Oklahoma State Department of Health
Tribal Listening Session
1332 Waiver

Hosted by the
Absentee Shawnee Health System
February 13, 2017
10:00 a.m. – 12:00 p.m.

Li-Si-Wi-Nwi Health Clinic
15951 Little Axe Drive
Norman, OK 73026

Purpose of Tribal Listening Session: The Oklahoma State Department of Health invited tribal leaders, elders and health facilities staff to attend a critical tribal listening session regarding a proposal to modernize Oklahoma's health insurance marketplace through the use of a 1332 waiver while protecting the Indian Health Care Improvement Act provisions currently embedded within the Affordable Care Act (ACA).

Participants: Rhonda Beaver, Muscogee Creek Nation; Jessica Buchanan, Sac and Fox Nation; Rhonda Butcher, Citizen Potawatomi Nation, Sheri Brown, Sac and Fox Nation; Leah Carver, Sac and Fox Nation; Sally Carter, Oklahoma State Department of Health; Melanie Fourkiller, Choctaw Nation; Judy Gibson; Indian Health Care Resource Center; Judy Goforth Parker, Chickasaw Nation; Melissa Gower, Chickasaw Nation; Sue Gastineau, Chickasaw Nation; Brian Hendrix, Office of the Oklahoma Secretary of Native American Affairs; Johnna Hurt, Oklahoma Department of Mental Health and Substance Abuse Services; Renee Hogue, Chickasaw Nation; Johnney Johnson, Oklahoma Health Care Authority; Jennifer LittleSun, Southern Plains Tribal Health Board; Dana Miller, Oklahoma Health Care Authority; Aly Miller, Absentee Shawnee Health; Lucinda Meyers, Blue Cross and Blue Shield of Oklahoma; Yvonne Myers, Citizen Potawatomi Nation; John Narcomey, Seminole Nation; Richard Palmer, Seminole Nation Health Board; Terri Parton, Wichita Tribe; J.T. Petherick, Blue Cross and Blue Shield of Oklahoma; Tracy Prather, Southern Plains Tribal Health Board; Mark Rogers, Absentee Shawnee Health; Eloise Rice, Sac and Fox Nation; Carmelita Skeeter, Indian Health Care Resource Center; Robyn Sunday-Allen, Oklahoma City Indian Clinic; Melpherd Switch, Absentee Shawnee Health; Brenda Teel, Chickasaw Nation; Marla Throckmorton, Absentee Shawnee Health.

Participants (continued)
Sandra Vaughn, Absentee Shawnee Health; Marty Wafford, Chickasaw Nation; Tenesha Washington, Oklahoma City Indian Clinic; Billie Womack, Chickasaw Nation

Phone Participants: Chelsea Bowman, Cherokee Nation; Melissa McCully, Oklahoma Health Care Authority; Theresa LaPerla, Health Management Associates

Discussion Highlights:

- **Welcome**
  Mr. Mark Rogers
  Executive Director, Absentee Shawnee Tribal Health System

- **Introductions and Opening Remarks**
  Ms. Julie Cox-Kain, Deputy Secretary of Health and Human Services
  Senior Deputy Commissioner of Health, Oklahoma State Department of Health

- **Overview and Discussion: Indian Health Care Improvement Act**
  Ms. Melissa Gower, Senior Advisor Policy Analyst, Chickasaw Nation

- **Overview and Discussion: 1332 State Innovation Waiver Concept Paper**
  Ms. Julie Cox-Kain and Ms. Buffy Heater, Health and Human Services Strategy Officer

- **Closing Remarks and Adjournment**
  Mr. Mark Rogers

Tribal Listening Session Summary

At 10:00 a.m., Mr. Mark Rogers opened the meeting by welcoming the participants and thanking them for their time. Mr. Rogers asked his Absentee Shawnee Tribal Health System Board Chairman, Mr. Swift to address the audience and he also welcomed the audience and expressed his gratitude to the participants for coming to the meeting and sharing their words of wisdom. Ms. Julie Cox-Kain expressed her appreciation to the Absentee Shawnee Tribe for allowing use of their facility, their generous hospitality and continued support.

