1332 State Innovation Waiver Concept Paper & Federal Proposal Overview
Objectives

• Overview of proposed 1332 Concept Paper developed with advice from Task Force

• Review recommendations in context of federal repeal and replace proposals

• General response to McCarthy letter

• Discussion of BC/BS letter

• Overview of Medicaid reform proposals

• General response to Medicaid letters
Concept Paper Development

- A State Innovation Waiver Task Force has met monthly since August 2016
- The 17 member Task Force has representatives from health plans, business, health providers, tribes, brokers and consumers.
- Workgroups with broader membership convened to provide data and information
- The Task Force reviewed data and identified five major pain points for Oklahoma’s individual market
- 62 potential solutions related to the pain points were compiled
- The Task Force and workgroups ranked each potential solution by survey
- The majority of the identified solutions in the concept paper are those with the highest rankings from the Task Force/workgroups
- Additional solutions from other state/national plans were included, as well as those that will complement solutions identified by the Task Force/workgroups
Market Pain Points

1. Low Enrollment
2. Churn
3. Lack of Competition
4. Plan Design
5. Lack of State Oversight

Multifaceted Approach = Healthy Pool & Sustainable Marketplace
Enrollment in the FFM is Low and Relatively Unhealthy
- In 2015, only 27% of Oklahoma’s eligible population was enrolled in the Federally Facilitated Marketplace (FFM)

Competition and Consumer Choices are Shrinking
- The FFM has gone from 5 insurance companies offering plans in Oklahoma in 2014 to 1 in 2017
- There has been a 67% reduction in plan options (consumer choices) between 2015 – 2017

Premiums are Increasing, as are subsidies
- As the FFM dropped to one insurer in 2017, premium rate increases of 75% were requested and granted by HHS
- Between 2015 and 2017, premiums for all ages, individuals and families have roughly doubled in price
- Average Silver Plan premium changes 2015 – 2017:

<table>
<thead>
<tr>
<th>Covered Individuals</th>
<th>2015 Monthly Premium Rate</th>
<th>2017 Monthly Premium Rate</th>
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</thead>
<tbody>
<tr>
<td>Individual Aged 27</td>
<td>$227</td>
<td>$454</td>
</tr>
<tr>
<td>Individual Aged 50</td>
<td>$387</td>
<td>$775</td>
</tr>
<tr>
<td>Family (Aged 30) with 2 kids (Aged 10)</td>
<td>$766</td>
<td>$1,535</td>
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- Premiums due (after subsidy) from Oklahoman’s has increased by 7% between 2014 and 2016
- Approx. 87% of the 130,000 enrolled receive tax credits and 62% receive cost sharing reductions

Deductibles are High
- Average deductibles for an individual ranges from $1,125 to $19,200
- Average deductibles for a family ranges from $3,375 to $41,357

Some individuals are not remaining insured throughout the course of the year
- In 2016, 15,000 Oklahomans (10% of enrollees) selected a plan but did not pay their premiums

Of the uninsured, 39% have incomes below 100% of FPL and are ineligible for FFM subsidies
### 1332 Concept Paper – The Proposal

| **Eliminate Use of the Federally Facilitated Marketplace (FFM)** | • Utilize technology built for Insure Oklahoma to determine eligibility  
• Let health plans or private exchanges enroll consumers |
| **Establish HSA-like Accounts** | • Encourages consumer directed health care  
• Can be used to provide incentives for continuity of coverage, healthy behaviors, and attract young enrollees |
| **Modify Essential Health Benefits (EHB)** | • Narrow EHBs to a small core and/or provide flexibility depending on consumer needs  
• Utilize actuarial value limits to ensure adequate coverage |
| **Simplify Plans to Provide More Consumer Focused Options** | • Eliminate metal tiers (gold, silver, bronze)  
• Eliminate actuarial value (AV) ranges and provide two “AV floors”  
• 60% High Deductible Health Plan  
• 80% Standard Health Plan  
• Excess subsidy remaining in HSA can be used to pay for out of pocket or other coverage (dental/vision)  
• Require health plans to communicate out of pocket costs in dollars & educate consumers |
### Change the Way Insurance Products are Priced & Subsidies Calculated

