A New Horizon

Recommendations for Oklahoma's Modernized Health Insurance Market

March 2017

Submitted by:

Secretary of Health and Human Services

State of Oklahoma

Contents

Executive Summary

The passage of the Patient Protection and Affordable Care Act (ACA) brought about numerous changes to the way health insurance coverage is provided to Oklahoma residents. While these changes have increased the number of Oklahomans with health care coverage, it has come with increased burden and cost for individuals, employers, and insurance carriers. Oklahoma continues to face a number of challenges related to providing individuals with access to affordable, quality, and sustainable health care coverage. Particularly telling of the necessity of swift intervention is the exodus of all but one carrier from Oklahoma's individual insurance market for plan year 2017, premium increases in excess of 75% on average for plan year 2017, and participation of only 31% of eligible individuals for plan year 2016.[1]

Fortunately, the availability of 1332 State Innovation Waivers – coupled with potential regulatory shifts at the federal level – gives our state the chance to make significant changes necessary to improve the health of our insurance market and citizens. As Congress considers the repeal and/or modification of the ACA, the State of Oklahoma is anticipating unique opportunities to implement innovative strategies for consumers, employers, and insurance carriers that are responsive to our state's needs.

Above all, the new health insurance market must institute a framework that focuses on improving health outcomes and quality while controlling costs. Health care coverage should be seen as an essential tool toward these aims rather than a stand-alone goal; that is, increasing the number of lives with coverage without addressing the necessary changes of the health care system at large is unsustainable.

Within this framework there is a great deal of opportunity to return flexibility to states to implement delivery system and payment reforms based on local conditions; reduce administrative burden on states and the health care industry; ease requirements that are driving up the cost of coverage for young, healthy individuals; and support small business and families access coverage. Specifically, Oklahoma has identified five guiding principles that are the foundation of the recommendations that follow:

- ✓ Increase flexibility at the state level by empowering our state regulatory entities to adapt to our state's needs
- ✓ Reduce costs by stabilizing the state's health insurance market
- ✓ Improve health outcomes by employing strategies to evaluate our health system's performance
- ✓ Embrace innovation through state-based solutions that promote high-quality care, continuity of coverage, and affordability
- ✓ Support individual control and choice by increasing competition and providing consumers with the tools they need to make informed decisions

The 1332 Waiver Task Force has met since August 2016 to discuss challenges and design solutions to support these guiding principles in order to stabilize Oklahoma's individual health insurance market. The state will likely pursue sequential 1332 Waivers and/or amendments to an initial waiver to implement the changes over time. It is anticipated that an initial waiver that would allow the state to assume more

[1] The Henry J. Kaiser Family Foundation. (2016). Marketplace enrollment as a share of potential marketplace population - March 31, 2016: http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/?currentTimeframe=0

responsibility over rate review and plan qualification would be submitted in July of 2017 at the earliest, with implementation in 2018. Additionally, some strategies may not require a waiver but rather state or federal action and can be phased in to complement the 1332 Waiver.

The 1332 Waiver Task Force proposes the following implementation timeline, recognizing some of these are dependent on significant and timely changes to the ACA:

2018 Implementation

- ✓ **Assume state regulatory control** over certain market functions that are currently being done at the federal level, including rate review, health plan certification, and actuarial value validation
- ✓ **Require a focus on health outcomes and cost containment** by implementing state quality measures and promoting value-based payments and care coordination within health plans
- ✓ **Change the way insurance products are priced** by broadening age ratios that limit the differences in age-based pricing

2019 Implementation

- ✓ **Reduce administrative burden on plans** related to reporting, risk mitigation, eligibility, and enrollment
- ✓ **Eliminate the use of the Federally Facilitated Marketplace (FFM)** and instead utilize the Insure Oklahoma platform to determine eligibility for coverage and calculate subsidies
- ✓ **Establish consumer health accounts** similar to health savings accounts (HSAs) to encourage consumer-directed care and implement consumer incentives
- ✓ **Change subsidy eligibility** to individuals with incomes between 0% and 300% of the Federal Poverty Level (FPL)
- ✓ **Standardize subsidies** based on age and income
- ✓ **Simplify plans** by eliminating metal tiers and providing easy-to-understand choices
- ✓ **Modify mandated benefits** so the state can be innovative and flexible in order to reduce costs while providing adequate coverage
- ✓ **Change rules for special enrollment requests, premium payment grace periods, and exemptions** to promote timely enrollment and streamline enrollment processes

Detailed descriptions and justifications for all proposed strategies are provided in the Recommended Strategies section of this paper, as well as in Appendix A.

Background

The Oklahoma Legislature passed Senate Bill 1386 (Sen. Kim David, R-Porter; Rep. Glen Mulready, R-Jenks) with strong bipartisan support to explore possible solutions to address the challenges of the current health insurance market. Following the passage of SB 1386, Governor Mary Fallin established the 1332 Waiver Task Force (Task Force) to bring together a diverse set of stakeholders to develop potential strategies. The Task Force includes representation from both public and private entities, including commercial insurance carriers, businesses, providers, consumer advocates, and tribal nations, with support from state agencies. As a result of meeting regularly on a monthly basis since August of 2016, participant input, and data analysis, the Task Force identified a number of recommendations that form the basis for the comprehensive set of solutions outlined in this document.

It should be noted that these recommendations will not necessarily translate into the final 1332 Waiver request as more thorough analysis with contract consultants and legislative review are necessary to determine a more detailed waiver proposal. Rather, this concept paper provides an overview of the options and issues to be explored and creates an opportunity for conversation with the new federal administration about potential solutions discussed by the Task Force.

Overview of 1332 State Innovation Waivers

1332 "State Innovation" Waivers allow states to pursue innovative strategies for providing state residents access to high- quality, affordable health insurance by waiving certain provisions of the ACA. These renewable five-year waivers may propose minor modifications to the ACA, or they can propose sweeping changes that could alter the way tax credits or subsidies are delivered in a state. Essentially, if Oklahoma were to pursue a 1332 Waiver, the state would redesign how the ACA is implemented in order to be more responsive to Oklahomans' needs.

1332 proposals may alter the following four ACA regulatory areas:

- ✓ Individual Mandate – States can modify or eliminate tax penalties.
- ✓ Employer Mandate – States can modify or eliminate penalties for large employers.
- ✓ Benefits and Subsidies – States can modify rules related to covered benefits and subsidies.
- ✓ Exchanges and Qualified Health Plans (QHPs) – States can modify or eliminate exchanges and QHPs as the means for determining subsidy eligibility and insurance enrollment.

While the waivers allow states flexibility with provisions of the ACA, the following criteria must be met within the State Innovation Waiver:

- ✓ Scope of Coverage – States must provide coverage to at least as many people as the ACA would provide coverage to without the waiver.
- ✓ Comprehensive Coverage – Coverage provided by states through the waiver must be at least as comprehensive as coverage offered though exchanges.
- ✓ Affordability of Coverage – Coverage must be as affordable as exchange coverage, and states must have cost sharing and out-of-pocket protections that are comparable.
- ✓ Federal Deficit – States' waivers must not increase the federal deficit.

Further sub-regulatory guidance provided by the Centers for Medicare and Medicaid Services (CMS) offered additional considerations for states exploring 1332 Waiver authority. There is uncertainty surrounding the future applicability of these federal, sub-regulatory guidance areas. Oklahoma's approach to developing solutions has been mindful of, yet not limited by these restrictions. These guidance areas included:

- ✓ States must assess the impact to vulnerable populations (elderly and low-income residents) across the waiver guardrails in their proposals.
- ✓ Waivers that require changes to the Federally Facilitated Marketplace (FFM) platform, such as the calculation of financial assistance or special enrollment periods, are not considered feasible at this time.
- ✓ Waivers that require changes to the Internal Revenue Service (IRS) administrative process, such as determining different premium tax credits for residents, are not considered feasible at this time.
- ✓ States will need to consider administrative costs to the federal government in their proposals.

Additionally, Oklahoma submitted a Sponsor's Choice 1115(a) Waiver, which would provide Medicaid funding for tribal premium assistance. This waiver would support the goals of the 1332 Waiver by promoting individual insurance coverage, and thus it may be beneficial to have these two waivers approved together and/or align provisions so that the waivers complement each other but do not duplicate efforts or hinder either waiver's goals. More specific considerations and recommendations are provided in the 1332 Waiver Tribal Considerations section of this paper.

Regardless of what changes occur at the federal level, a 1332 Waiver will remain as a mechanism to communicate state priorities and request federal regulatory flexibility. The proposals put forward by the Task Force attempt to combine and leverage all policy options in order to customize the best option for Oklahoma's unique needs.

