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CMS Relies on Flawed Legal and Economic Analyses to Suspend Georgia's State Innovation Waiver

PETER J. NELSON • SENIOR POLICY FELLOW

On April 29, Centers for Medicare & Medicaid Services (CMS) Administrator Chiquita Brooks-LaSure sent a letter to Georgia Governor Brian Kemp's office demanding a "corrective action plan" for the state's approved section 1332 State Innovation Waiver from certain Affordable Care Act (ACA) requirements.[1] In spite of the fact that the waiver has not yet been implemented, this demand is based on the Biden administration's determination that the state's waiver no longer complies with the statutory "guardrails" governing section 1332 waivers. Specifically, the CMS letter alleges the waiver will not meet the statutory requirement for a waiver to provide coverage to at least a "comparable" number of residents as would be provided such coverage without the waiver. The state may file a written challenge to this CMS action. If the state fails to respond before July 28, the Biden administration says it will suspend implementation of the waiver.

However, there is no legal basis for the Biden administration to demand a corrective action plan for a waiver that has not yet been implemented. Moreover, even if CMS could legally make this demand, the agency has failed to offer any substantive evidence showing the state's waiver would no longer comply with the guardrails. This report provides an analysis of the CMS demand letter, including the faulty economic assumptions and analyses it relies on. Ultimately, if CMS suspends implementation of the waiver, the agency will be in breach of the Specific Terms and Conditions (STCs) of the waiver, which is the underlying contract between CMS and Georgia governing the conditions of the waiver. Under the terms of the STC contract, Georgia will then be able to sue CMS for "specific performance" to require the agency to continue implementing the waiver.

"Ultimately, if CMS suspends implementation of the waiver, the agency will be in breach of the Specific Terms and Conditions (STCs) of the waiver"

Background

Section 1332 of the ACA provides for a "Waiver for State Innovation," allowing states to waive certain provisions of the law to implement innovative new State health care plans. This ACA provision recognizes the value in giving states flexibility to experiment with different approaches to providing access to health coverage through the individual health insurance market. The law allows these waivers

so long as the waiver meets specific criteria, often called "guardrails," to help ensure a comparable number of people retain access to coverage that is as comprehensive and affordable as would have occurred without the waiver. In addition, a waiver must be deficit neutral to the federal government.

In 2019, Georgia applied for a Section 1332 Waiver to address serious challenges the state's individual market was facing, including "drastic premium increases, low carrier participation in several counties across the state, and declining enrollment." After ongoing discussions and deliberations with CMS and stakeholders, the state eventually settled on a waiver that included two main parts. Part I of the waiver implements a state reinsurance program to lower premiums across the individual health insurance market and improve the affordability of coverage. This is similar to programs in other states that fund claims for people with high costs, which removes these high-dollar costs from the risk pool and lowers premiums for everyone in the market. Part II then implements the Georgia Access Model, which will transition Georgia from relying on HealthCare.gov to an innovative new health insurance delivery mechanism that takes advantage of private market resources to expand consumer access and enrollment by delivering a better consumer experience.

CMS approved Georgia's 1332 waiver plan on November 1, 2020 after concluding the plan met the law's guardrails. This conclusion was based on a finding by CMS's independent Office of the Actuary that the state's economic and actuarial analyses provided reasonable projections establishing how the waiver will meet the comprehensiveness, affordability, coverage, and deficit neutrality guardrails.

CMS Request for Updated Analyses

As expected, the transition from the Trump administration to the Biden administration brought a substantial shift in policies and priorities. Under President Biden's Executive Order 14009, CMS began reviewing all agency actions, including Georgia's section 1332 waiver. Citing this order, CMS sent a letter to Gov. Kemp on June 3, 2021 requesting updated actuarial and economic analyses of the waiver by July 3, 2021—just 30 days from the date of the letter.[2] The agency argued the update was necessary to account for "changes in federal law and policy" that occurred since the waiver was approved. The letter requested that the updated analyses account for recent changes in federal law under the American Rescue Plan Act (ARPA), the increase in federal funding for outreach marketing and navigators, and the COVID special enrollment period. Upon submission, CMS stated they would provide a 30-day federal comment period and then evaluate whether the waiver continues to satisfy the guardrails.

