

In The Matter Of:
Georgia Department of Coummunity Health

Hearing, PM Session
November 18, 2019

Regency-Brentano, Inc.
13 Corporate Square
Suite 140
Atlanta, Georgia 30329
404.321.3333



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GEORGIA DEPARTMENT OF COMMUNITY HEALTH
PUBLIC FORUM TO DISCUSS
GEORGIA SECTION 1332 - DRAFT WAIVER

GAINESVILLE CIVIC CENTER
CHATTAHOOCHEE ROOM
830 GREEN STREET
GAINESVILLE, GEORGIA 30501

November 18, 2019

1:00 p.m. Session

Reported by Jane P. Day

CCR# 5722-2335-0164-6848

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1 GEORGIA 1332 WAIVER

2 BY MR. MATTHEW KRULL:

3 Good morning. I'm Matt Krull, Health
4 Policy Counsel at the Department of Community
5 Health, and also General Counsel. Today is November
6 18, 2019 and it is now 1:00 p.m.

7 This is a public hearing on reinsurance and
8 Georgia Access, section 1332 State Relief
9 Waiver. This public notice was issued by
10 Governor Brian Kemp on November 4th of 2019.
11 This notice is incorporated into these
12 proceedings.

13 Pursuant to 31 CFR Section 33.112 and 45
14 CFR Section 155.1312. The state will provide a
15 public notice and comment period prior to
16 submitting the application for a new Section
17 1332 Waiver.

18 On November 4, 2019, the governor issued a
19 press release opening the 30-day public comment
20 period of this notice.

21 The public comment period will expire on
22 December 3, 2019. Individuals wishing to
23 provide written comments on or before December
24 3, 2019, may submit comments through an online
25 web form located at

1 medicaid.georgia.gov/patientsfirst, or mailed to
2 the office of the governor, care of Ryan Loke,
3 206 Washington Street, Suite 115, State Capitol,
4 Atlanta, Georgia 30334. Comment letters must be
5 postmarked by December 3, 2019 to be accepted.

6 At the conclusion of the comment period,
7 all oral comments presented today will be
8 transcribed and included in the final waiver
9 application. If you wish to make oral comments,
10 please sign the appropriate roster on the blue
11 table in the back.

12 At this time, does anyone needs the
13 services of the sign language interpreter?

14 You may be seated.

15 At this time, I'll introduce Mr. Ryan Loke,
16 from the offices of Governor Brian Kemp, Health
17 Policy Coordinator, to give an overview of the
18 1332 Waiver.

19 BY RYAN LOKE:

20 Thanks Matt. Can everybody hear me?

21 Okay. Great. Our court reporter said I
22 talk very fast, if I start talking too fast
23 somebody throw something at me and I'll slow
24 down a little bit. I'll try to speak up as much
25 as I can.

1 As Matt mentioned, my name is Ryan Loke.
2 I'm Special Projects Coordinator and Health
3 Policy Advisor to Governor Kemp.

4 I am here today to provide overview of the
5 Section 1332 Waiver Application, Reinsurance and
6 Georgia Access.

7 As Matt mentioned earlier, today is our
8 fourth public comment hearing. We've held three
9 already in Savannah, Macon and Bainbridge last
10 week. We will hold two more towards the end of
11 this week in Kennesaw and Rome. We will accept
12 written comments to the address above at my
13 office and then also online at the web-link
14 provided on the screen up there.

15 We will respond to all oral, written and
16 online comments in themes in our final waiver
17 application which we intend to submit by the end
18 of this calendar year.

19 A little bit of background on the Patients
20 First Act, Senate Bill 106 signed to law by
21 Governor Kemp on March 27 of this year after
22 passing the General Assembly during the 2019
23 legislative session. Senate Bill 106 granted
24 the governor the authority to apply for one or
25 more Section 1332 Waivers under the Affordable

1 Care Act. These 1332 Waivers must be submitted
2 by December 31st of 2020 -- 2021, and upon
3 eventual approval of these waivers, the state
4 will have the authority to implement as such in
5 line with the state of the law.

6 1332 Waivers have been in place since the
7 inception of the Affordable Care Act and began
8 being utilizes in 2017. Currently 13 states
9 have approved 1332 Waivers on the books, 12 of
10 which have been for state-based Reinsurance
11 Programs. I'll talk a little bit about
12 Georgia's approach to reinsurance here, in a
13 minute.

14 1332 authority per the Affordable Care Act
15 authorizes states to waive portions of the
16 Affordable Care Act to pursue integrative
17 strategies to provide access to high-quality
18 affordable health insurance. And within our
19 waiver application, the United States Department
20 of Health and Human Services, Centers for
21 Medicare and Medicaid Services, and the United
22 States Treasury will be evaluating our waiver
23 application against the four statutory
24 guardrails that you see up on the screen.

25 Those guardrails include comprehensiveness

1 in that the waiver application must provide
2 coverage that's at least as comprehensive as
3 provided absent the waiver, affordability, in
4 that we must provide cautionary protections
5 against excessive out-of-pocket spending, at
6 least as affordable as absent the waiver,
7 offering healthcare coverage to a comparable
8 number of residents as absent the waiver, and
9 then, most importantly in the federal
10 government's eyes, the waiver application must
11 be deficit-neutral to the federal government.

12 Again, those are the four statutory
13 guardrails that the United States Department of
14 Health and Human Services and the United States
15 Treasury will be evaluating our Section 1332
16 Waiver Application against.