Oklahoma's Health Landscape and the ACA

While Oklahoma has experienced a reduced number of uninsured following the implementation of the ACA, it remains high, and the state continues to struggle with high rates of chronic disease and lack of access to health coverage. Oklahomans are more likely to have chronic diseases and die at higher rates than most other states. Oklahoma had the fourth highest mortality rate in the nation in 2014 and a rate that was 23% higher than the national average.[2]

While Oklahoma's percentage of uninsured non-elderly adults has decreased over 4 percentage points since the implementation of the ACA (2013 to 2015), Oklahoma's decrease in the uninsured population is smaller than other comparable states. This phenomenon is likely due in large part to low enrollment in the FFM. In fact, Oklahoma only had 31% of its eligible population (those with incomes between 100-400% of the FPL) purchasing coverage through the FFM in 2016, relative to an average of 43% among other states similar to Oklahoma.[1]

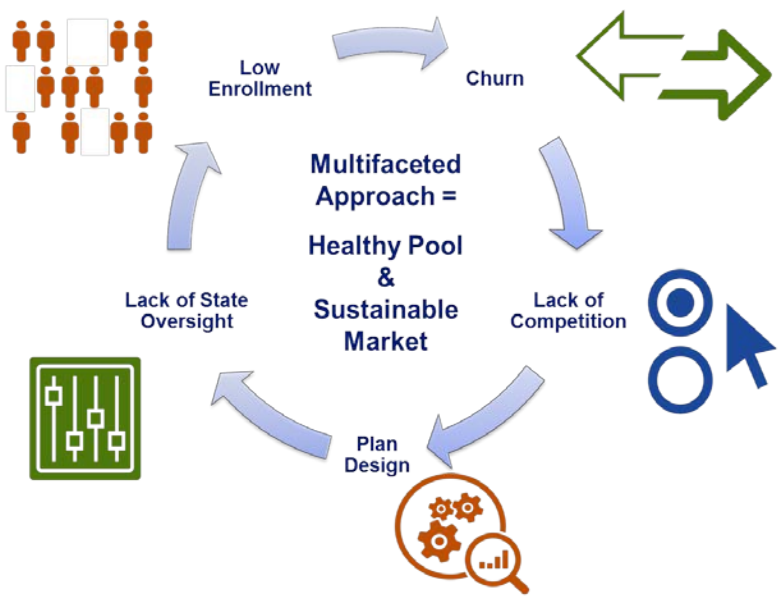
Premiums also continue to rise and options continue to dwindle, with only one carrier in Oklahoma offering plans on the FFM in 2017. Despite the current lack of competition on the exchange, policy

[2] Oklahoma Population Health Needs Assessment (2015). Pp. 10-11.

changes provide the opportunity for future competition. While still a relatively small market sector, the individual market (on and off-exchange) has grown by 22% since 2013 and has seen the largest growth across market sectors.[3] New state policy options may also provide opportunities to encourage plans to enter the market. These options include the movement of the Medicaid aged, blind, and disabled (ABD) populations into care coordination models per commercial managed care (as prescribed in House Bill 1566) and assessing the health of Medicaid populations to merge into the individual insurance market pool.

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

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



Images taken from: The Noun Project

The Task Force recognizes that all of these barriers must be addressed. Thus, a multifaceted approach that includes solutions to each one of these pain points is essential in order to fully address the challenges our state is facing to provide quality, affordable coverage to our residents.

Oklahoma's Challenges

Low Enrollment

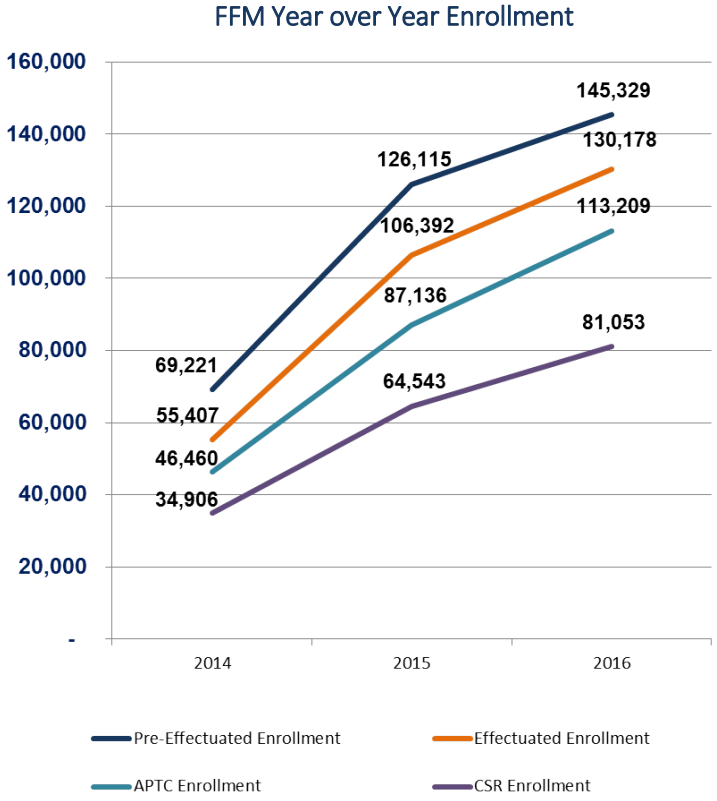
With only 31% of the eligible population enrolled through the FFM, Oklahoma's market is missing a significant number of individuals who can contribute to the health of the pool and mitigate risk for payers. The reasons for low enrollment need to be further explored, but the Task Force delineated three major reasons based on current available data, Task Force member experience, and anecdotal evidence:

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

1) certain state populations have been segmented from the market into the Medicaid program; 2) lack of perceived value by consumers; and 3) inadequacy of consumer supports.

The addition of uninsured and/or Children's Health Insurance Programs (CHIP) populations would increase the number of lives in the individual insurance market and diffuse risk for health plans. In 2015 over 836,000 people were enrolled in Medicaid/CHIP and nearly 544,000 individuals were uninsured.[3] Effectuated enrollment (enrollment in which a premium has been paid) on the FFM in that year represents less than 8% of these populations combined at 106,000.[4]

It should be noted that of the uninsured population, 39% have incomes under 100% of the FPL and are therefore currently ineligible for subsidies on the FFM. Also noteworthy is the significant proportion of the uninsured who are young adults ages 19-34 (44%),[3] indicating that there may be a significant number of healthier Oklahomans who are not enrolling in the FFM. And while nearly a quarter of the uninsured population has income over 250% of the FPL, only about 25,000 individuals in that income bracket are accessing coverage on the FFM.[5] Low participation of this group is presumably due in part to diminishing subsidies as income levels increase. See Appendix G for more detailed data about uninsured individuals and FFM enrollees by age and FPL, as well as year over year enrollment data.



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

In 2016, Oklahoma only had 31% of its eligible population purchasing coverage through the FFM, relative to an average of 43% among similar states.[1]

A possible reason that a significant number of eligible individuals are not enrolling in coverage is that they simply do not perceive it to be valuable to them – which may be especially true for young, healthy adults and those with minimal subsidies. While net premiums (post subsidy) have increased modestly since 2013, how consumers evaluate products also likely depends heavily on out-of-pocket (OOP) expenses (e.g., co-pays and deductibles). While over 60% of FFM enrollees received cost-sharing reductions (CSRs), they are limited to silver plans and may not be enough to encourage certain individuals to enroll.

[4] Centers for Medicare and Medicaid Services. (June 2015). March 31,2015 Effectuated Enrollment Snapshot: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html

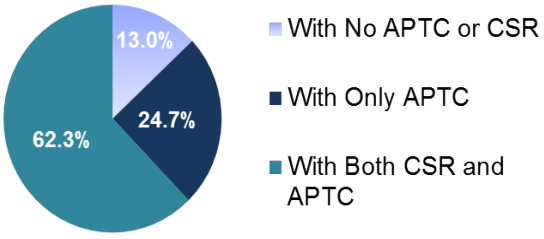
[5] Department of Health and Human Services (March 2016). Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: https://aspe.hhs.gov/sites/default/files/pdf/188026/MarketPlaceAddendumFinal2016.pdf

2015 Average Cost Sharing Summary			
	Bronze	Silver	Gold
Average Deductible (Single/Family)	$5,200/$11,400	$4,200/$9,300	$1,600/$4,400
Average OOP Max (Single/Family)	$6,400/$12,900	$6,000/$12,200	$3,800/$9,600

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

All 2016 bronze qualified health plans offered in Oklahoma had single medical OOP maximums in excess of $6,000, as well as nearly all of the 2016 silver plans. See Appendix G for more specific data.