Julie Cox-Kain's Introduction and Opening Remarks:
Ms. Cox-Kain introduced participants joining by phone. She encouraged participants to use the form provided to the audience to write down questions, a list of questions and answers will be posted on the tribal liaison web page on the Oklahoma State Department of Health (OSDH) website after conclusion of this event. A formal tribal consultation will be offered in June.

Ms. Cox-Kain went on to say a more intensive analysis and detailed waiver along with tribal consultation will take place later. She said, "Today is about shaping the concept paper and we will continue to have tribal communication moving forward." She explained a task force consisting of 17 members has been working on the concept paper including two tribal representatives. Ms. Cox-Kain mentioned a plan has been developed to have a section in the concept paper focused on Native American questions and concerns and how it will correspond with the 1332 waiver.

Melissa Gower:
Ms. Gower stated that we are looking for three policy recommendations, which are: 1) preservation of the Indian Health Care Improvement Act (IHCIA), 2) preserving constitutional considerations, such as payer of last resort, Medicare reimbursement, and tax exclusions, and 3) IHS exemption from Medicaid changes, that federal trust responsibility cannot be passed on to the states. Ms. Gower mentioned that it appears only sections of Affordable Care Act (ACA) will be repealed, and if this is the case, the IHCIA will not be affected. Ms. Gower explained there are special enrollment periods for Native Americans that are not limited to a set amount of months out of the year, but to certain days in the month. Eligibility for the market place is 100% - 400% Federal Poverty Level (FPL), if you have an insurance plan on the market place, the cost sharing is zero dollars ($0.00). Those over 400% FPL may seek care, but if that medical assistance is outside of Indian Health, a referral must be made beforehand. Lastly, there are three priority positions we want to preserve if there is a repeal of the ACA: 1) Payer of Last Resort Section 2901(b), 2) Medicare Reimbursement Section 2902, and 3) Tax exclusions for health benefits Section 9021.

Julie Cox-Kain:
The 1332 concept paper focuses on insurance provisions and regulations. The concept paper will focus on insurance provisions, with some potential crossover with Medicaid proposals.

Background on the concept paper: last legislative session (2016) there was a bill that authorized Oklahoma to look at two waivers. With the 1332 waiver (has no Medicare or Medicaid involvement – only insurance through the market place), a task force was created (but not mandated), to obtain advice and knowledge from experts. Health plans, providers, brokers, consumers, businesses, and tribal representatives comprise the task force; workgroups have provided data and surveys. Data has been reviewed with the task force and five pain points were identified as points to address in the concept paper. Sixty-two (62) solutions were developed to address the five major pain points, with the task force ranking each solution. Both state and federal proposals and plans were reviewed as recommendations were developed, with new proposals continuing to be circulated all the time. Since January of 2017 three congressional bills have been authored on the replacement, each having points incorporated into the concept paper.

There are several issues with the current ACA system. Low enrollment is concerning: because we do not have a large enrollment of healthy people, it is difficult for health insurance to balance this. Further, enrollees are not staying on for a full twelve (12) months and premiums are not being paid, which causes "churn." Oklahoma has gone from five competitors to one, so all competition has been eliminated on the exchange for 2017.

Only twenty-seven percent (27%) of people eligible to receive subsidies are currently enrolled; we have gone from five insurance companies in the marketplace to one since the start of the ACA, with a sixty-seven percent (67%) reduction in consumer choices since 2016. The state has seen significant premium costs, with subsidies keeping pace. Eighty-seven percent (87%) of enrolled lives receive advanced premium tax credits, and thirty-nine (39%) have incomes that fall below one-hundred (100%) of FPL and are ineligible for Federally Facilitated Marketplace (FFM) subsidies.

Regarding the Native American population breakdown from 2013, we have been watching market migration to see where people are being insured as of now. We have seen a reduction of uninsured with movement into the individual market since the implementation of ACA.

Buffy Heater:
Ms. Heater acknowledges this is a very complex topic, and she is going to stray away from the PowerPoint slides and have a discussion in conversation-style.

She again encouraged participants to ask questions throughout today's discussion. Ms. Heater directed participants to the list of acronyms provided by the OSDH Center for Health Innovation and Effectiveness. However it is her hope to avoid jargon and acronyms as much as possible.