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Georgia responded to this initial request for updated analyses with a letter dated July 2, 2021. Georgia's response expressed concerns that the agency's request did not follow the process set forth in the STCs, and would essentially reopen the initial approval of the waiver, which the state asserted was not permitted by the STCs.[3] The letter closed by asking for clarification on the request. CMS responded on July 30, 2021 with a letter that basically reiterated the earlier request and the legal basis for it.[4] In the letter, CMS denied the agency was trying to reopen the approval process, provided the state an additional 30 days to provide the analyses, and threatened that CMS "*may* consider the State to be in violation of the STCs" if the state does not provide the updated analyses (emphasis added). Georgia then responded on August 26, 2021 contending that CMS had no legal basis under the STCs to make the request for updated analyses. The letter closed by expressing the "hope that the Departments [of

HHS and Treasury] will adhere to their obligations under the STCs."[5]

After this back forth, CMS again waited until November 9, 2021 to respond.[6] That letter reiterated the agency's belief that changes in federal law and policy justified reviewing the waiver for compliance with the guardrails. In addition, without any updated analyses from the state, CMS announced they would proceed with their own review. To aid that review the agency announced a 60-day public comment period to gather information on the impact of changes in federal law and policy on the state's waiver. The most recent CMS demand letter to the state included a comprehensive review of these comments.

Request for updated analyses and the comment period violated the STCs

In July 2021, American Experiment published a report outlining why the CMS request for updated analyses was not allowed under the waiver's STCs.[7] This report argued the agency's reliance on STC 15—which governs evaluation of approved waivers—was misplaced because the STC is not yet relevant because the implementation of the Georgia Access Model under the waiver has not yet begun. In other words, it makes no logical sense to "evaluate" a waiver that has merely been approved but not yet implemented. Moreover, the report explains how CMS's demand for more information after the waiver was approved is effectively an effort to impermissibly reopen the initial approval process.

Without a clear legal or regulatory path to reopen the waiver approval, CMS then shifted to rely on another provision—STC 7—to claim the discretion to amend, suspend, or terminate the waiver. Under STC 7, CMS and the Department of the Treasury "reserve the right to amend, suspend, or terminate the waiver … as necessary to bring the waiver … into compliance with changes to existing applicable federal statutes enacted by Congress or applicable new statutes enacted by Congress." CMS claimed the ARPA's temporary expansion of premium subsidies nationwide would impact enrollment in Georgia's individual market and, therefore, justified the request for updated analyses. But that indirect influence on the waiver from a change in federal law is not the sort of change that would trigger CMS discretion. In addition, the ARPA's temporary expansion of premium subsidies expires before the Georgia Access Model goes into effect for plan year 2023. Contrary to CMS's claim that the enrollment impact of the temporary premium subsidy will extend beyond its expiration, the Congressional Budget Office (CBO) projects enrollment will drop back to pre-ARPA levels by 2024, just one year after the temporary premium subsidies expire.[8] Moreover, STC 7 only applies to changes "enacted by Congress" and, therefore, does not apply to other changes in policy and circumstances the CMS letters reference, including federal spending on outreach and COVID special enrollment periods.

"Early on, CMS likely recognized the weakness of their legal position, which is why they kept dragging out the process"

Early on, CMS likely recognized the weakness of their legal position, which is why they kept dragging out the process with the comment period. But this comment period was itself impermissible. No public comment periods are provided for in the STCs or regulations after the waiver is approved and before the waiver is implemented. American Experiment filed comments in response to CMS that offered the following explanation on why the comment period itself was impermissible and of no effect:

> CMS regulations provide a detailed framework for federal and state procedures to collect public comment and input. Regulations clearly require the state and federal governments to provide for 1) input to inform the approval of the waiver and 2) input for after the waiver is implemented. If CMS wants to gather public input outside this regulatory process, the agency must do so by amending these federal regulations through

the notice and comment rulemaking process governed by the Administrative Procedures Act (APA).[9]

This comment period and the series of CMS letters strongly suggest an intent by the agency to engage in delay tactics to stall and hamstring the state's implementation of the waiver. The agency issued impermissible demands on Georgia for updated analyses with unreasonably short time frames while at the same time delaying their own responses to the state's legitimate concerns. For example, CMS took nearly a month to respond to Georgia's first letter and over two months to respond to Georgia's second letter. The agency then opened their impermissible 60-day comment period which was double the standard 30-day comment period for section 1332 waivers. It was also double the time CMS initially gave Georgia to come up with extensive new economic and actuarial analyses. After this extended comment period ended on January 9, 2022, CMS then waited nearly five months to issue the letter threatening to suspend the Georgia waiver. The time frames spelled out in the letter will extend uncertainty over the waiver into August and possibly September, just months before the Georgia Access Model is planned to begin serving enrollees as the 2023 plan year open enrollment period begins in November. Altogether, this reveals a pattern of bad faith engagement on the part of CMS.

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CMS demand letter wrongly claims Georgia breached the STCs

To justify the demand for a corrective action plan and the waiver suspension, CMS first claims the failure of Georgia to respond to the agency's request for updated analyses constitutes a material breach of the STCs. In its most recent letter threatening to suspend the waiver, CMS appears to have dropped all reliance on STC 7 and, instead, focused on STC 15, the provision that requires the state "to submit all requested data and information" to aid the agency's evaluation of the waiver. This shift indicates CMS is still scrambling to find legal footing against the strong legal positions the state has asserted in its response letters, which are also consistent with the legal arguments American Experiment previously published.

Importantly, in claiming the state breached the STCs, CMS entirely failed to respond to the substance of the legal arguments Georgia set forward in their August 26, 2021 letter. Instead, CMS only repeated the baseless legal rationale the agency set forward from the beginning. Therefore, CMS has left the state without any clear indication on why the agency continues to oppose the waiver and has failed to respond to the state's specific legal positions. Without more engagement, CMS has sent a strong message that the agency has no interest in cooperating. This failure, among other actions, demonstrates the agency's arbitrary and capricious actions in this process. In addition, it is difficult to see how a court reviewing CMS's actions would uphold the agency's termination of an approved waiver without, at a minimum, CMS directly addressing the state's legal arguments in writing.

CMS demand letter relies on a flawed economic analysis

The second basis for the corrective action plan and suspension depends on an economic analysis CMS completed which concluded the waiver would result in coverage losses. CMS worked with a federal contractor, Acumen, LLC, to undertake this analysis. Specifically, the Acumen analysis attempted to model how changes in advertising spending and attrition due to changes in enrollment pathways would impact individual health insurance market enrollment. Unfortunately, instead of engaging in a good faith, independent economic or actuarial analysis, CMS employed an in-house contractor to conduct an analysis using cherry picked and often flawed assumptions to steer the analysis toward the

agency's desired outcome.

The Acumen analysis depended on key assumptions and parameters related to the effectiveness of federal, state, and private advertising spending; the amount of federal and state advertising spending; the 2023 advertising market size, and a range of possible attrition rates.

By limiting their analysis to only these assumptions, CMS ignored key features of the Georgia waiver and the underlying market dynamics in the state that support the state's actuarial analysis and coverage estimates undergirding the original approval of the waiver. CMS also ignored other relevant assumptions that would be necessary to consider for any kind of fair or comprehensive analysis. Below is a list of the key assumptions CMS ignored:

"CMS employed an in-house contractor to conduct an analysis using cherry picked and often flawed assumptions to steer the analysis toward the agency's desired outcome"

- **Web-broker marketing and outreach will increase and boost enrollment due to stronger incentives.** When the ACA exchanges first launched in 2014, many insurers scaled back broker commissions and instead, relied on the Exchanges. Enrollment fell far short of projections. Moreover, exchanges directly competed with brokers, making it harder for them to find customers. Transitioning to private sector enrollment will increase the customer base and the availability of commissions for brokers. This will greatly increase the incentives for brokers to participate.

