1332 State Innovation Task Force Meeting Agenda

June 29, 2017
1:00 p.m.-3:30 p.m.
Oklahoma State Capitol, Room 419 C
2300 N. Lincoln Blvd.
Oklahoma City, OK 73105

Section	Time		Presenter
Welcome and Introductions	**1:00**	**5 min**	**Buffy Heater, HHS Project Lead**
State and Federal Updates	**1:05**	**15 min**	**Buffy Heater**
Reinsurance Waiver Update	**1:20**	**30 min**	**Paul Houchens, Milliman**
Impact Assessment of Concept Paper Strategies	**1:50**	**45 min**	**Austin Bordelon, Leavitt Partners**
Overview of Task Force Report, Next Steps for Concept Paper Strategies	**2:35**	**30 min**	**Theresa LaPera, Health Management Associates**
Implementation Timeline	**3:05**	**15 min**	**Buffy Heater, Theresa LaPera**
Closing Remarks	**3:20**	**10 min**	**Buffy Heater**

State and Federal Updates

April 2017

- 4/18 Conducted Senate legislative review on Concept Paper

May 2017

- 5/1 Conducted House legislative review on Concept Paper
- 5/4 US House passes American Health Care Act (AHCA); Senate recrafting language
- 5/8 HB2406 introduced to Oklahoma legislature; passed JCAB 5/23; passed House floor 5/25; passed Senate floor 5/26; sent to Governor for signature 5/26
- 5/10 conducted reinsurance briefing with health plans

June

- 6/6 HB 2406 signed by the Governor
- 6/9 Actuarial contract secured
- 6/22 Senate Better Care Reconciliation Act released

Sequential Approach to Recommendations

2017: Planning and Authorization

- ✓ Engage federal partners
- ✓ Secure actuarial expertise
- ✓ Submit initial 1332 Waiver
- ✓ OID operational planning

2018: State Regulation and Federal Flexibility

- ✓ Market Stabilization via Reinsurance
- ✓ State Regulatory Control
- ✓ Health Outcomes Focus
- ✓ Support for Broadening Age Ratios & Continuing CSRs (Federal Law)
- ✓ Streamline Timely & Direct Enrollment (CMS Rule)

2019+: Oklahoma's Modernized Marketplace

- ✓ Change Subsidy Eligibility & Calculation
- ✓ Simplify Plans
- ✓ Create Consumer Health Accounts
- ✓ Leverage Insure Oklahoma
- ✓ Gain Benefit Flexibility

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Reinsurance Program Parameters

Discussion of Development Process

Paul Houchens, FSA, MAAA
June 29, 2017

State-Run Reinsurance Program Goals

- January 1, 2018 implementation date
  - Stabilize individual market
  - Maintain or increase enrollment
  - Increase affordability for households not eligible for federal premium assistance
  - Promote insurer competition and consumer choice

Agenda

1	Market Overview
2	Reinsurance Scenarios

Caveats

- Details of Oklahoma's reinsurance program are still in development. This presentation is intended to facilitate discussion and inform decisions moving forward.
- The values shared in this presentation are based on publicly available data published by the federal government. Many values have been estimated and are certain to vary from actual results.
- Values in this report are preliminary and subject to change. Pending federal legislation or regulatory changes may also impact results.

Market Overview

Insurance Market Population Changes

State of Oklahoma Health Insurance Market Enrollment: 2015 through 2017			
Market Segment	**2015**	**2016**	**2017**
Individual On-FFM ACA Compliant	100,000	118,000	124,000
Individual On APTC Eligible	80,000	102,000	115,000
Individual On Non-APTC Eligible	20,000	16,000	9,000
Individual Off-FFM ACA Compliant	59,000	52,000	44,000
Individual ACA Compliant	**159,000**	**170,000**	**168,000**
Individual Non-ACA Compliant	33,000	18,000	13,000
Total Individual	**192,000**	**188,000**	**181,000**
Total Small Group	**173,000**	**179,000**	**179,000**
Large Group Total	**442,000**	**419,000**	**400,000**
Self-Funded (Including Non-Medicare EGID)	**1,088,000**	**1,100,000**	**1,119,000**
Comprehensive Commercial Subtotal	**1,895,000**	**1,886,000**	**1,879,000**
Without Self-Funded and EGID	**807,000**	**786,000**	**760,000**

Insurance Market Premium Changes

State of Oklahoma Average Health Insurance Market Per Member Per Month Premium: 2015 through 2017			
Market Segment	**2015**	**2016**	**2017**
Individual On APTC Eligible	$ 292	$ 375	$ 629
Individual On APTC Assistance	$ 208	$ 299	$ 551
Individual On Net APTC Eligible	$ 83	$ 76	$ 78
Individual Off/On Non-APTC Eligible	$ 275	$ 329	$ 508
Individual ACA Compliant	$ 284	$ 357	$ 591
Individual Non-ACA Compliant	$ 247	$ 286	$ 309
Total Individual	**$ 277**	**$ 350**	**$ 571**
Total Small Group	**$ 383**	**$ 394**	**$ 413**
Large Group Total	**$ 404**	**$ 414**	**$ 435**
Self-Funded (Including Non-Medicare EGID)	**$ 404**	**$ 414**	**$ 435**
Comprehensive Commercial Subtotal	**$ 389**	**$ 406**	**$ 446**
Without Self-Funded and EGID	**$ 369**	**$ 394**	**$ 462**

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Commercial Health Insurance Premium Volume

State of Oklahoma Aggregate Premium ($ Millions): 2015 through 2017			
Market Segment	**2015**	**2016**	**2017**
Individual On APTC Assistance	$ 200	$ 367	$ 760
Percent of Premium Paid by Federal Government	37.0%	50.4%	63.8%
Individual ACA Compliant	$ 541	$ 727	$ 1,191
Individual Non-ACA Compliant	$ 98	$ 62	$ 48
Total Individual	**$ 639**	**$ 789**	**$ 1,239**
Total Small Group	**$ 796**	**$ 846**	**$ 888**
Large Group Total	**$ 2,143**	**$ 2,083**	**$ 2,088**
Self-Funded (Including Non-Medicare EGID)	**$ 5,275**	**$ 5,470**	**$ 5,842**
Comprehensive Commercial Subtotal	**$ 8,852**	**$ 9,188**	**$ 10,058**
Without Self-Funded and EGID	**$ 3,578**	**$ 3,718**	**$ 4,215**

Reinsurance Scenarios

State-Run Reinsurance Program

- Premium target for 2018 reinsurance fund: 2016 adjusted premiums
  - Insurers operated at a significant loss in 2016
  - Target approximately 80% medical loss ratio
  - A premium increase of approximately 21% relative to actual 2016 is necessary to have sustainable premium

	2016 Monthly Premium Rates	
	Actual	**Sustainable**
Estimated 2016 Individual ACA Compliant Premium PMPM	$ 357	$ 431
Premium Rate Increase		21%

Note: Actual 2017 premium rate changes impacted by trend, federal reinsurance expiration, insurer margin assumptions, and other factors.

Overview of Federal Pass-Through Funding

Illustrative Example of Pass-Through Calculations

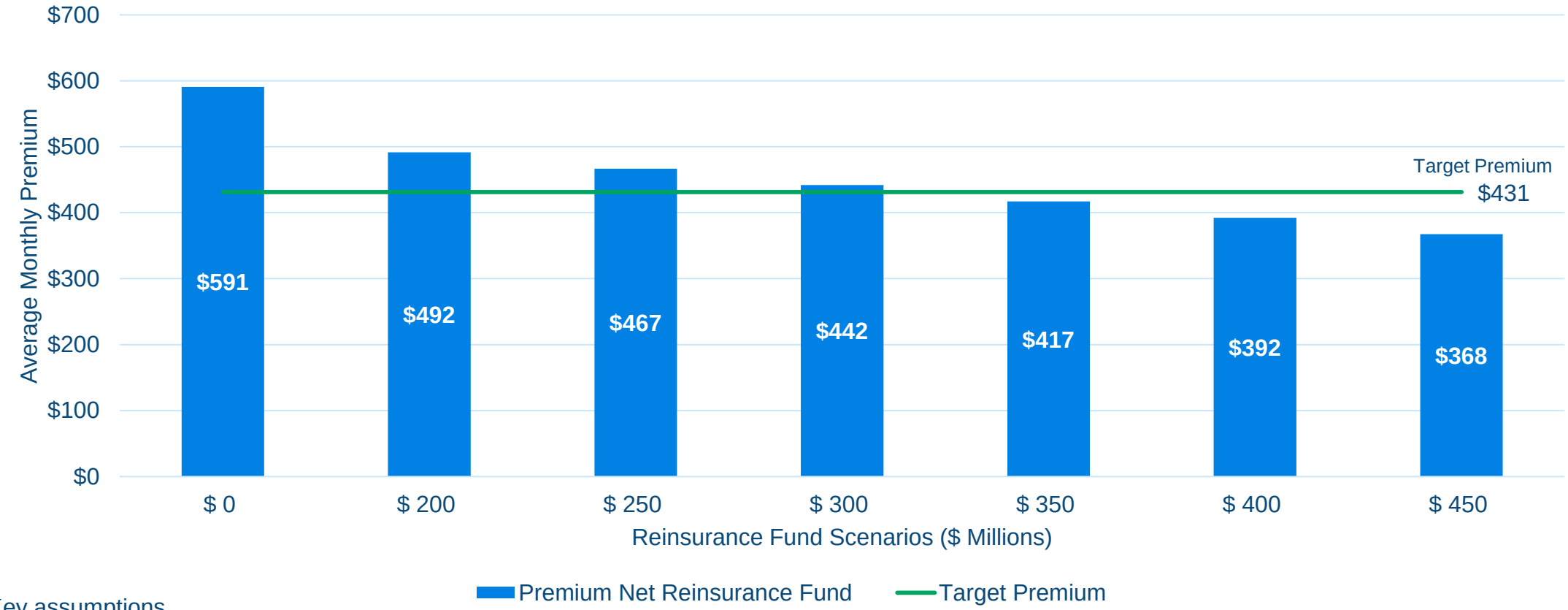
	Pre-Reinsurance Program Implementation			Post-Reinsurance Program Implementation			
Household	Full Premium	Premium Subsidy	Net Premium	Full Premium	Premium Subsidy	Net Premium	Net Premium Savings
A	$ 500	$ 300	$ 200	$ 450	$ 250	$ 200	$ 0
B	$ 500	$ 25	$ 475	$ 450	$ 0	$ 450	$ 25
C	$ 500	$ 0	$ 500	$ 450	$ 0	$ 450	$ 50

Household A: Federal government retains 100% of premium savings, which becomes pass-through funding under the 1332 waiver.

Household B: Federal government retains 50% of premium savings, which become pass-through funding under the 1332 waiver.

