1332 State Innovation Waiver Concept Paper and Indian Healthcare Improvement Act

Indian Healthcare Improvement Act

- The IHCIA is unrelated to the overall ACA, and revoking this law would have major impacts on the Indian health system and American Indians and Alaska Natives (AI/ANs) nationwide.
- It serves as the backbone legislation for the Indian Health Service (IHS)/Tribal/ and Urban Indian (collectively known as the I/T/U) health system.
- The law provides the foundational authority for the Indian Health Service to:
  - be reimbursed by Medicare, Medicaid and third party insurers
  - make grants to Indian Tribes and Tribal organizations
  - run programs designed to address specific, critical health concerns for Native Americans such as substance abuse, diabetes and suicide

ACA Indian Health Provisions

Special Enrollment Periods Section 1311 (c)(6)(d)	• Provides for special monthly enrollment periods for Indians.
Cost Sharing Reductions Section 1402(d)(1-3), 2901(a)	• Eliminates all cost-sharing for Indians under 300% of the federal poverty level enrolled in any individual market plan offered through a federal or state Exchange. • Indian beneficiaries enrolled in a qualified health plan are not charged cost sharing for any item or service provided directly by IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.
Exemptions Section 1501	• Exempts members of Indian tribes from the shared responsibility payment, or penalty, for failure to comply with the requirement to maintain minimum essential coverage.

ACA Indian Health Provisions

Payer of Last Resort
Section 2901(b)

- I/T/U providers are the payers of last resort for services provided to Indians by I/T/U for services provided through such programs.

Medicare Reimbursement
Section 2902

- Grants I/T/U providers permanent authority to collect reimbursements for all Medicare Part B services.

Tax Exclusions for Health Benefits
Section 9021

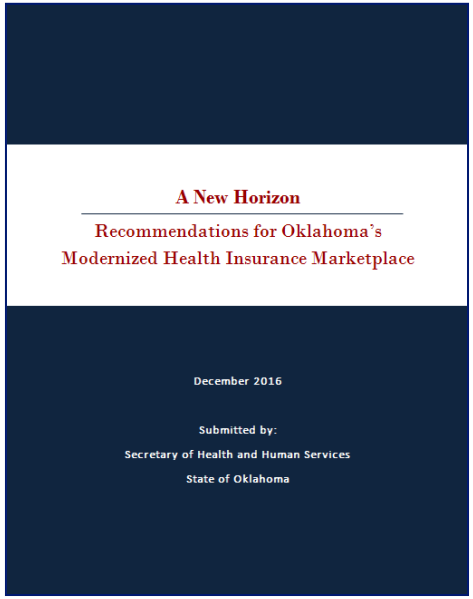
- Excludes the values of health benefits provided or purchased by the Indian Health Service, tribes, or tribal organizations from gross income.

Medicaid Policy Implications

- Under current law, the federal government reimburses States for 100 percent of the cost of providing Medicaid services to AI/ANs.
- Any plan to change the manner in which State Medicaid costs are reimbursed by the federal government must include a carve out for services provided to AI/ANs so that the federal government obligation is not shifted to the States.
- Even though this is not an ACA provision, it is a vital component to ensuring the stability of the Indian Health system in every state.

