HEALTH MANAGEMENT ASSOCIATES

LEAVITT PARTNERS

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

PREPARED FOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
BY

HEALTH MANAGEMENT ASSOCIATES
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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

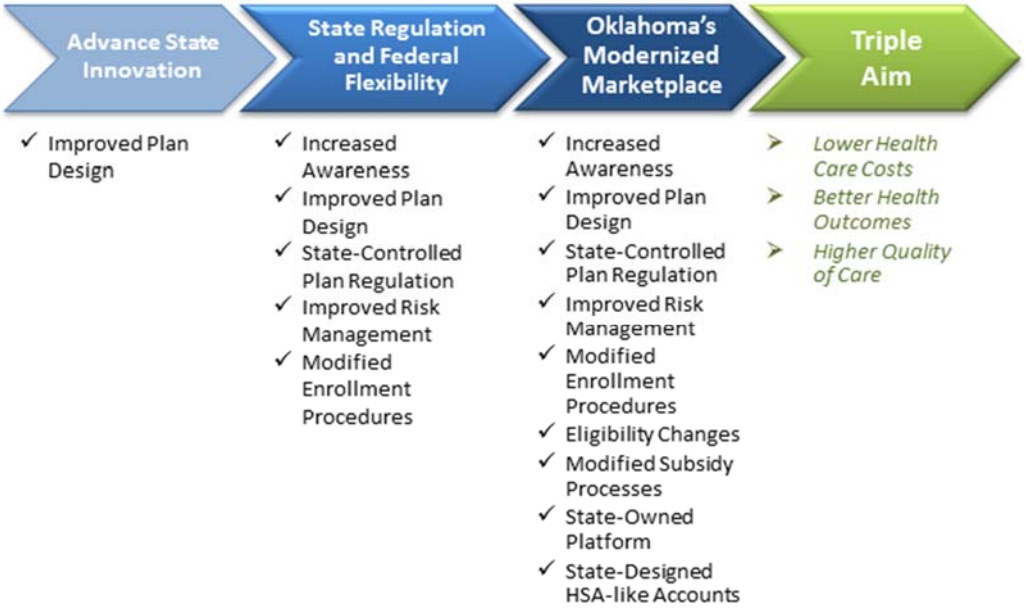
The Task Force Concept Paper served as a very important public artifact of the Task Force process, as well as a tool for gathering feedback on ideas. From the development of the initial Concept Paper to the publication of the final Concept Paper in March 2017[1], OSDH engaged deeply with Task Force members 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 months.

Introduction and Background

Context for this Report

Oklahoma has been focused on addressing its healthcare challenges and building on areas of strength for several years. The state concluded its State Innovation Model design grant in March 2016 with a report to CMS that highlighted problems and identified proposed changes to the way publicly financed health care is paid for and organized.[4] A September 2015 report by the actuarial and consulting firm Milliman for the Oklahoma State Department of Health (OSDH) noted that between 2013 and 2015, 113,400 fewer residents were uninsured, while the individual market grew by an estimated 101,400 lives.[5] However, over half a million Oklahomans (543,800) remained uninsured. In addition, carrier competition has declined, with only one carrier remaining in the Marketplace in 2017.

At the same time, only 31 percent of Oklahomans potentially eligible for premium assistance in the Federally-facilitated Marketplace (FFM) purchased coverage through the Marketplace in 2016. This is significantly lower than the average across other states that did not expand Medicaid (where the take-up rate was 43 percent).

Senate Bill 1386

In 2016, Legislators passed Senate Bill 1386, which authorized the pursuit of a Section 1332 State Innovation Waiver (referred to as Section 1332 Waiver within this report) that would help the state improve Oklahomans' health and access to health care while also containing costs (see Appendix A).[6] The legislation authorized the state to seek a waiver through Section 1332 of the Affordable Care Act (ACA), as well as a waiver through Section 1115 of the Social Security Act.[7] SB 1386 indicated that the Section 1115 Waiver proposal should focus on provider payment incentives for better health outcomes, through the establishment of a Delivery System Reform Incentive Payment (DSRIP) program, an

[4] Oklahoma State Department of Health, State of Oklahoma State Innovation Model (SIM) Design Grant: Oklahoma State Health System Innovation Plan. March 31, 2016. https://www.ok.gov/health2/documents/Oklahoma%20State%20Health%20System%20Innovation%20Plan%20(SHSIP)%20Final%20Draft.pdf. Additional Oklahoma SIM materials are available at: https://www.ok.gov/health/Organization/Center_for_Health_Innovation_and_Effectiveness/Oklahoma_State_Innovation_Model_(OSIM)/

[5] Milliman, *Oklahoma State Innovation Model Insurance Market Analysis Discussion Draft*. August 2015. https://www.ok.gov/health2/documents/Market%20Effects%20on%20Health%20Care%20Transformation.pdf

[6] Oklahoma Senate Bill 1386. 2016. https://www.sos.ok.gov/documents/legislation/55th/2016/2R/SB/1386.pdf

[7] Section 1332 of the Affordable Care Act allows states to get federal approval to utilize federal and state financing for a state coverage program that differs from a number of the requirements of the law, including premium tax credits and cost sharing assistance, some eligibility requirements, and qualified health plans. Section 1115 of the Social Security Act is the mechanism by which a state may apply to make changes to its Medicaid program in order to test and implement coverage approaches that do not otherwise meet federal program rules.

uncompensated care pool, or both.[8] SB 1386 also authorized the Oklahoma Insurance Department to conduct rate review upon implementation of a Section 1332 Waiver.

Section 1332 State Innovation Waiver Task Force

SB 1386 was motivated by a desire to improve healthcare quality and access in the state while reducing cost, and to better meet the needs of Oklahomans by developing a system that provides more affordable health care options. Given that Oklahoma currently participates in the FFM, the Section 1332 Waiver authorized under SB 1386 provides an opportunity for Oklahoma to develop its own unique program that is responsive to the state's needs.

In addition to authorizing the development of a Section 1332 Waiver, the Act also required the state to consult with private sector and other stakeholders in the development of the Waiver. In response to SB 1386, 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 (see Appendix B).[9]

The Task Force produced a draft Concept Paper for public comment in December 2016. The final Concept Paper, which incorporated input from stakeholders and consultants, was released in March 2017 (see Appendix C). Recommendations developed by the Task Force provide a basis for a Section 1332 Waiver, as well as changes that could be made through statutory, regulatory or other mechanisms. The details of the proposals in the Concept Paper, including the elements to be pursued through a Section 1332 Waiver, are discussed later in this report.

The Task Force includes representatives from insurance carriers, medical providers, consumer advocates, the business community, tribal nations, and insurance brokers. Staff from the Oklahoma Department of Health, the Oklahoma Health Care Authority, the Oklahoma Insurance Department, the Oklahoma Department of Mental Health and Substance Abuse Services, the Employee Group Insurance Division, and the Oklahoma Department of Human Services participated as conveners and advisors to the process (see Appendix D for a complete list of Task Force members). The group's goal was to develop a plan for establishing affordable, high quality healthcare coverage in Oklahoma's commercial insurance market that meets the needs of state residents. The Task Force began meeting in August 2016, and discussed the issues to be addressed by an Oklahoma-based health care solution. These issues included:

- Churn (people moving on and off coverage during the year);
- Low enrollment in the FFM by individuals eligible for financial assistance;
- Costs of premiums and enrollee cost-sharing;

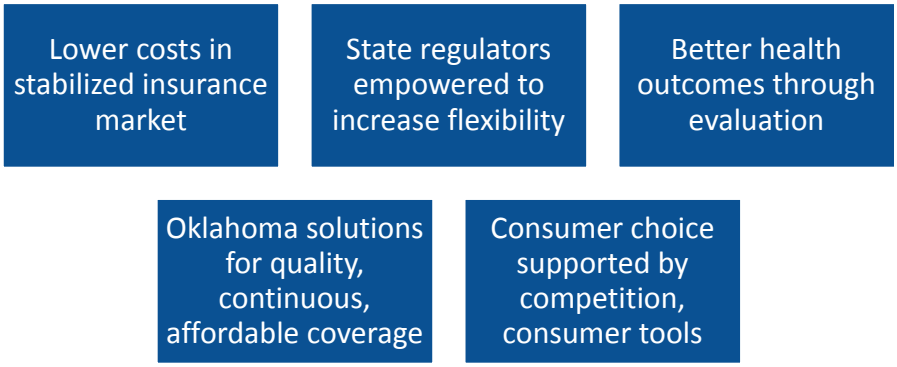
[8] DSRIP initiatives are a type of Section 1115 Waiver program that are used to promote payment and delivery system reforms. A DSRIP can provide the state with funding to support hospitals and other providers as they change how they provide care to Medicaid beneficiaries.

[9] Task Force website: https://ok.gov/health/Organization/Center_for_Health_Innovation_and_Effectiveness/1332_State_Innovation_Waiver_/

- Lack of competition among insurance carriers/limited choice;
- Limited assistance for consumers seeking to access, maintain, and understand coverage;
- Adverse selection (overrepresentation of sicker vs. healthier people in the insurance pool as compared to the general population);
- Ease of enrolling through special enrollment criteria (i.e. with the implication that not all special enrollments are truly justified and that this flexibility contributes to churn) ;
- Regulatory barriers at the state and federal level; and
- Federal plan design requirements.

Using five guiding principles, the group identified solutions that could improve access to and reduce costs of healthcare coverage in Oklahoma. These guiding principles are presented in Figure 1, below:

Figure 1. Guiding Principles Identified by the Oklahoma Section 1332 Waiver Task Force



The Section 1332 State Innovation Waiver Task Force began meeting in August of 2016, and has held another eight meetings since that time. See Table 1 below for the full list of meeting dates and agenda topics.

Table 1. Section 1332 Waiver Task Force Meetings

Meeting Date	Agenda Topics
August 30, 2016	• 1332 Task Force Purpose and Charge • Roles and Ground Rules for Discussion • 1332 Overview, Guiding Principles and Goals • 1332 Considerations, Current Insurance Market Issues • Discuss Task Force Perspectives on Pain Points of Market • Waiver Timeline & Next Steps
September 26, 2016	• Oklahoma Marketplace Overview • 1332 Policy Levers • Data Workgroup Discussions • FFM Problems, Data, and Policy Levers Discussion • FFM Special Enrollment Guidance Update • Waiver Timeline & Next Steps
October 18, 2016	• Data Workgroup Discussions • FFM Problems, Data, and Policy Levers Discussion • Consultant Support and Survey Data • Waiver Timeline and Next Steps
November 15, 2016	• Overview of Provider Survey Results • Discussion of Marketplace Pain Points and Possible Solutions • Next Steps
December 12, 2016	• Overview of Consumer and Business Surveys • Overview of Task Force Responses to Proposed Solutions • Discussion of Marketplace Options • Next Steps
January 24, 2017	• Update on Consumer and Business Surveys • Review of FFM and Uncompensated Care Data • Discussion of Concept Paper and Alignment with Federal Proposals • Discussion of Proposal Timing and Feasibility • Analytical Approach for Impact Analysis • Next Steps
February 21, 2017	• Consumer and Business Surveys: Initial Results • Insurance Market Analysis: Initial Results • Review of Public Comments on Concept Paper • Overview of Tribal Considerations • Discussion of Additional Strategies • Next Steps
April 18, 2017	• Federal Updates • Discussion of Reinsurance and High Risk Pools • Preliminary Impact Assessment of Concept Paper Strategies • Timeline and Next Steps
June 29, 2017	• Results of Solution Modeling • Next Steps

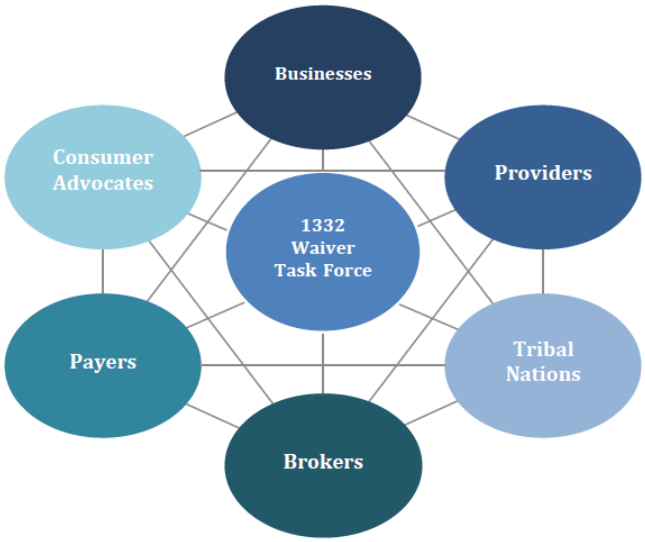
Task Force Participants

The 1332 State Innovation Waiver Task Force is made up of representatives from the following stakeholder groups:

- Consumer Advocates
- Businesses
- Tribal Nations
- Health Plans
- Healthcare Providers
- Health Insurance Brokers

Each of these stakeholders represents a constituent group affected by the outcomes produced by any proposed Section 1332 Waiver. Feedback from each of these groups is valuable in order to ensure that the proposed solutions that would be part of a Waiver application are balanced and consider the viewpoints and concerns of each of these groups. Stakeholder engagement was a requirement of SB 1386 and is also required under federal guidance related to the development of Section 1332 Waiver applications, which underscores the importance of obtaining such advice and feedback throughout the development of a Waiver proposal.

Figure 2. 1332 Waiver Task Force Participants



Task Force Data Groups

The Task Force established four data workgroups to identify, gather, analyze, review and report on relevant data sources informing the Task Force discussions. The four workgroups included health plans, providers, businesses, and consumers. These workgroups were asked to produce a list of data questions, supporting data tables/worksheets, findings and relevant conclusions to be drawn from the data, a report to the Task Force, and case studies of business and consumer experiences. Data workgroups were asked to consider the following discussion questions:

1. What data have your organizations collected to date and from what sources?
2. What do these data tell us about Oklahoma's marketplace?
3. What data are nonexistent or unavailable, and are there other groups who could provide alternatives?

Table 2 provides the members of each workgroup and the questions posed.

Table 2. Section 1332 Waiver Task Force Data Workgroups: Membership and Focus Areas

Data Workgroup	Organization	Potential Topics of Interest
Health Plan	Blue Cross Blue Shield of Oklahoma (BCBS) United HealthCare (UHC) Global Health Community Care Oklahoma Insurance Department (OID) Oklahoma Association of Health Plans (OAHP) Employees Group Insurance Division(EGID) Oklahoma Health Care Authority – Insure Oklahoma) (OHCA-IO) Oklahoma State Department of Health (OSDH)	• Data Question List: metal level enrollment; premium payment; continuity of coverage; special enrollments • Population management: ways to manage high needs patients, educate populous • Claims experience: pent up demand; prevalent conditions/diagnoses; by rating area at population level; comparative review to responses from community forums indicating areas of need
Provider	OHA OSMA OOA Chickasaw Nation Cherokee Nation Integris St. John OHCA OSDH	• Data Question List: bad debt; access and use of preventive care; cost drivers • Medical Director perspective: acuity differences of FFM vs. other coverage; prevalent conditions/diagnoses; hospital discharge by plan/rating area • Q&A on rates, pent-up demand, ways to incorporate value based incentives among FFM plans • Case mix and panel size; how insurance coverage and source of coverage affects these decisions; urban vs. rural
Business	Devon State Chamber OAHU HealthSmart OHCA-IO OSDH	• Data Question List • Business Survey (update to and building off of previous Milliman report) • Interview/Town Hall on business decisions • Case Studies: positive and negative experience • Medical Expenditure Panel Survey and FFM analysis on employer/employee costs; penalty assessment vs. offering coverage trends among businesses
Consumer	Community Service Council (CSC) Community Action Agency (CAA) Health Alliance for the Uninsured (HAU) OHCA-IO OK Department of Human Services (DHS) OK Department of Mental Health and Substance Abuse (DMH) OSDH	• Focus Group Q&A/Town Hall on experiences, possibly hosted by CSC • Case Studies: positive and negative experiences • Data Question List: numbers of enrollments, exception requests, referrals worked by navigators • Process Considerations: barriers to completing enrollment or continuing coverage, e.g. checking account management; stable address to send/reply to correspondence (for renewal); OOP reimbursement requests; mid-year status change reporting

Table 3 summarizes the feedback provided by each data workgroup.

Table 3. Feedback from Data Workgroups

Data Workgroup	Feedback Provided
Consumer Advocates	Jan Figart and others presented on lessons learned from the Claiming Your Coverage initiative and data on the affordability of coverage in the state
Businesses	Presented on an employer client survey that provided information on employer benefits provided to employees nationwide
Commercial Health Insurance Carriers	United HealthCare, Global Health, and Blue Cross Blue Shield of Oklahoma provided information on the following data points: • Enrollment data • Rate of premium payment among enrollees • Number of special enrollment periods requested and performed • Percent of enrollees receiving APTC and CSR • Service expenditure costs for FFM and off-Marketplace enrollees • Utilization trends • Prevalent diagnoses among enrollees • Care management practices • Use of preventive care services by FFM enrollees Blue Cross Blue Shield of Oklahoma also provided information on the state of the market and its experience participating in the Marketplace
Healthcare Providers	Presented results of a 1332 Task Force provider survey answered by 114 Oklahoma providers. An informal email survey was also sent to Oklahoma tribes in September of 2016 as part of the Provider workgroup

The data workgroups identified the need for more formal survey data to inform their work. 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. These efforts are described in the section on Technical Assistance to the Task Force and OSDH later in the report.

1332 Task Force Deliberative Process

Oklahoma state officials fostered a collaborative environment to facilitate the discussion of potential Section 1332 Waiver proposals through the Task Force process. OSDH posted all meeting agendas, presentations, and supporting materials online prior to each meeting. Participants were prompted with discussion questions at each meeting to elicit feedback and were provided materials to review in advance of each meeting. OSDH also held frequent small group meetings with Task Force members and their constituents in order to obtain more robust and complete feedback outside of the Task Force meeting format. In addition, OSDH received written comments and feedback from stakeholders throughout the Task Force process. OSDH also presented Task Force recommendations and the Concept Paper to groups of stakeholders prior to, during, and after the Concept Paper comment period. Some stakeholders requested meetings with OSDH to discuss their comments on the draft Concept Paper, which were later incorporated into the final version.

Section 1332 Waiver

Oklahoma's Task Force was established to help shape a plan to stabilize the individual insurance market. One component of the Task Force's work was to identify changes the State could make with a Waiver

versus those that could only be made through a change to regulations or the ACA. A Section 1332 Waiver allows a state to request federal authority to pursue innovative strategies for providing state residents access to high quality, affordable health insurance.[10] Section 1332 Waivers can be approved for up to five years and are renewable. A state's Section 1332 Waiver proposal may generally include changes to any of the following four areas of the ACA:

- Part I of subtitle D, related to benefits and Qualified Health Plans;
- Part II of subtitle D, related to Marketplaces and associated functions and requirements;
- Section 1402, related to cost-sharing reductions; and
- Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986, related to premium tax credits and the individual and employer mandates.

All Section 1332 Waivers must meet four "guardrails" set forth in the ACA:[11]

1. **Comparability.** Coverage must be available to a comparable number of people as would have been covered in the absence of the Waiver;
2. **Comprehensiveness.** Coverage provided under the Waiver program must be as comprehensive as coverage provided in the absence of the Waiver, i.e. as comprehensive as the Essential Health Benefits that are provided under the current Marketplace program;
3. **Affordability.** Coverage must be as affordable as it is in the absence of the Waiver program; and
4. **Budget Neutrality.** The program must be budget neutral to the federal government.

In addition to publishing regulations regarding Section 1332 Waivers in February 2012, CMS provided additional guidance (sometimes referred to as the "sub-regulatory guidance") in December 2015.[12] The 2015 guidance echoed the 2012 regulations, with special focus on the guardrails described above and clarification of two key points. First, the guidance made clear that a waiver application could not consider savings in Medicaid due to a Section 1115 waiver to offset costs in another program for purposes of meeting the budget neutrality requirement. Second, it clarified that any increase in federal administrative costs as a result of the proposed waiver must also be considered in the budget neutrality calculation. In July 2015, CMS released a Fact Sheet on the application process and a Frequently Asked Questions document.[13]

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[10] CMS Center for Consumer Information and Insurance Oversight, *Section 1332: State Innovation Waivers*. https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-.html

[11] Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Application, Review, and Reporting Process for Waivers for State Innovation*. 45 CFR Part 155. Published in the Federal Register, Vol. 77, No. 38, February 27, 2012. https://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf

[12] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *45 CFR Part 155 Guidance*. Published in the Federal Register, Vol. 80, No. 241, December 16, 2015. https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf

[13] CMS, *Frequently Asked Questions about the 1332 State Innovation Waivers*. https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-

In May 2017, CMS provided a Section 1332 Waiver checklist that includes information on: federal review timelines; public notice and tribal consultation requirements; the requirements for state authorizing legislation; the detail required on the ACA provisions to be waived; requirements for actuarial and economic analyses, data and assumptions; implementation timelines, and reporting targets.[14] The CMS site also includes links to the applications from and correspondence with states that have submitted Section 1332 Waiver requests.[15],[16]

An approved Section 1332 Wavier gives a state access to federal funds that would otherwise be spent on premium tax credits, cost sharing reductions and/or small business tax credits for program participants. The state can use these funds to support programs planned under the Waiver.

Before submitting a Section 1332 Waiver request, the state must provide an opportunity for public input (including but not limited to holding public hearings, consulting with Tribes, and providing a 30 day notice and comment period). The application must include actuarial and economic analyses that provide evidence that the Waiver program will comply with the four "guardrails" and other requirements set forth in regulations and guidance, and include data and assumptions to support these analyses. The Waiver application also requires a ten-year budget that shows federal budget neutrality, the state legislation enacted to support the proposal, and a detailed plan and timeline for how the Waiver will be implemented.

Environmental Scan

In 2015, Milliman conducted an insurance market analysis for the OSDH Center for Health Innovation and Effectiveness (see Appendix E). The analysis was completed as part of Oklahoma's State Innovation Model Design Grant and provides information related to the market effects of the ACA on the state's insurance markets and citizens. A summary of the analysis is provided below.[17]

Oklahoma Geography and Population

Oklahoma's population was 3,923,561 as of July 2016.[18] About a quarter of the population are under age 18. The age breakdown is shown in Table 4 below:

waivers/section_1332_state_innovation_waivers-.html#Frequently Asked Questions about 1332 State Innovation Waivers

[14] CMS, *Checklist for Section 1332 State Innovation Waiver Applications, including specific items applicable to High Risk Pool/State-Operated Reinsurance Program Application*s. May 11, 2017. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf

[15] CMS, *About the 1332 State Innovation Waiver Application Process*. https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-.html#About the 1332 State Innovation Waiver Application Process

[16] Section 1332 State Innovation Waiver Applications. https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-.html#Section 1332 State Waiver Applications

[17] Milliman, op cit.; Oklahoma State Department of Health, op cit.

[18] U.S. Census Bureau, *Quick Facts: Oklahoma*. 2015 is the latest year for which data are available.

Table 4. Oklahoma Residents by Age, Percent of Population (2015)[19]

Age	Percent of Population
0 to 5 years	6.9%
5 to 19 years	20.6%
20 to 39 years	14.3%
40 to 49 years	12.2%
50 to 59	13.3%
60 to 74 years	13.8%
75 years and over	6.1%

Table 5 shows the state's race and ethnic make-up.

Table 5. Oklahoma Residents by Race and Hispanic Origin (2015)[20]

Race and Hispanic Origin	Percent of Population
White	74.8%
Black	7.8%
American Indian or Alaska Native	9.1%
Asian	2.2%
Native Hawaiian, Other Pacific Islander	0.2%
Two or More Races	6.0%
Hispanic/Latino	10.1%

Over 350,000 American Indian and Alaska Native (AI/AN) individuals live in Oklahoma. There are 39 tribal governments in Oklahoma, 38 of which are federally recognized. The 38 federally recognized Indian tribes produce an estimated $10.8 billion impact on Oklahoma's economic output.[21]

Statewide, the median household income was $48,568 in 2015.[22] While this represents a 6.2 percent increase from three years prior, it was also $7,207 lower than the national median. The average per capita income in Oklahoma was $25,032 in 2015.[23] Table 6 shows income by quintile in the state:

Table 6. Income Ranges for Oklahoma Residents by Quintile[24]

Quintile	Income Range (2016 data)
Lowest Income Quintile	$0 - $20,169
Second Income Quintile	$20,170 - $37,917
Third Income Quintile	$37,918 - $59,598
Fourth Income Quintile	$59,599 - $92,775
Highest Income Quintile	$92,776 and up

[19] U.S. Census Bureau, *Community Facts: Oklahoma*. 2015. The Census Bureau compiles and releases data are from the American Community Survey, 2011-2015 estimates.
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
[20] Numbers do not sum to 100% due to rounding. Hispanic/Latino identification is asked separately from race.
[21] Steven C. Agee Economic Research & Policy Institute at Oklahoma City University.
[22] U.S. Census Bureau, American Community Survey. 2015. https://www.census.gov/programs-surveys/acs/
[23] U.S. Census Bureau, *Quick Facts: Oklahoma.*
[24] American Community Survey. 2016

Health Insurance Coverage by Sector

Between 2013 and 2015, Oklahoma's individual health insurance market grew by 101,400 lives and the number of uninsured residents dropped by 113,400. As of 2015, 3,900,200 Oklahomans were distributed across payers as shown in Table 7:

Table 7. Oklahoma Residents by Source of Health Insurance Coverage[25]

Market Segment	# of Participants
Self-Funded Group	854,500
Medicaid/CHIP (including dual eligibles)	826,700
Uninsured	543,800
Medicare (excluding dual eligibles)	504,200
Large Group Market	493,200
Individual Market	223,500
Public Employee and Retiree Coverage[26]	184,500
Small Group Market	177,300
Dual Eligibles (Medicare and Medicaid eligible)	110,500
Other Public Programs	92,500

Urban residents account for 71.6 percent of the state's population. Urban and rural residents differ in their insurance coverage, with 45 percent of the urban population covered by employer-based health insurance, compared to 39 percent in rural areas of the state.[27] Government-sponsored coverage, including Medicare, Medicaid, and other coverage programs, cover 36 percent of urban Oklahomans and 41 percent of rural residents. The number of uninsured individuals decreased in both urban and rural areas of the state between 2013 and 2015. In its analysis, Milliman found the change in uninsured lives over this period did not differ between urban and rural areas.

Among individuals living in households with income below 100 percent of the federal poverty level (FPL), 23 percent are uninsured and 52 percent are enrolled in Medicaid.[28] Almost 13 percent of this population have employer-sponsored insurance (ESI), while only one percent of the lowest income Oklahomans purchase individual insurance on the commercial market. Table 8 shows the percent uninsured by household income in 2015.

[25] Milliman, op cit. Values are rounded.

[26] Coverage for current and former public employees is managed by the Office of Management and Enterprise Services, Employees Group Insurance Department (EGID). EGID administers, manages and provides group health, dental, life and disability insurance for current and former employees of state agencies, school districts and other governmental units of the State of Oklahoma.

[27] Milliman, op cit.

[28] Milliman, op cit. The 2017 federal poverty level for an individual is $11,880. 100% FPL is $24,300 for a family of 4.

Table 8. Oklahoma Residents, Percent Uninsured by Household Income[29]

Household Income	Percent Uninsured
$0 - $25,000	21.7%
$25,000 - $49,999	18.1%
$50,000 - $74,999	13.0%
$75,000 - $99,999	10.2%
$100,000 and over	5.9%

Table 9. Oklahoma Residents, Percent Uninsured by Percent of Federal Poverty Level[30]

Percent of Federal Poverty Level	Percent Uninsured
Below 138% FPL	24.3%
138% – 199% FPL	18.8%
200% – 399% FPL	12.5%
400% FPL or above	5.2%

As income rises, so does the likelihood that someone will have ESI coverage. Among Oklahomans in households with income above 250 percent of the FPL in 2015, 68 percent were enrolled in ESI.[31] In its comparison of 2013 and 2015 data, Milliman found no loss of employer-based coverage related to the ACA.

The uninsured rate varies by race in Oklahoma. Table 10 provides information analyzed by the State Health Access Data Assistance Center (SHADAC) based on 2015 American Community Survey (ACS) data.

Table 10. Oklahoma Residents, Percent Uninsured by Race/Ethnicity[32]

Race or Ethnicity[33]	Percent Uninsured
White non-Hispanic	9.9%
Black/African American	16.8%
American Indian or Alaska Native	27.7%
Asian	11.8%
Native Hawaiian or Other Pacific Islander	23.0%
Some other race	32.9%
Two or more races	16.4%
Hispanic/Latino of any race	27.6%

[29] State Health Access Data Assistance Center (SHADAC), *Uninsurance Rates for Oklahoma in 2014 and 2015.* http://www.shadac.org/sites/default/files/state_pdf/aff_s2701_OK_2014_2015.pdf Information is provided by household unit and is not adjusted for household size.
[30] SHADAC, op cit.
[31] Milliman, op.cit..
[32] State Health Access Data Assistance Center, op cit.
[33] Race categories are defined as single race, with the exception of the "two or more races" category. Individuals self-identifying as Hispanic or Latino residents may have identified as any race. White residents have an uninsurance rate of 11.3% when individuals who identify as both White and Hispanic/Latino are included.

Existing Data and Market Trends of the Marketplace

Oklahoma faces a number of health care challenges, including a high uninsured rate and relatively low median income compared to the nation. While individual coverage throughout the state has grown since the ACA became law, as of 2015, 17 percent of Oklahomans still lacked insurance.[34] The state's uninsured rate was higher than the 2015 national rate of 11.2 percent.[35] Among states that expanded Medicaid, the average rate of uninsured is 8.7 percent, as many low income residents of these states gained coverage through the expansion.

Since implementation of the ACA in 2010, Oklahoma's uninsured rate among non-elderly adults has decreased by 24.2 percent, compared to 38.4 percent nationally.[36] The greatest coverage gain was seen for individuals with income between 138-199 percent of the FPL.[37] However, just 31 percent of individuals with income between 100-400 percent FPL who were eligible to receive tax credit subsidies chose to purchase coverage through the FFM in 2016.[38] Interviews with stakeholders indicate that the cost of insurance premiums is a leading reason that people remain uninsured.[39]

Despite coverage gains in the individual market, the state experienced volatility in the commercial insurance market. Prior to the ACA, Blue Cross Blue Shield of Oklahoma (BCBS OK) covered the majority of individual market and group coverage enrollees. In 2014, BCBS OK insured more than 500,000 lives, while CommunityCare and UnitedHealthcare each insured more than 100,000 lives. Across the fully insured market (individual and group coverage, excluding lives covered by self-insured employers), six carriers held a large portion of total covered lives:

Table 11. Lives in Oklahoma's Fully Insured Markets, by Insurance Carrier (2014)[40]

Insurance Carrier	Fully Insured Lives
BCBS of Oklahoma	531,500
UnitedHealthcare	136,600
CommunityCare	127,500
Aetna	67,000
Global Health	41,500
Humana	29,100

[34] Bowen Garrett and Anuj Gangopadhyaya, *Who Gained Health Insurance Coverage Under the ACA, and Where Do They Live?* Urban Institute. December 2016. http://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf

[35] Ibid.

[36] Ibid.

[37] Milliman, op cit.

[38] The Henry J. Kaiser Family Foundation, *Marketplace enrollment as a share of potential marketplace population* March 31, 2016. http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/?currentTimeframe=0

[39] Presentation materials, September 26, 2016 Task Force meeting.

[40] Milliman, op cit.

Individual coverage through the Marketplace was similarly lopsided. In 2015, BCBS OK had over 97 percent of the enrollees through the Marketplace, with Global Health, CommunityCare, and Time/Assurant together making up less than 3 percent of covered lives.[41] BCBS OK's market dominance increased over time, and Milliman estimated that the carrier served over 90 percent of individuals with coverage through the FFM in 2015. Aetna did not offer individual market coverage after the 2014 plan year, while UnitedHealthcare exited at the end of 2016 after one year offering coverage through the Marketplace. Global Health also left after 2016. Humana did not participate in the individual market.

In 2016, only BCBS OK and CommunityCare participated in the FFM. In 2017, BCBS OK is the only insurer offering coverage in Oklahoma's individual Marketplace. Adding to this volatility, BCBS OK received rate increases of between 58 percent and 96 percent for the 2017 plan year, resulting in a 76 percent average increase for the plans it offered on the FFM in the 2016 coverage year. This brought Oklahoma's rates, previously lower than the national average, up to a comparable level with other states.[42]

Table 12: Health Insurance Carriers Participating in the Marketplace

Health Insurance Carrier	2014	2015	2016	2017
Aetna	X	-	-	-
Blue Cross and Blue Shield of Oklahoma	X	X	X	X
CommunityCare of Oklahoma	X	X	-	-
Coventry Health and Life	X	-	-	-
Coventry Health Care of Kansas, Inc.	X	-	-	-
GlobalHealth	X	X	-	-
UnitedHealthcare of Oklahoma, Inc.	-	-	X	-

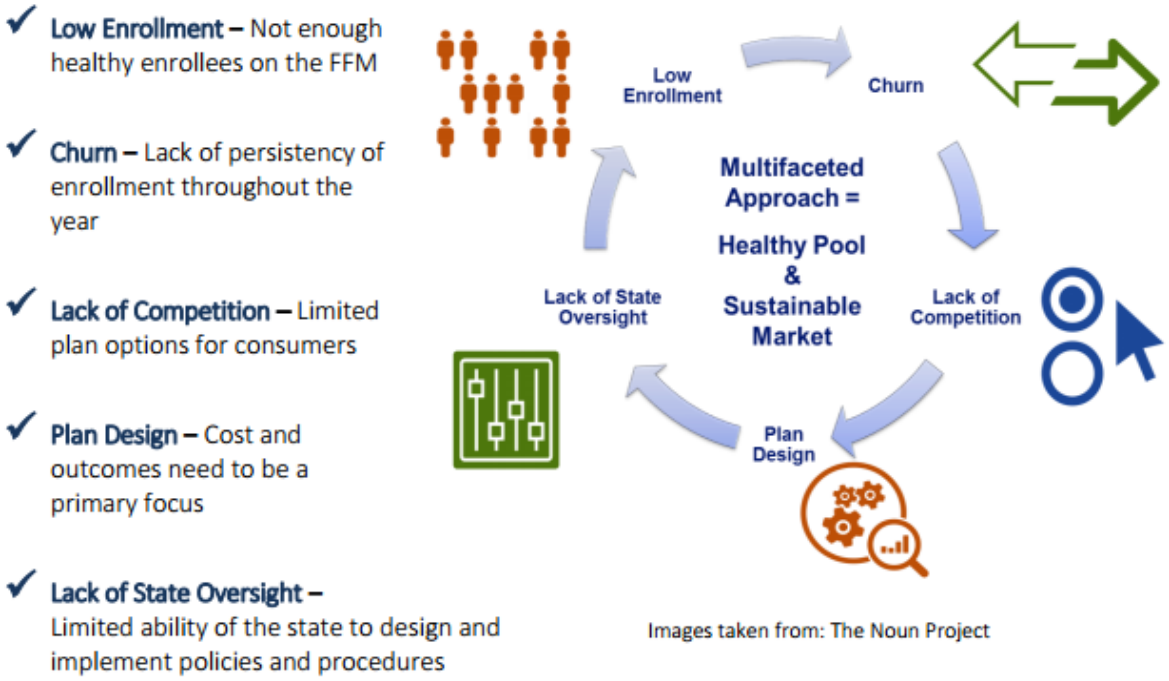
Pain Points in Oklahoma's Health Insurance Market and their Impact

The Task Force Concept Paper included five "pain points" that are creating challenges in the Oklahoma individual market.

[41] Louise Norris, *Oklahoma health insurance marketplace: history and news of the state's exchange.* March 31, 2017. https://www.healthinsurance.org/oklahoma-state-health-insurance-exchange/

[42] https://pay.apps.ok.gov/triton/modules/newsroom/newsroom_article.php?id=157&article_id=26028

Figure 3. Oklahoma Individual Market Issues



The challenges facing Oklahoma's health insurance market include low enrollment in the FFM, especially by those eligible for premium tax credits, the number of enrollees who do not maintain coverage throughout the year, and a lack of carrier competition. In addition, plan design requirements may not sufficiently emphasize cost-effectiveness or incentivize health outcomes, and the state has limited ability to develop and administer commercial market policies and procedures in the FFM.

Low Enrollment. Only 31 percent of individuals eligible for a premium tax credit signed up for coverage through the FFM in 2016. Many of those who did not enroll are younger and would help reduce overall risk to the insurance pool.

Churn. Not all enrollees stay enrolled for the entire plan year, which challenges insurers' ability to manage risk. FFM data show decreased enrollment in the third and fourth quarters of 2014, which may be due to the end of the required 90 day grace period for premium non-payment, leading covered individuals to be dropped for not paying for their coverage.[43] Other individuals drop coverage when they become eligible for Medicaid or gain access to employer coverage.

Lack of Competition. While there were several carriers in the individual market at the start of the FFM, BCBS OK had over 90% market share in the individual market, and eventually other carriers left the state's individual market. As in other states, higher than expected utilization was also an issue for carriers, as was the reduction in funding for federal risk mitigation programs.

[43] Milliman, op cit. CMS recently implemented a rule change that gives Insurers more flexibility to deny re-enrollment until past premiums are paid by the enrollee.

Plan Design. Carriers are bound by a set of requirements that impact costs and set a floor for comprehensiveness of coverage, which limits flexibility in plan design.

Limited State Oversight. As a participant in the FFM, the state is limited in its ability to design market rules to reduce costs and increase value for consumers. As a FFM state, Oklahoma's Marketplace plans are reviewed and approved by CMS, which assesses the plan elements and determines compliance with ACA requirements. Also, the state does not currently conduct rate review.

Interacting Factors Compound Impact

The impact of these challenges is magnified by the fact that each challenge interacts with the others. Individuals with medical needs continue to enroll, which increases costs, leading to increased premiums. A small individual market and high costs pushes carriers out of the market, and a lack of competition reduces the remaining carrier's incentives to find ways to manage price increases. The state currently does not have the authority to change market rules that could impact one or more of the levers affecting price. Also causing problems is the lack of consumer supports to navigate the complex system. Infrastructure to provide education and assistance to help consumers determine the right coverage is limited in Oklahoma.

At present, the cost of coverage affects both low and middle-income consumers. As noted previously, individuals with income below 100 percent FPL are not eligible for premium tax credits.[44] The price of coverage is hard to manage for a low-income individual or family, and this hardship is magnified as premiums continue to rise in the state. For Oklahomans at 300 percent FPL, there are other challenges as well. An individual making just over $36,000 is eligible for some premium assistance, but pays up to 9.7 percent of their income on premiums ($3,500/year) and faces deductibles of $1,600 to $5,200 per year.[45]

Technical Assistance to the Task Force and OSDH

Previous Research and Ongoing Projects

OSDH has received technical assistance and research services from four contractors in recent months that have supplemented the efforts of the Task Force. A brief summary of these efforts is provided below.

Evolve and VI Marketing and Branding

Evolve Research and VI Marketing and Branding conducted consumer and business research projects for OSDH. The goal of the consumer work was to understand why the FFM did not have more enrollment and why residents remain uninsured. They sought to understand 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.

[44] Oklahoma 1332 Waiver Task Force, *A New Horizon: Recommendations for Oklahoma's Modernized Health Insurance Market*. March 2017. An individual at 138% FPL earns $16,642 a year; a family of four has annual household income of $33,948.

[45] For a family of four: 300% FPL = $73,800, premium share is $7,151, and deductibles range from $4,400-$11,400.

Consumer Research. Researchers conducted 16 focus groups and 40 in-depth telephone interviews with over 160 total participants. Focus groups were held in both urban locations (Tulsa, Oklahoma City), and rural areas (McAlester, Enid). Participants were individuals at or below 400 percent FPL who have visited healthcare.gov (those who signed up and those who did not), have employer-based or individual coverage, or are uninsured.

Respondents indicated that insurance is expensive and difficult to understand. Many people were unsure what 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. Individuals who used healthcare.gov were motivated by the subsidy. When asked how to increase insurance coverage, responses followed three main themes:

Figure 4. Consumer Feedback: How to Encourage Purchase of Health Insurance

Respondents were asked how much an affordable health plan would cost. Uninsured respondents said $50-150/month, while those who had visited healthcare.gov (whether or not they purchased through it) said $150-200, and individuals with other private coverage said $200-400. The means that, without a subsidy or employer contribution, insurance is largely unobtainable for the participants.