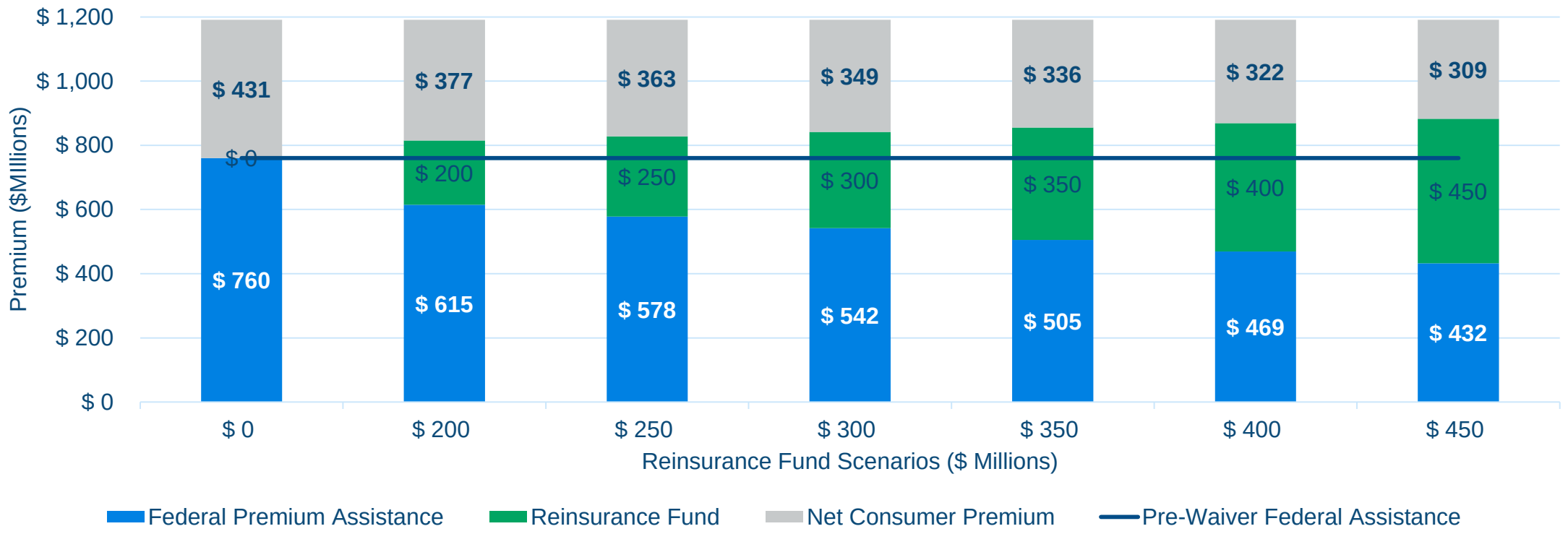
Household C: Consumer retains 100% of premium savings, no pass-through funding available.

Reinsurance Scenarios
Target Premium Level



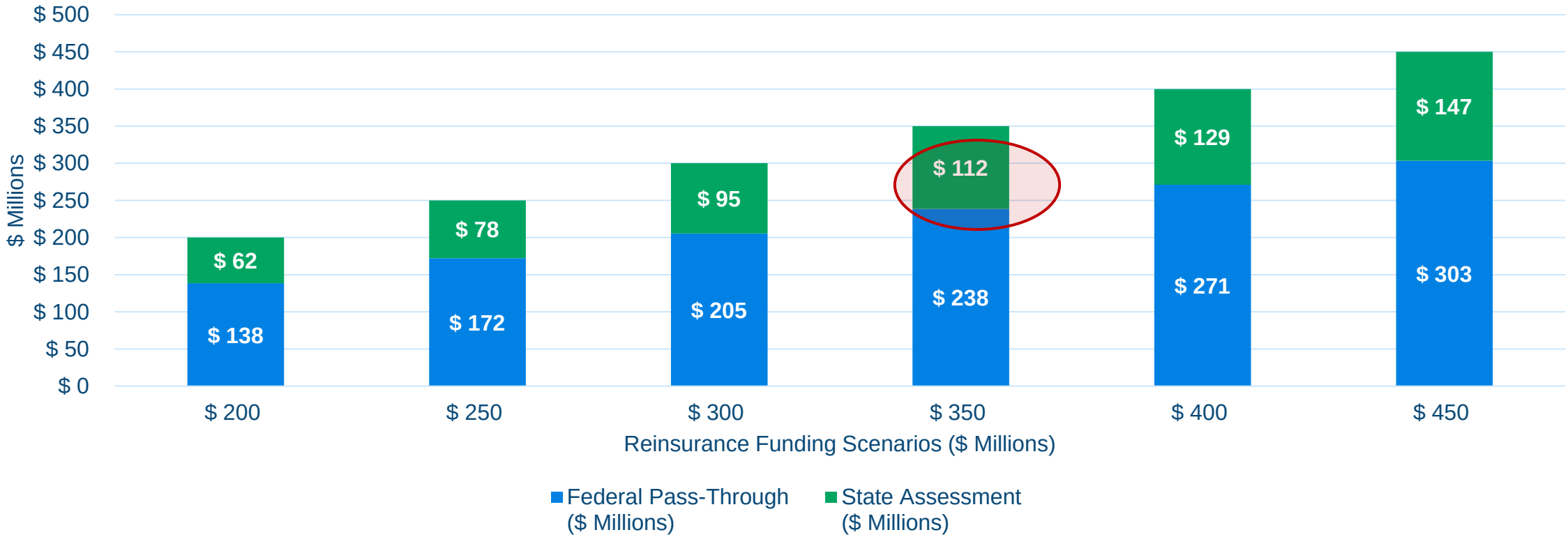
Key assumptions
1. Assumed 70% medical loss ratio in 2017 premium rates.
2. No change in non-benefit expense PMPM cost between scenarios (administrative costs kept constant).
3. Based on 2017 estimated enrollment, does not reflect impact of 2018 premium changes.

Reinsurance Scenarios
Change in Total Dollar Expenditures by Funding Source



Key assumptions
1. Assumed 70% medical loss ratio in 2017 premium rates.
2. No change in non-benefit expense PMPM cost between scenarios.
3. Based on 2017 estimated enrollment, does not reflect impact of 2018 premium changes.

Reinsurance Scenarios
Required Health Insurer Assessment



- Federal government estimated to contribute $0.65 to $0.70 for each $1 of reinsurance funding.

Key assumptions

1. Actual 2018 funding will be dependent on final insurer rate actions and estimated enrollment changes.
2. Values are illustrative estimates and will be dependent on insurers' premiums after reinsurance program implementation.
3. **Additional margin applied to pass-through funding to reflect potential for greater enrollment, assessment cost, and subsidy value reaching $0 for some consumers. For example, under $350 million scenario, estimated pass-through savings reduced from $255 million to $238 million.**

Reinsurance Scenarios
Assessment Methodology

Assessment Base	Required Revenue ($ Millions)	Enrollment	PMPM Assessment
All Commercial	$ 112	1,879,000	$4.95
Excluding Self-Funded	$ 112	760,000	$12.23

- Assessment reflects total reinsurance funding of $350 million
- Transitional reinsurance program assessment under the ACA ranged from $5.25 PMPM (2014) to $2.25 PMPM (2016), based on all commercial
- PMPM assessment (vs. percent of premium assessment) will be easier to administer
- Assessment base reflects comprehensive medical coverage

Key assumptions

1. Actual 2018 assessment will be dependent on final insurer rate actions and estimated enrollment changes.
2. Values are illustrative estimates and will change if a pass-through reinsurance program is implemented.
3. Estimated assessment does not reflect state administrative cost.

Reinsurance Scenarios
Estimated Impact to Market Enrollment

State of Oklahoma Health Insurance Market Enrollment: 2015 through 2017			
Market Segment	**2015**	**2016**	**2017**
Individual On-FFM ACA Compliant	100,000	118,000	124,000
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Individual ACA Compliant	**159,000**	**170,000**	**168,000**
Individual Non-ACA Compliant	33,000	18,000	13,000

- Without reinsurance, non-premium subsidy eligible population likely to have further affordability concerns. 25% to 35% premium reduction is estimated to be achieved from reinsurance program.
- Additional market attrition likely in 2018 without premium rate reduction.
- Estimate 5,000 to 15,000 improvement in enrollment as a result of $350 million in reinsurance funding and lower premiums for non-subsidy eligible population.

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Thank you

paul.houchens@milliman.com
June 29, 2017

Limitations

Limitations
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It should be emphasized that the values in this presentation are estimates based on assumptions and available data. It is certain that actual results will vary from the estimates provided in this presentation.

This analysis was completed under our signed contract agreement with OSDH dated June 8, 2017.

Qualifications
Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Paul Houchens is a member of the American Academy of Actuaries, and meets the qualification standards for performing the analyses in this report.

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Oklahoma 1332: Summary of Combined Solution Modeling

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June 29, 2017

Modeling Overview (A Refresher)

Leavitt Partners worked closely with Oklahoma Health Department staff to prioritize the following solutions from the Modernized Marketplace concept paper for comprehensive modeling and impact analysis:

- **Impact of a High-Risk Pool or Reinsurance Program –** Introducing new stability funding—whether through a reinsurance program or high-risk pool—has the ability to directly reduce the underlying cost of a risk pool and, in turn, lower premiums and slow cost growth.

- **Effects of Moving to a Wider Age Band –** Allowing greater variance to the age bands for underwriting insurance may support greater participation among younger age, and lower risk, Oklahomans.

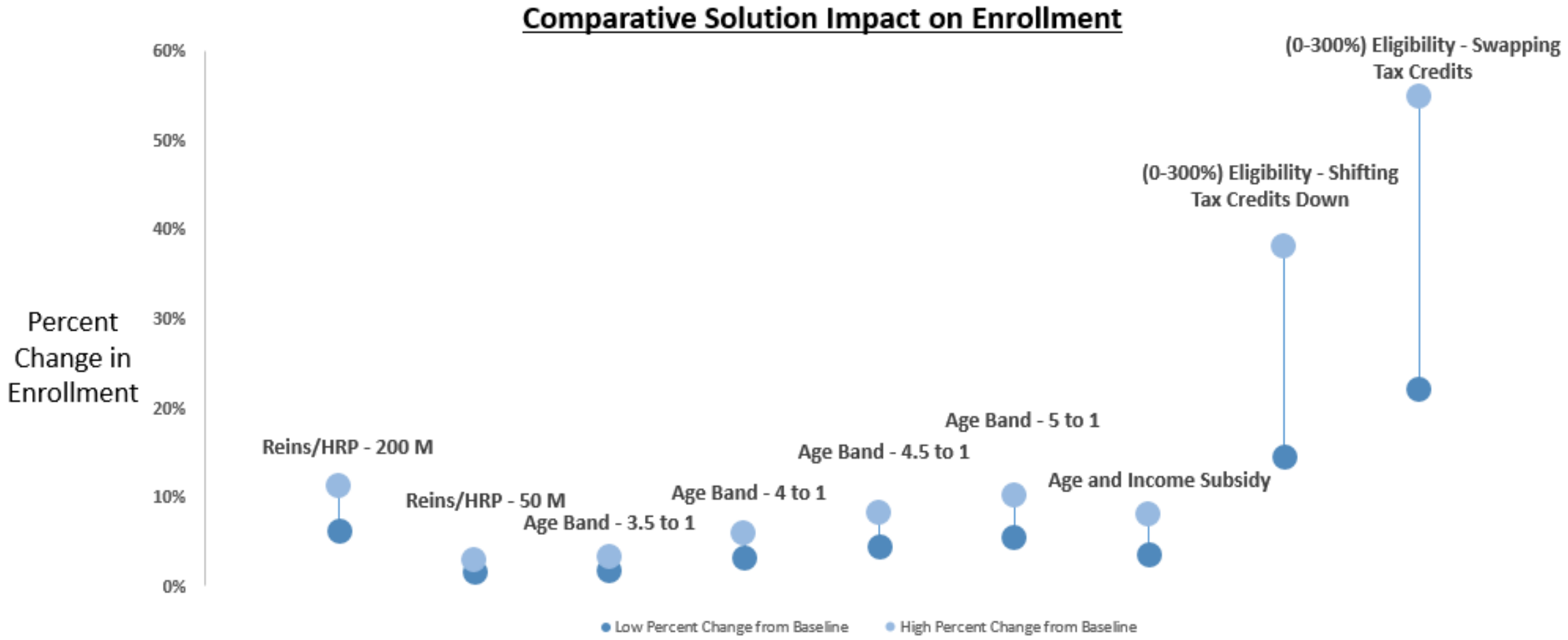
- **Standardizing Subsidies Based on Age and Income –** With the goal of providing additional support to younger populations and moving to a subsidy structure that also places more downward pressure on premiums, the State will evaluate calculating insurance subsidies based on age and income.

