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*Analysis and Technical Assistance on
Oklahoma's Section 1332 Waiver: Final Report
Executive Summary*

PREPARED FOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
BY

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Executive Summary

Background and Purpose of the 1332 State Innovation Waiver Task Force

During the 2016 session, Oklahoma’s legislature enacted Senate Bill (SB) 1386, which authorized the development of a Section 1332 State Innovation Waiver. The goals of the legislation were to improve healthcare quality and access in the state while reducing costs, and to meet the needs of Oklahomans by developing a system that provides more affordable health care options. A Section 1332 Waiver, which allows states to obtain flexibility within selected requirements of the Affordable Care Act (ACA), represents an opportunity for Oklahoma to develop its own unique program that is responsive to the needs of the state’s residents.

In addition to authorizing the development of a Section 1332 Waiver, SB 1386 also required the state to consult with private sector representatives and other stakeholders. To meet the requirement for stakeholder consultation, Governor Mary Fallin asked Secretary of Health and Human Services Terry Cline to establish a 1332 State Innovation Waiver Task Force (Task Force) to analyze options for reducing the financial burden to Oklahoma residents seeking affordable, quality healthcare coverage.

In addition to being a requirement of SB 1386, stakeholder engagement is also required under federal guidance related to the development of Section 1332 Waiver applications. The Task Force includes representatives from key stakeholder groups with an interest in the outcomes of any Section 1332 Waiver: consumer advocates, businesses, Tribal nations, health plans, healthcare providers, and health insurance brokers.

Method of Analysis and Approach to Information Gathering Used by the 1332 State Innovation Waiver Task Force

Throughout the nine meetings of the Task Force between August 2016 and June 2017, Oklahoma state officials fostered a collaborative environment to facilitate the discussion of potential Section 1332 Waiver proposals. State officials, Task Force members, and outside experts provided a great deal of background information and data, and the state leveraged additional data and analyses based on the evolution of Task Force discussions.

As one of its foundational steps, the Task Force established four data workgroups to identify, gather, analyze, review, and report on relevant data sources informing the Section 1332 Waiver discussions. Each of the four workgroups represented a stakeholder interest: health plans, providers, businesses, and consumers. These workgroups produced lists of data questions, supporting data tables/worksheets, case studies of business and consumer experiences, and findings and relevant conclusions based on the data. Each group reported its findings to the Task Force, and these early discussions informed the development of the draft Concept Paper discussed below.

In addition to bringing forward the results of their work, the data workgroups identified the need for more formal survey data to inform the ongoing deliberations. They requested specific efforts to collect

data through business and consumer surveys and focus groups, as well as a data collection tool for use with health plans.

In response, the state contracted with two firms, Evolve Research and Visual Image (VI) Marketing and Branding, to conduct consumer and business research projects. The goal of the consumer work was to understand why the Federally-facilitated marketplace (FFM) did not have higher enrollment and why residents remain uninsured. They sought to gain information on how people view the FFM and its value, and how well they understand it. The business research collected information from employers on insurance, costs, plans, wellness programs, and coverage.

The final report on the consumer research indicated that consumers feel that insurance is expensive and difficult to understand. Many people were unsure what their health care costs would be and they reported that getting information is difficult. Respondents said they chose plans primarily based on premium price. They reported a lack of understanding of cost sharing – particularly co-insurance – which causes frustration with bills. The research also indicated that scenario-based examples to which different plans can be applied (e.g., going the emergency room) can better explain costs to consumers.

The business research focused on employers with 1-24, 25-49, and 50 or more employees. Employers indicated that it is difficult to find enough appropriately skilled employees, and 81 percent said that offering insurance is very important to attracting and retaining employees. However, for 89 percent of respondents, insurance premiums have gone up over the prior plan year. In fact, nearly two-thirds of businesses indicated that the cost of health insurance is most burdensome for their businesses. Ninety-three percent of employers pay at least 25 percent of employee premiums, and 67 percent of employers contribute at least 50 percent. Only five percent do not offer employee insurance.