Employer Research. The business research focused on employers with 1-24, 25-49, and 50 or more employees. The employer work included an online survey, similar to an instrument fielded in 2014, and was administered to approximately 300 employers, as well as 65 in-depth telephone interviews. 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 mention the cost of health insurance is most burdensome for their business. Thirty percent of employers indicated they have added a High Deductible Health Plan in response to rising costs of health insurance.

Although 69 percent of employers offer health insurance to employees and family members, three out of four do not provide any financial contribution towards dependents. Ninety-three percent of employers pay at least 25 percent of employee premiums, and 67% percent contribute at least 50 percent. Only five percent do not offer employee insurance. Companies with an average workforce age of 41 or older are more likely to report that 81-100 percent of employees are covered than those with an average of 40 or younger.

Milliman

In its SIM analysis, Milliman assessed Oklahoma's FFM profile and the populations in its insurance market. The information presented in February 2017 was based on publicly available information provided by the federal government.[46] Milliman found 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, which along with employment gains 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.

Milliman estimates that the movement of the previously uninsured into individual Marketplace coverage plateaued in 2016. Thirteen percent of 2016 FFM enrollees were previously in other private coverage, while 7 percent were former Insure Oklahoma participants.

Most FFM enrollees purchased silver or bronze plans, while no one bought a platinum plan, and only 100 people enrolled in a catastrophic plan in 2016. While the percentage of eligible individuals who enroll in the FFM is below the national average, Oklahoma's growth in FFM participation was higher than the nation between 2015 and 2016.

Premium assistance has a large impact on what Oklahoma's FFM participants pay for coverage. The 2016 average premium was $376/month. After premium tax credits are applied, the average consumer share is $80, which is a 79 percent reduction from the total cost. Because of the premium subsidies, consumers receiving premium assistance did not pay more for coverage between 2014 and 2016 even though the total cost of premiums rose.

The majority of plans purchased on the FFM have a deductible of over $6,000/year. All bronze plans have out-of-pocket maximums of over $6,000 for an individual. Silver plans have more variation, though most have significant cost sharing and out-of-pocket maximums over $6,000.

In 2013, only three carriers had positive profit margins in the individual market. This number dropped to two in 2015, and one in 2016. Over this period, BCBS OK had significant gains in market share, but also experienced large financial losses. Losses were impacted by the lack of federal funding for the risk corridor program established under the ACA. BCBS OK also had financial gains in the small group market, which experienced less overwhelmingly negative profit margins across carriers.

Actuary Procurement

In April 2017 OSDH released a Request for Proposals (RFP) for the development of the actuarial certification and validation to support a series of Section 1332 Waivers and other healthcare proposals. The State has selected Milliman to conduct actuarial and economic analyses to help ensure a Section 1332 Waiver proposal meets current Waiver guardrail requirements for comparable coverage, affordability, comprehensiveness, and deficit neutrality.

[46] Milliman presentation, op cit.

Role of HMA and Leavitt Partners as Consultants to OSDH

In November 2016, the Oklahoma Office of Management and Enterprise Services, on behalf of the OSDH, released an RFP seeking proposals to provide health care policy, program, strategy and data consultation to help the state as it conducted analyses and planning in preparation for a possible Section 1332 Waiver proposal to CMS. Health Management Associates and its subcontractor Leavitt Partners were awarded the contract for this work in December 2016 and began assisting the state in January 2017.

The HMA/Leavitt Partners consulting team aided with preparations for Task Force meetings, solution modeling, 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.

Federal Landscape

Assumptions and the Shifting Federal Landscape

The consultants' work conducted to date took place during 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.

While the final outcome of federal efforts to amend or replace the Affordable Care Act is unknown, the current House bill supports ongoing state flexibility, and nothing in the legislation implies that states would have restricted ability to receive Waivers to implement innovative programs. In addition, the current Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma is considered the architect of Indiana's alternative market-based Medicaid expansion program. Indiana implemented its expansion by using Medicaid funds to provide a benefit package modeled after a high-deductible health plan and health savings account. On March 13, HHS Secretary Tom Price, in partnership with the Department of Treasury, sent a letter to state governors indicating that HHS would give states the

flexibility to develop innovative healthcare models that meet their residents' needs.[47] The letter highlights the use of Section 1332 Waivers to pursue reinsurance programs, promoting Alaska's application as an example of a state effort. The following day, CMS Administrator Verma and Secretary Price issued a letter to governors affirming the partnership between states and the federal government for Medicaid, and encouraging state innovation in program design.[48]

Impact of Evolving Policies

At present, the ACA continues to be federal law, but it is unclear whether parts or all of the law will be repealed and/or replaced by a new law. States developing Section 1332 Waiver applications are watching the federal process to understand the context for their efforts, while also proceeding with Waiver development under the current law and regulations. It is also unclear to what degree CMS may expand flexibility under the Section 1332 Waiver program in sub-regulatory guidance.

Federal Legislative Action

During the first half of 2017, Congress engaged in ACA repeal and replace discussions. After several proposals, including those by Representative Ryan, Representatives Coburn and Hatch, and Senators Cassidy and Collins, the House of Representatives passed the American Health Care Act (AHCA) on May 4, 2017.[49] See Appendix F for a summary of Federal proposals.

During the discussions leading to the House vote, several amendments were adopted in efforts to attract sufficient votes for passage. The version passed by the House was scored by the Congressional Budget Office (CBO) on May 24, 2017.[50] CBO estimated that the reform efforts would decrease the federal deficit by $119 billion between 2017 and 2026 and reduce the number of Americans with insurance coverage by 23 million, among other impacts.

The House's passage of the AHCA moves the debate to the Senate. A work group of Republican Senators has been meeting regularly and has released a draft of its proposal entitled the Better Care Reconciliation Act (BCRA).[51] It is not yet known what the Senate's final legislation will look like, but where it differs from the House version, members of the two chambers will have to meet in conference committee to agree on a single bill that gets through both chambers.

The AHCA passed by the House and the draft BCRA proposed by the Senate differ from the ACA in several key respects. Table 12 provides comparative information on key elements of the legislation.

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[47] Letter from HHS Secretary Tom Price to U.S. Governors regarding HHS support for state flexibility. March 13, 2017. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf

[48] Letter from HHS Secretary Tom Price and CMS Administrator Seema Verma to U.S. Governors regarding Medicaid. March 14, 2017. https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf

[49] H.R.1628, American Health Care Act. https://www.congress.gov/bill/115th-congress/house-bill/1628/text

[50] Congressional Budget Office and Joint Committee on Taxation, estimate of the direct spending and revenue effects of H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives. May 24, 2017. https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf

[51] Better Care Reconciliation Act Discussion Draft: https://www.budget.senate.gov/imo/media/doc/SENATEHEALTHCARE.pdf

Table 13. Comparison of American Health Care Act and Affordable Care Act Provisions

Provision	American Health Care Act (Version Passed by House)	Better Care Reconciliation Act of 2017 (Version Passed by the Senate)	Affordable Care Act
Premium assistance	Set subsidies (tax credits) based on age	Premium tax credits based on household income, age and cost of benchmark plan. Tax credit based on median-cost plan in enrollee's rating area with benefits actuarially equivalent to 58% AV of EHBs	Premium tax credits based on household income and the cost of benchmark plan that is adjusted for age; limit premium share to a percent of income
Eligibility for premium assistance	• Citizens and documented immigrants not incarcerated or eligible for employer plan, Medicare, Medicaid or CHIP, TRICARE • Full credit up to $75,000, partial credit above that	• Citizens and "qualified" immigrants (smaller group than documented immigrants) not incarcerated or eligible for an affordable employer plan, Medicare, Medicaid, CHIP, TRICARE • Eliminates 5-year waiting period for immigrants • Eligibility starts at state Medicaid limit, is capped at 350 percent of FPL	• Citizens and documented immigrants not incarcerated or eligible for an affordable employer plan, Medicare, Medicaid or CHIP, TRICARE • Citizens and documented immigrants above 100 percent FPL, up to 400 percent FPL, or 138 percent up to 400 percent if a state expanded Medicaid
Cost Sharing Assistance	Ends in 2020	Ends in 2020	Based on income, up to 250 percent FPL
Health Savings Accounts	• Increases contribution limits • Both spouses can make catch-up contributions to one HSA in 2018 • Can be used for medical expenses incurred before HSA was established, over the counter meds • Lowering the tax penalty for using an HSA to pay for unqualified medical expenses to 10%, from 20%	• Increases contribution limits • Both spouses can make catch-up contributions to one HSA in 2018 • Can be used for medical expenses incurred before HSA was established, over-the-counter meds • Lowering the tax penalty for using an HSA to pay for unqualified medical expenses to 10%, from 20%	Lower limits on contributions
Age Bands	5:1 default, states may set alternate	5:1 default starting 2019, states may set alternate	3:1 default
Coverage Gap	• Insurer may charge more to individual with coverage gap • State may waive some community rating rules	• Insurer may impose a 6 month waiting period on an enrollee who had a gap in coverage of 63 days or more during the prior 12 months • During waiting period, considered covered, no premiums due or claims paid	• Insurer may not charge more for individual with coverage gap • Community rating

Provision	American Health Care Act (Version Passed by House)	Better Care Reconciliation Act of 2017 (Version Passed by the Senate)	Affordable Care Act
Benefit Design	Essential Health Benefits are default, states may waive starting 2020	Essential Health Benefits are default, states may waive	Essential Health Benefits mandated
Eligibility for Coverage	Guaranteed issue during open enrollment period; may be charged more for pre-existing conditions if there is a coverage lapse	Guaranteed issue during open enrollment period, but insurer may impose 6 month waiting period for coverage gap	• Guaranteed issue • No pre-existing condition exclusions
Special Enrollment Rules	Tightens verification consistent with 2017 regulatory changes	Verification required; can be delayed by waiting period for coverage gap	Verification required
Waivers	Allows Waivers of many provisions, including health underwriting if state has high risk pool or reinsurance program	Section 1332 Waiver can include essential health benefits, actuarial value, and out-of-pocket limits; states can develop alternative approaches, make coverage less comprehensive, increase cost sharing	Section 1332 Waiver within allowed parameters
Marketplace	• Treasury will establish a system to deliver credits, may build on existing system • Federal government will determine tax credit eligibility	Retains State-based Marketplaces and Federally-facilitated Marketplace	State-based Marketplaces or Federally-facilitated Marketplace if a state does not operate a Marketplace
Risk Mitigation	Patient and State Stability Funds, encourages use of reinsurance and high risk pools	• State Stability and Innovation Program with $112 billion federal funding over 9 years, in two buckets: • Short-term funding ($50 billion) for CMS-run reinsurance program, 2018-2021, open to insurers in all states • States may use long-term funding ($62 billion) from 2019-2026 for: state reinsurance programs; high-risk pools; cost sharing subsidies; and direct payments to providers. States must use some funding for reinsurance, requires state match starting in 2022.	Temporary Reinsurance, Risk Corridor, and Risk Adjustment Programs

Provision	American Health Care Act (Version Passed by House)	Better Care Reconciliation Act of 2017 (Version Passed by the Senate)	Affordable Care Act
Individual mandate	No	No	Yes
Medicaid	• Rolls back enhanced FMAP for expansion • Per enrollee capped federal funding, with option for block grants for some populations	• Phases out enhanced FMAP for expansion: 90% in 2020 to regular match by 2024 • Per enrollee capped federal funding, with option for block grants for some populations	States may expand coverage to adults up to 138 percent FPL with higher federal match

Federal Timelines

Timeline for submitting and receiving approval on a Section 1332 Waiver application. When CMS and the Department of Treasury receive a state's Waiver application, they conduct a preliminary review within 45 days to determine whether the application is complete, and provide written notice to the state after this preliminary determination. The notice will either indicate the application is complete or identify what is missing. The next step is for the state to provide public notice and hold a comment period. The Departments work with the state during the process. Within 180 days of the determination of completeness, CMS and Treasury are required to issue a determination regarding Waiver approval. CMS has indicated a willingness to expedite this process in certain cases, including toward the goal of approving Oklahoma's first 1332 Waiver application implementing the Individual Health Insurance Market Stabilization Act prior to the 2018 coverage year.

Other Federal Timelines. While the timelines noted above guide the Waiver review and approval process, election cycles and changes in Congress or federal personnel affect the process and timing for federal approvals. Often in the lead-up to congressional and presidential elections, the administrative process slows down. It is worth keeping federal changes in mind when mapping out the likely timing for Waiver approval.

Other Key Federal Dates. The Children's Health Insurance Program (CHIP) is a joint state-federal partnership that provides health insurance to low-income children. The law was initially established by the Balanced Budget Act of 1997. It was most recently reauthorized for two years in 2015. It will expire in September 30, 2017 if not reauthorized, although services are funded through 2019. The requirement that states continue paying their share for CHIP ("maintenance of effort") runs through September 2019 as well. The maintenance of effort requirement keeps states from changing the program in ways that would limit enrollment.

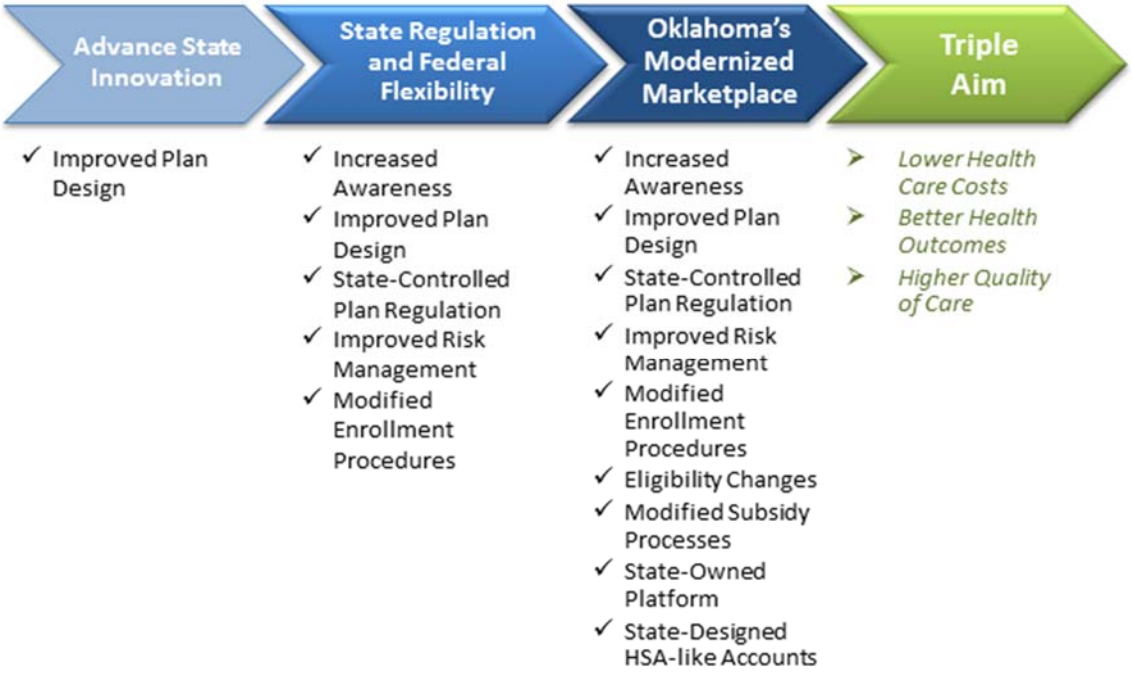
Task Force Concept Paper

As an output of the Task Force process, Oklahoma published a Draft Concept Paper at the end of December 2016. The Draft Concept Paper 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. As recommended in the March Concept Paper, OSDH will likely pursue a sequential approach to implementing policy changes under a 1332 Waiver. The state is under legislative direction to pursue a reinsurance program that would constitute the first 1332 Waiver proposal. This proposal would be followed by broader reforms aimed at assuming the functions of the Health Insurance Marketplace as well as changing the structure of subsidies that are provided to Oklahomans, among other changes.

Figure 5. Marketplace Strategies Roadmap

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



The Draft Concept Paper was presented and reviewed at the January 24, 2016 Task Force Meeting.

Table 14. 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

The Draft Concept Paper was also posted online and shared with Task Force members to obtain public comments within a 30 day timeframe. Task Force members were encouraged to share the paper with their own stakeholders. Additionally, OSDH briefed the state Senate on April 18, 2017 and the House on May 1, 2017. 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 March Concept Paper is the current version and reflects the most up to date recommendations and findings of the Task Force. The March Concept Paper is available for view on the Task Force website and is provided in Appendix C.[52]

Summary of Public Comments Received on the Draft Concept Paper

The Draft Concept Paper was available for public comment for 30 days. During the review period, OSDH received a total of nine public comments and edits. Table 15 lists the commenters on the Draft Concept Paper.

Table 15. Commenters on Draft Concept Paper

Commenter	Date Received
Global Health	1/4/2017
Mercy	1/15/2017
Chickasaw Nation Department of Health	1/22/2017
Oklahoma Health Care Authority	1/24/2017
Oklahoma Nurses Association	1/25/2017
Blue Cross Blue Shield	1/27/2017
DLGM Consulting	1/27/2017
Oklahoma Association of Health Plans	1/31/2017
Devon Energy	1/31/2017

Table 16 below provides a summary of formal public comments received on the Draft Concept Paper. A more detailed summary of public comments can be found in Appendix G.

[52] The March Concept Paper: https://www.ok.gov/health/documents/1332%20Waiver%20Concept%20Paper.pdf

Table 16. Public Comments on Draft Concept Paper

Topic Area	Summarized Comments
Plan Elements: Health Savings Accounts	• HSA concept needs more analysis on financial impact/cost (Consultant, Large Employer) • Concerned HSAs will split risk, with young with high deductible/low cost plans, older with lower deductible/high premium plans (Consultant) • HSAs require well-informed consumers, service/pricing transparency (Consultant) – Support use of HSAs (Insurer)
Plan Elements: Premium Caps	• Premium cap will discourage plan participation (Insurer, Large Employer) • Premium cap will help control health expenditures (Consultant)
Commercial Health Insurance Market	• Oppose requirement for Medicaid MCOs to participate in individual market (Insurer, Insurer Association) • Increase carrier competition (Healthcare Provider) • Was Marketplace competition hurt by carriers offering low premiums, attracting sicker consumers? (Consultant) • How would changes impact small employer marketplace? (Consultant)
Eligibility and Enrollment	• Support continuous coverage, tighter special enrollment requirements (Insurer) • Require full year premium or past premium to re-enter coverage (Large Employer) • Maintain AI/AN provisions from ACA (Tribal Nation) • Support 30 day grace period; pre-effectuation premium payment (Insurer)
Risk Management	• Support improved risk management via reinsurance or high risk pool (Insurer) • Risk adjustment, reinsurance, high risk pools are expensive and complicated to implement and maintain; study further (Consultant) • Support high risk pool (Tribal Nation) • Fund reinsurance via appropriation or broad-based assessment (Insurer) • Using high risk pool to penalize those who don't enroll at open enrollment ignores normal churn due to employment changes (Consultant)

Summary of Changes to Concept Paper

After publishing the initial Draft Concept Paper and reviewing public comments, OSDH developed and published a revised version in March 2017. Several significant changes were made to the Concept Paper in the March version. The most significant changes 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

Tribal Listening Session and Sponsors Choice Workgroup

Oklahoma held a formal Tribal Listening Session on the content of the Draft Concept Paper 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 Waiver, including a review of the contents of the Draft 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 Concept Paper.

Ongoing Refinement of the Task Force Recommendations

Since the March Concept Paper was published, there has been increased focus on moving ahead 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. Other significant changes to the recommendations include the inclusion of more focus on Tribal considerations related to the design of program elements.

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 aims 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.

Data Analysis

Oklahoma contracted with the HMA/Leavitt Partners team to quantitatively compare the impacts and feasibility of a subset of five policy solutions proposed by the Task Force. Through appropriate statistical methods and incorporating qualitative insights about the Oklahoma individual insurance market, Leavitt Partners estimated the impact of the five proposed solutions and what impact combining several different solutions would have on individual market enrollment, premiums, health care costs, and federal spending for the State of Oklahoma. Research findings and outcomes produced from this work have helped the Task Force prioritize solutions for evaluation and resulted in the recommendations included in this report.

Baseline Model Methods and Results

To understand the effects of the policy solutions, Leavitt Partners developed a baseline model for the Oklahoma individual insurance market. This benchmark established a point of comparison that is defined as the status quo and does not assume any policy intervention. The baseline model estimates insurance enrollment, premiums, and subsidy expenditures for Oklahoma's individual health insurance market.

Multiple data sources were compiled and applied to this baseline model to enable longitudinal analysis of trends to project future growth (See Appendix H -Model Sources and Limitations- for a comprehensive list of data sources compiled to support this analysis). We then adopted a two-step approach, layering expert qualitative insights over a baseline quantitative model using appropriate time series methods. This approach was adopted because of the limited access to historical data for the individual markets and substantial policy changes introduced by the ACA.

Enrollment Distribution

Several criteria were applied to effectively model Oklahoma's enrollment experience under the status quo and to develop the enrollment baseline. Enrollment under the status quo was projected for the on-marketplace individual market, off-marketplace individual market, and summed to provide total individual market projections. In addition, on-marketplace enrollment was projected for those receiving Advanced Premium Tax Credit (APTC) and cost-sharing reduction (CSR) subsidies under the baseline. Demographic adjustments were made for on-marketplace enrollment based on detailed information provided by CMS and the Marketplace public use files. This allowed for a breakdown of enrollment by age and income, resulting in more in-depth modeling results.

Premium Revenue Forecasting

Market premiums were set relative to the forecasted medical expense by assuming a constant medical loss ratio (MLR) of 80 percent. Historic incurred claims and medical expenditures were analyzed and forecasted using a variety of time series techniques. Because the model is limited in evaluating the effects that different policy actions will have on the underlying individual market risk pool, a constant medical loss ratio was assumed and used for these analyses. Further analysis is required to address feedback loops that occur by shifting risk as premiums and medical expenses are changed.

Subsidy (APTC + CSR) Forecasting

APTC funding was calculated by projecting the cost of the second lowest-cost silver plan and using this cost to develop the historic ratio of the second lowest-cost silver plan premium price to the average APTC. This allowed for the calculation of an average APTC per enrollee receiving the APTC tax credit. Further refinements were made with data provided by CMS, which allowed for the calculation of the average APTC credit as a function of age and income. Both estimates produced similar results.

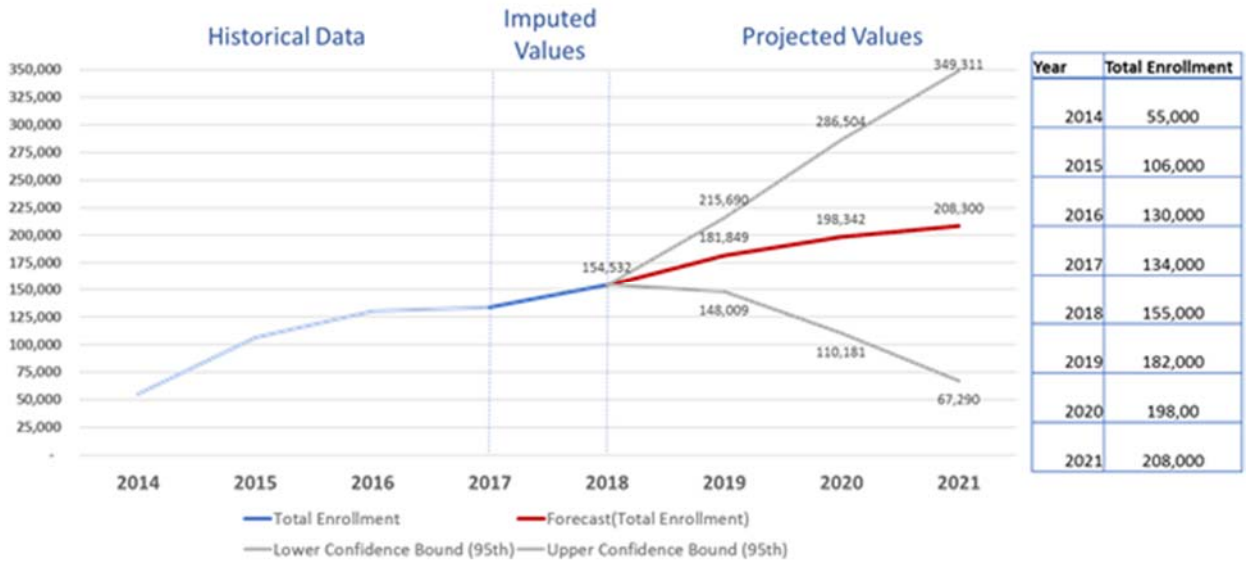
There was insufficient information available to project CSR subsidies for the Oklahoma market. As a result, many of the solutions analyzed assumed that CSR subsidies are left intact. If this is the case, the state could consider using the federal funds to provide additional financial assistance to vulnerable populations.

Baseline Modeling Results

Under the baseline model, Marketplace enrollment is estimated to grow slightly from approximately 145,000 in 2017 to 155,000 by 2018, and 208,000 by 2021. Incurred claims are estimated to grow from nearly $740M in 2016 to $926M by 2018, and $1,360M by 2021. This growth in claims is a result of both increased enrollment and increased health care costs. APTC subsidies are estimated to increase from $402M in 2016 to $830M by 2018, and to $1,140M by 2021. The growth of the APTC largely reflects rapid growth in the second lowest cost silver plan premium which increased over 69 percent from 2016 to 2017 alone.

Growth in the off-Marketplace market is estimated to remain relatively static hovering just above 70,000 enrollees through 2021. There is a large amount of uncertainty reflected in the baseline model with possibilities of extreme growth or a sharp decline among enrollment in the FFM. While this uncertainty is an important component for the solution modeling, we have assumed the average baseline case plays out and have analyzed two separate market reactions (as detailed below).

Figure 6: Baseline Enrollment Estimates for the Oklahoma Individual Market, 2018-2021



Year	Total Enrollment
2014	55,000
2015	106,000
2016	130,000
2017	134,000
2018	155,000
2019	182,000
2020	198,00
2021	208,000

Solution Impact Analysis

Working together with the Task Force and OSDH, the HMA/Leavitt Partners team assisted the group with prioritizing a subset of the policy solutions proposed by the Task Force in the Concept Paper for evaluation. The proposed policy solutions selected for modeling included:

- Effects of Moving to a Wider Age Band
- Impact of Adopting a Reinsurance Program
- Moving to Two Standardized Insurance Options (conventional plan + HDHP option)
- Standardizing Subsidies Based on Age and Income
- Reallocating Subsidies for the Non-Medicaid Population between 0-300 percent FPL

Each policy solution was modeled in isolation prior to being measured against the baseline to determine the relative impact of the solution. That is, each solution modeled here assumes that no other change has been implemented. Subsequent to being modeled in isolation, Leavitt Partners modeled the possible market impact of various combinations of these solutions.

About the Model and Solution Modeling Approach

To measure the effect that a policy intervention could have on Oklahoma's individual market, Leavitt Partners employed a demand elasticity model to estimate the impact of premium changes on enrollment. The model was applied in three main stages. First, the impact of each policy intervention on insurance premiums was compared to the baseline estimates. The effect on premiums was estimated based on specific enrollee attributes such as age, income, on-/off-marketplace, and subsidy eligibility. Second, the new premiums were compared to the former year's premiums for each population. Third, the price elasticity response of each individual (meaning the propensity of an individual to purchase insurance coverage) was estimated based on an individual's response to changes in premiums. Aggregate APTC subsidies were recalculated based on age, income, and anticipated premium amount of

the estimated enrollee population and were used to evaluate the solutions' effects on the budget. These same steps were taken for each solution and combination of solutions.

Previous work from Oklahoma's Task Force has shown that most consumers choose to purchase insurance primarily based on premium price.[53] For this reason, a consumer's sensitivity to premium, or price elasticity, is the main driver for enrollment changes. Based on our research, we have assumed that an individual's price elasticity for purchasing insurance would vary widely depending on their age and income. Another way to say this is that a change in price will affect an individual's behavior more or less depending upon considerations like age and income, i.e., an older individual is more likely to hold onto or purchase coverage despite a change in premium, provided their income is sufficient. Furthermore, two sets of price elasticity estimates were used to provide both a high and low estimate of how individuals may respond to premium changes.

It is important to note that the model produced a wide range of responses to premium changes. As such, these price elasticity estimates may not accurately reflect consumer decisions on the extremes. Limited research has been conducted on health insurance price elasticity when extreme changes in premiums occur, which makes it difficult to corroborate these findings.

Solution 1: Effects of Moving to a Wider Age Band

Solution Description

Age banding is the practice of limiting price differentials in premiums between the youngest and oldest populations in a market. A key provision of the ACA placed a limit on age bands used for pricing insurance at a 3:1 ratio. This means that, in the individual market, the oldest consumers (64+ years of age) may only be charged three times as much as a young consumer (26 years of age).

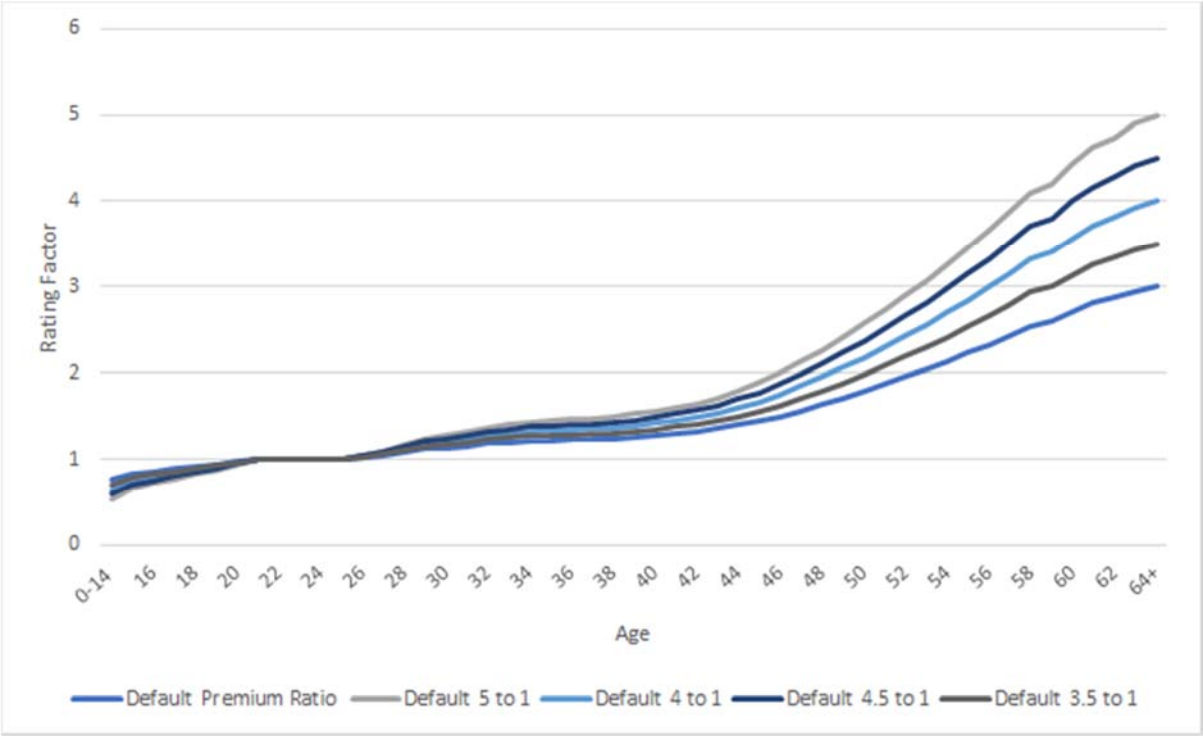
Widening the age band allows insurance companies to charge lower premiums to younger consumers and higher premiums to older consumers who are likely on average to have higher medical expenses. Younger consumers tend to be more price sensitive to health insurance premiums and respond to a change in price at a higher rate than older populations. Increasing age band limits is therefore expected to increase enrollment among the healthier and younger populations, but it also has potential to expose older populations to higher costs. It attempts to strike a balance between promoting market stability and sound risk pools, while preserving equity across ages.

Analytical Approach

Premium prices were modeled under several new age band limits ranging from 3.5:1 to 5:1. As the age band widened and greater price variation was observed, the change in premium prices, and resulting impact on enrollment, was evaluated for each age and income demographic profile based on the estimated demand elasticity for health insurance.

[53] Evolve Research (February 2017). "Consumer Research – Executive Summary" (Available here - https://www.ok.gov/health2/documents/1332%20Task%20Force%20Meeting_2.21.pdf)

Figure 7: Age Rating Factors and a Default Age Banding Curve



Modeling Results

The greatest impacts to premiums and enrollment resulting from wider age banding limits were observed under the 5:1 limit. Consumers between the ages of 18-25 could expect their premiums to be reduced by an average of 29 percent, while consumers between the ages of 55-64 could expect premiums to rise by an average of 21 percent. A reduced premium structure for young enrollees resulted in significant enrollment gains among the populations aged 18-34—ranging from 15,000-40,000 additional enrollees.

However, the corresponding increase in premiums of 21 percent for enrollees above the age of 45 has potential to result in enrollment losses among older populations who could be priced out of the market. Under the 5:1 age band, the model anticipates 2,000-4,000 disenrollments among the older population.

In this scenario, the opportunity for enrollment gains from the younger populations are estimated to offset the losses among the older populations resulting in net positive individual market growth of 16,900-31,800 lives after three years (please see Appendix I and Appendix J for additional modeling results).

Table 17: Estimated Enrollment Gains Under 5:1 Age Band

Year	Individual Market Enrollment Above the Baseline
2019	13,600 (5.4%) - 25,700 (10.1%)
2020	15,400 (5.7%) - 29,000 (10.7%)
2021	16,900 (6.0%) - 31,800 (11.3%)

Solution 2: Impact of Adopting a Reinsurance Program

Solution Description

In a state-based reinsurance program, the state shares the risk with insurance carriers and uses state and/or federal funds to reimburse participating carriers for a portion of high-cost enrollee medical expenses. Recently, several states have adopted state-based reinsurance programs for the individual market in an effort to lower premiums and entice insurance carriers to continue offering competitive products. Furthermore, states that adopt and fund these programs may be eligible for "pass-through" funds under Section 1332 Waivers due to the savings that are passed along to the federal government in the form of lower subsidy payments. The State of Oklahoma was interested in understanding the potential impact of adopting such a program for their individual market.

Analytical Approach

In evaluating the impact of a reinsurance or risk pool program on Oklahoma's individual market, the focus was to understand the relative impacts of directly subsidizing the risk pool using a range of reasonable program budget estimates. Expectations for reasonable program funding amounts were determined as approximately 5 percent, 10 percent, and 20 percent of the anticipated aggregate incurred claims for Oklahoma's individual market in 2018. This resulted in estimated program funding amounts of $50 million, $100 million, and $200 million for each year between 2018–2020. The introduction of this funding is also assumed to reduce incurred claims uniformly across all market demographics. Assuming a constant MLR ratio, the impact to individual market premiums was estimated and, based on our understanding of demand elasticity, effects on enrollment were assessed. This model evaluated the impact in a 3-year observation window beginning in 2018 since the Task Force and OSDH expressed an interest in evaluating the near-term impacts of adopting such a program.

Modeling Results

The analysis was structured to be agnostic to the exact structure and design (i.e. claims-based or conditions-based) of the state's reinsurance program, and the goal was to analyze the effects of a program that directly subsidizes the underlying costs of a risk pool. In terms of results, premium reductions of 5 percent, 11 percent, and 22 percent were observed across the individual market for the $50M, $100M, and $200M program funding amounts, respectively. These reductions in premiums resulted in potential enrollment gains between 1.5 percent-11.2 percent (or 3,600-25,400 individuals) for the individual market.

Table 18: Estimated Enrollment Gains Under the Adoption of a Reinsurance Program

Year[54]	Individual Market Enrollment Above the Baseline ($50M)	Individual Market Enrollment Above the Baseline ($100M)	Individual Market Enrollment Above the Baseline ($200M)
2018	3,500 (1.5%) - 6,300 (2.8%)	7,100 (3.1%) - 12,700 (5.6%)	14,100 (6.2%) - 25,400 (11.2%)
2019	3,400 (1.3%) - 6,000 (2.4%)	6,700 (2.6%) - 12,000 (4.7%)	13,400 (5.3%) - 24,000 (9.4%)
2020	3,200 (1.2%) - 5,700 (2.1%)	6,300 (2.3%) - 11,367 (4.2%)	12,600 (4.7%) - 22,700 (8.4%)

As premiums for the entire individual market are reduced, savings to the federal government from lower subsidy payments can also be realized and may be eligible to be recouped as "pass-through" savings or applied toward program funding in future years.[55] In comparing the federal government's savings under this program to the estimated baseline for federal spending, between 45 percent and 92 percent of the initial funding offered by the state could be eligible for reimbursement by the federal government.

Solution 3: Moving to Two Standardized Insurance Options (Conventional plan + HDHP option)

Solution Description

Moving to a market with two types of standardized insurance products is meant to simplify consumer options and increase incentives to enroll in a high deductible health plan (HDHP) with a corresponding health savings account (HSA). In this scenario, consumers in the individual market would be provided with two insurance product options. The first would be a conventional insurance plan with a low deductible and generous cost-sharing benefits, but relatively high monthly premiums. The second option would be a HDHP with a high annual deductible (greater than $2,500) and relatively lower premiums. With the high deductible, the insurance plan would provide few to no payments prior to meeting the deductible (exempting covered preventive care services under current law). A new form of premium subsidy would be designed to cover some amount of the conventional plan's premium or be applied to a greater portion of the HDHP premium (and, for the lowest income enrollees, potentially result in an HSA contribution if the subsidy exceeds the premium cost).

Analytical Approach

To model the effects of moving to two standardized plans, the calculation for premium subsidies was redesigned to account for the elimination of the silver benchmark plans. A subsidy structure where the base subsidy is a set percent (70 percent) of the conventional plan was used. The subsidy scales down from 70 percent to 60 percent of the conventional plan as income increases. For individuals where the

[54] This is the only solution to observe a 3-year observation window beginning in 2018 because the Task Force and OSDH expressed an interest in evaluating the near-term impacts of adopting such a program.

[55] At the time of publication, waiver proposals from states like Alaska and Minnesota to collect on "pass-through funding" from the federal government had not yet been approved but were widely expected to be successful in some respect given the Trump Administration's willingness to tout this approach as a viable solution to lowering premiums.

value of the subsidy is greater than the premium amount, the difference would be deposited into an HSA used to cover qualified health expenses.

To project changes in enrollment, the number of individuals who would be willing to purchase insurance at the conventional and HDHP premium levels was estimated. Individuals who would purchase at the conventional level are assumed to be willing to purchase at the HDHP level as well. This provides the baseline total enrollment. Based on price elasticities, we then evaluated how individuals in different demographic groups are likely to select between the conventional plan and HDHP.

Figure 8: Estimated Consumer Premium and Subsidy Amount Under Two Plan Policy

Age	Unsubs. Premium	Base Subsidy (70%)	Plan Type	Net Premium after Subsidy				
				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

Modeling Results

In migrating from the current metal level requirements to two standardized insurance plans, we acknowledge that there are aspects of program design that require further research and additional consideration. For example, there may be an opportunity to realize new enrollment gains for the individual market under this type of policy if the new, standardized HDHP represents a more affordable option to consumers than the products that are currently on the Marketplace. However, the ability to represent completely new product options in the model was limited given that the plans used as a template for the standardized conventional and HDHP policies are products in existence in the Marketplace today.

In this modeling approach, we evaluated the impact of a new format for subsidy calculation that is based on the conventional plan premium but can also be applied to the HDHP plan. Under this format, the premium of the HDHP plan is completely subsidized for the lowest income enrollees and any surplus subsidy is contributed into an HSA. In estimating the impact of such a program, the only gains in enrollment were observed in the HDHP plan—this may be a reflection that many individuals with a propensity to purchase the conventional insurance product are likely already enrolled in the market

today. The model also revealed that different demographics have different preferences for plan choice. Younger populations are much more likely to choose the HDHP, while older populations are more likely to choose a conventional plan.

Table 19: Estimated Enrollment Gains from Moving to Two Standardized Insurance Plans

Year	Individual Market Enrollment Above the Baseline
2019	47,000 (25.8%) - 91,000(50.0%)
2020	51,000 (25.8%) - 99,000 (50.0%)
2021	53,700 (25.8%) - 103,700 (49.8%)

Finally, we observed that subsidizing the entire premium for the HDHP—at no cost to the individual—has the potential to quickly generate costs above the baseline (we observed program costs to be more than 43 percent above the anticipated baseline funding).