- **Reallocating Subsidies for 0-300% FPL Population –** With a significant population lacking coverage below the Federal Poverty Line (FPL), Oklahoma would also like to evaluate the effects of moving eligibility for premium assistance down to 0-300$ FPL (adjusting from 100-400% FPL today).

The results of this analysis are preliminary and additional refinements to the model are predicted. Leavitt Partners and the Oklahoma team also expect to model a handful of select combinations of the solutions listed above.

Modeling Overview

The various solutions are likely to have different affects on total enrollment. Subsidizing the gap population (Solution 5) has the largest effect on total enrollment driven by large increases in spending for a new population.



Modeling Overview

Summary of the analysis and composite score for each proposed solution:

Methodology
Leavitt Partners utilized the following data and research in modeling the proposed solutions: – Secondary research and literature review – Time series modeling – CMS enrollment and premium data – MLR, NAIC, and U.S. Census market data – Price elasticity modeling – Regulatory research

	Legislative		Impact			Budget	Operations	
	Federal	State	Enrollment	Premiums	Market Stability	Financial Commitment	Implementation	Composite
Solution 1: Reinsurance / High Risk Pool	●	◕	◐	◕	◐	◔	◐	◕
Solution 2: Wider Age Band	◔	◕	◐	◐	◐	●	●	◕
Solution 3: Age + Income Subsidies	◕	◐	◔	◐	◐	●	○	◐
Solution 4: Moving Eligibility to 0-300% FPL	◐	◔	●	◔	◐	○	○	◐

○ ◔ ◐ ◕ ●

Unfavorable → Favorable

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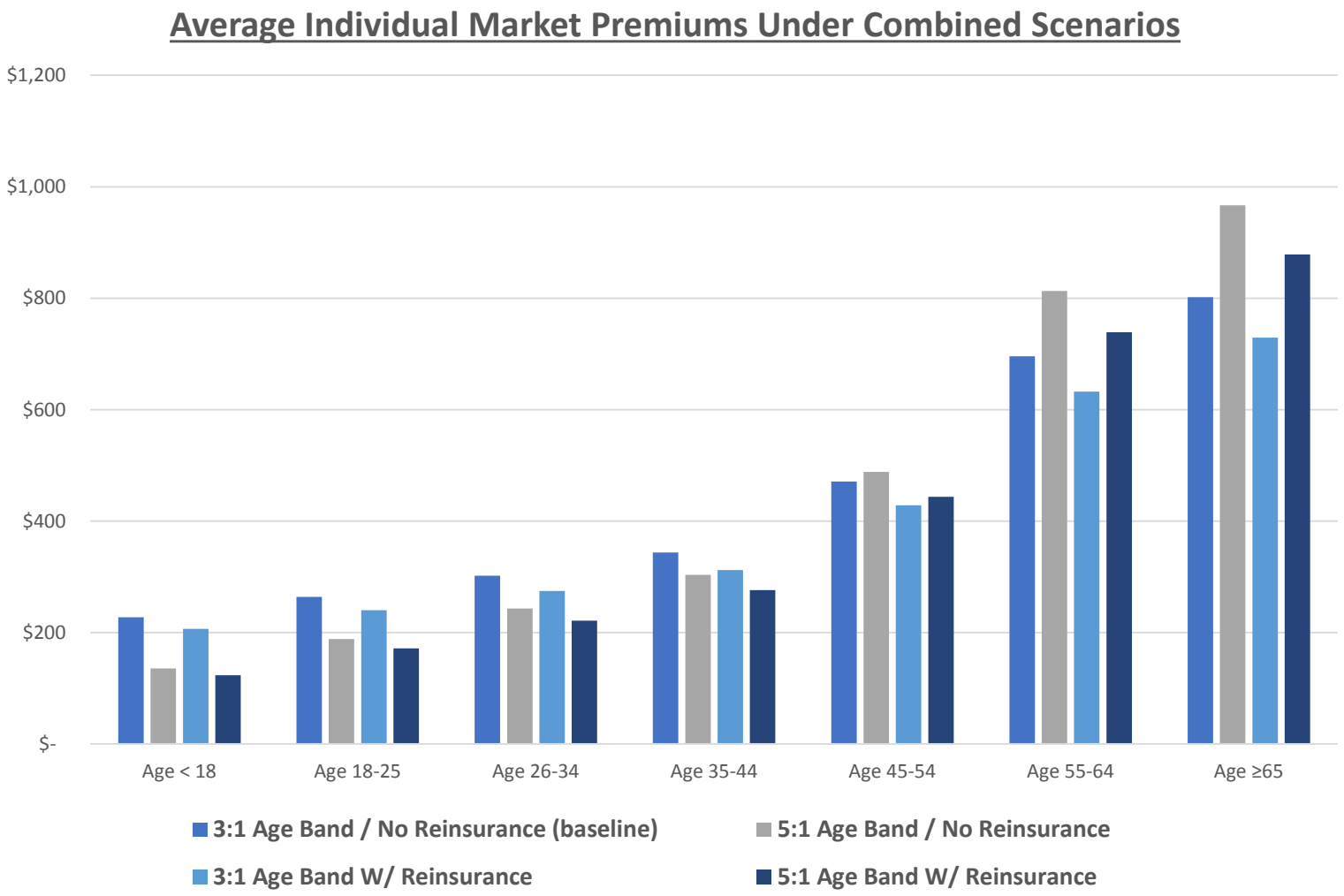
Modeling Combinations

- **Combination 1: Reinsurance Program + Changing Age-Band**
- **Combination 2: Reinsurance Program + Reallocating Subsidies for 0-300% FPL Population**
- **Combination 3: Reinsurance Program + Age/Income-Based Tax Credits + 5:1 Age Banding**
- **Combination 4: Reinsurance Program + Moving to Two Plan Standard**

Combination 1: Reinsurance + Changing Age-Band

Combination 1: Effects of Reinsurance + Age Banding



	Average Premiums ($)			
	No Reinsurance Program		Reinsurance Program	
	3:1 Age Band	5:1 Age Band	3:1 Age Band	5:1 Age Band
Age < 18	$228	$136	$207	$123
Age 18-25	$264	$189	$240	$171
Age 26-34	$302	$243	$275	$221
Age 35-44	$344	$304	$312	$276
Age 45-54	$471	$488	$428	$444
Age 55-64	$696	$813	$633	$739
Age ≥65	$802	$967	$729	$879

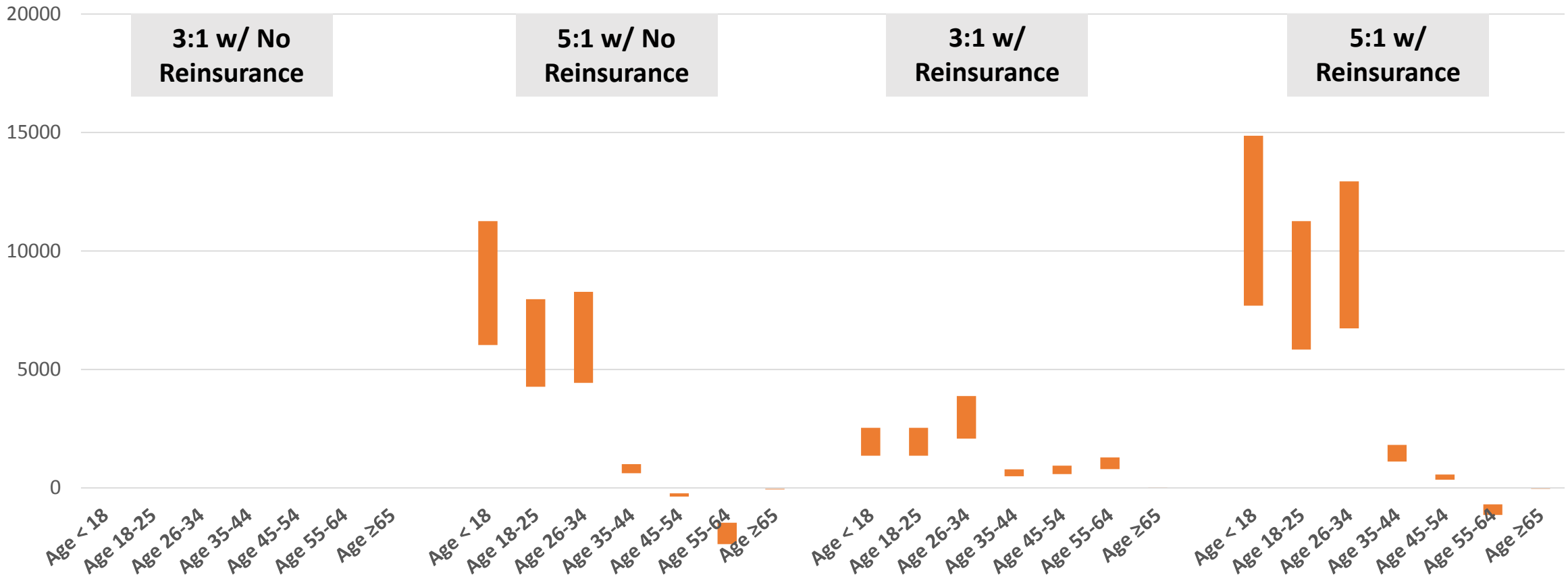
	Change in Premium from baseline (%)			
	No Reinsurance Program		Reinsurance Program	
	3:1 Age Band	5:1 Age Band	3:1 Age Band	5:1 Age Band
Age < 18	0%	-40%	-9%	-46%
Age 18-25	0%	-29%	-9%	-35%
Age 26-34	0%	-19%	-9%	-27%
Age 35-44	0%	-12%	-9%	-20%
Age 45-54	0%	4%	-9%	-6%
Age 55-64	0%	17%	-9%	6%
Age ≥65	0%	21%	-9%	10%