17 A little bit about our waiver development
18 process, following passage of Senate Bill 106 in
19 March, we engaged on this project in June,
20 brought on our consultants, Deloitte Consulting
21 shortly there after. Our team completed a
22 national environmental scan, and a Georgian
23 environmental scan, which are both posted to the
24 DCH website presently, and I encourage you to
25 read that. There are about 150 pages of data

1 points, dense documents about waiver
2 applications, both 1115 and 1332 nationwide, and
3 then a bunch of Georgia-specific data that we
4 compiled as a state for release for the first
5 time. And that was used as the backbone of
6 which we built both of our waiver applications.

7 Following the environmental scan release,
8 we convened a stakeholder group in July of about
9 55 stakeholders, members of the General
10 Assembly, wider organizations, other
11 representatives with their constituencies to
12 present the national and state-based
13 environmental scan. We presented overview of
14 1115 and 1332 Waiver authority. We were
15 beginning to comb through ideas that these folks
16 brought to us as we began drafting concepts for
17 our waiver.

18 The second phase was really waiver
19 development and modeling and we completed that
20 over the course of the fall. And then finally,
21 we released the draft waivers via DCH Board on
22 November 4th, and the Governor's press release,
23 as well on November 4th. In those waiver
24 applications, the public notice and this
25 Powerpoint slide, as well, are all on the

1 Department of Community Health's website, as
2 well as the Governor's Office website, as well.

3 It's important to highlight that we've been
4 engaged with our federal partner since the
5 beginning of this project. That was what they
6 were signally for states to do that were seeking
7 new and innovative approaches to 1332 authority.
8 We began very early on engaging with our
9 partners at CMS to help us through with this
10 project.

11 A little bit about the specifics of our
12 Draft 1332 Application itself, the goals of our
13 waiver are fairly straightforward. You can see
14 those up on the screen, I'll hit on a couple of
15 these. The overall goal was to improve access
16 and affordability for individual healthcare
17 coverage in Georgia. We've identified some sub
18 goals there that are up on the screen. Reducing
19 premiums, particularly in high-cost regions,
20 incentivize carriers to offer plans in more
21 counties across the state. Presently, we have
22 six carriers offering individual market coverage
23 in this state, and about a hundred counties that
24 only have one carrier in their county that's
25 offering coverage on Healthcare.gov. Fostering

1 innovation to provide better access to
2 healthcare coverage, expand choice and
3 affordability of options for consumers, attract
4 uninsured individuals into the market, maintain
5 access to the Affordable Care Act's qualified
6 health plans and catastrophic plans and then,
7 there's always maintain protections for
8 individuals with preexisting conditions.

9 Preexisting conditions protections are not
10 a waivable provision of the Affordable Care Act,
11 under 1332 authority or any other authority, but
12 we are not seeking to waive those protections.
13 And that's spelled out explicitly in our 1332
14 Application several times.

15 Our 1332 Waiver design is in two phases.
16 The first phase is a state-based reinsurance
17 program, which I'll talk about here in a minute.
18 That will begin in plan year 2021 and that's
19 designed to lower individual market premiums in
20 the state by an average of 10 percent. And
21 then, our second phase that would be Georgia
22 Access, we'll move the state away from
23 participating on the federally facilitated
24 exchange, notice Healthcare.gov and allow for a
25 network of web-brokers and insurance carriers to

1 serve as an enrollment portal for individual
2 market coverage in this state. And that's
3 anticipated to begin in the plan year 2022.

4 A little bit about our Reinsurance Program,
5 again, as I said earlier, 12 states have
6 received approval for 1332 authority to operate
7 a state-based reinsurance program. Where
8 Georgia is similar to another state in this
9 light is the state of Colorado, that has just
10 been approved for a similar reinsurance program.
11 It pertains to the way that the reinsurance and
12 coinsurance formulas are applied in various ways
13 across the state.

14 Again, I talked about the goals of our 1332
15 Application, we're to reduce premiums,
16 particularly in high-cost areas across the
17 state.

18 Last Friday, or last Thursday, excuse me,
19 we were in Bainbridge, Georgia, that's southwest
20 Georgia, that has an insurance rating in region
21 16 that has an average monthly premium for
22 individuals buying off Healthcare.gov in excess
23 of \$1,100 per month. And there are other areas
24 across the state just like Bainbridge in
25 northwest Georgia, northeast Georgia. And you

1 can see within our waiver application itself
2 where these premiums are presently at (where we
3 intend to target a reduction (indiscernible)).

4 Some of the key specifics of our
5 Reinsurance Program, we're setting out
6 attachment point at \$20,000 and a cap at
7 \$500,000 worth of claims. We're planning to
8 tier out coinsurance rates by highest-cost
9 areas. So tier one would be 15 percent
10 coinsurance, tier two would be 45 percent
11 coinsurance and then tier three, your very
12 high-cost, rural areas, in most cases will have
13 80 percent coinsurance rate. We intend to seek
14 a 10 percent reduction in premiums in year one
15 on the individual market, and the actual range
16 is about 5 percent to upwards of 25 percent in
17 those rural areas. And those specifics are
18 spelled out in the waiver application itself.

19 The second component is Georgia Access,
20 again, moving the state away from the FFE
21 Healthcare.gov and allowing for a network of
22 web-brokers and insurance carriers to act as the
23 enrollment portals for individuals seeking
24 individual market coverage in this state.

25 The state will maintain some critical

1 operations as we move through this process,
2 including certifying plans that are eligible for
3 subsidies. We are proposing to allow for
4 existing federal subsidies to be utilized from
5 what we're dubbing non-eligible qualified health
6 plans. And those may be health plans that offer
7 all of the consumer protections under the
8 Affordable Care Act, including preexisting
9 conditions protections and cannot medically
10 overwrite, may not offer the sweep of the 10
11 essential health benefits as outlined in the
12 Affordable Care Act.

