Closing the Coverage Gap

Policy Considerations for Public-Private Solutions to Expand Health Insurance in Georgia

Georgia Health Initiative

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Since the passage of the Affordable Care Act (ACA) in 2010, *addressing the coverage gap for the uninsured has been the center of many health policy debates in states. Georgia is also working to shape a unique solution to meet its health care goals. This paper outlines the issues for Georgia policymakers as they assess various policy solutions, with a focus on a public-private sector approach. The paper describes:*

- *The national coverage landscape;*
- *The current coverage landscape in Georgia;*
- *The design of Arkansas' coverage approach;*
- *Issues for assessing if a private option model is a good fit for Georgia; and*
- *Considerations for Georgia policymakers to address in covering the uninsured.*

Georgia Health Initiative commissioned **CapView Strategies** to research and write this publication. Georgia Health Initiative is an independent nonprofit organization with a mission to inspire and promote collective action that advances health equity for all Georgians. CapView Strategies is a boutique health policy consultancy committed to shaping health care transformation, and advancing access and quality of care.

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I. National Landscape & Medicaid Expansion

In 2012, the Supreme Court ruled that expanding Medicaid as outlined under the Affordable Care Act (ACA) would be left for each state to decide—25 states expanded Medicaid effective January 2014.[1] Since then, all but ten states have expanded coverage to "nonelderly adults" (ages 19-64) with incomes up to 138% of the federal poverty level (FPL), who otherwise would not be eligible for Medicaid. States have pursued Medicaid expansion to decrease the size of their uninsured populations, while also stabilizing their health care delivery systems—many have focused on designing programs to address health status issues and disparities in access.

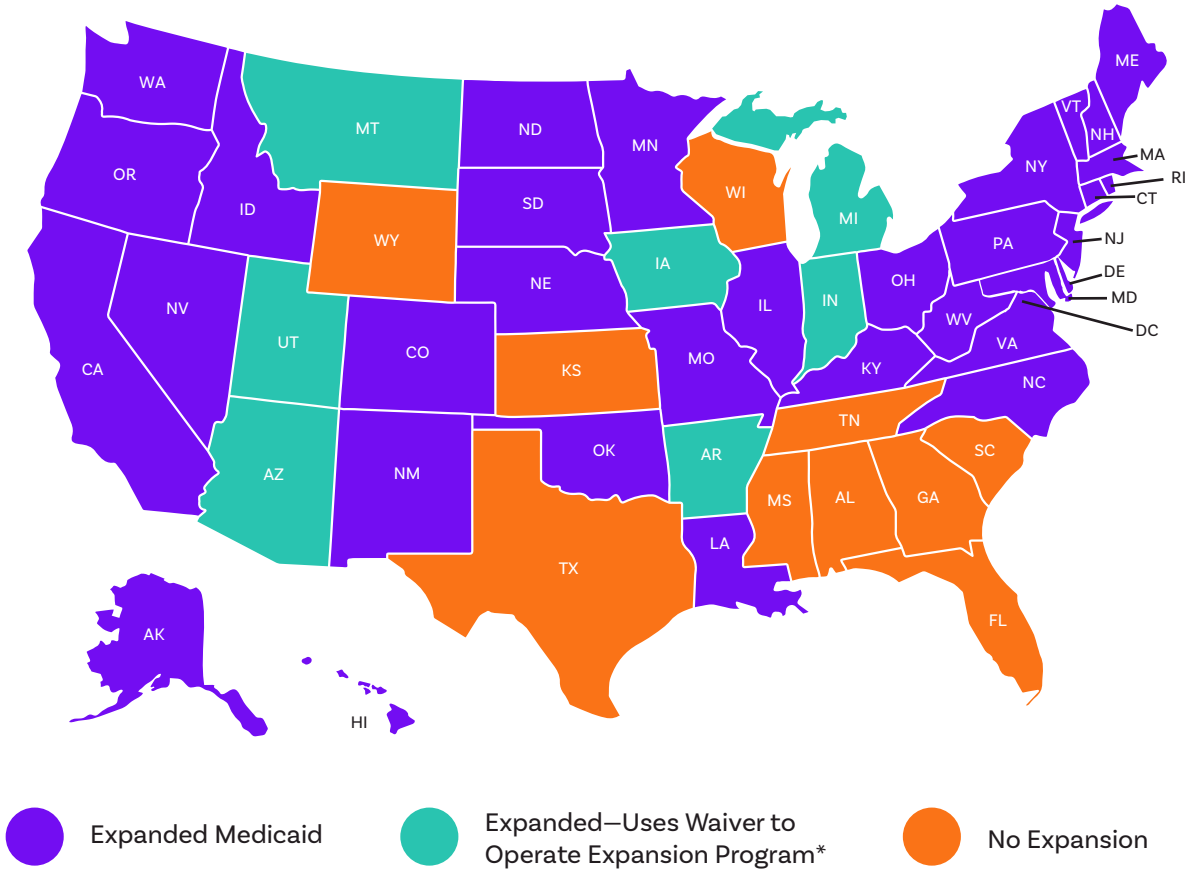
State Coverage Approaches and Federal Financing

Examining the national landscape and the experiences of individual states shows that Medicaid expansion can be accomplished with a variety of approaches. All states must submit a state plan amendment (SPA) to adopt Medicaid expansion. However, a number of expansion states have also used Section 1115 demonstration waivers to implement specific programs for their expansion populations, not otherwise allowed under federal law (*Exhibit 1*). Approaches have ranged from establishing premium contributions and cost sharing, personal responsibility requirements (e.g., work requirements, healthy behavior incentives), expanding services, and creating delivery system changes. Some states are also expanding access to services that are not otherwise covered to address health-related social needs.[2]

Federal Medical Assistance Percentage (FMAP). With expansion, states have benefited from enhanced federal funding, while also seeing improvements in access and reductions in uncompensated care costs. For the expansion population, the federal government paid 100% of Medicaid coverage costs from 2014 to 2016. Since then, the FMAP for this population phased down to and will remain at 90%. More recently, the American Rescue Plan Act (ARPA) of 2021 provides an additional incentive for states that had not expanded Medicaid as of March 11, 2021— a five percentage point increase to their regular FMAP for two years (in addition to the 90% enhanced FMAP for the expansion population).[3] The implications of this funding for Georgia are discussed in Sections II and IV.