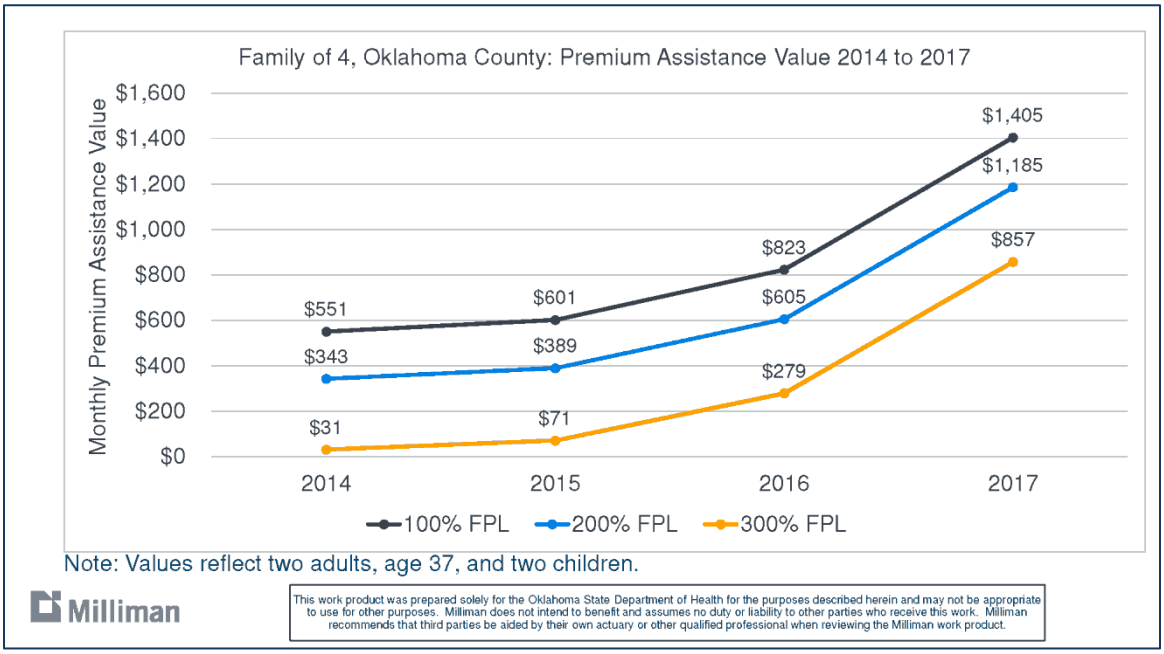
In 2016, 87% of Oklahomans who purchased health insurance on the FFM received an advanced premium tax credit (APTC), with an average monthly premium of $78 after APTC. The financial assistance individuals and families receive are likely effective mechanisms to encourage enrollment for many. However, APTCS may not be as effective for groups at the low (100-150% of FPL) and high (300-400% of FPL) income thresholds, as the subsidized costs may still be a significant portion of household income at the low end and the amount of APTC may be minimal at the high end. A family of three at 150% of the FPL earns just over $30,000 annually, while a family at 400% of the FPL earns over $80,000 per year. The proportion of income used for even highly subsidized coverage for a family earning $30,000 may still present a barrier to affordability, while minimal subsidies for a family earning $80,000 may not encourage enrollment. As a result, the state is considering changes to the distribution and calculation of subsidies.



	2014	2015	2016
Average Monthly Premium (all Metal Tiers)	$277	$295	$376
Average Monthly APTC	$212	$206	$298
Average Monthly Premium after APTC	$65	$89	$78

Source: CMS Effectuated Enrollment Snapshots

Further, APTC amounts are based on the income of the consumer and the premium cost, which is benchmarked on the second lowest-cost silver plan. This method means that premium assistance amounts rise with premium costs. While the net cost to the consumer may remain relatively stable, the cost of premiums and corresponding federal financial assistance has risen dramatically and is unsustainable in the long term.



Source: Milliman. (2017). Oklahoma Federally Facilitated Marketplace Profile and Insurance Market Population Movement: Preliminary Results.

Another potential barrier is the system's complexity and lack of consumer supports that effectively equip consumers to purchase products that make sense for their circumstances. In addition to needing to understand the complexities of health insurance (co-pays, co-insurance, deductibles, and metal tiers), variations in plan design and available benefits create additional differing factors. There may be significant differences in what covered benefits the plans include or exclude in the deductible. This level of complexity may discourage some individuals from enrolling and implies that simplified design and improved education and awareness of covered benefits could increase enrollment. While the CMS has instituted the labeling of "simple choice" plans that have a uniform set of features, none of the plans being offered in Oklahoma in 2017 meet those criteria.

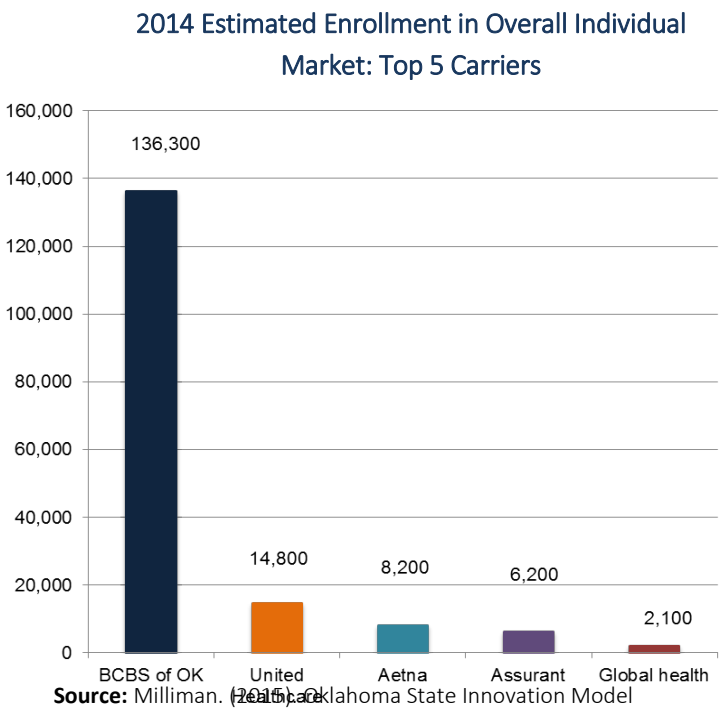
Churn

In addition to low enrollment, there are a number of individuals who enroll but do not maintain coverage throughout the year. This churn negatively impacts the individual insurance market and health plans, as individuals presumably pay premiums for a short period of time while they utilize services and then terminate their coverage. Others may simply lose coverage due to lack of payment, as current regulations allow a 90-day grace period for premium payment. In 2016, 15,000 Oklahomans – 10% of enrollees – selected a plan but did not pay their premiums and lost FFM coverage.[6]

Lack of Competition and Limited Consumer Choice

Blue Cross Blue Shield Oklahoma is the only carrier offering plans in 2017 and has had the vast majority of individual market enrollees since the FFM was implemented in 2014.

[6] Centers for Medicare and Medicaid Services. (June 2016). March 31,2016 Effectuated Enrollment Snapshot: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html



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

Payer representatives on the Task Force have indicated a number of reasons for declining health plan participation on the FFM, including higher than expected service utilization, low enrollment, inadequate risk protection mechanisms, and administrative burden. As to be expected with a new pool of insured lives, unknown characteristics create unpredictable costs. For instance, a portion of FFM enrollees likely have not had coverage previously and thus utilize more services than the average person with similar rating characteristics. In fact, one payer in Oklahoma estimated that utilization of FFM enrollees is four to five times that of off-exchange individual plans.

Plan Design

Modifications in plan design could produce a market that emphasizes cost-effectiveness and improved health outcomes. While this is a challenge not only of plan offerings on the FFM but with our health care system at large, the individual market is fertile ground for implementing and evaluating mechanisms that support the Triple Aim of reduced costs, higher quality care, and improved health outcomes. State flexibility to determine Essential Health Benefits (EHBs) based upon state-specific needs (waiving EHBs as they are currently prescribed in federal law) alongside emphasis being placed on the actuarial value of such benefits would reframe issuer approaches to designing their plans.