The Task Force also examined analyses from the actuarial and consulting firm Milliman. Milliman had previously produced analysis for Oklahoma's State Innovation Model application. That work included assessment of Oklahoma's FFM profile and the populations in its insurance market. They built on that analysis for a February 2017 presentation to the Task Force that detailed a movement of residents into the individual market (primarily through the FFM) between 2013 and 2016. With the growth in private sector employment, the number of people insured through an employer also grew. Some large employers moved from fully insured to self-funded plans. This movement, along with gains in employment, accounts for movement between employer coverage groups. The number of uninsured, which had been dropping since 2013, went up between 2015 and 2016, after Medicaid temporarily stopped allowing passive renewals.

To further support the work of the Task Force, the state issued a Request for Proposals for health care policy, program, strategy, and data consultation. The purpose of the project was to help the state fully understand policy options and to model the impact of various policy "levers" in preparation for submitting a Section 1332 Waiver. Health Management Associates and its subcontractor Leavitt Partners won the contract for this work in December 2016 and began assisting the state in January 2017.

In parallel with other contractors supporting the Task Force process, The HMA/Leavitt Partners consulting team aided with preparations for Task Force meetings, technical assistance (on Section 1332 Waivers, federal regulatory and statutory issues, funding mechanisms, timelines, and tracking federal

health reform legislation), and presentations on topics of interest to the Task Force and state team. As the Task Force and OSDH identified a menu of policy solutions to include in the Concept Paper, the HMA/Leavitt Partners team assisted with further analysis and understanding of their impact to the greater Oklahoma marketplace. For a subset of these policy solutions, the HMA/Leavitt Partners team also conducted robust modeling and simulations to better understand each solution's impact on enrollment, premium price, cost of care, and federal spending.

Section 1332 Concept Paper

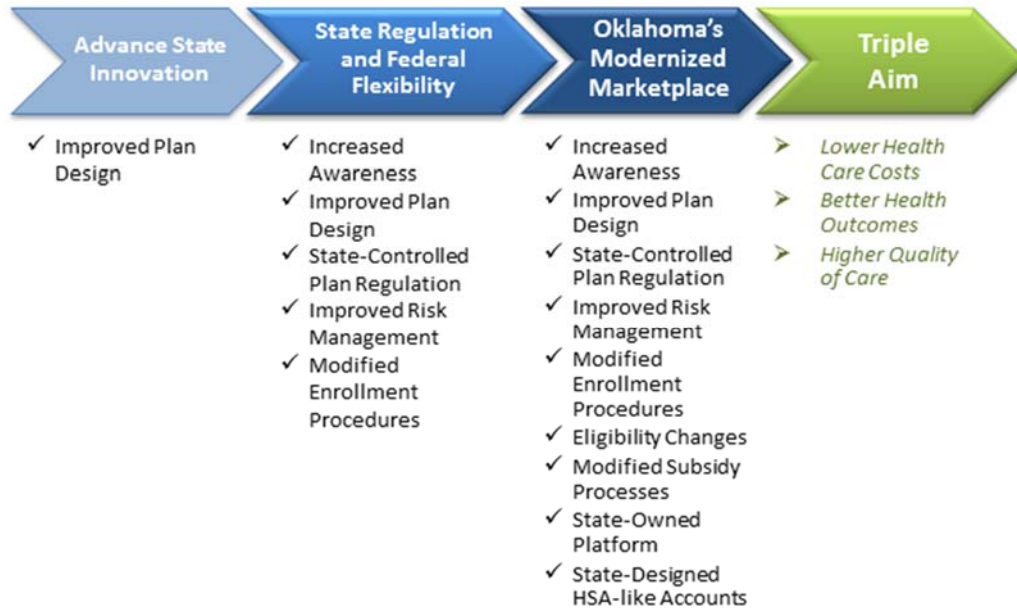
The Task Force Concept Paper served as a very important public artifact of the Task Force process, as well as a tool for gathering feedback on ideas. From the development of the initial Concept Paper to the publication of the final Concept Paper in March 2017¹, OSDH engaged deeply with Task Force members and other stakeholders for the purpose of soliciting feedback. OSDH posted all meeting agendas, presentations, and supporting materials online prior to each meeting. State staff prompted participants with discussion questions at each meeting to elicit feedback and provided materials to review before each meeting. OSDH received written comments and feedback from stakeholders throughout the Task Force process and revised the draft Concept Paper based on this feedback.