North Carolina and Arkansas offer some lessons learned for Georgia policymakers. Both states provide an example of a different policy approach to expanding coverage, including perspectives on the inclusion of personal responsibility policies.

Exhibit 1. Medicaid Expansions Across the U.S. *(February 2024)*



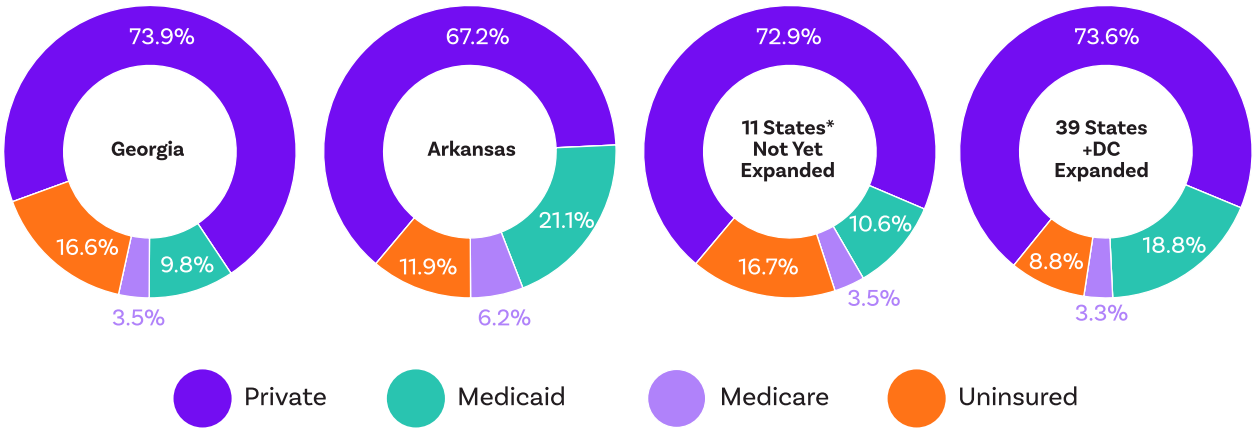
* Some states have waivers pending approval and, as a result, are not currently considered in this group.

Source: Adapted from KFF, Status of State Medicaid Expansion Decisions

North Carolina. In 2023, North Carolina passed legislation to expand Medicaid coverage to nonelderly adults with incomes up to 138% FPL using a SPA approach. The North Carolina legislature approved expansion to cover the uninsured and address hospitals' uncompensated care costs.[4] Enrollment for the expansion population began December 1, 2023 and as of February 2024, 346,000 of an estimated 600,000 eligible individuals had obtained coverage through Medicaid managed care organizations.[5] Since expansion occurred after ARPA was passed in 2021, the state will also receive an estimated $1.63 billion in the two years following expansion.[6] While North Carolina has not made a request to CMS to implement work requirements, the enacting legislation specifies that "if there is any indication that work requirements as a condition of participation in the Medicaid program may be authorized by the Centers for Medicare and Medicaid Services (CMS)" then the state will pursue approval.[7]

Arkansas. Georgia policymakers have expressed great interest in a private option model for expansion of coverage. Arkansas made policy choices that focused on private sector (Marketplace) solutions and strategies addressing personal responsibility, as well as other policy changes. This expansion approach and its potential as a model for Georgia is addressed in Parts III and IV of this paper. Exhibit 2 shows the health insurance status of all persons ages 19-64 in Georgia, Arkansas (post-expansion), all non-expansion states,[8] and all states that have expanded Medicaid.

Exhibit 2. Health Insurance Status of Adults Ages 19-64 (2022)



*AL, FL, GA, KS, MS, NC, SC, TN, TX, WI, WY (NC expanded in 2023)

Source: American Community Survey, Table HI-05 (2022)
Note: The Medicaid percentage in Arkansas most likely includes people in the expansion population even though most are enrolled in private health plans. North Carolina is counted here as a non-expansion state because it had not expanded coverage as of 2022. Veterans Affairs coverage was excluded. Percentages may not sum to 100% due to some individuals having multiple forms of coverage.

II. Uninsured Population and Health Coverage in Georgia

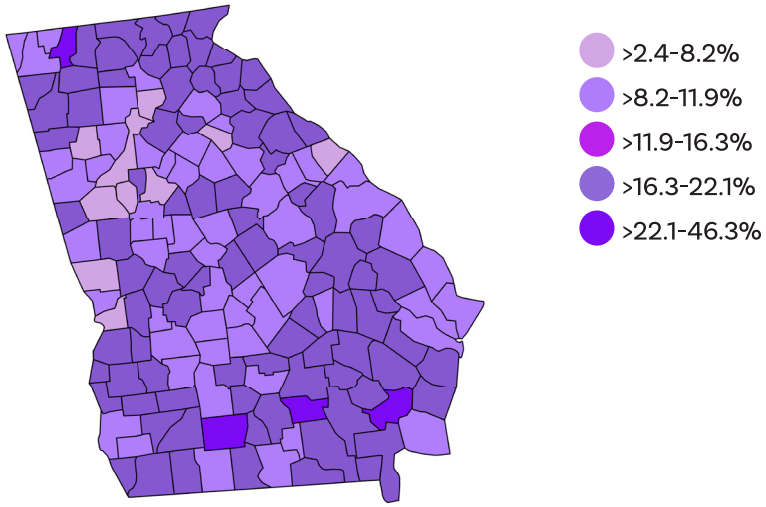
In 2023, Georgia's population reached 11 million.[9] In 2022—the latest year for which data are available—1.25 million of the state's residents were uninsured. Of these individuals, 1.07 million are between the ages of 19-64, which is the age group that, depending on income, could become eligible if the state expanded coverage under the ACA.[10] Estimates indicate that, of the 19-64 age group, 434,000 could be eligible for Medicaid.[11]