13 The state will also be responsible for
14 calculating eligibility for subsidies.
15 Presently, if you are an individual between the
16 poverty line and 400 percent poverty, you are
17 eligible for a subsidy. Under the Affordable
18 Care Act, the state will take control of that
19 subsidy structure and be the administrator of
20 that. And we propose to keep that existing
21 subsidy structure in place for the first year of
22 implementation. But I've reserved the right for
23 future years to adjust that with the federal
24 government's approval against the four statutory
25 guardrails that I discussed earlier.

1 The state will also be the issuer of those
2 subsidies on behalf of the individuals and will
3 be the ultimate program oversight compliance
4 motions as well.

5 We intend to rely heavily on the private
6 sector through a network of web-brokers and
7 insurance carriers to provide some operational
8 aspects to this program, as well. The
9 web-brokers and insurance carriers will be
10 allowed for consumers to shop, compare and
11 purchase plans through the private sector and
12 see all of the options available to them and not
13 be locked into just seeing the qualified health
14 plan by going to Healthcare.gov and having to go
15 to other websites to see other insurance
16 coverage options available to them.

17 And then the private sector will also be in
18 charge -- responsible for education outreach for
19 customer service.

20 Little bit about what stays the same and
21 what the benefits of moving away from the FFE
22 are; what stays the same, and I think it's
23 critical to discuss this, the access to current
24 ACA qualified health plans and high-deductible
25 health plan options like individual you see on

1 Healthcare.gov today will remain under this
2 option. Again, protection for individuals with
3 preexisting conditions and finally, the
4 subsidies that are placed presently,
5 administered by the federal government today to
6 support affordability.

7 A couple of the benefits, and I've
8 discussed a few of these a few moments ago, but
9 the ability for consumers to view all of the
10 plan options available to them, which are
11 license and withstanding with the state via the
12 web-broker platforms, the ability for
13 individuals to enroll directly with the
14 insurance carriers and not have to go through a
15 poor shopping process, like they do presently on
16 Healthcare.gov. Expanding consumer choice of
17 affordable options through those eligible
18 non-qualified health plans that I discussed
19 earlier. Again, those are the plans that offer
20 all of the consumer protections that the ACA
21 requires, including preexisting conditions
22 protections and cannot medically underwrite, but
23 may not offer the full sweep of essential health
24 benefits. And then, finally, provides
25 flexibility through the state to adjust the

1 program structure to best meet the needs of
2 Georgians in the future, rather than being
3 locked into Healthcare.gov and the federal
4 government program that we are in presently.

5 Again, I'd like to point you to the website
6 up there to provide online comments. That will
7 stay open until our comment period closes on
8 December 3rd. And if you'd like to mail in your
9 comments if you chose not to speak today, you
10 can mail them into the address above.

11 And I will turn it back to Mr. Krull now
12 for our public comment period.

13 Thank you.

14 BY MR. KRULL:

15 Thank you.

16 At this time I will go down the roster and
17 give each person who signed an opportunity to
18 speak. Please limit your comments to ten
19 minutes. Keep your comments limited to the
20 issues that directly relate to proposed public
21 notice.

22 At the end of your ten minutes, if you have
23 not completed your presentation, I may ask for a
24 brief closing statement. You will also be able
25 to submit the remaining comments in writing.

1 With that said, I'll call on the first
2 person on the list, and I have the microphone,
3 I'll bring you the microphone, you don't have to
4 come up here.

5 So the first person on the list is Senator
6 Nan Orrock.

7 SENATOR NAN ORROCK, REPRESENTING DISTRICT 36 SENATE,
8 ATLANTA:

9 Thank you very much. I'm Nan Orrock,
10 District 36 Senate in Atlanta. We didn't have a
11 downtown Atlanta hearing so I came to downtown
12 Gainesville. Traffic's not as bad here. But we
13 pushed and asked for a downtown Atlanta hearing
14 where I have constituents, neighbors, friends
15 and healthcare agencies that would very much
16 like to have been able to, in their community,
17 give testimony. The closest testimony to
18 downtown Atlanta is 32 miles away. That would
19 be a complaint that I would register, that to
20 ignore the capital city and not have a downtown
21 hearing there. And I'm very glad they're having
22 a hearing in Gainesville. Got a tremendous
23 hospital here, I've made site visits here and we
24 have much learned from Gainesville and how
25 they're providing services to this great

1 hospital to communities in north Georgia.

2 I feel that we are making a big mistake to
3 go in this direction. I'd like to flag several
4 things that occur to me and that could be
5 changed even within the structure, and I'll try
6 to address that before I close my ten minutes.

7 The overall picture is that will be
8 spending more dollars if we did full Medicaid
9 expansion we would be spending \$213 million in
10 state costs in 2022 and covering 486 people,
11 roughly. Instead, this plan we will be spending
12 \$215 million plus change and only covering it's
13 estimated in 2022, 79,000 or right at 80,000
14 Georgians.

15 So I fail to see how this is a remedy to
16 provide health coverage and insurance card to
17 the Georgians that are in desperate need. And
18 the source for these numbers is the lowest
19 enrollment estimate and the highest net
20 state-cost estimate comes from the Georgia
21 Department of Audits and Accounts when they did
22 a fiscal vote on a bill that was introduced to
23 actually expand Medicaid, that would be House
24 Bill 37, if you're willing to check it out.