There are three primary perspectives to approach the recommendations from: 1) Plan perspective, the concept paper proposes changes to marketplace plans, 2) State oversight, contrary to the way the marketplace works today, the concept paper wants the state to take more responsibility of regulation and monitoring, and 3) Consumer perspective, for individuals and the systems that support them.

Today, the FFM, which is the same as healthcare.gov, is where Oklahoma consumers go out to the marketplace to buy a plan that is qualified, and complies with all rules and requirements of the ACA. Consumers provide their demographic and household information to determine subsidy amounts on this site. Looking at potential future changes, the first area of impact for health plans is to modify essential health benefits. Today there are ten essential benefits that are required by plans. We are trying to determine if these essential benefits should be modified, or let the each plan determine what these benefits should be for the population served.

QUESTION: Marla Throckmorton, Absentee Shawnee Health: Since Oklahoma did not choose Medicaid expansion, how can Oklahoma direct or drive change since it is not Oklahoma's marketplace?

Ms. Heater responded as we talk about a future marketplace, the state will assume oversight of the market. Today federal government does all of the rate review, etc. One recommendation of the concept paper is for Oklahoma to receive responsibility for these functions. We would look to the Oklahoma Insurance Department, which would give our state more control and decision making power. The rate review recommendation and elements in the concept paper are separate and distinct functions from Medicaid. The 1332 waiver and Medicaid expansion are two different topics.

Ms. Heater stated we need to simplify the market: take the metal tiers away as consumers think they are too complex and don't understand the differences between the tiers. Coinsurance as a way to help the consumer bear costs, which consumers do not understand regarding dollars and cents.

We want to create two options; one being a standard option with a clear fixed dollar amount for coverage and services, the second option would be a high deductible health plan with lower premium on the front side with a high deductible in event of a catastrophic event.

Younger consumers might like this plan due to the initial lower price point. We recommend simplifying the plans with a standard plan and high deductible plan, coupled with a simplified message that consumers understand.

QUESTION: Rhonda Butcher, Citizen Potawatomi Nation: Are we really talking about the individual market or the small business market?

Ms. Heater responded by saying we are talking about consumers seeking and enrolling in a plan as an individual. Clarifying, there is an exchange people can purchase insurance via the healthcare.gov site and receive subsidies; an individual market still exists so consumers may go to health plans individually, however they would not receive financial assistance through subsidies. There is also an employee sponsored market where the employer and individual share costs. The Small Business Health Options Program (SHOP) is tailored to small businesses with financial benefits and subsidies for consumers and small businesses. In the SHOP marketplace, Oklahoma had less than 600 employers in plan year 2016, very few businesses participate. The solutions we are currently addressing are for consumers, not businesses.

Change the way product is priced and subsidies are calculated. Set premiums – today there is an age rating 3:1 older age vs younger age – can't be more than a three-fold difference in premiums between older vs younger age individuals. Today it is typically 5:1 in the commercial insurance market. We are proposing in our concept paper to ask the federal government to allow states to determine what that ratio should be. We are changing the way subsidies are calculated. Today a consumer purchases the product and the premium is calculated based on the price of the 2nd lowest cost silver insurance plan on the market place. We want to change this to allow more transparency to the consumer, and we would base it on age and income of the actual consumer; we want subsidies to be given based on a sliding scale of these two factors.

Another major change regarding pricing: currently now there are two strings of financial assistance for consumers – advanced premium tax credit (subsidy) and the second is cost sharing reductions; Native Americans are currently exempt, but other populations are receiving these to defray out of pocket costs. This solution proposes to blend the two financial assistance streams – combine both premium subsidy and cost sharing amounts, and consumer would have flexibility on how to apply that to their plans and costs.

Plans would periodically report on certain high value outcomes.

The State can move towards cost containment so that premium increases are minimized, by taking a more active role and cap annual premium increases from a policy perspective. We would put in hard and fast caps to keep cost growth down and additional management and coordination of care to bring down costs of healthcare expenses.