The Draft Concept Paper published in December 2016 provided a summary of the current individual insurance market and insurance coverage in Oklahoma, a discussion of the current pain points in the individual insurance market in the state, and the initial set of recommended strategies and Task Force recommendations to address the identified pain points. The Concept Paper also provided a high-level roadmap of recommended changes, laying out a sequential approach based on the federal authorities and state operational changes needed to implement the recommendations.

¹ The Concept Paper can be found at <https://www.ok.gov/health/documents/1332%20Waiver%20Concept%20Paper.pdf>

Figure i. Marketplace Strategies Roadmap

1. Lay the Foundation 2. Transition Processes & Policies 3. Establish Infrastructure 4. Achieve Outcomes



Task Force members reviewed and discussed the Concept Paper at the January 24, 2016 Task Force Meeting. The state also posted the Draft Concept Paper online with a 30-day public comment period. OSDH also encouraged Task Force members to distribute the paper to their own stakeholders. Oklahoma revised the Concept Paper based on feedback from the Task Force, public commenters, legislators, and others, as well as to reflect federal and other policy changes, and published a revised version in March. The significant changes to the Concept Paper in the March version included:

- Summary of consumer and business research conducted
- Updated federal landscape to reflect the situation at the time of publication
- Summary of comments received on the Draft Concept Paper
- Addition of a Tribal Considerations section including specific issues related to the recommendations of the Task Force
- Consideration of a process for making proposed changes to the Essential Health Benefits package
- Refinement of recommendations related to risk adjustment, reinsurance, and high risk pools
- Removal of the recommendation related to requiring Medicaid managed care plans to participate in the new Waiver program
- Addition of detail related to use of the Insure OK platform to support the new program
- Refinement of proposed changes to state regulatory requirements, including rate review

The March Concept Paper is the current version and reflects the most up to date recommendations and findings of the Task Force.