434,000
Georgians could gain health coverage if state expands Medicaid up to 138% FPL

Of Georgia's 159 counties, 120 are defined as rural.[12] In 2021, the poverty rate was higher in rural areas (19.4%) compared to urban areas (13.2%) in the state.[13] Exhibit 3 shows the percentage of each county's under-65 population that was uninsured.[14]

The unwinding of the Medicaid continuous enrollment provision that was in place during the COVID-19 public health emergency (PHE) through March 2023, has also impacted the size of the Medicaid, Marketplace, and uninsured populations in Georgia. As of February 2024, just over 503,000 Georgians who had maintained Medicaid coverage during the PHE have been disenrolled from the program.[15] Of these, only 15% were disenrolled due to ineligibility, while 85% were disenrolled for procedural reasons (e.g., did not complete the process, outdated contact information, etc.).

Exhibit 3. Percent of Each County's Uninsured Persons Under Age 65 *(2021)*

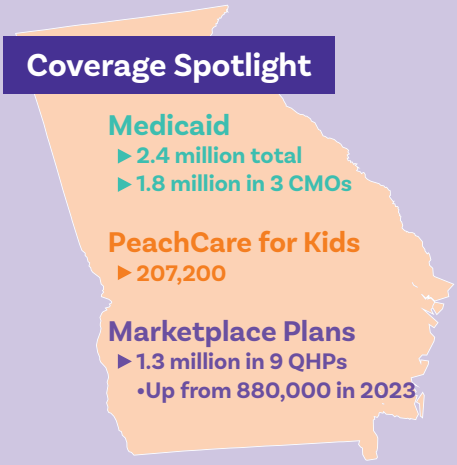


Source: US Census Bureau Small Area Health Insurance Estimates (SAHIE)
Note: Persons under age 19 could not be disaggregated.

Georgia Families® Programs – Medicaid, PeachCare for Kids®, and Pathways to Coverage™

Medicaid Coverage and Eligibility. One of every five Georgians is covered by Medicaid or PeachCare for Kids®, the State Children's Health Insurance Program (CHIP).[16]

- Most enrollees are children up to age 18 from low-income families or in foster care.
- Other eligible populations include low-income pregnant women and new mothers, and some very low-income adults ages 19-64 (e.g., parents or caretaker relatives with income up to 28% FPL).[17]
- The rest mostly qualify by being disabled, seriously mentally ill, or elderly with low income.



Source: Medicaid & PeachCare (as of December 2023); Marketplace: 2024 and 2023

The vast majority are enrolled in one of three Care Management Organizations (CMOs) that are each offered statewide.

Pathways to Coverage Waiver for Partial Medicaid Expansion. Georgia received approval of its Pathways to Coverage Section 1115 waiver (Pathways) in 2020. The waiver allowed the state to expand Medicaid eligibility to adults ages 19-64 with incomes up to 100% FPL, who would not otherwise be eligible for Medicaid. For 2024, 100% FPL equals an income of $15,060 for a single person and $31,200 for a family of four. At 138% FPL, it is $20,783 for a single person and $43,056 for a family of four.[18]

In Pathways, enrollees get coverage through one of the three statewide CMOs. Although the waiver was approved to run from October 2020 through September 2025, due to the disruption of the COVID-19 pandemic and policy disagreements with CMS related to the work requirement provision, enrollment into the program became effective July 1, 2023.

- **Enrollment**. 2,344 individuals—of the 64,000 estimated to be eligible—were approved to enroll by the end of 2023.[19, 20] Reports show many who applied were screened out for various reasons, and several thousand people were found to be eligible for Medicaid via another eligibility group, rather than under the Pathways program.[21]

Georgia Pathways' Unique Features:

- **Benefits.** Coverage in the waiver is consistent with traditional Medicaid except that non-emergency medical transportation (NEMT) is not covered.
- **Qualifying Activities (Community Engagement Requirements).** To be eligible, beneficiaries must perform 80 hours per month of qualifying activities (e.g., work, training/ education, or community service). Adherence is required for enrollment and must be reported monthly. There are limited "good cause" or disability related exemptions to participate in the qualifying activities.
- **Cost Sharing Requirements**. Enrollees with incomes between 50-100% FPL may be charged premiums, capped between 1-1.5% of household income. Currently, there are no cost sharing requirements, but it is anticipated they will be implemented in 2024.
- **Premium Assistance for Employer Sponsored Insurance (ESI)**. Enrollees eligible for employer sponsored coverage may be required to enroll in the Health Insurance Premium Payment (HIPP) Program and receive support for monthly premiums and cost sharing. Benefits will be limited to those in the ESI plan.
- **Reward Accounts and Healthy Behavior Incentives**. Enrollees will also have Member Reward Accounts (MRA) to be used for copayments and other expenses. Nonmonetary credits for healthy behaviors[22] will be deposited into MRAs and can eventually be converted into payments for benefits not covered under the state plan (e.g., dental, glasses, etc.). As of January 2024, these policies had not yet been implemented.

Georgia and CMS

Pathways to Coverage Waiver Timeline

- **October 2020:** CMS approves Georgia Pathways to Coverage waiver.
- **February 2021:** CMS sent letter to states outlining process for determining if it would withdraw approval of certain waiver authorities (e.g., work requirements).
- **December 2021:** CMS sent letter to GA withdrawing authority to require work activities as a condition of Medicaid eligibility or charge premiums beyond those allowed under Federal law.
- **August 2022:** Federal judge ruled CMS could not remove Georgia's work requirement.
- **February 2023:** Georgia asked CMS to extend the Pathways waiver for three more years due to the launch delay. CMS denied the request in October.

Georgia is the only state with work requirements in effect in 2024. CMS is currently not approving waivers that require enrollees to work or pay premiums.