The state could pursue requiring or preferring plans who offer coverage through Medicaid managed care to also offer plans on the market place. Other states have moved Medicaid lives into commercial managed care; this would promote competition because plans want Medicaid business, and would have to offer marketplace business. We will explore this further with the task force to see if this will be included in concept paper.

QUESTION: Dr. Judy Goforth Parker, Chickasaw Nation: What drives premium? Currently we do not have consumer responsibility for health outcomes, such as smoking cessation or Body Mass Index (BMI) control. Consumers could enjoy a lower premium having such a benefit.

Ms. Heater answered that the concept paper does not have a direct recommendation to base premium off of this, but will look to see if this should be added as a consumer element as well.

QUESTION: Melanie Fourkiller, Choctaw Nation: Cost containment – essential benefits package, should there even be one? Or have a fluid benefits package? Please address.

Ms. Heater doesn't have a direct answer; this is an outstanding question the task force is trying to determine a recommendation for. We also seek tribal input on the best approach to take. Should we allow the free market to determine what benefits are, and would this meet consumer needs?

Would this be cost effective, or should the state establish core floor of benefits that are non-negotiable? We are really trying to have dialog and to determine if the ten (10) essential benefits that exist today should remain, or change all together. The price point of plans will be determined by this.

QUESTION: Melanie Fourkiller, Choctaw Nation: Are we assuming the individual mandate goes away, or continues?

Ms. Heater responded the concept paper is silent about individual and businesses mandates. The task force needs to look into this, as the "jury is still out" if the mandate has truly prompted people to purchase on the exchange.

Only twenty-seven percent (27%) have enrolled, and this leads us to believe the mandate is not prompting people to buy. In the absence of an individual or employer mandate, we are looking for people to purchase insurance based on the value of the product. If the consumer sees the value in the product, we would hope the individual would not need a mandate.

QUSESTION: Carmelita Skeeter, Indian Health Care Resource Center: Looking at the amount of individuals enrolled, what role did the news have in public perception regarding "Obamacare," perhaps people didn't know that ACA and Obamacare were one in the same? Do you think a more positive message would help with future enrollment numbers?

Ms. Heater responded we can remember when the message was not positive, and there was a lot of speculation. We do not have hard data on whether or not these messages had an impact on enrollment. The concept paper recommends educating consumers about the benefits and importance of having health insurance.

QUESTION/COMMENT: Yvonne Myers, Citizen Potawatomi Nation: The current issue of how subsidies are approved based on employer sponsored insurance offered to an employee only, and the affordability of that employee to obtain coverage. When considering coverage provided through an employer plan for a spouse: affordability is based on the out of pocket cost for the employee only.

In many instances a business will contribute significantly higher amounts toward the employee only coverage than coverage that may be available to a spouse and family. Often, spouse and family coverage is unaffordable; however, the test is based on the employee only coverage and costs; the coverage costs for the family are much higher.

Ms. Heater responded, as we speak with health insurance agents, they too spoke this is a fundamental piece of ACA law, and should be added to recommended changes within the concept paper.

COMMENT: Judy Gibson, Indian Health Care Resource Center: Patient benefit coordinators are hearing people want three things: zero premium, zero deductible, and zero copay. Some of this sentiment may be due to the trust responsibility of the federal government to provide health care to tribal citizens in perpetuity.

Ms. Heater responded that initial price point determines if they will enroll or not based on monthly premium amount. Consumers are making decisions on their coverage based upon the monthly premium amount they can afford. Some consumers are willing to pay a low premium knowing they may be subject to a higher deductible. For some families, any additional funds needed for coverage are unaffordable for them.

Consumers are asking themselves individually, what can they afford in their budget?

Ms. Heater gave a third point, the consumer prospective. Consumers today go to healthcare.gov to enroll. As a result of the recommendations in the concept paper, we will move away from healthcare.gov, instead building upon Insure Oklahoma insurance program; which today provides premium assistance to employers as well as individuals; Employee Sponsored Insurance (ESI) and the Individual Plan (IP) operates on Medicaid waivers; and essentially we would add a third box under insure Oklahoma to serve market place consumers and serve people who today are not qualified for or using Medicaid.

The new market place using Insure Oklahoma as the eligibility platform would be separate and distinct from Medicaid.