Note: While it's informative to understand the changes in premium price for consumers at each end of spectrum, there are relatively few consumers enrolling in coverage below the age of 18 or above the age of 65; 88.6% of Oklahoma marketplace enrollees are between the ages of 18-64

Combination 1: Effects of Reinsurance + Age Banding

Lower premiums for populations less than 45 years of age result in significant enrollment gains; adding a reinsurance program intensifies gains but also reduces losses

Range of Possible Enrollment Gains Across Modeling Combinations, 2019

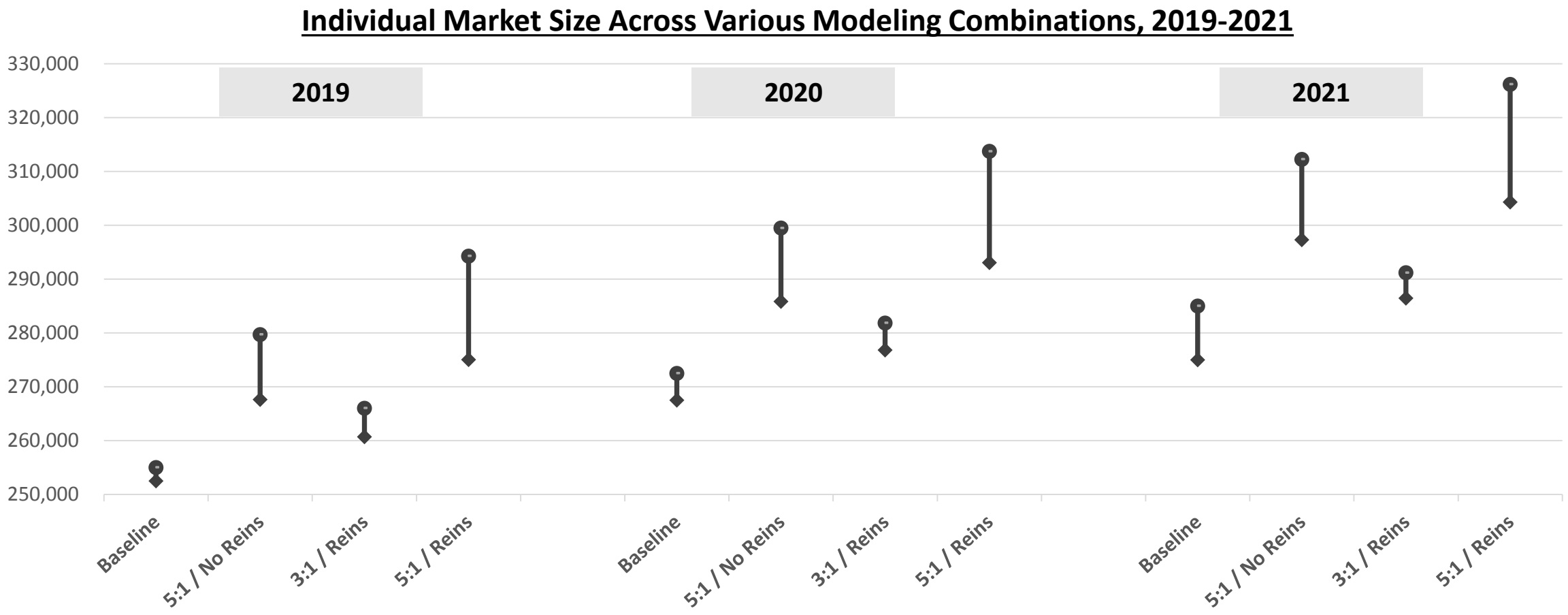


Note: High and low enrollment estimates reflect varied assumptions for consumer sensitivity to changes in price

Source: Market data obtained through Leavitt Partners analysis of CMS Medical Loss Ratio (MLR) data; Consumer elasticity data estimated through Literature Review

Combination 1: Effects of Reinsurance + Age Banding

Individual market experiences growth under each policy scenario; but most significant gains are under combined 5:1 age band and introduction of reinsurance



Note: 2017-18 baseline estimates for individual market are 206k and 226k; High and low ranges reflect varied assumptions for consumer sensitivity to changes in price

Source: Market data obtained through Leavitt Partners analysis of CMS Medical Loss Ratio (MLR) data; Consumer elasticity data estimated through Literature Review

Combination 1: Effects of Reinsurance + Age Banding

Key Takeaways:

- Introduction of a 5:1 age band limit reduces the premiums for individuals under the age of 45 and increases the premiums for individuals over the age of 45
- Introduction of a reinsurance program reduces the premiums for everyone (except for the very lowest income who hit the ACA income limit for subsidy calculation)
- Introduction of a 5:1 age band limit AND a reinsurance program produces the greatest reduction in premiums for young populations and minimizes rate increases for populations over the age of 45, thereby producing the greatest gains in enrollment to the market

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Combination 2: Reinsurance + Reallocating Subsidies for 0-300% FPL Population

Combination 2: Reinsurance + Revised Eligibility (0-300% FPL)

New premium assistance program for "gap population" results in significant growth among this population;

ACA subsidy **shifted** downward

	Gap Population (<100%)	100-138%	139-200%	201-250%	251-300%	301-400%
Individual FPL Guidelines (monthly):	$ 661	$ 1,211	$ 1,724	$ 2,294	$ 2,803	$ 3,565
Income Limit for Premium	2%	3-5.9%	6-7.85%	7.86-9.10%	9.11-9.69%	0%
Average Premium	$ 13.49	$ 49.39	$ 120.70	$ 197.83	$ 269.87	$ 419.23
Avg. Change in Premium	$ (405.74)	$ 24.69	$50.35	$ 37.26	$ 34.98	$ 117.68

ACA subsidy **swapped** from upper end

	Gap Population (<100%)	100-138%	139-200%	201-250%	251-300%	301-400%
Individual FPL Guidelines (monthly):	$ 661	$ 1,211	$ 1,724	$ 2,294	$ 2,803	$ 3,565
Income Limit for Premium	9.11-9.69%	2%	3-5.9%	6-7.85%	7.86-9.10%	0%
Average Premium	$ 64.07	$ 24.69	$ 70.35	$ 160.57	$ 234.89	$ 419.23
Avg. Change in Premium	$ (355.16)	$ -	$ -	$ -	$ -	$ 117.68

However, an important aspect to note is that **income caps for subsidy calculation largely shield population from any positive effects from reinsurance program**

Combination 2: Reinsurance + Revised Eligibility (0-300% FPL)

Looking at enrollment gains across FPL levels, we observe that the introduction of a reinsurance / HRP program has little impact across very low-income (<250% FPL)

Range of Marketplace Enrollment Gains Across Modeling Combinations, 2019

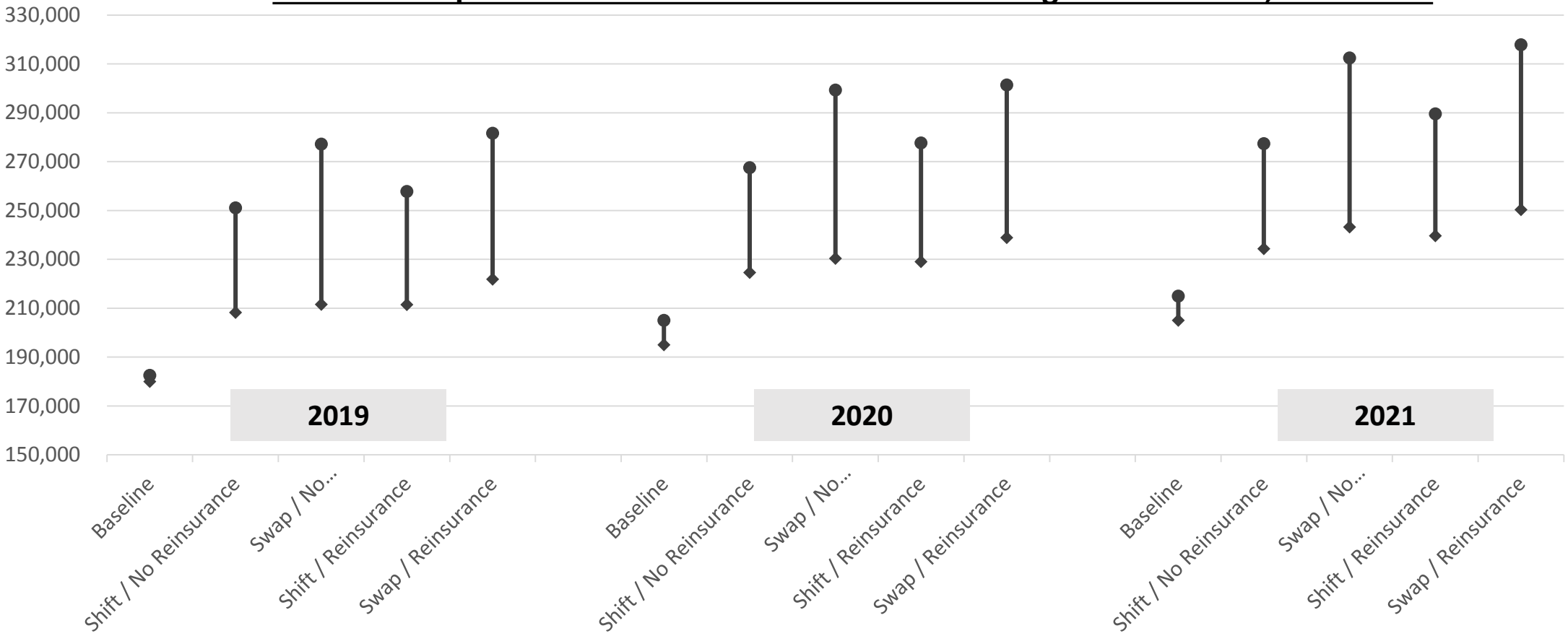
Note: High and low enrollment estimates reflect varied assumptions for consumer sensitivity to changes in price

Source: Market data obtained through Leavitt Partners analysis of CMS Medical Loss Ratio (MLR) data; Consumer elasticity data estimated through Literature Review

Combination 2: Reinsurance + Revised Eligibility (0-300% FPL)

As new population accesses premium assistance through the marketplace, enrollment has potential to grow significantly; however, the reinsurance program's inability to influence very low-income premiums results in little impact on marketplace enrollment

Total Marketplace Enrollment Across Various Modeling Combinations, 2019-2021



Note: High and low enrollment estimates reflect varied assumptions for consumer sensitivity to changes in price

Source: Market data obtained through Leavitt Partners analysis of CMS Medical Loss Ratio (MLR) data; Consumer elasticity data estimated through Literature Review

Combination 2: Reinsurance + Revised Eligibility (0-300% FPL)

Key Takeaways:

- Making available a new premium assistance program for the "gap population" is likely to result in significant gains in enrollment from such a sizeable population

- Introduction of a reinsurance program will reduce premiums and produce some enrollment gains among the off-exchange and middle-income populations; however, the very lowest income consumers (whom the premium assistance program is expanded to) are unlikely to realize any benefit from a reinsurance program due to the ACA income caps for subsidy calculation