FMAP for Pathways. Pathways does not meet the ACA expansion requirements because eligibility is not expanded up to 138% FPL.[23] Consequently, instead of receiving the

enhanced FMAP of 90% available to states that fully expand Medicaid, Georgia receives its default FMAP, which is 65.89% for federal fiscal year (FFY) 2024, rising slightly to 66.04% for FFY 2025.[24]

- Were Georgia to meet ACA expansion policies, the federal government would pay 90% of the costs. Additionally, the pandemic-era law (ARPA) enacted in 2021 included an incentive for states that newly take up expansion by raising the state's FMAP for traditional Medicaid by five percentage points for two years post-expansion. That bonus has been valued at $1.2 billion for Georgia.[25]

Marketplace Coverage and Georgia Access

Since 2014, Georgians lacking access to health coverage from ESI, Medicare, or Medicaid have had the option to purchase coverage through commercial insurers offering qualified health plans (QHPs) in the ACA Marketplace (Marketplace). In 2024, more than 1.3 million Georgians are enrolled in Marketplace coverage, up from just under 880,000 in 2023.[26] Nationally, participation in Marketplace plans grew significantly in January 2024, surpassing 21 million.[27] One reason for the big jump in enrollment was the unwinding of the continuous enrollment policy that was in effect during the federal PHE.[28]

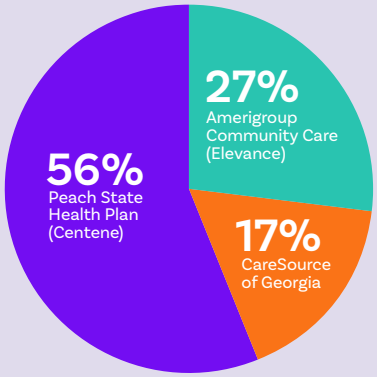
QHPs offer a broad, standardized benefits package and plans are grouped into three metal levels with varying cost sharing percentages – Gold, Silver, Bronze. All QHPs must offer the ten essential health benefits (EHB) defined in federal law and may also elect to offer extra benefits, such as dental and vision.[29] While anyone can purchase coverage on the Marketplace, individuals with incomes between 100% and 400% FPL may be eligible to receive federal subsidies that bring their premium costs down to very low amounts.[30]

Reinsurance and Georgia Access. In 2020, Georgia obtained a Section 1332 waiver to stabilize Marketplace plans through a reinsurance program. With the waiver, plans can access the reinsurance fund when health costs for an enrollee pass a certain level (e.g., $20,000 a year).[31] In 2023, Georgia gained approval to cease relying on the federally facilitated exchange (known as healthcare.gov), and implement a state-based exchange (GeorgiaAccess.gov), which is planned to begin full operation in time for the 2025 plan year open enrollment.

Medicaid and Marketplace Health Plan Landscape

Medicaid/CHIP. At present, all Georgia Medicaid and CHIP beneficiaries – except persons gaining coverage via the aged, blind, disabled (ABD) eligibility category – are required to enroll in one of three private health plans under contract with the Department

Exhibit 4. Georgia's Medicaid CMO's Share of Enrollees *(2020)*

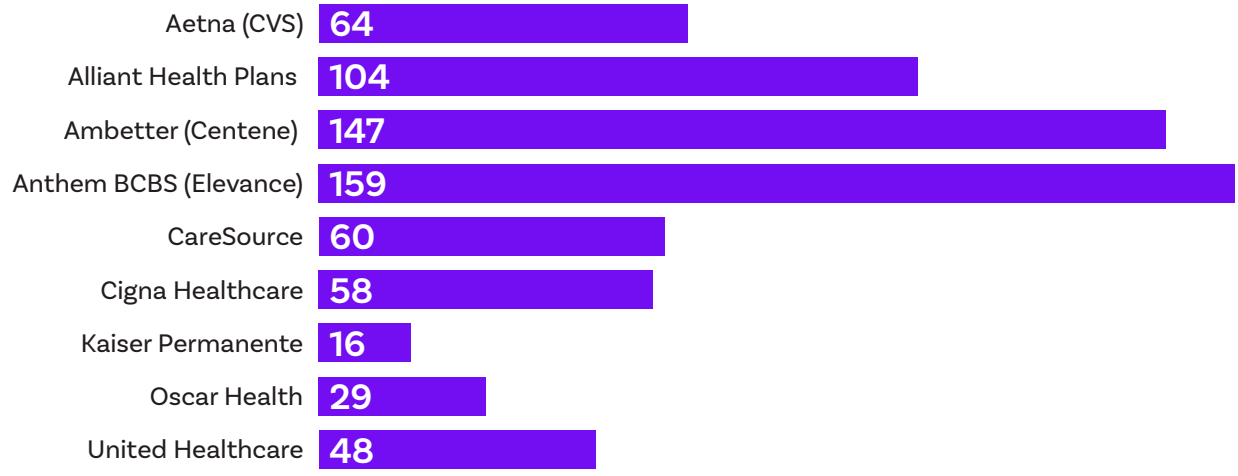


Source: Adapted from DCH Medicaid Dashboard.
Note: Centene acquired WellCare in 2021s

of Community Health (DCH) (*Exhibit 4*). Each of the CMOs receives a fixed monthly payment for each member. A CMO must also meet federal and state requirements to ensure that its provider network has adequate capacity and meets access standards outlined in DCH contracts. When Georgia completes its re-procurement for CMOs in mid-2024, it intends to have up to four CMOs under contract and to move certain ABD beneficiaries from fee-for-service (FFS) Medicaid into CMOs.[32]

