1332 State Innovation Task Force Meeting Agenda

February 21, 2017
1:30 p.m.-3 p.m.
Oklahoma State Capitol
2300 N. Lincoln Blvd., Room 419C
Oklahoma City, OK 73105

Section	Time		Presenter
Welcome and Introductions	1:30	5 min	Julie Cox-Kain, Deputy Secretary of Health and Human Services
Consumer and Business Surveys: Initial Results	1:35	10 min	Kevin Jessop, Evolve
Insurer Survey: Initial Results	1:45	20 min	Paul Houchens, Milliman
Review of Public Comments on Concept Paper	2:05	15 min	Julie Cox-Kain; Buffy Heater, HHS Project Lead; Theresa LaPera, Health Management Associates
Overview of Tribal Considerations	2:20	15 min	Julie Cox-Kain; Buffy Heater; Melissa Gower, Chickasaw Nation
Discussion of Additional Strategies	2:35	20 min	Julie Cox-Kain; Buffy Heater; Austin Bordelon, Leavitt Partners
Next Steps	2:55	5 min	Julie Cox-Kain, Buffy Heater

Business Online Poll – Executive Summary

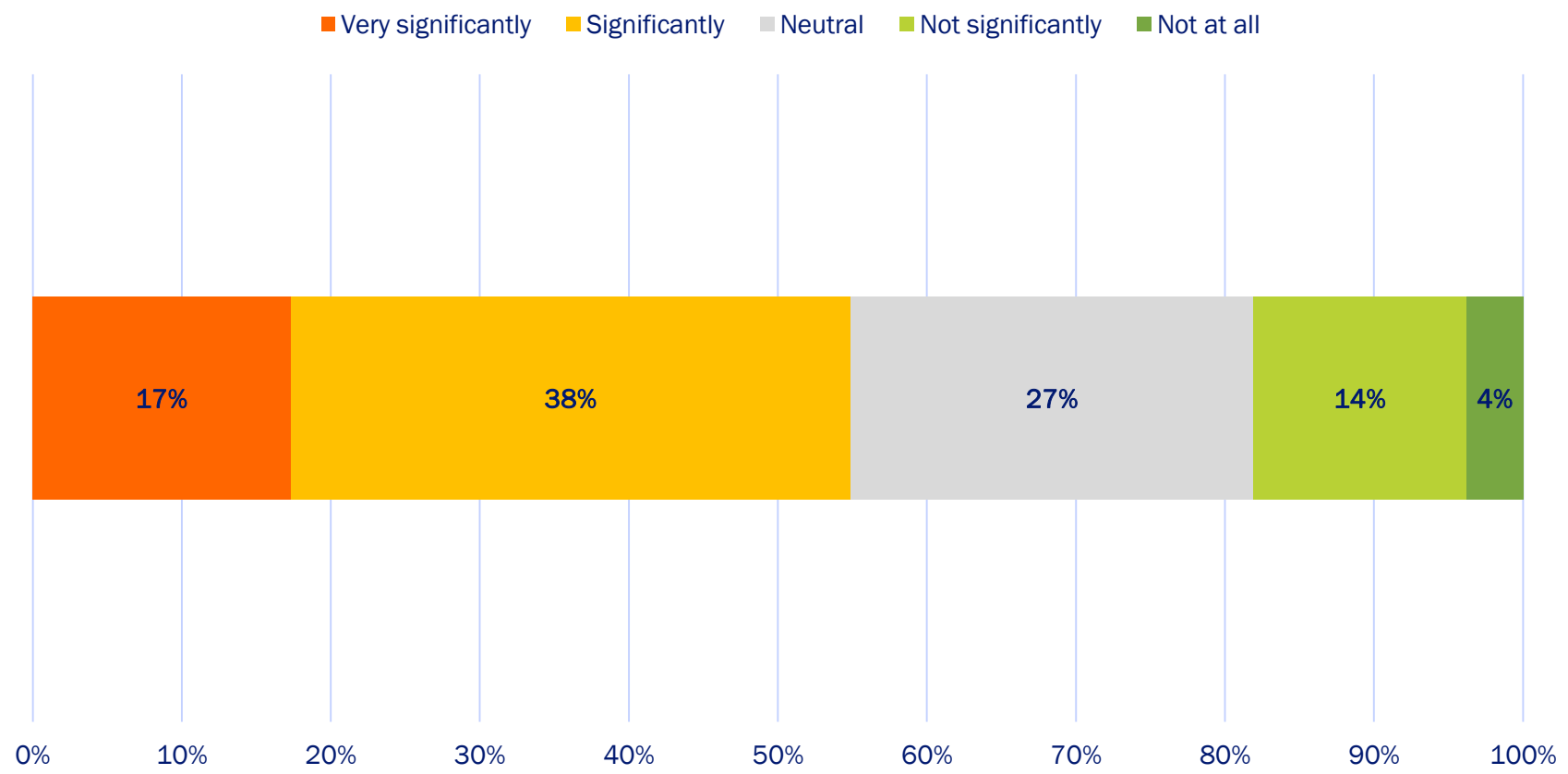
- Being able to offer **health insurance plays a major role in employee retention and acquisition.**
- Over a quarter of employers believe **access to health insurance is the biggest driver of a healthy workforce.**
- **Lack of basic skills**, technical skills and lack of problem solving/critical thinking are primarily **responsible for 40% of employers not being able to find capable employees.**

Business Online Poll – Executive Summary

- The top three items causing employers significant health challenges are:
  - Making positive healthy lifestyle choices
  - Losing weight
  - Reducing stress
- **Brokers play an extremely important role** in advising Oklahoma businesses of their health insurance options.
- **92% of employers reported increases to the cost of health insurance** at their last renewal.

Health Effects on Business

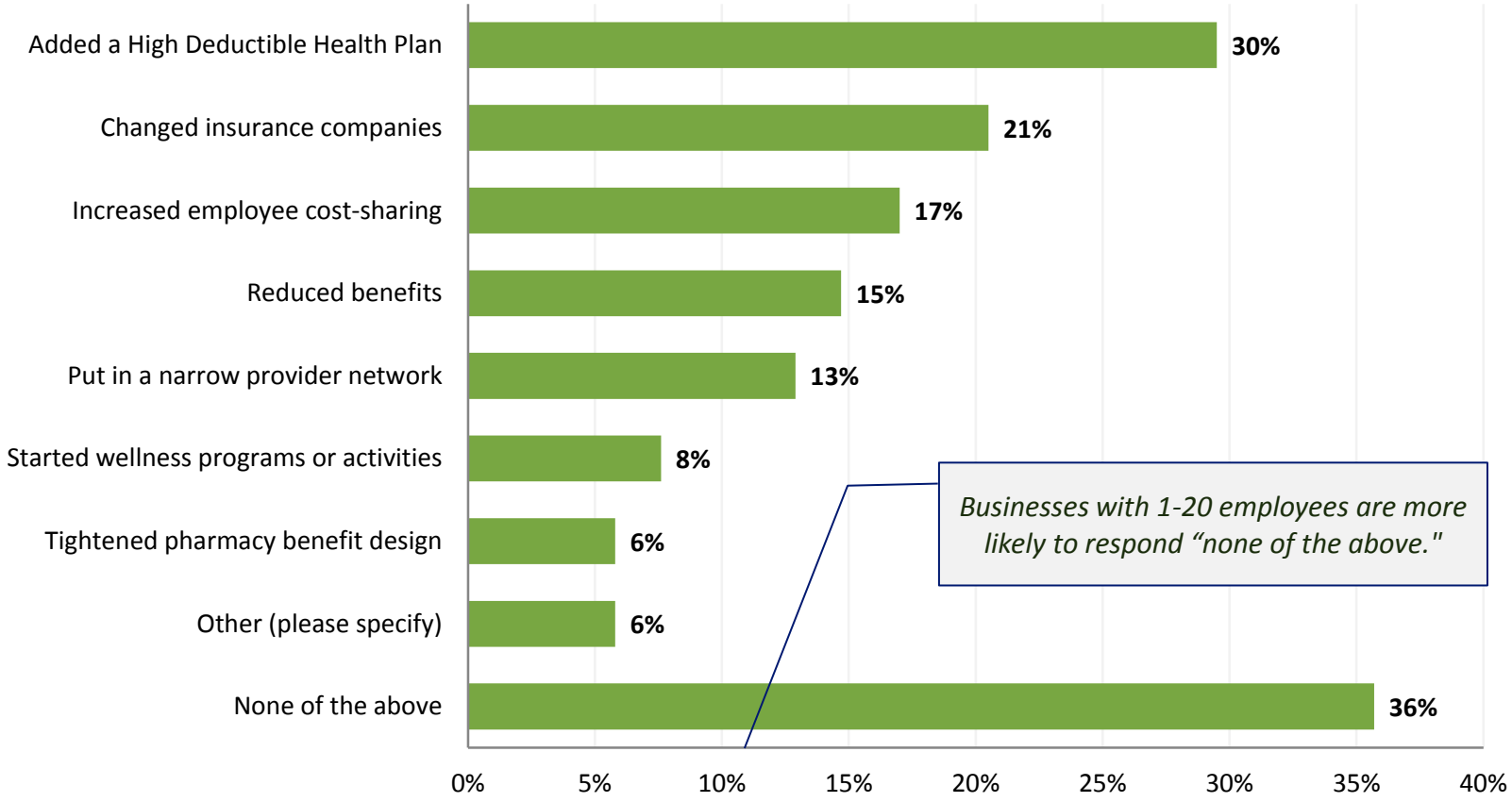
Q12 - Oklahomans on average feel they are "in poor physical health" 4 out of 30 days. To what degree does your employees' health affect your business?