- The introduction of both these programs represent a significant expense and the lowering of subsidy eligibility is less likely to save the federal government money, thereby reducing the 'pass-through savings' that the state may be eligible to receive

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Combination 3: Reinsurance + Age/Income-Based Tax Credits + 5:1 Age Banding

Combination 3: Reinsurance + Age/Income Tax Credits + 5:1 Age Band

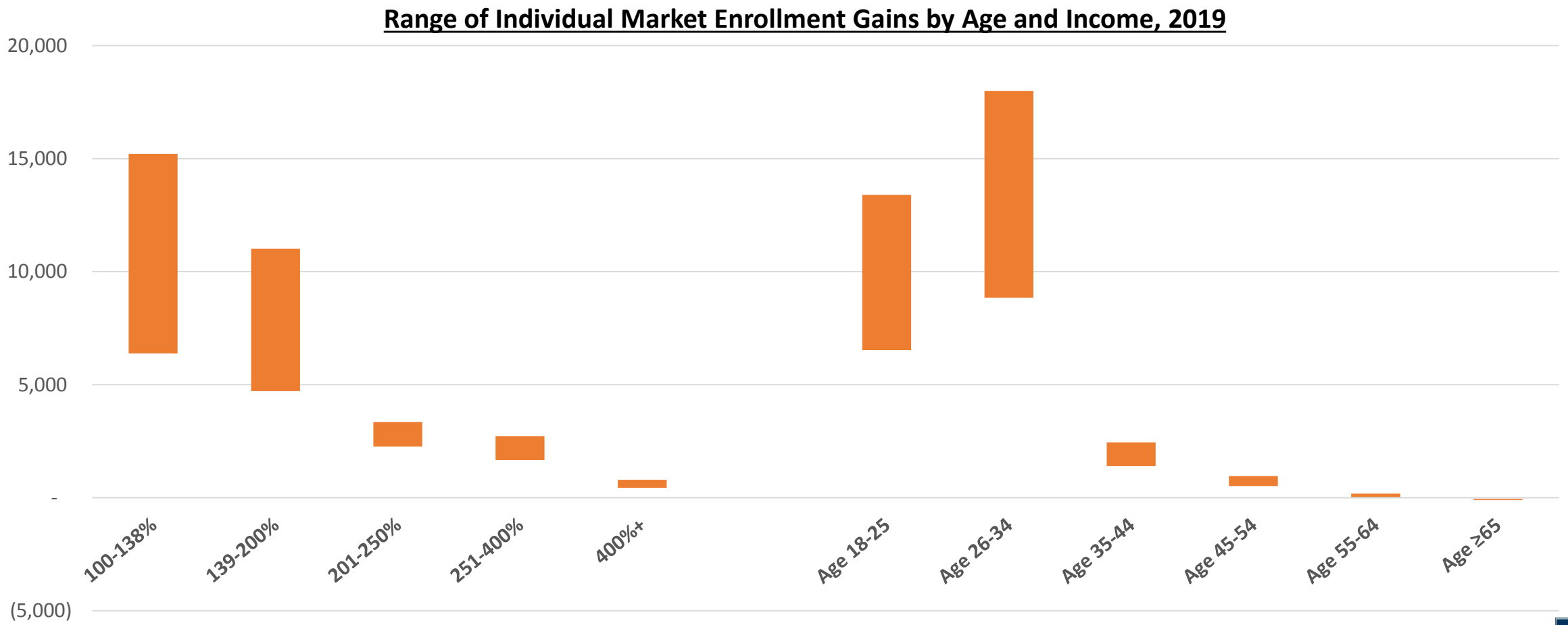
After taking into account the market impacts of Reinsurance and 5:1 age banding programs, the new tax credits were designed to A.) be budget neutral to the state's baseline spending; B.) minimize adverse impacts due to adjustment in age banding; and C.) decrease with income up to 400% FPL

New Subsidy Amount						
	100-138%		139-200%	201-250%	251-400%	400%+
	Monthly	Annual	94%	80%	60%	0%
Age 18-25	$255	$3,060	$2,876	$2,448	$1,836	$-
Age 26-34	$332	$3,984	$3,745	$3,187	$2,390	$-
Age 35-44	$408	$4,896	$4,602	$3,917	$2,938	$-
Age 45-54	$663	$7,956	$7,479	$6,365	$4,774	$-
Age 55-64	$1,122	$13,464	$12,656	$10,771	$8,078	$-
Age ≥65	$1,326	$15,912	$14,957	$12,730	$9,547	$-

	2019 Est. Baseline Premium	New Premium (pre subsidy)	New Premium Amount (post subsidy)					Premium Paid Percent Change				
			100-138%	139-200%	201-250%	251-400%	400%+	100-138%	139-200%	201-250%	251-400%	400%+
Age 18-25	$408	$265	$10	$25	$61	$112	$265	-61%	-64%	-65%	-65%	-35%
Age 26-34	$466	$342	$10	$30	$77	$143	$342	-59%	-57%	-56%	-56%	-27%
Age 35-44	$531	$426	$18	$43	$100	$182	$426	-26%	-39%	-43%	-44%	-20%
Age 45-54	$728	$685	$22	$62	$155	$287	$685	-11%	-11%	-11%	-11%	-6%
Age 55-64	$1,075	$1,142	$20	$87	$244	$468	$1,142	-22%	24%	40%	46%	6%
Age ≥65	$1,239	$1,357	$31	$110	$296	$561	$1,357	24%	58%	70%	74%	10%

Combination 3: Reinsurance + Age/Income Tax Credits + 5:1 Age Band

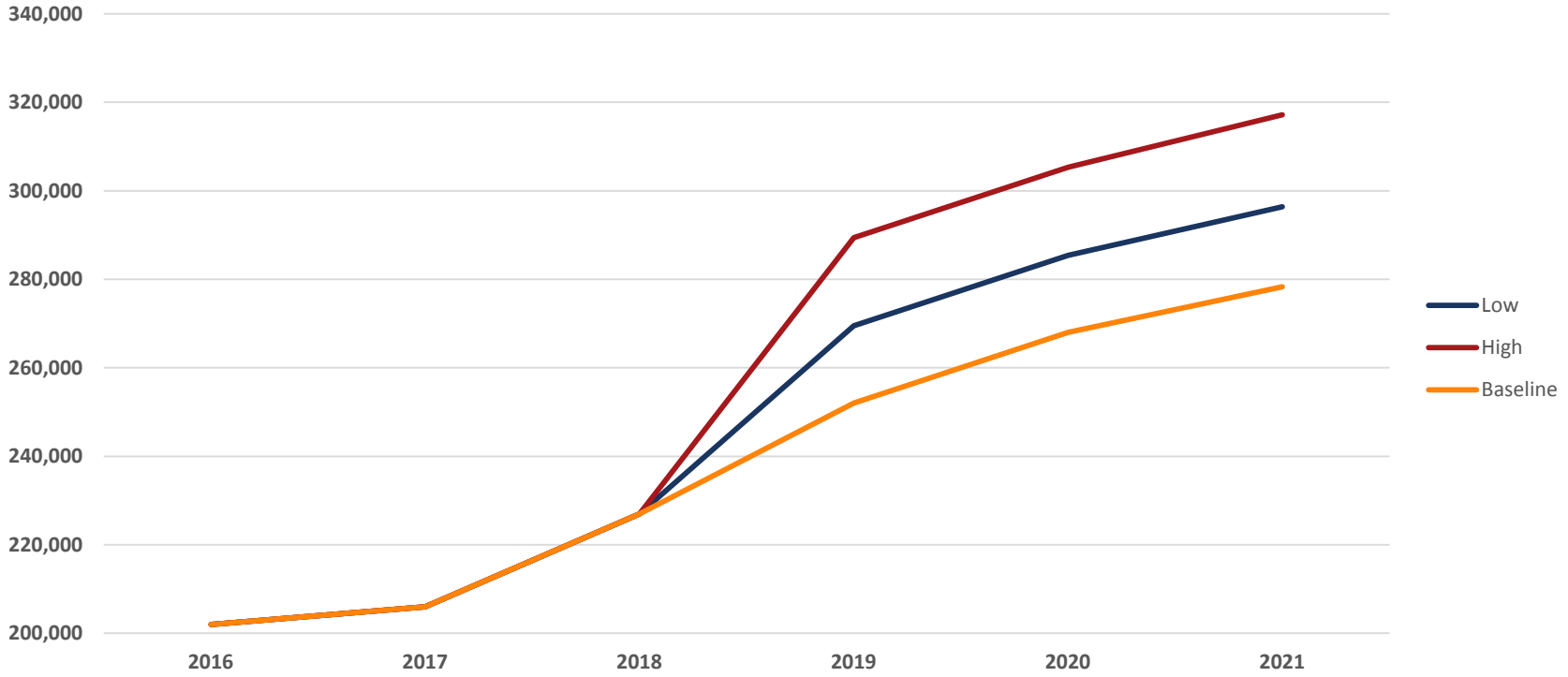
Enrollment gains due to Age Banding and Subsidy primarily occur among young and very low-income enrollees; furthermore, enrollment losses due to higher premiums largely mitigated



Combination 3: Reinsurance + Age/Income Tax Credits + 5:1 Age Band

Most significant enrollment gains made on the marketplace as tax credits and new affordability attract new populations; however, reinsurance and age-banding also encourage new participation in the off-exchange market

Reform Impact on Total Individual Market Enrollment, 2018-2021



Year	Baseline On-Marketplace	Baseline Off-Marketplace	New policy On-Marketplace enrollment	New policy Off-Marketplace enrollment
2019	182,000	70,000	197,000 - 215,000	72,480 - 74,440
2020	198,000	70,000	213,000 - 231,000	72,430 - 74,310
2021	208,300	70,000	224,000 - 243,000	72,370 - 74,210

Combination 3: Reinsurance + Age/Income Tax Credits + 5:1 Age Band

Key Takeaways:

- Introduction of a 5:1 age band limit reduces the premiums for individuals under the age of 45 and increases the premiums for individuals over the age of 45
- Introduction of a reinsurance program reduces the underlying premium structure for everyone (except for the very lowest income who hit the ACA income limit for subsidy calculation)
- Establishing a tax credit based on enrollee Age and Income to compensate for any adverse conditions under the 5:1 age band policy has potential to be very expensive for the state or federal government.
    - This is primarily due to two reasons: 1.) the older populations are subsidized to a very great extent (and would be subsidized to a greater extent under the 5:1 age band); 2.) there are so few enrollees in the younger age range that reallocation of their subsidies does not go very far

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Solution 5: Two Standardized Insurance Options

Solution 5: Moving to Two Plan Standard

Movement to a Two Plan Standard policy is premised on two plan options, a low-deductible (conventional) health plan and a high-deductible health plan. For the purposes of our model, we construct

Low-Deductible, Conventional Plan

Metal Level:	Gold
Deductible:	$500
Out-of-pocket:	$5,250
Coverage before deductible?	Yes
2017 Premium (25 y.o.):	$475
2017 Premium (50 y.o.):	$853

High-Deductible Health Plan (HDHP)