- **The number of entry points for consumers through the expansion of web brokers will increase, not decrease, access.** The added incentives for web-brokers and other private sector partners to participate will add to the number of entry points to the insurance market and expand access.

- **Web brokers and carriers will improve customer service.** Instead of the government monopolizing customer service through HealthCare.gov, competing web-brokers will compete to provide the best customer services which will improve the customer experience for enrollees across the state.

- **New enrollment due to Georgia Access will lower premiums.** The new enrollees drawn in by the Georgia Access Model will on average be healthier because they will largely be coming from the uninsured population who do not have a health condition that's already spurred them to get coverage.

- **Web brokers are more effective at attracting new enrollees.** CMS's own published data show that Enhanced Direct Enrollment partners—the model Georgia Access is using—attract a larger proportion of new enrollees than other enrollment pathways like HealthCare.gov or Navigators.[10] Independent private businesses have a large incentive to attract new customers and this CMS data suggests private brokers are acting on these incentives as expected.

- **Web brokers are more effective at retaining existing enrollees.** In the same way brokers have a stronger incentive and capability to attract new customers, they also have a stronger incentive and capability to retain customers. Existing customers enrolled by brokers will receive more follow-up and education than customers who relied solely on HealthCare.gov to enroll.

- **Funding for the Navigator Program would have a more effective impact on enrollment if it were redirected to premium reduction or private enrollment platforms.** CMS's own published data show the Navigator Program is not an effective enrollment platform. Navigators enrolled less than one percent of HealthCare.gov enrollees in 2017 and 2018.[11] Allocating these dollars to premium reduction or more effective enrollment programs will more effectively increase enrollment.

- **Federal advertising spending will likely supplant a portion of private advertising.** While the re-

search is mixed, some research suggests the level of federal and state advertising may adversely impact the level of private insurance advertising. For example, when the Trump administration reduced federal advertising spending from $100 million to $10 million in 2017, private advertising increased to the highest peaks in weekly volume when compared to all prior open enrollment periods.[12]

- **Federal advertising spending has not proven to substantially impact enrollment.** While the federal advertising effectiveness assumptions in the CMS analysis relies on a single study indicating that federal advertising increased enrollment by a small amount, other studies find federal advertising had no impact.[13] Beyond the single study showing a slight increase, the other studies CMS references are entirely related to the first open enrollment period. Yet, a review of television advertising spending over the first five open enrollment periods shows "the 2013-2014 open enrollment period demonstrates a strikingly different pattern than the following periods" and, therefore, concludes "it is likely inappropriate to extrapolate relationships between advertising and insurance outcomes in 2014 to the more recent periods."[14]

- **Enrollment gains from the temporary expansion of subsidies under ARPA will quickly disappear.** CMS claims there will be stickiness to enrollment gains under ARPA. If true, this stickiness likely has no impact on the waiver's coverage analysis because private brokers are likely more effective at both retaining and attracting new enrollees than HealthCare.gov. However, as noted previously, CBO projects that these ARPA enrollment gains will return to current law levels within one year after the expanded subsidies end.

By ignoring all of these assumptions, CMS has conveniently constructed an analysis that leads directly to the predetermined result they desired in search of some justification to suspend Georgia's section 1332 waiver. This is further evidence of bad faith on the part of CMS.

CMS analysis relies on a single, potentially flawed economic study

The CMS analysis relies entirely on one economic study to set their assumption for the effectiveness of federal, state, and private advertising. This study finds that a 1 percent increase in federal advertising leads to a 0.05 percent increase in the share of people enrolled in the Exchange.[15] By comparison, private advertising leads to a smaller 0.023 percent impact on the share of people enrolled. CMS chose this single study despite the fact that other studies find federal advertising has no impact.[16] If there is an issue with this single study, then the entire basis for the CMA analysis falls apart. A review of this study reveals several potential flaws that show it is likely not a reliable basis for the CMS analysis.

