

A New Horizon

Recommendations for Oklahoma's Modernized Health Insurance Marketplace

December 2016

Submitted by:

Secretary of Health and Human Services

State of Oklahoma

Contents

Introduction.....	1
Background.....	4
Recommended Strategies.....	10
Next Steps.....	16
Conclusion.....	17
Appendix A: Proposed Solutions.....	18
Appendix B: State Innovation Task Force Timeline.....	27
Appendix C: State Innovation Task Force Invitation Letter.....	28
Appendix D: State Innovation Task Force Members.....	29
Appendix E: Senate Bill 1386.....	30
Appendix F: Oklahoma Federally Facilitated Marketplace Data.....	32

Introduction

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 healthcare coverage, the number enrolled has been well below what was projected and 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. 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 marketplace 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 a 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 six guiding principles that are the foundation of the recommendations that follow:

- ✓ **Stabilize the state’s health insurance market** by implementing safeguards for individuals, employers, and carriers
- ✓ **Advance the Triple Aim of better care, lower costs, and healthier people** in order to create a sustainable health care system
- ✓ **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
- ✓ **Increase flexibility at the state level** by empowering our state regulatory entities to adapt to our state’s needs
- ✓ **Promote improved population health** by employing strategies to evaluate our health system’s overall impact on health outcomes in our state

Recognizing the new horizon ahead, 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 marketplace. Particularly telling of the necessity of swift intervention is the exodus of all but one carrier from Oklahoma’s marketplace for plan year 2017, premium increases in excess of 75% on average for plan year 2017, and participation of only 27% of

eligible individuals for plan year 2016. 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, tribal nations and state agencies. After six months of regular meetings, 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.

These solutions are designed to work together to address Oklahoma's complex challenges and include strategies that are allowed under a 1332 Waiver and others that will involve only state and/or federal action. While future changes at the federal level are uncertain, the Task Force has worked to identify what will be most effective for Oklahoma, regardless of what action or authority may be required.

Overview of 1332 State Innovation Waivers

1332 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 through 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 areas. 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 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.

Regardless of what changes occur at the federal level, a 1332 Waiver will remain as a mechanism to communicate state priorities and request 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, we continue 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.¹

I think it might be worthwhile to put in a section here that talks about the AI/AN health system in the state since we are not a race, but government entities? Something like:

The state has a robust Indian Health system throughout our state. There are thirty-eight tribes in Oklahoma. In FY 2015, the Oklahoma Indian Health user population was 348,380 or over 22% of the total IHS users which represents the largest Area in Indian Health Service (IHS), as well as the largest growth amongst all IHS Areas. The Oklahoma Indian health system is the lowest funded IHS Area per capita. The I/T/U health systems within the Area manage 8 hospitals, 50 health centers, 1 regional alcohol and substance abuse treatment center, and 2 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 our community.

According to the US Census 2014 American Community Survey, the number of American Indians and Alaska Natives alone or in combination with one or more other races in Oklahoma is 405,364. This is the service population, or the number of potential users of the IHS/Tribal/Urban health system. Although health disparities continue, the American Indian and Alaska Native population in Oklahoma has seen a

¹ Oklahoma Population Health Needs Assessment (2015). Pp. 10-11.

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 didn't demonstrate statistically significant decreases, we are optimistic that improvements will continue in the data. Our population has also seen significant decreases in the rates of leading cancer diagnoses including lung and bronchus, prostate, and rectal cancers. The Oklahoma IHS/Tribes/Urban is prioritizing the identification and treatment of Hepatitis C. Rather than referring out patients through Purchased/Referred Care, they are working to treat all Hepatitis C cases within the Indian health system. This decreases transportation, time and other barriers allowing for more patients to be treated and cured from Hepatitis C.

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 Federally Facilitated Marketplace (FFM). In fact, Oklahoma only had 27% of its eligible population (those with incomes between 100-400% of the federal poverty level (FPL)) purchasing coverage through the FFM in 2015, relative to an average of 39% among other states similar to Oklahoma.²

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 lack of competition on the exchange, policy 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.² 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 reviewing the Children's Health Insurance Program (CHIP) maintenance of effort requirements.

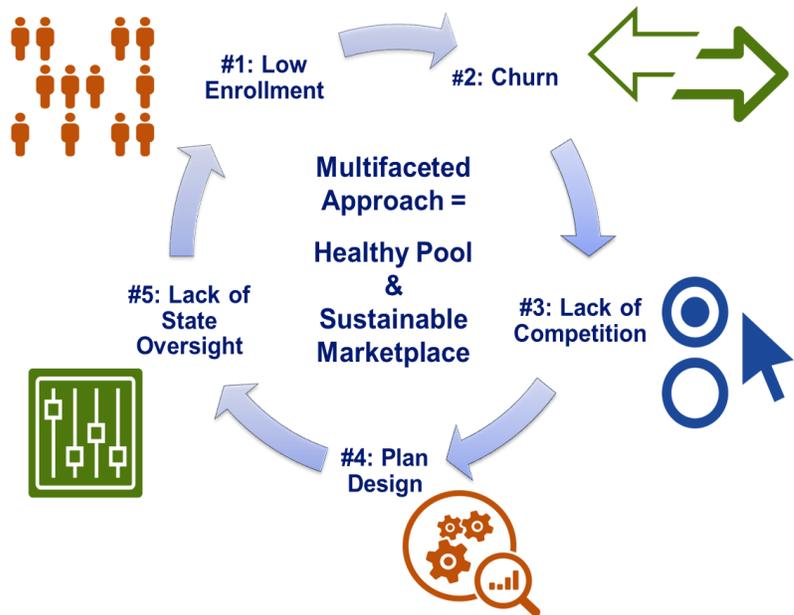
Maybe insert something here about the Tribes that are offering Tribal Premium Sponsorships which contribute to an increased number of citizens on the marketplace. They are mostly in the starting phase as pilot programs, but it is anticipated they will continue to grow and increase the number of insured.