Lack of State Oversight

The state currently assumes little regulatory control over the FFM, which limits our state's ability to design innovative, responsive strategies to stabilize the individual market. State entities could take a more active role in the review and approval of plan rates, mandated benefits, and the distribution and calculation of subsidies. Should the state assume more control of the plan certification process, it could incentivize or discourage certain policies while also establishing the necessary infrastructure for this oversight.

State and Federal Political Environment

The political landscape in Oklahoma, coupled with the ramifications of the implementation of the ACA, created a favorable environment for the exploration of a 1332 Waiver as authorized with the passage of SB 1386. Through the legislative process, the bill received only two no votes showing strong, bipartisan support and an acknowledgment of a failing system for Oklahomans to access health insurance. While there wasn't a specifically defined solution at the time of the bill's passage, it was clear that there was consensus on the existence of problems that need to be addressed. The state has attempted to harness that consensus as we moved forward in conversations to develop solutions. This concept paper is

intended to continue to facilitate conversations with Oklahoma elected officials and the new presidential administration as we work toward a more detailed 1332 Waiver.

As the transition to a new federal administration continues, presidential priorities and potential legislative intent are becoming clearer. The historical policy positions of Secretary of Health and Human Services Tom Price and CMS Administrator designee Seema Verma provide insight into the new administration's perspective. Proposals such as Paul Ryan's A Better Way and Tom Price's Empowering Patient's First Act, provide a glimpse into potential federal healthcare priorities. Common themes in these proposals include retaining insurance market reforms that have been proven effective and desirable, eliminating health insurance mandates, changing the methods for the determination and use of financial subsidies, and establishing re-imagined high risk pool programs. While Oklahoma developed its proposed solutions independently and prior to these federal administration announcements, similarities can be seen between these proposals

While the plans currently under discussion vary in their elements, a number of ideas are common to many of the proposals:

- Eliminate income as an eligibility factor for tax credits, and eliminate or simplify age as a factor.
- Encourage the use of Health Savings Accounts by increasing contribution limits and expanding how people can use them.
- Alter age rating by expanding to 5:1 or repealing federal limits entirely.
- In lieu of an individual coverage mandate, strengthen requirements for special enrollment periods and tie continuous coverage to guaranteed issue protections.

In addition, there are some parallels in a recently leaked House Republican ACA repeal bill, including tying tax credits factoring in age (but not income), and increasing the age rating band from 3:1 to 5:1. The bill was still a discussion draft as of the end of February and reports indicate there is not universal agreement amongst Republican leadership about all of the elements. Oklahoma will continue to analyze all viable federal proposals with an eye toward whether they present barriers or opportunities to our approach and adjust accordingly.

State Efforts to Date

Task Force

The Task Force includes representation from both public and private entities, including commercial insurance carriers, providers, businesses, consumer advocates, and tribal nations and is supported by representatives from multiple state agencies. The group has met monthly since August 2016 to review available data and discuss major pain points related to Oklahoma's insurance market. This data review included FFM and insurance enrollment trends and demographics, FFM subsidies and premium costs, uncompensated care costs, and prevalence of chronic conditions. Additionally, members provided data and information through surveys given to tribes, providers, and payers. Using data-informed decision making, the Task Force cast a broad net of gathering solutions that are believed to address each pain point, the extent to which is largely undetermined pending actuarial review and analysis underway.

Once this information was gathered and discussed in detail, a list of 62 possible solutions for each pain point was developed and presented during the November meeting. Task Force members, agency representatives, and data workgroup members were then provided with a survey to rate each proposed solution on a 0-3 scale, with 0 indicating strong opposition and 3 indicating strong approval. Nineteen

responses were received, including 11 of 18 Task Force members. Task Force responses included representation from each sector, including private payers, tribal nations, providers, businesses, brokers, consumer advocacy groups, and self-insured businesses. Average scores and rankings of the highest-rated solutions were provided at the December 2016 Task Force meeting. These solutions were then discussed in the context of pain points, ideology, and feasibility. The solution rankings, together with this discussion, form the basis of the recommendations provided in this document.

An initial draft of the concept paper was released to the public on the Oklahoma State Department of Health (OSDH) website on December 30, 2016. The comment period was open for one month, closing on January 31, 2017. Overall, written comments were received from 10 commenters. Of the commenters seven were on substance; three were editorial only. Comments were received from several representative groups including insurer, insurer association, Tribal Nation, consultant, provider, and large employer. The substantive topic areas addressed included:

- Health Plan Elements
- Affordability/Subsidies
- Eligibility and Enrollment Provisions
- Commercial Market
- Health Plan Risk Management
- American Indian/Alaska Native (AI/AN) Issues
- State Role
- Employer Issues

The following comments regarded Health 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)

The following comments regarded Health Plan Elements: Premium Caps:

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

The following comments regarded the Commercial Market:

- Oppose requirement for Medicaid managed care organizations (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)

The following comments regarded 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)

The following comments regarded 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)

The comments received have led to revisions within the concept paper, which are reflected in this final version. Moving forward, further discussion and input is expected through the Task Force and stakeholders as developments by the federal administration, analysis on the impact of recommendations as well as refinement to approaches become known.

Task Force meeting documents, including the full list of proposed solutions, are available through the OSDH website at:
https://ok.gov/health/Organization/Center_for_Health_Innovation_and_Effectiveness/1332_State_Innovation_Waiver_/

Data Workgroups

In addition to the Task Force, four data workgroups provided information to help identify barriers and guide the development of recommendations from diverse perspectives: businesses, consumers, health plans and providers. Data workgroup members provided the Task Force with data from the National Association of Health Underwriters Employer Survey, consumer subsidy and penalty data, tribal subsidy program offerings, plan information related to FFM enrollment and premium payment and results from an informal survey of various providers in Oklahoma regarding ability to collect out-of-pocket expenses and health challenges of patients. This information ensured that factors from each of these groups were considered as solutions were proposed and prioritized.

Additionally, data workgroups recognized the need for more formalized survey data to answer questions that arose through the course of their work. The workgroups requested specific efforts to collect data through business and consumer surveys and focus groups, as well as a data collection tool for use with health plans. The Business and Consumer Data Workgroups revisited the Milliman Employee Health and Wellness Survey,[7] released in 2014, for data on Oklahoma businesses' thoughts and perceptions on their ability to provide health insurance coverage to their employees.

Surveys and Focus Groups

The OSDH has engaged Visual Image and Evolve as contractors to gather information from businesses and consumers. Consumer surveys and focus groups have been conducted to better understand the low FFM enrollment in Oklahoma, consumers' perspectives on the value of coverage, and their purchasing experience. Business surveys and focus groups gathered thoughts from primarily small businesses on insurance costs, coverage options for employees, and wellness programs to gain a more comprehensive view of barriers employers are facing to providing coverage.

[7] Milliman. (2014). The State of Oklahoma Business Health and Wellness Survey: https://www.ok.gov/health2/documents/OOC-OSDH%20Business%20Health%20and%20Wellness%20Survey%20Report%202014.pdf

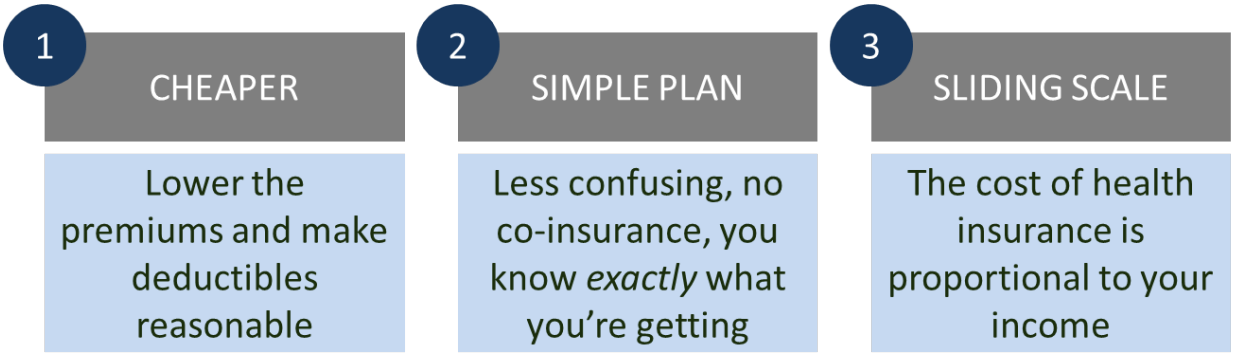
Consumer Research

Consumer focus groups and telephone surveys gathered information from four groups of Oklahomans: 1) the uninsured, 2) individuals who visited healthcare.gov but did not purchase a plan, 3) individuals who visited healthcare.gov and purchased a plan, and 4) individuals with private insurance outside of the FFM. Fieldwork occurred between December 2016 and January 2017 and included individuals from both rural and urban parts of the state. In total, 16 focus groups and 40 in-depth interviews were conducted and included 161 participants.