Table i. Task Force Recommendations

1	Retain ACA provisions related to AI/AN populations and the Indian Health Care Improvement Act
2	Increase marketing and outreach efforts
3	Maintain \$0 co-pays for certain preventive services, guaranteed issue, and dependent coverage up to age 26
4	Encourage the use of telehealth
5	Encourage plans to offer additional value-added benefits (e.g., dental and vision)
6	Eliminate metal plan AV criteria and replace them with a standard minimum AV of 80% for all traditional plans (non-HDHP) with simplified, fixed-cost benefits descriptions
7	Have the Oklahoma Insurance Department assume rate review and plan certification
8	Qualify plans that incorporate value-based payments
9	Implement quality measures related to chronic disease
10	Ensure plans implement case management/care coordination
11	Ensure qualified plan process includes validation of AV calculations
12	Implement state-assessed incentives and/or penalties on plans for failure to comply with regulations
13	Reduced administrative burden on plans related to reporting, risk mitigation, eligibility, and enrollment
14	Allow greater variance to the rating windows for age
15	Adopt Medicare Advantage-like plan quality rating program
16	Encourage plans to reinsure themselves and/or participate in continued federal reinsurance program
17	Continue to explore federally-funded, state-administered high-risk pools, reinsurance, and hybrid programs
18	More robust verification of special enrollment requests
19	Require premium to be paid before policy is issued for re-enrollment
20	Limit number of special enrollment periods and requests
21	Reduce to 30-day grace period for premium payments
22	Allow plans to direct market, solicit clients, assist in enrolling
23	Tighten exemption criteria and allow fewer exemptions
24	Allow the state to determine benefits; identify a core set and/or provide flexibility depending on consumer needs
25	Provide consumer incentives for continuous coverage and healthy behaviors
26	Broaden APTC and CSR eligibility to include gap populations (income less than 100% of the FPL)
27	Move additional populations into the individual market, i.e. CHIP population if CHIP not reauthorized
28	Shift APTCs and CSRs from higher incomes (e.g., 300-400% of FPL) to uninsured individuals (less than 100% of the FPL)
29	Standardize subsidies based on age and income
30	In lieu of FFM, leverage Insure Oklahoma eligibility and subsidy platform
31	Utilize automatic enrollment of certain individuals
32	Establish HSA-like consumer health accounts funded by redirecting APTCs and CSRs for consumers to purchase coverage and pay for out-of-pocket expenses
33	Establish two simple options for consumers to use their accounts: 1) purchase a traditional plan (non-HDHP) with at least 80% AV or 2) purchase a high-deductible plan and keep remaining subsidy dollars for health expenses

Another important step in the process was a formal Tribal Listening Session on the Concept Paper held on February 13, 2017. During this session, representatives from the state provided an overview of the Indian Health Care Improvement Act and the Section 1332 State Innovation Waiver, including a review of the contents of the Concept Paper. Tribal leaders and representatives asked questions about the proposals and other related topics and provided feedback on the content of the Draft Concept Paper. In addition, on February 22, 2017, Oklahoma reconvened the 1115(a) Waiver – Sponsor’s Choice work

group to consider what specific tribal considerations should be included in the development of the 1332 Waiver Concept Paper.

OSDH briefed the state Senate on April 18, 2017 and the House on May 1, 2017 on their plans to stabilize the insurance market based on the Task Force deliberations and related federal activity. Based on analysis of the recommendations and strategies, the state has decided to move forward in the short term with a reinsurance program similar to the approach implemented in Alaska through a Section 1332 Waiver. CMS has expressed increased federal support for approaches that utilize Section 1332 Waiver pass-through funding for reinsurance as a strategy to reduce premiums in the individual market. In response to this support, and given the need for immediate action to improve rates in the Oklahoma individual market, the state has passed enabling legislation to operate the Oklahoma Individual Health Insurance Market Stabilization Program. While the exact design details of this program are still being developed, the state will be moving ahead with the submission of a Section 1332 Waiver application to implement this program.

Oklahoma will continue to work to further refine the Task Force recommendations in the coming weeks and months, and will continue to engage stakeholders in this process. For example, Oklahoma will engage the Task Force on the next level of analysis related to the recommendations, including how these program changes would be designed, how consumers will be impacted, and how they should be consulted. The state also plans to hold public meetings and/or focus groups, and to engage health industry experts to further refine these recommendations, including providers, agents and brokers, and health plans. They will also continue to hold legislative briefings to keep members apprised of progress on the Oklahoma Individual Health Insurance Market Stabilization Program as well as other proposed program reforms. Oklahoma has also scheduled two additional Tribal listening sessions and a meeting of the Sponsors Choice workgroup to continue refining these recommendations and to inform the design of the Individual Health Insurance Market Stabilization Program. Oklahoma will also complete further actuarial modeling to take the analyses already completed to the next level of specificity. On an ongoing basis, Oklahoma will also refine recommendations based on actions taken at the federal level, either through guidance or legislation.