25 The plan, I think goes against a very

1 basics tenant of insurance and that is, the best
2 insurance coverage is where you have a large,
3 large group of people that are covered. You
4 have healthy people and you have sick people in
5 that same cohort, because some people are going
6 to just buzz along and not take any medicine
7 until they're 80; they're just blessed with good
8 health and they've maybe taken care, better care
9 of themselves than somebody else, and look,
10 their fortune smiled on them. My mother was one
11 of those, my father was one of those.

12 But other people, I have a girlfriend with
13 a child born with a congenital heart defect,
14 who's now facing her fourth surgery in 25 years.
15 So all of that, you never know at the start.
16 And you all get in -- create a great, big pool
17 that has both healthy people and unhealthy
18 people and that's the way you keep premiums low.

19 Now what this plan does is offer premium
20 support, not for those who are the lowest income
21 but for those who are over 400 percent of
22 poverty. It's going to provide premium support
23 for them. Well, they're at the top of the heap
24 compared to these lower-income people. I don't
25 know if people are realizing that. That

1 actually that premium support is going to go to
2 people over 400. So those who have less need
3 for premium support are going to get it first.
4 That's a definite problem.

5 But, it's also going to, as you've heard
6 Ryan say, that this is going to unhook us from
7 the Affordable Care Act, and not require
8 insurance companies in Georgia to provide all
9 the things that are required in the Affordable
10 Care Act.

11 Maternal care. Did you know we have one of
12 the highest rates of maternal death, maternal
13 mortality in the nation. I believe we are in
14 the bottom five. And to be out here selling
15 insurance plans, offering insurance plans that
16 don't have that. And a person will buy because
17 it's cheaper at the time.

18 Also, you can sell a plan that doesn't have
19 the required prescription coverage. Horrors if
20 you as you wind up needing an expensive cancer
21 treatment drug. The mental-health coverage can
22 be(indiscernible) from that.

23 Now the one thing they held onto,because
24 it's so damn popular is that you can have a
25 preexisting condition you can't be denied that,

1 because that a classic thing that we've all
2 experienced, pre-existing conditions in the
3 private insurance market, right? So they will
4 not be allowed to back off from that one. But,
5 mental health and substance abuse. We have
6 opioid abuse crisis. Not so much in our making
7 but because of what's been going on in the
8 market, how these opioids have been pushed out.
9 And that could be not covered.

10 So you have very inadequate plans out there
11 and people spending money to get inadequate
12 coverage. That's a waste. That's a waste of
13 money.

14 And you know, we've already spent millions
15 of dollars and years looking at this question of
16 healthcare in Georgia, the cost and how to
17 cover everybody. The fact that we have such a
18 high rate of uninsured people.

19 And we have hospitals closing and I don't
20 represent a rural area, I represent downtown
21 area. My daddy came from Mitchell County, you
22 know I have many, many relatives, big old family
23 out in rural areas and anybody that, the
24 hospital folks can certainly tell you, that
25 rural hospitals need help in every way. And if

1 we would expand into the this Medicaid
2 expansion, we would have a real shot at creating
3 new jobs and new money for the healthcare
4 industry in Georgia, and coverage for all these
5 people that present at the hospitals, and they
6 don't have coverage, and the hospitals have to
7 eat it. That's why hospitals are in crisis.

8 So there are ways to do this 1332 state
9 innovation waiver. Keep the proposed structure
10 of the reinsurance program that include
11 directing more funding to areas with higher
12 premiums.

13 Number two, don't allow premium subsidies
14 to be used for non-qualified health plans.
15 That's what I was just speaking of. Doing so
16 would create a shift in the market and increase
17 costs for comprehensive qualified health plans.
18 And we all know that. We all know that. That
19 is not debatable, I would love to hear somebody
20 tell me I'm wrong on that. It's a basic tenet
21 of insurance and underwriting.

22 Number three, remove the cap on the premium
23 subsidies. Do you know what caps on premium
24 subsidies are going to wind up doing? It means
25 you get a capped amount of federal dollars and

1 with the dollars, when you run out of that
2 capped amount, you go on a waiting list. Well,
3 your dog-gone tonsillectomy or your pregnancy or
4 your cancer doesn't wait on a waiting list, does
5 it? So the waiver is not going to help that.
6 So that's a very important problem with this
7 that should be addressed. Remove the cap on the
8 premium subsidies.

9 And then, maintain a centralized enrollment
10 experience, such as Healthcare.gov and invest in
11 an outreach and enrollment assistance to help
12 more people get enrolled, instead of relying on
13 a decentralized system, which is the heart of
14 this waiver. Decentralized, privatized system
15 of private entities to be responsible for all
16 outreach and enrollment. And you know that the
17 money the insurance companies are responsible
18 for the outreach and enrollment, and then the
19 consumer education, did they always look out for
20 our best interest?

21 Let me hear you make that case. No. No,
22 they've been part of the problem. And so you're
23 going to let the fox get in the hen house. An
24 insurance company advising you on policies,
25 they're just going to advise you what's in their

1 interest to sell you. Not necessarily what's in
2 yours. So that's a fundamental flaw in this
3 endorsed privatized approach.

4 How's my time going?

5 MR. KRULL: You've got a minute left.

6 SENATOR ORROCK: Oh. Okay, well I will
7 wrap up. And I say where do we go when we're sick
8 and need that intensive intervention of health? We
9 go to the doctor and we go to the hospital. And
10 you know the hospitals are saying? The head of the
11 Georgia Hospital Association, Earl Rogers said that
12 this plan will not move the needle. Will not move
13 the needle. And I think every hospital Georgia is
14 a member of that. The Community Hospitals
15 Association say while we appreciate anything you
16 can do, but sure need you to do a lot more than
17 this. So I think we should sound the alarm that
18 this needs to go back to the drawing boards. And
19 within the application you can make some huge
20 enhancements that don't burden Georgians and that
21 truly would, in Governor Kemp's words, "cover more
22 working Georgians."