Consumer focus groups and telephone surveys[8] have revealed the following findings:

- ✓ Health insurance is expensive. The biggest barrier to obtaining health insurance is affordability. Without a subsidy or employer contribution, insurance is largely unobtainable.
- ✓ 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. When asked to name a monthly premium price that was realistic, fair, and affordable, responses indicated the following:
  - $50-$150 for uninsured individuals
  - $150-200 for individuals who visited or purchased a plan on healthcare.gov
  - $200-$400 for individuals with private insurance
- ✓ Health insurance is confusing. Oklahomans are not certain how health insurance works, and thus sign up and pay for health insurance knowing that they do not entirely understand what it covers or what they are entitled to.
- ✓ In particular, Oklahomans do not understand out-of-pocket expenses and co-insurance. Deductible and OOP are used interchangeably, and 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.
- ✓ Scenario-based examples can better explain plans. Insurance plans are not communicated in clear language, so applying different plans to a selection of scenarios can help explain the actual cost implications of a plan.

In sum, Oklahoma consumers indicated that the following is necessary to make sure every person in Oklahoma has health insurance:



[8] Evolve. (2017). OSDH Consumer Surveys: Draft Results.

Business Research

Data was obtained from business decision makers via online and in-depth telephone surveys. Respondents were recruited with assistance from the Task Force. Questions for the online survey are similar to those asked in the 2014 Employee Health and Wellness Survey. To date, 291 online interviews and 65 in-depth interviews have been completed, with more participation anticipated.

Business online and telephone surveys[9] thus far have revealed the following findings:

- ✓ Being able to offer health insurance plays a major role in employee retention and acquisition.
- ✓ Brokers play an extremely important role in advising Oklahoma businesses of their health insurance options.
- ✓ Insure Oklahoma is seen as a vital resource in making healthcare affordable to employees.
- ✓ 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.
- ✓ 92% of employers reported increases to the cost of health insurance at their last renewal.
- ✓ Increases in healthcare coverage costs have impacted businesses in a number of ways, including:
  - Less profit available for general business growth
  - Holding off on employee salary increases
  - Increased medical plan deductibles
  - Increased prices
  - Increasing employees' share of premiums
  - Delaying purchases of new equipment
  - Holding off on implementing growth strategies

Engagement of Consultants and Experts

Early on, Oklahoma recognized the need to engage experts in the exploration of solutions to stabilize and grow our individual insurance market. Information had already been gathered on Oklahoma's market through the previous efforts of the Oklahoma State Innovation Model initiative. A comprehensive market analysis (referenced in the Background section of this paper) was released in 2015 by Milliman. This analysis provided data on enrollment trends, market characteristics, and insurance carrier performance to inform state policymakers. An update to this market analysis is underway, again using the experience and expertise of Milliman. Initial, limited results were provided by Milliman to the Task Force in February of 2017, with full report on the market analysis to be delivered in June of 2017.

Acknowledging that Oklahoma-specific individual plan data are critical to the impact assessment of each pain point, Milliman is also being utilized to develop an insurer survey data collection tool and analysis. The insurer survey will be utilized to gather data on premiums, enrollment, and claims experience in the individual market – on and off the FFM. This insurer data is anticipated to be collected and analyzed by

[9] Evolve. (2017). OSDH Business Surveys: Draft Results.

Milliman in the Spring of 2017 to inform the impact analysis of potential changes to Oklahoma's individual insurance market. Oklahoma is also utilizing a contractor, Health Management Associates (HMA) and Leavitt Partners (LP), to provide expert review, conduct analysis, and assist Oklahoma in working with federal partners as the state looks to submit a 1332 Waiver or other mechanism to implement changes. In June of 2017 HMA/LP will be providing a final report on the 1332 Waiver exploration and development activities to date. If the state chooses to pursue and write a 1332 Waiver, an actuary contractor will be procured to provide the necessary analysis. The actuarial procurement process is expected to begin in March of 2017.

Recommended Strategies

While the future landscape of the ACA and health care is uncertain at both the state and federal level, what is clear is that Oklahoma needs to make significant changes to the way coverage is regulated and to the processes through which consumers access coverage. It is the position of the Task Force that minor changes to the existing infrastructure will not produce a stable market or help our state achieve the Triple Aim. Further, the Task Force acknowledges that health care and health coverage are best provided and regulated locally. States should be given latitude to design, implement, and evaluate methods that meet residents' needs and are responsive to the environment of the state. Thus, the recommendations that follow include solutions that are actionable at the state level as well as those that require federal authority.

The nine broad recommended strategies are as follows:

- ✓ Increased Awareness to ensure individuals are personally responsible for and aware of the coverage options available to them, engaged in their coverage decisions, and understand what their coverage means
- ✓ Improved Plan Design that supports innovative, flexible, and comprehensive coverage and efficient delivery of services
- ✓ State-Controlled Plan Regulation that holds health plans accountable to achieve improved health outcomes by moving them toward value-based payment structures and care coordination while promoting flexibility and reducing administrative burden
- ✓ Improved Risk Management to provide adequate financial safeguards to plans and promote plan participation
- ✓ Modified Enrollment Procedures to promote timely enrollment and premium payment, as well as continuity of coverage and longevity with a plan, to achieve a more stable pool of enrollees
- ✓ Eligibility Changes to ensure vulnerable and gap populations can access coverage that is affordable to them
- ✓ Modified Subsidy Processes to more effectively deploy federal dollars by changing eligibility rules and subsidy calculations while creating a streamlined, simple process
- ✓ State-Owned Platform that will remove Oklahoma from the FFM and leverage the existing state-designed, subsidy-eligibility determination system used for Insure Oklahoma, with regulations and processes controlled by the state

- ✓ State-Designed HSA-like Accounts coupled with simple options to empower consumers to use dollars in a way that makes sense for their situation

In order to achieve a modernized market, Oklahoma will need a sequential, phased approach over time that starts with the state identifying innovative approaches to address health care needs, continues with changes at the federal level that move our state toward a redesigned individual insurance market, and ends with a state-owned, federally-supported platform that allows Oklahoma to calibrate its market through state-based policies and procedures. This oversight at the state level will allow the market to evolve with changes in the environment and target specific outcomes related to bending the cost curve of health care, improving the quality of care, and improving population health.

The Task Force also acknowledges that not only should the state have oversight on how to best provide its citizens health care and health coverage, but so should tribal nations. Strategies offered within this concept paper and subsequent waiver proposals do not support replacing or removing any portion of the Indian Health Care Improvement Act (IHCIA). Specific notation for each proposed solution that may have an impact on American Indian health care has been solicited and is provided in the 1332 Waiver Tribal Considerations section of this paper.

The state will likely pursue sequential 1332 Waivers and/or amendments to an initial waiver to implement the changes over time. It is anticipated that an initial waiver that would allow the state to assume more responsibility over rate review and plan qualification would be submitted in July of 2017 at the earliest, with implementation in 2018.

Individual Insurance Market Strategies Roadmap

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

Advance State Innovation

The initial phase of implementation will be for planning and authorization, whereby Oklahoma can keep ACA policies that work in place, accommodate changes to mandates, improve outreach, and work with health plans to improve service delivery and access.

Oklahoma believes that good policies should remain intact. These policies should retain inclusion of preventive services, guaranteed issue, and dependent coverage up to age 26. Additionally, the state supports the preservation of the IHCIA and its permanency, as well as the preservation of provisions within the ACA separate from the IHCIA that have significant implications for the Indian health system. As the federal government considers whether individual and employer mandates will remain in place, Oklahoma will continue to work toward designing mechanisms to improve the health of the insurance pool. It is unclear to what extent the individual mandates actually encouraged enrollment, as it has remained low in Oklahoma. Therefore, regardless of the status of mandates the state's proposed strategies are aimed at increasing the viability of the health insurance pool by addressing chronically low enrollment on the individual insurance market.

As mentioned previously and supported with to recent Oklahoma focus group and survey results from consumers, the biggest barrier to obtaining health insurance is affordability. The next barrier identified is that health insurance is often confusing to Oklahomans. By addressing these barriers through changes to plan design, greater state oversight and control of plan regulation, as well as more streamlined financial assistance mechanisms for the most vulnerable consumers, Oklahoma expects the need for mandates to be eclipsed by these somewhat larger, more comprehensive changes. To implement such changes initially, Oklahoma will request access to federal revenues collected as a result of the mandates. Then, as the market stabilizes and enrollment increases, reliance on such revenues is anticipated to decrease, the extent to which will be analyzed further within anticipated actuarial work.