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

² Milliman. (2015). Oklahoma State Innovation Model Insurance Market Analysis: <https://www.ok.gov/health2/documents/Market%20Effects%20on%20Health%20Care%20Transformation.pdf>

Images taken from: The Noun Project

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



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.

Background

The passage of Senate Bill 1386 signaled our state’s readiness to make changes to our health insurance market, as well as the necessity of change. As many Oklahomans continue to struggle to access coverage that meets their needs, the Task Force was put in place to create an alternative pathway to affordable, high-quality health care coverage. Utilizing FFM data, survey results, health data currently available, and the expertise of the members, the Task Force has explored contributing factors as well as potential solutions within each of the five pain points.

It should be noted that these options 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.

Oklahoma's Challenges

Low Enrollment

With only 27% 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: 1) certain state populations have been segmented from the marketplace; 2) lack of perceived value by consumers; and 3) inadequacy of consumer supports.

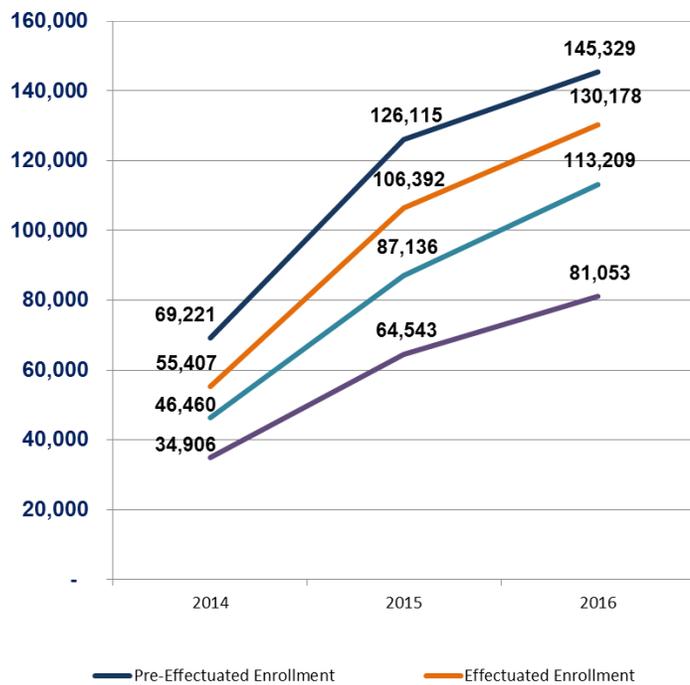
The addition of CHIP and/or uninsured populations would increase the number of lives in the marketplace and diffuse risk for health plans. In 2015 over 836,000 people were enrolled in Medicaid/CHIP and nearly 544,000 individuals were uninsured.²

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 106,000.³

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%),² 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.⁴ Low participation of this group is presumably due in part to diminishing subsidies as income levels increase. See Appendix F for more detailed data about uninsured individuals and FFM enrollees by age and FPL, as well as year over year enrollment data.

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),

FFM Year over Year Enrollment²



In 2015, Oklahoma only had 27% of its eligible population purchasing coverage through the FFM, relative to an average of 39% among similar states.

³ 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>

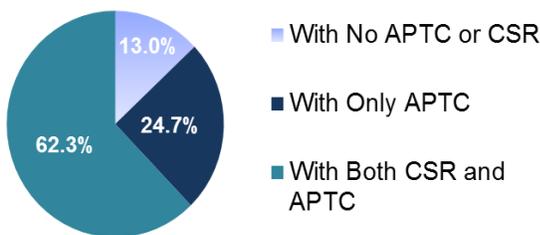
⁴ Department of Health and Human Services (March 2016). Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: <https://aspe.hhs.gov/sites/default/files/pdf/188026/MarketPlaceAddendumFinal2016.pdf>

they are limited to silver plans and may not be enough to encourage certain individuals to enroll.

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.

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 the same family earns over \$80,000 a year at 400% of the FPL. 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