Solution 4: Standardizing Subsidies Based on Age and Income

Solution Description

Basing premium subsidies on age and income has been proposed as an alternative solution to basing subsidies on income and premium amount in an individual's service area. It is theorized that using a fixed subsidy amount may discourage excessive premium increases that negatively affect consumer affordability. The design of new premium subsidies could also be used to incentivize greater enrollment among specific aged populations, provide more assistance to very low income populations, or complement other reforms being considered (i.e., 5:1 age band limit or alternate standardized insurance products).

Analytical Approach

Based on the priorities articulated by OSDH and the Task Force, we modeled the effect of insurance subsidies based on both age and income. Rather than pegging the subsidy as a percent of an individual's income, a new approach was designed. This approach calculates a base subsidy amount for the lowest income, youngest population. From there the subsidy increases as age increases and decreases as income increases. At the oldest age, the subsidy is 2.8 times greater than the youngest age. Similarly, the highest eligible income (400 percent of FPL) receives a subsidy that is just over half (55 percent) of what the lowest income group receives.

Modeling Results

In developing the modeling approach, we considered two formats for age- and income-based subsidies with the intentions to (1) bring additional younger enrollees into the individual market and (2) correct for undesirable impacts of combined policy solutions (i.e., possible premium increases for older consumers under a 5:1 age band). In both situations, we observed opportunities to improve enrollment gains among target populations that were prioritized in the design of the age and income subsidy.

Table 20: Estimated Enrollment Gains under Subsidies Calculated Based on Age and Income

Year	Individual Market Enrollment Above the Baseline
2019	6,500 (3.6%) - 14,500 (8.0%)
2020	7,100 (3.6%) - 16,900 (8.5%)
2021	6,100 (3.0%) - 16,400 (7.9%)

Solution 5: Reallocating Subsidies for the Non-Medicaid Population 0-300 Percent FPL

Solution Description

As a way to make coverage more affordable for the non-Medicaid eligible "gap population," we considered the effects of lowering eligibility for premium subsidies to 0-300 percent FPL (as opposed to the current 100-400 percent FPL eligibility range) to offer assistance for low-income populations. While there are many ways to design such a policy and calculate subsidies for the newly covered population, we have selected two subsidy approaches that leave the ACA structure intact (to keep the design simpler and logistically feasible). The modeled subsidy approaches were intended to be illustrative of how such a program might function. But if the state were to adopt such a policy change, there would be a wide range of options for them to consider in program design.

Analytical Approach

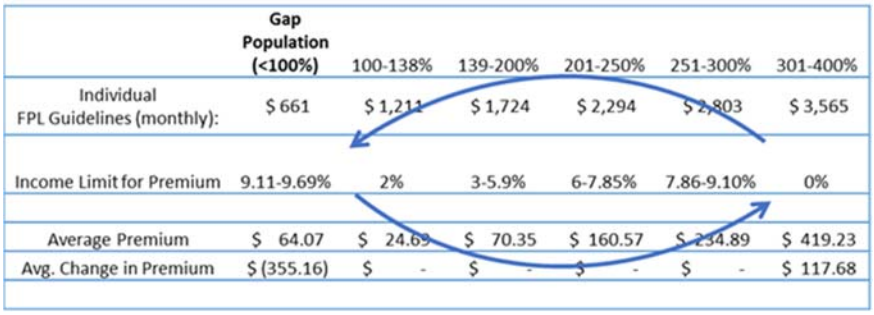
The two possible approaches for adjusting the premium subsidy to cover those with income from 0–300 percent FPL include: (1) "shifting" the subsidy downward, or (2) "swapping" the eligible populations. The "shift" option was designed so that the populations with income between 300-400 percent FPL do not receive a subsidy, and each subsequent lower FPL level receives a subsidy level that "shifted" down one level.

Figure 9: Example of Income Caps Used for Subsidy Calculation under "Shift" Scenario

	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

The "swap" option moves the subsidy so that the per capita subsidy currently received by the group between 300-400 percent FPL is instead offered to the "gap population" below 100 percent FPL. Applying this subsidy structure to those with income below 100 percent FPL would limit their premium to approximately 9 percent of their income.

Figure 10: Example of Income Caps Used for Subsidy Calculation under "Swap" Scenario



We determined the size/composition of the Oklahoma "gap population" based on previous work conducted by both Leavitt Partners and the state of Oklahoma. These estimates, in conjunction with additional demographic data, allowed us to integrate the "gap population" with the individual market population. Based on the new subsidy structure, we then evaluated the premiums paid on the individual market for an average plan to see how enrollment changes for each age and income.

Modeling Results

Based on the parameters outlined above, we observed significant enrollment gains in the range of 99,000-118,400 from the "gap population" as a new premium subsidy program was introduced.

One primary distinction between our two scenarios that would be a key factor to consider in the design of such a program is the degree to which premium subsidies change for the other low income populations (i.e., 100-300 percent FPL). In the "shift" subsidy calculation scenario, the premiums for the population between 100-300 percent FPL are actually increased slightly as the greatest premium subsidy is provided to the 0-100 percent FPL. We observed that incrementally reducing the level of subsidies across the currently eligible population in the name of offering new assistance to the "gap population" could inadvertently reduce access to coverage among these low-income populations.

Table 21: Estimated Enrollment Gains Under New Spread for Premium Subsidy Eligibility

Year	Individual Market Enrollment Above the Baseline	
	"Shift" Scenario	"Swap" Scenario
2019	26,400 (14.5%) - 69,300 (38.1%)	40,000 (22.0%) - 99,800 (54.9%)
2020	26,200(13.2%) - 69,200 (34.9%)	40,500 (20.4%) - 101,000 (50.9%)
2021	26,000 (12.5%) - 69,000 (33.1%)	42,000 (20.2) - 104,000 (50.0%)

It is also important to note that the coverage gains among the "gap population" will not be inexpensive. The solution repurposes existing APTC and potentially CSR federal funding to provide assistance to the gap population. Due to the anticipated popularity of offering a new Marketplace premium subsidy program to this population and the extent to which coverage would need to be subsidized to be affordable, we observed program costs in excess of 43-56 percent of the estimated federal Marketplace spending baseline. However, because this is a population frequently covered by Medicaid, there may be an opportunity to negotiate an innovative approach for supporting Marketplace coverage with federal funds.

Combined Solution Modeling Results

A key point of interest of the Task Force is understanding the confluence and interacting impact if two or more reforms are adopted. To address this interest, Leavitt Partners modeled several permutations of combined policy solutions of interest to the Task Force. Each combination was analyzed based on the specific policies introduced. In some instances, the sequencing of the policy effects are specified such that more general changes, such as age banding, occur before changes tied to specific dollar amounts such as reinsurance.

General Approach

Modeling combined solutions presents a unique challenge where additional feedback loops may occur. For this reason, the modeling process was simplified, and we acknowledge that these estimates represent a theoretical approximation assuming that, when combined, the solutions do not have drastically different outcomes than when modeled individually.

The combined solutions all include the assumed adoption of a reinsurance program as a base. This solution assumes that the risk pool cost will be diluted equal to the funding amount of the reinsurance program budget. For the combined solution modeling, we assume a constant annual funding level of $100M, which represents about 10 percent of the market's incurred claims in 2018. Based on the changes in premium after a reinsurance program is introduced, enrollment is calculated based on consumers' price sensitivity.

Combination 1: Reinsurance Program & 5:1 Age Banding

The 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. This increase in premiums is slightly mitigated by lower premiums that result for everyone who qualifies for subsides from the introduction of a reinsurance program.

Analyzing the combined effects of a 5:1 age band limit and a reinsurance program reveals lower premiums for younger populations and limited rate increases for populations over the age of 45, resulting in a 9 percent increase in enrollment in the individual market (or between 23,000-42,000 new enrollees). Combining reinsurance and age banding would result in changes that affect the entire individual market including those on the FFM as well as those in the off-Marketplace commercial market.

Table 22: Estimated Enrollment Gains Under Combination 1

Year	Individual Market Enrollment Above the Baseline
2019	15,000 (5.9%) - 28,400 (11.2%)
2020	15,700 (5.8%) - 29,800 (11.0%)
2021	16,400 (5.8%) - 31,000 (11.1%)

Combination 2: Reinsurance Program & Reallocating Subsidies to 0-300 Percent FPL

Making subsidies available to the "gap population" is likely to result in significant enrollment gains with or without reinsurance. Depending on the new program structure, we estimate that the gains would range between 16–56 percent.

Introduction of a reinsurance program will reduce premiums and produce some enrollment gains for those in the off-Marketplace commercial market and other middle-income populations; however, those with the lowest income (to whom the subsidy program is expanded) are unlikely to realize any benefit from a reinsurance program in terms of net premium reductions because their premiums are subsidized to such a great extent.

The introduction of both of these programs would represent a significant expense for the state or federal government. Furthermore, we've observed that lowering subsidy eligibility for consumers is likely to result in additional spending above the baseline, which could also reduce the "pass-through" savings that the state may be eligible for because of the reduced premium structure under reinsurance.

Table 23: Estimated Enrollment Gains Under Combination 2

Year	Individual Market Enrollment Above the Baseline
2019	45,600 (25.1%) - 89,500 (49.2%)
2020	49,700 (25.0%) - 97,500 (49.2%)
2021	53,500 (25.7%) - 104,000 (50%)

Combination 3: Reinsurance Program & Age/Income-Based Subsidies & 5:1 Age Banding

Introduction of a 5:1 age band limit reduces 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 reach the ACA threshold limit for subsidy calculation).

Changing the subsidy structure so it is 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 for two reasons: 1) older populations would be heavily subsidized under the 5:1 age band; and 2) there are so few enrollees in the younger age range that reallocation of their subsidies does not cover the increase in subsidy costs from the older population. Enrollment among consumers between the ages of 18-34 is projected to increase between 15,000-31,000 individuals while enrollment for ages 54-64 is projected to decrease less than 2,000. Enrollment for all income groups is projected to increase, with the largest gains for those between 100-200 percent FPL.

Table 24: Estimated Enrollment Gains Under Combination 3

Year	Individual Market Enrollment Above the Baseline
2019	17,400 (9.6%) - 37,300 (20.5%)
2020	17,100 (8.6%) - 37,100 (18.7%)
2021	17,600 (8.4%) - 39,200 (18.8%)

Combination 4: Reinsurance Program & Two Standardized Insurance Options

The introduction of reinsurance to the two standardized plan options has no significant impact on enrollment. All new enrollees in the HDHP are estimated to have low incomes, and the reinsurance program only serves to enhance the HSA contributions, which are estimated to increase between 5-7 percent with the new funding. While the increased HSA contributions are likely to increase utilization for those enrolled in the HDHP, we do not anticipate these being a driver for new enrollment. Therefore, while the introduction of reinsurance mitigates some exposure that exists by incentivizing people towards a HDHP, a large amount of exposure would still exist.

When modeled in isolation, enrollment gains under a two plan standard were observed into the HDHP because of increased affordability in the new subsidy format. But, when paired with the reinsurance program, even greater enrollment gains were observed into the HDHP and slight enrollment gains occurred in the conventional plan due to a lowered premium structure for both policies.

Table 25: Estimated Enrollment Gains Under Combination 4

Year	Individual Market Enrollment Above the Baseline
2019	47,000 (25.8%) - 91,000(50.0%)
2020	51,000 (25.8%) - 99,000 (50.0%)
2021	53,700 (25.8%) - 103,700 (49.8%)

Recommendations and Next Steps

Analysis of Concept Paper Recommendations

As mentioned previously, OSDH will likely pursue a sequential approach to implementing policy changes under a 1332 Waiver. The state is under legislative direction to pursue a reinsurance program that would constitute the state's first Section 1332 State Innovation Waiver proposal. This proposal would be followed by broader reforms aimed at assuming the functions of the Health Insurance Marketplace as well as changing the structure of subsidies that are provided to Oklahomans, among other changes.

The sections below present analysis of each of the concept paper recommendations that are outlined in Table 13 above, broken into two groups: Task Force recommendations that were modeled and those that were not modeled. We have provided a description of each recommendation, a discussion of the results associated with those solutions that were modeled, and design and operational considerations for each recommendation.

Analysis of Modeled Task Force Recommendations

Greater Variance to the Rating Windows for Age

In order to better balance health care costs across age groups, Oklahoma may seek to increase the variance allowed in age rating from the current 3:1 ratio up to a 5:1 ratio, though the final proposed ratio has not been determined. For Oklahoma to have the flexibility to make this change, a statutory change would be required to the ACA. While the AHCA as passed by the US House of Representatives

would make this change, it is unknown at the time of the writing of this report whether this proposed change will be passed.

Key Findings

In our analysis, we observe that widening the age band limit was likely to result in enrollment gains among younger and healthier populations. However, increasing the age band limit also resulted in significant premium increases for the older populations. The current 3:1 age band limit is widely viewed as a consumer protection and benefit for older populations. Increasing the proportion for premium variation results in immediate reductions in premiums for younger populations and increases in premiums for older populations. 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. The reduction in premiums is likely to encourage significant gains in enrollment among the younger population, but comes at the expense of pricing some older enrollees out of the market. The state could customize this solution or pair it with other reforms to mitigate negative impacts on Oklahoma's population.

Design Considerations

Adjusting the age band limits for pricing insurance is frequently discussed as a policy solution to encourage greater enrollment by younger populations. If the state becomes interested in pursuing this option as a viable market reform, there are other policy adjustments that could be adopted to complement and minimize adverse effects. For instance, introducing a reinsurance or risk pooling program at the same time as widening the age band limit could help to minimize premium increases for the older populations, while also bringing premiums down for younger enrollees. Alternatively, premium subsidies could be redesigned to be relatively more generous to older populations. Finally, the state would have the ability to design a custom age curve and adjustment factors that suit the Oklahoma population.

Operational and Timing Considerations

Section 2701(a)(1)(A)(iii) of the ACA currently limits age variation in premiums to a 3:1 ratio. For Oklahoma to implement a 5:1 age rating window, a statutory change is needed, as this change currently cannot be authorized through a Section 1332 Waiver. Recently proposed changes to regulations mentioned a potential increase to the age rating ratio to 3.49:1, but this provision was not included in the regulation.[56] The AHCA and BCRA do include a statutory change to a 5:1 rating ratio, with the flexibility for states to set an alternate standard. If this statutory change is included in law, Oklahoma could make this change without a waiver (though the state may need to issue regulations to require health plans in the state to utilize a 5:1 ratio moving forward). The timing and implementation of this change is unknown given federal legislative uncertainty.

It is also important to note that if the state takes on Marketplace functions from the federal government in lieu of participating in the FFM, it will need to implement a function that calculates each individual's premium based on the 5:1 age rating ratio, unless all plan selection and premium calculation functions

[56] CMS-9929-F, located here: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-07712.pdf

are carried out directly by participating health plans. The state will also need to ensure that plans adhere to the 5:1 age rating ratio through the annual plan selection and review process as well as through ongoing oversight of qualified plans. The operational process for implementing this, and other Marketplace functions, are discussed in greater detail later in this report.

Exploration of Reinsurance and High Risk Pools

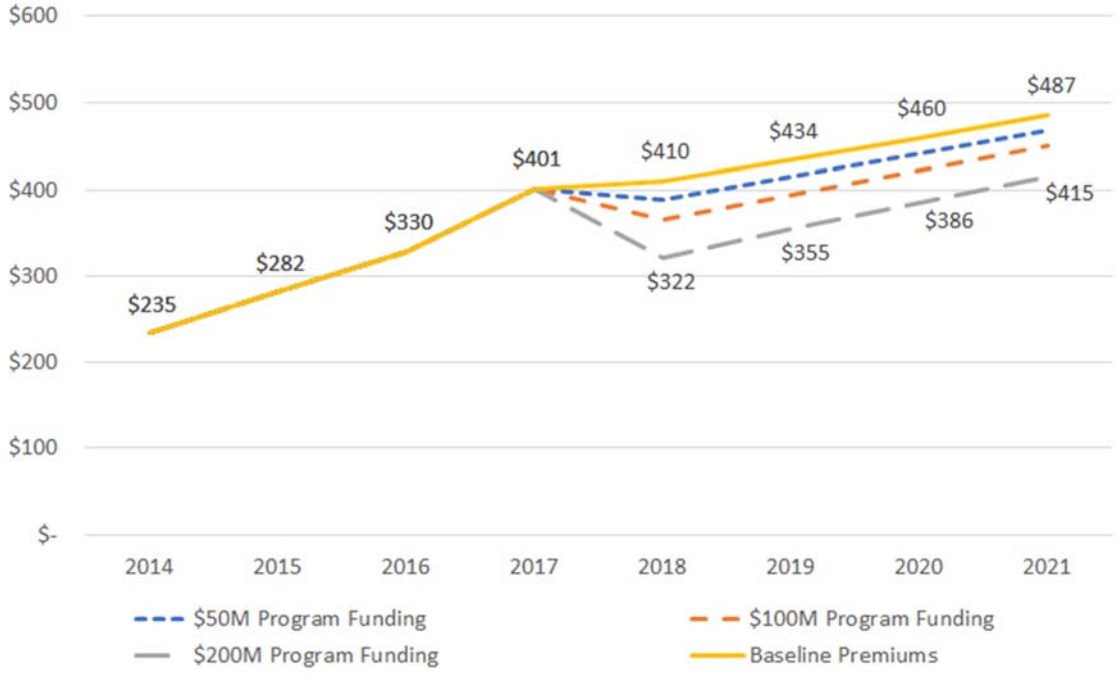
The Concept Paper indicated that Oklahoma would explore options for a federally-funded, state-managed high-risk pool, reinsurance program, or hybrid program to help mitigate risk for health plans with the goal of reducing premiums in the individual market. Since the Concept Paper was published in March, Oklahoma has developed and passed the Oklahoma Individual Health Insurance Market Stabilization Program (HB 2406), which was signed by the Governor on June 6, 2017.[57] This program will provide payments to health plans with respect to claims for eligible, high risk members with the goal of lowering individual market premiums. It is anticipated that a reinsurance program will be utilized to implement the law. Initially the program will be funded by assessments on health plans and reinsurers. The state will seek a Section 1332 Waiver to obtain pass through funding for the program from the federal government based on the potential savings from reductions in premium subsidies as a result of lower premiums in the individual market.

Key Findings

In our analysis, the introduction of a program that shared 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 to consumers. 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, it is believed that state-wide insurance premiums could be reduced by 5 percent and 22 percent, respectively.

[57] Final bill language can be viewed here: http://webserver1.lsb.state.ok.us/cf_pdf/2017-18%20ENR/hB/HB2406%20ENR.PDF

Figure 11: Average Individual Market Premium Price Relative to Various Reinsurance Program Funding Scenarios, 2018-2021



Such a reduction in premiums would also support enrollment gains in the range of 3 percent to 11 percent. Furthermore, the introduction of such a program would also provide relief and encourage continued participation among the unsubsidized enrollees in Oklahoma's market that have been heavily impacted by recent premium increases with little to no assistance.

Design Considerations

Reinsurance programs are intended to directly address the underlying costs of the enrolled populations. Before adopting such a program, the state would need to conduct additional research on the appropriate design, level of funding, and ongoing administration needs for optimal effectiveness. For example, the state would need to consider how risk is shared among insurance carriers (i.e., triggers for reinsurance payment can be claims-based or condition-based). The state may also consider a variety of ways to segment and directly subsidize the highest risk enrollees in a market. This could include a design similar to the "invisible high-risk pools" that have been considered in Alaska and in Maine where high-risk enrollees are directly subsidized, but a consolidated risk pool is maintained.[58,59]

[58] Alaska Department of Commerce, Community, and Economic Development and Division of Insurance (November 2016). "Alaska 1332 Waiver Application" (Available here - https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=105952)

[59] Archambault, J., Allumbaugh, J., and Bragdon, T., (March 2017). "Invisible High-Risk Pools: How Congress Can Lower Premiums And Deal With Pre-Existing Conditions" (Available here - http://healthaffairs.org/blog/2017/03/02/invisible-high-risk-pools-how-congress-can-lower-premiums-and-deal-with-pre-existing-conditions/)

Operational and Timing Considerations

To implement the Oklahoma Individual Health Insurance Market Stabilization Program, the state will need to make various key decisions that will lay the groundwork for the program. HB 2406 specifies that the program must be operated by a nonprofit legal entity, with administrative and operational support from the Insurance Department.[60] Before full implementation can be completed, this organizational structure will need to be established. The responsibility for the program lies with the Insurance Commissioner, who is required to appoint a board of directors to oversee the program. HB 2406 specifies the composition of the nine-member board and board member terms. Once appointed, the board of directors will then need to develop a plan of operation, articles, bylaws and operating rules within 180 days. The board must also hire an executive director to oversee the program. Operational and administrative support for the program will be provided by the Insurance Department.

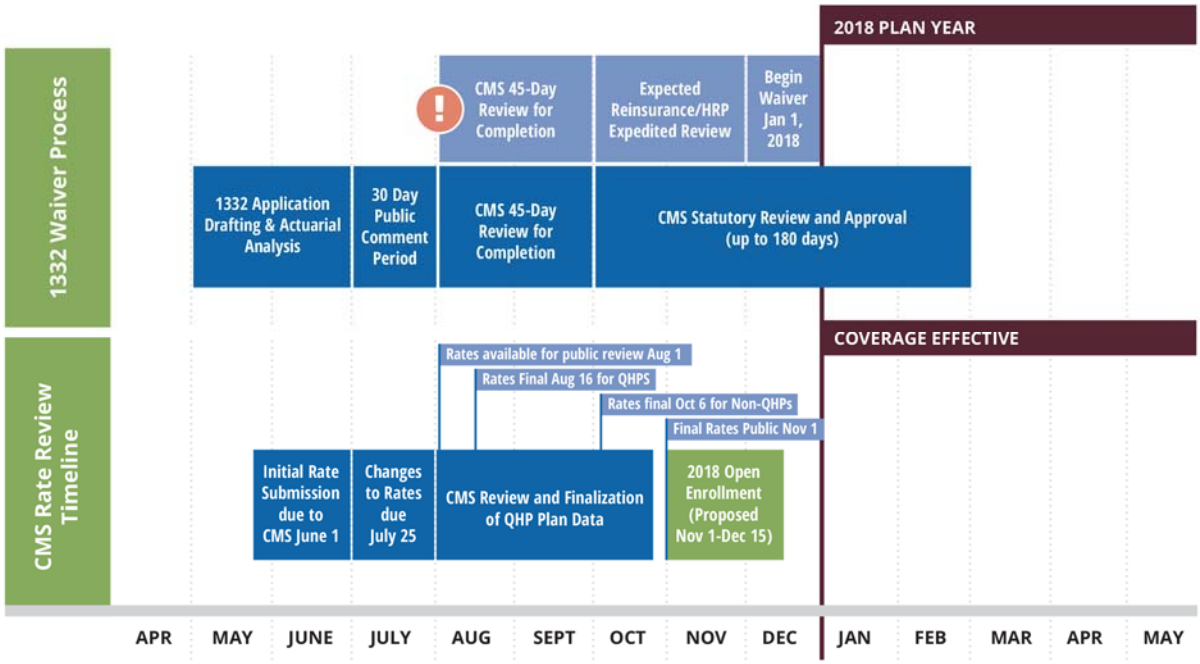
HB 2406 also specifies many of the operational requirements that will need to be defined to successfully implement the program, including determining the assessment amount that will be paid by insurers in the market, establishing the standards for qualification for health plan members to participate in the program, and determining the payment amounts and rates of payment that will be provided to health plans. The program will need to establish operational functions to support these program parameters, including a funding mechanism that will facilitate making payments to plans and the schedule on which these funds flow, a process for determining eligibility for the program, a process for calculating payment amounts, and a process for payment reconciliation and audit, among other functions. Additionally, oversight requirements will need to be established to ensure that plans are complying with program rules.

The state will also need to apply for and secure approval of a Section 1332 Waiver which would request ongoing funding for the program in the form of pass-through funding that represents savings to the federal government from the reduction in premiums and associated APTCs. In order to implement this program for the 2018 coverage year, the Waiver application would need to be submitted by mid-summer and approved by the fall, so plans could have an opportunity to revise their rates ahead of the start of the coverage year.

Oklahoma will need to work with CMS to request the opportunity for Oklahoma plans to revise their rates to account for the implementation of the program. To meet the 2018 coverage year timeframe, the Insurance Commissioner will also need to select the program's board of directors quickly, preferably before the end of July 2017 in order to allow sufficient time for implementation of the program. In the meantime, the Insurance Commissioner should immediately begin to develop an operational plan and potentially procure a contractor to support the provision of payments to health plans. Standing up this operational function will likely require process modeling and the development of standard operating procedures to ensure the process is implemented smoothly and consistently. Administrative funding will need to be allocated for these activities.

[60] HB 2406 can be viewed here: https://legiscan.com/OK/text/HB2406/id/1624145

Figure 12: Timeline for Reinsurance Program Implementation



Simplified Plan Options

The Task Force also considered numerous proposals to simplify plan options for consumers in the individual market and encourage use of HDHP and HSA pairings. One such proposal includes eliminating the metal tier requirements currently in place under the FFM and opting for two standardized plan options—one conventional, low-deductible plan and another option that is a high-deductible plan paired with an HSA. Under the HDHP, the enrollee would be able to use their health account funds to pay for first-dollar, out of pocket expenses. Another proposal included limiting all "traditional health plans" to a standardized 80 percent actuarial value minimum. Traditional plans are defined as those plans that do not otherwise meet requirements to be a HDHP. But, under each proposal, the standardized plan options would be intended to simplify the consumer shopping experience and encourage additional enrollment in HDHPs. Furthermore, because a new format for subsidy calculation would need to be designed as the state moves away from metal levels, there is additional opportunity to allocate subsidies on a more effective basis.

Key Findings

In modeling the effects of adopting such a policy, we generally observed that there would be opportunity to make enrollment gains to the extent that the HDHP policy has a more affordable premium structure than is available on the marketplace today. Furthermore, if the premium subsidy is redesigned to require an even lower contribution among populations than is required today, there is also an opportunity for gains in enrollment. Alternatively, while regular contributions into an 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.

Design Considerations

Further consideration of policies to restructure available plan options and fundamentally redesign the way premium subsidies are calculated will require additional research and stakeholder engagement, including further input from consumers and consumer advocates. Increased adoption of HDHP/HSA pairings could encourage responsible health care spending. However, the additional regulation of health plan products could also discourage health plan innovation and result in fewer options for consumers. Additionally, the state would need to carefully consider access to care under such a proposal. HDHPs can be beneficial for many types of consumers but to avoid creating any barriers to care, there would likely need to be greater cost-sharing assistance for lower income consumers (i.e., potentially through cost-sharing reduction funds) and maintained access to preventive care.

Operational and Timing Considerations

In order to standardize the plan options that are provided to eligible enrollees through the new Oklahoma program, Oklahoma will need actuarial support to develop standardized plan designs that adhere to the specified actuarial value minimums that are established by the state. The state will need to determine these minimums, potentially through legislation or regulations, and then design the cost-sharing structure that will support these specified actuarial value amounts. These standardized plan designs will need to be provided well in advance of the upcoming coverage year to allow plans to design their products and submit their rates and form filings for approval by the Insurance Department. The state may also wish to allow health plans to have a comment period during which they can review these proposed plan designs and provide feedback to the state. The Insurance Department will be responsible for reviewing the plans and rates submitted by each health plan to ensure that each plan adheres to these standardized plan designs, including specified cost sharing amounts. It is unlikely the state could implement such a change until the 2020 coverage year at the earliest due to the upfront work required to develop these plan designs as well as the lead time needed for health plans to implement these plan designs.

In order to implement changes to the plan offerings that are offered on the Marketplace, Oklahoma will need to include this design change in a Section 1332 Waiver application to the federal government and will need to request to waive 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. Currently, the Marketplace requires health plans to fall into the bronze, silver, gold, and platinum metal tiers with associated actuarial values.

Oklahoma will also need to implement its own state-based program to provide access to coverage for Marketplace enrollees given that it participates today in the FFM. Making a change to the required plan designs within the FFM would result in administrative costs to the federal government, which would fail to meet the deficit neutrality requirements of implementing a Section 1332 Waiver. Oklahoma would have to include the review of plan designs in its annual plan selection process, which would be carried out by the Insurance Department as part of rate and form review. A more detailed analysis of the operational considerations for performing this function are provided later in this report. For a detailed analysis of the specific statutory provisions of the ACA that would need to be waived to support this change and others, please see Appendix K.

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 Consumer Health Accounts 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 a mechanism for maintaining a roster of current account holders and to update this information on a regular basis. The state will also need to determine the list of services and expenses that are eligible for reimbursement through the accounts.

In addition, the state and the TPA will need to determine the mechanism through which payments are made from these accounts to health plans for the subsidy amounts associated with each individual. It is advisable that these funds flow directly from the state/TPA to the health plans to avoid the need for the consumer to effectuate a monthly payment amount from the account in the amount of the subsidy. If the consumer is going to use the account to make additional payments to the plans for their remaining net premium after the application of the subsidy, there will also need to be a mechanism to support this. The state could utilize the TPA to provide debit cards to consumers who are utilizing accounts so these payments can be made directly. Otherwise, account holders will need to make payments upfront and then request reimbursement from the account, another process that would need to be supported by the TPA with clear guidelines for acceptable documentation and eligible expenses. This approach also has a greater potential to confuse participants given the complexity of the reimbursement process.

Administrative expenses for operating consumer health accounts through a TPA could range from $2 million to $4 million per year, depending on the number of participants and the complexity of the accounts, based on other similar models such as San Francisco's SF Covered program which provides premium subsidies for the purchase of health plans through California's Marketplace, Covered California.[61]

APTC and CSR Eligibility and Distribution

Oklahoma proposes in the Concept Paper to change the way subsidies are provided to consumers. First, the Concept Paper proposes to redistribute federal subsidy dollars from individuals between 100-400 percent FPL to individuals between 0-300 percent FPL. This assumes that federal funds will be available to cover those who are currently eligible for APTCs but are not enrolled. In addition, eligibility for subsidies will also take into account affordability of other coverage available to the individual and their family.

Key Findings

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,

[61] http://sfcityoption.org/employeeresources/sfcoveredmra/

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" was estimated at approximately 210,000 individuals in 2015.[62] 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 potentially significant. As the state phases out subsidies to the population between 300-400 percent FPL, there are some savings accrued toward subsidizing the new population <100 percent 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.

Design Considerations

Determining the ideal program design for adjusting the window of APTC/CSR eligibility will require significant additional research and stakeholder engagement, including further input from consumers and consumer advocates. 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, overtures that the current administration has made to states to consider leveraging new flexibility under existing waiver programs are encouraging.[63]

Operational and Timing Considerations

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. As discussed previously in this report, to be approved a Section 1332 Waiver, under current law and guidance, the program must provide coverage to 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 FPL are no longer eligible for subsidies, even with decreases in premiums across the individual market as a result of other reforms, coverage may be less affordable to them. As a result, fewer people may receive coverage. Oklahoma will need to further examine based on specific policies whether this approach will meet current federal guidelines, and whether CMS would consider allowing the state to consider savings in its Medicaid program from the absence of providing coverage to the expansion population to offset Marketplace program costs for making this eligibility shift. Iowa recently submitted a 1332 Waiver application that would require changes to federal statutory

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

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

and regulatory requirements related to 1332 Waivers in order to be approved, so CMS may see more states moving toward requests for greater flexibility in order to deal with challenging market dynamics.

To operationalize this change, Oklahoma would need to implement its own Marketplace-like program, including the calculation and administration of subsidies, as the FFM would not be able to accommodate such robust changes within their system without potentially significant operational costs that would impact the budget neutrality requirement for the Section 1332 Waiver. Implementing such a process would require an eligibility determination function, a subsidy calculation function, and a mechanism to pay subsidies on behalf of eligible individuals.

Subsidy Calculations

In addition to making changes to eligibility requirements for subsidies, Oklahoma proposes to change the way subsidy amounts are calculated. Today, under federal law, APTC amounts are calculated based on 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. Oklahoma proposes to simplify this subsidy calculation and base subsidy calculations only on age and income.

Key Findings

Several formats for calculating age and income-based subsidies were evaluated and we found that there is a wide degree of flexibility for how such a policy reform could be interpreted. Based 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 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 one target group is likely to improve enrollment.

Design Considerations

There are numerous ways that premium subsidies could be redesigned and based on the age and income of a potential enrollee. The ultimate design of such a subsidy format would likely be determined by the enrollment goals and priorities of the State for greater penetration among target populations. In addition to the opportunities for new enrollment gains among target populations, there are other systemic benefits that could be generated by 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 policies are clearly outlined for the public. In order to determine the appropriate design for this proposal, the state will need to conduct further research and stakeholder engagement, including with consumers and consumer advocates.

Operational and Timing Considerations

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. Oklahoma would also need to take on Marketplace functions in lieu of participating in the FFM in order to meet the budget neutrality requirement of a Section 1332 Waiver.

The state would need to determine how the process for subsidy calculation would be implemented. The Concept Paper recommends a direct enrollment process under which health plans would directly market to potential enrollees and move them through the application and plan selection process. Subsidy calculation based on age and income could in theory be a part of this process. However, today, all eligibility determinations for Marketplace participation must be processed by the state or federal government, and certain information must be verified through the Data Services Hub, a system operated by the federal government. However, the federal government has signaled that they will move toward supporting direct enrollment in the coming months.

Greater exploration will be needed to determine exactly what functions related to subsidy eligibility and calculation could be carried out by the state and by health plans, and to what extent eligibility parameters must be verified by the federal government. In addition, decisions will likely need to be made about what sources of documentation are necessary to confirm income, what income standard will be utilized, and how all of this information will be verified by the state.

Task Force Recommendations Not Modeled

Retaining Policies that Work

This category of recommendations from the Concept Paper includes policies that the Task Force recommends stay in place under any reform effort. OSDH does not propose any changes to these existing policies at this time. It is important to note, however, that there is some uncertainty about these provisions of current law given activities at the federal level. These policies include:

- Retain ACA provisions related to AI/AN populations and the Indian Health Care Improvement Act
- Ensure the special protections and provisions, exemptions, as well as special enrollment period for American Indian/Alaska Native populations are retained
- Retain inclusion of preventive services
- Retain guaranteed issue
- Retain dependent coverage up to age 26

Recommendations Related to State Oversight of the Individual Market

The following Task Force recommendations are categorized as changes to state regulation and federal flexibilities as part of a broader reform effort under a Section 1332 Waiver. A key priority of the Section 1332 Waiver collaborative effort is to establish state oversight of the Oklahoma insurance market. By implementing market-based reforms and taking advantage of federal flexibilities available under Section

1332, Oklahoma aims to make positive changes to its insurance market, including lowering premiums in the individual market by providing relief to health insurance carriers, and making increased financial assistance available to Oklahomans who are having trouble affording health coverage. Oklahoma also wants to help move health plans toward more accountable, high quality care using policy levers available under a modernized market. Proposals under this category are described in more detail below.

Oklahoma will use its regulatory control over the individual market under a Section 1332 Waiver to require health plans to implement more accountable practices and to increase health care quality in certain areas. Oklahoma would utilize penalties or incentives to enhance or motivate these changes, such as requirements for plan selection or corrective action plans. To accomplish this goal, OSDH would require health plans to carry out the following functions and changes. The operational and timing considerations associated with these recommendations follow.

Specific Plan Selection Recommendations

Implement Value-based Payment Arrangements

Oklahoma aims to have at least 80 percent of all provider payments under a value-based arrangement by 2020. One strategy to achieve this goal is to require health plans participating in Oklahoma's modernized market to demonstrate that they are implementing value-based payment arrangements in their provider contracts. Oklahoma will determine a set of requirements for the degree to which health plans must implement these payment arrangements and will verify this as part of plan selection. If Oklahoma carries out its own plan selection process, this recommendation does not require a Section 1332 Waiver.

Quality Measures Related to Chronic Disease

As part of plan approval under the modernized market, Oklahoma would require health plans to report on a set of pre-determined chronic disease measures, and performance against these measures would be tracked over time. Oklahoma's Health and Human Services Cabinet is leading an effort to gather existing measures for a variety of public programs related to chronic disease. This initial list of approximately 12 measures, all but one defined by the National Quality Forum, was finalized in the spring of 2017 and will provide a baseline of standardized, reportable quality measures among all plans. If Oklahoma carries out its own plan selection process, this recommendation does not require a Section 1332 Waiver.

Care Management and Care Coordination

Oklahoma will encourage plans to implement comprehensive care management and care coordination programs to provide more accountable care for their members. The state also supports mechanisms to provide consumers with incentives for participating in case management/care coordination. Additionally, case management/care coordination activities and quality measures for chronic disease will be aligned with value-based payments. If Oklahoma carries out its own plan selection process, this recommendation does not require a Section 1332 Waiver.

Encourage Plans to offer Dental and Vision Coverage

In addition to the requirements outlined above, Oklahoma will encourage health insurance carriers to offer dental and vision benefits in addition to their standard benefit packages to increase the value of health plans for consumers and to increase enrollment.

Encourage the use of Telehealth

Oklahoma will also work with health plans to encourage greater use of telehealth across the state. Oklahoma will explore methods for encouraging its use, either through workgroups and conferences, development of best practices, incentives, or other means.

Operational and Timing Considerations

In order to implement the recommendations above that relate to new requirements placed on health plans that serve the Marketplace, Oklahoma will need to take on the functions of Plan Management, through an arrangement with the federal government similar to the Partnership Marketplace. A Partnership Marketplace is an arrangement with the federal government under which the state carries out the Qualified Health Plan (QHP) certification process and other plan management functions, consumer assistance functions, or both. Several states operate as Partnership states today, carrying out these select functions, while the FFM carries out the remaining Marketplace functions. By taking on the plan management functions, including reviewing plans and their rates each year during the annual QHP certification process, as well as conducting ongoing oversight of QHPs, the state maintains a measure of control over its own individual market. In the absence of partnership, the FFM carries out all functions and has ultimate authority for QHP certification with some state input.

To carry out plan selection, Oklahoma would need approval from CMS. Oklahoma will likely need to notify CMS of its desire to operate plan management functions several months before the beginning of the QHP certification process for the upcoming plan year and will need to comply with a CMS schedule of reviews to assess readiness. As part of carrying out these functions, the state would have some flexibility to tailor the QHP certification requirements that are set forth in federal regulation.[64] The program changes related to placing certain requirements on health plans could be incorporated into the annual QHP certification process and reviewed by the Insurance Department each year. The state would likely need to pass legislation or issue regulations containing these additional requirements, and will need to examine carefully the level of flexibility that is allowed while still participating in the FFM. The state could likely implement such an approach by the summer of 2018 in order to be ready for the 2019 coverage year.

Alternatively, the state could decide to wait to carry out plan management functions until it has implemented its own program through the Insure Oklahoma platform, which is described in more detail on page 55. Under this approach, the state could apply for a Section 1332 Waiver that incorporates a waiver of the QHP certification requirements as set forth in Section 1311(c) of the ACA and would therefore have complete flexibility to define the QHP certification requirements, including the requirements outlined above, as well as other requirements related to standardized plan designs and

[64] 45 CFR Part 156.

participation in the state's Individual Health Insurance Market Stabilization Program. The state may need to enact legislation or issue regulations containing the requirements related to plan selection for plans wishing to participate in the program. To operationalize the new platform and include plan certification functions as part of that implementation, the state would likely need to implement this approach in 2019 for the 2020 coverage year.

Quality Reporting

Oklahoma will examine methods for streamlining quality reporting for health plans by evaluating measure sets already in use for Medicare and other public programs. Additionally, Oklahoma will examine opportunities to provide more standardized quality information to consumers, potentially modeling its approach on the Medicare Advantage Star ratings. Oklahoma will also consider the existing Quality Rating System (QRS) in place for all Marketplace plans.

Operational and Timing Considerations

Any effort to change quality reporting requirements for health plans should be considered in the context of reporting that is already in place both for the Medicare Star ratings as well as under the QRS that is a requirement for all Marketplace plans. Currently, all Marketplace plans are required to collect and submit third-party validated QRS clinical measure data and QHP Enrollee Survey response data that will be used by CMS to calculate QRS ratings. The QRS measure set includes 43 measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability, and management. QHP issuers are required to collect and submit data for these 43 measures. The QHP Enrollee Survey is largely based on items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. CMS uses a standardized methodology to calculate QRS scores and ratings based on the measure data submitted by each QHP issuer. A summary rating and enrollee survey score are also displayed on Healthcare.gov and are required to be displayed on each State-based Marketplace website.

Oklahoma could waive the required QRS and associated measure reporting under a Section 1332 Waiver by applying to waive Section 1311(c)(3) of the ACA. However, doing so would require the state to establish its own quality rating reporting process and to develop a methodology for calculating plan ratings. Utilizing the federally-developed and supported QRS would reduce administrative burden for the state. If the state determines it would like to implement its own rating system, it would likely take until 2021 to implement such a program given the necessary lead time and data lag for measure reporting, the development of systems to support such reporting, and the process for calculating and displaying plan ratings to consumers.