Federal Uncertainties

An important factor to acknowledge is the rapidly changing environment in which this work took place. This is a period of significant political and policy change in the country. Over the course of the project, the federal administration changed hands, which meant significant changes in administration personnel, including the President's cabinet and federal Department of Health and Human Services (HHS) leadership. This change is significant because the state requested consulting assistance with the assumptions embedded in the Affordable Care Act, including the ability to pursue a Section 1332 Waiver. As the House debate occurred in the winter and spring of 2017, HMA assessed the proposed legislation to understand any impacts it could have on state flexibility, federal funding availability, and federal support for state projects. The team kept OSDH staff and the Task Force abreast of the latest developments throughout the project, and any technical advice contained in the report (e.g., regarding necessary waivers and/or statutory or regulatory changes) reflects the status as of the publication of this

report in June 2017. Subsequent new developments could affect the advice or recommendations contained in this report in ways not anticipated by the authors.

Findings and Next Steps Related to Proposed Solutions

A critical part of the HMA/Leavitt Partners scope of work was to compare the impact of a subset of five policy solutions proposed by the Task Force. This is important for determining the relative impact/benefit of each option, making modifications if necessary, and determining which options the state should prioritize in the interest of stabilizing the market in the short term, given that some solutions will have a more significant, immediate effect while others require a multi-year process of federal approval and state operational adjustments. OSDH and HMA/Leavitt Partners mutually agreed on the five solutions because they met several criteria, including having significant likely impact and being subject to examination with statistical analysis. Using appropriate statistical methods and incorporating qualitative insights about the Oklahoma individual insurance market, Leavitt Partners estimated the impact of each of the five proposed solutions, as well as the impact of several combinations of solutions. The areas of impact examined were individual market enrollment, premiums, health care costs, and federal spending for the State of Oklahoma. The modeling approach and assumptions were discussed at Task Force meetings in the early part of 2017, and preliminary results were presented at the group's April 2017 meeting.

The five solutions that were modeled were: allowing insurers to increase the variance in premiums between different age groups; lowering premiums via adoption of a reinsurance program; limiting health insurance policies to two simplified plan designs as opposed to the current metal tier system; redistributing premium subsidies; and changing the way subsidies are calculated.

Effects of Moving to a Wider Age Band: As part of a strategy to increase enrollment, the state has considered increasing the variance allowed in age rating from the current 3:1 ratio to a 5:1 ratio. This change can only take place if Congress changes current law, as the ACA requires the 3:1 ratio. While the American Health Care Act (AHCA) as passed by the U.S. House of Representatives would make this change, as would the Better Care Reconciliation Act (BCRA) under discussion in the U.S. Senate, it was unknown at the time of the writing of this report whether this proposed change will survive the full legislative process.

In our analysis, we observe that widening the age band limit is likely to result in enrollment gains among younger and healthier populations. However, increasing the age band limit would also have the effect of increasing premiums for older enrollees. In our modeling, we observed premium reductions of approximately 29 percent for consumers between the ages of 18-25, while consumers between the ages of 55-64 could expect premiums to rise by an average of 21 percent. We believe the reduction in premiums is likely to encourage significant gains in enrollment among the younger population. The state will need to consider the impact of the accompanying premium increases for older consumers. Of course, the state would have the opportunity to customize this solution or to pair it with other reforms to mitigate negative impacts on Oklahoma's population. Besides advocating for Congress to allow such a move as was proposed in the AHCA, there is no immediate recommended next step for this solution. If

Congress changes the law, Oklahoma will carefully consider how to offset any unintended negative effects on older individuals.

Some of the key takeaways from the Leavitt Partners modeling of this solution are as follows:

- Introduction of a 5:1 age band limit reduces premiums for individuals under the age of 45 and increases premiums for individuals over the age of 45.
- If the current ACA subsidy structure is kept in place, widening the age band will actually have very little impact for approximately 80% of the individual market that is receiving a subsidy (i.e., the current "income cap" for subsidy calculation will prevent them from paying any more than they do today).
- Introduction of a 5:1 age band limit *and* a reinsurance program would have the potential to produce greater reductions in premiums for young populations while minimizing rate increases for individuals over the age of 45.