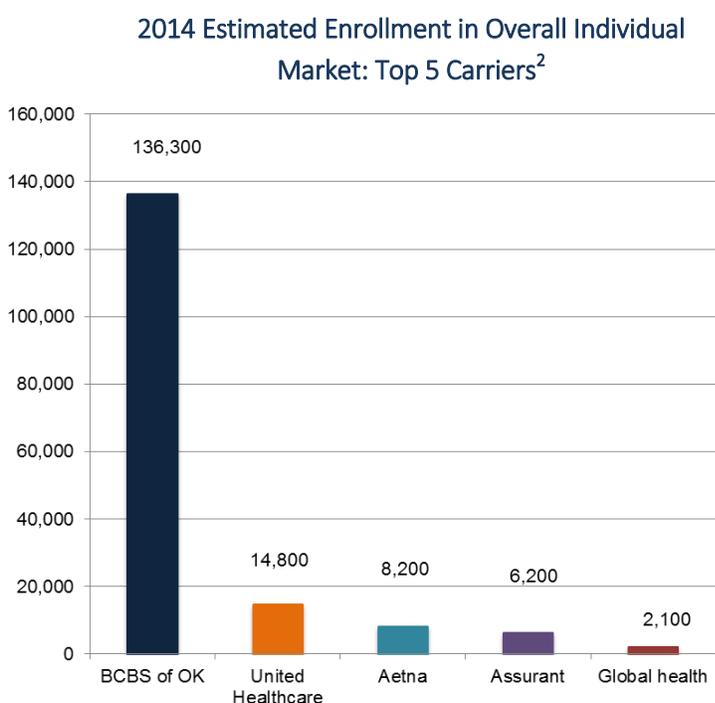
Another potential barrier is the system’s complexity and lack of consumer supports that effectively equip consumers to purchase products that make sense for their circumstances. In addition to needing to understand the complexities of health insurance (co-pays, coinsurance, deductibles, and metal tiers) variations in plan design and available benefits create additional differing factors. Support mechanisms must be in place that ensures comprehension of the relative payment generosity of available plans and the specific benefits or services available that are important to the individual consumer. For example, 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 Centers for Medicare and Medicaid Services (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 will meet the 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 marketplace 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.⁵ Tighter regulations around exemptions, special enrollment periods, and premium payment grace periods could improve the sustainability of the marketplace.

Lack of Competition and Limited Consumer Choice

Blue Cross Blue Shield Oklahoma will be the only carrier offering plans in 2017 and has had the vast majority of individual market enrollees since the FFM was implemented in 2014. As mentioned previously, there also are no “simple choice” plans available to consumers in 2017.



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.

The state may be able to employ a number of strategies to encourage health plan participation. These strategies include state developed based risk management tools like reinsurance (as Alaska is proposing), high-risk pools and state-prescribed attribution formulas that guarantee health plans a certain percentage of newly covered lives. Additionally, the state could align purchasing pools and require carriers to offer coverage in the marketplace in order to participate in Medicaid/CHIP populations.

Plan Design

Modifications in plan design could produce a marketplace that emphasizes cost-effectiveness and improved health outcomes. While this is a challenge not only of plan offerings on the FFM but with our

⁵ 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>

health care system at large, the individual market is fertile ground for implementing and evaluating mechanisms that support the Triple Aim. 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 plans approaches to designing their plans. Modifications could include certain flexibilities in price ratings, networks, and covered services of health plans that would be coupled with safeguards that promote quality. For example, the state could allow a higher variance to age rating windows and create a “copper” plan with limited networks and benefits while also instituting quality measures related to chronic disease outcomes and state-based QHP processes that allow for additional incentive payments as well as encourage value-based payment (VBP) methods.

Lack of State Oversight

State entities could take a more active role in the review and approval of plan rates, as well as qualification of marketplace plans. Should the state assume more control of the QHP process, it could incentivize or discourage certain policies while also establishing the necessary infrastructure for this oversight. For instance, the state could establish limits on annual premium increases aligned with state health care cost growth goals or ensure health plans employ certain methods to bend the health care cost curve. These methods include requiring VBP arrangements and employment of care coordination strategies, and the state could create disincentives for QHPs that do not meet certain outcome improvement benchmarks. In addition to employing a VBP system, the state would seek flexibility to design a core set of ‘essential health benefits’. Such state-identified core benefits would be a smaller list than those previously required and included in a plans design in order to be considered a QHP. Broad benefit categories may include preventive and wellness office visits and screenings, prescription drug coverage, behavioral health and others as determined by the state. The state-identified core benefits would align with statewide quality improvement areas and likely offered by plans due to their relationship to incentive payments and **consumer demand**.

The state also could redirect the funds received for APTCs and CSRs to alternative offerings for consumers. Accounts similar to health savings arrangements could increase consumer control and flexibility while empowering individuals to become active participants in their health care and health expenditures. APTC funding in Oklahoma for 2016 is estimated at over \$465 million⁵ and given the value of APTCs that are available to all potential eligible individuals, there is a significant funding stream that could be leveraged and modified to be more responsive to the needs of consumers. If given flexibility, the state could more finely tune the deployment of subsidies so that vulnerable groups and gap populations (individuals with incomes below 100% of the FPL) have improved access to coverage.

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 of the bill 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 are becoming clearer as appointees are being named for cabinet positions. The historical policy positions of recently nominated Tom Price for Secretary of Health and Human Services and Seema Verma as CMS administrator provide insight into the new administration's perspective. Many changes will be seen in the coming months and years and a variety of 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, the elimination of health insurance mandates as well as changes in the methods for determining and uses of financial subsidies and the establishment of re-imagined high risk pool programs. While Oklahoma's solutions were developed independently and prior to these federal administration announcements, similarities can be seen between these proposals.

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.

Task Force meeting documents, including the full list of proposed solutions, and instructions for public comment on this paper are available through the Oklahoma State Department of Health website at: [https://ok.gov/health/Organization/Center for Health Innovation and Effectiveness/1332 State Innovation Waiver /](https://ok.gov/health/Organization/Center%20for%20Health%20Innovation%20and%20Effectiveness/1332%20State%20Innovation%20Waiver/)

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 Marketplace Employee Health and Wellness Survey,⁶ 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 Oklahoma State Department of Health is currently engaging contractors to gather information from businesses, consumers and health plans. Consumer surveys and focus groups are being conducted to better understand the low FFM enrollment in Oklahoma, consumers' perspectives on the value of coverage and the purchasing experience. Business surveys and focus groups will obtain 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. An insurer survey will be utilized to gather data on premiums, enrollment and claims experience in the individual market – on and off the FFM. These tools will be used to provide a clearer picture of which solutions are high-value and how they can be more effectively implemented.