Core Health Benefits

Oklahoma may undertake a comprehensive process to evaluate the Essential Health Benefits package that is in place under the Affordable Care Act, and will consider making changes to the benefit package to increase affordability of coverage. The state will also revisit mandatory benefit requirements to ensure that standards in place are optimal and supported by evidence-based medicine. While the state may consider more flexibility within individual health plan options, it would ensure that consumers still have access to the same benefits currently offered through the ACA within the Marketplace overall.

Operational and Timing Considerations

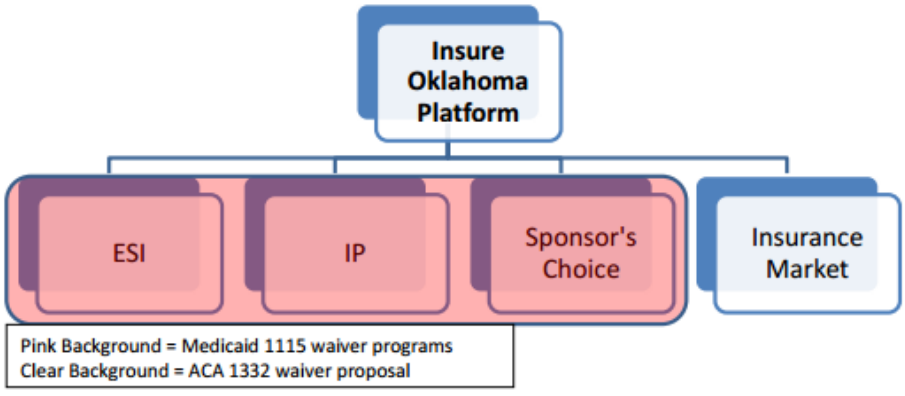
Any effort to change the Essential Health Benefits package for individual market plans is likely to be controversial and require the engagement and consultation of numerous stakeholders, as well as the assistance of an actuarial contractor and clinical support from the provider community. Multiple stakeholder groups will have a strong interest in determining the benefits that are required to be offered through the state's individual market assistance program. The state's existing mandated benefits will also need to be considered as well as questions related to spreading risk across the population. The state would likely need to pass legislation and issue regulations to implement an alternate benefit package, and would also need to apply for and secure a Section 1332 Waiver to make this change, unless other changes to federal law take place that afford this flexibility without a waiver.

An important clarification is that any change to the benefits package offered through a Section 1332 Waiver program must provide a set of benefits that is as comprehensive as the Essential Health Benefits required by the ACA. Therefore, Oklahoma would only be able to implement under a Section 1332 Waiver a benefit package that provides a comparable level of coverage as the coverage provided under the ACA in the absence of the waiver. An actuarial analysis is required to determine the comprehensiveness of coverage that would be provided under an alternate benefit package. Given the time it would take to implement a robust stakeholder process to develop a new benefit package, and then the time it would take for waiver review and approval, it is unlikely such a change could be implemented before the 2020 coverage year.

Oklahoma's Modernized Market

In order to implement certain Task Force recommendations under a Section 1332 Waiver, Oklahoma would need to take control of all eligibility and enrollment, plan certification, and other FFM functions to operate its own modernized market for individual health insurance plans with associated subsidies. The need for this change is based on the inability of Oklahoma to rely on the FFM structure to support the many program reforms that have been proposed due to the requirement that all changes proposed under a Section 1332 Waiver be budget neutral to the federal government, including administrative costs.

Figure 12: Insure Oklahoma Platform Responsibilities



To implement many of the Task Force recommendations, Oklahoma can leverage the existing Insure Oklahoma platform to the extent possible to ensure efficiencies in administration across programs. If the Sponsor's Choice Waiver is approved by CMS, the same platform will also be used to determine eligibility for that program. The Insure Oklahoma platform supports the provision of health coverage to

certain eligible employees and individuals who are between the ages of 19-64, meet income requirements, and are not covered by other public coverage. The program has an online portal and application process that could be leveraged to support portions of the Marketplace platform.

Task Force recommendations that will require the state to move away from the FFM structure are listed in Table 26 below.

Table 26: Task Force Recommendations Requiring Movement to Oklahoma Platform

Changes to Subsidy Calculation (based on age and income)
Changes to Subsidy Eligibility (shift from 100%-400% FPL to 0%-300% FPL)
Movement to Two Standardized Plan Options
Consumer Health Accounts
Changes to Age Rating Window (depending on federal action)
Changes to Benefit Package Offerings
Reduced Administrative Burden for Health Plans
Changes to Exemption Criteria
Consumer Incentives
Automatic Enrollment
Direct Enrollment
Moving New Populations into the Market (i.e. CHIP)

To implement its own modernized market and carry of the functions that are today being supported by the FFM, Oklahoma will need the capability to carry out the major functions listed below:

- Selection of participating plans and associated requirements for participation, including review of rate and form filings and validation of actuarial value levels, among other reviews
- Eligibility determination and verification
- Calculation of premiums and subsidies for eligible individuals and families
- Enrollment into selected health plans for individuals and families
- Subsidy administration including payments, tracking, and reconciliation
- Development and maintenance of an online portal for eligibility and plan selection
- Presentation of quality ratings on the online portal
- Risk adjustment if the state determines it will use its own process outside of the federal process
- Ongoing oversight of health plans
- Consumer support and outreach
- Data collection and analysis

Governance Structure

One of the first steps Oklahoma would need to take to establish the waiver program is to identify and put into place the governance structure. According to the ACA, a Marketplace program must be operated by a governmental entity or non-profit entity that meets the requirements of regulations at 45 CFR 155.110 that relate to conflicts of interest and the required governing board structure.[65] The

[65] 45 CFR 155.110, available at: https://www.law.cornell.edu/cfr/text/45/155.110

process for setting up this governance structure may require the state to enter into a contract with a non-profit entity to operate the program. Some states have chosen to operate Marketplaces within their Medicaid agencies while others have established quasi-governmental entities that have certain governmental functions and oversight but are also governed by an independent board.

In Oklahoma, one possible approach would be to operate the program through the Oklahoma Health and Human Services Cabinet, staffed by OSDH, which would maintain oversight over the program, and have the Insurance Department manage and operate the annual plan selection process, including rate and form review, and ongoing oversight of selected plans. Such a hybrid approach is common among other Marketplaces where plan management functions have remained within the state's department of insurance. Functions that may be carried out by the Insurance Department could include:

- Verification of benefit package and actuarial value
- Review for discriminatory benefit design
- Review of Rates and/or forms
- Review of plan marketing materials
- Review of administrative information
- Review of licensure and standing
- Review of network adequacy
- Verification of accreditation
- Review of quality data
- Monitoring and oversight

Required Resources for IT Systems and Start-up

The shift to an Oklahoma platform for administering the waiver program will require considerable resources and investment of time in order to stand up and operate the needed IT systems and operational functions. IT system investments will be needed to take the existing Insure Oklahoma infrastructure and modify it to support broader and more complex functions in addition to eligibility determinations. For example, the establishment of an online portal and plan selection process requires considerable IT investment to support the collection of detailed health plan data to populate the portal, back-end processes to display health plan information to consumers in a standardized format, a rating engine to calculate premiums for each individual and family based on complex rating rules that can vary by plan, functionality to determine eligibility for the program and for subsidies, and functionality to calculate subsidy amounts and enroll individuals and families into selected health plans. Such an IT build would likely require considerable financial resources. For this reason, and other challenges associated with the operation of Marketplace online portals, several states like Hawaii and Oregon have moved away from operating their own Marketplaces and are instead working in tandem with the FFM to operate these complex functions, rather than carrying out these processes on their own.

Today, there are no federal funds available specifically to establish a State-based Section 1332 Waiver program and to administer the program. Previous funds were provided under the Exchange Planning and Establishment Grants but the authorization for these funds ended on December 31, 2014. Funding is available for eligibility system enhancement and maintenance through Medicaid, but these funds must be cost allocated between Medicaid and the Marketplace program.[66] Oklahoma will need to work

[66] https://www.medicaid.gov/affordable-care-act/provisions/downloads/key-cost-allocation-qas-10-05-12.pdf

closely with CMS to identify any additional funding sources that could be utilized for the administration of the waiver program, if any. On an ongoing basis, the waiver program could be funded through assessments on health plans, which is the model in use for most successful State-based Marketplaces today due to the ACA requirement that Marketplaces be self-sustaining as of January 1, 2015.

Timeline

In terms of the timeline required to stand up the Section 1332 Waiver program through an OK platform, it is unlikely that Oklahoma would be able to begin operations prior to the 2020 plan year. This timeline is influenced by several factors. First, Oklahoma would be required to submit a Blueprint to CMS to indicate that it wishes to take on these functions and to demonstrate its readiness to do so 15 months prior to beginning enrollment. Oklahoma would also need to have an approved operational assessment and Blueprint no later than 14 months prior to beginning enrollment. In order to have this approval, the state would need to be able to demonstrate readiness to operate the required functions, including having an established governance structure, demonstrating enough progress on IT systems to indicate readiness to begin operating within 14 months, and providing various plans and documentation of stakeholder consultation, data collection, outreach, and other activities.[67] In addition, it will take several months to build the infrastructure to support all required functions, including the build and testing of IT systems, both independently and with health plans. Ideally, the state would have a year to 18 months to develop and test the needed IT system infrastructure alone.

The table below presents a high level implementation timeline for establishing a state-based Section 1332 Waiver program.

Table 27: High Level Implementation Timeline for Oklahoma Modernized Market

Task	Approximate Timing
Submit Section 1332 Waiver Application	TBD
Section 1332 Waiver Approval	TBD
Pass Enabling Legislation	May 2018
Establish Governance Structure	June 2018
Procure IT Contractor	June 2018
Begin IT System Development	July 2018
Submit Exchange Blueprint	August 2018
Hire Staff	September 2018
Procure Consumer Health Accounts TPA	October 2018
Begin Plan Selection Process	March 2019
Conduct Plan Selection and Eligibility IT System Testing	May 2019
Select Plans and Collect Plan Data	August 2019
Launch Consumer Health Accounts	August 2019
Open Enrollment Begins	November 2019
Coverage Begins	January 2020

[67] https://www.cms.gov/CCIIO/Resources/Files/Downloads/hie-blueprint-11162012.pdf

Small Business Health Options Program (SHOP)

Under the proposed reforms recommended by the Task Force, it does not appear that Oklahoma needs to take on the functions of a SHOP Marketplace at this time. Oklahoma can remain a part of the FFM for purposes of operating the SHOP, unless it determines that it would prefer to operate both the individual and small group markets together. Recent guidance from CMS indicated that states operating State-based Marketplaces are no longer required to also support an online shopping experience for SHOP.

Other Task Force Recommendations

Tighter Restrictions on Premium Payment Grace Periods and Enrollment Changes

The Concept Paper recommends a change from the statutorily required 90 day grace period for non-payment of premium in the Marketplace to a 30-day grace period. This change is proposed to help stabilize the individual insurance market. Moving from a 90 to 30 day grace period would require a statutory change to current law under the Affordable Care Act. Today, health plans can pend claims after 30 days of non-payment and can terminate coverage at the end of the 90 day period. They also receive APTC payments during the three month grace period. The health plan is allowed to keep the first month's APTC, but must refund APTC payments to the federal government that are received for the second and third month if the enrollee does not make premium payments during the second and third months of the grace period. The Concept Paper also contemplates strengthening verification for special enrollment periods.

Operational and Timing Considerations

The federal government issued a Final Rule on April 18, 2017 that includes provisions related to non-payment of premiums and the open enrollment period, among other regulatory changes.[68] The final rule allows health plans to attribute payments made by enrollees to outstanding debt for coverage under any of its products during the previous 12 months. The insurer is also able to deny further coverage until outstanding premiums are paid. This interpretation applies during open and special enrollment periods. The final rule also shortens the open enrollment period for the 2018 coverage year, which will run from November 1 to December 15, 2017. The final rule does not make changes to the 90 day grace period for non-payment of premiums since this would require a statutory change. For those changes that were included in the final rule, health plans participating in the FFM will make changes to comply, so Oklahoma does not need to take any action to implement them at this time.

Automatic Enrollment

Oklahoma will explore potential opportunities for utilizing an automatic enrollment process to streamline eligibility and enrollment across Medicaid and the new modernized market operated under Insure Oklahoma. For example, an individual might apply for an eligibility determination for Medicaid and be determined ineligible, and the Insure Oklahoma platform would automatically redirect the person for enrollment in an individual market plan.

[68] Market Stabilization Final Rule, Published in the Federal Register April 18, 2017. Available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-07712.pdf

Operational and Timing Considerations

In order to implement this function, the eligibility system in place under Oklahoma's modernized market will need to seamlessly provide a "no wrong door" approach to eligibility under which an individual is determined eligible for either Medicaid or commercial insurance subsidies simultaneously. Oklahoma likely will not be able to automatically enroll an individual into a given plan because the current ACA ensures that consumers have a choice of health plan. But, Oklahoma could help facilitate this process by following up with people who drop out of the process and by making the online application process as easy to use as possible.

Movement of Populations to the Individual Market

The state will examine opportunities to move other populations into the individual market, including the Children's Health Insurance Program (CHIP) enrollee population. The future of CHIP is uncertain given that the program is set to expire in 2017 if Congress does not reauthorize it. If this occurs, children in Oklahoma who are covered by CHIP would lose coverage. Oklahoma may decide to shift this population into the new program and allow purchase of subsidized coverage in the individual market for eligible Oklahomans, in lieu of their loss of coverage altogether.

Operational and Timing Considerations

In order to determine the feasibility of this option, Oklahoma will need to examine the legal authorities that would be needed to transition other populations into the individual market. It would also need to determine what level of funding would be required to provide subsidies for the purchase of coverage. Oklahoma could include this population in the operational implementation of its modernized market and allow families to purchase coverage through the new waiver program. However, waiver funding may be insufficient to provide subsidies to this population. An actuarial analysis will be needed to determine whether and what level of subsidy may be possible. The state could also consider rolling this population in a Section 1115 Medicaid waiver. It is unlikely that the state could transition this population prior to the 2020 coverage year.

Consumer Incentives

Oklahoma will examine opportunities to incentivize healthy behaviors among the population receiving subsidies through consumer health accounts. Such incentives may include reduced premiums for individuals who enroll in coverage during the open enrollment period, reductions in cost sharing over time when an individual remains consistently enrolled, and rollover of unused account funds to the following year for the receipt of recommended health screenings or primary care visits.

Operational and Timing Considerations

Oklahoma will want to carefully consider the operational implications of implementing consumer incentives, and the ability of consumers to understand and fully utilize these incentives. Implementing incentives such as reduced premiums and reduced cost-sharing can have significant operational implications for the back-end system that supports premium calculation and that displays cost-sharing amounts to consumers when they are shopping for coverage. Health plans may also identify significant operational complexities related to having differing premium amounts for the same types of individuals and different cost-sharing amounts, which operationally means different plan designs. Oklahoma may

want to consider simpler approaches like the use of gift cards or cash vouchers that can more easily be provided to consumers and do not require actions on the part of health plans to tailor products and premiums accordingly. Simpler incentives can be implemented more quickly and at a much lower administrative cost.

Exemption Criteria

Under the scenario in which Oklahoma maintains control of the subsidized individual market, Oklahoma would consider eliminating certain exemptions from the individual responsibility requirement. For example, Oklahoma could eliminate the exemption criteria related to affordability, financial hardship, or closing the coverage gap (0-100 percent FPL) under the new program. This assumes that the individual responsibility requirement remains; the AHCA and BCRA eliminate the individual mandate.

Operational and Timing Considerations

The state can propose to make changes to the exemptions required under the ACA through including these changes in a Section 1332 Waiver. Under a modernized market where Oklahoma is performing Marketplace functions, the state could choose to have exemptions processed by the federal government, or process exemptions on its own. This process would require collection and verification of documentation to validate exemption requests.

Direct Enrollment

One of the Task Force recommendations is to allow health plans participating in the modernized market to directly enroll individuals and families rather than requiring them to enroll through the state program as is the requirement today. Such a program change would allow an individual to go directly to a health plan of his or her choosing to apply for coverage through the new Oklahoma program.

Operational and Timing Considerations

The main reason people are not able to directly enroll through health plans today is the need for federal verification of their eligibility, a process that must be carried out by the federal government. Up to this point, CMS has been unable to implement a process whereby health plans could assist a consumer with selecting a plan and directly determine their eligibility, rather than referring the individual to the Marketplace for eligibility determination. However, CMS recently issued guidance stating that they would begin to allow direct enrollment in the individual and SHOP markets for the 2018 coverage year, yet it is still unclear whether this new approach will be implemented and operational in time.[69] CMS has indicated that they will begin testing this functionality with approved direct enrollment entities in September 2017, and will support this function for both State-based Marketplaces and in the FFM.

Reduced Administrative Burden for Health Plans

Under Oklahoma's modernized market, administrative requirements placed on health plans will be evaluated to identify opportunities for streamlining or eliminating these requirements while still maintaining the ability to oversee plan quality and operational performance.

[69] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-for-the-Proxy-Direct-Enrollment-Pathway-for-2018-Individual-Market-Open-Enrollment-Period.pdf

Operational and Timing Considerations

As Oklahoma works to implement its operation of certain functions, it can consider ways to ease the administrative burden on health plans. This could be accomplished through streamlining the data collection required for annual certification, streamlining reporting to reduce the number and frequency of reports required from health plans, and allowing plans to directly market and enroll individuals in their plans. Opportunities for reducing administrative burden should be considered throughout the implementation process, while still balancing the need for effective plan oversight.

Next Steps

Based on the modeling results, the design considerations, and operational and timing considerations provided above, Oklahoma will first need to determine the core set of programmatic changes it recommends be included in upcoming Section 1332 Waiver applications. The broad approach to implementing a reinsurance program is decided at this point, but other changes like changing subsidy eligibility and moving to two standardized plan options still require additional analysis to get to the next level of detail in terms of how they will be designed, what associated impacts those design choices will have, and whether they will be feasible under Section 1332.

In parallel, Oklahoma should consider a phased approach to submitting Section 1332 Waiver applications, beginning with the most urgent implementation issues, which at this time should focus on implementing the recently authorized Oklahoma Individual Health Insurance Market Stabilization Program. OSDH and the Insurance Department can also begin planning and implementation activities related to standing up the Individual Health Insurance Market Stabilization Program, including identification of board members and the subsequent development of an operational plan and the hiring of any needed contractors to support systems development for the program.

Once these activities are under way, the Insurance Department should also begin planning for assuming responsibility of the QHP certification process under a Partnership arrangement to allow the state to develop procedures and functions that will later support a full Oklahoma modernized market. Oklahoma would need to notify CMS of its intention to take on plan management functions in the near term in order to meet operational timelines. Moving to a Partnership arrangement with the FFM will provide Oklahoma with greater flexibility in how it reviews health plans for QHP certification.

In order to carry out the majority of the reforms outlined in this report, including changes to subsidy calculations, subsidy eligibility, and standardization of plan designs, Oklahoma will need to submit a Section 1332 Waiver application and prepare to take on the majority of Marketplace functions. Oklahoma will also likely want to include the more robust changes to QHP certification requirements, like requiring value-based payment arrangements and care coordination, in its full implementation of Marketplace-like functions given the need for plans to have significant lead time in addressing process changes and associated product design changes. This undertaking will require significant time and resources, and Oklahoma should start planning this fall to determine the level of resources required and the timeline for implementation, and examine potential funding sources to support the administrative costs of operating a the program. For these reasons, Oklahoma should aim to begin operating these functions for the 2020 plan year, with open enrollment beginning in November 2019.

The figure below presents the recommended timing for each of the Task Force recommendations.

Figure 13: Task Force Recommendation Timing and Associated Waiver Requirements

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

Conclusion

Oklahoma has engaged in a robust stakeholder engagement process to develop and vet possible proposals that could be submitted to the federal government in a Section 1332 Waiver application. In addition, the analyses presented in this report provide valuable insight into how the state could proceed in the coming months to implement various proposals, some of which require other federal authority outside of a Section 1332 Waiver and others that can be accomplished through state action. Oklahoma must continue to conduct research and stakeholder engagement related to the proposals recommended by the Task Force and outlined in this report, including collecting further input from consumers and consumer advocates as the design details for each proposal are developed. However, the work done to date on developing and analyzing potential paths forward sets the table for the more detailed implementation work ahead. By piecing together a number of complementary strategies over time, Oklahoma has the potential to stabilize its individual market and increase access to health insurance for its residents.

Appendices

A. SB 1386 Language
B. Task Force Description
C. March Concept Paper
D. Task Force Membership
E. Milliman Environmental Scan
F. Evolve Research Report
G. Federal Proposal Crosswalk
H. Summary of Public Comments on Draft Concept Paper
I. Data Modeling Sources and Limitations
J. Detailed Modeling Results
K. Detailed Analysis of Task Force Recommendations - Statutory and Regulatory Analysis

Appendix A
SB 1386 Language

An Act

ENROLLED SENATE
BILL NO. 1386

By: David of the Senate

and

Mulready of the House

An Act relating to health insurance; creating the State Innovation Waiver; allowing for multiple waiver submissions; establishing certain procedures for development; requiring certain entities to submit information for approval; authorizing the Insurance Department to review health insurance market after waiver implementation; providing for codification; and providing an effective date.

SUBJECT: State Innovation Waiver

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1416 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. There is hereby authorized the creation and submission of a State Innovation Waiver for the purpose of creating Oklahoma health insurance products that improve health and healthcare quality while controlling costs.

B. The State Innovation Waiver may include multiple waiver submissions under federal waiver authorities, including:

1. Waivers as provided in Section 1332 of the federal Affordable Care Act for the purpose of waiving certain federal

insurance and tax regulations to create more state flexibility within the health insurance market; and

2. Waivers as provided in Section 1115 of the federal Social Security Act for the purpose of participating in the Delivery System Reform Incentive Payment Program or uncompensated care pools or both the Delivery System Reform Incentive Payment Program and uncompensated care pools with the aim of incentivizing providers through payment for achieving better health outcomes.

C. The State Innovation Waiver shall be created consistent with the innovation design plan developed through the Oklahoma Health Improvement Plan. It shall be presented to the Oklahoma Legislature along with a summary of comments received from public hearings and shall include the identification of specific provisions of the Affordable Care Act to be waived in the State of Oklahoma.

D. Participating agencies, including but not limited to the State Department of Health, the Oklahoma Health Care Authority, the Department of Mental Health and Substance Abuse Services and the Insurance Department, shall develop the State Innovation Waiver with input from the private sector partners and various subject matter experts and submit any and all necessary information for approval to all relevant entities.

E. The Insurance Department is hereby authorized to conduct rate review for the individual and small group health insurance market upon implementation of the State Innovation Waiver under Section 1332 of the federal Affordable Care Act.

SECTION 2. This act shall become effective November 1, 2016.

Passed the Senate the 9th day of May, 2016.

_____
Presiding Officer of the Senate

Passed the House of Representatives the 14th day of April, 2016.

_____
Presiding Officer of the House
of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____ day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____ day of _____, 20_____, at _____ o'clock _____ M.

_____
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____ day of _____, 20 _____, at _____ o'clock _____ M.

By: _____

Appendix B
Task Force Description

Oklahoma 1332 State Innovation Waiver Task Force

August 30, 2016

Oklahoma Senate Bill1386, enacted during the 2016 legislative session, has been created to explore potential methods to reduce the financial burden for Oklahoma residents and employers seeking affordable, quality healthcare coverage. As a result of this legislation, a task force comprised of numerous Oklahoma stakeholders will investigate and analyze the options for Oklahoma pursuing a 1332 "State Innovation" Waiver. The 1332 State Innovation Waiver was included in the Affordable Care Act to allow states to waive certain provisions of the Affordable Care Act (ACA) and develop innovative, state-based solutions to address its healthcare coverage needs.

The 1332 Waiver task force will explore what Oklahoma needs to ensure affordable and robust healthcare coverage for its residents and, with public input, decide how best to address our state's needs and whether to develop a 1332 Waiver. The goal is to create an alternative pathway for affordable, high quality healthcare coverage in Oklahoma's commercial insurance market that meets the needs of Oklahomans.

1332 "State Innovation" Waiver Overview

A 1332 waiver allows states to request federal authority to pursue innovative strategies for providing state residents access to high quality, affordable health insurance. These renewable five-year waivers may propose modifications to provisions of the ACA within a set of parameters that that could alter the way tax credits or subsidies are delivered in a state. Medicaid **is not** included or impacted by a 1332 waiver, since the waiver focuses on the commercial health insurance market in a state allowing some modifications to the insurance regulations imposed by the ACA.

A state's 1332 waiver proposal may alter one or many of the following four ACA regulatory areas:

- **Individual Mandate:** States can modify or eliminate tax penalties.
- **Employer Mandate:** States can modify or eliminate penalties for large employers.
- **Benefits and Subsidies:** States can modify rules related to covered benefits and subsidies.
- **Exchanges and Qualified Health Plans (QHPs):** States can modify or eliminate exchanges and QHPs as the means for determining subsidy eligibility and insurance enrollment.

Waiver Guardrails

While the waiver allow states flexibility with provisions of the ACA, the federal government has imposed the following criteria in their review and approval of 1332 waiver proposals:

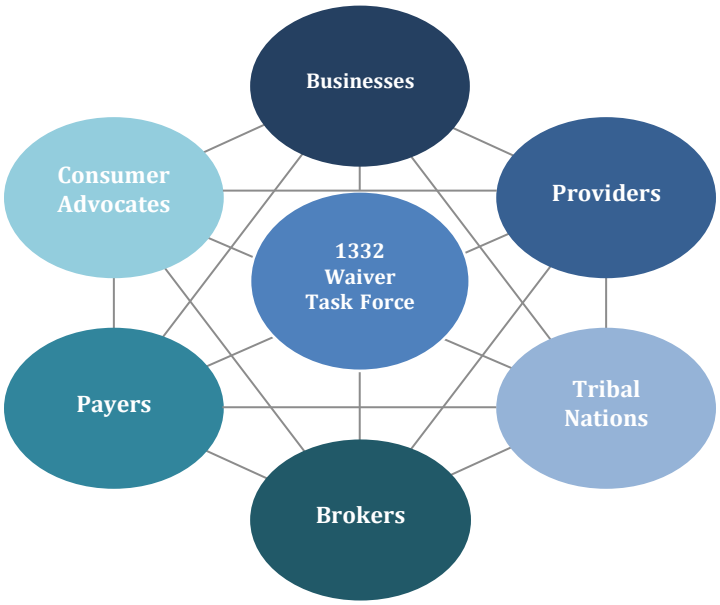
- **Scope of Coverage:** States must provide coverage to at least as many people as currently covered under the ACA.
- **Comprehensive Coverage:** Coverage provided by states through the waiver must be at least as comprehensive as coverage offered though exchanges.
- **Affordability of Coverage:** Coverage must be as affordable as exchange coverage, and states must have cost sharing and out-of-pocket protections that are comparable.
- **Federal Deficit:** State waivers must not increase the federal deficit.

1332 "State Innovation" Waiver Task Force

To support SB1386, a 1332 Waiver task force has been created to identify and analyze options, and provide advice on the development of a 1332 Waiver. The 1332 Waiver task force consists of private and public stakeholders that will meet regularly to discuss possibilities for an Oklahoma 1332 waiver proposal. Public meetings will be held periodically, and any interested stakeholder may provide input throughout the development process. Stakeholder feedback will assist the state with development of a waiver. A high-level concept paper is anticipated to be presented to the public and elected officials in early 2018.

The task force includes representatives of:

- Consumer Advocates
- Businesses
- Tribal Nations
- Commercial Health Insurance Carriers
- Healthcare Providers
- Health Insurance Brokers



1332 Waiver Support Staff

To help support 1332 waiver development, actuarial and technical assistance consultants, project managers, and program coordinators will be provided to capture taskforce and stakeholder feedback, as well as draft taskforce recommendations. Additionally, at the request of the Oklahoma Health and Human Services Cabinet Secretary, state agencies have been asked to participate as conveners, assisting the task force in an advisory role. The Oklahoma agencies include: State Department of Health; Health Care Authority; Insurance Department; Department of Mental Health and Substance Abuse Services; Employee Group Insurance Division; and Department of Human Services.

Waiver Development and Implementation Timeline

Per federal regulation enactment of a 1332 waiver cannot begin before January 1, 2017. There is no deadline for submission of waiver applications. States must provide opportunities for public review and input prior to submission of the waiver. Once the waiver is determined to be complete, the Secretary of Health and Human Services (HHS) will notify the state of waiver approval or denial within 180 days.

HHS recommends submission of a 1332 waiver one year in advance of enactment. In Oklahoma, should a waiver be pursued and approved, the waiver could be effective no earlier than January 1, 2018. Waiver requirements include:

- The list of provisions the state seeks to waive, including the rationale for the specific requests;
- Data, assumptions, targets, and other information sufficient to determine that the proposed waiver will comply with federal waiver guidelines;
- Actuarial analyses and actuarial certifications to support state estimates that the waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement;
- A detailed 10-year budget plan that is deficit neutral to the federal government;
- A detailed analysis of the impact of the waiver on health insurance coverage in the state;
- A description and copy of the enacted state legislation providing the state authority to implement the proposed waiver;
- A detailed plan as to how the state will implement the waiver, including a timeline.

Appendix C
March Concept Paper

A New Horizon

Recommendations for Oklahoma's Modernized Health Insurance Market

March 2017

Submitted by:

Secretary of Health and Human Services

State of Oklahoma

Contents

Executive Summary

The passage of the Patient Protection and Affordable Care Act (ACA) brought about numerous changes to the way health insurance coverage is provided to Oklahoma residents. While these changes have increased the number of Oklahomans with health care coverage, it has come with increased burden and cost for individuals, employers, and insurance carriers. Oklahoma continues to face a number of challenges related to providing individuals with access to affordable, quality, and sustainable health care coverage. Particularly telling of the necessity of swift intervention is the exodus of all but one carrier from Oklahoma's individual insurance market for plan year 2017, premium increases in excess of 75% on average for plan year 2017, and participation of only 31% of eligible individuals for plan year 2016.[1]

Fortunately, the availability of 1332 State Innovation Waivers – coupled with potential regulatory shifts at the federal level – gives our state the chance to make significant changes necessary to improve the health of our insurance market and citizens. As Congress considers the repeal and/or modification of the ACA, the State of Oklahoma is anticipating unique opportunities to implement innovative strategies for consumers, employers, and insurance carriers that are responsive to our state's needs.

Above all, the new health insurance market must institute a framework that focuses on improving health outcomes and quality while controlling costs. Health care coverage should be seen as an essential tool toward these aims rather than a stand-alone goal; that is, increasing the number of lives with coverage without addressing the necessary changes of the health care system at large is unsustainable.

Within this framework there is a great deal of opportunity to return flexibility to states to implement delivery system and payment reforms based on local conditions; reduce administrative burden on states and the health care industry; ease requirements that are driving up the cost of coverage for young, healthy individuals; and support small business and families access coverage. Specifically, Oklahoma has identified five guiding principles that are the foundation of the recommendations that follow:

- ✓ Increase flexibility at the state level by empowering our state regulatory entities to adapt to our state's needs
- ✓ Reduce costs by stabilizing the state's health insurance market
- ✓ Improve health outcomes by employing strategies to evaluate our health system's performance
- ✓ Embrace innovation through state-based solutions that promote high-quality care, continuity of coverage, and affordability
- ✓ Support individual control and choice by increasing competition and providing consumers with the tools they need to make informed decisions

The 1332 Waiver Task Force has met since August 2016 to discuss challenges and design solutions to support these guiding principles in order to stabilize Oklahoma's individual health insurance market. The state will likely pursue sequential 1332 Waivers and/or amendments to an initial waiver to implement the changes over time. It is anticipated that an initial waiver that would allow the state to assume more

[1] The Henry J. Kaiser Family Foundation. (2016). Marketplace enrollment as a share of potential marketplace population - March 31, 2016: http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/?currentTimeframe=0

responsibility over rate review and plan qualification would be submitted in July of 2017 at the earliest, with implementation in 2018. Additionally, some strategies may not require a waiver but rather state or federal action and can be phased in to complement the 1332 Waiver.

The 1332 Waiver Task Force proposes the following implementation timeline, recognizing some of these are dependent on significant and timely changes to the ACA:

2018 Implementation

- ✓ **Assume state regulatory control** over certain market functions that are currently being done at the federal level, including rate review, health plan certification, and actuarial value validation
- ✓ **Require a focus on health outcomes and cost containment** by implementing state quality measures and promoting value-based payments and care coordination within health plans
- ✓ **Change the way insurance products are priced** by broadening age ratios that limit the differences in age-based pricing

2019 Implementation

- ✓ **Reduce administrative burden on plans** related to reporting, risk mitigation, eligibility, and enrollment
- ✓ **Eliminate the use of the Federally Facilitated Marketplace (FFM)** and instead utilize the Insure Oklahoma platform to determine eligibility for coverage and calculate subsidies
- ✓ **Establish consumer health accounts** similar to health savings accounts (HSAs) to encourage consumer-directed care and implement consumer incentives
- ✓ **Change subsidy eligibility** to individuals with incomes between 0% and 300% of the Federal Poverty Level (FPL)
- ✓ **Standardize subsidies** based on age and income
- ✓ **Simplify plans** by eliminating metal tiers and providing easy-to-understand choices
- ✓ **Modify mandated benefits** so the state can be innovative and flexible in order to reduce costs while providing adequate coverage
- ✓ **Change rules for special enrollment requests, premium payment grace periods, and exemptions** to promote timely enrollment and streamline enrollment processes

Detailed descriptions and justifications for all proposed strategies are provided in the Recommended Strategies section of this paper, as well as in Appendix A.

Background

The Oklahoma Legislature passed Senate Bill 1386 (Sen. Kim David, R-Porter; Rep. Glen Mulready, R-Jenks) with strong bipartisan support to explore possible solutions to address the challenges of the current health insurance market. Following the passage of SB 1386, Governor Mary Fallin established the 1332 Waiver Task Force (Task Force) to bring together a diverse set of stakeholders to develop potential strategies. The Task Force includes representation from both public and private entities, including commercial insurance carriers, businesses, providers, consumer advocates, and tribal nations, with support from state agencies. As a result of meeting regularly on a monthly basis since August of 2016, participant input, and data analysis, the Task Force identified a number of recommendations that form the basis for the comprehensive set of solutions outlined in this document.

It should be noted that these recommendations will not necessarily translate into the final 1332 Waiver request as more thorough analysis with contract consultants and legislative review are necessary to determine a more detailed waiver proposal. Rather, this concept paper provides an overview of the options and issues to be explored and creates an opportunity for conversation with the new federal administration about potential solutions discussed by the Task Force.

Overview of 1332 State Innovation Waivers

1332 "State Innovation" Waivers allow states to pursue innovative strategies for providing state residents access to high- quality, affordable health insurance by waiving certain provisions of the ACA. These renewable five-year waivers may propose minor modifications to the ACA, or they can propose sweeping changes that could alter the way tax credits or subsidies are delivered in a state. Essentially, if Oklahoma were to pursue a 1332 Waiver, the state would redesign how the ACA is implemented in order to be more responsive to Oklahomans' needs.

1332 proposals may alter the following four ACA regulatory areas:

- ✓ Individual Mandate – States can modify or eliminate tax penalties.
- ✓ Employer Mandate – States can modify or eliminate penalties for large employers.
- ✓ Benefits and Subsidies – States can modify rules related to covered benefits and subsidies.
- ✓ Exchanges and Qualified Health Plans (QHPs) – States can modify or eliminate exchanges and QHPs as the means for determining subsidy eligibility and insurance enrollment.

While the waivers allow states flexibility with provisions of the ACA, the following criteria must be met within the State Innovation Waiver:

- ✓ Scope of Coverage – States must provide coverage to at least as many people as the ACA would provide coverage to without the waiver.
- ✓ Comprehensive Coverage – Coverage provided by states through the waiver must be at least as comprehensive as coverage offered though exchanges.
- ✓ Affordability of Coverage – Coverage must be as affordable as exchange coverage, and states must have cost sharing and out-of-pocket protections that are comparable.
- ✓ Federal Deficit – States' waivers must not increase the federal deficit.

Further sub-regulatory guidance provided by the Centers for Medicare and Medicaid Services (CMS) offered additional considerations for states exploring 1332 Waiver authority. There is uncertainty surrounding the future applicability of these federal, sub-regulatory guidance areas. Oklahoma's approach to developing solutions has been mindful of, yet not limited by these restrictions. These guidance areas included:

- ✓ States must assess the impact to vulnerable populations (elderly and low-income residents) across the waiver guardrails in their proposals.
- ✓ Waivers that require changes to the Federally Facilitated Marketplace (FFM) platform, such as the calculation of financial assistance or special enrollment periods, are not considered feasible at this time.
- ✓ Waivers that require changes to the Internal Revenue Service (IRS) administrative process, such as determining different premium tax credits for residents, are not considered feasible at this time.
- ✓ States will need to consider administrative costs to the federal government in their proposals.

Additionally, Oklahoma submitted a Sponsor's Choice 1115(a) Waiver, which would provide Medicaid funding for tribal premium assistance. This waiver would support the goals of the 1332 Waiver by promoting individual insurance coverage, and thus it may be beneficial to have these two waivers approved together and/or align provisions so that the waivers complement each other but do not duplicate efforts or hinder either waiver's goals. More specific considerations and recommendations are provided in the 1332 Waiver Tribal Considerations section of this paper.

Regardless of what changes occur at the federal level, a 1332 Waiver will remain as a mechanism to communicate state priorities and request federal regulatory flexibility. The proposals put forward by the Task Force attempt to combine and leverage all policy options in order to customize the best option for Oklahoma's unique needs.

Oklahoma's Health Landscape and the ACA

While Oklahoma has experienced a reduced number of uninsured following the implementation of the ACA, it remains high, and the state continues to struggle with high rates of chronic disease and lack of access to health coverage. Oklahomans are more likely to have chronic diseases and die at higher rates than most other states. Oklahoma had the fourth highest mortality rate in the nation in 2014 and a rate that was 23% higher than the national average.[2]

While Oklahoma's percentage of uninsured non-elderly adults has decreased over 4 percentage points since the implementation of the ACA (2013 to 2015), Oklahoma's decrease in the uninsured population is smaller than other comparable states. This phenomenon is likely due in large part to low enrollment in the FFM. In fact, Oklahoma only had 31% of its eligible population (those with incomes between 100-400% of the FPL) purchasing coverage through the FFM in 2016, relative to an average of 43% among other states similar to Oklahoma.[1]

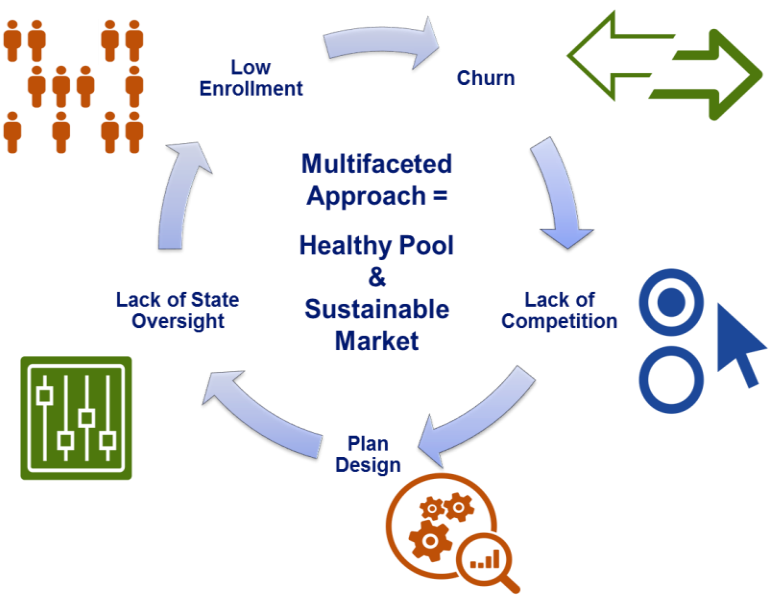
Premiums also continue to rise and options continue to dwindle, with only one carrier in Oklahoma offering plans on the FFM in 2017. Despite the current lack of competition on the exchange, policy

[2] Oklahoma Population Health Needs Assessment (2015). Pp. 10-11.

changes provide the opportunity for future competition. While still a relatively small market sector, the individual market (on and off-exchange) has grown by 22% since 2013 and has seen the largest growth across market sectors.[3] New state policy options may also provide opportunities to encourage plans to enter the market. These options include the movement of the Medicaid aged, blind, and disabled (ABD) populations into care coordination models per commercial managed care (as prescribed in House Bill 1566) and assessing the health of Medicaid populations to merge into the individual insurance market pool.