Impact of Adopting a Reinsurance Program: The March 2017 version of the Concept Paper indicated that Oklahoma would explore options for a federally-funded, state-managed high-risk pool, reinsurance program, or hybrid program to help mitigate risk for health plans with the goal of reducing premiums in the individual market. Since OSDH published the final Concept Paper, Oklahoma enacted legislation directing OSDH to seek a Section 1332 Waiver to implement a reinsurance program to provide payments to health plans to offset claims for eligible, high-risk members with the goal of lowering individual market premiums. Initially Oklahoma would fund the program with assessments on health plans and reinsurers. The state will seek a waiver to obtain pass through funding for the program from the federal government based on the potential savings from the reinsurance program to the federal government.

In our analysis, the introduction of a program that shares risk with participating carriers—along the lines of a reinsurance or risk pooling program—had the effect of reducing the overall premium amount necessary to cover the individual health insurance market and in turn resulted in lower premiums. We evaluated the potential influence of such a program with annual budget amounts between \$50 million and \$200 million. At these varied amounts of program funding, our analysis shows that statewide insurance premiums would drop by between 5 percent and 22 percent, respectively. Essentially, it is estimated that the individual market would experience roughly a 1 percent reduction in premiums for every \$10 million in reinsurance funding. This is a promising strategy, and Oklahoma is already moving forward with securing the approvals necessary to stabilize the state's market in this fashion.

The key takeaways from the Leavitt Partners modeling of this solution include:

- Across the various funding scenarios analyzed, the adoption of a state-based reinsurance program for Oklahoma would have a meaningful impact on lowering premium prices for the individual market and is likely to result in enrollment gains.
- The introduction of such a program and a risk-sharing arrangement between the State and participating carriers is also likely to support continued participation among insurance carriers that may be prone to exiting the market.

Moving to Two Standardized Insurance Options: The Task Force also considered numerous proposals to simplify plan options for consumers in the individual market. One strategy would be to encourage use of high-deductible health plan (HDHP) and health savings account (HSA) pairings. Under this proposal, the state would eliminate the metal tier requirements currently in place under the FFM and opt for two standardized plan options—one conventional, low-deductible plan and another option that is a high-deductible plan paired with a consumer health account.

In modeling the effects of adopting such a policy, we generally observed that there would be an opportunity for enrollment gains to the extent that the HDHP policy has a more affordable premium structure than is available on the Marketplace today. Furthermore, if Oklahoma redesigns the premium subsidy to require an even lower premium contribution among eligible populations than is required today, there is also an opportunity for gains in enrollment. Alternatively, while regular state contributions into a personal HSA account may be attractive to a potential enrollee, we have assumed that this would not be the primary determinant in a consumer's decision to enroll in a HDHP. Rather, the premium affordability of the new standardized plans is the strongest determinant of opportunities for new enrollment.

In order to implement changes to the plan offerings on the Marketplace, Oklahoma would need to include this design change in a Section 1332 Waiver application to the federal government. The state would also need waivers of ACA provisions related to the required metal tiers and associated actuarial values, as well as the requirement that all health insurance carriers provide both gold and silver offerings on the Marketplace.

Oklahoma would also need to implement its own state-based program to provide coverage to Marketplace enrollees given that it participates today in the FFM. This is because making a change to the required plan designs within the FFM would result in administrative costs to the federal government, which would disqualify the proposal based on these costs. Oklahoma would have to include the review of plan designs in the annual plan selection process that the Insurance Department would carry out. In addition, the operational considerations related to the implementation of consumer health accounts are significant. Oklahoma will need to sort through the differences between HSAs administered by health plans and the concept of Consumer Health Accounts recommended by the Task Force, which differ from HSAs in some respects. Additionally, Oklahoma will need to consider the potential tax implications of HSAs and delivering subsidies through accounts to consumers rather than paying subsidies directly to health plans.