Under the concept paper recommendation, an individual goes onto the Insure Oklahoma website and shops through the marketplace. Today consumers go on healthcare.gov and receive subsidies in the form of advance premium tax credits and cost share reductions. This arrangement could change instead using the Insure Oklahoma platform to determine eligibility, shop for qualified health plans, and to create an account to operate like a health savings account.

The amount of subsidy and cost sharing reduction would be populated into each consumer's account so the consumer can see exactly how much they have each month. Amounts would be used for premiums and out of pocket costs. Premium payments would automatically be sent monthly to the health plan the consumer had selected. This approach would operate like an account to promote cost transparency and consumer awareness to see transactions as they come in and out.

Shift subsides to lowest income and most vulnerable in Oklahoma. Financial assistance towards payment of premiums today is for consumers with incomes from one-hundred to four hundred percent (100-400%) FPL, we want to shift this income eligibility down to be zero to three hundred percent (0-300%) FPL. We need to have additional conversation regarding how making this change potentially affects Native Americans and existing federal law.

The gap population (0-100% FPL) is currently not afforded subsidies and largely not qualified for other public programs; shifting to zero percent (0%) would provide access to coverage to this gap population and allow them to receive subsidies.

Consumers would stay on insurance for a twelve (12) month period. We wanted to strengthen the ability to have consumers remain covered by a health plan for a year-long period of time. The task force acknowledges there is quite a bit of churn – consumers are not paying premiums consistently, as a result losing coverage mid-year – and there is not a steady stream of participants in the market. We need to strengthen longevity of coverage; tighten special enrollment period criteria and validate; reduce payment grace periods from ninety (90) days to thirty (30) days. This would help insulate providers and plans from situations where they have rendered and paid for services during a period where coverage wasn't in place due to non-payment of premiums.

Requiring payment of premiums due for re-enrollment: if a consumer had an amount that was back due for a previous coverage period, we want that consumer to become whole on past due amounts. Tribal premium payment programs may not work this way and more conversations about this would be helpful.

QUESTION: Rhonda Butcher, Citizen Potawatomi Nation: People are very concerned about a Health Savings Account (HSA) type system for Native American payments because the incentives are all wrong. She doesn't believe it will work well within the Native American system. She thinks we should stick with using a waiver as incentives are great for the private sector but would not work for Native American patients.

Ms. Gower responded we should allow a Sponsors Choice 1115(a) waiver that has already been submitted to Centers for Medicare and Medicaid Services (CMS), that this would be the Native American option, essentially an alternative plan for Native Americans. Using the illustration described previously, the Sponsor's Choice waiver for Native Americans could be seen as a 4th box underneath the Insure Oklahoma framework. (The IO umbrella would encompass 4 areas: ESI, IP, Sponsor's Choice, and the market place using HSA-like accounts.)

COMMENT: Dr. Judy Goforth Parker, Chickasaw Nation: There is concern about people moving between the approach outlined in the 1332 waiver concept paper and the 1115(a) Sponsor's Choice waiver.

Ms. Heater responded that additional discussion is needed with the tribes and people involved in the Sponsor's Choice waiver development to determine the questions needing answers and how the approaches can be aligned and coordinated.

COMMENT: Melanie Fourkiller, Choctaw Nation: Regarding back premiums for those who go out and come back in to the system: would all applicable subsidies remain available to them? Were cost or cap limits discussed as a permanent barrier for someone coming back in? Feel there needs to be some exemption for tribal sponsorship.

Ms. Heater responded that these were good questions that hadn't previously arisen. Additional discussion would be helpful.

COMMENT: Yvonne Myers, Citizen Potawatomi Nation: In real life – premiums are very valid points, providers have become very astute and one health plan is very active in how they put out information – many facilities will not see you until you pay your bill; they are turning patients away when they see a person has outstanding bill. One plan now has a 3rd party and will not send a card until a payment has been made and people aren't receiving a card until well past thirty (30) days. The processes and timing of such should be added to the list of considerations.

Ms. Heater acknowledged the point made about processes and timing of effective coverage.

She realizes this is a lot of information to digest. She reminded the group that general questions had been sent out that may help frame conversation going forward.