- Expand age ratio from 3:1 to up to 5:1 in order to reduce price for young healthy people
- Factor in both age and income into subsidy calculation to ensure older people get more subsidy as the age ratio is broadened
- Eliminate multiple subsidy requirements (APTCs and CSRs) and make one, streamlined subsidy

### Shift Subsidies to Lowest Income, Most Vulnerable People

- Begin subsidy at 0% of Federal Poverty Level
- Cap subsidy at 300% of Federal Poverty Level

### Stabilize the Insurance Market During the Transition & Long Term

- Integrate healthy Medicaid populations into individual market/pool with or without Medicaid subsidies
- Tighten special enrollment period criteria and validate
- Reduce payment grace periods from 90 days to 30 days
- Require payment of premium due for reenrollment
- Establish a high-risk pool to remove very high-cost lives and/or extend temporary reinsurance program
- Potential to use high-risk pool as a mechanism to insure persons who did not maintain continuous coverage
- Simplify and improve risk adjustment mechanisms
## 1332 Concept Paper – The Proposal

<table>
<thead>
<tr>
<th>Require a Focus on Health Outcomes &amp; Cost Containment</th>
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<tbody>
<tr>
<td>• Include reporting &amp; improvement by insurance plans on high value health outcomes (cost-drivers)</td>
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<tr>
<td>• Tobacco</td>
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<td>• Obesity</td>
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<td>• Diabetes</td>
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<td>• Hypertension</td>
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<td>• Behavioral Health</td>
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<tr>
<td>• Cap allowable premium cost growth and allow insurance plans to innovate on care coordination and value based insurance design</td>
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<th>Assume State Regulatory Control</th>
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<td>• Conduct effective rate review</td>
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<tr>
<td>• Implement state regulatory controls and enforce them among participating plans with state determined incentives or penalties</td>
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<tr>
<td>• Require plan participation in marketplace if contract for Medicaid lives</td>
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<th>Maintain Policies that are Proven to Work</th>
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<tr>
<td>• No pre-existing condition exclusions</td>
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<tr>
<td>• No lifetime caps</td>
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<tr>
<td>• Insuring children to age 26</td>
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<tr>
<td>• No co-pay for preventive services</td>
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<th>Simplify Administrative Rules &amp; Reporting Requirements</th>
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<td>• Simplify insurance regulation rules</td>
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<tr>
<td>• Simplify Qualified Health Plan requirements</td>
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<tr>
<td>• Reduce reporting requirements for insurance companies, businesses, and individuals</td>
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<tr>
<td>• Simplify Risk Adjustment</td>
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Marketplace Strategies Roadmap

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

Advance State Innovation
- Planning & Authorization Phase
  - Increased Awareness
  - Improved Plan Design
  - State-Controlled Plan Regulation
  - Improved Risk Management
  - Modified Enrollment Procedures

State Regulation and Federal Flexibility
- Increased Awareness
- Improved Plan Design
- State-Controlled Plan Regulation
- Improved Risk Management
- Modified Enrollment Procedures
- Eligibility Changes
- Modified Subsidy Processes
- State-Owned Platform
- State-Designed HSA-like Accounts

Oklahoma’s Modernized Marketplace
- Lower Health Care Costs
- Better Health Outcomes
- Higher Quality of Care

Plan Year 2017
Plan Year 2018
Plan Year 2019
2020+
Next Steps

• 12/30 – 1/31 - Public comment period on concept paper
• Late-Jan – Tribal provisions with partners
• Mid-Feb – Legislative review of concept paper
• Late-Feb – Submission of concept paper to CMS
• Data gathering for waiver development:
  – Actuarial Analysis (Milliman)
    • Repeat market impact study
    • Analyze insurance claims to quantify pain points
  – Consumer and Business Impacts (Evolve)
    • Consumer focus groups
    • Repeat business survey & in-depth interviews
  – Proposal Refinement (HMA & Leavitt Partners)
    • Rapid analysis and prioritization of solutions
    • Incorporation of public and legislative comment
  – Actuarial Analysis (TBD)
    • Estimate short and long term impact of waiver solutions
• Waiver submission with phased implementation
State Level Policy Considerations

- High-risk pool – Do we have necessary legislative authority? Who will administer?
- Does OID have all required regulatory authority?
- If implemented as state delivered subsidy who will administer the program? New agency/authority?
- Are insurance plan assessments or fees necessary to sustain the operation?
- If Insure Oklahoma platform is used as an eligibility technology who manages?
- What legislative authority is required to merge Medicaid lives into marketplace?
Federal Insurance Market Proposals & Letter Responses
### Potential Federal Proposals and State Response