During the planning and authorization phase, it will be vital for the state to engage insurance brokers, agents, and health plans, as well as community-based resources and community health centers, as these entities will be essential to assist consumers in accessing and understanding their coverage options – particularly for previously uninsured populations. In the recent focus group and survey efforts of Oklahoma businesses, they indicated that brokers/agents played an extremely important role providing advice on health insurance options. Moving forward, Oklahoma's plan recognizes the importance of both brokers and plans themselves (through direct marketing and enrollment assistance specifically) to develop relationships with a newly covered population.

The state can also take measures to encourage plans to improve efficiency, access, and participation through plan design elements. Particularly in a rural state with provider shortages, telehealth as a covered plan service when appropriate is one avenue by which plans can increase access to quality health care.

State Regulation and Federal Flexibility

The foundational element to a modernized Oklahoma market is to establish state-based regulatory policies and processes on this segment of the market. If given flexibility, the Oklahoma Insurance Department will assume control of rate review and the rules surrounding the qualification of participating health plans, which will allow the state to design mechanisms to advance the health system through plan-based strategies while implementing appropriate guardrails for insurers. Oklahoma wants to support insurers to be successful in the individual insurance market while having the ability to require certain

elements that shift the health care system in the right direction. The Task Force has recommended the state should require or provide incentives for the following:

✓ Value-Based Payments

Requiring plans to have a minimum amount of value-based payments will support the state's health improvement goal of having 80% of payments to providers be value-based by 2020. This requirement will increase plan and provider accountability and improve management of costly conditions, ultimately improving health outcomes and decreasing costs. Value-based purchasing at its simplest is a strategy to measure, report, and reward excellence in health care delivery. As the state continues to advance toward value-based payments, plans are recognized for their role to improve Oklahoman's health rather than retaining the status quo.

✓ Quality Measures Related to Chronic Disease

The Oklahoma State Innovation Model (OSIM)[10] identified diabetes, hypertension, obesity, behavioral health, and tobacco use as five key areas where quality measures are being implemented in order for Oklahoma to improve outcomes in those areas. Oklahoma continues to experience high prevalence in all of these areas, which impedes our state's ability to bend the health care cost curve. Quality measures tied to value-based payments can effectively move our state toward the Triple Aim.

To support performance measurement related to quality measures, the state will develop and pursue avenues to obtain and analyze patient-level data from health plans. Led by Oklahoma's Health and Human Services Cabinet, all cabinet agencies alongside the Employee Group Insurance Division and the Oklahoma Insurance Department are working to gather existing measures currently reported for a variety of public programs that are of mutual benefit to the OSIM health areas listed above. This initial list of approximately 12 measures defined by the National Quality Forum are expected to be finalized in the Spring of 2017 and will provide a baseline of standardized, reportable quality measures among all market plans. The state intends to use these measures to determine improvements in individual insurance market population health over time, and as a way to identify best practices.

✓ Case Management and Care Coordination

Comprehensive health insurance coverage should not only provide payment for acute medical needs, but should also be expected to better the health of covered populations by effectively managing care and reducing preventable events and conditions. Case management and care coordination are effective mechanisms to achieve these objectives, which are consistent with the Oklahoma Health Improvement Plan (OHIP) 2020 goal of reducing the rate of potentially preventable hospitalizations by 20%.[11] Oklahoma will support plan innovation to meet these goals rather than mandates. The state also supports mechanisms to provide consumers with incentives for participating in case management/care coordination. Additionally, case management/care coordination activities and quality measures for chronic disease will be aligned with value-based payments.

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[10] Oklahoma State Health System Innovation Plan. (2016). https://www.ok.gov/health2/documents/Oklahoma%20State%20Health%20System%20Innovation%20Plan%20(SHSIP)%20Final%20Draft.pdf

[11] Oklahoma Health Improvement Plan (2015). http://ohip2020.com/

✓ Standard Minimum Actuarial Value Across All Traditional Health Plan Offerings

In an effort to improve ease of consumer understanding, actuarial value (AV) regulations will be simplified by establishing a standard minimum AV floor of 80% for all traditional plans. Traditional plans are defined as those plans that do not otherwise meet requirements to be a high-deductible health plan (i.e., annual, individual deductible of $1,300 per IRS). This minimum AV will be coupled with easy-to-understand, fixed-cost descriptions of benefits. These requirements will provide consumer protections, increasing their understanding of health coverage and perhaps the value of health care coverage to them. Plans may be given a transitional period (e.g., minimum 70% AV for the first year) to implement this change. This will not preclude the option of qualifying alternative plans, like high-deductible plans with an AV floor lower than 80%, coupled with a consumer health account on the individual insurance market. The requirement for plans to provide easy-to-understand, fixed-cost descriptions of benefits will also apply to high-deductible plans.

The Oklahoma Insurance Department will have the ability to provide incentives and/or assess penalties on plans for failure to comply with these requirements and to validate AV calculations to ensure that consumers' options are reliable and high-quality. Examples of such incentives could include implementing conditions for plan approval, and implementing corrective action plans and penalties (financial, administrative, etc.) through the Oklahoma Insurance Department.

Plans will also be encouraged to offer optional value-added benefits like dental and vision as affordable add-ons to medical coverage as a way to increase the value of coverage for individuals and encourage enrollment.

Similar to the Medicare Advantage incentive options, the state will identify areas that align payment with quality care measures. Medicare Advantage utilizes Star ratings to evaluate health plan performance based on measures in five broad categories: 1) outcomes, 2) intermediate outcomes, 3) patient experience, 4) access, and 5) process. These measures include management of chronic conditions, such as diabetes and hypertension, as well as overall care coordination and management.[12] Oklahoma can use this model as a basis for its quality measures, which would achieve alignment of performance measures for providers. The state may also pursue consumer-side rating systems (like the Medicare Advantage Star Rating System) in which highest-rated plans are listed first, ratings are viewable by consumers, and consumers are notified if their current plan is rated low or has a decline in rating allowing a different plan selection to be made (i.e., the consumer may move coverage to a higher-rated plan).

To support plans in meeting these requirements and in finding success in the individual market, the state will provide the following:

✓ Reduced Administrative Burden

Based on feedback from health plans, administrative requirements related to reporting, risk mitigation, eligibility, and enrollment will be eliminated, modified, and/or streamlined.

✓ Greater Variance to the Rating Windows for Age

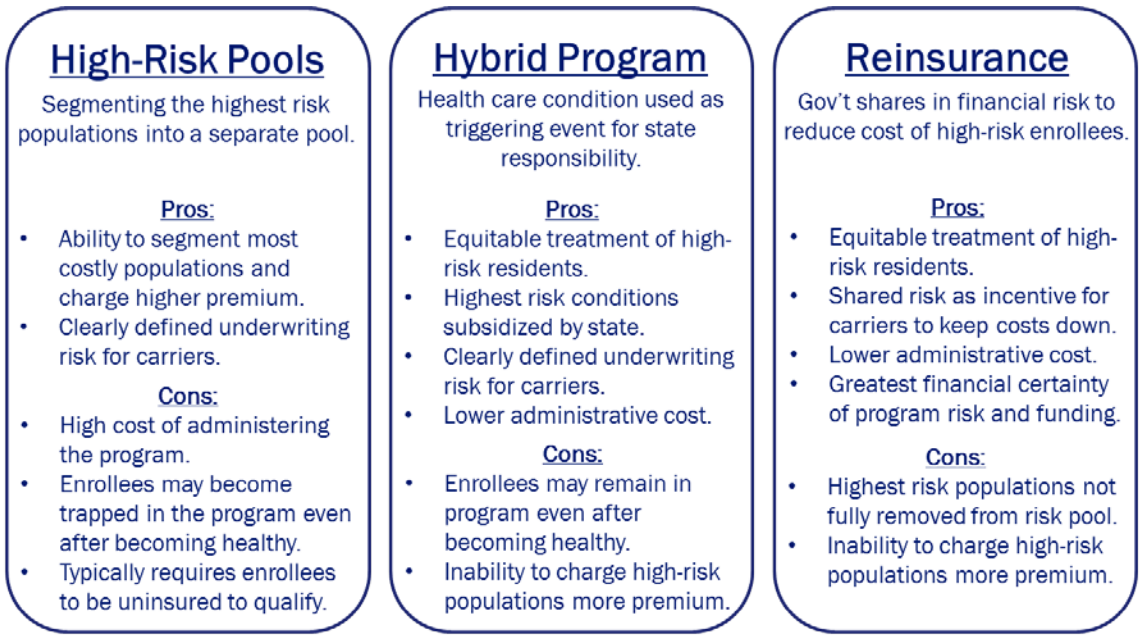
To encourage greater participation among young, healthy individuals age rating variance will be increased. It is apparent that young Oklahomans are disproportionately sensitive to the high cost

[12] Centers for Medicare and Medicaid Services. (2016). 2017 Star Ratings: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-12.html

of insurance, but it is very important to include them in the market because of their ability to cross-subsidize and offset the cost of higher-cost populations. The age rating ratio will be analyzed and will not exceed a 5:1 ratio. This flexibility will likely result in lower premiums for younger individuals and will be coupled with subsidy calculations that include age to assist older individuals with paying premiums, as described in the next section.