"Federal advertising spending has not proven to substantially impact enrollment"

Considering the difficulty of capturing the actual impact of federal advertising spending on enrollment in the mix of all the noise surrounding individual enrollment decisions, the study authors started from a seemingly sound approach. Their study estimates enrollment changes in counties on either side of the border of digital market areas (DMAs) in states using the federally facilitated exchange (FFE), CA, and NY. The DMA border provides a natural separation between different levels of ad spending. They assume the counties on the edge of DMA regions will be similar and, therefore, any difference in federal ad spending on either side of the DMA border will account for Exchange enrollment differences. They implement several controls to account for differences that might nonetheless exist across these borders.

This type of border analysis has become a common and effective approach to isolating the impacts of policy decisions. So, on a first impression, the border approach appears like a good choice. However, a closer review of the study reveals several potential flaws and odd outcomes which question the reliability of the results.

- **Potential market size assumptions.** The study measures how much federal advertising spending increases the share of enrollment from the potential market of enrollees. The potential market size appears to be based on the total number of uninsured and the number who purchase coverage individually without adjustment. However, a substantial portion of the uninsured are non-citizens or Medicaid-eligible which removes them from the potential market for Exchange coverage. Not accounting for the ineligible uninsured could substantially undercount the spending per potential enrollee in areas with higher-than-average concentrations of non-citizens and Medicaid eligible uninsured.

- **Accounting for the overlap in state and federal funding.** The study includes choropleth maps that depicts the level of federal and state ad funding per capita. These maps reveal substantial variation in the extent to which state funding overlaps with federal funding. Minnesota ad spending overlaps substantially into North Dakota and Wisconsin. Arkansas overlaps substantially with Louisiana and Tennessee. The Boston DMA and DMAs in New Mexico, Colorado, Utah, and Nevada have both state and federal ads. State spending in the Chicago area in Illinois appears to supplant federal funding despite the state's participation in the federal exchange. It's not clear whether the study design accounts for how more state funding might compliment and add to the effectiveness of federal funding or supplant federal funding.

- **Effectiveness of the inclusion of fixed effects by rating area.** Understanding the county borders don't provide a perfect control, the study includes fixed effects controls by insurance rating area in the regression to control for the effects of different plan characteristics on enrollment. Notably, it does not appear to include specific plan characteristics in the regression models estimating enrollment impacts. However, the use of fixed effects by rating area may be compromised by the fact that DMA borders often overlap with insurance rating area borders because both aim to segment consumer markets in a similar way. Due to this overlap, there can be dramatic variation between premium level and plan availability that can occur across a DMA border when it shares a rating area border, especially in the case of a large metro area with lower premiums and more plan selections. For instance, St. Francois County and Madison County Missouri are on either side of the St. Louis DMA. They are also on the border of rating area 6 (St. Louis) and rating area 10 (southeast Missouri). CMS plan data from 2018—the final year covered by the study—shows the premium for the lowest cost silver plan for a 50-year-old was $855 just outside the St. Louis DMA in Madison County. It was a much lower $588 inside the St. Louis DMA side in St. Francois County. In theory, fixed effects may be able to control for the much lower premiums in rating area 6, but that amount of premium difference will have a substantial impact on consumer demand on either side of the border. The study did test an alternative approach which restricted the analysis to only border pairs in the same rating area. They find their results are robust to this alternative specification. Nonetheless, it's not clear whether the study's approach can effectively control for this overlap between borders.

"[A] closer review of the study reveals several potential flaws and odd outcomes which question the reliability of the results."