Metal Level:	Bronze
Deductible:	$6,500
Out-of-pocket:	$6,500
Coverage before deductible?	No
2017 Premium (25 y.o.):	$300
2017 Premium (50 y.o.):	$530

Solution 5: Moving to Two Plan Standard

Revised Subsidy Approach

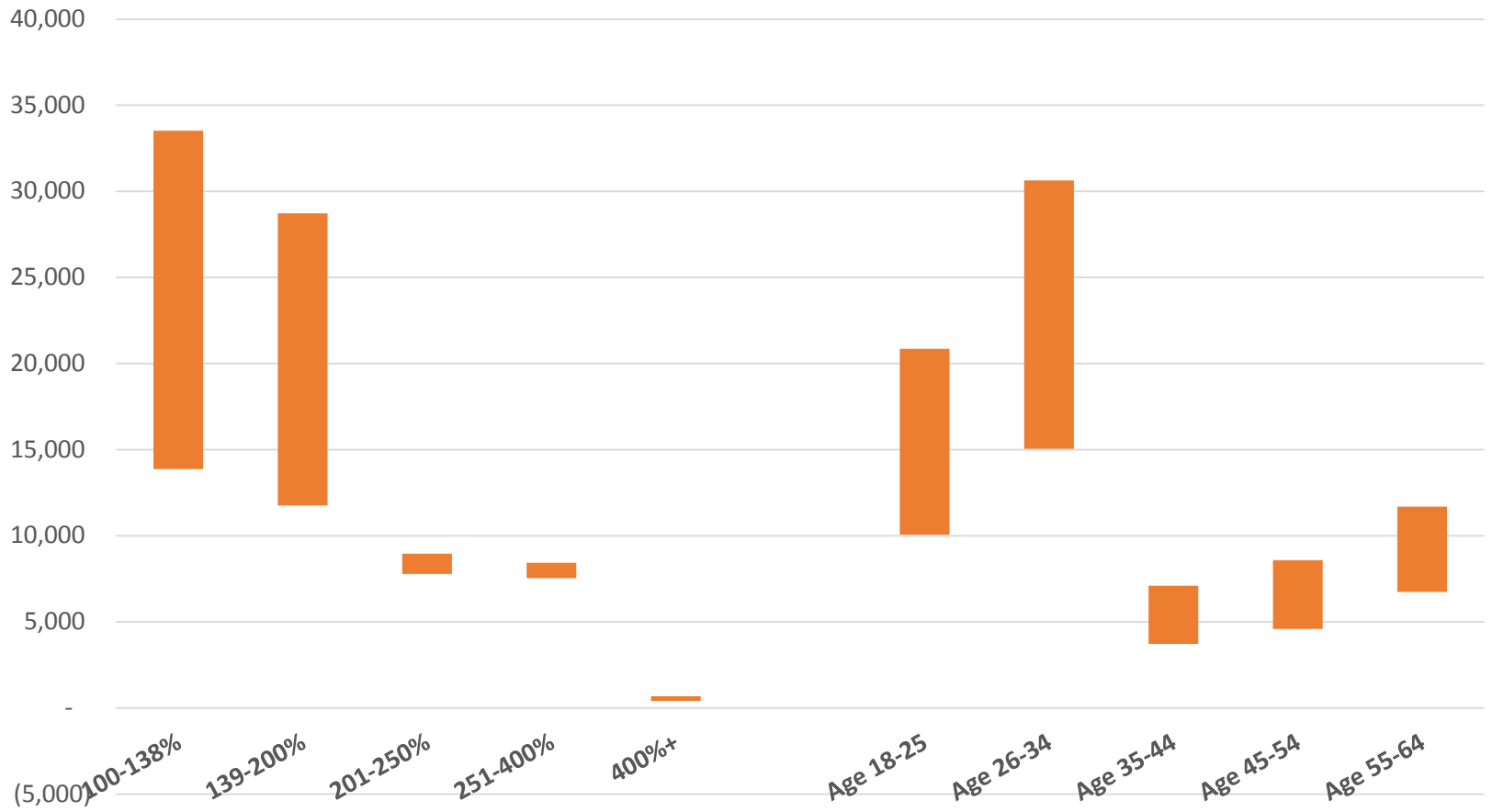
To effectively model the Two Plan Standard policy, an alternative method for premium subsidy calculation was developed. Subsidy is calculated as a percentage of premium for the low-deductible, conventional policy, then indexing to an enrollee's income, and allowing them to apply to the HDHP or conventional policy

Age	Unsubs. Premium	Base Subsidy (70%)	Plan Type	Net Premium				
				100-138%	139-200%	201-250%	251-400%	400%+
Age 18-25	$324	$362	HDHP	$(38)	$(20)	$(2)	$16	$324
	$517	$362	Conventional	$155	$173	$191	$209	$517
Age 26-34	$367	$411	HDHP	$(43)	$(23)	$(2)	$18	$367
	$587	$411	Conventional	$176	$197	$217	$238	$587
Age 35-44	$414	$462	HDHP	$(49)	$(25)	$(2)	$21	$414
	$660	$462	Conventional	$198	$221	$244	$268	$660
Age 45-54	$578	$646	HDHP	$(68)	$(36)	$(3)	$29	$578
	$923	$646	Conventional	$277	$309	$342	$374	$923
Age 55-64	$879	$982	HDHP	$(103)	$(54)	$(5)	$44	$879
	$1,403	$982	Conventional	$421	$470	$519	$568	$1,403

Solution 5: Moving to Two Plan Standard

Greatest enrollment gains are made among younger populations as they are able to purchase a HDHP for a lower premium—largely based on subsidy amounts

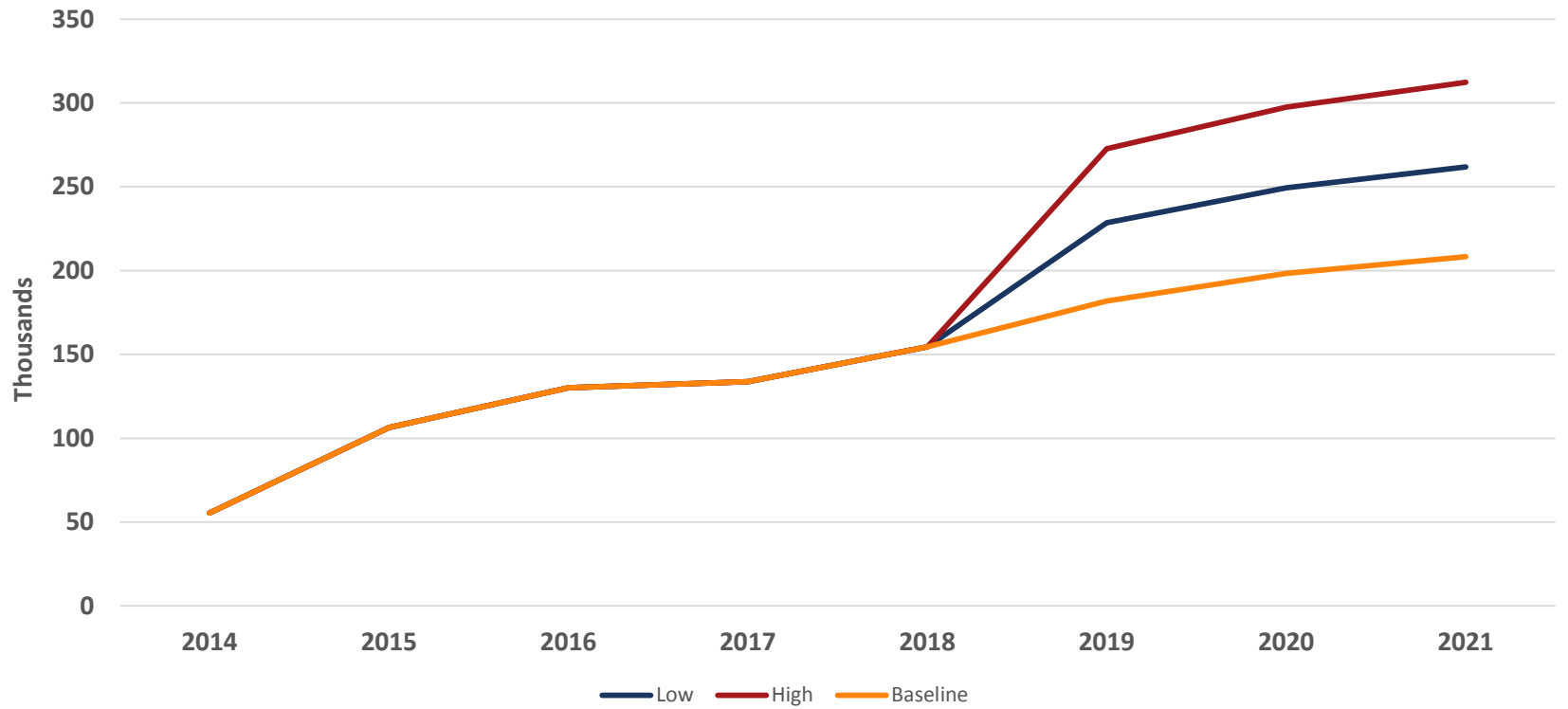
Range of Marketplace Enrollment Gains Across Modeling Combinations, 2019



Note: Aspects of this policy—such as the increased financial risk born by consumers under a HDHP—could not be expressed by the chosen modeling approach and are likely to be key factors in decision-making and possible deterrents of enrollment under this policy

Solution 5: Moving to Two Plan Standard

Introduction of a two plan standard and a very generous subsidy format (covering all premiums and making an HSA contribution) results in massive enrollment gains—and quickly generates costs above the baseline



Year	Baseline On-HIX	New policy On-HIX enrollment		Conventional	HDHP
2019	182,000	229,000	273,000	25-29%	71-75%
2020	198,000	248,000	297,000	22-26%	74-78%
2021	208,300	262,000	312,000	21-25%	75-79%

Note: High and low enrollment estimates reflect varied assumptions for consumer sensitivity to changes in price

Note: Aspects of this policy—such as the increased financial risk born by consumers under a HDHP—could not be expressed by the chosen modeling approach and are likely to be key factors in decision-making and possible deterrents of enrollment under this policy

Solution 5: Moving to Two Plan Standard

Key Takeaways:

- Introduction of a “two plan standard” is likely to produce gains in enrollment as a low-cost option is introduced and subsidies make High-Deductible Health Plan more affordable than under ACA
- All new enrollment gains occur into High-Deductible Health Plan
- Due to the cost of insurance in Oklahoma, subsidizing coverage to the point of surplus subsidy spilling over into a Health Savings Account for low-income is likely to generate costs above the baseline
- A likely result of either scenario is that a high-proportion of the market will be covered by policies that may not actually improve access to care but only provide a back-stop for catastrophic loss

Combination 4: Reins + Moving to Two Plan Standard

The introduction of reinsurance to the two plan solution has no significant effect on enrollment. All new enrollees are enrolling into the HDHP with very low incomes and the reinsurance program only serves to enhance the HSA contributions

Introduction of reinsurance increases the HSA contributions between 5-7% on average