240 surveyed Dec. 2016-Jan. 2017

Changes to Health Insurance Plan

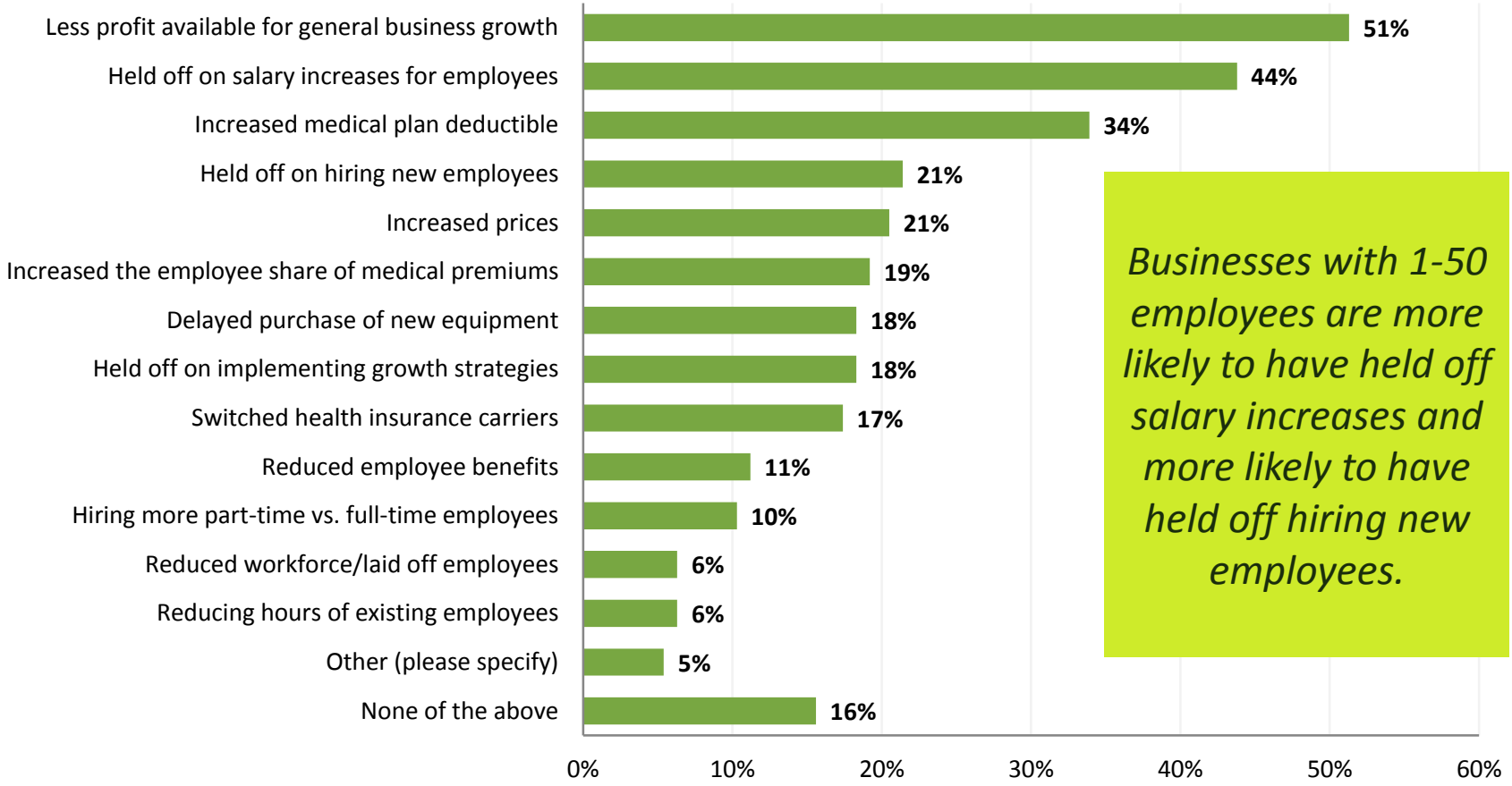
Q32 - To help with rising costs, have you made any of the following changes in the last 2 years? (check all that apply)



240 surveyed Dec. 2016-Jan. 2017

Impact of Premium Cost Increase

Q33 - What impact, if any, have increases in the cost of healthcare or the amount of healthcare-related requirements on employers had on your business? (check all that apply)



Businesses with 1-50 employees are more likely to have held off salary increases and more likely to have held off hiring new employees.

240 surveyed Dec. 2016-Jan. 2017

Business Telephone Poll – Executive Summary

- Most participants offered their employees health insurance.
  - The amount of coverage differs from employer to employer, but **affordability is key and dictates what an employer can offer**.
- Health insurance is viewed as something that can **attract and retain employees**.
  - Benefits can be **just as important as salary**.

Business Telephone Poll – Executive Summary

- Workforce **issues tend to relate to attracting "quality" or qualified staff.**
- **Insure Oklahoma is seen as a vital resource in making healthcare affordable** to employees.
- Most companies have **seen insurance costs increase** this year.

Business Telephone Poll – Executive Summary

- Employers **typically contribute between 50-100%** of employee premiums.
- Spouses and dependents are eligible on most plans; however, the **employee usually must pay for their family members**.
  - In some cases the employer will contribute towards the **spouse and family, but its usually a lower percentage** than what they pay for employee-only plans.

Employee Out-of-Pocket Expenses

PREMIUMS	DEDUCTIBLES	COPAY	CO-INS	PRESCRIPTIONS
20-25% OR $150-$400	*$500 - $1,500*	*$20 - $30 (GENERAL) $60 - $75 (SPECIALIST)*	*20% (80/20)*	*VARIES*

65 surveyed Jan. 2017

Consumer Research – Executive Summary

- Health insurance is **expensive.**
  - The biggest barrier to obtaining health insurance is **affordability**.
  - **Without a subsidy or employer contribution, insurance is largely unobtainable.**

- Health insurance is **confusing**.
  - Oklahomans are not certain how health insurance works.
  - Oklahomans sign up and pay for health insurance knowing that they do not entirely understand what it covers or what they are entitled to.

