (medical and prescription drug) is 0.17% for every 1% of migration towards a better health risk factor. The 0.17% claims reduction factor was based on data reported by Asset Health and Wilson Partners. Nyhart did not review the underlying experience data and relied on Wilson Partners as to its accuracy. It is our professional opinion the factor represents a conservative and appropriate savings estimate for modeling purposes.
Claims Reduction Due to Participation in Wellness Program	Both Innovations were modeled assuming 3% of wellness program participants (across all insured markets) would improve their overall health risk in year one. In each succeeding year, an additional 3% of wellness program participants would improve their overall health risk. The 3% wellness participation assumption, in conjunction with an anticipated 0.17% claims reduction per 1% of migration towards a better health risk factor, produces an effective claims reduction of 0.51% system-wide.
Migration to Primary Care Access Option	Innovation 2 was modeled assuming 5% of enrollees (across all insured markets) migrate to the Direct Primary Care Access Option in year one. In each succeeding year, an additional 5% of the non-Primary Care Access enrollees migrate to the Primary Care Access Option.
Claims Reduction Due to Direct Primary Care Model	A 15% reduction in total claims (medical and prescription drug) was assumed. The factor is based on research and case studies prepared by Wilson Partners and represents the low end of possible savings.

Certification of Actuarial Qualifications and Objectivity

I, Randy Gomez, certify that I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries, and meet the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States promulgated by the American Academy of Actuaries and have the education and experience necessary to provide this actuarial review.

Neither Nyhart nor any of its employees has any relationship with Anderson Economic Group or Wilson Partners that could impair or appear to impair the objectivity of our review. Our professional work is in full compliance with the American Academy of Actuaries "Code of Professional Conduct" Precept 7 regarding conflict of interest.

Randy Gomez
Nyhart

Appendix F: Alternative Innovations

Additional Healthcare Innovations

The two primary innovations we consider in this memorandum are joined with a set of others that have been discussed under the rubric of state 1332 waivers. A number of these are contemplated in the Executive Order of the President dated November 2017.[1] Below, we briefly describe a small set of healthcare policy alternatives that have been posed in the larger healthcare policy debate.

This list is not exhaustive, and does not include the options described in the text.

Health Sharing Plans. A healthcare sharing ministry facilitates the sharing of healthcare costs among individual members who have a common ethical or religious belief. Typically, the ministry does not use actuaries, does not accept risk or make guarantees, and does not purchase reinsurance policies on behalf of its members. Members are exempt from the individual mandate requirements of the ACA. Approximately 30 states have safe harbor laws that distinguish healthcare ministries from health insurance organizations.

Limited Benefit Indemnity Insurance. These plans pay a fixed amount of money for each medical incident, regardless of the actual cost of care, and, generally, there is no deductible. Currently, some large insurers do offer such plans, but they are not considered major medical insurance. A popular form of this plan pays for primary care but provides less coverage for in-patient care.

Health Reimbursement Arrangements (HRA). HRAs are described in the Executive Order as "tax-advantaged, account-based arrangements that employers can establish for employees to give employees more flexibility and choices regarding their healthcare." HRAs have been limited by IRS rule, and then expanded by federal legislation.[2]

In general, HRAs are funded entirely by an employer. They differ from Health Savings Accounts (HSA), which are limited to those covered by a "High Deductible Health Plan" or HDHP.[3]

Short-term Insurance. This type of insurance is typically purchased by households who need to fill a gap in coverage. Short-term insurance is exempt from ACA regulations, including the mandated benefits and a prohibition of pricing based on expected health expenses. It is sometimes called "short term limited duration" or "STLD" insurance. STLD insurance is included in the list of alternatives in the President's October 2017 Executive Order.

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1. The text of the order is available at: https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/.
2. IRS Notice 2013-54.
3. On eligibility, see IRS publication 969 (2018), which is explicit regarding the requirement of an HDHP to be eligible for an HSA. The same publication (and other sources) describe the differences in eligibility between HRAs and HSAs.