Engagement of Consultants and Experts

Early on, Oklahoma recognized the need to engage experts in the exploration of solutions to stabilize and grow our marketplace. Information had already been gathered on Oklahoma's marketplace through the previous efforts of the Oklahoma State Innovation Model (OSIM) initiative. A comprehensive marketplace 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 marketplace analysis is underway, again using the experience and expertise of Milliman. Acknowledging that Oklahoma-specific individual plan data are critical to the impact assessment of each pain point, Milliman is also being utilized to develop a data collection tool and analysis. Efforts are currently underway to procure a contractor 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.

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

⁶ 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>

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
- ✓ **Eligibility Changes** to ensure vulnerable and gap populations can access coverage that is affordable to them
- ✓ **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
- ✓ **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 marketplace, Oklahoma will need a phased approach 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 marketplace and ends with a state-owned, federally-supported platform that allows Oklahoma to calibrate its marketplace through state-based policies and procedures. This oversight at the state level will allow the marketplace 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 that tribal nations should be given the same authorization. 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. Specific notation

for each proposed solution that may have an impact on American Indian health care has been solicited, and will be provided in future versions of the concept paper.

Marketplace Strategies Roadmap

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



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

Advance State Innovation

Oklahoma believes that good policies should remain intact. These policies include \$0 copays for A- and B-rated preventive services, guaranteed issue and dependent coverage up to age 26. 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 modern Oklahoma marketplace 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 marketplace 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 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.

✓ **Quality Measures Related to Chronic Disease**

The Oklahoma State Innovation Model⁷ identified diabetes, hypertension, obesity, behavioral health, and tobacco use as five key areas where quality measures need to be 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.

✓ **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%.⁸

✓ **Limits on Premium Increases**

The state will prescribe guidelines for annual premium increase, which will be tied to the OHIP 2020 goal of 2% less than projected health expenditures average annual percentage growth rate.

✓ **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. 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 healthcare 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 coupled with an HSA on the marketplace.

The state 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 high-

⁷ Oklahoma State Health System Innovation Plan. (2016).

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

⁸ Oklahoma Health Improvement Plan (2015). <http://ohip2020.com/>

quality. Plans will also be encouraged to offer 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. Examples of such incentives could include withholding a percentage of payments to low scoring providers and using those funds to reward top performing providers; and assessing penalties of providers who have high rates of avoidable hospital readmissions.

As Oklahoma continues to make progress toward moving the Medicaid aged, blind, and disabled (ABD) populations to outsourced Medicaid managed care plans, the state will have the opportunity to leverage its purchasing power. By preferring or requiring that managed care organizations offer coverage in the individual market in order to participate in the Medicaid managed care program, the state can increase plan participation and options for consumers. Other states such as Iowa, New Mexico and Arizona have actively considered this approach and can be looked to as a resource for information on the extent to which positive impacts on competition were expected or realized.

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 participation from young, healthy individuals age rating variance will be increased. The ratio will be set based on further data analysis and will not exceed a 5:1 ratio. This flexibility will result in lower premiums for younger individuals and will be coupled with subsidy calculations that include age, as described in the next section.

✓ **Adoption of Medicare Advantage-like Risk Adjustment Models and Ratings and Exploration of Reinsurance**

Medicare Advantage employs effective risk adjustment models that will likely translate well in the individual market. This risk adjustment system, called the CMS Hierarchical Condition Category (CMS-HCC) system, makes adjustments based on age, sex, Medicaid status, disability, and institutional status.⁹ Medicare Advantage also 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.¹⁰ Oklahoma can use this model as a basis for its quality measures, which would achieve alignment of performance measures for providers.

Oklahoma will also explore a state-based high-risk pool, reinsurance program or hybrid as an additional avenue to mitigate risk for health plans.

⁹ Center for Health Strategies, Inc. (2006). Medicare Advantage Rate Setting and Risk Adjustment: http://www.chcs.org/media/Medicare_Advantage_State_Primer.pdf

¹⁰ 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>

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

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.

Oklahoma's Modernized Marketplace

Once the state becomes firmly established in its role in regulating plan design, QHP 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 the individual marketplace. This state-owned, subsidy-leveraging technology 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. Oklahoma can repurpose federal funds for APTC and CSR to include gap populations while maintaining subsidies available to 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.

✓ **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. This 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 HSA-like accounts that will be populated by federal subsidy dollars. 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 health care expenses.

✓ **Plan Options**

In lieu of metal tiered plans, plan options will be limited to two basic choices: 1) a plan with a minimum actuarial value of 80% or 2) a high-deductible plan with a minimum actuarial value of 60%. Consumers can choose to use their health accounts to purchase more comprehensive coverage or opt for lesser coverage and more funds for out-of-pocket expenses available through their health account.

✓ **Movement of Populations to the Individual Market**

When appropriate and efficient, the state can move certain populations from other state programs to the individual market. For instance, if the CHIP maintenance of effort expires, those individuals could be moved to the marketplace pool. This shift would accomplish several objectives: 1) families could access the same coverage in the same place, 2) included children would continue to have comprehensive benefits, 3) a large pool of relatively healthy, young lives would enter the marketplace, and 4) federal funds from Medicaid could 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, copays 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.).