<table>
<thead>
<tr>
<th>Potential Federal Proposal</th>
<th>State Response</th>
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| **Eliminate Individual Mandate** | - Strong incentives for enrollment and continuous coverage  
- Potential use of Medicare-like penalties for failure to enroll (premium increase or high-risk pool)  
- Low-cost high-deductible plan to encourage participation by young people  
- Migrate healthy Medicaid populations into marketplace w/Medicaid subsidy |
| **Eliminate Employer Mandate** | - Review, strengthen and expand Insure Oklahoma  
- Migrate Insure Oklahoma populations to marketplace with Medicaid subsidy |
| **Standardize Subsidies through Federal Tax Credit** | - Encourage subsidy factoring age and income (alongside age ratio expansion)  
- If strong federal proposal for tax credit/federal HSA-like, consider shifting focus on state qualification and regulation of qualified health plans |
| **Sale Across State Lines** | - Already permitted through compacting, but practically very difficult to put into operation  
- Encourage federal government to ease compacting among states but do NOT build federal regulatory processes to manage interstate sale of insurance products  
- Pursue only where it might make sense (look initially at hospital referral regions) OR permit it broadly and allow plans to propose |
Five main concepts

- Return control to states (healthcare is local)
- Improve outcomes and control costs while expanding coverage
- Reduce complexity and administrative burden on business, individuals and health system
- Continue policies with track record of success
- Markets MUST be stabilized throughout the transition
Proposed Federal Medicaid Reforms
Major Medicaid Reform Proposal (Ryan)

**Fixed Allotment Proposal**
- Allotment Based on Current Match Rate & Enrollees
- Allotment for Each Aid Category: Children, Aged, Blind & Disabled, Adults
- Adjusted for Inflation
- Per Enrollee Allotment Allows for Growth During Recessions
- DSH & GME Payments Are Excluded from Allotment

**Rolls Back Medicaid Expansion**
- States that Haven’t Expanded Can’t
- States that Have Expanded Have Enhanced Match Rolled Back to Standard FMAP
- Eliminates Enhanced Match for CHIP

**Medicaid Reforms**
- Permits Requirements for Able Bodied to Seek Work & Pay Premiums
- Allows Defined Contribution/Premium Assistance for those who are Working or Preparing for Work (Similar to Insure Oklahoma)
- Streamlines Waiver Process & Implements Clock
- Grandfathers Managed Care Into State Plan
- Requires States to Report on Outcomes

**Limits Entitlement**
- Limited Benefit Plans
- Waiting Lists, Caps and New Enrollee Freeze permitted
- Limits Discretion of HHS Secretary to provide Federal Funding for Non-Matched Expense
Major Medicaid Reform Proposals (Ryan)

States Can Opt Into Medicaid Block Grant

- Eliminates Waivers
- State Flexibility
- Must Serve Mandatory Populations (Elderly & Disabled)

Funding Based on “Base Year”

- Shared Risk/Shared Savings
Response to Medicaid Capped Allotments & Block Grants

• In general, Congress and the administration should focus on controlling costs by monitoring the improvement of health outcomes, ensuring funds for prevention and providing payment and delivery system flexibility that would allow pay for performance at the insurance plan, health provider and individual level.

• If capped allotments or Medicaid block grants are proposed the following should be considered:
  – Reasonable inflationary factors must be incorporated
  – Should consider state recessionary periods
  – Payments should consider acuity of population, population growth and health burden
  – Actuarial soundness of payments to states should be required to ensure appropriate levels of federal funding
  – Do not permanently preclude states that have not expanded Medicaid from adding populations that make sense or meet certain criteria
  – Payments should consider protection of the state safety net
  – Unforeseen events must be considered (e.g., Zika, hepatitis C medications, natural disasters)
  – Retrospective payment to states for very high cost individuals that could not be anticipated if those costs cause aid category exceedance
  – Outcomes should be built on State Health Improvement Plan (SHIP)
  – Public health funding for prevention must be secured in or out of PPHF
  – New quality and reporting requirements should replace existing and not be in addition to current
  – Potential movement of healthy lives out of Medicaid into Marketplace will leave this population/pool more vulnerable