The Task Force identified five major pain points that capture our state's challenges related to a sustainable individual insurance market:

- ✓ **Low Enrollment** – Not enough healthy enrollees on the FFM
- ✓ **Churn** – Lack of persistency of enrollment throughout the year
- ✓ **Lack of Competition –** Limited plan options for consumers
- ✓ **Plan Design** – Cost and outcomes need to be a primary focus
- ✓ **Lack of State Oversight** – Limited ability of the state to design and implement policies and procedures



Images taken from: The Noun Project

The Task Force recognizes that all of these barriers must be addressed. Thus, a multifaceted approach that includes solutions to each one of these pain points is essential in order to fully address the challenges our state is facing to provide quality, affordable coverage to our residents.

Oklahoma's Challenges

Low Enrollment

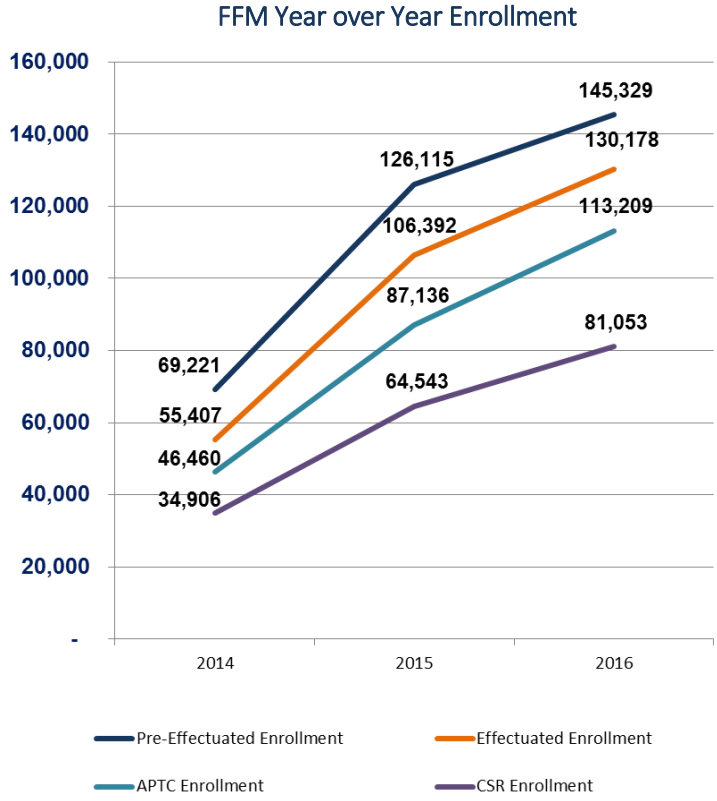
With only 31% of the eligible population enrolled through the FFM, Oklahoma's market is missing a significant number of individuals who can contribute to the health of the pool and mitigate risk for payers. The reasons for low enrollment need to be further explored, but the Task Force delineated three major reasons based on current available data, Task Force member experience, and anecdotal evidence:

[3] Milliman. (2015). Oklahoma State Innovation Model Insurance Market Analysis: https://www.ok.gov/health2/documents/Market%20Effects%20on%20Health%20Care%20Transformation.pdf

1) certain state populations have been segmented from the market into the Medicaid program; 2) lack of perceived value by consumers; and 3) inadequacy of consumer supports.

The addition of uninsured and/or Children's Health Insurance Programs (CHIP) populations would increase the number of lives in the individual insurance market and diffuse risk for health plans. In 2015 over 836,000 people were enrolled in Medicaid/CHIP and nearly 544,000 individuals were uninsured.[3] Effectuated enrollment (enrollment in which a premium has been paid) on the FFM in that year represents less than 8% of these populations combined at 106,000.[4]

It should be noted that of the uninsured population, 39% have incomes under 100% of the FPL and are therefore currently ineligible for subsidies on the FFM. Also noteworthy is the significant proportion of the uninsured who are young adults ages 19-34 (44%),[3] indicating that there may be a significant number of healthier Oklahomans who are not enrolling in the FFM. And while nearly a quarter of the uninsured population has income over 250% of the FPL, only about 25,000 individuals in that income bracket are accessing coverage on the FFM.[5] Low participation of this group is presumably due in part to diminishing subsidies as income levels increase. See Appendix G for more detailed data about uninsured individuals and FFM enrollees by age and FPL, as well as year over year enrollment data.



Source: Milliman. (2015). Oklahoma State Innovation Model Insurance Market Analysis.

In 2016, Oklahoma only had 31% of its eligible population purchasing coverage through the FFM, relative to an average of 43% among similar states.[1]

A possible reason that a significant number of eligible individuals are not enrolling in coverage is that they simply do not perceive it to be valuable to them – which may be especially true for young, healthy adults and those with minimal subsidies. While net premiums (post subsidy) have increased modestly since 2013, how consumers evaluate products also likely depends heavily on out-of-pocket (OOP) expenses (e.g., co-pays and deductibles). While over 60% of FFM enrollees received cost-sharing reductions (CSRs), they are limited to silver plans and may not be enough to encourage certain individuals to enroll.

[4] Centers for Medicare and Medicaid Services. (June 2015). March 31,2015 Effectuated Enrollment Snapshot: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html

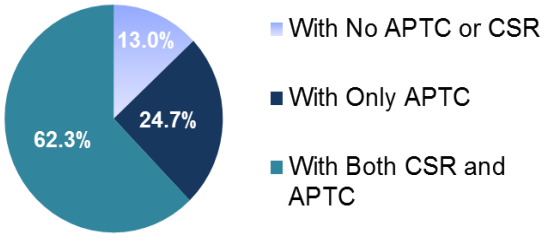
[5] Department of Health and Human Services (March 2016). Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: https://aspe.hhs.gov/sites/default/files/pdf/188026/MarketPlaceAddendumFinal2016.pdf

2015 Average Cost Sharing Summary			
	Bronze	Silver	Gold
Average Deductible (Single/Family)	$5,200/$11,400	$4,200/$9,300	$1,600/$4,400
Average OOP Max (Single/Family)	$6,400/$12,900	$6,000/$12,200	$3,800/$9,600

Source: Milliman. (2015). Oklahoma State Innovation Model Insurance Market Analysis.

All 2016 bronze qualified health plans offered in Oklahoma had single medical OOP maximums in excess of $6,000, as well as nearly all of the 2016 silver plans. See Appendix G for more specific data.

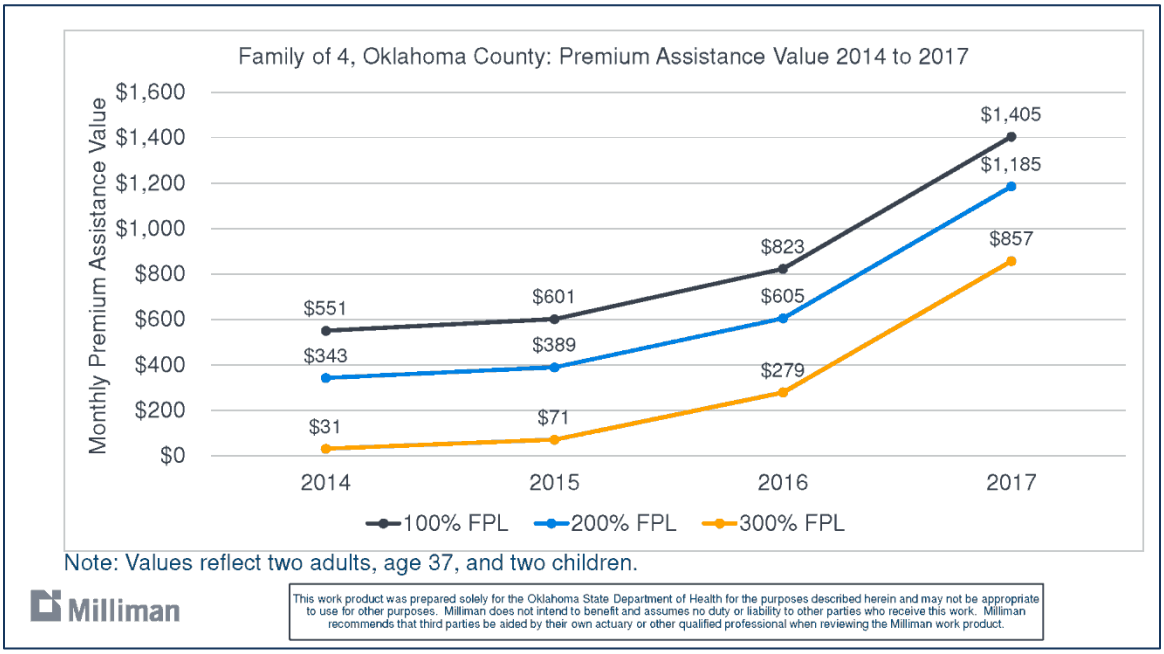
In 2016, 87% of Oklahomans who purchased health insurance on the FFM received an advanced premium tax credit (APTC), with an average monthly premium of $78 after APTC. The financial assistance individuals and families receive are likely effective mechanisms to encourage enrollment for many. However, APTCS may not be as effective for groups at the low (100-150% of FPL) and high (300-400% of FPL) income thresholds, as the subsidized costs may still be a significant portion of household income at the low end and the amount of APTC may be minimal at the high end. A family of three at 150% of the FPL earns just over $30,000 annually, while a family at 400% of the FPL earns over $80,000 per year. The proportion of income used for even highly subsidized coverage for a family earning $30,000 may still present a barrier to affordability, while minimal subsidies for a family earning $80,000 may not encourage enrollment. As a result, the state is considering changes to the distribution and calculation of subsidies.



	2014	2015	2016
Average Monthly Premium (all Metal Tiers)	$277	$295	$376
Average Monthly APTC	$212	$206	$298
Average Monthly Premium after APTC	$65	$89	$78

Source: CMS Effectuated Enrollment Snapshots

Further, APTC amounts are based on the income of the consumer and the premium cost, which is benchmarked on the second lowest-cost silver plan. This method means that premium assistance amounts rise with premium costs. While the net cost to the consumer may remain relatively stable, the cost of premiums and corresponding federal financial assistance has risen dramatically and is unsustainable in the long term.



Source: Milliman. (2017). Oklahoma Federally Facilitated Marketplace Profile and Insurance Market Population Movement: Preliminary Results.

Another potential barrier is the system's complexity and lack of consumer supports that effectively equip consumers to purchase products that make sense for their circumstances. In addition to needing to understand the complexities of health insurance (co-pays, co-insurance, deductibles, and metal tiers), variations in plan design and available benefits create additional differing factors. There may be significant differences in what covered benefits the plans include or exclude in the deductible. This level of complexity may discourage some individuals from enrolling and implies that simplified design and improved education and awareness of covered benefits could increase enrollment. While the CMS has instituted the labeling of "simple choice" plans that have a uniform set of features, none of the plans being offered in Oklahoma in 2017 meet those criteria.

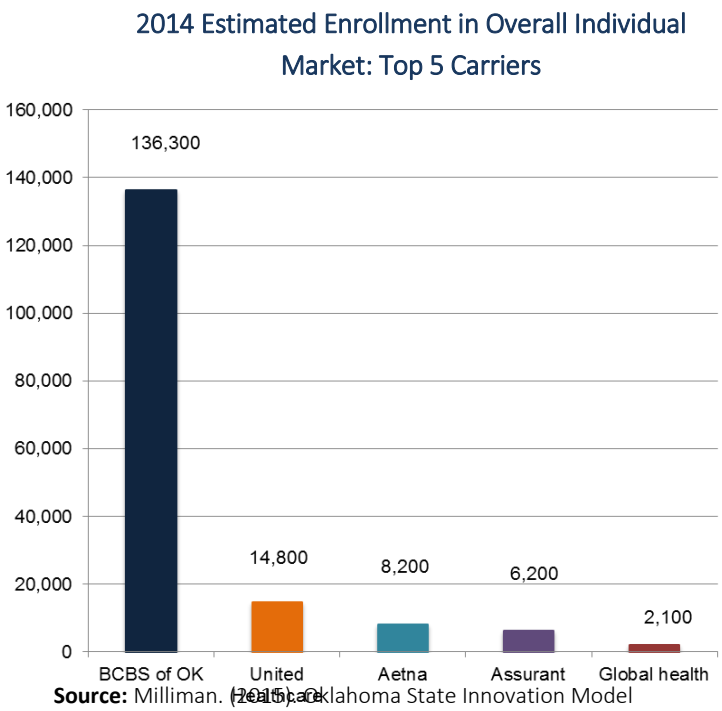
Churn

In addition to low enrollment, there are a number of individuals who enroll but do not maintain coverage throughout the year. This churn negatively impacts the individual insurance market and health plans, as individuals presumably pay premiums for a short period of time while they utilize services and then terminate their coverage. Others may simply lose coverage due to lack of payment, as current regulations allow a 90-day grace period for premium payment. In 2016, 15,000 Oklahomans – 10% of enrollees – selected a plan but did not pay their premiums and lost FFM coverage.[6]

Lack of Competition and Limited Consumer Choice

Blue Cross Blue Shield Oklahoma is the only carrier offering plans in 2017 and has had the vast majority of individual market enrollees since the FFM was implemented in 2014.

[6] Centers for Medicare and Medicaid Services. (June 2016). March 31,2016 Effectuated Enrollment Snapshot: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html



Source: Milliman. (2015). Oklahoma State Innovation Model (SIM) Insurance Market Analysis.

Payer representatives on the Task Force have indicated a number of reasons for declining health plan participation on the FFM, including higher than expected service utilization, low enrollment, inadequate risk protection mechanisms, and administrative burden. As to be expected with a new pool of insured lives, unknown characteristics create unpredictable costs. For instance, a portion of FFM enrollees likely have not had coverage previously and thus utilize more services than the average person with similar rating characteristics. In fact, one payer in Oklahoma estimated that utilization of FFM enrollees is four to five times that of off-exchange individual plans.

Plan Design

Modifications in plan design could produce a market that emphasizes cost-effectiveness and improved health outcomes. While this is a challenge not only of plan offerings on the FFM but with our health care system at large, the individual market is fertile ground for implementing and evaluating mechanisms that support the Triple Aim of reduced costs, higher quality care, and improved health outcomes. State flexibility to determine Essential Health Benefits (EHBs) based upon state-specific needs (waiving EHBs as they are currently prescribed in federal law) alongside emphasis being placed on the actuarial value of such benefits would reframe issuer approaches to designing their plans.

Lack of State Oversight

The state currently assumes little regulatory control over the FFM, which limits our state's ability to design innovative, responsive strategies to stabilize the individual market. State entities could take a more active role in the review and approval of plan rates, mandated benefits, and the distribution and calculation of subsidies. Should the state assume more control of the plan certification process, it could incentivize or discourage certain policies while also establishing the necessary infrastructure for this oversight.

State and Federal Political Environment

The political landscape in Oklahoma, coupled with the ramifications of the implementation of the ACA, created a favorable environment for the exploration of a 1332 Waiver as authorized with the passage of SB 1386. Through the legislative process, the bill received only two no votes showing strong, bipartisan support and an acknowledgment of a failing system for Oklahomans to access health insurance. While there wasn't a specifically defined solution at the time of the bill's passage, it was clear that there was consensus on the existence of problems that need to be addressed. The state has attempted to harness that consensus as we moved forward in conversations to develop solutions. This concept paper is

intended to continue to facilitate conversations with Oklahoma elected officials and the new presidential administration as we work toward a more detailed 1332 Waiver.

As the transition to a new federal administration continues, presidential priorities and potential legislative intent are becoming clearer. The historical policy positions of Secretary of Health and Human Services Tom Price and CMS Administrator designee Seema Verma provide insight into the new administration's perspective. Proposals such as Paul Ryan's A Better Way and Tom Price's Empowering Patient's First Act, provide a glimpse into potential federal healthcare priorities. Common themes in these proposals include retaining insurance market reforms that have been proven effective and desirable, eliminating health insurance mandates, changing the methods for the determination and use of financial subsidies, and establishing re-imagined high risk pool programs. While Oklahoma developed its proposed solutions independently and prior to these federal administration announcements, similarities can be seen between these proposals

While the plans currently under discussion vary in their elements, a number of ideas are common to many of the proposals:

- Eliminate income as an eligibility factor for tax credits, and eliminate or simplify age as a factor.
- Encourage the use of Health Savings Accounts by increasing contribution limits and expanding how people can use them.
- Alter age rating by expanding to 5:1 or repealing federal limits entirely.
- In lieu of an individual coverage mandate, strengthen requirements for special enrollment periods and tie continuous coverage to guaranteed issue protections.

In addition, there are some parallels in a recently leaked House Republican ACA repeal bill, including tying tax credits factoring in age (but not income), and increasing the age rating band from 3:1 to 5:1. The bill was still a discussion draft as of the end of February and reports indicate there is not universal agreement amongst Republican leadership about all of the elements. Oklahoma will continue to analyze all viable federal proposals with an eye toward whether they present barriers or opportunities to our approach and adjust accordingly.

State Efforts to Date

Task Force

The Task Force includes representation from both public and private entities, including commercial insurance carriers, providers, businesses, consumer advocates, and tribal nations and is supported by representatives from multiple state agencies. The group has met monthly since August 2016 to review available data and discuss major pain points related to Oklahoma's insurance market. This data review included FFM and insurance enrollment trends and demographics, FFM subsidies and premium costs, uncompensated care costs, and prevalence of chronic conditions. Additionally, members provided data and information through surveys given to tribes, providers, and payers. Using data-informed decision making, the Task Force cast a broad net of gathering solutions that are believed to address each pain point, the extent to which is largely undetermined pending actuarial review and analysis underway.

Once this information was gathered and discussed in detail, a list of 62 possible solutions for each pain point was developed and presented during the November meeting. Task Force members, agency representatives, and data workgroup members were then provided with a survey to rate each proposed solution on a 0-3 scale, with 0 indicating strong opposition and 3 indicating strong approval. Nineteen

responses were received, including 11 of 18 Task Force members. Task Force responses included representation from each sector, including private payers, tribal nations, providers, businesses, brokers, consumer advocacy groups, and self-insured businesses. Average scores and rankings of the highest-rated solutions were provided at the December 2016 Task Force meeting. These solutions were then discussed in the context of pain points, ideology, and feasibility. The solution rankings, together with this discussion, form the basis of the recommendations provided in this document.

An initial draft of the concept paper was released to the public on the Oklahoma State Department of Health (OSDH) website on December 30, 2016. The comment period was open for one month, closing on January 31, 2017. Overall, written comments were received from 10 commenters. Of the commenters seven were on substance; three were editorial only. Comments were received from several representative groups including insurer, insurer association, Tribal Nation, consultant, provider, and large employer. The substantive topic areas addressed included:

- Health Plan Elements
- Affordability/Subsidies
- Eligibility and Enrollment Provisions
- Commercial Market
- Health Plan Risk Management
- American Indian/Alaska Native (AI/AN) Issues
- State Role
- Employer Issues

The following comments regarded Health Plan Elements: Health Savings Accounts:

- HSA concept needs more analysis on financial impact/cost (Consultant, Large Employer)
- Concerned HSAs will split risk, with young with high deductible/low cost plans, old with lower deductible/high premium plans (Consultant)
- HSAs require well-informed consumers, service/pricing transparency (Consultant)
- Support use of HSAs (Insurer)

The following comments regarded Health Plan Elements: Premium Caps:

- Premium cap will discourage plan participation (Insurer, Large Employer)
- Premium cap will help control health expenditures (Consultant)

The following comments regarded the Commercial Market:

- Oppose requirement for Medicaid managed care organizations (MCOs) to participate in individual market (Insurer, Insurer Association)
- Increase carrier competition (Healthcare Provider)
- Was Marketplace competition hurt by carriers offering low premiums, attracting sicker consumers? (Consultant)
- How would changes impact small employer marketplace? (Consultant)

The following comments regarded Eligibility and Enrollment:

- Support continuous coverage, tighter special enrollment requirements (Insurer)
- Require full year premium or past premium to re-enter coverage (Large Employer)
- Maintain AI/AN provisions from ACA (Tribal Nation)
- Support 30 day grace period; pre-effectuation premium payment (Insurer)

The following comments regarded Risk Management:

- Support improved risk management via reinsurance or high-risk pool (Insurer)
- Risk adjustment, reinsurance, high-risk pools are expensive and complicated to implement and maintain; study further (Consultant)
- Support high-risk pool (Tribal Nation)
- Fund reinsurance via appropriation or broad-based assessment (Insurer)
- Using high risk pool to penalize those who don't enroll at open enrollment ignores normal churn due to employment changes (Consultant)

The comments received have led to revisions within the concept paper, which are reflected in this final version. Moving forward, further discussion and input is expected through the Task Force and stakeholders as developments by the federal administration, analysis on the impact of recommendations as well as refinement to approaches become known.

Task Force meeting documents, including the full list of proposed solutions, are available through the OSDH website at:
https://ok.gov/health/Organization/Center_for_Health_Innovation_and_Effectiveness/1332_State_Innovation_Waiver_/

Data Workgroups

In addition to the Task Force, four data workgroups provided information to help identify barriers and guide the development of recommendations from diverse perspectives: businesses, consumers, health plans and providers. Data workgroup members provided the Task Force with data from the National Association of Health Underwriters Employer Survey, consumer subsidy and penalty data, tribal subsidy program offerings, plan information related to FFM enrollment and premium payment and results from an informal survey of various providers in Oklahoma regarding ability to collect out-of-pocket expenses and health challenges of patients. This information ensured that factors from each of these groups were considered as solutions were proposed and prioritized.

Additionally, data workgroups recognized the need for more formalized survey data to answer questions that arose through the course of their work. The workgroups 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. The Business and Consumer Data Workgroups revisited the Milliman Employee Health and Wellness Survey,[7] released in 2014, for data on Oklahoma businesses' thoughts and perceptions on their ability to provide health insurance coverage to their employees.

Surveys and Focus Groups

The OSDH has engaged Visual Image and Evolve as contractors to gather information from businesses and consumers. Consumer surveys and focus groups have been conducted to better understand the low FFM enrollment in Oklahoma, consumers' perspectives on the value of coverage, and their purchasing experience. Business surveys and focus groups gathered thoughts from primarily small businesses on insurance costs, coverage options for employees, and wellness programs to gain a more comprehensive view of barriers employers are facing to providing coverage.

[7] Milliman. (2014). The State of Oklahoma Business Health and Wellness Survey: https://www.ok.gov/health2/documents/OOC-OSDH%20Business%20Health%20and%20Wellness%20Survey%20Report%202014.pdf

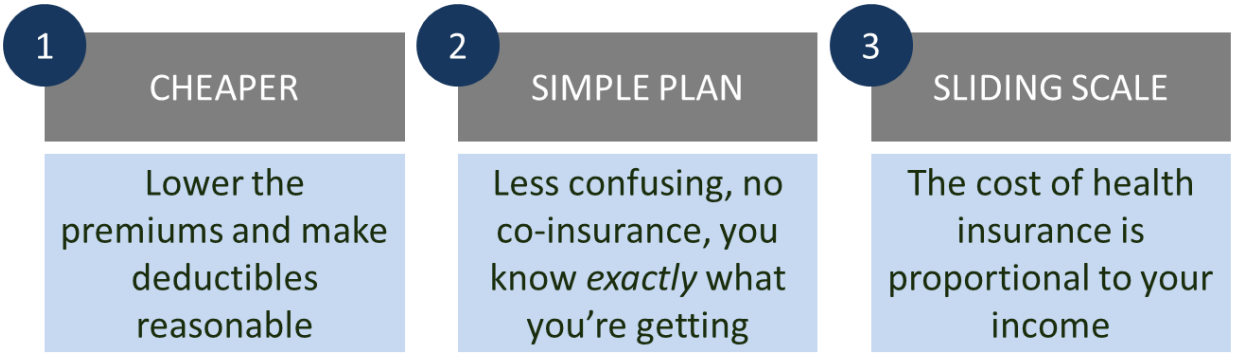
Consumer Research

Consumer focus groups and telephone surveys gathered information from four groups of Oklahomans: 1) the uninsured, 2) individuals who visited healthcare.gov but did not purchase a plan, 3) individuals who visited healthcare.gov and purchased a plan, and 4) individuals with private insurance outside of the FFM. Fieldwork occurred between December 2016 and January 2017 and included individuals from both rural and urban parts of the state. In total, 16 focus groups and 40 in-depth interviews were conducted and included 161 participants.

Consumer focus groups and telephone surveys[8] have revealed the following findings:

- ✓ Health insurance is expensive. The biggest barrier to obtaining health insurance is affordability. Without a subsidy or employer contribution, insurance is largely unobtainable.
- ✓ Plan selection is dictated by premium price. Other factors are involved, but Oklahomans initially qualify a plan by its monthly impact on their pocket-book. When asked to name a monthly premium price that was realistic, fair, and affordable, responses indicated the following:
  - $50-$150 for uninsured individuals
  - $150-200 for individuals who visited or purchased a plan on healthcare.gov
  - $200-$400 for individuals with private insurance
- ✓ Health insurance is confusing. Oklahomans are not certain how health insurance works, and thus sign up and pay for health insurance knowing that they do not entirely understand what it covers or what they are entitled to.
- ✓ In particular, Oklahomans do not understand out-of-pocket expenses and co-insurance. Deductible and OOP are used interchangeably, and Oklahomans are willing to sign up for plans which have co-insurance without understanding what co-insurance is. This is potentially a huge financial misunderstanding, as most assume it is related to having two insurance plans.
- ✓ Scenario-based examples can better explain plans. Insurance plans are not communicated in clear language, so applying different plans to a selection of scenarios can help explain the actual cost implications of a plan.

In sum, Oklahoma consumers indicated that the following is necessary to make sure every person in Oklahoma has health insurance:



[8] Evolve. (2017). OSDH Consumer Surveys: Draft Results.

Business Research

Data was obtained from business decision makers via online and in-depth telephone surveys. Respondents were recruited with assistance from the Task Force. Questions for the online survey are similar to those asked in the 2014 Employee Health and Wellness Survey. To date, 291 online interviews and 65 in-depth interviews have been completed, with more participation anticipated.

Business online and telephone surveys[9] thus far have revealed the following findings:

- ✓ Being able to offer health insurance plays a major role in employee retention and acquisition.
- ✓ Brokers play an extremely important role in advising Oklahoma businesses of their health insurance options.
- ✓ Insure Oklahoma is seen as a vital resource in making healthcare affordable to employees.
- ✓ Employers typically contribute between 50-100% of employee premiums. Spouses and dependents are eligible on most plans; however, the employee usually must pay for their family members.
- ✓ 92% of employers reported increases to the cost of health insurance at their last renewal.
- ✓ Increases in healthcare coverage costs have impacted businesses in a number of ways, including:
  - Less profit available for general business growth
  - Holding off on employee salary increases
  - Increased medical plan deductibles
  - Increased prices
  - Increasing employees' share of premiums
  - Delaying purchases of new equipment
  - Holding off on implementing growth strategies

Engagement of Consultants and Experts

Early on, Oklahoma recognized the need to engage experts in the exploration of solutions to stabilize and grow our individual insurance market. Information had already been gathered on Oklahoma's market through the previous efforts of the Oklahoma State Innovation Model initiative. A comprehensive market analysis (referenced in the Background section of this paper) was released in 2015 by Milliman. This analysis provided data on enrollment trends, market characteristics, and insurance carrier performance to inform state policymakers. An update to this market analysis is underway, again using the experience and expertise of Milliman. Initial, limited results were provided by Milliman to the Task Force in February of 2017, with full report on the market analysis to be delivered in June of 2017.

Acknowledging that Oklahoma-specific individual plan data are critical to the impact assessment of each pain point, Milliman is also being utilized to develop an insurer survey data collection tool and analysis. The insurer survey will be utilized to gather data on premiums, enrollment, and claims experience in the individual market – on and off the FFM. This insurer data is anticipated to be collected and analyzed by

[9] Evolve. (2017). OSDH Business Surveys: Draft Results.

Milliman in the Spring of 2017 to inform the impact analysis of potential changes to Oklahoma's individual insurance market. Oklahoma is also utilizing a contractor, Health Management Associates (HMA) and Leavitt Partners (LP), to provide expert review, conduct analysis, and assist Oklahoma in working with federal partners as the state looks to submit a 1332 Waiver or other mechanism to implement changes. In June of 2017 HMA/LP will be providing a final report on the 1332 Waiver exploration and development activities to date. If the state chooses to pursue and write a 1332 Waiver, an actuary contractor will be procured to provide the necessary analysis. The actuarial procurement process is expected to begin in March of 2017.

Recommended Strategies

While the future landscape of the ACA and health care is uncertain at both the state and federal level, what is clear is that Oklahoma needs to make significant changes to the way coverage is regulated and to the processes through which consumers access coverage. It is the position of the Task Force that minor changes to the existing infrastructure will not produce a stable market or help our state achieve the Triple Aim. Further, the Task Force acknowledges that health care and health coverage are best provided and regulated locally. States should be given latitude to design, implement, and evaluate methods that meet residents' needs and are responsive to the environment of the state. Thus, the recommendations that follow include solutions that are actionable at the state level as well as those that require federal authority.

The nine broad recommended strategies are as follows:

- ✓ Increased Awareness to ensure individuals are personally responsible for and aware of the coverage options available to them, engaged in their coverage decisions, and understand what their coverage means
- ✓ Improved Plan Design that supports innovative, flexible, and comprehensive coverage and efficient delivery of services
- ✓ State-Controlled Plan Regulation that holds health plans accountable to achieve improved health outcomes by moving them toward value-based payment structures and care coordination while promoting flexibility and reducing administrative burden
- ✓ Improved Risk Management to provide adequate financial safeguards to plans and promote plan participation
- ✓ Modified Enrollment Procedures to promote timely enrollment and premium payment, as well as continuity of coverage and longevity with a plan, to achieve a more stable pool of enrollees
- ✓ Eligibility Changes to ensure vulnerable and gap populations can access coverage that is affordable to them
- ✓ Modified Subsidy Processes to more effectively deploy federal dollars by changing eligibility rules and subsidy calculations while creating a streamlined, simple process
- ✓ State-Owned Platform that will remove Oklahoma from the FFM and leverage the existing state-designed, subsidy-eligibility determination system used for Insure Oklahoma, with regulations and processes controlled by the state

- ✓ State-Designed HSA-like Accounts coupled with simple options to empower consumers to use dollars in a way that makes sense for their situation

In order to achieve a modernized market, Oklahoma will need a sequential, phased approach over time that starts with the state identifying innovative approaches to address health care needs, continues with changes at the federal level that move our state toward a redesigned individual insurance market, and ends with a state-owned, federally-supported platform that allows Oklahoma to calibrate its market through state-based policies and procedures. This oversight at the state level will allow the market to evolve with changes in the environment and target specific outcomes related to bending the cost curve of health care, improving the quality of care, and improving population health.

The Task Force also acknowledges that not only should the state have oversight on how to best provide its citizens health care and health coverage, but so should tribal nations. Strategies offered within this concept paper and subsequent waiver proposals do not support replacing or removing any portion of the Indian Health Care Improvement Act (IHCIA). Specific notation for each proposed solution that may have an impact on American Indian health care has been solicited and is provided in the 1332 Waiver Tribal Considerations section of this paper.

The state will likely pursue sequential 1332 Waivers and/or amendments to an initial waiver to implement the changes over time. It is anticipated that an initial waiver that would allow the state to assume more responsibility over rate review and plan qualification would be submitted in July of 2017 at the earliest, with implementation in 2018.

Individual Insurance Market Strategies Roadmap

Specific solutions related to each strategy are described below and provided in Appendix A.

Advance State Innovation

The initial phase of implementation will be for planning and authorization, whereby Oklahoma can keep ACA policies that work in place, accommodate changes to mandates, improve outreach, and work with health plans to improve service delivery and access.

Oklahoma believes that good policies should remain intact. These policies should retain inclusion of preventive services, guaranteed issue, and dependent coverage up to age 26. Additionally, the state supports the preservation of the IHCIA and its permanency, as well as the preservation of provisions within the ACA separate from the IHCIA that have significant implications for the Indian health system. As the federal government considers whether individual and employer mandates will remain in place, Oklahoma will continue to work toward designing mechanisms to improve the health of the insurance pool. It is unclear to what extent the individual mandates actually encouraged enrollment, as it has remained low in Oklahoma. Therefore, regardless of the status of mandates the state's proposed strategies are aimed at increasing the viability of the health insurance pool by addressing chronically low enrollment on the individual insurance market.

As mentioned previously and supported with to recent Oklahoma focus group and survey results from consumers, the biggest barrier to obtaining health insurance is affordability. The next barrier identified is that health insurance is often confusing to Oklahomans. By addressing these barriers through changes to plan design, greater state oversight and control of plan regulation, as well as more streamlined financial assistance mechanisms for the most vulnerable consumers, Oklahoma expects the need for mandates to be eclipsed by these somewhat larger, more comprehensive changes. To implement such changes initially, Oklahoma will request access to federal revenues collected as a result of the mandates. Then, as the market stabilizes and enrollment increases, reliance on such revenues is anticipated to decrease, the extent to which will be analyzed further within anticipated actuarial work.

During the planning and authorization phase, it will be vital for the state to engage insurance brokers, agents, and health plans, as well as community-based resources and community health centers, as these entities will be essential to assist consumers in accessing and understanding their coverage options – particularly for previously uninsured populations. In the recent focus group and survey efforts of Oklahoma businesses, they indicated that brokers/agents played an extremely important role providing advice on health insurance options. Moving forward, Oklahoma's plan recognizes the importance of both brokers and plans themselves (through direct marketing and enrollment assistance specifically) to develop relationships with a newly covered population.

The state can also take measures to encourage plans to improve efficiency, access, and participation through plan design elements. Particularly in a rural state with provider shortages, telehealth as a covered plan service when appropriate is one avenue by which plans can increase access to quality health care.

State Regulation and Federal Flexibility

The foundational element to a modernized Oklahoma market is to establish state-based regulatory policies and processes on this segment of the market. If given flexibility, the Oklahoma Insurance Department will assume control of rate review and the rules surrounding the qualification of participating health plans, which will allow the state to design mechanisms to advance the health system through plan-based strategies while implementing appropriate guardrails for insurers. Oklahoma wants to support insurers to be successful in the individual insurance market while having the ability to require certain

elements that shift the health care system in the right direction. The Task Force has recommended the state should require or provide incentives for the following:

✓ Value-Based Payments

Requiring plans to have a minimum amount of value-based payments will support the state's health improvement goal of having 80% of payments to providers be value-based by 2020. This requirement will increase plan and provider accountability and improve management of costly conditions, ultimately improving health outcomes and decreasing costs. Value-based purchasing at its simplest is a strategy to measure, report, and reward excellence in health care delivery. As the state continues to advance toward value-based payments, plans are recognized for their role to improve Oklahoman's health rather than retaining the status quo.

✓ Quality Measures Related to Chronic Disease

The Oklahoma State Innovation Model (OSIM)[10] identified diabetes, hypertension, obesity, behavioral health, and tobacco use as five key areas where quality measures are being implemented in order for Oklahoma to improve outcomes in those areas. Oklahoma continues to experience high prevalence in all of these areas, which impedes our state's ability to bend the health care cost curve. Quality measures tied to value-based payments can effectively move our state toward the Triple Aim.

To support performance measurement related to quality measures, the state will develop and pursue avenues to obtain and analyze patient-level data from health plans. Led by Oklahoma's Health and Human Services Cabinet, all cabinet agencies alongside the Employee Group Insurance Division and the Oklahoma Insurance Department are working to gather existing measures currently reported for a variety of public programs that are of mutual benefit to the OSIM health areas listed above. This initial list of approximately 12 measures defined by the National Quality Forum are expected to be finalized in the Spring of 2017 and will provide a baseline of standardized, reportable quality measures among all market plans. The state intends to use these measures to determine improvements in individual insurance market population health over time, and as a way to identify best practices.

✓ Case Management and Care Coordination

Comprehensive health insurance coverage should not only provide payment for acute medical needs, but should also be expected to better the health of covered populations by effectively managing care and reducing preventable events and conditions. Case management and care coordination are effective mechanisms to achieve these objectives, which are consistent with the Oklahoma Health Improvement Plan (OHIP) 2020 goal of reducing the rate of potentially preventable hospitalizations by 20%.[11] Oklahoma will support plan innovation to meet these goals rather than mandates. The state also supports mechanisms to provide consumers with incentives for participating in case management/care coordination. Additionally, case management/care coordination activities and quality measures for chronic disease will be aligned with value-based payments.

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[10] Oklahoma State Health System Innovation Plan. (2016). https://www.ok.gov/health2/documents/Oklahoma%20State%20Health%20System%20Innovation%20Plan%20(SHSIP)%20Final%20Draft.pdf

[11] Oklahoma Health Improvement Plan (2015). http://ohip2020.com/

✓ Standard Minimum Actuarial Value Across All Traditional Health Plan Offerings

In an effort to improve ease of consumer understanding, actuarial value (AV) regulations will be simplified by establishing a standard minimum AV floor of 80% for all traditional plans. Traditional plans are defined as those plans that do not otherwise meet requirements to be a high-deductible health plan (i.e., annual, individual deductible of $1,300 per IRS). This minimum AV will be coupled with easy-to-understand, fixed-cost descriptions of benefits. These requirements will provide consumer protections, increasing their understanding of health coverage and perhaps the value of health care coverage to them. Plans may be given a transitional period (e.g., minimum 70% AV for the first year) to implement this change. This will not preclude the option of qualifying alternative plans, like high-deductible plans with an AV floor lower than 80%, coupled with a consumer health account on the individual insurance market. The requirement for plans to provide easy-to-understand, fixed-cost descriptions of benefits will also apply to high-deductible plans.

The Oklahoma Insurance Department will have the ability to provide incentives and/or assess penalties on plans for failure to comply with these requirements and to validate AV calculations to ensure that consumers' options are reliable and high-quality. Examples of such incentives could include implementing conditions for plan approval, and implementing corrective action plans and penalties (financial, administrative, etc.) through the Oklahoma Insurance Department.

Plans will also be encouraged to offer optional value-added benefits like dental and vision as affordable add-ons to medical coverage as a way to increase the value of coverage for individuals and encourage enrollment.

Similar to the Medicare Advantage incentive options, the state will identify areas that align payment with quality care measures. Medicare Advantage utilizes Star ratings to evaluate health plan performance based on measures in five broad categories: 1) outcomes, 2) intermediate outcomes, 3) patient experience, 4) access, and 5) process. These measures include management of chronic conditions, such as diabetes and hypertension, as well as overall care coordination and management.[12] Oklahoma can use this model as a basis for its quality measures, which would achieve alignment of performance measures for providers. The state may also pursue consumer-side rating systems (like the Medicare Advantage Star Rating System) in which highest-rated plans are listed first, ratings are viewable by consumers, and consumers are notified if their current plan is rated low or has a decline in rating allowing a different plan selection to be made (i.e., the consumer may move coverage to a higher-rated plan).

To support plans in meeting these requirements and in finding success in the individual market, the state will provide the following:

✓ Reduced Administrative Burden

Based on feedback from health plans, administrative requirements related to reporting, risk mitigation, eligibility, and enrollment will be eliminated, modified, and/or streamlined.