✓ **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.

✓ **High-risk Pools**

High-risk pools have been an effective risk mitigation method in Oklahoma. 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) marketplace 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 marketplace enrollees with exceptionally high cost conditions and utilization. The state will determine the specific criteria for inclusion in a high-risk pool. It is anticipated high-risk pool qualification will be limited to consumers who otherwise qualify for marketplace coverage.

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 while 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 early 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 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 A: Proposed Solutions

The following table describes each proposed solution, grouped by which phase it would be completed in (continued state support, state regulation and federal flexibility, or Oklahoma’s modernized marketplace). For each solution, information is provided related to which pain point is addressed, the level of impact the solution would have on that pain point, the relevant section of the ACA that the solution falls under, and the justification for a 1332 Waiver, if applicable.

Pain Point Addressed: Each solution is designed to address one or more of Oklahoma’s five marketplace pain points:

- Low Enrollment – Not enough 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 primary focus
- Lack of State Oversight – Limited ability of the state to design and implement policies and procedures

Level of Impact:

- Low Enrollment – Indicates the proportion of the eligible population (100-400% FPL) that will be impacted: Low = <25% impacted; Moderate = 26-75% impacted; High = >75% impacted
- Churn – Indicates how much the solution would increase the longevity of enrollment in coverage: Low = <3 month change; Moderate = 3-9 month change; High = >9 month change
- Competition – Indicates the number of plans that the solution would attract to the market in a timely manner: Low = 1 plan in 2 years; Moderate = 2 plans in 2 years; High = >2 plans in 1 year
- State Oversight – Indicates the number of pain point areas affected by the change: Low = 1 area impacted; Moderate = 2 areas impacted; High = 3 or more areas impacted
- Plan Design – Indicates the likelihood that the solution would decrease premiums and increase enrollment among those eligible for coverage: Low = <25% impacted; Moderate = 26-75% impacted; High = >75% impacted

Waiver-Relevant ACA Section: Describes which ACA rules and regulations the solution would require change through a waiver to accomplish.

Justification: Describes why a 1332 Waiver would be needed and what Oklahoma would propose related to that solution.

Effective Plan Year: Indicates which plan year (calendar year) the solution would be implemented in.

Continued State Support					
Solution	Pain Point Addressed	Level of Impact	Waiver- Relevant ACA Section	Justification	Effective Plan Year
Consumer Outreach					
Provide assistance to families to access financial tools and understand coverage	Low Enrollment	Low	None – no federal authority needed to pursue	OK proposes, on a continual basis after marketplace improvements are realized, to engage plans, advocates, etc. to reach and educate consumers on health insurance options.	2018 – for transition planning; 2019 - for implementation after marketplace improvements are made
Increase marketing efforts; create advertisements; state-level campaign to encourage enrollment	Low Enrollment	Low	None – no federal authority needed to pursue	OK proposes to encourage plans to deliver marketing campaigns, networking with community supports.	2018
Improved Plan Design					
Maintain \$0 co-pays for preventive services, guaranteed issue, and dependent coverage up to age 26	Plan Design	Moderate	None – no federal authority needed to pursue	OK proposes to retain these provisions and continue use of effective policies.	2018
Encourage the use of telehealth	Plan Design	Moderate	None – no federal authority needed to pursue	OK proposes to encourage plans and providers to utilize telehealth where appropriate and effective.	2018

State Regulation and Federal Flexibility					
Solution	Pain Point Addressed	Level of Impact	Waiver- Relevant ACA Section	Justification	Effective Plan Year

Improved Plan Design					
Encourage plans to offer additional value-added benefits (e.g., dental and vision)	Plan Design	Moderate	None – no federal authority needed to pursue	OK proposes to give preference to plans whose qualification criteria include additional services being offered alongside the EHB	2018
Eliminate metal plan AV criteria and replace them with a standard minimum AV of 80% for all plans with simplified, fixed-cost benefits descriptions	Low Enrollment Plan Design	Moderate	Section 1301: Definition of QHP Section 1302: EHB Requirements	OK proposes to waive the requirement for at least 1 silver plan and waive the definition of metal tier by AV	2019
State-Controlled Plan Regulation					
Have the Oklahoma Insurance Department assume rate review and QHP certification	State Oversight	High	None - federal authority provided outside 1332 waiver	OK proposes to change its federal oversight status and assume state responsibility	2018
Qualify plans that incorporate value-based payments	Plan Design State Oversight	Moderate	Section 1301: Definition of QHP	OK proposes to waive the definition of QHPs to include a VBP provision.	2018
Implement quality measures related to chronic disease	Plan Design State Oversight	Moderate	Section 1301: Definition of QHP	OK proposes to waive the definition of QHPs to include quality measure reporting and associated payments for improvements related to chronic disease	2018
Ensure QHPs implement case management/care coordination	Plan Design State Oversight	Moderate	Section 1301: Definition of QHP	OK proposes to waive the definition of QHPs to include a provision for required case management/care coordination activities and responsibilities by plans	2018