23 I thank you for your time and look forward
24 to hearing any responses and other people's
25 testimony. Thank you.

1 MR. KRULL: Two seconds to spare.

2 Elaine Kovacs.

3 ELAINE KOVACS:

4 So this is my first time ever being to a
5 public hearing, so I'm just going to kind of
6 preface that, that I am not nearly as prepared
7 as this lady was. So I work as a mental health
8 professional here in Georgia. I've worked with
9 hospitals and in the emergency rooms doing
10 behavioral health assessments. I've also worked
11 in addictions, working with opioid addiction
12 recovery, as well. So my main focus is on
13 mental health, but I feel very, very strongly
14 about these particular things, related to how it
15 might impact mental health.

16 So I'm just going to kind of -- I read
17 through this thingamajig, this public notice
18 thing, so I'm just going to kind of write
19 down -- I made little notes on it about some of
20 the concerns that I have.

21 So like she was saying about removing the
22 single risk pool, when you create two different
23 pools of coverage, it's going to make it less
24 effective in terms of providing benefits for all
25 the people who need the benefits, that's one

1 thing.

2 The insurance, oh yeah, when she talked
3 about the over 400 percent of the Federal
4 Poverty line, it sounds like it's really helping
5 more people who can afford the costs, not the
6 people who are under that level. More
7 cost-effective means, a reduction in coverage
8 options, like of essential healthcare standards,
9 you know through the ACA. So basically you're
10 saying you're affordable but you're affordable
11 because you're not providing those 10 essential
12 health benefits, so it's kind of a lie.

13 Dismantling Healthcare.gov, I mean, I refer
14 people a lot to Healthcare.gov so that they can
15 actually compare plans that all meet the same
16 guidelines and the same standards. I refer
17 them to a lot of that. And I have some real
18 serious issues when they're being referred to
19 these individual insurance companies because
20 they're going to try to sell their product.
21 They're going to want your business, so they're
22 going to advertise in a way that may seem like
23 it's a great deal, this is a great option, but
24 it's not. So you're kind of like, deregulating
25 the enrollment process, which puts a lot of

1 consumers at risk. That they may buy a plan
2 thinking it's a great deal and not realizing
3 that it's not.

4 I see that as a major issue with people
5 who do come into the emergency room, who might
6 think, Oh my daughter or my relative has a
7 hectic, emergency crisis, oh, that's covered,
8 right? They can go to the hospital and get
9 their depression addressed, oh, whoa, whoops,
10 nevermind. That's not covered anymore, sorry.
11 We've got the full bill for ya. So that's kind
12 of an issue with not making it comparable levels
13 of care.

14 I also had an issue with the whole setting
15 a cap on the funds, the same issue with like, so
16 basically, you could like lose your job and you
17 like, want to go on Healthcare.gov and get a
18 plan, those who job had anyone could get a plan,
19 you know, well, good luck to you if can get the
20 subsidy or not. Well, if it's already capped
21 out, yeah, you're on a waiting list. You don't
22 get that extra -- you don't get that subsidy.
23 So I mean, it's not really not very fair because
24 then it just really depends on if you happen to
25 be lucky enough that, when those -- the cap

1 hasn't run out yet. So that's really not equal
2 care at all. So it's kind of like, it's eroding
3 the QHP market with these, like different levels
4 of plans that are non-eligible versus eligible.

5 So like, yeah. So basically, like, if
6 you're in good times of health you don't think
7 you need a higher-cost care, so yeah, you're
8 going to buy the cheaper plan but that may lead
9 to some serious problems like I mentioned with,
10 you end up needing emergency care and you don't
11 have those additional funds.

12 I also tried to get here in time for the
13 Waiver, the Medicaid Waiver thing this morning,
14 but I got here at 10:00, 10:15, you guys were
15 already like shut down with your whole process
16 here, so if I've got still some time I'm just
17 going to kind of go over that stuff. Is that
18 okay?

19 MR. KRULL: Yes, sure.

20 MS. KOVACS: Okay, cool. All righty.

21 MR. KRULL: You have four minutes left.

22 MS. KOVACS: All right, cool.

23 So an example that I just wanted to bring
24 up about the Medicaid stuff that, you know,
25 really bothered me, in terms just a story is you

1 know, through the addiction's treatment stuff
2 that I was doing, there was a client who had
3 Medicaid in Delaware and he was in his 30s or so
4 and he moved down to Georgia to be closer to his
5 sister, and what I found out was that he did
6 have Medicaid access coverage while he was in
7 Delaware, but not when he was here, when he
8 moved to Georgia. And he was getting treatment
9 for behavioral health issues, as well as opioid
10 addiction. And once, after a few months of him
11 living here, he was using private pay care to
12 deal with his opioid addiction. But over time,
13 he realized he could not afford to private pay.
14 And so he basically didn't have any other health
15 insurance. He became uninsured, basically. And
16 I saw how much, over those few months from being
17 covered under Medicaid to not being covered,
18 that he relapsed and started using opioids
19 again. So it had real impacts on this man's
20 life that that Medicaid was no longer an option
21 for him.