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


A New Horizon

Recommendations for Oklahoma's Modernized Health Insurance Marketplace

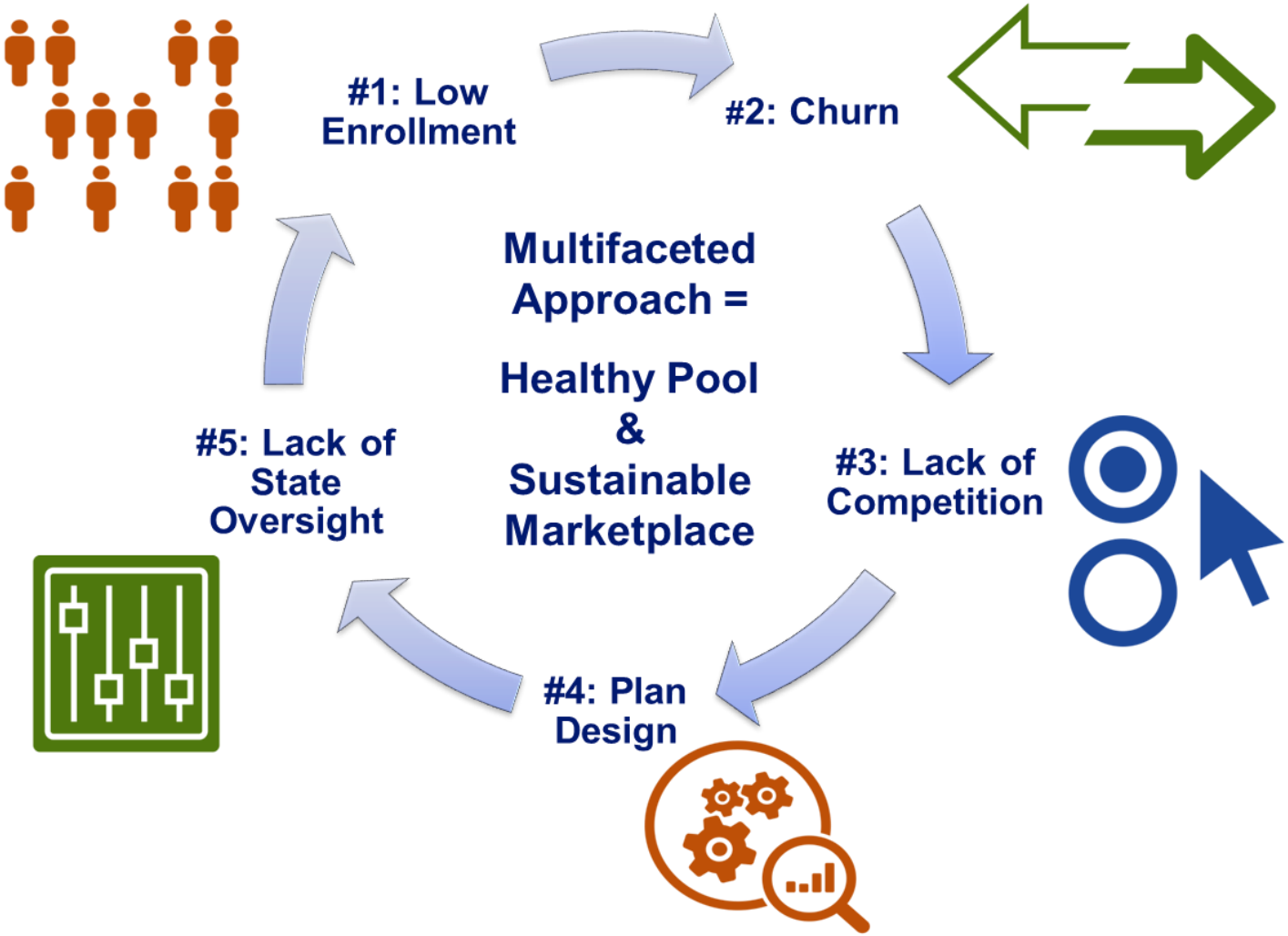
December 2016

Submitted by:

Secretary of Health and Human Services

State of Oklahoma

Market Pain Points



Oklahoma Marketplace Data

- 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:

Covered Individuals	2015 Monthly Premium Rate	2017 Monthly Premium Rate
Individual Aged 27	$ 227	$ 454
Individual Aged 50	$ 387	$ 775
Family (Aged 30) with 2 kids (Aged 10)	$ 766	$ 1,535

  - 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

Oklahoma Insurance Coverage Data

Figure 3- Including Over 65 Estimated Oklahoma Population Distribution by Insurance Coverage Calendar Year 2013		
Market	Total	Native American Population[1]
Individual Market	134,985	17,852
ESI - Small Group (50 or fewer employees)	323,932	63,444
ESI - Medium Group (51 to 100 employees)	166,193	32,550
ESI - Large Group (more than 100 employees)		
Fully Insured	334,700	65,553
Self-Insured	714,125	139,865
Medicaid / CHIP[2]	641,458	137,523
Other Government Programs (Veterans, TRICARE, Medicare)	230,175	6,725
Uninsured[3]	641,916	139,573
Medicare[4]	512,659	72,842
Total Population	3,700,143	675,927

Source: US Census: Current Population Survey. http://www.census.gov/cps/data/cpstablecreator.html

Note: To avoiding counting some people multiple times. Adjustments were made to determine primary source of insurance.