Ensure QHP process includes validation of AV calculations	Plan Design State Oversight	Low	Section 1301: Definition of QHP Section 1302: EHB Requirements	OK proposes to waive the definition of metal tiers by AV and require validation of QHPs AV by the state	2018
Implement state-assessed incentives and/or penalties on plans for failure to comply with regulations	State Oversight	Moderate	None – no federal authority needed to pursue	OK proposes to design criteria to assess financial incentives and/or penalties on plans when appropriate.	2018
Cap annual premium increases to no more than 2 percent of medical inflation	State Oversight	Moderate	Section 1301: Definition of QHP and offering plans conforming to metal levels	OK proposes to qualify plans who submit rates with increases that do not exceed specified limits.	2019
Reduced administrative burden on plans related to reporting, risk mitigation, eligibility, and enrollment	Competition	Low	None – federal authority provided outside 1332 waiver	OK proposes modification to federal regulations allowing state specified risk adjustment methods; continued federal reinsurance; and potential hybrid models	2018-for reporting and risk mitigation 2019-for eligibility and enrollment alongside the use of the Insure Oklahoma platform
Allow greater variance to the rating windows for age	Plan Design	Moderate	None – federal authority provided outside 1332 waiver	Ok proposes modification to federal regulations allowing flexible age rating up to a 5:1 ratio	2018

Leverage the state’s purchasing power by requiring plans to offer individual coverage to be allowed to participate as Medicaid Managed Care Organizations (MMCOs)	Competition	Moderate	None – no federal authority needed to pursue	OK proposes to increase choice and competition by contracting with carriers who participate concurrently on marketplace and MMCO	2019
Improved Risk Management					
Adopt Medicare Advantage-like risk adjustment models and ratings	Competition	Low	None – federal authority provided outside 1332 waiver	OK proposes modifications to allow MA-like risk adjustment and ratings in lieu of other federal risk programs	2019
Encourage plans to reinsure themselves and/or participate in continued federal reinsurance program	Competition	Moderate	None- federal authority provided outside 1332 waiver	OK proposes federal continuation of reinsurance program; and state flexibility to prefer QHPs whose carriers have secured adequate reinsurance policies.	2018
Modified Enrollment Procedures					
More robust verification of special enrollment requests	Churn	Low	Section 1311: Providing consumers a health insurance exchange; other federal authority outside 1332 waiver	OK proposes modifications to federal regulations allowing state verification of SEPs as a condition of marketplace eligibility through the Insure Oklahoma platform <u>Retain the special enrollment period for American Indians/Alaska Natives.</u>	2019

Require premium to be paid before policy is issued for re-enrollment	Churn	Low	Section 1311: Providing consumers a health insurance exchange; other federal authority outside 1332 waiver	OK proposes modifications to federal regulations allowing state designed premium payment policies as a condition of marketplace eligibility through the Insure Oklahoma platform	2019
Limit number of special enrollment periods and requests	Churn	Low	Section 1311: Providing consumers a health insurance exchange; other federal authority outside 1332 waiver	OK proposes modifications to federal regulations allowing elimination of SEP reasons (exceptional circumstance, attested Medicaid denial) as a condition of marketplace eligibility through the Insure Oklahoma platform <u>Retain the special enrollment period for American Indians/Alaska Natives</u>	2019
Reduce to 30-day grace period for premium payments	Churn	Moderate	Section 1311: Providing consumers a health insurance exchange; other federal authority outside 1332 waiver	OK proposes modifications to federal regulations allowing state designed premium payment policies as a condition of marketplace eligibility through the Insure Oklahoma platform	2019

Oklahoma's Modernized Marketplace

Solution	Pain Point Addressed	Level of Impact	Waiver- Relevant ACA Section	Justification	Effective Plan Year
Consumer Outreach					
Allow plans to direct market, solicit clients, assist in enrolling	Low Enrollment	High	Section 1312: Consumer Choice to enroll via exchange and agents	OK proposes to waive the FFM allowing plans and their agents to directly enroll consumers	2019
State-Controlled Plan Regulation					
Tighten exemption criteria and allow fewer exemptions	Churn	Low	Section 1311: Providing consumers a health insurance exchange; other federal authority outside 1332 waiver	OK proposes modification allowing elimination of exemptions for affordability, financial hardship and coverage gap, as a condition of eligibility through the Insure Oklahoma platform <u>Retain the exemption for American Indians/Alaska Natives</u>	2019
Improved Risk Management					
Re-establish state-based high-risk pools for high cost enrollees and to provide temporary coverage for those who fail to join during open enrollment	Competition	Moderate	None – federal authority provided outside 1332 waiver	OK proposes federally funded and state administered HRP as a means to limit premium increases due to churn and exceptional needs consumers	2019
Modified Enrollment Procedures					

Promote continuous coverage and enrollment longevity through reductions in premiums or loyalty incentives	Churn	Moderate	Section 1402/36B: Provisions and eligibility for APTC & CSR	OK proposes to waive APTC & CSR provisions to include additional subsidy for consumers who maintain continuous coverage Retain the APTC and CSR provisions specific to the American Indian/Alaska Native populations.	2018
Eligibility Changes					
Broaden APTC and CSR eligibility to include gap populations (income less than 100% of the FPL)	Low Enrollment	High	Section 1402/36B: Provisions and eligibility for APTC & CSR	OK proposes to waive APTC & CSR provisions allowing their use for gap populations Retain the APTC and CSR eligibility/provisions specific to the American Indian/Alaska Native populations	2019
Upon CHIP maintenance of effort expiring, allow CHIP members to enter marketplace pool as a means to keep family coverage together	Low Enrollment	High	Section 1402/36B: Provisions and eligibility for APTC & CSR	OK proposes to waive APTC & CSR provisions allowing their use for populations who previously were subject to the CHIP MOE Retain the APTC & CSR eligibility/provisions specific to the American Indian/Alaska Native populations	2020 – effective 10/1/19 with expiration of MOE
Modified Subsidy Processes					
Shift APTC from higher incomes (e.g., 300-400% of FPL) to uninsured individuals (less than 100% of the FPL)	Low Enrollment	High	Section 1402/36B: Provisions and eligibility for APTC & CSR	OK proposes to waive APTC & CSR provisions allowing reduction of subsidies for consumers with incomes between 300-400% FPL Retain the APTC & CSR provisions specific to the American Indian/Alaska Native	2019

