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

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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

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GEORGIA 1332 WAIVER

BY MR. MATTHEW KRULL:

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

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

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

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

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

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

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

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

You may be seated.

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

BY RYAN LOKE:

Thanks Matt. Can everybody hear me?

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

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

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

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

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

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

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

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

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

Those guardrails include comprehensiveness

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The state will maintain some critical

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

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

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

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

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

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

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

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

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

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

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

Thank you.

BY MR. KRULL:

Thank you.

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

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

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

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

SENATOR NAN ORROCK, REPRESENTING DISTRICT 36 SENATE, ATLANTA:

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

hospital to communities in north Georgia.

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

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

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

The plan, I think goes against a very

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How's my time going?

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

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

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

MR. KRULL: Two seconds to spare.

Elaine Kovacs.

ELAINE KOVACS:

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

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

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

thing.

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

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

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

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

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

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

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

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

MR. KRULL: Yes, sure.

MS. KOVACS: Okay, cool. All righty.

MR. KRULL: You have four minutes left.

MS. KOVACS: All right, cool.

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

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

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

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

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

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

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

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

All right. That's it.

MR. KRULL: Thank you for your comments. Helen Robinson.

HELEN ROBINSON, DIRECTOR OF ADVOCACY YWCA, GREATER ATLANTA:

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

empowerment.

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

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

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

Thank you.

MR. KRULL: Thank you. Deb Bailey.

DEB BAILEY REPRESENTING NORTHEAST GEORGIA HEALTH SYSTEM:

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

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

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

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

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

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

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

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

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

Thank you.

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

MS. M. IRMA ALVARADO, PROFESSOR AT BRENAU UNIVERSITY:

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

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

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

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

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

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

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

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

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

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

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

MR. KRULL: Thank you, Ms. Alvarado. Dhaval Patel.

DR. DHAVAL PATEL, ICU DOCTOR:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Evidence suggests policymaking (indiscernible) why is it not?

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

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

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

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

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

MR. ROBERT HORNE, REPRESENTING CCC, INC.:

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

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

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

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

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

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

Thank you.

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

BY REPRESENTATIVE LEE HAWKINS:

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

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

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

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

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

Thank you.

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

We would like to thank each of you for

coming today to provide oral comments into this presentation.

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

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

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