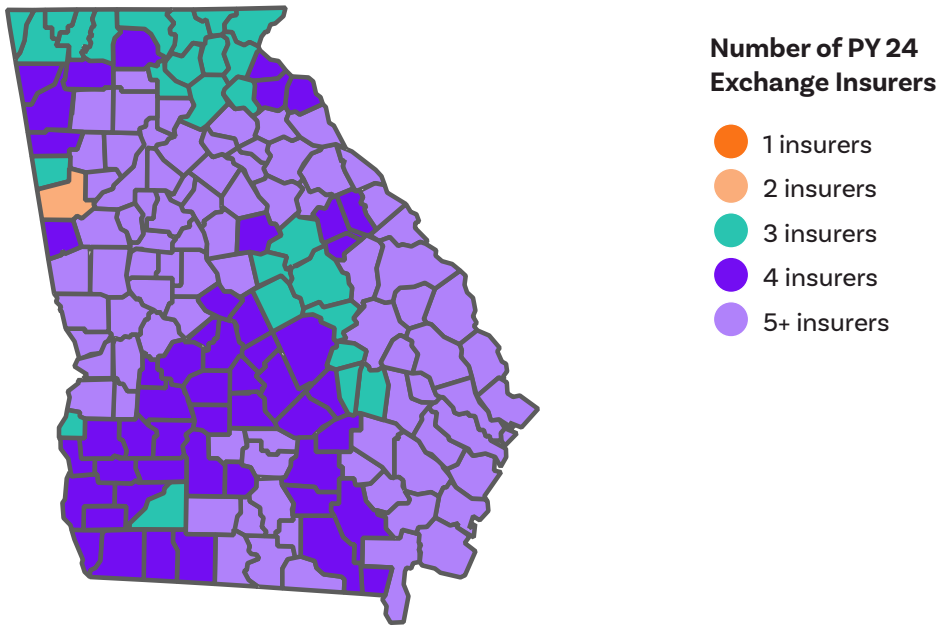
Marketplace. Nine insurance carriers offer QHPs in Georgia.[33] Insurers offering Marketplace plans may choose which counties they serve. Just one insurer (Anthem BCBS (Elevance)) covers all of Georgia's 159 counties. Though, as shown in Exhibit 6, every county has at least two plans, and four out of five Georgians live in counties where four or more insurers offer coverage.

Exhibit 5. Distribution of QHPs Across Georgia's Counties *(2024)*



Source: CapView Strategies Analysis of HealthCare.gov 2024 QHP landscape data

Exhibit 6. Number of Marketplace Insurers, by County *(2024)*



Source: 2024 Projected Health Insurance Exchange Coverage Map, Current snapshot: Insurer Participation in Health Insurance Exchanges, CMS (October 2023).

III. Arkansas' Model of Medicaid Expansion

In 2014, Arkansas expanded Medicaid to adults ages 19-64 with incomes up to 138% FPL. Unlike most expansion states, Arkansas took a two-pronged approach to implementing its program. The state extended Medicaid to the newly eligible population via a SPA in return for the enhanced FMAP. As a result, the state received 100% FMAP for the expansion population initially, which has phased down to and will remain at 90% moving forward.

Arkansas also used a Section 1115 waiver ("Health Care Independence Plan" otherwise known as the "Private Option") through which it used premium assistance to place expansion enrollees into Marketplace plans, rather than Medicaid FFS. It also implemented other program features not otherwise permitted under federal law, which are described below. The state had several reasons for this approach:

- Desire for a private sector oriented solution to reduce the number of uninsured;

- Its Medicaid FFS program did not have the provider capacity to serve the influx of the expansion population—potentially limiting new enrollee access;
- The state had not yet begun contracting with managed care organizations;[34] and
- Arkansas' Marketplace plan offerings were limited, and the state wanted to stabilize its individual insurance market.

Since its initial Private Option waiver was approved, two additional waivers were implemented, which continued premium assistance to support enrollment in Marketplace plans. The waivers also included features such as work and community engagement requirements, and programs to improve rural health care services and health outcomes, and address maternal and infant health, among others. Benefits offered under these waivers followed standards required by the ACA with some exceptions identified below.

Health Care Independence Plan ("Private Option"). This Section 1115 waiver was approved in September 2013 and ran through 2016. The program included additional benefits not covered in the standard QHP package (e.g., NEMT, family planning, EPSDT) available under the state's Medicaid FFS program. These services were provided separately as a wraparound service outside the QHPs.

- **Premiums and Cost Sharing Requirements**. Participants with incomes between 50-100% FPL were charged a monthly premium ranging from $5-25, depending on their income. These enrollees also received "Independence Accounts," into which participants' monthly contributions were deposited.[35] Balances in Independence Accounts (also partly funded by the state) were used to pay copayments or coinsurance.

Arkansas Works. The state's second Section 1115 waiver program was effective January 2017 through December 2021, and continued premium assistance for adults ages 19-64 with incomes up to 138%.

Arkansas' work requirements were only in place from June 2018 – March 2019.

Work requirements are not currently in place.

- **Premiums and Cost Sharing Requirements.** Enrollees with incomes between 100-138% FPL were required to make a monthly premium payment of up to 2% household income. Independence Accounts were not continued under this waiver. Individuals with income above 100% were subject to cost sharing within Medicaid limits.
- **Work and Community Engagement Requirements.** Able-bodied adults without dependents, ages 19-49 were required to participate in 80 hours per month of

qualifying activities (e.g., employment/training, education, volunteering). The phase-in of work and community engagement requirements began in June 2018, but this provision was canceled just nine months later (see discussion below).

- **Temporary Premium Assistance for ESI.** The state initially added a premium assistance program for people with ESI to strengthen the market. However, participation was low, and the program was phased out in 2018.

Arkansas Health and Opportunity for Me (ARHOME). The most recent waiver runs from January 2022 through December 2026.[36] It continues enrollment of individuals in QHPs. CMS allowed the state to continue charging premiums, but only for participants with incomes above 100% FPL, capped at 2% of household income, and only through the end of 2022. As of January 2023, cost sharing for individuals with incomes above 20% FPL follows federal Medicaid requirements. Premiums and cost sharing for all enrollees are subject to an aggregate cap of 5% of household income. QHPs are required to offer health improvement incentives to encourage beneficiaries to adhere to healthy behaviors or routine care such as wellness visits, mammograms, or screenings, among other activities.[37] Work requirements are not included.