Consumer Research – Executive Summary

- Plan **selection is dictated by premium** price.
  - Other factors are involved, but Oklahomans initially qualify a plan by its monthly impact on their pocket-book.
- Oklahomans do **not understand out of pocket expenses and co-insurance**.
  - Deductible and OOP are used interchangeably.
  - Oklahomans are willing to sign up for plans which have co-insurance without understanding what co-insurance is.
    - This is **potentially a huge financial misunderstanding,** as most assume it is related to having two insurance plans.

Consumer Research – Executive Summary

- There are mixed views about the usability of Healthcare.gov.
  - Some **Oklahomans report the website is generally not difficult to use** – it clearly guides you through the process.
  - Most problems are related to confusion surrounding terminology, trying to use the site to figure it out, and a **lack of understanding about health insurance.**
- **Scenario-based examples** can better explain plans.
  - Insurance plans are not communicated in a clear language.
  - Applying different plans to a selection of scenarios can help explain the actual cost implications of a plan.

The Sweet Spot

How much would an affordable health plan cost?

Uninsured	Visitors	Purchasers	Private
$50-150	$150 -200	$150 -$200	$200-$400

Research participants were asked to name a premium price that was realistic, fair and affordable. It was agreed family coverage should cost more than individual.

161 surveyed Dec. 2016-Jan. 2017

Alternatives

"What can be done to make sure every person in Oklahoma has health insurance?"

1	2	3
CHEAPER	SIMPLE PLAN	SLIDING SCALE
Lower the premiums and make deductibles reasonable	Less confusing, no co-ins, you know *exactly* what you're getting	The cost of health insurance is proportional to your income

161 surveyed Dec. 2016-Jan. 2017

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Oklahoma Federally Facilitated Marketplace Profile and Insurance Market Population Movement

Preliminary Draft Results

Paul Houchens, FSA, MAAA
February 21, 2017

Agenda

1. Insurance Market Population Changes
2. ACA Federal Subsidies
3. Marketplace Plan Designs
4. Commercial Health Insurer Financial Results

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Caveats

- The values shared in this presentation are based on publicly available data published by the federal government. Many values have been estimated and are certain to vary from actual results.

- We anticipate receiving proprietary insurer data concerning many of the topics covered in our analysis. This data will provide further data points and clarity on a number of ACA related topics. Values in our final report are certain to vary from this presentation.

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Insurance Market Population Changes

Insurance Market Population Changes

2013 to 2016: Estimated Enrollment

State of Oklahoma Estimated Enrollment by Insurance Source Calendar Years 2013 through 2016				
Population	**2013**	**2014**	**2015**	**2016**
Uninsured	657,800	602,600	540,500	559,500
Individual	121,500	166,400	192,100	198,300
Small Group	185,400	180,300	173,100	166,200
Large Group	485,800	486,500	442,300	437,900
Self-Funded	801,100	809,600	893,800	910,600
EGID	219,400	222,700	225,500	226,200
Medicaid (Including Duals)	792,500	805,800	818,800	798,400
Medicare	495,600	514,700	537,000	538,000
Other Public Programs	91,400	89,400	88,200	88,400
Total	**3,850,500**	**3,878,000**	**3,911,300**	**3,923,500**

Note: rounded values reflect estimated average monthly enrollment.

- Shift from uninsured into individual market (through marketplaces)
- Growth in private sector employment
  - Approximately 40,000 person increase from 2014 to 2015
  - Self-funded coverage increases driven by employment increases and shift from large group fully insured to self-funded
- Medicaid decrease from 2015 to 2016 as a result of temporary pause in passive renewals, drives uninsured increase from 2015 to 2016

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Insurance Market Population Changes

2013 to 2016: Individual Market

State of Oklahoma Estimated FFM Enrollment Migration Insurance Source Calendar Years 2014 through 2016			
Pre-ACA Cohorts	**2014**	**2015**	**2016**
FFM Previously Individual	4,900	29,800	40,000
FFM Previously Uninsured	29,100	48,800	52,900
FFM Previously Public	8,300	8,300	8,300
FFM Previously ESI	5,600	11,600	15,500
Total FFM	**47,800**	**98,400**	**116,600**

Notes:
1. Values reflect estimated market enrollment differences to the extent the ACA was not implemented.
2. Values reflect estimated average monthly effectuated enrollment.
3. Values are rounded.

- Previously Uninsured marketplace participation estimated to have plateaued in 2016
- Previous Public reflects former Insure Oklahoma population with income between 100% and 200% FPL
- Approximately 13% of marketplace enrollees are estimated to have previously had ESI coverage
- CMS has announced 146,000 plan selections for Oklahoma's FFM in 2017, an increase of approximately 700 relative to 2016

2017 selections: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-02-03.html

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Insurance Market Population Changes

Effectuated Enrollment by Metallic Tier

State of Oklahoma FFM Enrollment Distribution by Metal Level			
Metal Level	**2014**	**2015**	**2016**
Bronze	10,200	25,300	33,700
Silver	33,000	66,000	77,400
Gold	4,000	6,900	5,300
Platinum	400	0	0
Catastrophic	100	300	100
Total	**47,800**	**98,400**	**116,600**

Notes:
1. Values reflect estimated average monthly effectuated enrollment.
2. Plan selection data from HHS marketplace open enrollment reports for each year.
3. Values rounded.

- Enrollment concentrated in bronze and silver metallic tier
  - Purchase of silver plan tied to CSR-eligibility for households with income between 100% and 250% FPL
  - Native Americans with income below 300% qualify for zero-cost sharing plan with the purchase of any QHP
- Gold level plans reflect approximately 5% of enrollment in 2016

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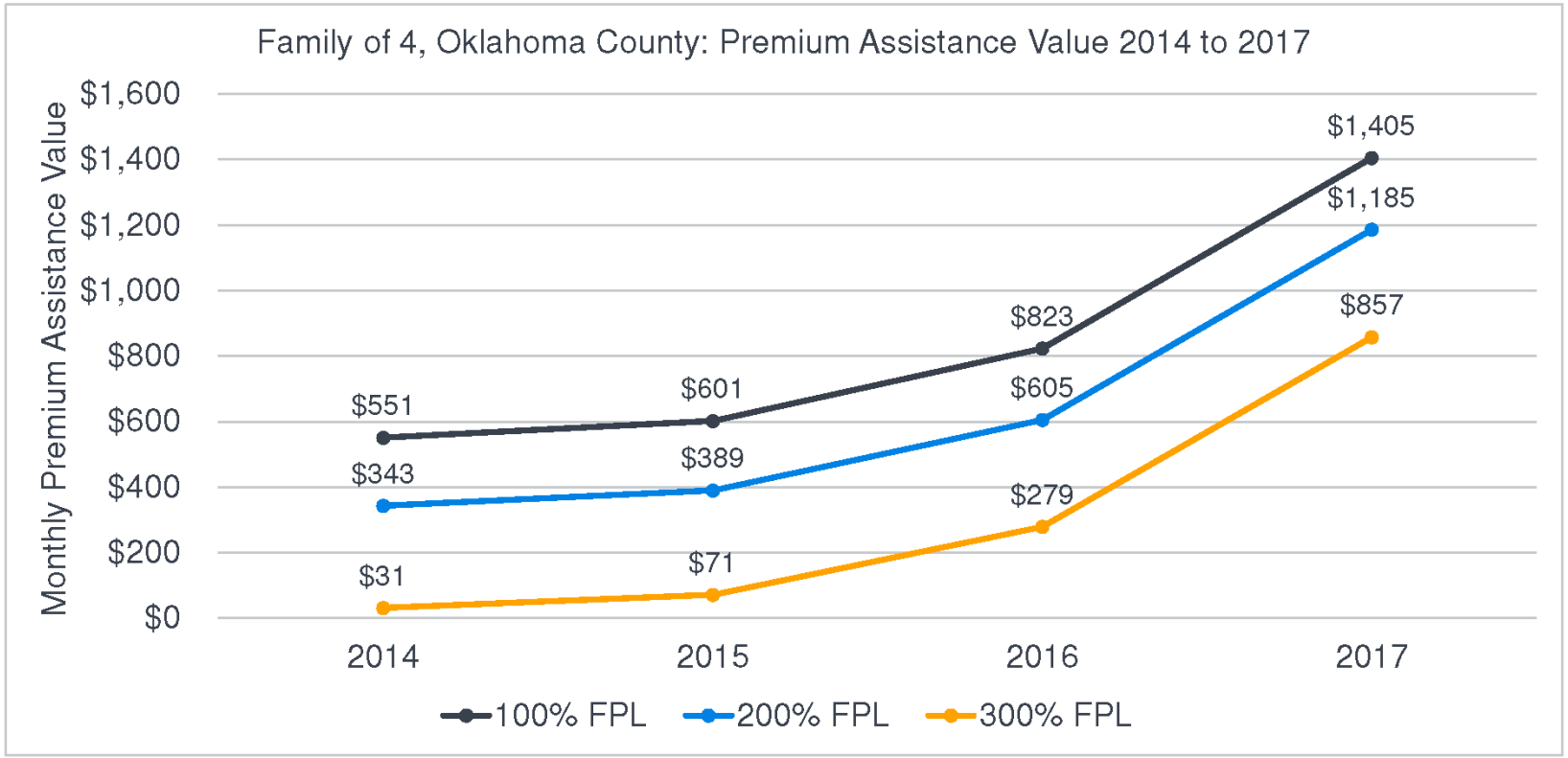
Insurance Market Population Changes