				populations	
Standardize subsidies based on age and income	Low Enrollment	Moderate	Section 1402/36B: Provisions and eligibility for APTC & CSR	OK proposes to waive provisions allowing subsidy amounts to be based upon income and age on a sliding scale. Retain the APTC & CSR provisions specific to the American Indian/Alaska Native populations	2019
State-Owned Platform					
In lieu of FFM, leverage Insure Oklahoma eligibility and subsidy platform	State Oversight	High	Section 1311: Providing consumers a health insurance exchange; other federal authority outside 1332 waiver	OK proposes to waive federal exchange systems and processes, replacing them with the Insure Oklahoma platform overseen by the state. The state-designed, subsidy leveraging, eligibility infrastructure will utilize regulations and processes controlled by the state. Ensure all special provisions and protections for American Indian/Alaska Native populations are retained.	2019
State-Designed HSA-like Accounts					
Establish HSA-like accounts funded by redirecting APTCs and CSRs for consumers to purchase coverage and pay for out-of-pocket expenses	State Oversight	High	Section 1311: Providing consumers a health insurance exchange Section	OK proposes to waive federal exchange systems and processes, replacing them with the Insure Oklahoma platform overseen by the state, and	2019

			1402/36B: Provisions and eligibility for APTC & CSR	utilizing HSA-like accounts managed by consumers. The state-designed, subsidy leveraging, eligibility infrastructure will utilize regulations and processes controlled by the state. APTC and CSR funds will be combined and repurposed to fund the HSA-like accounts. <u>Retain the APTC & CSR special provisions and protections for American Indian/Alaska Native populations.</u>	
Establish two simple options for consumers to use their accounts: 1) purchase a plan with at least 80% AV or 2) purchase a high-deductible plan and keep remaining subsidy dollars for health expenses	Plan Design State Oversight	High	Section 1301: Definition of QHP Section 1302: EHB Requirements Section 1312: Consumer Choice	OK proposes to waive the metal tier AV definitions; the metal tier plan qualifications; and the consumer choice provisions allowing instead two simple plan design options. The state establishes a minimum AV floor of 80% for all marketplace plans. A transition period of one year will allow for current metal plans to migrate to a single AV floor. A lower AV option will also be available through the HDHP, but will be coupled with HSA-like accounts to allow consumers the option of directly purchasing needed services. <u>Ensure the special protections and provisions for the American Indian/Alaska Native populations</u>	2018 – transition to a consistent AV floor among plans begins 2019 – establishment of the 80% AV floor, coupled with offering HDHP coupled with HSA-like accounts

				<u>are retained.</u>	
--	--	--	--	----------------------	--

Appendix B: State Innovation Task Force Timeline

As of December 30, 2016



Date	Milestone	Task
5/2016	◆	Legislative and Gubernatorial Approval to Research 1332 State Innovation Waiver and Form 1332 Task Force
8/1/2016		Form 1332 Task Force and Schedule Monthly Meetings; Regulatory Research Begins
8/30/2016		First 1332 Task Force Meeting, Identify Problems and Supporting Data Sources, Data Requests
9/2016		Second 1332 Task Force Meeting, Data Presented
10/2016		Third 1332 Task Force Meeting, Recommendation Development Begins
11/2016		Fourth 1332 Task Force Meeting, Prioritization of Recommendations Begins
12/2016		Fifth 1332 Task Force Meeting, Draft of Prioritized Recommendations
12/2016	◆	Draft of 1332 Policy Recommendations Concept Paper Available for Public Review
1/2017		Sixth 1332 Task Force Meeting, Public Comments Incorporated
2/2017	◆	Seventh 1332 Task Force Meeting, Concept Paper Finalized, Next Steps Determined

Appendix C: State Innovation Task Force Invitation Letter



Mary Fallin
Office of the Governor
State of Oklahoma
August 4, 2016

Senate Bill 1386 authorizes the creation and submission of a 1332 State Innovation Waiver for the purpose of ensuring the provision of high-quality and affordable health insurance products that improve health and healthcare quality while controlling costs. I have asked Dr. Terry Cline, Secretary of Health and Human Services, to lead this effort. To assist the State of Oklahoma in developing this waiver, I have also created a task force of stakeholders to identify issues within the current health insurance market and recommend policies and actions for inclusion in a 1332 waiver. I hope you, or a senior member of your organization, will agree to participate in the 1332 State Innovation Waiver Task Force.

A 1332 waiver is a tool that allows states to waive certain provisions of the Affordable Care Act (ACA) and develop state-based solutions that provide affordable, high quality healthcare coverage for its residents. These renewable five-year waivers may propose a range of modifications across many of the current insurance regulations included in the ACA, including changes to subsidies, benefits and mandates.

The 1332 State Innovation Waiver Task Force will meet regularly, with the first meeting occurring in late August. Please contact Isaac Lutz no later than August 17th to confirm your participation or provide the name of your organization's designee. If you have questions, please contact Isaac at 405-271-9444 ext. 52542 or IsaacL@health.ok.gov.