Approx.
240,000
Arkansans ages 19-64 were enrolled in ARHOME in December 2023

Source: ARHOME Quarterly Report, Dec 2023

ARHOME Waiver
Targeted Population Initiatives

The waiver includes additional programs to provide targeted support services to improve health outcomes for specific populations. This includes home visitation for persons with high-risk pregnancies, initiatives for intensive care coordination for individuals with serious mental illness (SMI) and substance use disorder (SUD) in rural areas and programs for young adults at risk for poverty due to a set of factors (e.g., incarceration, homelessness, etc.).

- The state submitted an amendment to the ARHOME waiver on June 1, 2023, requesting to implement a new program called "Opportunities for Success Initiative." The program would connect QHP enrollees ages 19-59 who have not demonstrated engagement in the workforce or their communities—specific activities could include education, workforce training, unemployment benefits, among others. For enrollees with higher incomes (e.g., above 20% FPL), care coordination services would not occur until the individual had been enrolled in Medicaid for a certain period of time (e.g., 24 or 36 months). Those who do not engage in care coordination services or targeted coaching would be disenrolled from a QHP and moved to FFS Medicaid after a certain period of time. The waiver amendment was pending CMS approval as of mid-February 2024.[38]

QHP Delivery System

In Arkansas today, two insurance companies – Arkansas Blue Cross Blue Shield and Centene Corporation (doing business as Ambetter)—offer QHPs on the Marketplace, both statewide. Medicaid expansion adults continue to be enrolled into QHPs—rather than the traditional FFS Medicaid program—with the following exceptions:[39]

- Enrollees whose QHP coverage is not yet effective or who have not yet chosen a plan receive FFS Medicaid in the interim.
- Enrollees deemed "medically frail" are served by FFS Medicaid. They need long-term services and supports, which QHPs do not cover.
- FFS Medicaid covers all enrollees' use of NEMT and a few other services not available through QHPs.

In addition, one condition of the waiver is that QHPs must give expansion enrollees access to the services of federally qualified health centers (FQHCs), which serve as a key access point in some communities.[40]

Assessing Arkansas' Experience with Its Expansion Model

Coverage and Access. Overall, Arkansas has been successful in expanding coverage using QHPs. Participation is robust and the percentage of uninsured people ages 19-64 fell from 26.1% in 2010 to 12% in 2022 *(Exhibit 7)*.

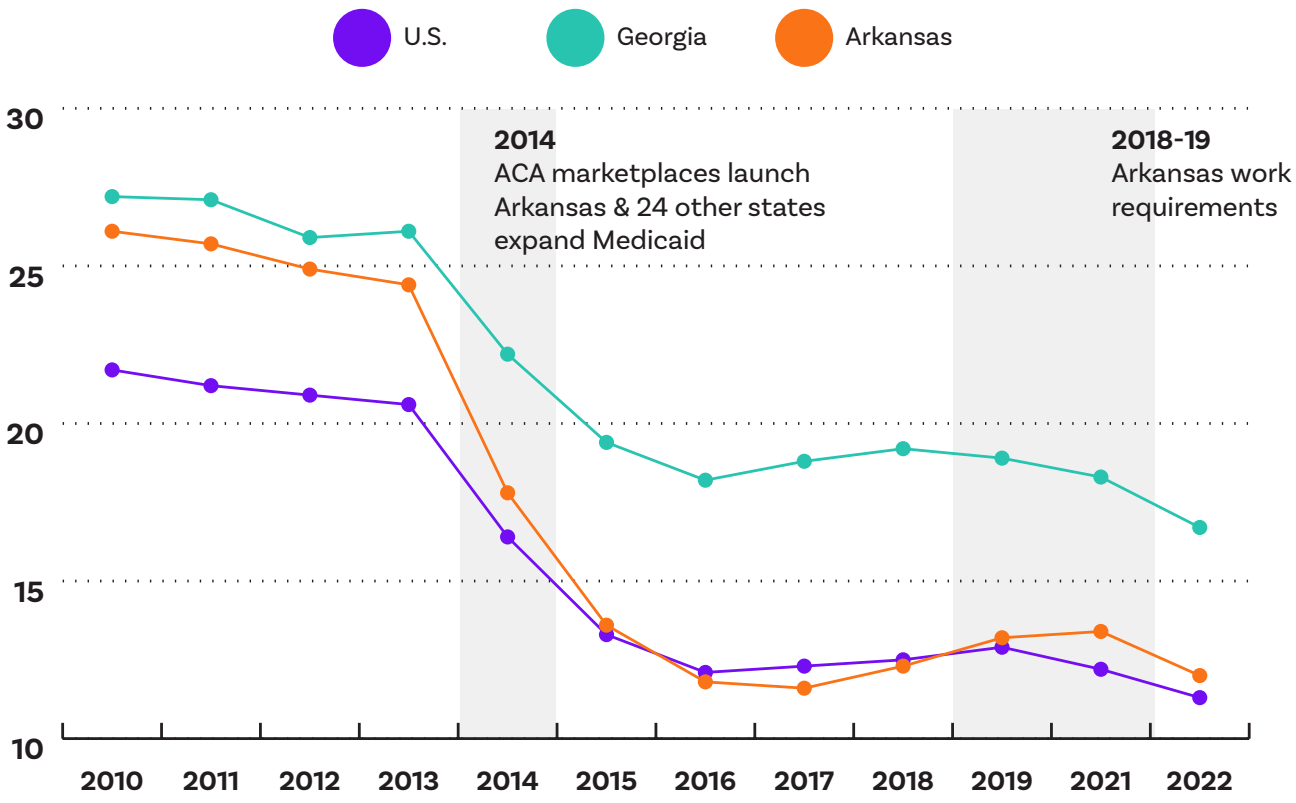
A 2016 paper comparing Arkansas' approach to Kentucky's traditional ACA Medicaid expansion reported that both states saw similar gains in persons insured and access to care, as measured by the shares of people who had connections to primary care providers or faced cost barriers to getting care.[41]

Insurance Market. Arkansas' Marketplace grew more stable through the use of QHPs to provide coverage for the expansion population. Since 2017, Marketplace premiums have been lower than in all surrounding states.[42]