✓ Exploration of Reinsurance and High Risk Pools

Oklahoma will also explore a federally-funded, state-managed high-risk pool, reinsurance program, or hybrid as an additional avenue to mitigate risk for health plans. As described in the figure below, there are advantages and disadvantages to each option, which would need to be evaluated by the state to determine the best model to employ.



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

In the past, high-risk pools have been an effective risk mitigation method in Oklahoma. Due to its inclusion in numerous federal ACA replacement plans, the state is encouraged that federally-funded high-risk pools may return. With supportive federal funding, the state will evaluate the re-establishment of a high-risk pool for a new purpose of providing temporary coverage to two primary groups: (1) consumers who fail to join during an initial open enrollment period and thereby experience higher premiums as a result of missing the discount period provided by continuous coverage provisions; and (2) for enrollees with exceptionally high cost conditions and utilization.

The state will determine the optimal framework and specific eligibility criteria for inclusion in a high-risk pool. Various approaches could include: 1) a traditional high-risk pool, in which enrollees are moved into a separately-run insurance pool managed by the state; 2) a high-risk pool reimbursement program, in which enrollees remain in the commercial insurance pool and a portion of claims above a specific threshold is reimbursed by the high-risk pool; or 3) a condition-based high-risk pool, in which enrollees remain in the commercial insurance pool and a portion of claims for a given set of conditions is reimbursed by the high-risk pool.

Each of these arrangements has advantages and drawbacks and should be evaluated along a spectrum instead of as distinct options for a state. For instance, a traditional high-risk pool would likely carry the highest administrative cost to the state, but would also give the greatest underwriting confidence to insurance carriers. Also, separating the risk pool and treating high-risk enrollees differently may prove unpopular to some stakeholders given that a consolidated pool exists today and shared risk between the state and carriers may provide additional incentive for carriers to keep costs low.

✓ Tighter Restrictions on Premium Payment Grace Periods and Enrollment Changes

Current ACA regulations allow up to a 90-day premium grace period, which means plans may cover an individual during that time and never receive payment. Oklahoma proposes that this time period be reduced to 30 days and that premium payment should be required before an individual re-enrolls.

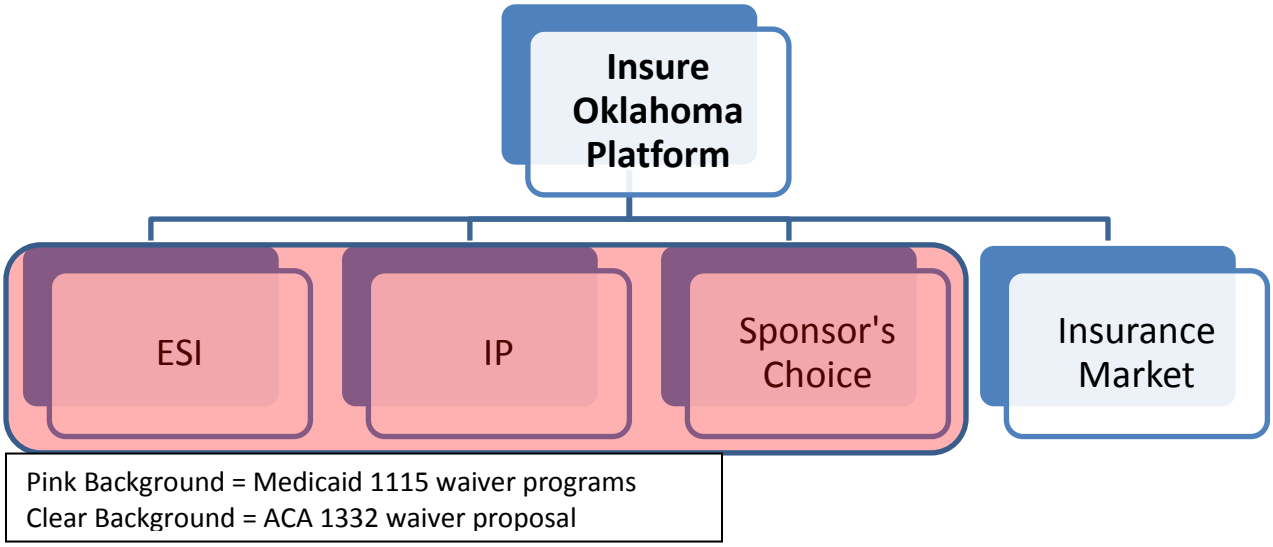
To promote timely enrollment, special enrollment requests will require more robust validation. For example, special enrollment requests for a Medicaid denial should provide validation that the applicant could reasonably expect that he or she might be eligible for Medicaid. The state will also have the ability to make changes to the open enrollment periods that support state infrastructure and prompt enrollment among consumers, such as coinciding open enrollment periods with consumers' birthdate. Specific options are continuing to be explored by the state.

Oklahoma's Modernized Market

Once the state becomes firmly established in its role in regulating plan design, plan certification, and rate review, an efficient and responsive eligibility platform can be developed. With federal support, the state will leverage the current capabilities of the Insure Oklahoma platform to modify the technology necessary to support state control of eligibility for financial assistance via subsidies and enrollment into consumer health accounts on the individual market.

The Insure Oklahoma system will be used as a technology platform that can be modified to determine a person's eligibility, not only for Medicaid and traditional Employer Sponsored Insurance (ESI) and Individual Plan (IP) Insure Oklahoma programs, but also for subsidies to purchase a qualified health plan through the individual insurance market. The Insure Oklahoma platform will also be explored as a way for Oklahoma consumers who qualify for coverage through the individual insurance market to enroll in and manage a consumer health account. Should the Sponsor's Choice Waiver be approved by CMS, the platform will also be used to determine eligibility for premium assistance through that program.

The state envisions assuming eligibility and enrollment responsibilities and functions currently provided and maintained by the FFM, and as these responsibilities are redirected, so must be federal resources currently devoted to these efforts. In order for the state to make this transition, federal investments already made in the state will need to be leveraged to create a more efficient, streamlined system that capitalizes on federal financial support to consumers while allowing the state to develop creative strategies.



This state-owned, subsidy-leveraging technology built upon the Insure Oklahoma infrastructure will allow the state to innovate and evolve by designing, implementing, and evaluating methods to increase the number of covered lives while creating a sustainable health system. Specifically, the state will have full authority to make decisions related to:

- ✓ APTC and CSR Eligibility and Distribution

  Nearly 40% of Oklahoma's uninsured population have incomes under 100% of the FPL and are therefore currently ineligible for subsidies on the FFM; conversely, there is likely a subset of eligible enrollees with higher incomes for which the minimal subsidy amount available to them makes a limited impact on premium costs. Notwithstanding federal proposals to reform Medicaid that may alter this position, Oklahoma can repurpose federal funds for APTC and CSR to include gap populations while maintaining subsidies available to those under 300% FPL not otherwise eligible for public programs. The state aims to utilize federal funds that currently are being distributed to individuals at 100-400% FPL to those with 0-300% FPL while changing the way subsidies are calculated for all recipients. The state also assumes that federal funds will be available for eligible but not enrolled populations; that is, funds for eligible individuals not currently accessing APTC and CSR will be made available to the state.

  Subsidy eligibility will be based on the amount of funding available, populations served, and projected impact on enrollment decisions. Oklahoma will work with CMS to ensure that eligibility changes will work alongside but not replace current public programs, including Medicaid.

  Separately, eligibility for APTCs should reconsider current exclusions under the ACA. For instance, in current law, if insurance is offered by the employer, affordability is based on only the employee premium cost – not the cost for insurance for the employee's spouse and/or children. The employee-only cost is often less that the 9.5% threshold; however, the costs for the family is significantly higher, often resulting in a decision to decline coverage. In order to facilitate coverage, families should be eligible for APTC in these instances.