Age	Unsubs. Premium	Base Subsidy (70%)	Plan Type	Net Premium				
				100-138%	139-200%	201-250%	251-400%	400%+
Age 18-25	$324	$362	HDHP	$(38)	$(20)	$(2)	$16	$324
	$517	$362	Conventional	$155	$173	$191	$209	$517
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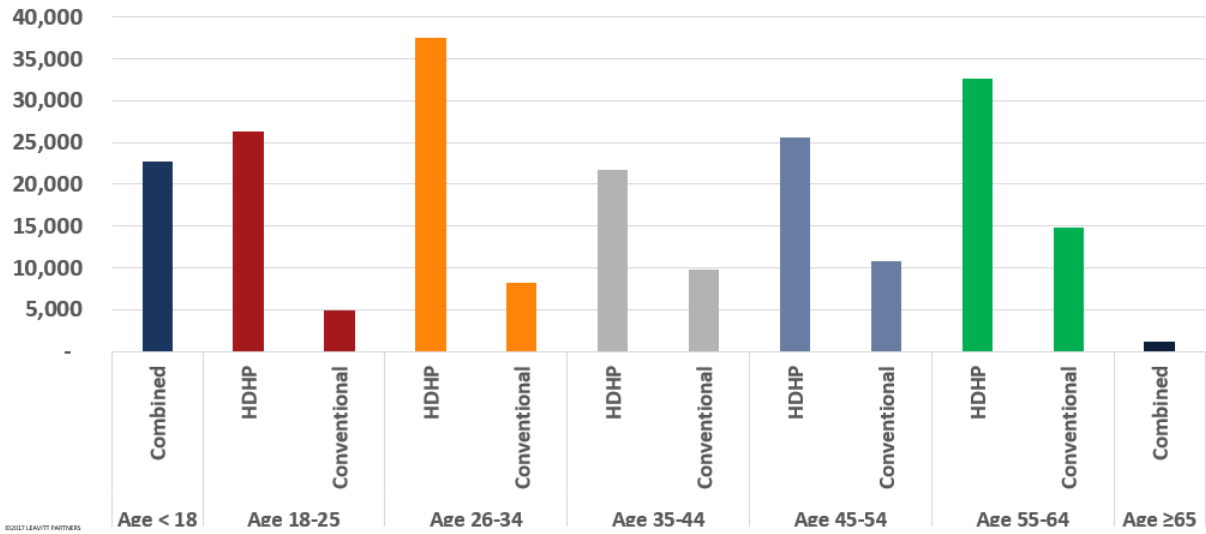
Age 55-64	$879	$982	HDHP	$(103)	$(54)	$(5)	$44	$879
	$1,403	$982	Conventional	$421	$470	$519	$568	$1,403

Conventional plans grow just over 1% as more people are willing to choose the conventional plan at the lower price point



Combination 4: Reins + Moving to Two Plan Standard

Key Takeaways:

- Reinsurance does not have a significant impact on total enrollment. For the HDHP premium under an aggressive subsidy, all income levels below 400% FPL already have access to a health plan without a premium.

- HSA access not a key driver of enrolling in a health plan. We anticipate HSAs to increase utilization, but those who will sign up for a free insurance plan are already likely to be on the exchange regardless of a 5-7% increase in HSA contributions.

In Summary…

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Methodology
Leavitt Partners utilized the following data and research in modeling the proposed solutions: – Secondary research and literature review – Time series modeling – CMS enrollment and premium data – MLR, NAIC, and U.S. Census market data – Price elasticity modeling – Regulatory research

	Legislative		Impact			Budget	Operations	
	Federal	State	Enrollment	Premiums	Market Stability	Financial Commitment	Implementation	Composite
Combination 1: Reinsurance + Changing Age Band	◐	◕	◕	◐	◕	◐	◐	◕
Combination 2: Reinsurance + Eligibility Shift to 0-300% FPL	◐	◐	●	◐	◐	○	◔	◐
Combination 3: Reinsurance + Age/Income Subsidy + 5:1 Age Band	◕	◐	◔	◐	◐	◐	○	◐
Combination 4: Reinsurance + Moving to Two Plan System	◐	◔	◐	◐	◔	◔	◔	◔

○ ◔ ◐ ◕ ●

Unfavorable → Favorable

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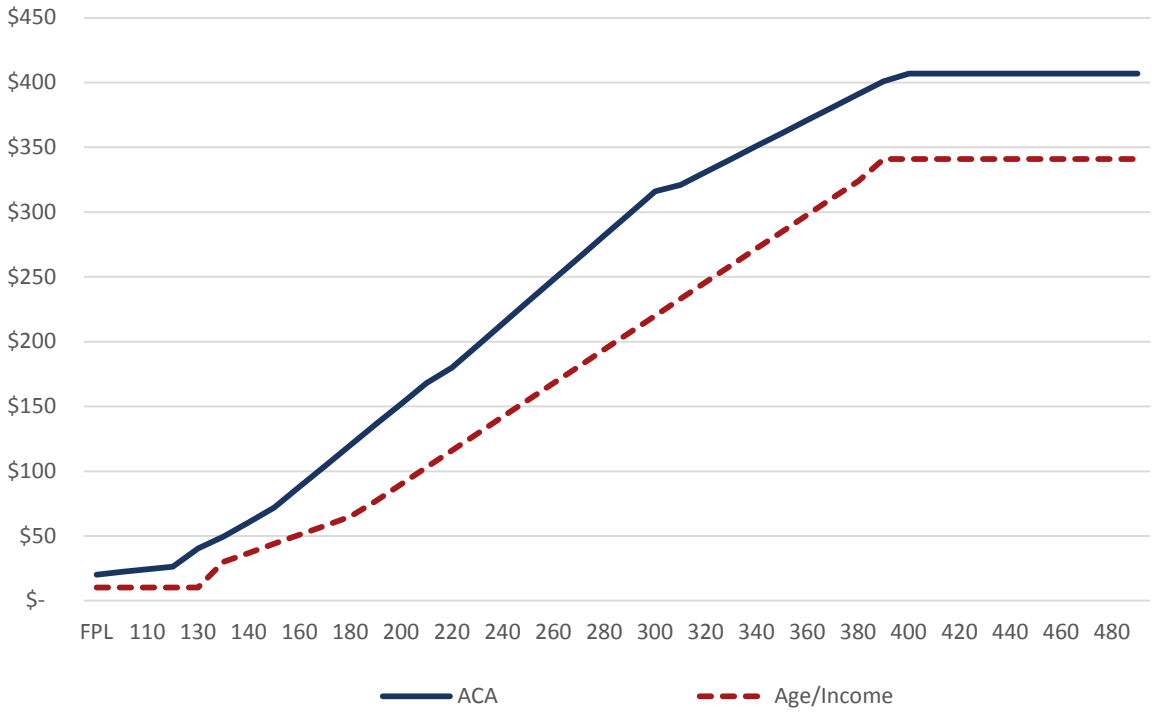
APPENDIX

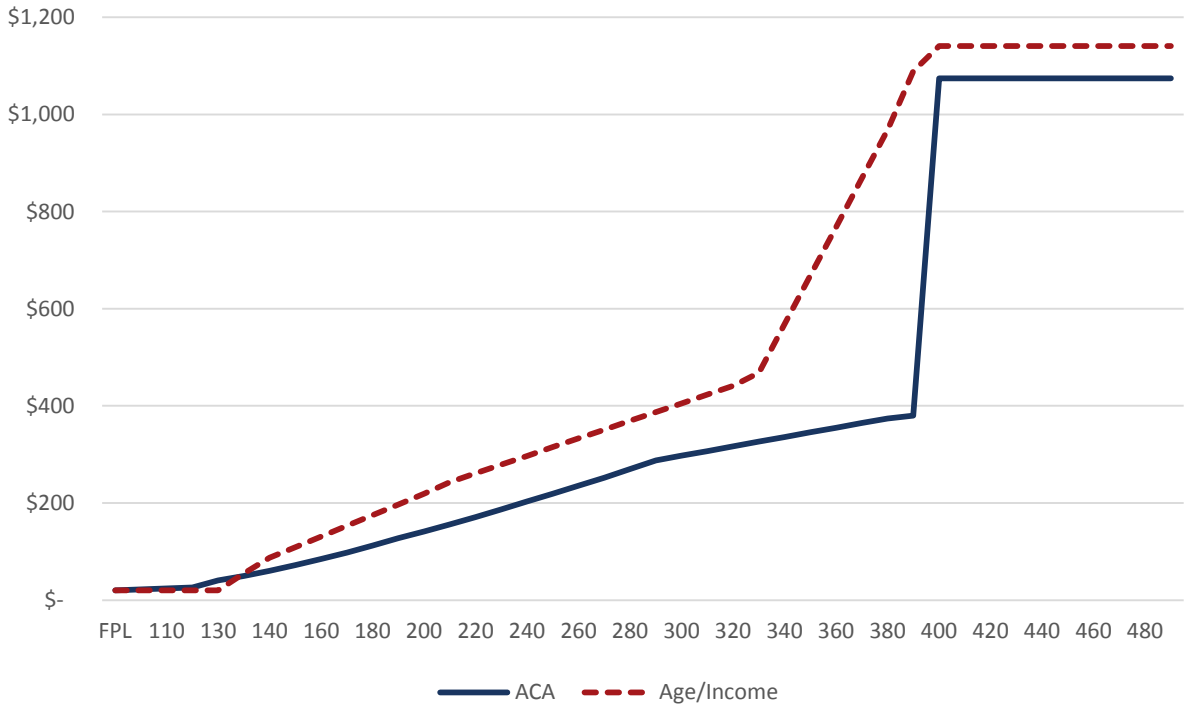
Combination 3: Reinsurance + Age/Income Tax Credits + 5:1 Age Band

Structure of new tax credits largely tracks alongside that of ACA premium subsidy; however, savings from reducing younger population's premium subsidy still not enough to generate lower premiums for older population at 5:1 ratio