Hospitals. Arkansas' hospitals have seen a marked decrease in uncompensated care, which has lessened the risk of service cutbacks and closures.[43] Analyses of other states indicate that rural hospitals were less likely to close in expansion states compared to non-expansion states.[44]

Work and Community Engagement. In Arkansas, the work and community engagement policy experienced several challenges. Analyses show that when the mandate was introduced in June 2018, the program encountered many process problems that led

Exhibit 7. Uninsured Rates for Population Ages 19-64 (%) *(2010 – 2022)*



Source: KFF State Health Facts. Data not available for 2020

to confusion and unintentional non-compliance. For example, enrollees found details of the requirements to be unclear. Enrollees also reported being unable to get the online accounts to work, encountering problems with telephone assistance, or having difficulties with monthly reporting (e.g., no/poor internet access). Others experienced employment challenges, particularly those who were already working—often their hours were limited and variable and they could not reach the 80 hours per month requirement. Some enrollees had chronic or mental disabilities that did not meet the criteria for an exemption, though their ability to comply was impeded.[45]

Nearly 18,000 people were disenrolled within the first few months of implementation and the mandate was quickly challenged in federal court.[46] The court vacated the provision in March 2019 and the policy was halted immediately. CMS ultimately rescinded its approval in 2021.[47] When the work requirements were in effect, the uninsured rate among the 19-64 age group rose—when withdrawn in 2021, the rate decreased (*Exhibit 7*).

Costs to the State. Arkansas also has faced challenges with the costs of its private option. There are estimates that covering Medicaid beneficiaries with QHPs cost more per enrollee than if placed in FFS Medicaid. However, an evaluation of the state's first waiver estimated that providing coverage comparable to that offered by QHPs would have been more expensive for the state, had Arkansas used its Medicaid FFS program rather than the premium assistance approach. This was in part because the state would have had to spend more to ensure a sufficient FFS provider network.[48] In an interim report on the ARHOME waiver, the state noted that it experienced unprecedented growth in enrollment during the PHE. As a result, Arkansas temporarily capped auto-enrollment into QHPs for new eligibles who did not choose a QHP, covering these individuals under Medicaid FFS.[49]

Budget Neutrality. Section 1115 waivers must be budget neutral to the federal government over the demonstration period—specifically not costing more than what the program would have cost without the waiver. Arkansas has met this requirement through most of its waiver lifespans. The state is required to continue to achieve budget neutrality over the five-year term of the ARHOME waiver and flexibilities exist in the waiver that allow the state to make necessary program adjustments to meet budget neutrality targets.

IV. A Private Option Style Model: Considerations and Questions for Georgia

Parts I-III identify issues for Georgia policymakers to consider in evaluating private sector/Marketplace QHP models for Medicaid expansion—like the Arkansas approach. Comparisons of population characteristics, health status indicators, as well as the features of Arkansas' and Georgia's coverage landscapes will be critical in shaping a unique coverage solution.

Demographics and Health Indicators

When comparing the populations of Georgia and Arkansas—and the nation— Arkansas is much more rural than Georgia and the nation and Georgia's population is more diverse racially (*Exhibit 8*). Health status indicators show significant challenges in both states, although Georgia appears to be somewhat healthier than Arkansas across some key health indicators.

Exhibit 8. Key Population and Health Measures

Demography	Georgia	Arkansas	U.S.
Population (2023)	11 million	3 million	335 million
Growth from 2010	14%	5%	9%
Ages 18-64	62%	59%	61%
Rural population (2020)	26%	45%	20%
White, non-Hispanic	51%	71%	59%
Black	33%	16%	14%
All Other	16%	13%	27%

Source: Adapted from U.S. Census Quick Facts (GA) (AR) (US), 2023 and US Census Urban and Rural, 2020

Health Indicators	Georgia Rank: 37		Arkansas Rank 48		U.S.
	Value	Rank	Value	Rank	
Avoid Care Due to Cost (Adults)	14.8%	48	13.8%	44	10.1%
Primary Care Providers per 100k	209	42	205	44	232
Mental Health Providers per 100k	186	47	279	31	325
Obesity (Adults)	37.0%	37	37.4%	38	33.6%
2+ Chronic Conditions (Adults)	10.7%	21	15.9%	46	11.2%
Low Birth Weight (% Live Births)	10.6%	48	9.5%	42	8.5%
Food Insecurity (% Households)	11.3%	31	16.6%	50	11.2%

Source: Adapted from America's Health Rankings 2023

Key Policy Issues

FMAP. Through its expansion approach, Arkansas met the ACA requirements for Medicaid expansion, allowing it to obtain the enhanced FMAP (initially, a 100% federal contribution for expansion costs that phased down to 90%). If Georgia makes a similar decision to cover adults with incomes up to 138% FPL, it will be eligible for the enhanced FMAP, plus a two-year supplement to its regular FMAP (due to ARPA) worth just over $1.2 billion.[50] If Georgia chooses an alternative to full expansion—not covering adults up to 138% FPL and incorporating personal responsibility policies—the state will likely pay about 34% of costs for that population (FMAP would only cover 66%).[51]

Personal Responsibility. The evidence from Arkansas, reinforced by Georgia's own recent experience, shows that personal responsibility policies may not only be difficult to implement but also create problems in gaining CMS waiver approval. Whether Georgia will continue to face barriers at the federal level regarding the inclusion of personal responsibility requirements in Medicaid expansion will largely depend on the policy perspectives at CMS and the White House, and potentially any future court decisions.

Delivery and Access Issues for QHPs vs CMOs

When Arkansas expanded coverage a decade ago, its Medicaid program was based on an FFS delivery system and, as discussed in Section III, a QHP-based approach best achieved the state's goals. In contrast, Georgia has three statewide Medicaid CMOs and a stable Marketplace program, with nine plans offering QHP coverage options in counties across the state. In selecting an approach to expansion and coverage, Georgia's policymakers will have to weigh delivery system capabilities, program goals, as well as implementation considerations (*Exhibit 9*). Issues include:

- Adequacy of provider networks to serve both new and existing enrollees in QHPs and CMOs;
- Program design provisions to support meeting the health and access to care needs of new enrollees, including behavioral health, maternal health, and other population health needs;
- Comparison of payment rates in QHPs to CMOs to assess which approach would create the best incentives for provider participation and result in improved access to care, while managing program costs;
- Necessity of using Medicaid FFS for select populations and specific services (regardless of whether expansion enrollees are in QHPs or CMOs); and
- State's capacity to ensure appropriate oversight.