✓ Greater Variance to the Rating Windows for Age

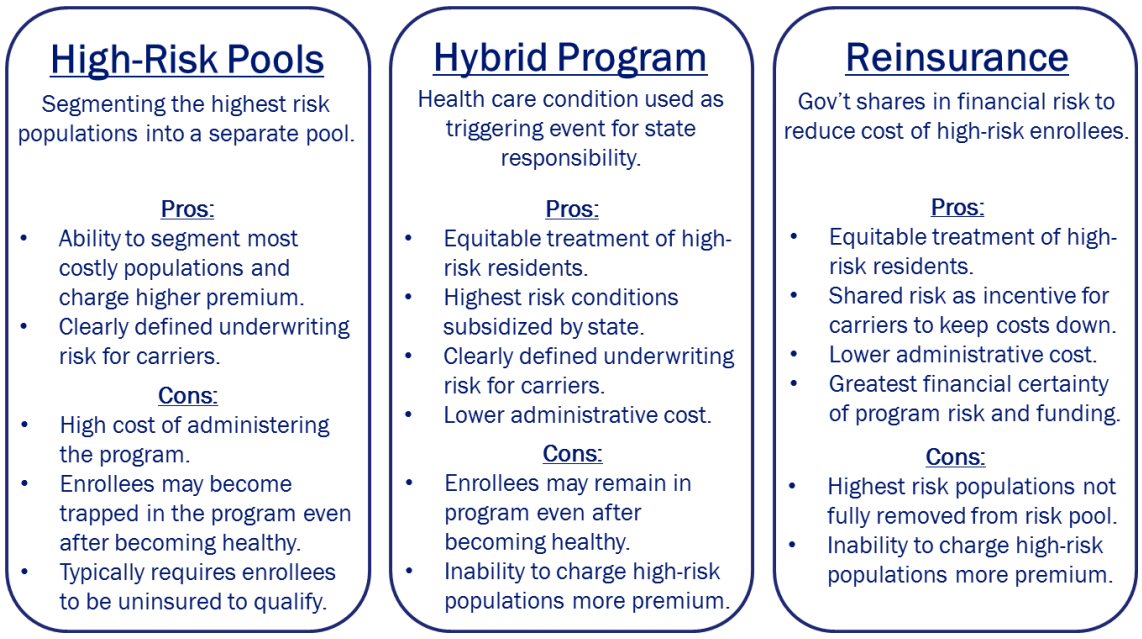
To encourage greater participation among young, healthy individuals age rating variance will be increased. It is apparent that young Oklahomans are disproportionately sensitive to the high cost

[12] Centers for Medicare and Medicaid Services. (2016). 2017 Star Ratings: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-12.html

of insurance, but it is very important to include them in the market because of their ability to cross-subsidize and offset the cost of higher-cost populations. The age rating ratio will be analyzed and will not exceed a 5:1 ratio. This flexibility will likely result in lower premiums for younger individuals and will be coupled with subsidy calculations that include age to assist older individuals with paying premiums, as described in the next section.

✓ Exploration of Reinsurance and High Risk Pools

Oklahoma will also explore a federally-funded, state-managed high-risk pool, reinsurance program, or hybrid as an additional avenue to mitigate risk for health plans. As described in the figure below, there are advantages and disadvantages to each option, which would need to be evaluated by the state to determine the best model to employ.



*Note: Pros and cons of these programs still very much contingent on aspects of program design.

In the past, high-risk pools have been an effective risk mitigation method in Oklahoma. Due to its inclusion in numerous federal ACA replacement plans, the state is encouraged that federally-funded high-risk pools may return. With supportive federal funding, the state will evaluate the re-establishment of a high-risk pool for a new purpose of providing temporary coverage to two primary groups: (1) consumers who fail to join during an initial open enrollment period and thereby experience higher premiums as a result of missing the discount period provided by continuous coverage provisions; and (2) for enrollees with exceptionally high cost conditions and utilization.

The state will determine the optimal framework and specific eligibility criteria for inclusion in a high-risk pool. Various approaches could include: 1) a traditional high-risk pool, in which enrollees are moved into a separately-run insurance pool managed by the state; 2) a high-risk pool reimbursement program, in which enrollees remain in the commercial insurance pool and a portion of claims above a specific threshold is reimbursed by the high-risk pool; or 3) a condition-based high-risk pool, in which enrollees remain in the commercial insurance pool and a portion of claims for a given set of conditions is reimbursed by the high-risk pool.

Each of these arrangements has advantages and drawbacks and should be evaluated along a spectrum instead of as distinct options for a state. For instance, a traditional high-risk pool would likely carry the highest administrative cost to the state, but would also give the greatest underwriting confidence to insurance carriers. Also, separating the risk pool and treating high-risk enrollees differently may prove unpopular to some stakeholders given that a consolidated pool exists today and shared risk between the state and carriers may provide additional incentive for carriers to keep costs low.

✓ Tighter Restrictions on Premium Payment Grace Periods and Enrollment Changes

Current ACA regulations allow up to a 90-day premium grace period, which means plans may cover an individual during that time and never receive payment. Oklahoma proposes that this time period be reduced to 30 days and that premium payment should be required before an individual re-enrolls.

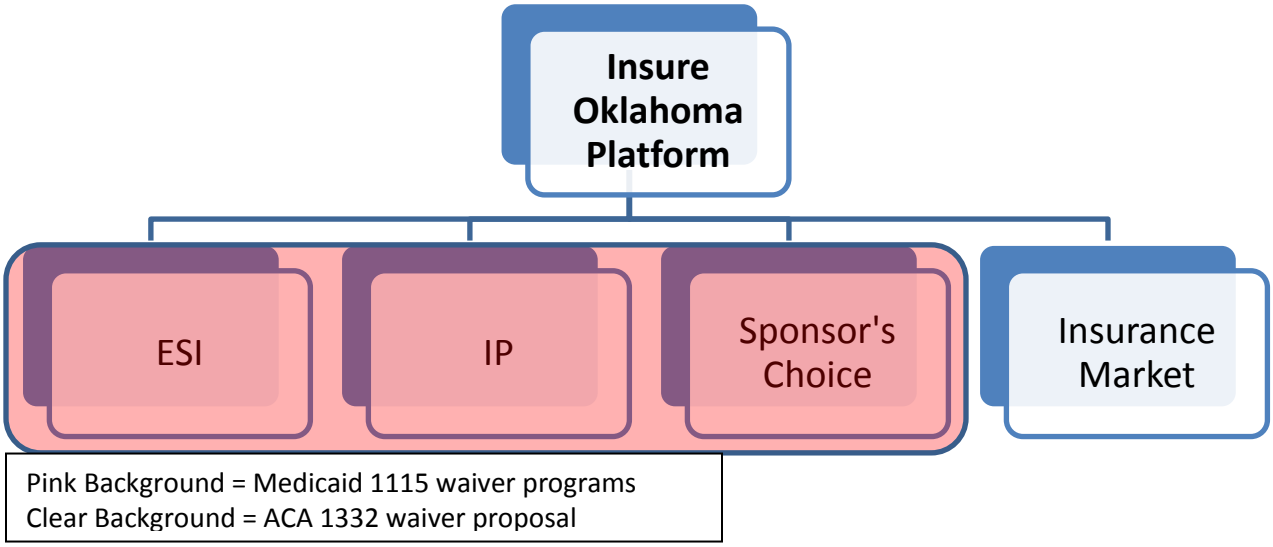
To promote timely enrollment, special enrollment requests will require more robust validation. For example, special enrollment requests for a Medicaid denial should provide validation that the applicant could reasonably expect that he or she might be eligible for Medicaid. The state will also have the ability to make changes to the open enrollment periods that support state infrastructure and prompt enrollment among consumers, such as coinciding open enrollment periods with consumers' birthdate. Specific options are continuing to be explored by the state.

Oklahoma's Modernized Market

Once the state becomes firmly established in its role in regulating plan design, plan certification, and rate review, an efficient and responsive eligibility platform can be developed. With federal support, the state will leverage the current capabilities of the Insure Oklahoma platform to modify the technology necessary to support state control of eligibility for financial assistance via subsidies and enrollment into consumer health accounts on the individual market.

The Insure Oklahoma system will be used as a technology platform that can be modified to determine a person's eligibility, not only for Medicaid and traditional Employer Sponsored Insurance (ESI) and Individual Plan (IP) Insure Oklahoma programs, but also for subsidies to purchase a qualified health plan through the individual insurance market. The Insure Oklahoma platform will also be explored as a way for Oklahoma consumers who qualify for coverage through the individual insurance market to enroll in and manage a consumer health account. Should the Sponsor's Choice Waiver be approved by CMS, the platform will also be used to determine eligibility for premium assistance through that program.

The state envisions assuming eligibility and enrollment responsibilities and functions currently provided and maintained by the FFM, and as these responsibilities are redirected, so must be federal resources currently devoted to these efforts. In order for the state to make this transition, federal investments already made in the state will need to be leveraged to create a more efficient, streamlined system that capitalizes on federal financial support to consumers while allowing the state to develop creative strategies.



This state-owned, subsidy-leveraging technology built upon the Insure Oklahoma infrastructure will allow the state to innovate and evolve by designing, implementing, and evaluating methods to increase the number of covered lives while creating a sustainable health system. Specifically, the state will have full authority to make decisions related to:

✓ APTC and CSR Eligibility and Distribution

Nearly 40% of Oklahoma's uninsured population have incomes under 100% of the FPL and are therefore currently ineligible for subsidies on the FFM; conversely, there is likely a subset of eligible enrollees with higher incomes for which the minimal subsidy amount available to them makes a limited impact on premium costs. Notwithstanding federal proposals to reform Medicaid that may alter this position, Oklahoma can repurpose federal funds for APTC and CSR to include gap populations while maintaining subsidies available to those under 300% FPL not otherwise eligible for public programs. The state aims to utilize federal funds that currently are being distributed to individuals at 100-400% FPL to those with 0-300% FPL while changing the way subsidies are calculated for all recipients. The state also assumes that federal funds will be available for eligible but not enrolled populations; that is, funds for eligible individuals not currently accessing APTC and CSR will be made available to the state.

Subsidy eligibility will be based on the amount of funding available, populations served, and projected impact on enrollment decisions. Oklahoma will work with CMS to ensure that eligibility changes will work alongside but not replace current public programs, including Medicaid.

Separately, eligibility for APTCs should reconsider current exclusions under the ACA. For instance, in current law, if insurance is offered by the employer, affordability is based on only the employee premium cost – not the cost for insurance for the employee's spouse and/or children. The employee-only cost is often less that the 9.5% threshold; however, the costs for the family is significantly higher, often resulting in a decision to decline coverage. In order to facilitate coverage, families should be eligible for APTC in these instances.

✓ Subsidy Calculations

As premium prices will have a greater variance based on age, subsidy calculations will be standardized by both age and income to ensure that there is equitable access to affordable coverage. Oklahoma recognizes that young, healthy consumers are more sensitive to the high cost of coverage and aims to reduce this cost while also providing subsidies to low-income consumers. The state will also be mindful of the affordability of coverage for older enrollees. Commensurate with changes to the age-bands, the calculation of premium subsidies for older consumers will also need to maintain a reasonable threshold of affordability. This proposed process differs from the current ACA calculations, which are based on income and premium cost.

✓ Consumer Health Accounts

To empower consumers to make the best decisions for themselves and their families, Oklahoma will establish consumer health accounts similar to health savings accounts (HSAs). These HSA-like accounts will be populated by federal subsidy dollars and automatically paid to health plans. This will put the power back in the hands of consumers to use the funds to purchase the plan of their choice and use any leftover dollars for qualified health care expenses. In order for a consumer to enroll into an account, the person must first select and purchase qualified health plan coverage.

The state will also explore the use of automatic enrollment to promote efficiency across systems. For example, if an Oklahoma consumer applied for Medicaid but was determined ineligible, he/she could automatically be enrolled in the lowest-cost plan on the individual market.

As the development of Oklahoma's modernized individual insurance market continues alongside a sequential waiver approach, the implementation of consumer health accounts is anticipated at earliest for plan year 2019, occurring in conjunction with proposed changes to a state-administered eligibility and enrollment platform, and away from the current, FFM platform. Additional information is needed on the administrative organization and expense to the state to operate and manage such consumer health accounts. Several operational models exist among other states – use of a third party administrator contracted to do business with the state; building upon in-state personnel and skillsets; or a combination of models. As development proceeds the state will look to information from consultants and Task Force/data workgroup members with experience overseeing consumer health accounts.

✓ Plan Options

In lieu of metal tiered plans, plan options will be simplified to two standardized plan options: 1) a comprehensive, traditional health plan with conventional cost-sharing and robust insurance coverage or 2) a high-deductible plan paired with a consumer health account. Consumers can choose to use their health accounts to purchase more comprehensive coverage or opt for lesser coverage and more funds for first-dollar, out-of-pocket expenses available through their health account.

✓ Core Health Benefits

Oklahoma plans to re-evaluate and reduce the Essential Health Benefits package that has been mandated by the ACA. The state will establish a framework for revisiting mandatory benefit requirements established under the ACA to ensure that the standards in place are optimal and supported by evidence-based medicine. For more specific information on current ACA-mandated Essential Health Benefits and state-mandated benefits, see Appendix H.

✓ Movement of Populations to the Individual Market

When appropriate, the state can move certain populations from other state programs to the individual market. For instance, the future of the Children's Health Insurance Program (CHIP) for states has been uncertain due to the lack of federal decision and clarity regarding the reauthorization of the program. Oklahoma faces implications if the CHIP program is not federally reauthorized. The current federal funding is set to expire later this year (2017) if Congress takes no action. The CHIP program currently operates under a federal maintenance of effort (MOE) which expires on September 30, 2019.

In the event the program is not reauthorized (the MOE expires) Oklahomans served by CHIP today would lose their coverage. In the event this would occur, those individuals could be moved to the individual insurance market pool. This shift would accomplish several objectives: 1) families could access coverage for all members of the household through one health insurance plan of their choice, 2) included children would continue to have benefits through a health plan, 3) a large pool of relatively healthy, young lives would enter the individual insurance market, and 4) to the extent that eligibility for existing Insure Oklahoma ESI or IP programs is applicable, federal funds from Medicaid could continue to be used to support subsidies via premium assistance programs.

✓ Consumer Incentives

Oklahoma can use its consumer health accounts to try new, creative strategies to promote continuous coverage, longevity of enrollment, open enrollment completion, and healthy behaviors. Incentives could include premium reductions for those who select and enroll in qualified coverage during an open enrollment period, co-pays or out-of-pocket costs whose amounts decrease over time the longer a consumer is consistently enrolled in coverage, or other options such as rollover of unused account funds to the following year if certain health screenings or activities are performed (e.g., annual preventive check-up with a provider, completion of evidence based tobacco cessation or weight-loss program, etc.). Although access to coverage has been a primary focus of the ACA, Oklahoma's plan looks to develop and implement a variety of ways to improve determinants of health, recognizing that recent studies[13] have shown that individual behavior determines the majority of health outcomes (approximately 40%).

✓ Exemption Criteria

Modifying rules around exemption criteria may promote a healthier pool of enrollees. Specifically, the state would modify or eliminate criteria related to affordability, financial hardship, and closing the coverage gap (0-100% FPL). These exemption categories should become unnecessary once the state implements changes to subsidy eligibility, distribution, and calculations to more adequately support affordability for gap populations and those with lower income.

[13] Edwin Choi et al., "Determinants of Health," Goinvo, accessed February 16, 2017,http://www.goinvo.com/features/determinants-of-health/

1332 Waiver Tribal Considerations

Background

The U.S. Constitution recognizes three sovereigns: the Federal government, States, and Indian Tribes. As sovereigns, Tribes predate the United States, and retain rights of self-government.[14] When the United States was established, the Constitution's Indian Commerce Clause granted Congress the authority to pass legislation specific to Indian Affairs.[15] The Supreme Court has upheld Indian-specific legislation, determining that it is political in nature, rather than based on an unconstitutional racial classification.[16] Health care reform legislation that reflects the unique federal responsibility to provide health care for American Indians and Alaska Natives is subject to rational basis review and does not violate the equal protection clause so long as it is "tied rationally to the fulfillment of Congress' unique obligation toward the Indians."[17]

Congress has the constitutional authority and responsibility to provide for Indian health care. Tribes signed treaties and negotiated other agreements with the United States in which they ceded vast amounts of territory in exchange for certain solemn promises. These promises include protecting Tribal self-government and providing for the health and well-being of Indian peoples.[18] Indian treaties are the supreme law of the land, and in carrying out these treaty obligations, the United States has "moral obligations of the highest responsibility and trust."[19]

Congress has passed numerous Indian-specific laws to provide for Indian health care, including establishing the Indian health care system and passing the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601 *et seq.* In the IHCIA, for instance, Congress found that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." *Id.* § 1601(1). In the Indian Self-determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 *et seq.*, Congress enabled Tribes to contract to run their own health care programs while also preserving Tribes' right to choose that services continue to be provided directly by the Indian Health Service. Congress has also legislated to provide Indians with access to general health programs, such as Medicaid, while creating Indian-specific protections within those programs that reflect this unique political relationship.

Congress has full constitutional authority to legislate with regard to Indian health care, and should continue to promote Tribal sovereignty and uphold the government-to-government relationship between the United States and Tribes in fulfillment of its trust and legal responsibilities in any health care reform proposal, including current efforts to repeal and replace the ACA.

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[14] *Worcester v. State of Ga.*, 31 U.S. 515, 559 (1832).
[15] U.S. CONST., art. I, § 8, cl. 3; *see also Morton v. Mancari*, 417 U.S. 535, 552–55 (1974).
[16] *Morton*, 417 U.S. at 555; *see also Moe v. Confederated Salish & Kootenai Tribes of Flathead Reservation*, 425 U.S. 463, 479–80 (1976); *Washington v. Washington State Commercial Passenger Fishing Vessel Ass'n*, 443 U.S. 658, 673 n.20 (1979); *United States v. Antelope*, 430 U.S. 641, 645–47 (1977); *Am. Fed'n of Gov't Employees, AFL-CIO v. United States*, 330 F.3d 513, 520-21 (D.C. Cir. 2003).
[17] *Morton*, 417 U.S. at 555.
[18] *See United States v. Winans*, 198 U.S. 371, 380–81 (1905).
[19] *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942); *see also* U.S. CONST., art. VI, cl. 2; *Worcester*, 31 U.S. at 539.

Overview

Oklahoma has 38 Tribal governments, and the federal Oklahoma City Area Indian Health Service (IHS) represents the largest Area within the IHS, with a user population of 355,435, or over 22% of total IHS active patients. The Oklahoma City Area is the lowest-funded IHS Area per patient. The state's Indian health system is robust – the Indian Health Service/Tribal/Urban (I/T/U) health systems within the Area manage eight hospitals, 50 health centers, one regional alcohol and substance abuse treatment center, and two urban Indian health centers. The large number of tribal health care facilities and programs is a strong reflection of the partnership and cooperation to fulfill the existing health care needs of the population.

Although health disparities continue, the American Indian and Alaska Native (AI/AN) population in Oklahoma has seen a number of improvements in health indicators. The rates of death due to stroke and kidney disease have seen statistically significant decreases over the past five years. Additionally, there have been decreases in the rates of death due to heart disease, cancer, diabetes mellitus, and influenza and pneumonia. Although these specific leading causes of death do not demonstrate statistically significant decreases, there is good potential for continued improvements. The Oklahoma Indian health system is also prioritizing the identification and treatment of Hepatitis C.

In 2013 there were nearly 140,000 uninsured Native Americans, representing nearly 22% of the state's uninsured population.[20] However, Tribal Premium Sponsorship programs, whereby Tribes sponsor (pay) the individual's net premium after federal subsidies is contributing to an increased number of citizens receiving health insurance coverage on the individual market. These programs are mostly in the starting phase as pilot programs, but it is anticipated that they will continue to grow and increase the number of insured AI/ANs. Additionally, Oklahoma submitted a Sponsor's Choice Waiver, authorized under section 1115, which if approved would provide Medicaid funding for tribal premium assistance. This waiver would support the goals of the 1332 Waiver by promoting individual insurance coverage, and thus it makes sense to have these two waivers approved together. The state intends to make two changes to the Sponsor's Choice Waiver to ensure it aligns with the 1332 waiver:

- Change income eligibility from 0-200% to 0-300% FPL to align with the 1332 Waiver eligibility
- Withdraw the Amendment submitted to CMS on October 3, 2016 which limited the provider network to in or through an I/T/U

Indian Health Systems and the Affordable Care Act

In 2010, the ACA permanently reauthorized the IHCIA within Section 10221, which was first enacted in 1976. Therefore, changes to the ACA or repeal of the ACA can impact the IHCIA. The IHCIA serves as the backbone legislation for I/T/U health systems and provides the foundational authority for the IHS to be reimbursed by Medicare, Medicaid, and third party insurers; to make grants to Indian Tribes and Tribal organizations; and to run programs designed to address specific, critical health concerns for Native Americans, such as substance abuse, diabetes, and suicide. The preservation of the IHCIA and its permanency are essential for the continued provision of health care to the AI/AN population, as well as the preservation of previously mentioned ACA provisions for $0 copays for preventive services, guaranteed issue, and dependent coverage up to age 26.

[20] Used 2013 US Census data to obtain Native American population by market. This number includes all individuals that identify themselves as having Native American heritage.

Furthermore, there are a number of provisions within the ACA separate from the IHCIA that have significant implications for the Indian health system. Those include, but may not be limited to:

- ✓ Special Enrollment Periods (Section 1311) – Provides for special monthly enrollment periods for Indians.
- ✓ Cost Sharing Reductions (Section 1402(d)) – AI/ANs who are members of federally recognized Tribes and whose household income is below 300 percent FPL are protected from paying *any* cost sharing when receiving essential health benefits from any provider, I/T/U or non-I/T/U, under Exchange QHPs. This coverage is identified in the Exchange plan offerings as the "zero cost sharing" plan variation. Also under Exchange QHPs, members of federally-recognized Tribes who are above 300 % FPL or whose income is not determined are not required to pay cost-sharing at I/T/U facilities or when referred for services by an I/T/U. This coverage is identified in the Exchange plan offerings as the "limited cost sharing" plan variation.
- ✓ Exemptions (Section 1501) – Exempts members of Indian tribes from the shared responsibility penalty for failure to comply with the requirement to maintain minimum essential coverage.
- ✓ Payer of Last Resort (Section 2901) – Establishes that I/T/U providers are the payers of last resort for services provided to Indians by I/T/U for services provided through such programs.
- ✓ Tax Exclusions for Health Benefits (Section 9021) – Excludes the values of health benefits provided or purchased by the Indian Health Service, tribes, or tribal organizations from gross income.
- ✓ Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics (Section 2902)– Makes permanent reimbursement for all Medicare Part B services furnished by Indian Health hospitals and clinics.

1332 Waiver Considerations

In consideration of these provisions, the following recommendations have been developed related to certain strategies proposed in this paper:

- ✓ Quality Measures Related to Chronic Disease

  The I/T/U system currently reports on a number of quality measures, one example being those required under the Government Performance and Results Act (GPRA). Quality measures for providers overall should align with these measures to eliminate duplication and limit the administrative burden on I/T/U providers. Additionally, baseline measures for these providers need to take into account that populations served by the I/T/U system are not currently included in statewide baseline data and health outcomes and status are statistically different for this population.

- ✓ Tighter Restrictions on Premium Payment Grace Periods and Special Enrollment Requests

  Changes to special enrollment requests need to take into account that AI/ANs currently can enroll on a monthly basis. Section 1311 will continue to be effective in the 1332 Waiver application. If this population were restricted to the open enrollment period, Tribal Premium Sponsorship would be significantly impacted. Additionally, preserving the monthly enrollment periods for AI/AN will facilitate the 1332 Waiver working more seamlessly with the 1115 Sponsor's Choice Waiver.

Requirements related to premium payment for past months of non-payment when an individual re-enrolls in a plan must exempt the Tribal Sponsorship program to ensure tribes are not restricted in helping individuals access coverage through this program. Insurer processes regarding invoicing and covered lives rosters should be evaluated alongside these changes to ensure the timing of payments and continuation of coverage are reasonable. In addition, for individuals, payment of past month's premiums should include a limit to avoid the amount in arrears becoming a permanent barrier to re-enrollment.

✓ APTC and CSR Eligibility and Distribution

If eligibility for APTCs is shifted to 0-300% of the FPL, the net cost of premiums that the Tribal Sponsorship program is providing would be impacted. This shift could potentially result in cost savings for the program, as many sponsored individuals have incomes below 100% of the FPL.

Assuming that AI/AN continue to be exempted from all cost sharing as provided in section 1402(d), consideration would need to be given to distribution of CSRs to a consumer health account.

✓ Consumer Health Accounts

The administration of consumer health accounts need to consider the current Tribal Sponsorship program operations and ensure that the program can continue to support access to coverage for the AI/AN population. Tribal Sponsorship programs currently have assurance that the federal portion of the premium payment has been made on behalf of the individual and that the tribal contribution completes the total payment. This ensures the individual indeed receives health insurance coverage. The consumer health account should also provide direct payments to insurers, continuing the assurance to Tribal Sponsorship programs that insurance coverage is paid in full. Finally, enrollment and purchasing insurance should be a prerequisite to access the consumer health account.

✓ Exploration of Reinsurance and High-Risk Pools

Reinsurance mechanisms should include the AI/AN population, since they would support carriers to cover those with high utilization costs but would not require consumers to pay a higher premium. If the state should choose to employ a high-risk pool, however, enrollment of AI/AN individuals should be a last resort after all other potential eligibility avenues have been exhausted. If an AI/AN receives coverage through Medicaid, their continuation with the Medicaid program (or Medicaid-funded participation in tribal premium assistance) should be permitted.

✓ State-Controlled Plan Regulation

Any changes implemented by the Oklahoma Insurance Department with regard to the state assuming responsibility for review and regulatory oversight of payers need to include contractual provisions currently identified for the Sponsor's Choice program. These provisions include the requirement that insurers must contract with I/T/Us using the CMS Model Indian Addendum to ensure that service provision is not interrupted, as well as utilizing the encounter rate as the payment rate to I/T/U providers.

✓ Core Health Benefits

The Essential Health Benefits required to be included in QHPs should retain Preventive Health and Behavioral Health Services, which are high priorities for Tribes. The Indian health system is a

very comprehensive system of care, and I/T/Us provide these services as well as public health and sanitation facilities in addition to clinical services. There is strong research support that investments in Preventive Health and Behavioral Health result in better health outcomes.

Next Steps

These recommended strategies are an initial proposal designed to convey the state's overarching approach to redesign the individual market and to elicit further feedback from a variety of stakeholders. In particular, it will be essential that the state legislature and state agency officials review the proposal and provide input on whether the strategies will meet the desired goals of increasing access to coverage will minimizing costs and improving quality. The proposal will likely evolve as more comprehensive information, perspectives, and analysis are gathered and integrated into the ultimate 1332 State Innovation Waiver submission.

While changes to policies and regulation are uncertain at the federal level, Oklahoma's market pain points and barriers will remain constant. This paper is a first look at how the state can fix the problems that persist and work with federal authorities to explore flexibilities or changes that will support the state's goals. As transitions to a new administration occur and future changes are identified, their impacts on Oklahoma's solutions will be evaluated.

While SB 1386 only requires legislative review for the waiver application, it is understood that legislative input and engagement throughout the process is crucial. Without active state legislative buy-in, it would be impossible for Oklahoma to achieve its policy goals, which may have impacts and require changes to the health insurance regulatory structure and state statutes. With that understanding, there will be an opportunity for legislators to be briefed, ask questions, and provide comment into the concept paper. The legislative review process is envisioned to include a briefing for all interested legislators on the concept paper by Health and Human Services project staff, followed by questions and comments. Invitations to the briefing and convening members would be led by House and Senate leadership. After the briefing, requested follow up meetings will be accommodated by HHS project staff. These activities will occur in the 2017 legislative session, with input to be incorporated into the final report, as well as identification of necessary modifications to statute or regulations.

Additionally, the Task Force will continue to meet regularly with dates secured for April and June of 2017, and state leaders will engage national experts and contractors to further refine and operationalize the strategies into a more detailed plan. By June 2017, the Task Force will produce a report that outlines this plan with more robust data and information currently being sought from surveys, focus groups, and contractors.

Conclusion

While the ACA provided additional avenues for individuals to obtain health insurance coverage, it did so with a national framework that provided limited flexibility to states and sacrificed the focus on health outcomes and cost. Oklahoma is faced with identifying opportunities to make the law more responsive to the needs of Oklahomans while addressing the challenges that persist related to consumer choice, competition, and cost. The state anticipates that changes in administration at the federal level will produce opportunities for states to communicate what has and has not worked and be given the

authority to respond to those realities. Oklahoma is well positioned to leverage existing assets and has a long history of developing innovative, state-based solutions that, with latitude at the federal level, will catalyze the establishment of a stable health insurance market and a sustainable health care system.

At the crux of this proposal is the philosophy that states can most effectively make decisions about how the health insurance market should be regulated and designed, and that families can most effectively decide what coverage options are best for them. If more flexibility is given to Oklahoma, the state can design, implement, and assess new and creative strategies that will ultimately promote lower costs, better care, and healthier people.

Appendix D
Task Force Membership

State Innovation Task Force Members

Stakeholder Type	Organization	Designee
Private Payers	Oklahoma Association of Health Plans	Laura Brookins-Fleet, Executive Director
	Blue Cross Blue Shield of Oklahoma	Stephania Grober, VP of Sales
	United Health Care	Jeff Hudson, Public Exchange Leader
Tribal Nations	Chickasaw Nation	Melissa Gower, Senior Advisor, Policy Analyst
	Cherokee Nation	Mitch Thornbrugh, COO Hastings Hospital
Providers	Oklahoma Hospital Association	Craig Jones, President
	Oklahoma State Medical Association	Melissa Johnson, Healthcare Policy Director
	Oklahoma Osteopathic Association	Duane Koehler, DO, Assistant to the Dean of Rural Health, Oklahoma State University
	INTEGRIS Health	Greg Meyers, VP of Revenue Integrity
	St. John Medical Center	Richard Todd
Brokers	Oklahoma Association of Health Underwriters	Roger Flippo, President
Consumer Advocacy Groups	Community Service Council	Jan Figart, RN, Associate Director, member of the Oklahoma Nurses Association
	Health Alliance for the Uninsured	Pam Cross, Executive Director
	Opportunities, Inc.	Keri Divis, Facility Manager
Self-insured Businesses	Devon	Jeremy Colby, VP of Benefits
	Oklahoma State Chamber	Jennifer Lepard, VP of Government Affairs
	HealthSmart	Eric Wright, Sr. Vice President

State Innovation Data Workgroup Members

Data Workgroup	Organization	Designee
Health Plan	Blue Cross Blue Shield of Oklahoma	Stephania Grober, VP of Sales
	United Health Care	Jeff Hudson, Public Exchange Leader
	Global Health	David Thompson, SVP and Chief Operating Officer
	Global Health	Dee Delapp, VP of Business Development
	Community Care	Greg Burn, Director of Marketing
	Oklahoma Insurance Department	Mike Rhodes, Deputy Commissioner of Health Insurance
	Oklahoma Insurance Department	Rebecca Ross, Insure OK Liaison
	Oklahoma Association of Health Plans	Laura Brookins-Fleet, Executive Director
	Employees Group Insurance Department	Diana O'Neal, Deputy Administrator
	Oklahoma Health Care Authority	Becky Pasternik-Ikard, Chief Executive Officer
	Oklahoma Health Care Authority	Melissa McCully, Insure Oklahoma Administrator
	Oklahoma State Department of Health	Derek Pate, Director of Center for Health Statistics
Provider	Oklahoma Hospital Association	Rick Snyder, VP Finance and Information Services
	Oklahoma State Medical Association	Melissa Johnson, Healthcare Policy Director
	Oklahoma Osteopathic Association	Duane Koehler, DO, Assistant to the Dean of Rural Health, Oklahoma State University
	Chickasaw Nation	Melissa Gower, Senior Advisor, Policy Analyst
	Cherokee Nation	Mitch Thornbrugh, COO Hastings Hospital
	INTEGRIS Health	Greg Meyers, VP of Revenue Integrity
	St. John Medical Center	Richard Todd
	Oklahoma Health Care Authority	Becky Pasternik-Ikard, Chief Executive Officer
	Oklahoma State Department of Health	Derek Pate, Director of Center for Health Statistics
Business	Devon Energy	Jeremy Colby, VP of Benefits
	State Chamber of Commerce	Jennifer Lepard, VP of Government Affairs and Executive Director

	Oklahoma Association of Health Underwriters	Roger Flippo, President
	HealthSmart	Eric Wright, Sr. Vice President
	Oklahoma Health Care Authority	Becky Pasternik-Ikard, Chief Executive Officer
	Oklahoma Health Care Authority	Melissa McCully, Insure Oklahoma Administrator
	Oklahoma State Department of Health	Derek Pate, Director of Center for Health Statistics
Consumer	Community Service Council	Jan Figart, RN, Associate Director, member of the Oklahoma Nurses Association
	Opportunities Inc., Navigator grantee for Community Action Agency	Keri Divis, Facility Manager
	Health Alliance for the Uninsured	Pam Cross, Executive Director
	Oklahoma Health Care Authority	Becky Pasternik-Ikard, Chief Executive Officer
	Oklahoma Health Care Authority	Melissa McCully, Insure Oklahoma Administrator
	Oklahoma Department of Human Services	Mark Jones, Director, Community Living and Support Services
	Oklahoma Department of Mental Health and Substance Abuse Services	Traylor Rains-Sims, Senior Director, Policy and Provider Regulation
	Oklahoma Department of Mental Health and Substance Abuse Services	Carrie Hodges, Deputy Commissioner Treatment and Recovery Services
	Oklahoma State Department of Health	Derek Pate, Director of Center for Health Statistics

Appendix E
Milliman Environmental Scan

Oklahoma Federally Facilitated Insurance Marketplace Premium Rate Changes from 2014 through 2017

Milliman, Inc. was requested by the Oklahoma State Department of Health (OSDH) to summarize premium rate changes in the State's federally facilitated marketplace from 2014 through 2017. Using publicly available premium data from data.healthcare.gov, we have illustrated marketplace premiums for each calendar year (CY) for select qualified health plans (QHPs), counties, family sizes, and ages. Actual premiums for each calendar year will vary by insurer, the age of individuals in a household, and county residence. The information in this document is limited to presenting high level premium rate changes that have occurred in the federally facilitated marketplace during the 2014 through 2017 time period. Our analysis of drivers of premium rate changes in the insurance marketplace will be provided to OSDH at a later date.

Limitations

The information contained in this document has been prepared for the Oklahoma State Department of Health (OSDH), related agencies, and their advisors. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented. Users should have an understanding of the Affordable Care Act's (ACA) premium rate rules and premium assistance structure when interpreting the information in this document.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for OSDH by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

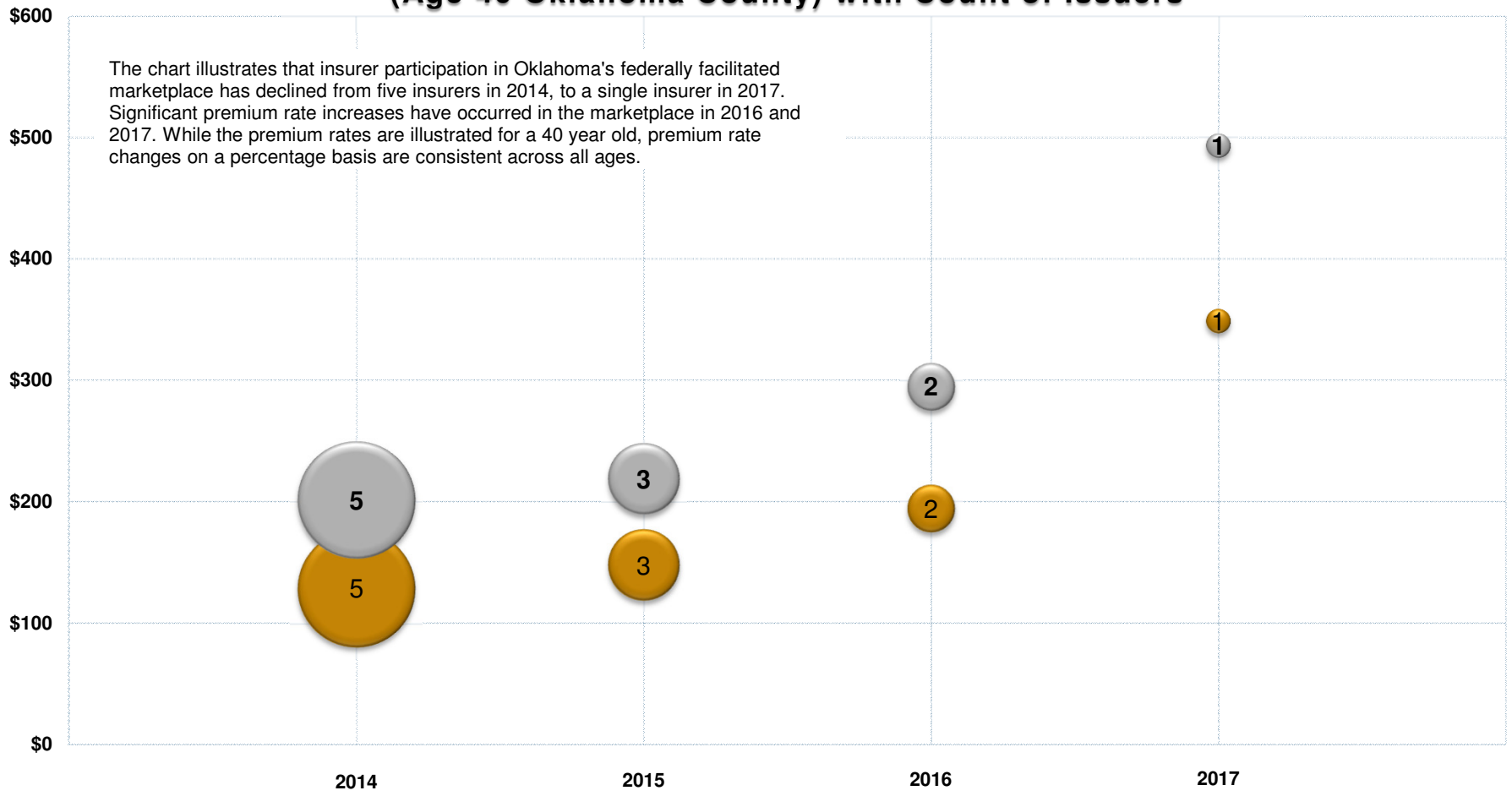
Milliman has relied upon certain data and information made publicly available by the federal government. The values presented in this document are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data.

This analysis was completed under our signed contract agreement with OSDH dated December 16, 2016.

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.

Oklahoma Health Insurance Marketplace
2nd Lowest Cost Silver and Lowest Cost Bronze Premiums*
(Age 40 Oklahoma County) with Count of Issuers



**Gross premiums prior to any applicable premium subsidies*

Source

PREMIUM DATA FROM DATA.HEALTHCARE.GOV, REFLECTS NON-TOBACCO USERS
PREMIUMS BY AGE WILL VARY BY THE FEDERAL AGE RATING CURVE

	2014	2015	2016	2017
2nd Lowest Cost Silver Premium	$ 201	$ 219	$ 295	$ 493
Lowest Cost Bronze Premium	$ 129	$ 148	$ 194	$ 349

Figure 1-A
Family Coverage in the Individual Market
Monthly Premium Rates for Lowest Cost Bronze Plan

	Urban				Rural			
Plan Participants	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Example Family #1								
Age 37 Male	$ 125	$ 143	$ 188	$ 338	$ 139	$ 141	$ 186	$ 343
Age 37 Female	$ 125	$ 143	$ 188	$ 338	$ 139	$ 141	$ 186	$ 343
Age 12 Male	$ 64	$ 73	$ 96	$ 173	$ 72	$ 72	$ 96	$ 176
Age 10 Female	$ 64	$ 73	$ 96	$ 173	$ 72	$ 72	$ 96	$ 176
Pre-Subsidy Total	$ 377	$ 433	$ 569	$ 1,022	$ 422	$ 426	$ 564	$ 1,039
Post-Subsidy Premium Cost								
Family Income Level:								
100% FPL	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
200% FPL	$ 34	$ 44	$ 0	$ 0	$ 23	$ 48	$ 0	$ 0
300% FPL	$ 347	$ 362	$ 290	$ 165	$ 335	$ 366	$ 293	$ 158
400%+ FPL	$ 377	$ 433	$ 569	$ 1,022	$ 422	$ 426	$ 564	$ 1,039

1. For all plans, urban premiums are those quoted in Oklahoma County; whereas rural premiums reflect those offered in Adair County.
2. For all individuals, the following outlines the lowest cost bronze plan for each year:
   2014 - Urban: Blue Advantage Bronze PPO 006, Rural: Blue Preferred Bronze PPO 006
   2015 - Urban: Blue Advantage Bronze PPO? 006, Rural: Blue Advantage Bronze PPO? 006
   2016 - Urban: Blue Advantage Bronze PPO? 105 - One $0 PCP Visit, Rural: Blue Advantage Bronze PPO? 105 - One $0 PCP Visit
   2017 - Urban: Blue Advantage Bronze PPO? 105 - One $0 PCP Visit, Rural: Blue Advantage Bronze PPO? 105 - One $0 PCP Visit

Figure 1-B
Family Coverage in the Individual Market
Annual Premium Increases for Lowest Cost Bronze Plan

	Urban			Rural		
Plan Participants	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
Example Family #1						
Age 37 Male	14.9%	31.3%	79.7%	1.0%	32.3%	84.4%
Age 37 Female	14.9%	31.3%	79.7%	1.0%	32.3%	84.4%
Age 12 Male	14.9%	31.3%	79.7%	1.0%	32.3%	84.4%
Age 10 Female	14.9%	31.3%	79.7%	1.0%	32.3%	84.4%
Pre-Subsidy Total	14.9%	31.3%	79.7%	1.0%	32.3%	84.4%
Post-Subsidy Premium Cost						
Family Income Level:						
100% FPL	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
200% FPL	28.0%	(100.0%)	0.0%	106.6%	(100.0%)	0.0%
300% FPL	4.5%	(19.8%)	(43.2%)	9.1%	(19.8%)	(46.1%)
400%+ FPL	14.9%	31.3%	79.7%	1.0%	32.3%	84.4%

Figure 1-A and Figure 1-B illustrate premium rate changes on a dollar and percentage change basis from the prior year, respectively, for the lowest-cost bronze plan offered in Oklahoma County (urban) and Adair County (rural). For some subsidy-eligible households, it is possible to purchase a bronze plan at no cost. While significant premium rate increases occurred in CY2016 and CY2017, households qualifying for premium assistance in many cases experienced out-of-pocket premium rate decreases, as the growth in premium subsidy assistance exceeded growth in bronze premium amounts (particularly evident by post-subsidy premium rate changes for family income at 300% FPL). It should be noted that non-native Americans with household income between 100% and 250% FPL forgo additional cost sharing assistance if a bronze, rather than silver plan, is purchased.