- **Rating areas are imperfect proxies for plan characteristics.** One reason the study may have found similar results when using all border pairs and just border pairs in the same rating area is because rating areas are imperfect proxies for plan characteristics. That's because insurers offering coverage in a region do not necessarily offer coverage in every county in the region. For instance, CMS plan data from 2018 shows Upson County, Georgia in Rating Area 8 and the Atlanta DMA includes only Anthem BCBS plans. The premium for the lowest cost silver plan for a 50-year-old in Upson County was $784. By contrast, Ambetter plans were the only plans available in Taylor County, Georgia which is located in the same rating area but on

the other side of the Atlanta DMA in the Macon DMA. The premium for the lowest cost silver plan here was substantially less at $570. Obviously, the difference in premium will impact the demand function on either side of this border. Yet, it is not clear whether the study accounts for this possibility and it is not clear how widespread this might be. The study does control for time-varying characteristics, including the number of insurers and the market size, for county pairs. While this may control for this difference, it may only control for the change in the number of insurers from year to year within each specific county and not across the border. Moreover, it would not appear to control for the large premium differences.

- **Enrollment data relies on FFE states, California, and New York.** The study compares state ad spending versus elsewhere but this appears to be more of a comparison of state spending in FFE states because the only state based exchanges (SBEs) included are California and New York. Yet, most FFE states did not provide ad spending and if they did it was likely substantially less than California. Therefore, the study is basically assessing the effectiveness of state ad spending in the FFE, California, and New York without acknowledging the huge differences between FFE states and California and New York.

- **The study finds a statistically significant effect from federal ads but no effect from state ads.** It seems hard to believe that a model using valid assumptions would find that federal funding has a positive impact on enrollment but state ads have no impact. While the ads may be different, they have the same message that is identified in their search terms of the ad transcripts. The CMS analysis actually acknowledges how the study finds state ads virtually have no impact, but, nonetheless, assumes state advertising from Georgia would have the same impact on enrollment as federal ads. Thus, recognizing the study's results do not square with what would be expected, CMS changed the assumption.

"It seems hard to believe that a model using valid assumptions would find that federal funding has a positive impact on enrollment but state ads have no impact."

- **Democratic political advertising is just as effective as federal ads.** The study also includes additional categories of advertising to control for other factors which interestingly finds that democratic political advertising has virtually the same enrollment impact as federal ads. In fact, it's more statistically significant. That leads to an interesting sidebar question. Was federal advertising steered to Democratic areas similar to democratic advertising? This may explain why you see larger enrollment simply because federal ad spending targeted more Democratic areas with people who were more agreeable with the ACA. Research shows Democrats were more likely to enroll in coverage through the Exchanges.[17] It's not clear that these political sentiments are controlled for in the study.

Conclusion

This analysis shows how CMS has cherry picked its assumptions and relied on a single, potentially flawed study as the basis for their impermissible effort to reopen and revoke Georgia's approved Section 1332 waiver. No one's personal name is on the CMS study, just the company Acumen, a CMS vendor. By contrast, the approval of Georgia's waiver in 2020 relied on an actuarial analysis signed and certified by licensed actuary Timothy FitzPatrick with Deloitte Consulting. This analysis included robustness checks to test the results and abided by actuarial standards. Furthermore, as part of the waiver approval process, FitzPatrick's analysis was reviewed and found to be reasonable by CMS's own internal Office of the Actuary. While actuarial analyses are by no means perfect, the process provides a more reliable result than the current CMS analysis.

Moreover, nothing has changed in law, policy or market conditions that would upset the results of this 2020 actuarial analysis. The initial CMS requests for updated analyses were transparent efforts to reopen the waiver application and begin the process of revoking a duly approved waiver. These actions violated the waiver's STCs. CMS has stated that Georgia can submit a written challenge before July 28, 2022. The state has substantial grounds to challenge CMS actions and, should CMS suspend the waiver or otherwise act to prevent or impede its implementation, it should do so.

However, there remains hope that the Biden administration will allow the waiver to go forward in good faith and work with the state to ensure the successful implementation of the Georgia Access Model. While presidential administrations change and priorities shift, in order to innovate and improve access to affordable health insurance, states must be able to rely on the federal government and be able to work together in partnership. ■

Endnotes

1 Letter, Administrator Chiquita Brooks-LaSure to Grant Thomas, April 29, 2022, available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Suspension-Letter-GA-Access-Model.pdf.