22 And that's something that I see with a
23 number of clients who are uninsured, who are
24 trying to get opioid addiction treatment, is
25 they may be working but they're not getting

1 coverage. So that would help a lot of them, if
2 they got on Medicaid, but I have some issues
3 with that of it not being the same Medicaid
4 level as the 138 percentile that's common with
5 the other Medicaid people. So it's a lower
6 percentage. And I'm not a fan of the work
7 requirements and education requirements and all
8 that jazz. Also, the transportation, it kind of
9 wasn't super clear, and I wasn't sure if you're
10 waiving the non-emergency transport as an option
11 under this program, but that's one of the hugest
12 issues for a lot of these low-income clients is
13 lack of transportation to get to their care
14 provider. And, so if you are going to expand
15 Medicaid, even a little tiny bit, don't get rid
16 of the transportation option. You know, that's
17 really, really important to make sure that they
18 get the care they need. You know, that's a huge
19 issue for a lot of people.

20 Not a big fan of the premiums, either. I
21 think that just has an undue purpose. It says
22 you're also, like, getting rid of vision and
23 dental, as like, essential to the -- this
24 Medicaid waiver thing. So again, not a huge fan
25 of that 'cause vision and dental stuff is

1 really, really, really important. It should be
2 part of the coverage if you are going to --
3 because I see a lot of clients who, you know,
4 they don't take care of their teeth, they don't
5 take care of their vision, and that can really
6 impact their day-to-day life. They might lose
7 their dentures, they might lose their glasses,
8 and then it's kind of like, well, that's that.

9 So I think it's real important to include,
10 don't separate those things, the transportation,
11 the vision and the dental.

12 So I mean, it seems kind of like a
13 half-assed approach, this whole situation.

14 All right. That's it.

15 MR. KRULL: Thank you for your comments.

16 Helen Robinson.

17 HELEN ROBINSON, DIRECTOR OF ADVOCACY YWCA, GREATER
18 ATLANTA:

19 Thank you for the opportunity to provide
20 public comment. My name is Helen Robinson,
21 director of advocacy at the YWCA of greater
22 Atlanta. We are a nonprofit organization that
23 brings women's voices to the table, when
24 statewide policy is being considered that
25 affects women's health, safety and economic

1 empowerment.

2 We appreciate the reinsurance program
3 included in this waiver plan, but we are
4 concerned that this waiver will subsidize health
5 plans that do not cover the 10 essential health
6 benefits, which include maternity care and
7 newborn care. So women may find themselves
8 without the coverage that they need to access
9 this critical care or women who need
10 comprehensive coverage may find that they are
11 shouldering a greater cost for it. This change
12 would work across purposes to the other
13 initiatives that our state legislature is
14 currently working on to improve maternal
15 outcomes. In a state that has one of the
16 highest rates of uninsured women, preterm births
17 and maternal mortality in the country.

18 In this waiver, please restrict this use of
19 premium subsidies to qualified health plans
20 offering all essential health benefits. This
21 will help ensure that women in Georgia have
22 access to and can afford coverage that includes
23 maternity care, and that women are not being
24 charged more for health insurance for being
25 female.

1 On behalf of the women who could not be
2 here on this Monday afternoon, we asked that the
3 state not rollback existing health insurance
4 protections for women through this waiver.

5 Thank you.

6 MR. KRULL: Thank you. Deb Bailey.

7 DEB BAILEY REPRESENTING NORTHEAST GEORGIA HEALTH
8 SYSTEM:

9 Thank you. And thank you for the
10 opportunity to have comment today on the 1332
11 Waiver. My name is Deb Bailey and I represent
12 the Northeast Georgia Health System in
13 Gainesville, Dahlonega, Braselton, Habersham and
14 Winder. And of course, three of those
15 communities are rural communities.

16 I'm speaking today unlike Earl Rogers, with
17 the Georgia Hospital Association. I am speaking
18 on behalf of the Northeast Georgia Health System
19 and we're speaking in support of the Section
20 1332 Waiver that was passed by the Georgia
21 General Assembly and signed into law by
22 Governor Kemp.

23 We are grateful the state recognizes too
24 many of it's working, low-income citizens do not
25 have access to or are unable to afford

1 healthcare coverage. However, Northeast Georgia
2 Health System, in the last year has continued to
3 care for these people.

4 Last year alone, we provided \$220 million
5 of charity and indigent care. And that's at a
6 300 percent Federal Poverty Level, for the
7 definition of charity. Unfortunately, that was
8 \$56 million greater than the prior year. As a
9 percentage of our net-patient revenue, that is
10 19.8 percent, almost 20 percent of our net
11 patient revenue of charity and indigent care.
12 That is over 28,000 individual patient
13 encounters last year.

14 In addition to the charity and indigent
15 care, last year, the Northeast Georgia Health
16 System incurred \$116 million of bad debt, 10.8
17 percent of our net-patient revenue, as reflected
18 in our last audited financial statement.

19 However, with this, in our continued effort
20 we have now almost \$1 billion, \$977 million of
21 bonded, outstanding, long-term debt. So the
22 numbers that I have mentioned to you are
23 unsustainable.

24 So as a system, we are supporting all
25 efforts in our communities and applaud, and

1 appreciate the efforts of Governor Kemp and the
2 Georgia General Assembly, which there are
3 members here today, to provide coverage to any
4 of those that before had no opportunity, but now
5 do.

6 Thank you.

7 MR. KRULL: Thank you, Ms. Bailey. Irma
8 Alvarado.

9 MS. M. IRMA ALVARADO, PROFESSOR AT BRENAU

10 UNIVERSITY:

11 Thank you for this opportunity. My name is
12 Irma Alvarado, I live in Riverside County. I am
13 a professor at Brenau University at the Norcross
14 and Gainesville campuses. I've been an
15 occupational therapist for 43 years. I provide
16 services, in-home health, early intervention,
17 babies can't wait, clinic-based therapy, and
18 co-manage a clinic in Cumming and one in
19 (indiscernible). That's all I need to say about
20 myself.