Ms. Cox-Kain thanked the participants for the comments, and reminded everyone the 1332 development team members are still considering points. While the team is trying to resolve issues as fast as possible, this is a fast changing environment at this time.

The 1332 team is considering 2017 as the planning and authorization phase and 2018 as the implementation phase. Ms. Cox-Kain did clarify that was an ambitious timeline. This may be difficult to achieve due to plans' rate filing dates occurring in April and May each year. Changes requiring state regulation and federal flexibility, as well as potential limits on premium growth may begin as early as plan year 2019. These changes would need to occur before we could talk about a modernized marketplace in Oklahoma, putting such changes occurring no earlier than 2019. The next task force meetings will be in April and June, 2017 and a formal tribal consultation in June, 2017.

Ms. Cox-Kain asks that we take the next 1-2 weeks to digest what was discussed today, and asks participants to continue to provide input and ask questions. She referenced a two page document provided to participants entitled, "1332 State Innovation Waiver Tribal Considerations". These considerations for Native Americans and the systems that serve them are to be incorporated into the concept paper. The concept paper will more fully discuss federal obligation, treaty obligations, and more fully describe 1332 waiver considerations for tribes.

We have talked about many aspects of the current market place that could be changed to improve the stability and longevity of the insurance market. The fact that we are saying we would like to take advanced premium tax credits and cost sharing reductions and merge into a combined premium subsidy requires additional discussion with tribes. The 1115 Sponsor's Choice waiver may be a better avenue for Native Americans, as an alternative to the recommendations in the concept paper, and we would like to explore this with you. Consumer health accounts and tribal sponsorship programs and if or how these might work in conjunction with each other needs further exploration. High risk pools have also been a topic of interest among federal proposals and task force members. Common themes include HRP being federally funded state managed high risk pools, reinsurance, or a hybrid approach. We are open to evaluating high risk pools and reinsurance programs, exploring and analyzing the pros and cons of each approach. We would love tribal input.

QUESTION/COMMENT: Carmelita Skeeter, Indian Health Care Resource Center: We do not want to be in a position where we aren't taking advantage of federal dollars, and multiple congressional proposals are including high risk pools.

Ms. Cox-Kain responded we will continue to look into HRP, reinsurance, as well as a hybrid of the two options. We are open. The Federal government would put money in a high risk pool. There are multiple ways an individual could buy into the high risk pool. Federal funding through subsidies would help keep premiums down for people in high risk pool. For example, high cost conditions such as chronic Hepatitis C and HIV patients could buy coverage in the high risk pool. The HRP could also be used as a mechanism for individuals to maintain continuous coverage, as has been proposed by federal leaders.

If no individual mandate exists and people didn't sign up during enrollment period, they would fit into this pool potentially (Speaker Ryan's plan speaks to this). We will further assess the options. Managing high risk pools is a costly proposition and is hard to fund.

COMMENT: Marla Throckmorton, Absentee Shawnee Health: Central health benefit portion: there are lots of employee-sponsored programs that do not include the essential benefits, including the one offered by her tribe. She thinks we need to look at the highest priority services to include.

Ms. Cox-Kain replied the maternity benefit is one of the biggest considerations mentioned today. The question whether all individuals should share in the expense of maternity coverage is one example of the benefits discussion. Each of the current essential benefits could be assessed for their impact on premiums, as well as level of value to the covered individuals.

QUESTION: Terri Parton, Wichita Tribe: What happens if the 1332 is approved and the 1115 (a) waiver (Sponsor's Choice) is not?

Ms. Cox-Kain responded that CMS has issued sub-regulatory guidance. Initial guidance said we can't consider both an 1115(a) waiver alongside a 1332 waiver for budget neutrality. "Savings" accrued from one waiver cannot be utilized for the other waiver. Budget neutrality calculations must remain separate and specific to either the 1115(a) or 1332 waiver. Since we are in a new administration, our actuarial analysis would apply to both and our opening comment on the waiver would be that they are contingent on one another. We would see about aligning and coordinating the waiver's together, though each would remain as separate documents going through their appropriate review and approval processes. The 1115(a) has already been officially submitted to CMS.