Enrollment Shifts

- Premium increases in the marketplace create greater premium assistance value



Note: Values reflect two adults, age 37, and two children.

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Federal Subsidies

Federal Subsidies

Financial Assistance Recipients

State of Oklahoma Individual FFM Premium Assistance Financial Assistance Recipients					
Year	Without Financial Assistance	With Financial Assistance		Total	Total Growth
		With APTC	With CSR		
2014	7,700	40,000	30,100	47,800	N/A
2015	18,700	79,700	59,500	98,400	106%
2016	12,200	104,400	71,600	116,600	19%

FFM National Composite Individual FFM Premium Assistance Financial Assistance Recipients					
Year	Without Financial Assistance	With Financial Assistance		Total	Total Growth
		With APTC	With CSR		
2014	445,200	3,273,400	2,323,700	3,718,600	N/A
2015	928,800	5,696,800	3,954,400	6,625,600	78%
2016	826,600	6,704,900	4,521,400	7,531,500	14%

- 2015 and 2016 Oklahoma FFM growth has exceeded National FFM composite

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Federal Subsidies

Financial Assistance Recipients

State of Oklahoma Individual FFM Premium Assistance Financial Assistance Recipients			
Year	Without Financial Assistance	With Financial Assistance	
		With APTC	With CSR
2014	16%	84%	63%
2015	19%	81%	60%
2016	11%	89%	61%

FFM National Composite Individual FFM Premium Assistance Financial Assistance Recipients			
Year	Without Financial Assistance	With Financial Assistance	
		With APTC	With CSR
2014	12%	88%	62%
2015	14%	86%	60%
2016	11%	89%	60%

- Proportion of Oklahoma FFM enrollment receiving financial assistance very similar to national FFM composite

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Federal Subsidies

Impact of Premium Assistance

State of Oklahoma Individual FFM Premium Assistance Impact of Premium Assistance			
	2014	**2015**	**2016**
Average Monthly Premium before APTC	$277	$295	$376
Average Monthly APTC	$202	$206	$296
Average Premium after APTC	$75	$89	$80
Average Percent Reduction in Premium after APTC	73%	70%	79%

FFM National Composite Individual FFM Premium Assistance Impact of Premium Assistance			
	2014	**2015**	**2016**
Average Monthly Premium before APTC	$346	$364	$396
Average Monthly APTC	$264	$263	$290
Average Premium after APTC	$82	$101	$106
Average Percent Reduction in Premium after APTC	76%	72%	73%

Source: U.S. DHHS Office of the Assistant Secretary for Planning and Evaluation, marketplace selection analysis.

- Net premium for Oklahoman marketplace enrollees receiving premium assistance did not materially change from 2014 to 2016
- Value of per capita premium assistance in Oklahoma on par with FFM national composite in 2016

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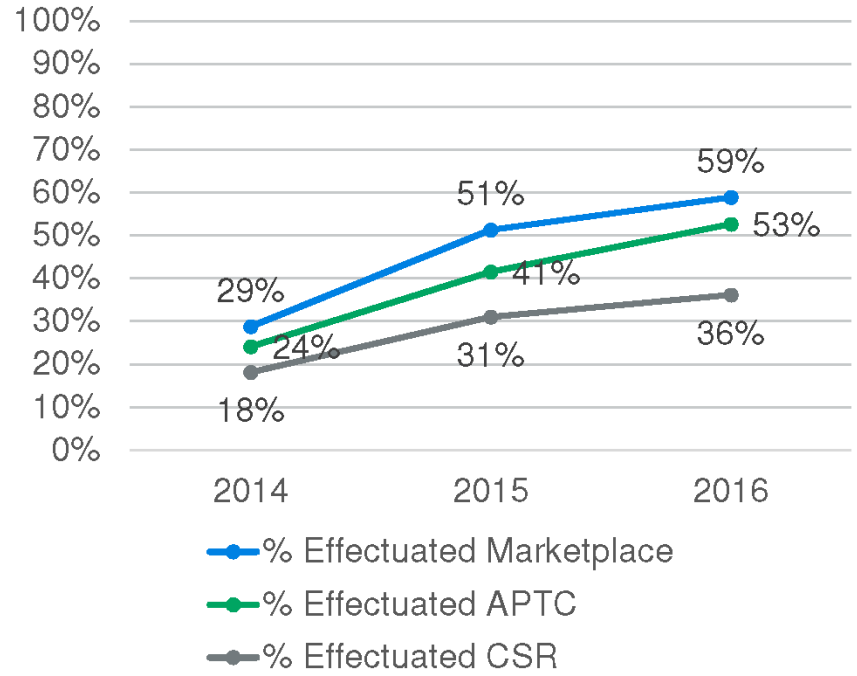
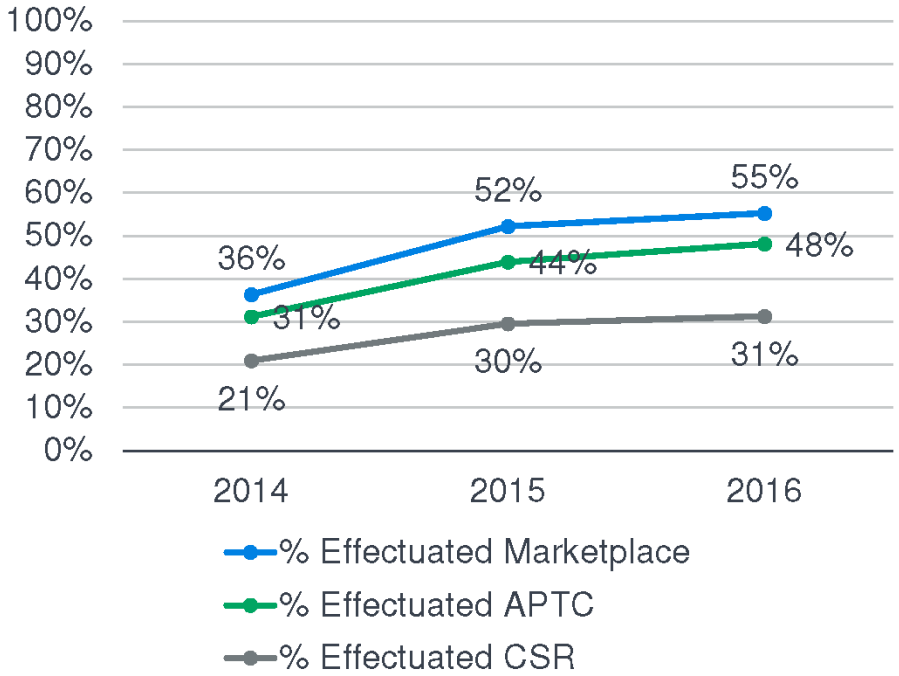
Summary of Marketplace Enrollment

INSURANCE MARKETPLACE ENROLLMENT AND ACA SUBSIDIES

Oklahoma



National (All States)



- 2016 individual market premium data estimated based on 3Q2016 statutory filings.
- "% Effectuated" values represent enrollment for respective enrollees as a percentage of total individual market enrollment.