Figure 2-A
Family Coverage in the Individual Market
Monthly Premium Rates for Second Lowest Cost Silver Plan

	Urban				Rural			
Plan Participants	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Example Family #1								
Age 37 Male	$ 195	$ 212	$ 286	$ 478	$ 214	$ 208	$ 283	$ 486
Age 37 Female	$ 195	$ 212	$ 286	$ 478	$ 214	$ 208	$ 283	$ 486
Age 12 Male	$ 100	$ 109	$ 146	$ 245	$ 110	$ 107	$ 145	$ 249
Age 10 Female	$ 100	$ 109	$ 146	$ 245	$ 110	$ 107	$ 145	$ 249
Pre-Subsidy Total	$ 590	$ 641	$ 864	$ 1,446	$ 646	$ 630	$ 856	$ 1,470
Post-Subsidy Premium Cost								
Family Income Level:								
100% FPL	$ 39	$ 40	$ 41	$ 41	$ 39	$ 40	$ 41	$ 41
200% FPL	$ 247	$ 252	$ 259	$ 260	$ 247	$ 252	$ 259	$ 260
300% FPL	$ 559	$ 570	$ 586	$ 589	$ 559	$ 570	$ 586	$ 589
400%+ FPL	$ 590	$ 641	$ 864	$ 1,446	$ 646	$ 630	$ 856	$ 1,470

1. For all plans, urban premiums are those quoted in Oklahoma County; whereas rural premiums reflect those offered in Adair County.
2. For all individuals, the following outlines the second lowest cost silver plan for each year:
   2014 - Urban: Blue Advantage Silver PPO 004, Rural: Blue Preferred Silver PPO 004
   2015 - Urban: Blue Advantage Silver PPO? 004, Rural: Blue Advantage Silver PPO? 004
   2016 - Urban: Blue Advantage Silver PPO? 102, Rural: Blue Advantage Silver PPO? 102
   2017 - Urban: Blue Advantage Silver PPO? 103, Rural: Blue Advantage Silver PPO? 103

Figure 2-B
Family Coverage in the Individual Market
Annual Premium Increases for Second Lowest Cost Silver Plan

	Urban			Rural		
Plan Participants	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
Example Family #1						
Age 37 Male	8.7%	34.8%	67.3%	(2.4%)	35.8%	71.7%
Age 37 Female	8.7%	34.8%	67.3%	(2.4%)	35.8%	71.7%
Age 12 Male	8.7%	34.8%	67.3%	(2.4%)	35.8%	71.7%
Age 10 Female	8.7%	34.8%	67.3%	(2.4%)	35.8%	71.7%
Pre-Subsidy Total	8.7%	34.8%	67.3%	(2.4%)	35.8%	71.7%
Post-Subsidy Premium Cost						
Family Income Level:						
100% FPL	1.8%	2.7%	0.7%	1.8%	2.7%	0.7%
200% FPL	1.9%	2.8%	0.5%	1.9%	2.8%	0.5%
300% FPL	1.9%	2.7%	0.5%	1.9%	2.7%	0.5%
400%+ FPL	8.7%	34.8%	67.3%	(2.4%)	35.8%	71.7%

Figure 2-A and Figure 2-B illustrate premium rate changes on a dollar and percentage change basis from the prior year, respectively, for the second lowest-cost silver plan offered in Oklahoma County (urban) and Adair County (rural). The second-lowest cost silver plan, also known as the subsidy benchmark plan, is used to calculate premium assistance amounts for qualifying households. While significant premium rate increases occurred in CY2016 and CY2017, households qualifying for premium assistance were insulated from the premium rate increases due to growth in premium assistance amounts that corresponded to the overall premium rate increases (as evident by post-subsidy premium rate changes for family incomes at 100%, 200%, and 300% FPL).

Data sources: Marketplace premium information for each calendar year is publicly available at data.healthcare.gov. Premiums illustrated reflect non-tobacco users. Premium subsidies are based on prescribed percentages in 26 U.S. Code § 36B, with annual indexing as prescribed by the calendar year's annual notice of benefit and payment parameters. Household income levels for each calendar year are defined by the prior year's federal poverty level, published annually by the U.S. Department of Health and Human Services: https://aspe.hhs.gov/poverty-guidelines.

Figure 3-A
Family Coverage in the Individual Market
Monthly Premium Rates for Lowest Cost Bronze Plan

	Statewide Composite			
Plan Participants	**2014**	**2015**	**2016**	**2017**
Example Family #1				
Age 37 Male	$ 135	$ 148	$ 200	$ 355
Age 37 Female	$ 135	$ 148	$ 200	$ 355
Age 12 Male	$ 69	$ 76	$ 102	$ 182
Age 10 Female	$ 69	$ 76	$ 102	$ 182
Pre-Subsidy Total	$ 407	$ 449	$ 604	$ 1,075
Post-Subsidy Premium Cost				
Family Income Level:				
100% FPL	$0	$0	$0	$0
200% FPL	$32	$41	$0	$0
300% FPL	$344	$359	$293	$146
400%+ FPL	$407	$449	$604	$1,075

Figure 3-B
Family Coverage in the Individual Market
Annual Premium Increases for Lowest Cost Bronze Plan

	Statewide Composite		
Plan Participants	**2015**	**2016**	**2017**
Example Family #1			
Age 37 Male	10.4%	34.6%	77.8%
Age 37 Female	10.4%	34.6%	77.8%
Age 12 Male	10.4%	34.6%	77.8%
Age 10 Female	10.4%	34.6%	77.8%
Pre-Subsidy Total	10.4%	34.6%	77.8%
Post-Subsidy Premium Cost			
Family Income Level:			
100% FPL	0.0%	0.0%	0.0%
200% FPL	28.7%	(100.0%)	0.0%
300% FPL	4.4%	(18.4%)	(50.0%)
400%+ FPL	10.4%	34.6%	77.8%

Figure 3-A and Figure 3-B illustrate premium rate changes on a dollar and percentage change basis from the prior year, respectively, for the statewide composite lowest-cost bronze plan. The statewide composite premium was calculated by weighting the lowest cost bronze plan offered in each county by QHP selections in each county during the calendar year. County weighting for CY2017 reflects CY2016 QHP selections. On a statewide composite basis, premium rate changes did not differ significantly from those illustrated in Figures 1-A and 1-B. For some subsidy-eligible households, it is possible to purchase a bronze plan at no cost. While significant premium rate increases occurred in CY2016 and CY2017, households qualifying for premium assistance in many cases experienced out-of-pocket premium rate decreases, as the growth in premium subsidy assistance exceeded growth in bronze premium amounts (particularly evident by post-subsidy premium rate changes for family income at 300% FPL). It should be noted that non-native Americans with household income between 100% and 250% FPL forgo additional cost sharing assistance if a bronze plan, rather than silver plan, is purchased.

Figure 4-A
Family Coverage in the Individual Market
Monthly Premium Rates for Second Lowest Cost Silver Plan

	Statewide Composite			
Plan Participants	**2014**	**2015**	**2016**	**2017**
Example Family #1				
Age 37 Male	$ 206	$ 218	$ 297	$ 501
Age 37 Female	$ 206	$ 218	$ 297	$ 501
Age 12 Male	$ 106	$ 112	$ 152	$ 257
Age 10 Female	$ 106	$ 112	$ 152	$ 257
Pre-Subsidy Total	$ 622	$ 660	$ 897	$ 1,517
Post-Subsidy Premium Cost				
Family Income Level:				
100% FPL	$39	$40	$41	$41
200% FPL	$247	$252	$259	$260
300% FPL	$559	$570	$586	$589
400%+ FPL	$622	$660	$897	$1,517

Figure 4-B
Family Coverage in the Individual Market
Annual Premium Increases for Second Lowest Cost Silver Plan

	Statewide Composite		
Plan Participants	**2015**	**2016**	**2017**
Example Family #1			
Age 37 Male	6.1%	35.9%	69.0%
Age 37 Female	6.1%	35.9%	69.0%
Age 12 Male	6.1%	35.9%	69.0%
Age 10 Female	6.1%	35.9%	69.0%
Pre-Subsidy Total	6.1%	35.9%	69.0%
Post-Subsidy Premium Cost			
Family Income Level:			
100% FPL	1.8%	2.7%	0.7%
200% FPL	1.9%	2.8%	0.5%
300% FPL	1.9%	2.7%	0.5%
400%+ FPL	6.1%	35.9%	69.0%

Figure 4-A and Figure 4-B illustrate premium rate changes on a dollar and percentage change basis from the prior year, respectively, for the statewide composite second lowest-cost silver plan. The second-lowest cost silver plan, also known as the subsidy benchmark plan, is used to calculate premium assistance amounts for qualifying households. The statewide composite premium was calculated by weighting the second-lowest cost silver plan offered in each county by QHP selections in each county during the calendar year. County weighting for CY2017 reflects CY2016 QHP selections. On a statewide composite basis, premium rate changes did not differ significantly from those illustrated in Figures 2-A and 2-B. While significant premium rate increases occurred in CY2016 and CY2017, households qualifying for premium assistance were insulated from the premium rate increases due to growth in premium assistance amounts that corresponded to the overall premium rate increases (as evident by post-subsidy premium rate changes for family incomes at 100%, 200%, and 300% FPL).

Note: Statewide composite weighted by county-level enrollment

Data sources: Marketplace premium information for each calendar year is publicly available at data.healthcare.gov. Premiums illustrated reflect non-tobacco users. Premium subsidies are based on prescribed percentages in 26 U.S. Code § 36B, with annual indexing as prescribed by the calendar year's annual notice of benefit and payment parameters. Household income levels for each calendar year are defined by the prior year's federal poverty level, published annually by the U.S. Department of Health and Human Services: https://aspe.hhs.gov/poverty-guidelines.

Figure 5 2016 Annualized Family Subsidies in the Individual Market Based on the Benchmark Plan								
Household Composition	**FPL**	**Premium Percentage (Maximum Out-of-Pocket Cost for Benchmark Plan)**	**Member Location**	**Benchmark Plan Annual Premium**	**Potential Annual Subsidy**	**Marketplace Plans Offered**		**Annual Premium After Subsidy**
37 year-old 37 year-old 12 year-old 10 year-old	100% or $24,250	2.03% or $492	Urban	$10,370	$9,878	Bronze	$6,828	$0
						Silver	$10,370	$492
			Rural	$10,271	$9,779	Bronze	$6,763	$0
						Silver	$10,271	$492
	200% or $48,500	6.41% or $3,109	Urban	$10,370	$7,261	Bronze	$6,828	$0
						Silver	$10,370	$3,109
			Rural	$10,271	$7,162	Bronze	$6,763	$0
						Silver	$10,271	$3,109
	300% or $72,750	9.66% or $7,028	Urban	$10,370	$3,342	Bronze	$6,828	$3,485
						Silver	$10,370	$7,028
			Rural	$10,271	$3,243	Bronze	$6,763	$3,519
						Silver	$10,271	$7,028
	400%+ or >$97,000	Customer pays full price	Urban	$10,370	N/A	Bronze	$6,828	$6,828
						Silver	$10,370	$10,370
			Rural	$10,271		Bronze	$6,763	$6,763
						Silver	$10,271	$10,271

The above table illustrates non-tobacco premium rates for a family of four, as well as the derivation of the annual premium subsidy amount made available to households with income at 100%, 200%, and 300% of the federal poverty level (FPL). The "Premium Percentage (Maximum Out-of-Pocket Cost for Benchmark Plan)" column reflects the maximum the household must pay under the ACA for the second lowest cost silver plan (known as the "subsidy benchmark plan"), in terms of either a percentage of household income or annual out-of-pocket expense. For example, a family at 200% FPL would pay a maximum of 6.41% of household income or $3,109 for the second lowest cost silver plan. The "Benchmark Plan Annual Premium" reflects the annual premium (prior to premium assistance) for the family of four in a selected urban versus rural county. The "Potential Annual Subsidy" is calculated based on the difference between the full premium amount of the benchmark plan and the maximum out-of-pocket cost for the benchmark plan prescribed by the ACA. For example, a family of four at 200% FPL in the urban county would receive an annual premium subsidy of $7,261 ($10,370 - $3,109). The premium subsidy may be applied to any metallic plan offered in the marketplace. Under the "Marketplace Plans Offered" columns, the full premium amounts are listed for the lowest cost bronze plan in the counties, as well as the second lowest cost silver plan (benchmark plan). The final column illustrates the annual out-of-pocket premium after premium assistance is applied (full premium amount less potential annual subsidy). To the extent the full premium amount is less than the value of premium assistance, the household does not separately receive the unused subsidy value (for example, a household at 100% or 200% FPL purchasing bronze coverage).

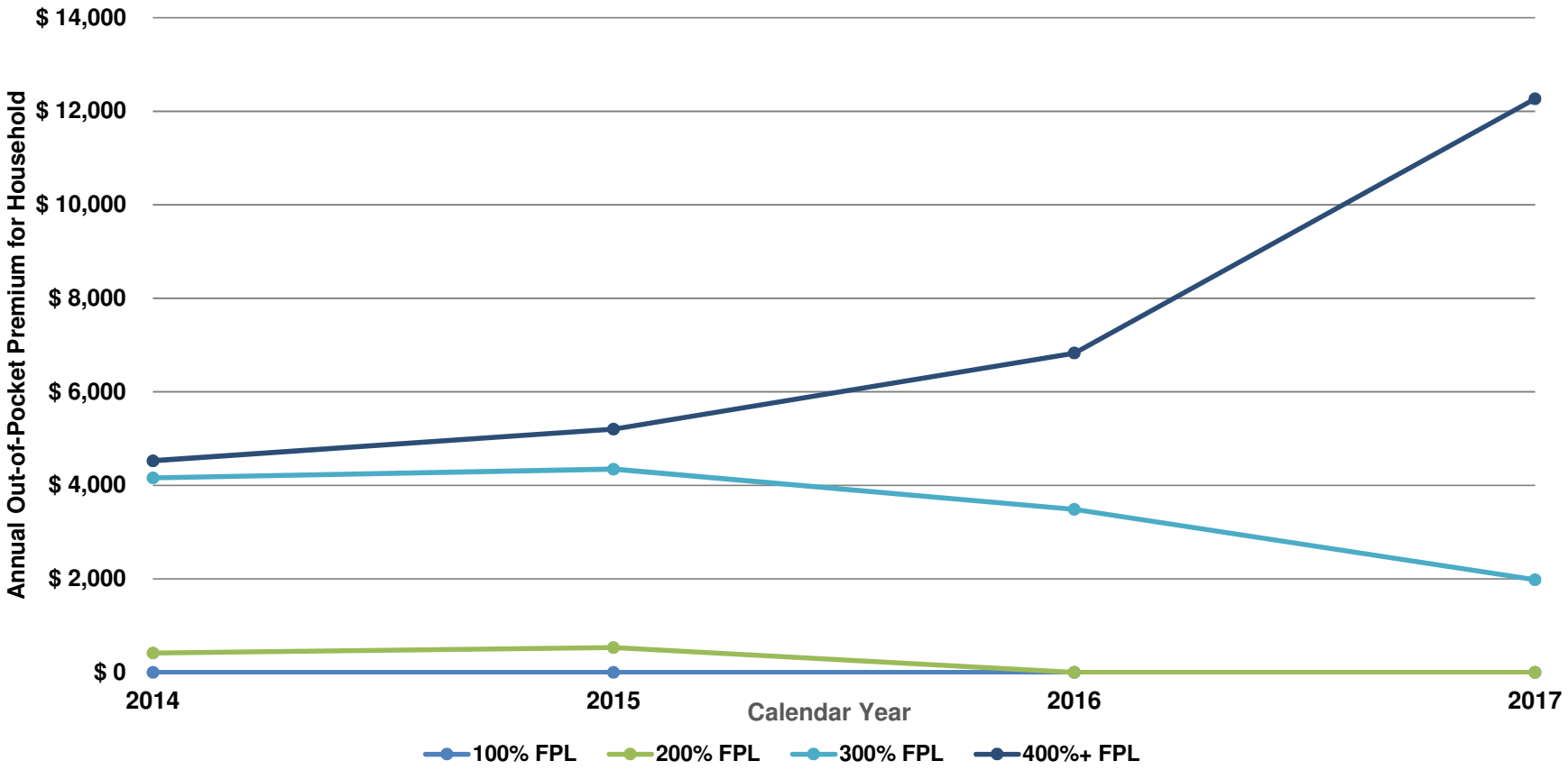
Data sources: Marketplace premium information for each calendar year is publicly available at data.healthcare.gov. Premiums illustrated reflect non-tobacco users in Oklahoma (urban) and Adair (rural) counties. Marketplace plans offered reflect the lowest cost bronze plan and the second-lowest cost silver plan (also referred to as the 'subsidy benchmark plan'). Premium subsidies are based on prescribed percentages in 26 U.S. Code § 36B, with annual indexing as prescribed by the calendar year's annual notice of benefit and payment parameters. Household income levels for each calendar year are defined by the prior year's federal poverty level, published annually by the U.S. Department of Health and Human Services: https://aspe.hhs.gov/poverty-guidelines.

Figure 6 2017 Annualized Family Subsidies in the Individual Market Based on the Benchmark Plan								
Household Composition	**FPL**	**Premium Percentage (Maximum Out-of-Pocket Cost for Benchmark Plan)**	**Member Location**	**Benchmark Plan Annual Premium**	**Potential Annual Subsidy**	**Marketplace Plans Offered**		**Annual Premium After Subsidy**
37 year-old 37 year-old 12 year-old 10 year-old	100% or $24,300	2.04% or $496	Urban	$17,350	$16,854	Bronze	$12,267	$0
						Silver	$17,350	$496
			Rural	$17,635	$17,139	Bronze	$12,469	$0
						Silver	$17,635	$496
	200% or $48,600	6.43% or $3,125	Urban	$17,350	$14,225	Bronze	$12,267	$0
						Silver	$17,350	$3,125
			Rural	$17,635	$14,510	Bronze	$12,469	$0
						Silver	$17,635	$3,125
	300% or $72,900	9.69% or $7,064	Urban	$17,350	$10,286	Bronze	$12,267	$1,981
						Silver	$17,350	$7,064
			Rural	$17,635	$10,571	Bronze	$12,469	$1,898
						Silver	$17,635	$7,064
	400%+ or >$97,200	Customer pays full price	Urban	$17,350	N/A	Bronze	$12,267	$12,267
						Silver	$17,350	$17,350
			Rural	$17,635		Bronze	$12,469	$12,469
						Silver	$17,635	$17,635

The above table illustrates non-tobacco premium rates for a family of four, as well as the derivation of the annual premium subsidy amount made available to households with income at 100%, 200%, and 300% of the federal poverty level (FPL). The "Premium Percentage (Maximum Out-of-Pocket Cost for Benchmark Plan)" column reflects the maximum the household must pay under the ACA for the second lowest cost silver plan (known as the "subsidy benchmark plan"), in terms of either a percentage of household income or annual out-of-pocket expense. For example, a family at 200% FPL would pay a maximum of 6.43% of household income or $3,125 for the second lowest cost silver plan. The "Benchmark Plan Annual Premium" reflects the annual premium (prior to premium assistance) for the family of four in a selected urban versus rural county. The "Potential Annual Subsidy" is calculated based on the difference between the full premium amount of the benchmark plan and the maximum out-of-pocket cost for the benchmark plan prescribed by the ACA. For example, a family of four at 200% FPL in the urban county would receive an annual premium subsidy of $14,225 ($17,350 - $3,125). The premium subsidy may be applied to any metallic plan offered in the marketplace. Under the "Marketplace Plans Offered" columns, the full premium amounts are listed for the lowest cost bronze plan in the counties, as well as the second lowest cost silver plan (benchmark plan). The final column illustrates the annual out-of-pocket premium after premium assistance is applied (full premium amount less potential annual subsidy). To the extent the full premium amount is less than the value of premium assistance, the household does not separately receive the unused subsidy value (for example, a household at 100% or 200% FPL purchasing bronze coverage).

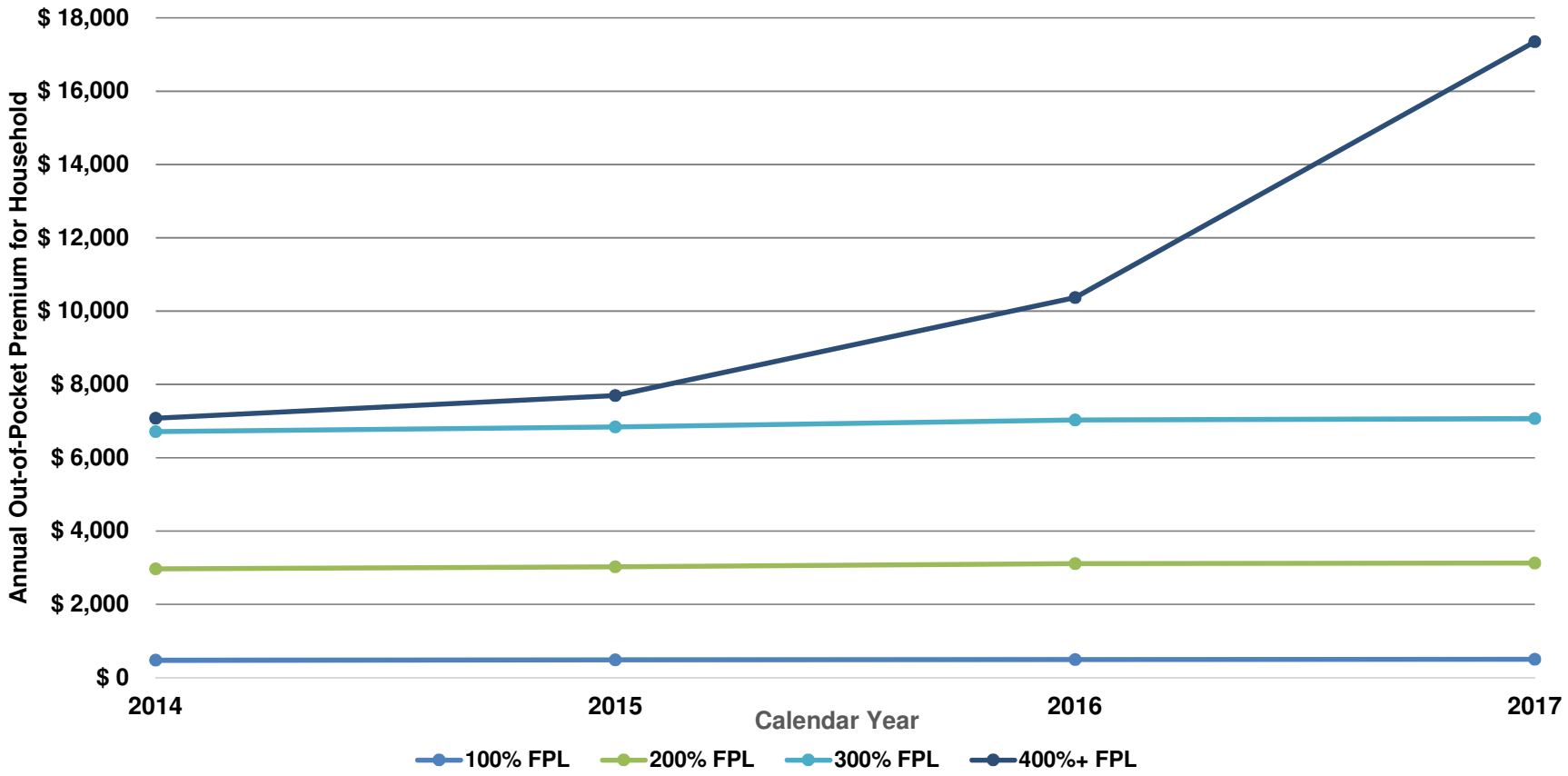
Data sources: Marketplace premium information for each calendar year is publicly available at data.healthcare.gov. Premiums illustrated reflect non-tobacco users in Oklahoma (urban) and Adair (rural) counties. Marketplace plans offered reflect the lowest cost bronze plan and the second-lowest cost silver plan (also referred to as the 'subsidy benchmark plan'). Premium subsidies are based on prescribed percentages in 26 U.S. Code § 36B, with annual indexing as prescribed by the calendar year's annual notice of benefit and payment parameters. Household income levels for each calendar year are defined by the prior year's federal poverty level, published annually by the U.S. Department of Health and Human Services: https://aspe.hhs.gov/poverty-guidelines.

Oklahoma Federally Facilitated Health Insurance Marketplace
Lowest Cost Bronze Annual Net Premiums by Federal Poverty Level (FPL)
Family of 4 Oklahoma County



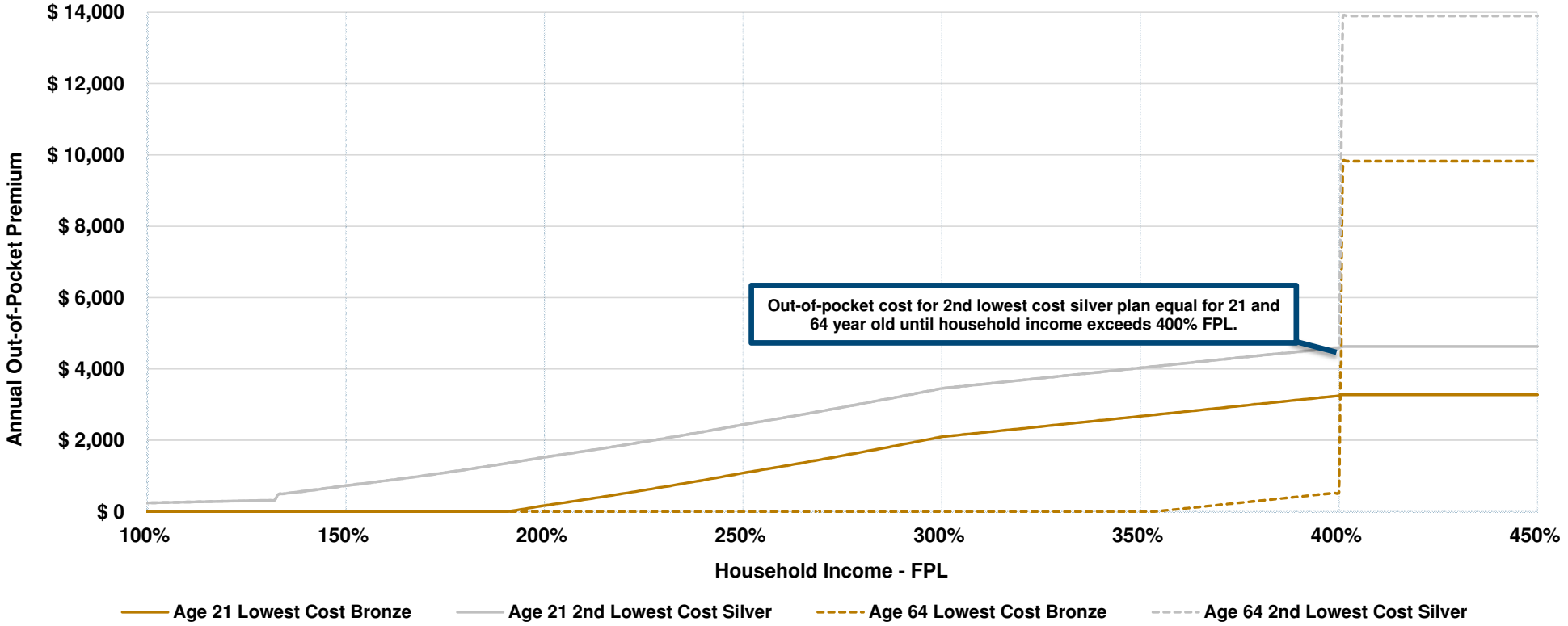
The above chart illustrates the annual out-of-pocket premium for a family of four (two adults age 37, two children under age 21) purchasing the lowest-cost bronze plan offered in Oklahoma County in CY2014 through CY2017 at varying household income levels. For households with income of 100%, 200%, or 300% FPL, premium assistance is received from the federal government in each calendar year that reduces the household's out-of-pocket premium. For households with income above 400% FPL, premium assistance is not available. As shown in the chart, premium assistance insulates qualifying households from the premium rate increases in the marketplace, and the structure and calculation of the premium assistance amounts has actually reduced out-of-pocket premiums for the household at 300% FPL significantly in CY2016 and CY2017. For the households at 100% and 200% FPL, the out-of-pocket premium is $0 in CY2016 and CY2017.

Oklahoma Federally Facilitated Health Insurance Marketplace
2nd Lowest Cost Silver Net Premiums by Federal Poverty Level (FPL)
Family of 4 Oklahoma County



The above chart illustrates the annual out-of-pocket premium for a family of four (two adults age 37, two children under age 21) purchasing the second lowest-cost silver plan offered in Oklahoma County in CY2014 through CY2017 at varying household income levels. For households with income of 100%, 200%, or 300% FPL, premium assistance is received from the federal government in each calendar year that reduces the household's out-of-pocket premium. For households with income above 400% FPL, premium assistance is not available. As shown in the chart, premium assistance insulates qualifying households from the premium rate increases in the marketplace, and has resulted in no significant changes in out-of-pocket premiums during the four year period. However, for households with income above 400% FPL, annual premiums have increases by over $10,000 from CY2014 to CY2017.

Oklahoma Health Insurance Marketplace
CY2017 2nd Lowest Cost Silver and Lowest Cost Bronze Net Premiums by Federal Poverty Level (FPL)
Ages 21 and 64 Oklahoma County



The above chart illustrates the annual out-of-pocket premium for a single household age 21 or age 64 purchasing either the second lowest-cost silver plan or lowest cost bronze plan offered in Oklahoma County in CY2017 with household income ranging from 100% to 450% of the federal poverty level (FPL). The variance in out-of-pocket premium cost by age and household income is a result of premium assistance provide by the federal government. For U.S. citizens with household income between 100% and 400% FPL who do not have acess to affordable employer-sponsored insurance or other government health insurance programs, premium assistance may be used to purchase any non-catastrohpic health insurance plan offered in the federally facilitated marketplace. Premiums illustrated reflect a non-tobacco user.

For the lowest cost bronze plan, out-of-pocket premium is $0 until income reaches nearly 200% FPL for both a 21 and 64 year old. As household income increases above 200% FPL, the out-of-pocket premium for the bronze plan remains $0 for the 64 year old until income is approximately 350% FPL. For the 21 year old with income of 350% FPL, out-of-pocket annual premium for the bronze plan is nearly $2,700. The out-of-pocket cost for the second lowest cost silver plan for subsidy-eligible households is identical for 21 and 64 year olds. This is a result of the ACA's premium subsidy structure capping the out-of-pocket premium for the second lowest cost silver plan at a specified percentage of household income, regardles of age. For both 21 and 64 year olds, the full premium amount of the second lowest cost silver plan exceeds the income cap for all subsidy-eligible income levels.

When household income exceeds 400% FPL, households are no longer eligible for premium assistance. Particularly for older adults, the value of premium assistance is significant even at 400% FPL. For a single 64 year old in Oklahoma County, premium assistance is approximately $9,300 annually. As income exceeds 400% FPL, this results in a "subsidy cliff", increasing the out-of-pocket premium for a 64 year old from approximately $4,600 to $13,900 for the second lowest cost silver plan (a similar effect occurs when purchasing the lowest cost bronze plan, increasing out-of-pocket premium from approximately $500 to $9,800). For a 21 year old, the subsidy cliff is less pronounced, as premium assistance at 400% FPL is less than $30 annually.

Appendix F
Federal Proposal Crosswalk

Federal Legislative Proposal Crosswalk – As of July 10, 2017

	OK Task Force	House Bill	Senate Bill	HHS Regulations and Administrative Action
Proposal Title	A New Horizon	American Health Care Act (AHCA)	Better Care Reconciliation Act (BCRA)	CMS Proposed Rule, 2/15/17 Final Rule 4/13/17
Financial assistance for coverage purchasers (Premium Tax Credits)	Allow tax credits for under 100% FPL population while maintaining for other eligible consumers Standardize assistance based on age and income	Tax credits, payable monthly Under age 30: $2,000/year Age 30-39: $2,500 Age 40-49: $3,000 Age 50-59: $3,500 Age 60+: $4,000 Credits capped at $14k/family, can be used for up to 5 oldest members Expands types of plans that can be subsidized, including catastrophic, limited benefit Credits can be use off-exchange Plan for making credits advancable by 2020 Managers amendment instructs the Senate to build a $75 billion reserve fund to support premiums for older, lower income adults. No details on the structure were provided.	2018-2019, ACA premium tax credit formula and eligibility standards are unchanged, except, no cap on repayment of excess payments, 25% penalty for claim for tax credit for which individual is not eligible. Tax credits cannot be used for plans that cover abortion (2018). In 2020, eligibility changes (see below). Individual contribution for people with income above 150% FPL is reduced for younger individuals and increased for older individuals at a given income.	

Federal Legislative Proposal Crosswalk – As of July 10, 2017

	OK Task Force	House Bill	Senate Bill	HHS Regulations and Administrative Action
Tax Credit Eligibility	Repurpose federal APTC, CSR funds to include gap population, maintain subsidies for those under 250 or 300% FPL. Subsidy eligibility will be based on the amount of funding available, populations served, and projected impact on enrollment decisions	Citizens and legal immigrants who are not incarcerated or eligible for employer plan, Medicare, Medicaid or CHIP, TRICARE, or a health care sharing ministry Full credits available to individuals up to $75k MAGI, families up to $150K and drops by $100 for every $1,000 income higher than those thresholds	Starting 2020 - eligibility for tax credits is 0-350% FPL. Tax credit is tied to the median priced marketplace plan with actuarial value of 58%.	
Cost Sharing Assistance	See Financial Assistance and HSA sections	Repeals CSRs in 2020	Repeals CSRs in 2020	The House filed a lawsuit in 2014 saying Congress had not appropriated CSR funding, making Obama Administration reimbursements illegal The suit is on hold, no current information on how Congress or the Trump Administration will proceed

	OK Task Force	House Bill	Senate Bill	HHS Regulations and Administrative Action
Health Savings Accounts	Establish HSA-like accounts funded by redirecting APTCs and CSRs for consumers to purchase coverage and pay for out-of-pocket expenses	Increases contribution limit to maximum sum of annual deductible & OOP expenses allowed under HDHP (at least $6,550 individual; $31,000 for family coverage in 2018) Both spouse can make catch-up contributions to one HSA in 2018 HSA may pay for medical expenses incurred before HSA was established, if established within a 60-days of HDHP enrollment Allows HSA to pay for OTC medications (2018) Repeals limit on FSA contributions after 12/31/17	Modifies rules as of 2018: Increases annual tax free contribution limit to limit on out-of-pocket cost sharing under qualified high deductible health plans ($6,550 for 2017 self only $13,100 for family coverage, indexed for inflation). Allows catch up contribution of up to $1,000 for persons over age 55. Both spouses can make catch up contributions to the same HSA. Withdrawals for qualified medical expenses are not taxed. QME definition expanded to include over-the-counter medications and expenses incurred up to 60 days prior to date HSA was established. Tax penalty for non-qualified expenditures is reduced to 10%.	
Premium Rating Rules: Age Bands	Will be set based on additional analysis, not to exceed 5:1	Default is 5:1 rating band, allows state waivers for larger variance	Default is 5:1 rating band, allows state waivers for alternative	

Federal Legislative Proposal Crosswalk – As of July 10, 2017

	OK Task Force	House Bill	Senate Bill	HHS Regulations and Administrative Action
Premium Rating Rules: Other Factors	Cap premium increases at 2% less than average medical expenditures growth rate	Premium can be 30% higher for individuals with coverage gap Maintains ACA rule re community rating, except if changed by waiver (cannot waive ban on rating by gender, health status, or change 5:1 age rating)	Retain private market rules, including guaranteed issue, pre-existing condition exclusion ban, requirement to allow dependent coverage to age 26. Keeps prohibition on health status rating with state option to waive for individual market applicants who have not maintained continuous coverage.	
Benefit Design	Two plan types: 1. Plan with 80% minimum AV 2. High-deductible plan with 60% minimum AV Require plans pay providers using value based payments (80% by 2020) Utilize case management and care coordination	State will determine EHBs for purpose of calculating tax credits in 2018. HHS still defines EHB (includes the 10 mandatory categories and is equivalent to typical employer plan), states can waive starting in 2020	In 2020, states can apply for waivers to re-define EHB in individual or small group market. Retains maximum out-of-pocket limit on cost sharing Sunsets requirement for plans to be offered at specified actuarial values/metal levels as of 12/31/2019. Maintains ban on lifetime and annual limits, but only applies to EHBs. Maintains coverage for preventive care without cost-sharing.	In 4/13/17 regulation: Allow increased variation to four percentage points below the standard actuarial value for each metal level (increases the AV range used to determine the level of coverage in a plan) This does not change the range for silver plan variations used for CSR eligible individuals

Federal Legislative Proposal Crosswalk – As of July 10, 2017

	OK Task Force	House Bill	Senate Bill	HHS Regulations and Administrative Action
Eligibility and enrollment	Require premium payment for re-enrollment and reduce grace period to 30 days Allow some populations covered by state programs to move into individual market	Anyone can purchase individual coverage Maintains guaranteed issue during open enrollment Maintain ACA prohibition on preexisting condition exclusions and discrimination based on gender, maintain guaranteed issue and renewability requirements, coverage of adult children up to age 26 on their parent's plans	Maintains annual open enrollment and special enrollment periods. Maintains pre-existing condition exclusion ban. Require waiting periods of 6 months for people who buy non-group coverage unless they have had continuous coverage throughout the prior 12-month period.	In 4/13/17 regulation: 2018 Open Enrollment Period will be Nov 1 - Dec 15, 2017 Allow carriers to require payment of prior year unpaid premiums before enrolling consumer in coverage with the same carrier for next year
Special Enrollment rules	Require more validation for special enrollment	Tightens verification (mirrors proposed HHS rule) Continuous coverage in effect at SEP starting in benefit year 2018	Require waiting periods of 6 months for people who buy non-group coverage unless they have had continuous coverage throughout the prior 12-month period.	In 4/13/17 regulation: Require documentation of qualifying life event for all who seek to enroll through a special enrollment period on HealthCare.gov; recommend state based exchanges also implement In all individual markets, limit plan changes for current covered individuals
Continuous Coverage	Use portability protections under HIPAA (guaranteed issue with no pre-ex limits, rating limits for individuals leaving group coverage who have maintained continuous coverage for at least 18 months	Issuers can charge 30% higher premiums if individual lacks continuous coverage (>63 continuous days without coverage in prior 12 months) 2019 plan year for open enrollment, 2018 for SEP Allows state waivers permitting higher premiums for sick consumers based on 63 day rule	Require waiting periods of 6 months for people who buy non-group coverage unless they have had continuous coverage throughout the prior 12-month period. Waiting period does not count as a gap in coverage.	