2 Letter, Administrator Chiquita Brooks-LaSure to Governor Brian Kemp, June 3, 2021, available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Request-Updated-GA-Analysis-Letter.pdf.

3 Letter, Grant Thomas to Administrator Chiquita Brooks-La-Sure, July 2, 2021, available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Response-1332-GA-request-Updated-GA-Analysis-Letter.pdf.

4 Letter, Administrator Chiquita Brooks-LaSure to Grant Thomas, July 30, 2021, available at https://www.cms.gov/files/document/response-1332-ga-depts-follow-letter.pdf.

5 Letter, Grant Thomas to Administrator Chiquita Brooks-LaSure, August 26, 2021, available at https://www.cms.gov/files/document/1332-georgia-letter-cms-82621.pdf.

6 Letter, Administrator Chiquita Brooks-LaSure to Grant Thomas, November 9, 2021, available at https://www.cms.gov/files/document/depts-letter-comment20period.pdf.

7 Peter Nelson, *CMS Impermissibly Seeks to Reopen Georgia's 1332 Waiver Application and Approval Process,* (American Experiment Policy Spotlight, July 2021), available at https://www.americanexperiment.org/reports/cms-impermissibly-seeks-to-reopen-georgias-1332-waiver-application-and-approval-process.

8 Congressional Budget Office, Reconciliation Recommendations of the House Committee on Ways and Means, February 15, 2021, available at https://www.cbo.gov/publication/57005.

9 Letter, Peter Nelson, RE: Request for Comment on the Georgia Access Model, available at https://files.americanexperiment.org/wp-content/uploads/2022/01/CAE-GA-Comments-to-CMS.pdf.

10 Centers for Medicare & Medicaid Services, *Impact of Enhanced Direct Enrollment During the Open Enrollment Period for 2021 Coverage,* CCIIO Data Brief Series (January 2021), available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Impact-EDE-OEP-2021-Coverage.pdf.

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

12 Sarah Gollust, et al., "Health Insurance Television Advertising Content And The Fifth Open Enrollment Period Of the Affordable Care Act Marketplaces," *Health Affairs Forefront,* November 8, 2018, available at https://www.healthaffairs.org/do/10.1377/forefront.20181107.968519/full/.

13 Paul Shafer, et al., "Competing Public and Private Television Advertising Campaigns and Marketplace Enrollment for 2015 to 2018," *Journal of Social Sciences,* Vol. 6, No. 2 (July 2020), available at https://muse.jhu.edu/article/761091.

14 Sarah Gollust, et al., "Health Insurance Television Advertising Content And The Fifth Open Enrollment Period Of the Affordable Care Act Marketplaces," Health Affairs Forefront, November 8, 2018, available at https://www.healthaffairs.org/do/10.1377/forefront.20181107.968519/full/.

15 Naoki Aizawa and You Suk Kim, "Public and Private Provision of Information in Market-Based Public Programs: Evidence from Advertising in Health Insurance Marketplaces," NBER Working Paper 27695 (April 2021), available at https://www.nber.org/papers/w27695.

16 Paul Shafer, et al., "Competing Public and Private Television Advertising Campaigns and Marketplace Enrollment for 2015 to 2018," *Journal of Social Sciences,* Vol. 6, No. 2 (July 2020), available at https://muse.jhu.edu/article/761091.

17 Michael W. Sances and Joshua D. Clinton, "Who Participated in the ACA? Gains in Insurance Coverage by Political Partisanship," *Journal of Health Politics, Policy and Law,* Vol. 44, Iss. 3 (June 2019), available at https://read.dukeupress.edu/jhppl/article-abstract/44/3/349/137547/Who-Participated-in-the-ACA-Gains-in-Insurance.

8421 Wayzata Boulevard ★ Suite 110
Golden Valley, MN 55426

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