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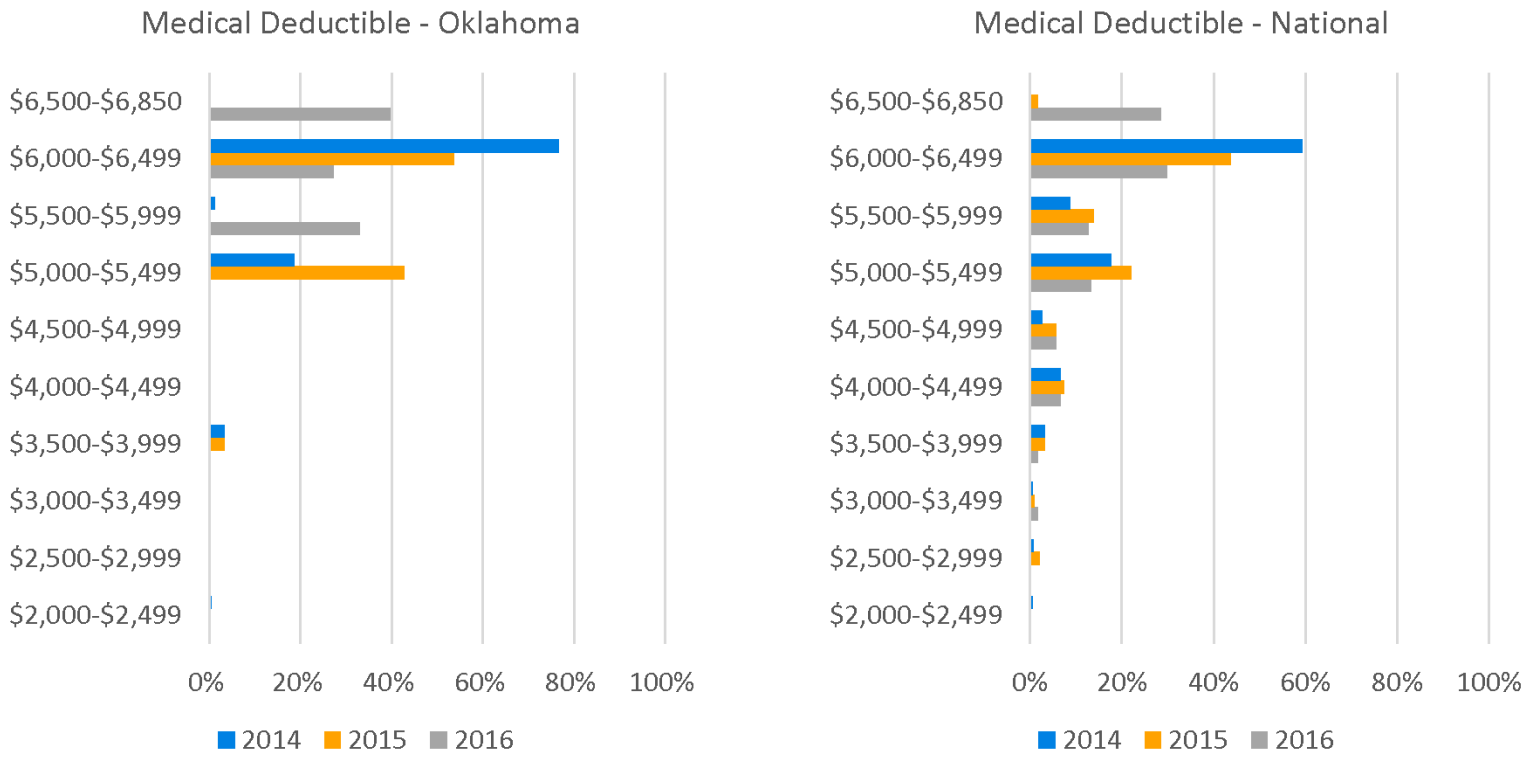
Marketplace Plan Designs

Marketplace Plan Designs

Bronze Plans Medical Deductible Distributions



Source: Federally facilitated marketplace data, available at data.healthcare.gov

- Majority of bronze QHPs have single deductibles in excess of $6,000 in Oklahoma and on FFM

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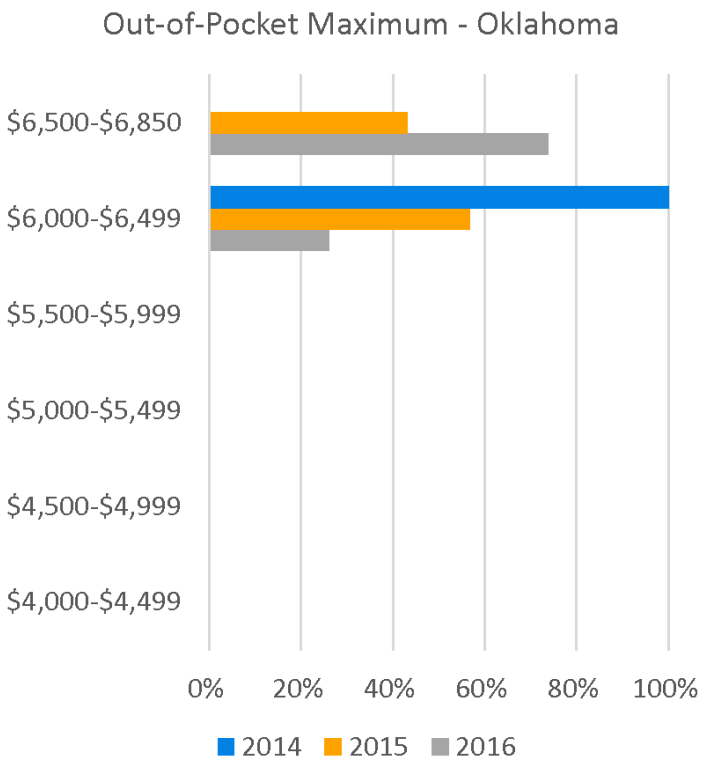
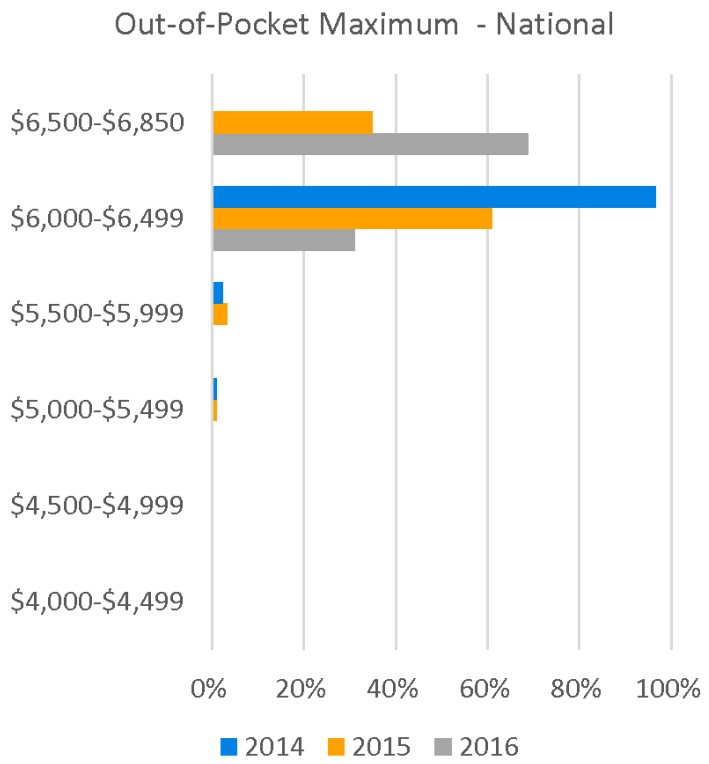
Marketplace Plan Designs