21 I appreciate the comments that are made
22 today and would like to make a few comments
23 myself regarding the essential health benefits
24 offered by the qualified health plans versus the
25 benefits covered by proposed non-qualified

1 health plans, which will, as you say, may not
2 offer the full suite EHPs. So I would like to
3 know, what guarantee does the public or the
4 impaired or the chronically disabled person or
5 individual have that their health plan will have
6 this comprehensive care? That's one question.

7 Another guardrail issue that was brought
8 up, the comparable of the residents or that
9 statement I'm sorry I'm not that eloquent about
10 it, but you know, families of the disabled,
11 which I'm very, very, well acquainted with in my
12 work, who can at least afford care, have to pay
13 that premium and co-pay of up to \$30, which may
14 not seem like a lot to some people, but it is to
15 some. They can also potentially lose their
16 coverage if they miss a payment, lapsed to
17 months, indefinitely lose their coverage if they
18 lapse three months. So that's an issue that I
19 would like to be addressed or, at least
20 considered.

21 Regarding the reinsurance program, as I
22 said, everybody that's spoken openly about these
23 changes, but you know, the subsidy cost exceed
24 the federal and state funds about those
25 enrollment caps. People will be placed on

1 waiting lists. Now, there are waiting lists.
2 The kids I work with -- we've been open since
3 2007, there are 16, 15, 19, 22 year olds now.
4 And they're already going to be placed on
5 waiting lists. So this is yet another wait list
6 that can happen.

7 Last week, regarding the federal and the
8 state money, which in essence are my tax
9 dollars, we all pay federal taxes, if you live
10 in Georgia. They're seeming, in my opinion, to
11 be wasted on developing and managing these
12 plans, all in the name of not expanding
13 Medicaid, and, excuse me, calling it
14 reinsurance, when really, that's what it is.

15 It now uses decentralizing programs that --
16 I've been in Georgia now 26 years. Before that,
17 I was in Texas practicing, but this just -- I
18 think that Medicaid, Medicare Programs are doing
19 well in Georgia. And for the people, they've
20 got their flaws but why just not work on
21 improving what is already a system that's
22 serving the Georgia people, to the best of it's
23 ability.

24 And lastly, regarding the charity and
25 indigent care major systems. Again, I know what

1 write-offs can be, I know they benefit systems
2 and yeah, it's huge that these systems are
3 covering this, but that is just to show you what
4 the need is.

5 That's all I have to say. Thank you, very
6 much, for this opportunity.

7 MR. KRULL: Thank you, Ms. Alvarado.

8 Dhaval Patel.

9 DR. DHAVAL PATEL, ICU DOCTOR:

10 My name is Dhaval Patel. I'm an ICU
11 Doctor. I have significant concerns, grave
12 concerns, if you will. Dr. Hawkins' son is my
13 dentist. And, I work here in Gainesville.

14 I have to tell you, you all made some
15 amazing points, but the thing that you are
16 missing here, is that you don't see the patients
17 that I do. You don't see the people dying that
18 I do. You don't see the young people like the
19 gentleman I pronounced him braindead two weeks
20 ago, same age. That man did not have insurance.
21 And we are here, sitting here, trying to derive
22 policies based on philosophies, rather than
23 evidence.

24 I am supposed to practice medicine based on
25 evidence. Why are you all allowed to make

1 policies based on philosophies? Why? The
2 evidence suggests that full Medicaid expansion
3 works. We are 1 of 14 states that have not
4 expanded, right? Am I wrong? Why? Why does
5 Georgia need to manage medicine different? Are
6 we made of different physiology? Are our
7 mathematics different? So why? Why do you not
8 care about what happens to people, but you put
9 those policies in place. I can tell you stories
10 after stories after stories of people dying
11 because they did not have basic insurance. They
12 fell out of insurance. People who should not
13 die. Government people, people, regular people.
14 I can tell you a story about a guy who was a
15 train conductor, has a disabled wife. They
16 could not afford insurance. He had diabetes and
17 decided he was going to share his insulin
18 because they could not afford insurance. Guess
19 what happened. His diabetes went out of
20 control, he ended up in ICU comatose. Why do
21 you not care about that?

22 A young lady diagnosed with gastric mass,
23 mass in her stomach, lost work, couldn't afford
24 insurance. Three years go passed, she doesn't
25 have a follow-up, cancer spreads. She had a

1 six-year-old daughter. Ended up in my ICU on
2 the verge of death. Are you going to come and
3 fix that?

4 That's the end product of your policies.
5 That's the view of you being a Republican or a
6 Democrat. Who gives a -- who?

7 You end up in my ICU, I'm going to treat
8 you the same way as you are a family member.

9 I have pronounced so many young people
10 dead. I'm sick of it. Hospitals devastated in
11 northwest Georgia, devastated. Communities
12 devastated. Opioid crisis uncontrollable,
13 people out of work, people going to jail,
14 families destroyed.

15 What are you going to do about that? You
16 going to sit there and debate this? For God's
17 sakes. Your communities are getting destroyed.
18 Your people are getting destroyed.

19 Georgia is going to be behind every other
20 state in every outcome imaginable that you can
21 think of. And you sit down and play Republican
22 while people die. Braindead, young people
23 invest in us -- I just said, the same age, it
24 reminded me of that guy, what are you going to
25 do about that? 26 year old I pronounce

1 brain-dead. Expand your insurance and cover
2 everybody. This does not work. At some point
3 you're going to smell up -- you're going to wake
4 up and smell the coffee. What in God's name?

5 I am angry because I see this. I am
6 frustrated because you all sit here and debate
7 this endlessly. And not one, not one person
8 speaks of what has worked, what has evidence,
9 why things work, no. You care about your
10 philosophy. And your philosophy leads to people
11 dying in my ICU.