QUESTION: Terri Parton, Wichita Tribe: How do we access comments that the different tribes make once the concept paper and todays notes are posted?

Ms. Cox-Kain responded all questions received by Tuesday, February 21st will be posted online. These questions will be submitted to Julie and her team to prepare responses. The responses will also be sent to everyone who registered for this event, as well as posted on the website. Further, there will be a series of waivers as well as a series of tribal consultations, and will have further discussion between OSDH and the tribes.

Julie Cox-Kain asked if there is anything we have missed or that needs to be considered regarding Medicaid proposals and ACA.

QUESTION: Rhonda Butcher, Citizen Potawatomi Nation: How does the Medicaid block grant fit into this concept? She is concerned about Native Americans being swept into the general population with a general block grant. She stated that this doesn't seem to work for Native Americans.

Julie Cox-Kain responded that Native Americans should be exempt from any block grant proposal.

COMMENT: The proposal of subsidies being allowed to less than one hundred percent (100%) FPL is very exciting – there are a lot of tribal members that fall into this category. It is important for this population to receive subsidies and assistance.

QUESTION: Melanie Fourkiller, Choctaw Nation: To what extent should we address the Sponsors Choice waiver, and what bucket would a person be put in to maximize our proposal? If a person is eligible for Sponsors Choice, should they be put there at a one-hundred percent (100%) match (using the current OMB rate structure)? To what extent do we want to mention these points?

Julie Cox-Kain responded the 1115(a) Sponsors Choice waiver is not included in the 1332 concept paper, and asks if we should include cross reference to this language as an alternative choice for Native Americans in the concept paper. Group agrees reference to the separate, Sponsor's Choice 1115(a) waiver should be included in the concept paper. This is mentioned in the draft tribal consideration document as well.

Melissa Gower responded income eligibility for Sponsor's Choice is two-hundred percent (200%) FPL in current 1115(a) waiver document and this should probably be updated to three-hundred percent (300%) FPL. This change would align the eligibility groups between 1332 and 1115 waivers, as well as correspond to federal law exempting Native Americans from cost sharing.

QUESTION: Robyn Sunday-Allen, Oklahoma City Indian Clinic: Is there a possibility the new administration may have us pick one of the waivers, and if so, which one is best for patients?

Julie Cox-Kain responded we are trying to evaluate which approach may best serve Oklahoma; she is unsure as of the direction the administration may take at this time. There are current conversations about the different proposals that may come out, and it is all subject to change in real time. If budget neutrality is not achieved on the 1332 waiver, we will not submit it. This would not impact the Sponsor's Choice waiver that has already been submitted. Actuarial analysis for ten (10) years is required alongside submission of a 1332 waiver. After such analysis we will be able to determine if the numbers will work or not for the state to pursue a 1332 waiver.

Ms. Cox–Kain stated we are out of time, and thanked the audience for the great dialog. She acknowledged between now and June, our legislature will be getting updates regarding whether or not the submittal is favorable. Two senators have authored the bill and have been fully briefed. Other than changing renewal periods to coincide with a person's birthday, there have not been any legislative modifications to what has been proposed.

Ms. Cox-Kain presented Mr. Mark Rogers with a certificate of appreciation for hosting the Listening Conference. She asks that comments be provided to Ms. Sally Carter, Tribal Liaison, Oklahoma State Department of Health so we can address and respond as appropriate. She may be reached by email: SallyC@health.ok.gov or by calling 405-271-5170.

Ms. Melissa Gower also asked if anyone has questions or would like to talk about the discussion today, they may contact her as well.

Mr. Mark Rogers thanked everyone for participating, and expressed appreciation to the state representatives for making time to seek tribal input and the ongoing collaborative partnerships that we enjoy. He closed out the session at 12:00 p.m.

Handouts

- Tribal Listening Session Agenda, question list, question form, evaluation form
- A New Horizon: Recommendations for Oklahoma's Modernized Health Insurance Marketplace - 1332 Waiver Concept paper – Dated December 2016
- PowerPoint Presentation: 1332 State Innovation Waiver Concept Paper and Indian Health Care Improvement Act
- 1332 State innovation Waiver Tribal Considerations