To implement Consumer Health Accounts as envisioned by the Task Force, Oklahoma would likely need to procure a contract with a third party administrator (TPA) to design and operate these accounts. Together with the TPA, Oklahoma would need to design multiple operational details, covered in detail later in this report. We recommend that as Oklahoma moves forward with the initial limited Section 1332 Waiver, it continues to refine the operational details for this proposed change.

Reallocating Subsidies for the Non-Medicaid Population between 0-300 percent of the FPL: Oklahoma proposed in the Concept Paper to change the way consumers receive subsidies. First, the Concept Paper

proposes to redistribute federal subsidy dollars from individuals between 100-400 percent of the Federal Poverty Level (FPL) to individuals between 0-300 percent FPL. This assumes that federal funds will be available to cover those who are currently eligible for, but not receiving, advance premium tax credits (APTCs). This is a significant assumption that will require negotiation with the federal government. In addition, eligibility for subsidies will also take into account affordability of other coverage available to the individual and their family.

As the possible design of such a program was considered, we acknowledged that the enrollee cost-sharing requirements for the under 100 percent FPL, “gap population” needed to be nominal. As such, we contemplated multiple cost-sharing arrangements for offering subsidized insurance to the “gap population” and, in each case, opportunity for enrollment gains were significant. Oklahoma’s uninsured “gap population” consisted of approximately 210,000 individuals in 2015.² We have observed that making a new premium subsidy program available to this population has potential to result in significant enrollment gains; however, the costs of making such a program available are similarly significant. As this solution phases out subsidies to the higher income population (300-400 percent of FPL), there are some savings accrued toward subsidizing the new population with income below 100 percent of FPL. However, the gains in enrollment due to a new premium subsidy program for the “gap population” are likely to result in program costs above the anticipated status quo baseline federal funding.

Determining the ideal program design for adjusting the window of APTC and cost-sharing reduction (CSR) eligibility will require significant additional research. Setting member premiums and cost-sharing for the very low income “gap population” would require a careful balance of individual affordability—to bring in good risk (i.e., infrequent utilizers of health care services)—and personal responsibility. Furthermore, the rate setting for this population and coverage of program costs above the anticipated status quo of baseline federal funding is likely to require negotiations with federal regulators. However, we remain encouraged by overtures that the Trump Administration has made to states to consider leveraging new flexibility under existing waiver programs.³

The most significant operational consideration for this solution is whether an approach that redistributes subsidies from the 100-400 percent FPL group to the 0-300 percent FPL group would meet the coverage and affordability requirements of a Section 1332 Waiver. In order to gain federal approval under current law, a Section 1332 Waiver must cover a comparable number of people as were covered in the absence of the waiver, and must be forecast to be as affordable overall for state residents as coverage absent the waiver. If individuals between 300 and 400 percent of FPL are no longer eligible for subsidies, even with decreases in premiums across the individual market because of other reforms, coverage may be less affordable to them. As a result, fewer people may receive coverage. Oklahoma will need to examine whether this approach will meet current federal guidelines, and whether CMS would consider allowing the state to consider federal savings from not expanding Medicaid under the ACA to

² Milliman (September 2015). "Oklahoma State Innovation Model Insurance Market Analysis" *Prepared for the Oklahoma State Department of Health – Center for Health Innovation and Effectiveness*

³ HHS Secretary Tom Price, MD (March 2017). Letter to State Governors (Available here - https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf)

offset program costs for making this eligibility shift. Because Oklahoma’s proposal is not one that was contemplated in the ACA, Oklahoma will need to continue conversations with CMS on the degree of the federal agency’s flexibility. It is likely that other states that are losing carriers in the marketplace are also exploring federal flexibility, and CMS may be willing to make changes to sub-regulatory guidance and procedures to increase flexibility for states.