12 I will hold each and every one of you
13 responsible for all of those young people dying.

14 So if you're going to do something right,
15 do it right away. If I have to follow evidence,
16 if I have to be held responsible for not
17 following evidence, you should be held
18 responsible for doing the same thing.

19 Evidence suggests policymaking
20 (indiscernible) why is it not?

21 Why? Georgia values, what are Georgia
22 values? People die the same way, people breathe
23 the same way. We all wear clothes the same way.
24 What exactly are Georgia values?

25 If you're going to do this, if you're going

1 to do this to save lives, as you all talk about,
2 then do it to save lives. Don't put on a show.
3 It is redundantly pointless.

4 You know this doesn't work. You know this.
5 Studies after studies shows this. Mathematics
6 shows it. Evidence shows it. There are
7 300-some studies on Medicaid Expansion. Pick
8 one. Why? Why do you get to be different than
9 I do? I'm done.

10 MR. KRULL: Thank you Mr. Patel for your
11 comments. Mr. Horne, do you want to speak now?

12 MR. ROBERT HORNE, REPRESENTING CCC, INC.:

13 It's going to be a little difficult to
14 speak after such a speaker. I don't agree with
15 your viewpoint at all, but I want to move to
16 another sector, which is outside what we've been
17 talking about here.

18 What were talking about essentially to
19 those people under 65 years old who have
20 financial problems. I want to talk about a
21 different group, in particular, that is the
22 retired citizens who are retiring with no net
23 worth. And we are going to go into problems in
24 five years or so time, I can tell.

25 If you take us who are age 65 today, in the

1 middle of the baby boomers, and they're about to
2 retire. In another 10 years, they'll be 75, in
3 another 20 years, they'll be 85. And they're
4 retiring now, the average person is retiring
5 with essentially no net worth. They may have a
6 house, but there are less people retiring with a
7 house. and their problems are going to get
8 bigger. And all they have to do is have a look
9 at their retirement, their Social Security,
10 they've got onto Medicare, but Medicare is
11 expensive, you know. You have to pay for all
12 the extra programs. So that's going to have a
13 drain on their net worth.

14 And a couple of other things nobody talked
15 about here, opioids. I'm a grandparent being
16 caught in the opioid program. Not that they
17 themselves have been caught in it, it's their
18 children who have. And their children have
19 children, which, therefore parents or
20 grandparents come to help these people. So when
21 somebody is moving towards finding true
22 difficulty at the age, of, should I say 70, what
23 should happen? We're not sure whether the
24 programs you're putting in place here will deal
25 with that problem.

1 If not Medicaid, what if I have Medicare?
2 An I just want to make sure that all of the
3 changes that are being proposed here in Georgia,
4 don't put a more difficult scenario for senior
5 citizens. It's as simple as that. And I'll
6 leave the experts to work on it.

7 Thank you.

8 MR. KRULL: Thank you, Mr. Horne, for your
9 comments. And the last person, Representative Lee
10 Hawkins.

11 BY REPRESENTATIVE LEE HAWKINS:

12 Thank you. Pleasure being with you today.
13 And I want to begin by thanking these two
14 gentlemen up front for all of the work they put
15 in in the last year. Ryan and Blake,
16 unbelievable amount of time and effort because
17 this is a complex subject. There's no one quick
18 fix. It's been evolving over the years. I've
19 been a dentist for 40 years and I've seen a lot
20 of changes. And I share Dr. Patel's passion for
21 taking care of patients and dealing with their
22 challenges and their healthcare.

23 These two waivers are a beginning step, an
24 they are big steps. We have a problem with
25 Medicaid but this attempts to address the

1 hardworking Georgians that are below federal
2 income level. 1332 Waiver addresses health
3 insurance for those who have access to
4 healthcare, but due to the costs, deductible and
5 co-pays, they really can't access healthcare.
6 So this is a two-pronged approach, like I said,
7 this is a beginning. I appreciate everyone
8 coming here today and letting us hear your
9 comments and your thoughts. They're very
10 valuable.

11 I do want to say this. At the end of the
12 day, we, as a state have to pay for it.
13 Remember, Medicaid is a state administered
14 federal project and our co-pays are pretty high.
15 You know, but it's a co-pay for the state.

16 And again, these 1332 waivers for our
17 health insurance, we've got people I can send
18 you that qualify, and actually get it through
19 their employers but can't access it. So these
20 two approaches are a beginning, a good start on
21 solving some of our challenges.

22 Thank you.

23 MR. KRULL: Thank you, Representative
24 Hawkins, for your comments.

25 We would like to thank each of you for

1 coming today to provide oral comments into this
2 presentation.

3 Let me reiterate that public comment period
4 for the proposed changes will expire on December
5 3rd of 2019. As I indicated earlier, written
6 comments will be introduced into the official
7 record, as well as the transcription of the oral
8 comments that we've heard this afternoon.

9 Thank you, once again, for your attendance.
10 There being no further person who wishes to make
11 a comment, this public hearing is adjourned at
12 1:58 p.m.

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CERTIFICATE

STATE OF GEORGIA:

I hereby certify that the foregoing transcript was taken down, as stated in the caption, and the questions and answers thereto were reduced to writing under my direction; that the foregoing pages 1 through 46 represent a true and correct transcript of the evidence given.

I further certify that I am not of kin or counsel to the parties in the case; am not in the regular employ of counsel for any of said parties; nor am I in anywise interested in the result of said case.

This, the 20th day of November, 2019.



Jane P. Day, CCR
5722-2335-0164-6848

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