Thank you for your consideration, and we look forward to your participation in this important endeavor to improve Oklahoma's healthcare needs.

Sincerely,

A handwritten signature in black ink that reads "Mary Fallin".

Mary Fallin
Governor

Appendix D: 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, Health Policy Advisor
	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, Associate Director
	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 Leopard, VP of Government Affairs
	HealthSmart	Eric Wright, Sr. Vice President

Appendix E: Senate Bill 1386

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.

Appendix F: Oklahoma Federally Facilitated Marketplace Data

2015

Medicaid/CHIP (with duals)	Uninsured	FFM Enrollment
826,700	543,800	106,400

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

Uninsured (Calendar Year 2015) and FFM Enrollees (as of 3/31/2016) by Age						
Uninsured	Under 19	19-34	35-49	50-64	Over 64	Total
	22,900	241,100	167,400	97,400	14,900	543,800
	4%	44%	31%	18%	3%	100%
FFM*	Under 18	18-34	35-44	45-64	Over 64	Total
	15,986	40,692	23,252	63,944	0	145,327
	11%	28%	16%	44%	0%	100%

Uninsured (Calendar Year 2015) and FFM Enrollees (as of 3/31/2016) by FPL						
Uninsured	<100%	100-138%	139-200%	201-250%	251-400%	>400%
	210,600	59,000	99,800	51,800	83,500	39,000
	39%	11%	18%	10%	15%	7%
FFM**	<100%	100-150%	>150-200%	>200-250%	>250-400%	>400%
	5,371	51,021	30,881	21,483	22,825	2,685
	4%	38%	23%	16%	17%	2%

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

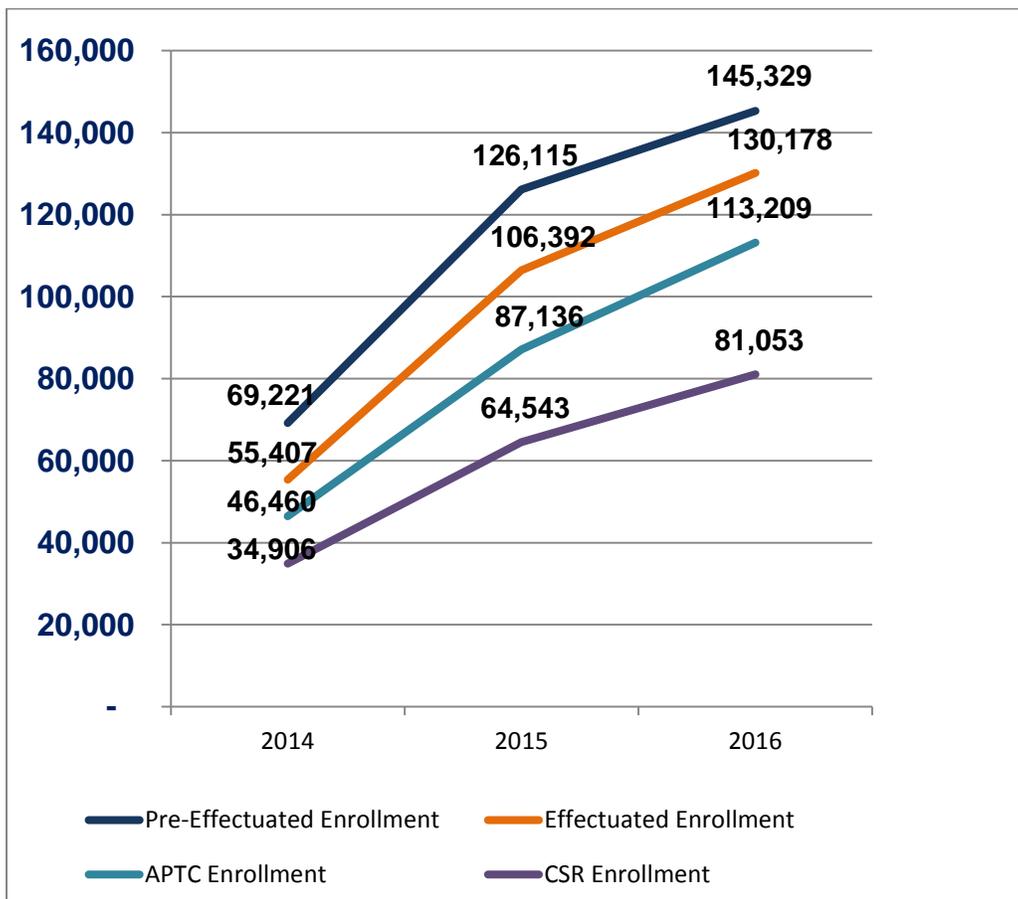
Department of Health and Human Services (March 2016). Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: <https://aspe.hhs.gov/sites/default/files/pdf/188026/MarketPlaceAddendumFinal2016.pdf>

*Number of individuals based on percentages

**FPL percentages based on total of 134,266 with available data

FFM Year over Year Enrollment

	2014		2015		2016		Compound Annual Growth Rate (Effectuated)
	Pre-effectuated	Effectuated	Pre-effectuated	Effectuated	Pre-effectuated	Effectuated	
Enrollment	69,221	55,407	126,115	106,392	145,329	130,178	32.94%
APTC Enrollment	46,460		87,136		113,209		34.57%
CSR Enrollment	34,906		64,543		81,053		32.42%



Source: 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>