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

2 Medicaid / CHIP enrollment excludes programs that cover limited services or only provide premium subsidies, such as the Sooner Plan and Insure OK. All members of this population with dual Medicare and Medicaid coverage are shown in the Medicare population.

3 Undocumented uninsured are not eligible for Medicaid or ACA expansion or subsidies4 Medicare Market includes members over age 65.

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 use 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

1332 Concept Paper – The Proposal

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

Require a Focus on Health Outcomes & Cost Containment

- Include reporting & improvement by insurance plans on high value health outcomes (cost-drivers)
  - Tobacco
  - Obesity
  - Diabetes
  - Hypertension
  - Behavioral Health
- Cap allowable premium cost growth and allow insurance plans to innovate on care coordination and value based insurance design

Assume State Regulatory Control

- Conduct effective rate review
- Implement state regulatory controls and enforce them among participating plans with state determined incentives or penalties
- Require plan participation in marketplace if contract for Medicaid lives

Maintain Policies that are Proven to Work

- No pre-existing condition exclusions
- No lifetime caps
- Insuring children to age 26
- No co-pay for preventive services

Simplify Administrative Rules & Reporting Requirements

- Simplify insurance regulation rules
- Simplify Qualified Health Plan requirements
- Reduce reporting requirements for insurance companies, businesses, and individuals
- Simplify Risk Adjustment

Marketplace Strategies Roadmap

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

Advance State Innovation

- ✓ Planning & Authorization Phase

State Regulation and Federal Flexibility

- ✓ Increased Awareness
- ✓ Improved Plan Design
- ✓ State-Controlled Plan Regulation
- ✓ Improved Risk Management
- ✓ Modified Enrollment Procedures