25 y.o. Monthly Premium Amounts Under Each Subsidy Method



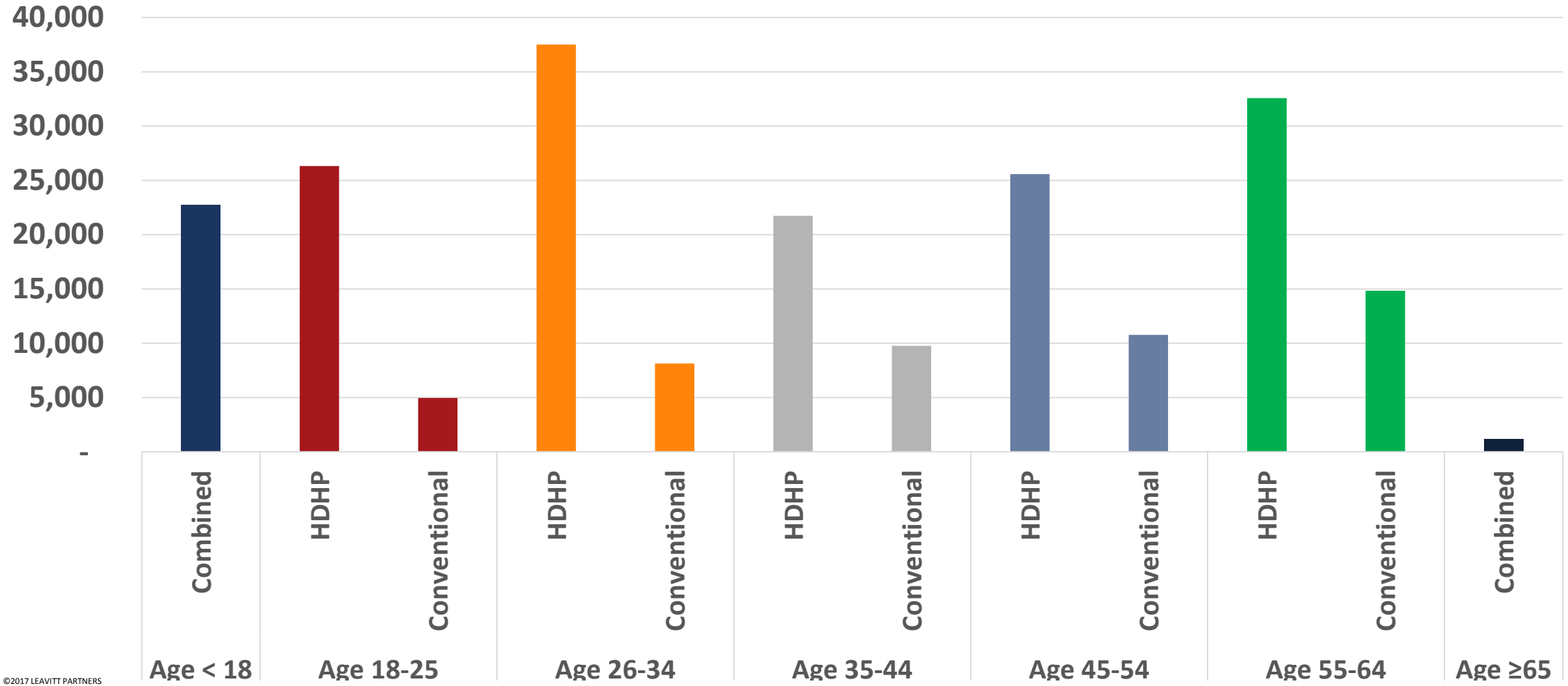
60 y.o. Monthly Premium Amounts Under Each Subsidy Method



Source: 2017 ASPE Enrollment Summary; 'average marketplace premium paid by demographic' adjusted to reflect impacts of policy reforms

Solution 5: Moving to Two Plan Standard

Different populations have different preferences for plan choice. Young populations see a higher percent choosing the HDHP, while older populations are more likely to choose a conventional plan



Note: This shows only one scenario for the conservative funding option under a high elasticity assumption.

1332 State Innovation Task Force Meeting Agenda

June 29, 2017
1:00 p.m.-3:30 p.m.
Oklahoma State Capitol, Room 419 C
2300 N. Lincoln Blvd.
Oklahoma City, OK 73105

Section	Time		Presenter
Welcome and Introductions	**1:00**	**5 min**	**Buffy Heater, HHS Project Lead**
State and Federal Updates	**1:05**	**15 min**	**Buffy Heater**
Reinsurance Waiver Update	**1:20**	**30 min**	**Paul Houchens, Milliman**
Impact Assessment of Concept Paper Strategies	**1:50**	**45 min**	**Austin Bordelon, Leavitt Partners**
Overview of Task Force Report, Next Steps for Concept Paper Strategies	**2:35**	**30 min**	**Theresa LaPera, Health Management Associates**
Implementation Timeline	**3:05**	**15 min**	**Buffy Heater, Theresa LaPera**
Closing Remarks	**3:20**	**10 min**	**Buffy Heater**

Overview of Discussion

- Major Proposed Changes
- Waiver vs. Non-Waiver Proposals
- Operational Considerations
- Sequence and Timing of Proposals
- Next Steps

Major Proposed Changes

1. Reinsurance
   - Reducing premiums by addressing high-cost claims
2. Reducing Plan Options to Two Standardized Types
   - Eliminate metal tiers – offer only a conventional and a HDHP/HSA combination
3. Reallocating APTC Funds
   - Providing more assistance to lower income individuals
4. Simplifying Subsidy Calculation
   - Subsidies to be based only on age/income; cost of premium not a factor
5. Moving to a Wider Age Band
   - Allowing premiums to vary by a ratio of 5:1 instead of the current 3:1

Reinsurance

- Implement in 2018
- Legislation passed and signed by the Governor
- Need to appoint a board and begin operational planning and definition of specific program parameters
- Section 1332 Waiver development underway – procured actuarial support to develop application elements
- Need to develop full 1332 Waiver application and submit to HHS/Treasury this summer
- 1332 Waiver will provide ongoing funding for reinsurance support

Reducing Plan Options to Two Standardized Types

- Requires Section 1332 Waiver to implement
- Requires moving to the OK Modernized Market to implement
- State will need to consider consumer impacts of high deductible plan options and understanding of HSAs
- State will require actuarial support to develop plan designs and will need to review and approve plans each year
- State will need to carefully consider consumer health account design in context of HSA accounts, including tax implications, ease of use, etc.
- Will require a third party administrator to administer consumer health accounts

Reallocating APTC Funds and Changing Subsidy Calculations

- Will require a Section 1332 Waiver and movement to the OK modernized market
- Will require additional actuarial analysis to determine if policy changes meet the affordability and coverage guardrails of Section 1332
- Under modernized market, OK would need to make subsidy eligibility determinations and calculate subsidy amounts

Moving to Wider Age Band

- Would require a statutory change to current law; current law is 3:1 age band
- If a federal change is implemented, the state may not need to make any changes to accommodate this change as the FFM would move to a 5:1 age band
- If OK is taking on previous options, including subsidy changes, this changed age band would need to be built into the premium calculation process for all eligible individuals

Waiver vs. Non-Waiver Proposals

- Not all changes can be accomplished via a Section 1332 Waiver
  - *Can be waived*: Reinsurance/risk pooling, simplified plan options, APTC/CSR eligibility and distribution, subsidy calculation
  - *Requires change in federal law*: Increase in age band variation

- Additional proposed strategies can be accomplished without a Section 1332 Waiver
  - Value-based payment, quality measures related to chronic disease, care management and care coordination requirements, outreach, encouraging use of telehealth, etc.

Task Force Recommendations that Require OK Modernized Market

- Several Task Force recommendations require OK to both receive approval of a Section 1332 waiver AND to move to carry out all Marketplace-like functions, likely for the 2020 plan year.

Task Force Recommendations Requiring OK-Specific Platform and Section 1332 Waiver	
Changes to Subsidy Calculation	Reduced Administrative Burden
Changes to Subsidy Eligibility	Changes to Exemption Criteria
Movement to 2 Plan Options	Consumer Incentives
Changes to Age Bands (assuming Fed flexibility)	Auto Enrollment
Benefit Package Changes	Moving New Populations into Individual Market
Consumer Health Accounts	

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High Level Timeline for Task Force Recommendations

2018 Coverage Year	2019 Coverage Year	2020 Coverage Year	2021 Coverage Year
REFORM PROPOSAL			
Individual Health Insurance Market Stabilization Program Increased outreach Encourage use of telehealth Direct Enrollment	QHP Certification through Partnership Changes to QHP Cert standards: VBP, vision and dental, care coordination, etc.	Oklahoma's Modernized Market: • Subsidy Calculation • Subsidy Eligibility • 2 Plan Options • Age Rating Changes • EHB Changes • Consumer Health Accounts • Reduced Administrative Burden • Exemption Criteria Changes • Consumer Incentives • Auto Enrollment • Moving New Populations into Market	Changes to Quality Rating

Sequential Approach to Recommendations

Task Force Recommendation	Fulfilled by CMS Final Rules/Guidance	2018 Implementation (2019 Plan Year)	2019 Implementation (2020 Plan Year)
Provide financial tools and increase marketing/outreach efforts	✓ Direct enrollment available beginning plan year 2018		
Maintain $0 co-pays for certain preventive services, guaranteed issue, and dependent coverage up to age 26		✓ Requires no action unless federal changes occur	
OID conducts rate review and plan qualification		✓ Requires state action and submission of CMS Notification	
Encourage plans to use telehealth and offer value-added benefits		✓ Requires state action and submission of CMS Notification	
Encourage value-based payments, care coordination, and quality measures		✓ Requires state action and submission of CMS Notification	

Sequential Approach to Recommendations

Task Force Recommendation	Fulfilled by CMS Final Rules/Guidance	2018 Implementation (2019 Plan Year)	2019 Implementation (2020 Plan Year)
Eliminate metal tiers and offer two standard plans			✓ 1332 Waiver and OK Modernized Market
Reduce administrative burden on plans	✓ Eliminates duplicative review of network adequacy		✓ 1332 Waiver and OK Modernized Market
Increase variance to rating windows for age		✓ Requires federal statutory change; potentially available through MacArthur Waiver	
Explore reinsurance		✓ 1332 Waiver in progress – For Plan Year 2018	

Sequential Approach to Recommendations

Task Force Recommendation	Fulfilled by CMS Final Rules/Guidance	2018 Implementation (2019 Plan Year)	2019 Implementation (2020 Plan Year)
More robust verification of special enrollment requests	✓ Requires all individuals to submit supporting documentation		
Require premium to be paid before policy is issued for re-enrollment	✓ Allows issuers to require individuals to pay back past due premiums before enrolling with the same issuer the following year		
Limit number of special enrollment periods and requests	✓ Increased verification		
Reduce to 30-day grace period for premium payments		✓ Requires federal statutory change	

Sequential Approach to Recommendations

Task Force Recommendation	Fulfilled by CMS Final Rules/Guidance	2018 Implementation (2019 Plan Year)	2019 Implementation (2020 Plan Year)
Allow plans to direct market, solicit clients, assist in enrolling	✓ Direct enrollment available beginning plan year 2018		
Tighten exemption criteria and allow fewer exemptions			✓ 1332 Waiver and OK Modernized Market
Allow the state to determine core benefits			✓ 1332 Waiver and OK Modernized Market
Implement enrollee incentives			✓ 1332 Waiver and OK Modernized Market
Broaden APTC and CSR eligibility to include gap populations			✓ 1332 Waiver and OK Modernized Market

Sequential Approach to Recommendations

Task Force Recommendation	Fulfilled by CMS Final Rules/Guidance	2018 Implementation (2019 Plan Year)	2019 Implementation (2020 Plan Year)
Shift APTCs and CSRs from higher incomes (e.g., 300-400% of FPL) to uninsured individuals (less than 100% of the FPL)			✓ 1332 Waiver and OK Modernized Market
Standardize subsidies based on age and income			✓ 1332 Waiver and OK Modernized Market
In lieu of FFM, leverage Insure Oklahoma eligibility and subsidy platform			✓ CMS Blueprint
Establish HSA-like consumer health accounts			✓ 1332 Waiver and OK Modernized Market
Establish two plan options – conventional and HDHP			✓ 1332 Waiver and OK Modernized Market

Next Steps

- OK will need to complete several Federal submissions to meet the timeframes for implementation of the Task Force recommendations, including waiver applications and other required documentation.