Bronze Plans Medical Out-of-Pocket Maximum Distributions





- 100% of bronze QHPs have single OOP Maximum in excess of $6,000 in Oklahoma, similar to national FFM

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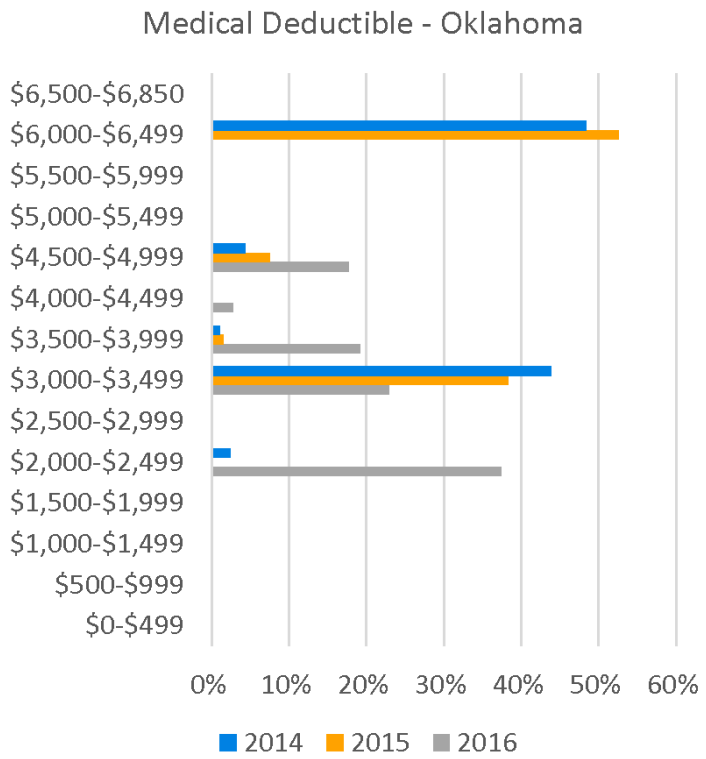
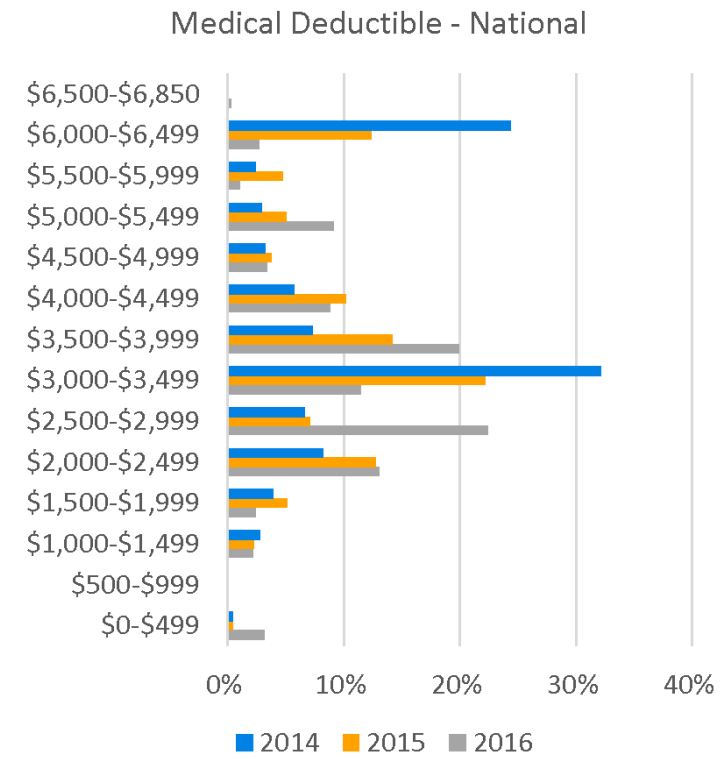
Marketplace Plan Designs

Silver Plans Medical Deductible Distributions





- Wider distribution in silver deductible distribution, lower deductible values generally have high coinsurance and copays values

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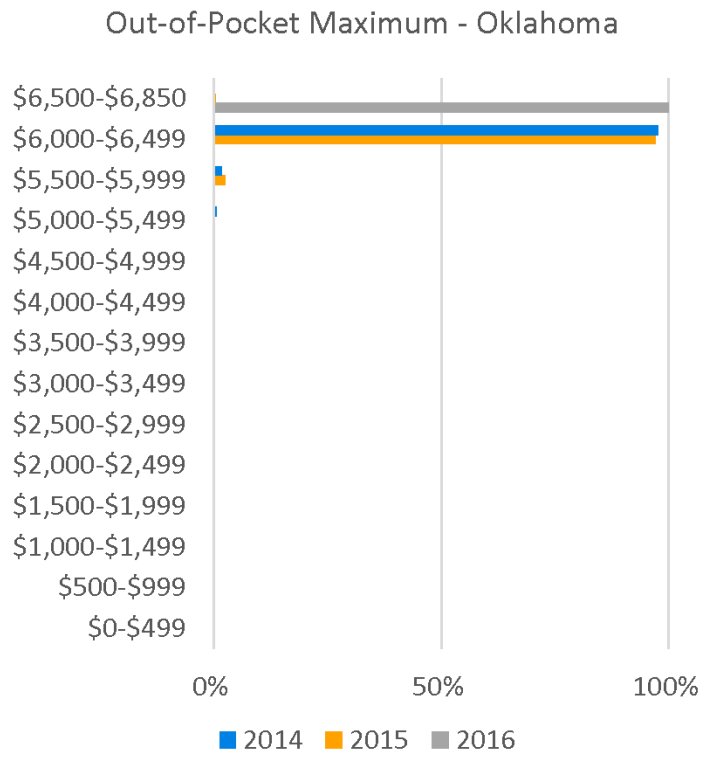
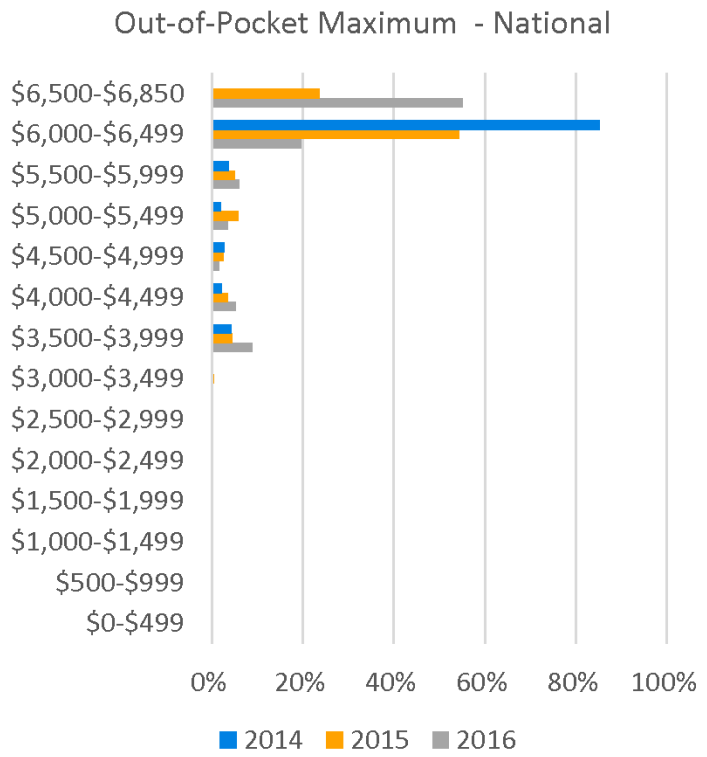
Marketplace Plan Designs