Oklahoma's Modernized Marketplace

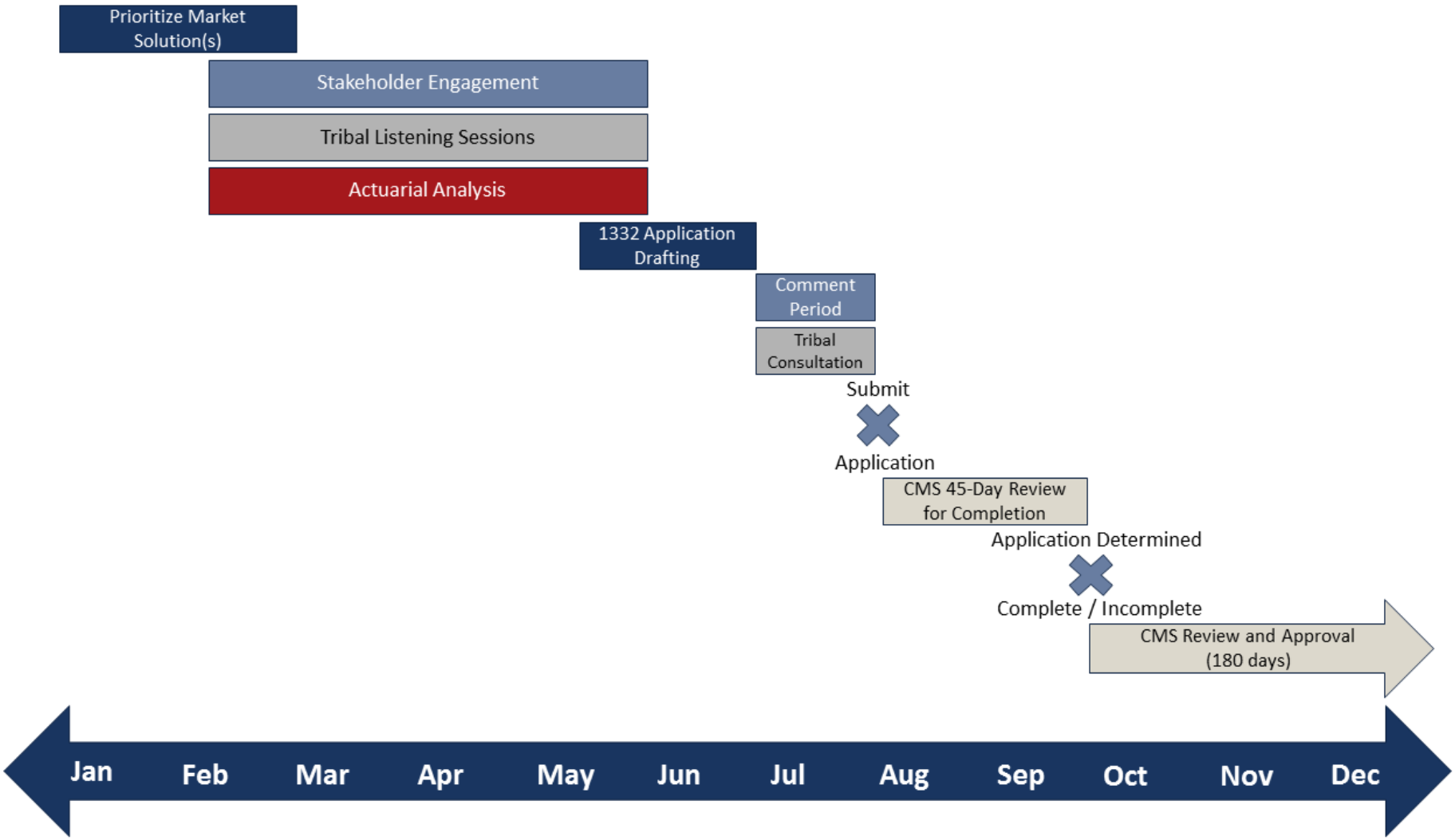
- ✓ Increased Awareness
- ✓ Improved Plan Design
- ✓ State-Controlled Plan Regulation
- ✓ Improved Risk Management
- ✓ Modified Enrollment Procedures
- ✓ Eligibility Changes
- ✓ Modified Subsidy Processes
- ✓ State-Owned Platform
- ✓ State-Designed HSA-like Accounts

Triple Aim

- ➢ *Lower Health Care Costs*
- ➢ *Better Health Outcomes*
- ➢ *Higher Quality of Care*

Plan Year 2017 | Plan Year 2018 | Plan Year 2019 | 2020+

1332 WAIVER APPLICATION AND APPROVAL PROCESS – Up to 1 Year



Next Steps

Concept paper may be found at: https://www.ok.gov/health/

February 21 Task Force Meeting:

- Final concept paper reviewed
- Results of consumer and business surveys reviewed

By February 28:

- Concept paper submitted to Governor's Office and Legislature

Additional Task Force Meetings: April and June

By June 30:

- HMA will conduct and share results of impact analysis
- Milliman will gather and analyze relevant health plan data illustrating pain points
- Final Task Force Report will be completed
- Actuarial analysis of recommended changes complete
- Next steps for 1332 Waiver development pursued

Discussion Questions

1. The 1332 concept paper needs to address potential impacts and other considerations for Indian health. What impacts should be considered?

2. What should be addressed in the 1332 concept paper with regards to ITU facilities, tribal nations, IHS, ability for tribes to continue financially supporting their members' premium payments, policies on exclusions and/or exemptions, etc?

Discussion Questions

3. Should we prioritize certain strategies over others? Are there critical steps that can be taken in the short term to help provide relief to consumers, plans, the state, the tribe?

4. With the proposed changes to the ACA and recommendations coming from the 1332 task force, what additional areas of the ACA should be analyzed for potential impact upon Indian health?

Discussion Questions

5. What are the most critical impacts on Indian health related to the IHCIA?

6. Are there intersecting points of the ACA Indian Health provisions and the recommendations presented by the 1332 concept paper?