Exhibit 9. Comparison of Implementation Issues for Qualified Health Plans (QHPs) and Care Management Organizations (CMOs)

Issue	Marketplace, Using QHPs	Medicaid, Using CMOs
Health Plan Choice for Participants	• At least two insurers in all counties • As many as eight in some counties (*Exhibit 6*)	• Three CMOs covering all counties (up to four in 2025)[52]
Benefits Covered and Care Management	• ACA-defined essential health benefits (EHBs) • State must manage and pay for Medicaid benefits not covered by QHPs • Care management techniques can be negotiated between state and plans	• Full Medicaid benefits • Benefits for expansion population must include EHBs • Care management specified in CMO contracts for Georgia's medically underserved and provider shortage areas • Ability to target clinical needs, such as perinatal health for new mothers, diabetes prevention and care management for chronic conditions
Provider Network Adequacy Standards	• QHPs must assure CMS of meeting basic access standards in application • Enforcement of requirements post-implementation may need additional resources at state-level; federal process and standards under development	• CMS requires CMOs to assure DCH that they meet standards for network access and provider capacity (e.g., wait times, travel distance, provider-patient ratios) in bids and in regular audits • Strong federal and state oversight required in CMO contracts
Quality Assurance	• QHPs must commit to continuous quality improvement and are largely self-regulated • State insurance commissioner may choose to review, though resources may limit scope	• CMOs must commit to multiple quality assurance efforts and reporting specified in federal rules and state contracts • DCH must do annual, in-depth quality review using certified external quality review organization

Source: CapView Strategies Analysis

Health Plan Contracting. If the expansion is built on QHPs, the state must develop new contracts, negotiate with insurers to participate in the program, and establish standards to ensure access to care. If CMOs are used, current contracts may have to be amended and new CMOs may need to be selected to assure appropriate access. Specific issues to consider include:

- Determining how coverage will be achieved across regions of the state—assessing which plan type (QHP vs CMO) has the greatest potential to address geographic coverage issues;
- Developing programs to tailor coverage to the health care needs of the population, as identified by health and access to care indicators;
- Assessing if QHPs will deliver full Medicaid benefits, or if Medicaid FFS will have to be used to augment coverage;
- Adapting CMO benefits or care management programs to address EHB requirements and the health needs of the expansion population; and
- Evaluating if enrolling new eligibles in CMOs or QHPs will provide greater opportunities to maintain continuity of care (e.g., access to providers, benefits) during future income fluctuations that may impact eligibility for Medicaid, Marketplace, or other coverage.

Beneficiary Outreach. Regardless of the type of health plan used (QHP or CMO), the state—in partnership with plans and others such as navigators and brokers—will need to communicate eligibility and enrollment processes to potential enrollees. Those wanting to enroll or to ask questions about coverage will need online resources that are easy to navigate and access. Trained enrollment advisors accessible via the phone and in person will be necessary.

Eligibility Determination. The state will need to assess its ability to leverage current capabilities (e.g., web portals, personnel, hotlines, auto-assignment processes) to determine eligibility and facilitate enrollment. The state will also need to decide if and when auto-assignment into plans will be used.

Premium and Cost Sharing Administration. If Georgia's new coverage expansion requires beneficiary cost sharing, the state, in collaboration with health plans, will need to set up a process to bill and collect monthly premiums as well as copayments associated with health care encounters.

Agency Capacity, Program Oversight, and Workforce. State agencies will need to develop resources and capacity to manage this new population, including outreach, eligibility determination, enrollment, and delivery system oversight. DCH, the Office of

the Commissioner of Insurance, and the new state health insurance exchange may all have parts to play. New tools—or modifications to existing ones—may be needed across phases of program implementation and operations.

V. Key Issues for Georgia Policymakers

Based on the analysis in this report, the following are key issues for policymakers to consider in designing a Medicaid expansion.

Populations and Financing. Decisions on covering the number of uninsured (i.e., extending coverage up to 138% FPL), on delivery system issues (QHP vs. CMO), as well as personal responsibility policies will potentially result in different levels of federal financing and likelihood of waiver approval.

- It will be critical to evaluate short-term and long-term goals for covering the uninsured and to consider the level of federal financing required. The recent shift in the numbers of the uninsured and Medicaid enrollment due to the Medicaid unwinding policies post-COVID are also important issues entering into decisions.

Marketplace versus Medicaid Solutions. In evaluating the two delivery system options for covering the expansion population—Marketplace QHPs and Medicaid CMOs—the analysis reveals that implementation steps are not the same for both, nor are the strategic policy incentives.

- Policymakers will need to evaluate long-term state priorities as well as programmatic capacity, multi-agency delivery system oversight, and workforce issues. Decisions will influence how the health care system evolves in Georgia—to be more oriented towards private sector solutions with QHPs, or one that leverages the state's robust CMO system.

Beneficiary Personal Responsibility. As seen in the Pathways program, Georgia's policymakers have supported personal responsibility programs that require enrollees to engage in work, study, or community service and share in health care costs to receive benefits.

- Experience with these policies has often not produced intended results—implementation has been problematic, federal approval and current support by CMS is limited, and the courts have stopped states from implementing work requirement policies. Policymakers' decisions on these issues will drive both program design and the likelihood of federal approval, impacting federal financing support.

Stakeholder Collaboration. Stakeholder engagement and collaboration will be critical to the success of any type of Medicaid expansion, regardless of the use of QHPs or CMOs.

- Vital in advancing a solution will be clear communication of program information and participation requirements to all stakeholders—as well as efforts to ensure the perspectives of enrollees, caregivers, providers, hospitals, and health plans are taken into account in program design and implementation.

Endnotes

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