Federal Legislative Proposal Crosswalk – As of July 10, 2017

	OK Task Force	House Bill	Senate Bill	HHS Regulations and Administrative Action
Other ACA Rules	Modify or eliminate some exemption criteria	Maintains dependent coverage to age 26, pre-existing condition exclusion ban, MLR standards Repeals prevention and public health trust funds, Cadillac tax, medical device tax, Medicare surcharge (beginning January 2023), tanning tax Establishes tax on employees for the value of generous employer health benefits (plans at/above the 90th percentile of current premiums) Repeals DSH cuts - 2018 in expansion states, 2020 in others Allows waiver of ACA rules, including health status underwriting if the state has a high risk pool or participates in national reinsurance program (starting 2019). Sick customers could be charged more if they had coverage lapse of >63 days	Minimum medical loss ratio standards for all health plans sunset for plan years beginning in 2019. Thereafter, States shall establish minimum medical loss ratios for group and non-group policies and rules governing annual rebates to enrollees	

Federal Legislative Proposal Crosswalk – As of July 10, 2017

	OK Task Force	House Bill	Senate Bill	HHS Regulations and Administrative Action
State functions	State may provide incentives or assess penalties if plans fail to comply with AV or quality requirements Minimize administrative requirements on carriers, consumers Use Medicare Advantage models to establish price adjustments	State may set age rating ratio or use federal 5:1 EHB federal standard, state can apply for waiver to establish own standard State option to establish a Basic Health Program remains State option to obtain 5 year waiver of certain new health insurance requirements (Section 1332 waiver) remains	States may change requirements from federal standards via waiver.	States, including those using healthcare.gov, will establish network adequacy for QHPs offered in their states Allow carriers to write-in essential community providers not on HHS list Lower ECP standard to 20%
Insurance Marketplace	Establish Insure Oklahoma eligibility and subsidy platform	Treasury will establish a system to deliver credits, may build on existing system Federal government will determine tax credit eligibility	maintained	CMS will release a revised timeline for QHP certification and rate review for plan year 2018
State Flexibility (with or without a waiver)	Establish State program via a 1332 Waiver or other federal-state authority depending on federal rules going forward	Maintains 1332 Allows waiver of EHBs, community rating rules. Waiver will be approved if state attests changes will reduce premiums increase the number of people covered, or advance another benefit to the state public interest - this means almost any waiver could be approved. Supports expedited waiver processing.	States may use State Stability and Innovation Program grants to fund high-risk pools, and for other purposes.	see state functions
Reinsurance	Explore state-based reinsurance (or hybrid reinsurance/risk pool)	See HRP section on Patient and State Stability Fund	See High Risk Pool section/State Stability and Innovation Program	

	OK Task Force	House Bill	Senate Bill	HHS Regulations and Administrative Action
High Risk Pools	Explore state-based high-risk pool (or hybrid reinsurance/risk pool)	P&SSF: Funding to states for high risk pool or to: • encourage rate stabilization • offset cost of providing insurance for high utilizers in individual and small group markets, including due to low population density • increase plan options • promote access to prevention, dental, vision, MH/SA services • support providers offering certain services • offer state CSR supports Fund may support maternity coverage, newborn care. Clarifies that mental health/substance use disorder services in the fund includes inpatient and outpatient clinical care for addiction and mental illness; early ID, intervention for children, young adults with serious mental illness. Appropriates an additional $15 billion to Fund for States for maternity coverage, newborn care, and MH/SUD.	Establishes State Stability and Innovation Program within Title XXI of the Social Security Act, which provides short-term and long-term assistance: Short-term: $50 billion for 4 calendar years ($15 billion for each of calendar years 2018 and 2019, $10 billion for each of calendar years 2020 and 2021) for CMS administered reinsurance. No state matching funds are required for short term reinsurance program. Long-term (2019-2026): $62 billion for 8 years ($8 billion for calendar year 2019, $14 billion for each of calendar years 2020 and 2021, $6 billion for each of calendar years 2022 and 2023, $5 billion for each of calendar years 2024 and 2025, and $4 billion for calendar year 2026). States must apply for funding for a year by March 31 of the prior year.	

	OK Task Force	House Bill	Senate Bill	HHS Regulations and Administrative Action
Patient Stability Fund, Continued (financing)		$15 billion/year CY18-19 $10 billion CY20-26 85% of 18-19 funding: based on claims incurred during benefit year 2015 or 2016. To get other 15%, state must have < 3 exchange plans in 2017 or total uninsured rate that increased 2013-2015. In 2020, HHS will set allocation methodology based on cost, risk, low-income uninsured, issuer competition; state match will be phased in starting 2020 $10 billion/year 2020-2026 CMS may use funds to help stabilize premiums in states that do not set up a program	Long term program, continued: Funding can be used for one or more of 4 purposes: for financial help for high-risk individuals, to stabilize private insurance premiums, to provide cost sharing subsidies, or to make direct payments to health care providers. In 2019, 2020, and 2021, at least $5 billion of the amounts appropriated for each year must be used for state reinsurance programs. Requires state matching funding of 7% starting in 2022, phasing up to 35% in 2026.	
Quality Measurement	Track quality measures related to chronic disease, tie to value-based payments Use Medicare Advantage Star ratings as model for health plan performance measurement			
Plan Rules	Allow plans to direct market, solicit clients, assist in enrolling			

Federal Legislative Proposal Crosswalk – As of July 10, 2017

	OK Task Force	House Bill	Senate Bill	HHS Regulations and Administrative Action
Exchanges/ Associations		Remain with a federal fallback High Deductible plans can be offered	Maintained	4/13/17 rules intended to stabilize markets (pre-enrollment verification, shorter open enrollment period, wider AV range) 2018 QHP Filing Dates: -6/21 products, rates filed -8/1 CMS or State publishes proposed rate increases -8/16 plan applications finalized -9/27 States send QHP recommendations to CMS -10/12 CMS sends insurers final QHP certification notices
Encourage the use of telehealth	Encourage carriers and providers to use where appropriate and effective			
Individual mandate		Repealed, retroactive to 1/1/16	Eliminates penalties	
Employer requirements		Repeals employer mandate, retroactive to 1/1/16 Repeals small business tax credits in 2020 and restricts use Postpones effective date of Cadillac tax until 2025	Eliminates employer mandate, eliminates tax credits as of 2020 Establish authority for new small business association plans, called "small business health plans" (SBHP). SBHPs must be fully insured health plans offered in the large group market, where modified community rating and essential health benefits are not required.	

Federal Legislative Proposal Crosswalk – As of July 10, 2017

	OK Task Force	House Bill	Senate Bill	HHS Regulations and Administrative Action
Medicaid	Could allow some populations to access tax credits and individual market plans	Allows states to continue to cover childless adults, with eligibility redetermined every 6 months. Permits non-expansion states to expand until 2019. Enhanced match available through 2019. After that those continuously enrolled (no more than 1 month gap) would receive FMAP at 80%. Those with a gap and new childless adult enrollee would be matched at the states regular FMAP. Rolls back FPL mandatory eligibility to 100% FPL for children 6-19 (12/31/19); children under 100% may be covered under CHIP Eliminates mandatory 3 month retroactive eligibility 2020: caps growth in per-enrollee payments for most beneficiaries at medical care portion of CPI States may require able-bodied adult recipients to work, participate in job training or do community service States may choose block grant for non-disabled adults and children	Limit and phase down enhanced match for expansion populations to 90% in CY 2020 (same as current law), 85% in 2021, 80% in 2022, 75% in 2023 and then to the regular state match rate in 2024 and beyond. Federal Medicaid match uses a per capita cap starting in 2020. Total state expenditures are the sum of the per enrollee amounts for 5 groups - elderly, blind and disabled, children, expansion adults, and other adults – multiplied by the number of enrollees in each group. The base year for per enrollee amounts is determined using state-selected 8 consecutive quarters of expenditure data from FY 2014 through the third quarter of FY 2017 for enrollees subject to the per capita caps. Block grant is allowed at state option.	
Interstate sales			not addressed	

Appendix G
Summary of Public Comments on Draft Concept Paper

Summary of Public Comments

Broad Topic Area	Issue	Comment	Commenter Sector
Plan Elements (Benefits; Structure)	Plan Design	Supports state choices in plan design (improved access to prevention, dependent coverage to age 26, guaranteed coverage with continue coverage requirements, risk mitigation programs)	Insurer
	Value Added Benefits	Value added benefits concept is not in line with actuarial value calculation. Concerned plan will have to cover without being able to include in premium	Insurer
	Value Based Payments	Support concept, but VBP requires volume and network participation, so should be limited to metro areas. Do not support requiring a percentage of payments to be VBP within a set time frame	Insurer
	Quality Measures	Allow carrier flexibility to innovate, make quality measurement align with carrier VBP programs	Insurer
	Case Management/Care Coordination	Allow carrier flexibility to innovate, make care coordination align with carrier VBP programs Encourage/incentivize members to participate in case management/care coordination	Insurer
	Incentives or penalties for plan compliance	Do not support state assessed incentives or penalties, see as too Medicaid/Medicare	Insurer
	Health Savings Accounts	Section is under-developed. Need more detail on HSA interaction with tax credits, cost sharing reductions. HSA requires well informed consumers, services and pricing transparency. Concerned that rural state will limit competition, propose modeling of impacts. Allowing HSA could hurt market if young choose high deductible/low cost plan, older choose lower deductible with high premiums	Consultant

		Supports use of HSA to help lower income individuals pay deductibles	Health Care Provider
		What administrative fee will be imposed by the hosting financial institution? This could be enough to make HSAs not an efficient use of funds	Large Employer
	Premiums caps	Do not support annual premium cap of no more than 2% medical inflation – will discourage plan participation	Insurer
		Support premium cap, requires controlling and curbing health expenditures	Consultant
		It is unclear how cap would encourage current or potential carriers from participating in the market	Large employer
Affordability	Subsidies	Oppose moving subsidies from 250-300% population to 0-100% population, not actuarially or economically sound, penalizes higher income population, could hurt the risk pool if they don't enroll	Consultant
	Affordability	Waiver proposal does not address the 210,000 uninsured without affordable coverage. This population will not be able to afford coverage with the subsidies proposed, given their low income.	Consultant
Market	Carrier Competition	Take steps to increase competition in marketplace. Limited carrier competition has hurt providers.	Health Care Provider
	Market participation requirement	Do not support requirement that carriers must participate in individual market to participate in OK Medicaid managed care – markets require different skills	Insurer
		Do not support requirement for Medicaid MCOs to participate in Marketplace	Insurer Association
	Competition	Was marketplace competition reduced by carriers other than BCBS offering lower premiums and attracting sicker consumers or those less able to pay premiums, making the marketplace less profitable for them?	Consultant
	SHOP marketplace	Would proposed changes impact small business marketplace? What was overall annual premium increase in OK 2000-15?	Consultant
AI/AN	AI/AN provisions	Clarify that the proposed changed will not impact IHCIA and identify where Oklahoma plan will specifically address issues to ensure	Tribal Nation

		changes do not void previous AI/AN provisions and protections (SEP, APTC/CSR special provisions, exemptions, etc)	
	Background – health landscape	Include background on AI/AN health system, Tribal premium sponsorships (includes suggested language)	Tribal Nation
Enrollment and Eligibility	Pre-existing conditions	Why is state not proposing to ensure individuals with pre-existing conditions can still get coverage?	Consultant
	Enrollment Procedures	Supports continuous coverage, tightening special enrollment requirements, limiting special enrollment periods and requests Suggests earlier implementation than 2019	Insurer
		Maintain special enrollment periods for American Indians/Alaska Natives	Tribal Nation
	Premium Payment	If individual mandate remains, to limit insurer risk could require premiums for the whole year, requiring premiums for past uninsured months paid forward to new insurer, or individual tax applied to reinsurance	Large Employer
	Grace Period	Supports 30 day grace period, premium payment prior to plan effectuation	Insurer
		Currently the 90 day grace period only applies to tax credit recipients. Others have 30 day grace period. Unclear what the prevalence of non-payment is/impact of a change.	Consultant
Risk Management	Reinsurance	Does not support reinsurance as envisioned in the plan, should be structured for individual market, funded via direct appropriation or broad based assessment	Insurer
	High Risk Pool	Exclude self-funded employers from reinsurance requirement.	Large employer
		Include high risk pool in discussion of risk management activities	Tribal Nation
		Supports federally funded state high risk pool	Insurer
		Oppose using high-risk pool to penalize people who do not enroll at open enrollment, ignores normal churn related to employment changes.	Consultant
	Risk management general	Supports improved risk management (state or federal reinsurance or high-risk pool).	Insurer

		Risk adjustment, reinsurance, high-risk pools are expensive and complicated to implement, maintain. Not clear if the full cost is understood; should study.	Consultant
State Role	Consumer Education	Supports efforts to educate and engage consumers about coverage	Insurer
	State Marketplace	Ok with Insure Oklahoma platform if managed in a seamless and cost effective manner, utilizes data exchange transactions similar to FFM	Insurer
	Oversight	State Insurance Department must provide oversight, have authority to protect both patients and providers.	Health Care Provider
Employer	Support for Employers	Support recognition of employer burden, costs. Would like more information about employer mandate and assurance that proposal would not disrupt employer insurance market for employers offering health insurance	Large Employer
Non-substantive/ Editorial	Editorial comments	Task force member's credentials were not listed	Association
		Grammatical and other editorial comments Suggests using a different graphic for Marketplace Strategies Roadmap (not specified)	Tribal Nation
	Participation in Task Force	Concerned that they were not included in Task Force membership	Insurer

Appendix H
Data Modeling Sources and Limitations

Appendix I – Model Sources and Noteworthy Limitations

Data Sources Used as Model Inputs

Source	Information Gathered
CMS Medical Loss Ratio Data and System Resources (CCIIO)	Individual Market Enrollment, Premiums, APTC Subsidy amounts, and Incurred Claims data
CMS Health Insurance Marketplaces: Final State-Level Public Use Files	On-Exchange Market Enrollment, Premium, APTC Subsidy data
CMS Health Insurance Marketplaces: Additional Data (CCIO)	Detailed demographics for marketplace enrollees
U.S. Bureau of Economic Analysis	OK healthcare expenditures
American Community Survey (ACS) and Census Demographic Variables	Age, Income, Health Status, Insurance Status
Regulatory research	Used to inform modeling parameters
Leavitt Partners Analysis, Kaiser Family Foundation Report, and State Report on Medicaid Gap Population	Medicaid Gap Population Estimates
Literature Review	Used to inform modeling parameters- specifically elasticity of demand estimates

Modeling Limitations

As noted in the section *About the Model and Solution Modeling Approach,* there many limitations to these modeling results. These results are based on theoretical outcomes assuming that consumers make the insurance purchasing decision based on changes in premium prices. As we acknowledge in the body of the paper, this sets aside some important considerations such as out of pocket expenses, marketing, and ideological beliefs. Based on strict assumptions, we've built out two scenarios to see how consumers might react to these new solutions. This will often lead to solutions which increase out of pocket expenses to appear more favorable than they might seem. We've made addressed this throughout the paper. Additional actuarial modeling will help inform this analysis.

In addition, it is important to note that for many of these changes there is no historical precedent. The details of how these solutions are implemented may affect these estimates either positively or negatively. The messaging and context which these solutions are implemented will also affect their success. Based on focus group feedback, one obstacle to enrollment for many individuals is being able to understand what options exist and digesting the options in a way that enables them to decide.

For the baseline model, we adopted a two-step approach layering expert qualitative insights over a baseline quantitative model using appropriate time series methods. We employ this approach because of the limited access to historical data for the individual markets and substantial policy changes introduced by the Affordable Care Act (ACA).

Appendix I
Detailed Modeling Results for Individual Solutions

Appendix J – Detailed information on all individual solutions.

Figure 1 contains information on individual solution modeling enrollment and budget results. Figures 2-7 provide additional detail on premium changes for these solutions. Note: all changes reflected are relative to the baseline model (i.e., the status quo projections assuming no policy intervention).

Figure 1 - Detailed information on enrollment and budgetary information.

Solution	Target of Reform	Enrollment Effect (Yr 1)	Enrollment Effect (Yr 2)	Enrollment Effect (Yr 3)	Notes Relative to Budget
Solution 1: Effects of Moving to a Wider Age Band - 5 to 1	Total Indiv Mkt	13,600 (5.4%) - 25,700 (10.1%)	15,400 (5.7%) - 29,000 (10.7%)	16,900 (6.0%) - 31,800 (11.3%)	No changes to subsidy structure or eligibility
Solution 2: Impact of Adopting a Reinsurance Program - 50 M	Total Indiv Mkt	3,500 (1.5%) - 6,300 (2.8%)	3,400 (1.3%) - 6,000 (2.4%)	3,200 (1.2%) - 5,700 (2.1%)	Program costs of $3-17.5M in funding (in addition to pass-through savings)
Solution 2: Impact of Adopting a Reinsurance Program - 100 M	Total Indiv Mkt	7,100 (3.1%) - 12,700 (5.6%)	6,700 (2.6%) - 12,000 (4.7%)	6,300 (2.3%) - 11,367 (4.2%)	Program costs of $6-35M in funding (in addition to pass-through savings)
Solution 2: Impact of Adopting a Reinsurance Program - 200M	Total Indiv Mkt	14,100 (6.2%) - 25,400 (11.2%)	13,400 (5.3%) - 24,000 (9.4%)	12,600 (4.7%) - 22,700 (8.4%)	Program costs of $12-70M in funding (in addition to pass-through savings)
Solution 3: Moving to Two Standardized Insurance Options (conventional plan + HDHP option)	Marketplace Only	47,000 (25.8%) - 91,000(50.0%)	51,000 (25.8%) - 99,000 (50.0%)	53,700 (25.8%) - 103,700 (49.8%)	Program costs increase between $22-36% ($239-391M additional funding)
Solution 4: Standardizing Subsidies Based on Age and Income	Marketplace Only	6,500 (3.6%) - 14,500 (8.0%)	7,100 (3.6%) - 16,900 (8.5%)	6,100 (3.0%) - 16,400 (7.9%)	Designed to be budget neutral
Solution 5: Reallocating Subsidies for the Non-Medicaid Population 0-300 Percent FPL - "Swap" Scenario	Marketplace Only	40,000 (22.0%) - 99,800 (54.9%)	40,500 (20.4%) - 101,000 (50.9%)	42,000 (20.2) - 104,000 (50.0%)	Program costs increase between 14-36% ($150-387M additional funding)
Solution 5: Reallocating Subsidies for the Non-Medicaid Population 0-300 Percent FPL - "Shift" Scenario	Marketplace Only	26,400 (14.5%) - 69,300 (38.1%)	26,200(13.2%) - 69,200 (34.9%)	26,000 (12.5%) - 69,000 (33.1%)	Program costs increase between 18-46% ($194-499M additional funding)

Figure 2 – Change to average premiums under various age banding options.

Age Banding Premium Percent Change					
	3 to 1	3.5 to 1	4 to 1	4.5 to 1	5 to 1
Age 18-25	0%	-9%	-17%	-23%	-29%
Age 26-34	0%	-6%	-11%	-16%	-19%
Age 35-44	0%	-4%	-7%	-9%	-12%
Age 45-54	0%	1%	2%	3%	4%
Age 55-64	0%	5%	10%	14%	17%

Figure 3 – Change to average premiums under various reinsurance levels.

Reinsurance Premium Percent Change			
Year	Low (50 M)	Medium (100 M)	High (200 M)
2018	-5.4%	-10.8%	-21.6%
2019	-4.5%	-9.1%	-18.2%
2020	-4.0%	-8.1%	-16.1%

Figure 4 – Change to average premium when transitioning to two plan standard options with a new subsidy structure.

Two Standardized Insurance Options Premium Paid Percent Change						
	Plan Type	100-138%	139-200%	201-250%	251-400%	400%+
Age 18-25	HDHP	-100%	-100%	-100%	-95%	-12%
	CONV	492%	137%	5%	-38%	40%
Age 26-34	HDHP	-100%	-100%	-100%	-95%	-25%
	CONV	572%	169%	19%	-30%	20%
Age 35-44	HDHP	-100%	-100%	-100%	-94%	-26%
	CONV	656%	202%	34%	-21%	19%
Age 45-54	HDHP	-100%	-100%	-100%	-91%	-24%
	CONV	957%	323%	87%	11%	21%
Age 55-64	HDHP	-100%	-100%	-100%	-87%	-22%
	CONV	1506%	542%	184%	68%	24%

Figure 5 – Change to average premium when transitioning to a subsidy based on age and income that is also budget neutral.

Standardizing Subsidies Based on Age and Income					
	100-138%	139-200%	201-250%	251-400%	400%+
Age 18-25	-48%	-48%	-36%	-53%	0%
Age 26-34	-51%	-43%	-28%	-54%	0%
Age 35-44	-31%	-31%	-16%	-23%	0%
Age 45-54	46%	12%	20%	8%	0%
Age 55-64	91%	57%	75%	59%	0%
Age ≥65	431%	185%	135%	96%	0%

Figure 6 - Change in premium paid by reallocating premiums from 100-400% FPL to 0-300% FPL following the "shift" scenario for subsidy calculation.

Reallocating Subsidies for Non-Medicaid Population 0-300% FPL – Premium Paid Percent Change with "Shift" Scenario							
	Gap Population (0-100%)	100-138%	139-200%	201-250%	251-300%	301-400%	400%+
Age < 18	-94%	100%	72%	34%	0%	0%	0%
Age 18-25	-95%	100%	72%	21%	5%	0%	0%
Age 26-34	-95%	100%	72%	21%	20%	0%	0%
Age 35-44	-96%	100%	72%	21%	36%	0%	0%
Age 45-54	-97%	100%	72%	21%	14%	29%	0%
Age 55-64	-98%	100%	72%	21%	14%	90%	0%
Age ≥65	-98%	100%	72%	21%	14%	119%	0%

Figure 7 - Change in premium paid by reallocating premiums from 100-400% FPL to 0-300% FPL following the "swap" scenario for subsidy calculation.

Reallocating Subsidies for Non-Medicaid Population 0-300% FPL – Premium Paid Percent Change with "Swap" Scenario							
	Gap Population (0-100%)	100-138%	139-200%	201-250%	251-300%	301-400%	400%+
Age < 18	-70%	0%	0%	0%	0%	0%	0%
Age 18-25	-74%	0%	0%	0%	0%	0%	0%
Age 26-34	-78%	0%	0%	0%	0%	0%	0%
Age 35-44	-80%	0%	0%	0%	0%	0%	0%
Age 45-54	-86%	0%	0%	0%	0%	29%	0%
Age 55-64	-90%	0%	0%	0%	0%	90%	0%
Age ≥65	-92%	0%	0%	0%	0%	119%	0%

Appendix J
Detailed Modeling Results for Combined Solutions

Appendix K – Detailed information on all combined solution solutions.

Figure 1 contains information on combined model enrollment results. Figures 2-5 provide additional detail on premium changes for these solutions. Note: all changes reflected are relative to the baseline model (i.e., the status quo projections assuming no policy intervention).

Figure 1 - Detailed information on combined model enrollment results.

Solution	Enrollment Effect (Yr 1)	Enrollment Effect (Yr 2)	Enrollment Effect (Yr 3)
Combination 1: Reinsurance Program & 5:1 Age Banding	15,000 (5.9%) - 28,400 (11.2%)	15,700 (5.8%) - 29,800 (11.0%)	16,400 (5.8%) - 31,000 (11.1%)
Combination 2: Reinsurance Program & Reallocating Subsidies to 0-300 Percent FPL	45,600 (25.1%) - 89,500 (49.2%)	49,700 (25.0%) - 97,500 (49.2%)	53,500 (25.7%) - 104,000 (50%)
Combination 3: Reinsurance Program & Age/Income-Based Subsidies & 5:1 Age Banding	17,400 (9.6%) - 37,300 (20.5%)	17,100 (8.6%) - 37,100 (18.7%)	17,600 (8.4%) - 39,200 (18.8%)
Combination 4: Reinsurance Program & Two Standardized Insurance Options	47,000 (25.8%) - 91,000(50.0%)	51,000 (25.8%) - 99,000 (50.0%)	53,700 (25.8%) - 103,700 (49.8%)

Figure 2 – Change in premium paid for Combination 1 (Reinsurance Program & 5:1 Age Banding)

Premium Paid Percent Change with Reinsurance and Age Banding (5 to 1)					
	100-138%	139-200%	201-250%	251-400%	400%+
Age 18-25	0%	0%	0%	-18%	-35%
Age 26-34	0%	0%	0%	0%	-27%
Age 35-44	0%	0%	0%	0%	-20%
Age 45-54	0%	0%	0%	0%	-6%
Age 55-64	0%	0%	0%	0%	6%

Figure 3 – Change in premium paid for Combination 2 (Reinsurance Program & Reallocating Subsidies to 0-300 Percent FPL)

Reallocating Subsidies for Non-Medicaid Population 0-300% FPL with Reinsurance – Premium Paid Percent Change							
	Gap Population	100-138%	139-200%	201-250%	251-300%	301-400%	400%+
Age < 18	-67%	0%	0%	0%	-8%	-8%	-8%
Age 18-25	-72%	0%	0%	0%	0%	-8%	-8%
Age 26-34	-75%	0%	0%	0%	0%	-8%	-8%
Age 35-44	-78%	0%	0%	0%	0%	-8%	-8%
Age 45-54	-84%	0%	0%	0%	0%	17%	-8%
Age 55-64	-89%	0%	0%	0%	0%	73%	-8%
Age ≥65	-91%	0%	0%	0%	0%	99%	-8%

Figure 4 - Change in premium paid for Combination 3 (Reinsurance Program & Age/Income-Based Subsidies & 5:1 Age Banding)

Premium Percent Change for Age by Income with Reinsurance and Age Banding					
	100-138%	139-200%	201-250%	251-400%	400%+
Age 18-25	-61%	-64%	-65%	-65%	-35%
Age 26-34	-59%	-57%	-56%	-56%	-27%
Age 35-44	-26%	-39%	-43%	-44%	-20%
Age 45-54	-11%	-11%	-11%	-11%	-6%
Age 55-64	-22%	24%	40%	46%	6%
Age ≥65	24%	58%	70%	74%	10%

Figure 5 - Change in premium paid for Combination 4 (Reinsurance Program & Two Standardized Insurance Options)

Two Standardized Insurance Options Premium Percent Change with Reinsurance						
	Plan Type	100-138%	139-200%	201-250%	251-400%	400%+
Age 18-25	HDHP	-100%	-100%	-100%	-95%	-16%
	CONV	464%	125%	0%	-41%	34%
Age 26-34	HDHP	-100%	-100%	-100%	-95%	-28%
	CONV	540%	156%	13%	-33%	14%
Age 35-44	HDHP	-100%	-100%	-100%	-94%	-29%
	CONV	621%	188%	28%	-24%	13%
Age 45-54	HDHP	-100%	-100%	-100%	-92%	-28%
	CONV	907%	303%	78%	6%	15%
Age 55-64	HDHP	-100%	-100%	-100%	-88%	-26%
	CONV	1430%	512%	171%	60%	19%

Appendix K
Detailed Analysis of Task Force Recommendations
Statutory and Regulatory Analysis

Statutory/Regulatory Analysis of Task Force Recommendations

Task Force Recommendation	Statutory/Regulatory Reference	Recommended Pathway/Discussion	Accommodated by Existing FFM Platform?	Requires Move to SBM-like Model	1332 Guardrails Considerations (set by the ACA)
Improved Plan Design					
Encourage plans to offer additional value-added benefits (dental and vision)	Section 1311(c) - QHP certification requirements	Encouraging plans to do so doesn't require any changes. If the state wanted to condition QHP certification on this, that would likely only be possible if the state operated its own SBM. The FFM would likely not support such a policy under the partnership model. There are legal limitations to how much flexibility partnership states can have beyond FFM QHP certification requirements. This would need to be discussed with CMS if OK considers taking on partnership.	No	Yes	
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 benefit descriptions	Section 1301 - Definition of a QHP Section 1302 - EHB Requirements Section 1402 - Cost-sharing reductions	**1332 Waiver of the folllowing provisions:** Section 1301 - Definition of a QHP Section 1302 - EHB Requirements, which includes metal tier requirements Section 1402 - Cost-sharing reductions, which are based on the silver plan offering	No, this would require IT system changes on the part of the FFM, which would not be budget neutral for the federal govt. Changes would need to be made to the plan offerings that are presented on the FFM, the back-end calculations supporting the FFM rating engine, and the administration of cost-sharing reductions.	Yes. OK would need a mechanism to display plans and their associated AV levels, as well as a new way to benchmark cost-sharing reductions if they are continued.	The 1332 waiver must ensure that coverage is as affordable as it was in the absence of the waiver. Changes to cost sharing impact the potential affordability of plans under the waiver.
Have the OID conduct rate review	State regulations	The OID may have the authority to restrict rate increases for the individual market. Does not require a waiver or the state to become a partnership state. Rate review is considered a state regulatory function that is not part of QHP certification.	Yes	No	Instituting more aggressive rate review could have a positive impact on the affordability of plans offered under the waiver program.
Have the OID conduct QHP certification	Section 1311(c)(1) and Section 1311(d)(4)	This would most easily be carried out through OK becoming a partnership state. This does not require a 1332 waiver. OK would likely be required to submit a Blueprint to CMS requesting to become a partnership state. Based on regulations, it is possible this blueprint would need to be submitted 3 months prior to taking on the function. This creates a challenge for plan year 2018 because QHP certification functions begin this spring. CMS might be open to a phased approach to taking on QHP certification such as conducting review of rates and forms at some point during the summer.	Yes	No	
Qualify plans that incorporate value-based payments	Section 1311(c) and 1311(d)(4)(A)	Under the Insure OK platform or under a partnership model, OK could utilize the plan selection and approval process to require participating plans to incorporate value-based payment arrangements.	Yes	No	
Implement quality measures related to chronic disease.	Section 1311(d)(4)(D)	The quality measure reporting required of QHPs under the FFM would be waived by waiving the Exchange requirements in Section 1311.	No, all plans displayed on the FFM have to adhere to the CMS established Quality Rating System. However, OK could require plans to report on these quality measures through other authorities, such as a state regulation enforced by OID.	No for data collection purposes, but yes for display to consumers during the shopping process. If the state decided to collect quality data for its own rating, it would need authority to do so, either under QHP certification, or some other mechanism.	
Ensure plans implement case management/care coordination	Section 1311(c) and 1311(d)(4)(A); state regulation	Under the Insure OK platform or under a partnership model, OK could utilize the plan selection and approval process to require participating plans to implement case management/care coordination.	Yes, because this information is not reviewed by CMS or displayed to consumers on the FFM.	No, the state could require this through other means like a state regulation that would be enforced by OID.	
Ensure qualified plan process includes validation of AV calculations		This is already a requirement of QHP certification. Plans are reviewed for AV. If OK takes on QHP certificaiton, this would be a function they would need to perform.	No, the FFM would not be able to support a different AV level requirement for OK plans.	Yes. OK will need a process for validating the AVs of plans that are submitted for certification. Could potenitally use the FFM AV Calculator.	
Implement state-assessed incentives and/or penalties on plans for failure to comply with regulations	Section 1311; state regulations	By waiving the exchange requirements and operating a new program through Insure OK, the state could select health plans for participation and enforce incentives or penalties. May require additional state regulation for incentive payments or penalties.	Yes, this is not implicated by the FFM. The FFM would still maintain authority to assess penalties on QHPs that already exist today.	No, though the state may require additional regulation and this would likely need to be enforced by OID.	
Reduce administrative burden on plans related to reporting, risk mitigation, eligibility, and enrollment	Section 1311	By waiving the Exchange, the state would be waiving all FFM requirements on health plans. The state would need to implement its own reporting requirements. Health plans would still need to comply with market wide reporting requirements.	No, the FFM will still maintain its existing policies and procedures related to reporting requirements unless the state becomes an SBM.	Yes	
Allow greater variance to the rating windows for age	2701(a)(1)(A)(iv)	Would require statutory change. The Administration is considering a change through regulation to 3.49 to 1 from 3 to 1. This has been floated but not yet included in a proposed regulation.	No	No, this requires a federal statutory change.	Changing the age rating ratio implicates affordability of plans offered under the waiver program. Under the waiver, coverage must be as affordable as it is in the absence of the waiver.
Improved Risk Management					
Adopt Medicare Advantage-like risk mitigation models and plan quality rating programs	Section 1343 and the Annual Notice of Benefit and Payment Parameters	FFM issuers all utilize the Federal methodology. Could operate a different risk adjustment methodology under the Insure OK platform once the FFM is no longer in use for OK.	No	Yes, but this would require significant administrative changes to accommodate calculations for collections and payment as well as a payment mechanism to support risk adjustment.	

Adopt Medicare Advantage-like quality rating system	Section 1311(c)(3) related to the Quality Rating System	The FFM will begin displaying public quality star ratings for QHPs in the 2018 plan year. This information will be reported and displayed for FFM states, FFM states performing plan management functions, and SBMs utilizing the federal platform. Given this, it may not be necessary to move to a Medicare-like quality rating system since the Marketplace system beginning in 2018 is modeled after Medicare Advantage. The CMS-established Quality Rating System applies to all QHPs regardless of Marketplace model. QHP issuers submit quality date to CMS and CMS provides the quality rating information to SBMs. If OK desired to build its own quality rating system, it would need to waive Section 1311(c)(3).	No	Yes, assuming the federal QRS is waived.	
Encourage plans to reinsure themselves and/or participate in continued federal reinsurance	Section 1341	Would require a statutory change to continue federal reinsurance. The state could encourage plans to reinsure themselves without any additional authority but if this were to be a QHP certification requirement, it would likely not be possible until the state moves to an SBM-like model.	No, reinsurance as a QHP requirement would not be allowed under the FFM.	If the state wants to require plans to reinsure themselves, this would need to be an SBM QHP certification requirement.	Could have a positive impact on affordability and could result in an increase in the number of people with coverage.
Continue to explore federally-funded, state-administered high-risk pools, reinsurance, and hybrid programs for high cost enrollees and to provide temporary coverage for those who fail to join during open enrollment	Section 1101; Section 5000A; Section 1312	Would require a new federal statutory provision to provide federal funding for high risk pools. Section 1332 waiver to allow OK to waive individual mandate and Section 1312 related to the single risk pool for the individual market.	No, the FFM would not be able to use specific eligibility rules to determine someone ineligible for regular QHP coverage and can not accommodate a separate risk pool.	Yes. OK would need a mechanism to enroll individuals in a high risk pool program through a separate risk pool.	Could have a positive impact on affordability and could result in an increase in the number of people with coverage.
Modified Enrollment Procedures					
More robust verification of special enrollment requests.	Section 2702(b)(3); 45 CFR 155.420 and 45 CFR 147.104	This would be an operational change, not something that would require a waiver. Additionally, the federal government has proposed a rule that makes changes to the validation process for special enrollment periods to begin to address this issue.	No, the FFM would continue its own verification process.	Yes, to do things differently than the FFM would require an SBM model.	This could have a slight positive impact on affordability but it would be hard to measure.
Require premium to be paid before policy is issued for re-enrollment	Section 1412(c)(2)(B)(iii)(II); Section 2703	The federal government proposed a rule in Feb. 2017 that would allow allow issuers to apply a premium payment to an individual's past debt owed for coverage from the same issuer enrolled in within the prior 12 months. This would permit an issuer to require a policyholder whose coverage is terminated for non-payment of premium in the individual or group market to pay all past due premium owed to that issuer after the applicable due date for coverage enrolled in the prior 12 months in order to resume coverage from that issuer.	Yes	No	This could have a slight positive impact on affordability but it would be hard to measure.
Limit number of special enrollment periods and requests	Section 2702(b)(3); 45 CFR 155.420 and 45 CFR 147.104	The federal government has proposed a rule with some changes to the special enrollment periods allowed and the validation process. Special enrollment periods are not waivable under 1332 and apply market wide.	No	OK would need to comply with federal regulations around special enrollment periods as they apply market wide.	This could have a slight positive impact on affordability but it would be hard to measure.
Reduce payment grace periods from 90 days to 30 days	Section 1412(c)(2)(B)(iii)(II)	Would require a statutory change.	No	No, would require a statutory change.	This could have a slight positive impact on affordability but it would be hard to measure.
Consumer Outreach					
Allow plans to direct market, solicit clients, and assist in enrolling.	Section 1311(d)(4)(F) - requirement for Exchange to determine eligibility and enroll Section 1411 - Procedures for Determining Eligibility	**1332 waiver** - By waiving 36B, it appears that technically, enrollees in the new OK program would no longer be "elible" for APTCs or CSRs under the ACA and would instead be determined eligible for the alternative program. This appears to remove the requirement that exchanges verify eligibility for assistance, which has been the biggest barrier to true direct enrollment in the past.	No, enrollments need to go through the FFM unless the state operates an SBM.	Yes	This could have a slight positive impact on coverage in the state.
State-controlled Plan Regulation					
Tighten exemption criteria and allow fewer exemptions	Section 5000A(e) Section 1311(d)(4)(H) 1411(b)(5)	1332 waiver of related provisions of the ACA	No, any changes would result in an increase in administrative costs for the FFM.	Yes	
Allow the state to determine benefits; identify a core set and/or provide flexibility depending on consumer needs	Section 1301(a)(1) - Definition of QHP Section 1302 - EHB Requirements	**1332 Waiver of the following provisions:** Section 1301(a)(1) - Definition of QHP Section 1302 - EHB Requirements	No, the EHB benefits package can't be altered other than changing the EHB benchmark plan. CMS uses detailed plan data entry templates that are built on the concept of EHB as defined in the ACA. The FFM wouldn't be able to support a separate set of templates for plans operating in OK.	Yes	Coverage would have to be as affordable and as comprehensive under the waiver program as in the absence of the waiver. Efforts to simplify or pare back the benefit package offered would implicate comprehensiveness.
Promote continuous coverage, enrollment longevity, and healthy behaviors through reductions in premiums or loyalty incentives	1311(c) QHP certification requirements 45 CFR 156.210 which requires QHP issuers to set the premium amount for the entire benefit year.	1332 waiver of 1311(c) related to QHP certification standards. Loyalty incentives might need to be administered directly by QHPs to avoid income tax implications for individuals.	No, the FFM would not be able to accommodate reductions in premiums during the benefit year.	Yes	This could have a slight positive impact on affordability but it would be hard to measure.

Broaden APTC and CSR eligibility to include gap populations (income less than 100% of the FPL); Shift APTCs and CSRs from higher incomes (e.g., 300-400% of FPL) to uninsured individuals (less than 100% of the FPL); standardize subsidies based on age and income.	Section 36B of Internal Revenue Code	**1332 Waiver of the folllowing provisions:** Section 36B of the Internal Revenue Code. Any changes to subsidy calculations, eligible populations, etc. are included in Section 36B and can be waived under Section 1332. Implicates Section 1332 guardrail related to affordability, which is statutory. Also, pass through funds available under 1332 are tied to "participants" in the Exchange, not people who would be eligible but are not enrolled. " the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of **participants** in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver."	No, the FFM would not be able to accommodate a separate subsidy calculation and payment process for OK residents.	Yes	This option has implications for both coverage and affordability. Without subsidies, higher income people may drop coverage, which would run afoul of the coverage guardrail. In addition, coverage must be as affordable under the waiver program as it is in the absence of the waiver. By reducing subsidies for certain income groups, affordability could be decreased.
Upon CHIP maintenance of effort expiring or failed reauthorization at the federal level, allow CHIP members to enter individual market pool as a means to keep family coverage together.	Section 1115 waiver	It is unclear how subsidies would be paid for this population. Would they be funded out of the 1332 funds? Or Medicaid? If 1332, this is unlikely to be possible given the affordability guardrail. If Medicaid, this would require an 1115 waiver.	No, unless these people would otherwise be eligible for exchange coverage in the individual market.	Yes	This could reduce affordability for certain children and families. It could also result in fewer children having coverage if coverage becomes more expensive.
State-owned Platform					
In lieu of FFM, leverage Insure OK eligibility and subsidy platform	Section 1332 Section 1311 - Establishment of an Exchange (and associated regulations)	This technically doesn't require a waiver in itself because it would be the platform supporting the waiver. Note, there are considerable costs to operating Marketplace functions through a new platform that may not be supportable with Medicaid funds.	No	Yes	
Utilize automatic enrollment of certain individuals into the lowest cost plan (e.g., for consumers determined ineligible for Medicaid)	Section 1312(a) - Consumer Choice	**Section 1332 waiver** of Section 1312(a) which says that any quaified individual can enroll in any QHP for which they are eligible.	No, the FFM would not be able to accommodate a different enrollment process for OK.	Yes	This could increase the number of people who have coverage.
State-designed HSA-like Accounts					
Establish HSA-like consumer health accounts funded by redirecting APTCs and CSRs for consumers to purchase coverage and pay for out-of-pocket expenses. (See section on AV levels re: plan choices)	Section 36B - APTC Section 1402 – Cost-sharing reductions	**1332 Waiver of the following provisions:** Section 36B - APTC Section 1402 – Cost-sharing reductions	No, under the existing platform, APTCs and CSRs are paid directly to QHP issuers.	Yes, though there are significant operational considerations and costs for the administration of such accounts, and there also may be income tax implications of putting subsidy dollars into an HSA-like account for consumers. Other states utilizing HSAs in their Medicaid programs are not doing so in the way envisioned by OK; they are not depositing benefit dollars into an account for use by the consumer.	