Silver Plans Medical Out-of-Pocket Maximum Distributions





- Vast majority of single silver OOP Max exceeds $6,000 in Oklahoma and in national FFM

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Commercial Health Insurer Financial Results

Insurer Financial Results

Individual Market

State of Oklahoma Carrier Financial Results Individual Market Calendar Year 2013 through 2015									
	2013			2014			2015		
GROUP_AFFILIATION	Market Share	MLR	Profit Margin (Without PDR)	Market Share	MLR	Profit Margin (Without PDR)	Market Share	MLR	Profit Margin (Without PDR)
HCSC GRP	65.0%	80.4%	0.6%	76.6%	99.3%	(19.5%)	88.0%	108.6%	(24.3%)
UNITEDHEALTH GRP	16.3%	81.6%	3.8%	10.1%	87.9%	1.4%	6.6%	102.3%	(14.0%)
Assurant Inc Grp	5.9%	74.4%	1.8%	4.2%	82.0%	(0.2%)	2.5%	96.3%	(11.9%)
CommunityCare Grp	1.2%	89.5%	(3.7%)	1.0%	72.5%	7.7%	1.3%	82.8%	7.4%
AETNA GRP	7.2%	83.2%	(0.3%)	5.3%	104.5%	(12.2%)	0.6%	128.0%	(50.9%)
All Other	4.4%	75.4%	(0.8%)	2.7%	103.7%	(13.8%)	1.0%	119.0%	(28.7%)
Individual Market	**100.0%**	**80.2%**	**0.9%**	**100.0%**	**97.6%**	**(16.5%)**	**100.0%**	**107.7%**	**(23.2%)**

Notes:
1. Source: Commercial medical loss ratio filings submitted to CMS.
2. PDR = Premium Deficiency Reserve.
3. Profit margin reflects underwriting gain (losses) and excludes investment income.

- Significant market share gains by HCSC (Blue Cross Blue Shield of OK)
  - Market share losses by primary competitors of BCBS of OK
- HCSC experienced significant losses in 2014 and 2015
  - This was materially influenced by full risk corridor funding not being provided by the federal government

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Insurer Financial Results

Small Group Market

State of Oklahoma Carrier Financial Results Small Group Market Calendar Year 2013 through 2015									
	2013			2014			2015		
GROUP_AFFILIATION	Market Share	MLR	Profit Margin (Without PDR)	Market Share	MLR	Profit Margin (Without PDR)	Market Share	MLR	Profit Margin (Without PDR)
HCSC GRP	60.1%	81.0%	3.7%	65.4%	87.9%	0.2%	71.1%	91.2%	(2.3%)
UNITEDHEALTH GRP	14.6%	75.6%	8.6%	12.9%	82.9%	2.6%	11.4%	77.7%	9.1%
CommunityCare Grp	9.7%	87.8%	(0.4%)	9.6%	94.4%	(5.0%)	10.1%	97.6%	(6.9%)
Aetna Inc	13.6%	78.7%	0.5%	10.5%	81.8%	2.2%	6.1%	74.5%	2.8%
FEDERATED MUT GRP	0.8%	87.8%	(5.5%)	0.9%	86.1%	(2.1%)	1.0%	96.7%	(10.7%)
All Other	1.3%	79.8%	2.0%	0.7%	74.3%	8.8%	0.3%	77.4%	7.0%
Small Group Market	**100.0%**	**80.6%**	**3.6%**	**100.0%**	**87.1%**	**0.3%**	**100.0%**	**89.3%**	**(1.1%)**

Notes:
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2. PDR = Premium Deficiency Reserve.
3. Profit margin reflects underwriting gain (losses) and excludes investment income.

- Material market share gains by HCSC (Blue Cross Blue Shield of OK)
- Less volatile profit margins relative to individual market
- MLR increases driven by 8% administrative PMPM cost decrease (‘13 to ‘15) and premium increases of 6% (‘13 to ‘15)

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Insurer Financial Results

Large Group Market

State of Oklahoma Carrier Financial Results Large Group Market Calendar Year 2013 through 2015									
	2013			2014			2015		
GROUP_AFFILIATION	Market Share	MLR	Profit Margin (Without PDR)	Market Share	MLR	Profit Margin (Without PDR)	Market Share	MLR	Profit Margin (Without PDR)
HCSC GRP	54.5%	89.6%	3.0%	54.2%	90.4%	2.1%	54.0%	93.4%	(0.8%)
UNITEDHEALTH GRP	11.1%	83.9%	7.4%	12.5%	86.6%	5.0%	14.5%	88.7%	3.0%
CommunityCare Grp	17.0%	86.7%	1.4%	16.4%	88.2%	1.3%	13.7%	88.7%	0.8%
Aetna Inc	8.9%	86.6%	(2.0%)	8.6%	85.2%	0.3%	9.0%	88.8%	(0.7%)
GLOBALHEALTH HOLDINGS GRP	0.0%	0.0%	0.0%	8.0%	88.1%	1.4%	8.4%	88.1%	1.4%
All Other	8.5%	87.2%	2.0%	0.3%	91.2%	4.1%	0.5%	90.3%	2.0%
Large Group Market	**100.0%**	**88.1%**	**2.7%**	**100.0%**	**89.1%**	**2.1%**	**100.0%**	**91.4%**	**0.1%**

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- Minimal market share and profit margin changes

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Thank you

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February 21, 2017

Limitations

Limitations

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

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

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

It should be emphasized that the values in this presentation are estimates based on assumptions and available data. It is certain that actual results will vary from the estimates provided in this presentation.

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

Qualifications

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Paul Houchens is a member of the American Academy of Actuaries, and meets the qualification standards for performing the analyses in this report.

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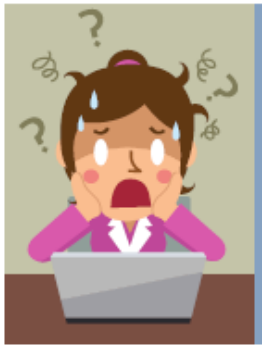
CURRENT SYSTEM



SHOPPING FOR COVERAGE

Today, even though consumers don't have a lot of plans to choose from, it's hard for them to know what they are getting for their money. People might choose based on price alone, but they might not understand what the costs and benefits will be.

BUYING COVERAGE

Many people do not qualify for help with the cost of coverage today. This means some people are shut out of the market. Not having as many people in the market is part of why coverage might be so expensive.

USING COVERAGE

The biggest problem with a complicated plan is that you might get a large bill you aren't expecting. This is one reason why people drop their insurance or don't buy it in the first place – they feel it is too expensive.

STABILIZING THE MARKET

When the cost of insurance is high and there isn't a lot of competition, there aren't enough consumers in the picture to keep things in balance.

INSURE OKLAHOMA PLATFORM

SHOPPING FOR COVERAGE

Our proposal is designed to make things simpler for plans and for people. More plans will want to sell coverage, so there will be more competition. Competition brings the price down, so more people will want to buy insurance. And if the costs and benefits are easier to understand, people will feel more confident about their choice.