In modeling the impact of the proposed solutions, Leavitt looked at this change in concert with the reinsurance program, and the key takeaways were as follows:

- 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-marketplace and middle-income populations; however, the very lowest income consumers (to whom the premium assistance program is expanded) are unlikely to realize any benefit from a reinsurance program due to the format for subsidy calculation under the ACA (i.e., at the lowest incomes, individuals are limited to paying approximately 2% of their income towards insurance premiums regardless of the base premium amount).
- The introduction of both of these programs in tandem represents a significant expense and the lowering of subsidy eligibility is less likely to save the federal government money, thereby reducing “pass-through” savings that would be available for the program.

Standardizing Subsidies Based on Age and Income: In addition to proposing changes to eligibility requirements for subsidies, Oklahoma proposes to change the way it would calculate the amount of subsidy. Today, under federal law, a combination of the individual’s income and the cost of the second lowest cost silver plan that is available to an individual in his or her service area determines APTC amounts. Oklahoma proposes to simplify this subsidy calculation by using only age and income.

We evaluated several formats for calculating age and income-based subsidies and found that there is a wide degree of flexibility for how to interpret such a policy reform. Contingent on the priorities of the State, such a program could be used to incentivize greater enrollment among specific aged populations, provide greater assistance to very low income populations, or be used to complement other reforms being considered (i.e., 5:1 age band limit or alternate standardized insurance products). Our analysis compared several formats for calculating a premium subsidy based on age and income. We observed that reconstructing the premium subsidies to enhance affordability for any target group is likely to improve enrollment for that group.

There are numerous ways the state could redesign premium subsidies according to age and income. The enrollment goals and priorities would drive the ultimate design of such a subsidy format. In addition to the opportunities for new enrollment gains among target populations, there are other systemic benefits from moving to an age and income-based subsidy. In today’s market, where premium subsidies are calculated based on premium amounts, there may be less incentive for insurance carriers to keep premiums low and affordable. Alternatively, introducing a fixed subsidy amount based on age and income may encourage insurance carriers to keep premium prices and yearly increases confined to an

affordable range for consumers. In addition, there are likely to be administrative improvements and greater consumer awareness when subsidy availability and eligibility is simplified and the public can better understand these policies.

Oklahoma will need to include any proposed change in the calculation of subsidies in a Section 1332 Waiver application. Making changes to the subsidy calculation through a Section 1332 Waiver would require these changes to meet all requirements of the waiver, including ensuring that coverage is as affordable under the waiver as it is in the absence of the waiver and that a comparable number of people receive coverage. Under current regulations, Oklahoma would also need to take on Marketplace functions in lieu of participating in the FFM in order to implement a change that would require federal administrative modifications.

Leavitt Partners analyzed the impact of implementing a subsidy calculation change as described above with a new reinsurance program and a change in the age band limit. The key takeaways for this combination of solutions include:

- There are a variety of ways the state could redesign premium subsidies according to age and income that will cater to specific populations. Depending on the priorities of the State, such a program could be used to incentivize greater enrollment among specific aged populations, provide greater assistance to very low income populations, or be used to complement other reforms being considered (i.e., 5:1 age band limit or alternate standardized insurance products).
- Establishing a tax credit based on enrollee age and income to completely compensate for premium increases under the 5:1 age band methodology has the potential to be very costly to the state or federal government. This is because the older populations are already subsidized to a great extent in the current market and would be subsidized even more with a 5:1 age band.

In summary, the Task Force and Oklahoma staff identified a set of policy options that have the potential to significantly reduce premiums and increase enrollment. The state has already started work on a reinsurance waiver that would make a significant short-term impact. The federal government has indicated it is receptive to such an approach, and it has the potential to set a foundation to enhance additional changes in the future. Other proposed solutions would likely magnify the positive impact, but some of these, such as changing the distribution of subsidies and the design of health plan offerings, will need significant further analysis in the coming month.