BUYING COVERAGE

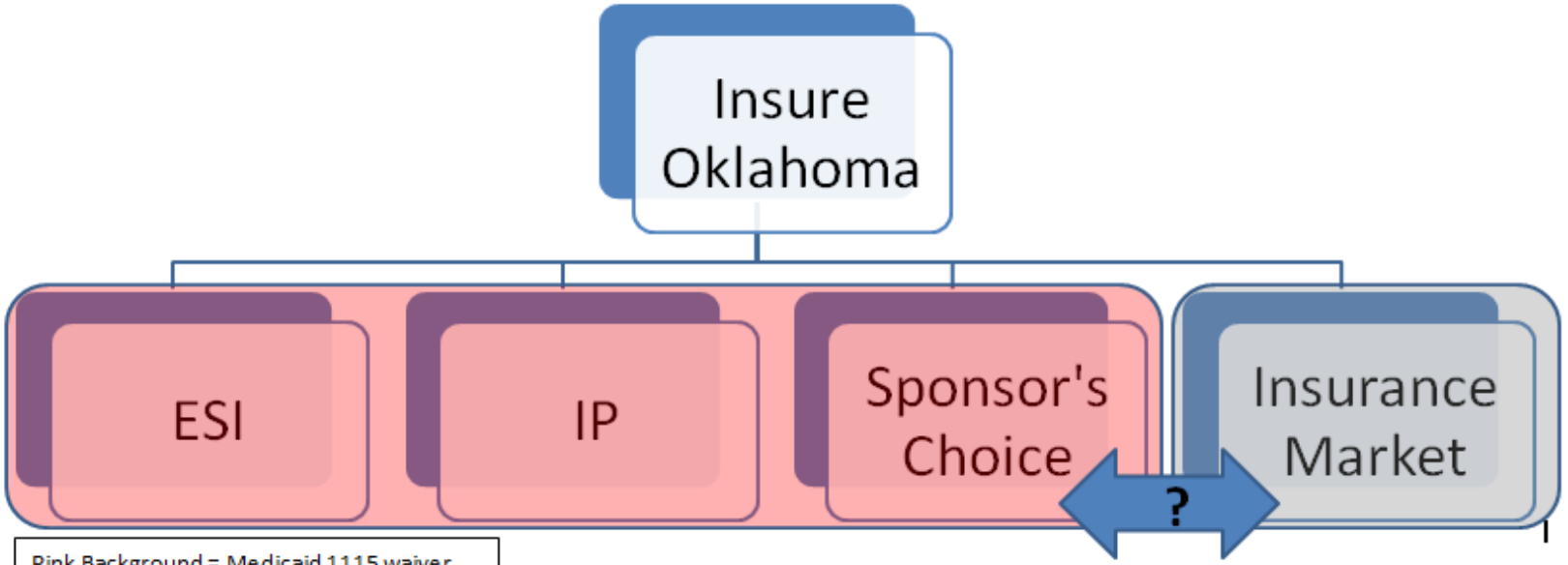
More people will get help paying for their coverage. Our proposal would set up accounts that would belong to people. We are still working out the details but the goal is to help with premiums and out-of-pocket costs.

USING COVERAGE

Making costs and benefits understandable means you won't be surprised by a high bill from the doctor. If you can afford your premiums you will keep your insurance, and that means you can visit the doctor when you need to, without worrying.

STABILIZING THE MARKET

If there is enough competition and plans are easy to understand and affordable, more people can buy coverage and things are in better balance.



Pink Background = Medicaid 1115 waiver
Gray Background = ACA 1332 waiver

Waiver submitted to CMS

0-200% FPL

Premium Assistance

Qualified Health Plans

Medicaid Funded/OMB Rate

Plans Contract with ITU's

No Out of Pocket Costs

Concept paper in development

Sequential waiver submissions to HHS & Treasury

0-300% FPL

Premium Assistance

Qualified Health Plans

ACA Funded (APTC & CSR)

Out of Pocket Costs

AI/AN Exemptions (cost sharing, penalty, special enrollment)

Questions:

1) What are the similarities between Sponsor's Choice and the Insurance Market? The differences?
2) In what ways could the waivers align and coordinate with each other?
3) Should the Sponsor's Choice 1115 waiver and the Insurance Market 1332 waiver become companions? What are pros/cons?
4) What changes are needed?

Public Comments on Concept Paper: Summary

- 10 Commenters (7 on Substance; 3 Editorial only)
- Comments from insurer, insurer association, Tribal Nation, consultant, provider, large employer
- Substantive Topic Areas:
  - Health Plan Elements
  - Affordability/Subsidies
  - Eligibility and Enrollment Provisions
  - Commercial Market
  - Health Plan Risk Management
  - American Indian/Alaska Native Issues
  - State Role
  - Employer Issues

Public Comments on Concept Paper: Hot Topics

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

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

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

Public Comments on Concept Paper: Hot Topics, Continued

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

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

1332 State Innovation Task Force Meeting Agenda

February 21, 2017
1:30 p.m.-3 p.m.
Oklahoma State Capitol
2300 N. Lincoln Blvd., Room 419C
Oklahoma City, OK 73105

Section	Time		Presenter
Welcome and Introductions	1:30	5 min	Julie Cox-Kain, Deputy Secretary of Health and Human Services
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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.

Tribal Premium Sponsorship program

- 1332 Waiver needs to take into consideration how operations of the program could be impacted and ensure the program continues support health coverage access if the waiver is implemented

Sponsor's Choice Waiver

- State may want consider approving 1332 and Sponsor's Choice waivers together
- May also want to look at aligning efforts – for instance, having the same income ceiling for subsidies and eligibility for coverage through both the 1332 Waiver (currently 300% federal poverty level) and Sponsor's Choice (currently 200% federal poverty level)

Quality Measures Related to Chronic Disease

- Quality measures for providers overall should align with current I/T/U measures to eliminate duplication
- Baseline measures need to take into account that AI/AN data is not currently included

Tighter Restrictions on Premium Payment Grace Periods and Special Enrollment Requests

- In consideration of current ACA provisions and the Tribal Sponsorship program, exemption from tighter restrictions on special enrollment/premium payment needs to be considered for this population.

APTC and CSR Eligibility and Distribution

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

Consumer Health Accounts

- The administration of consumer health accounts needs to ensure that the Tribal Sponsorship program can continue to support access to coverage for the AI/AN population.

High-Risk Pools

- The need for AI/ANs to obtain coverage through a high-risk pool should be a last resort after all other potential eligibility avenues have been exhausted.

State-Controlled Plan Regulation

- Any changes implemented by the Oklahoma Insurance Department with regard to the state assuming responsibility for review and regulatory oversight of payers need to include contractual provisions currently identified for the Sponsor's Choice program.

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Additional Strategies for Discussion

- **Essential Health Benefits (EHBs)**
  - What should be mandated?
- **Capping Cost Growth**
  - What alternatives exist to managing premium growth?
  - What mechanisms should be used to slow growth and encourage proper management of covered lives?
- **Auto-enrollment**
  - Would this be an effective tool within the Insure Oklahoma Platform? For example, if someone is ineligible for Medicaid could he/she be automatically enrolled in a low-cost commercial, qualified health plan?
- **Actuarial Value**
  - How can we effectively regulate value within plans?

Essential Health Benefit Alternatives

How robust should a benefits package be to adequately pool risk?

Risk Management for the Individual Market

What's the best way to isolate risk and ensure affordability to all consumers?

High-Risk Pools

Segmenting the highest risk populations into a separate pool.

Pros:

- Ability to segment most costly populations and charge higher premium.
- Clearly defined underwriting risk for carriers.

Cons:

- High cost of administering the program.
- Enrollees may become trapped in the program even after becoming healthy.
- Typically requires enrollees to be uninsured to qualify.

Hybrid Program

Health care condition used as triggering event for state responsibility.

Pros:

- Equitable treatment of high-risk residents.
- Highest risk conditions subsidized by state.
- Clearly defined underwriting risk for carriers.
- Lower administrative cost.

Cons:

- Enrollees may remain in program even after becoming healthy.
- Inability to charge high-risk populations more premium.

Reinsurance

Gov't shares in financial risk to reduce cost of high-risk enrollees.

Pros:

- Equitable treatment of high-risk residents.
- Shared risk as incentive for carriers to keep costs down.
- Lower administrative cost.
- Greatest financial certainty of program risk and funding.

Cons:

- Highest risk populations not fully removed from risk pool.
- Inability to charge high-risk populations more premium.

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

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Next Steps

February 22:

- Sponsor's Choice/1332 Waiver Workgroup Meeting

By February 28:

- Concept paper submitted to Governor's Office and Legislature

Next 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