✓ Subsidy Calculations

As premium prices will have a greater variance based on age, subsidy calculations will be standardized by both age and income to ensure that there is equitable access to affordable coverage. Oklahoma recognizes that young, healthy consumers are more sensitive to the high cost of coverage and aims to reduce this cost while also providing subsidies to low-income consumers. The state will also be mindful of the affordability of coverage for older enrollees. Commensurate with changes to the age-bands, the calculation of premium subsidies for older consumers will also need to maintain a reasonable threshold of affordability. This proposed process differs from the current ACA calculations, which are based on income and premium cost.

✓ Consumer Health Accounts

To empower consumers to make the best decisions for themselves and their families, Oklahoma will establish consumer health accounts similar to health savings accounts (HSAs). These HSA-like accounts will be populated by federal subsidy dollars and automatically paid to health plans. This will put the power back in the hands of consumers to use the funds to purchase the plan of their choice and use any leftover dollars for qualified health care expenses. In order for a consumer to enroll into an account, the person must first select and purchase qualified health plan coverage.

The state will also explore the use of automatic enrollment to promote efficiency across systems. For example, if an Oklahoma consumer applied for Medicaid but was determined ineligible, he/she could automatically be enrolled in the lowest-cost plan on the individual market.

As the development of Oklahoma's modernized individual insurance market continues alongside a sequential waiver approach, the implementation of consumer health accounts is anticipated at earliest for plan year 2019, occurring in conjunction with proposed changes to a state-administered eligibility and enrollment platform, and away from the current, FFM platform. Additional information is needed on the administrative organization and expense to the state to operate and manage such consumer health accounts. Several operational models exist among other states – use of a third party administrator contracted to do business with the state; building upon in-state personnel and skillsets; or a combination of models. As development proceeds the state will look to information from consultants and Task Force/data workgroup members with experience overseeing consumer health accounts.

✓ Plan Options

In lieu of metal tiered plans, plan options will be simplified to two standardized plan options: 1) a comprehensive, traditional health plan with conventional cost-sharing and robust insurance coverage or 2) a high-deductible plan paired with a consumer health account. Consumers can choose to use their health accounts to purchase more comprehensive coverage or opt for lesser coverage and more funds for first-dollar, out-of-pocket expenses available through their health account.

✓ Core Health Benefits

Oklahoma plans to re-evaluate and reduce the Essential Health Benefits package that has been mandated by the ACA. The state will establish a framework for revisiting mandatory benefit requirements established under the ACA to ensure that the standards in place are optimal and supported by evidence-based medicine. For more specific information on current ACA-mandated Essential Health Benefits and state-mandated benefits, see Appendix H.

✓ Movement of Populations to the Individual Market

When appropriate, the state can move certain populations from other state programs to the individual market. For instance, the future of the Children's Health Insurance Program (CHIP) for states has been uncertain due to the lack of federal decision and clarity regarding the reauthorization of the program. Oklahoma faces implications if the CHIP program is not federally reauthorized. The current federal funding is set to expire later this year (2017) if Congress takes no action. The CHIP program currently operates under a federal maintenance of effort (MOE) which expires on September 30, 2019.

In the event the program is not reauthorized (the MOE expires) Oklahomans served by CHIP today would lose their coverage. In the event this would occur, those individuals could be moved to the individual insurance market pool. This shift would accomplish several objectives: 1) families could access coverage for all members of the household through one health insurance plan of their choice, 2) included children would continue to have benefits through a health plan, 3) a large pool of relatively healthy, young lives would enter the individual insurance market, and 4) to the extent that eligibility for existing Insure Oklahoma ESI or IP programs is applicable, federal funds from Medicaid could continue to be used to support subsidies via premium assistance programs.

✓ Consumer Incentives

Oklahoma can use its consumer health accounts to try new, creative strategies to promote continuous coverage, longevity of enrollment, open enrollment completion, and healthy behaviors. Incentives could include premium reductions for those who select and enroll in qualified coverage during an open enrollment period, co-pays or out-of-pocket costs whose amounts decrease over time the longer a consumer is consistently enrolled in coverage, or other options such as rollover of unused account funds to the following year if certain health screenings or activities are performed (e.g., annual preventive check-up with a provider, completion of evidence based tobacco cessation or weight-loss program, etc.). Although access to coverage has been a primary focus of the ACA, Oklahoma's plan looks to develop and implement a variety of ways to improve determinants of health, recognizing that recent studies[13] have shown that individual behavior determines the majority of health outcomes (approximately 40%).

✓ Exemption Criteria

Modifying rules around exemption criteria may promote a healthier pool of enrollees. Specifically, the state would modify or eliminate criteria related to affordability, financial hardship, and closing the coverage gap (0-100% FPL). These exemption categories should become unnecessary once the state implements changes to subsidy eligibility, distribution, and calculations to more adequately support affordability for gap populations and those with lower income.

[13] Edwin Choi et al., "Determinants of Health," Goinvo, accessed February 16, 2017,http://www.goinvo.com/features/determinants-of-health/

1332 Waiver Tribal Considerations

Background

The U.S. Constitution recognizes three sovereigns: the Federal government, States, and Indian Tribes. As sovereigns, Tribes predate the United States, and retain rights of self-government.[14] When the United States was established, the Constitution's Indian Commerce Clause granted Congress the authority to pass legislation specific to Indian Affairs.[15] The Supreme Court has upheld Indian-specific legislation, determining that it is political in nature, rather than based on an unconstitutional racial classification.[16] Health care reform legislation that reflects the unique federal responsibility to provide health care for American Indians and Alaska Natives is subject to rational basis review and does not violate the equal protection clause so long as it is "tied rationally to the fulfillment of Congress' unique obligation toward the Indians."[17]

Congress has the constitutional authority and responsibility to provide for Indian health care. Tribes signed treaties and negotiated other agreements with the United States in which they ceded vast amounts of territory in exchange for certain solemn promises. These promises include protecting Tribal self-government and providing for the health and well-being of Indian peoples.[18] Indian treaties are the supreme law of the land, and in carrying out these treaty obligations, the United States has "moral obligations of the highest responsibility and trust."[19]

Congress has passed numerous Indian-specific laws to provide for Indian health care, including establishing the Indian health care system and passing the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601 *et seq.* In the IHCIA, for instance, Congress found that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." *Id.* § 1601(1). In the Indian Self-determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 *et seq.*, Congress enabled Tribes to contract to run their own health care programs while also preserving Tribes' right to choose that services continue to be provided directly by the Indian Health Service. Congress has also legislated to provide Indians with access to general health programs, such as Medicaid, while creating Indian-specific protections within those programs that reflect this unique political relationship.

Congress has full constitutional authority to legislate with regard to Indian health care, and should continue to promote Tribal sovereignty and uphold the government-to-government relationship between the United States and Tribes in fulfillment of its trust and legal responsibilities in any health care reform proposal, including current efforts to repeal and replace the ACA.

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[14] *Worcester v. State of Ga.*, 31 U.S. 515, 559 (1832).
[15] U.S. CONST., art. I, § 8, cl. 3; *see also Morton v. Mancari*, 417 U.S. 535, 552–55 (1974).
[16] *Morton*, 417 U.S. at 555; *see also Moe v. Confederated Salish & Kootenai Tribes of Flathead Reservation*, 425 U.S. 463, 479–80 (1976); *Washington v. Washington State Commercial Passenger Fishing Vessel Ass'n*, 443 U.S. 658, 673 n.20 (1979); *United States v. Antelope*, 430 U.S. 641, 645–47 (1977); *Am. Fed'n of Gov't Employees, AFL-CIO v. United States*, 330 F.3d 513, 520-21 (D.C. Cir. 2003).
[17] *Morton*, 417 U.S. at 555.
[18] *See United States v. Winans*, 198 U.S. 371, 380–81 (1905).
[19] *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942); *see also* U.S. CONST., art. VI, cl. 2; *Worcester*, 31 U.S. at 539.

Overview

Oklahoma has 38 Tribal governments, and the federal Oklahoma City Area Indian Health Service (IHS) represents the largest Area within the IHS, with a user population of 355,435, or over 22% of total IHS active patients. The Oklahoma City Area is the lowest-funded IHS Area per patient. The state's Indian health system is robust – the Indian Health Service/Tribal/Urban (I/T/U) health systems within the Area manage eight hospitals, 50 health centers, one regional alcohol and substance abuse treatment center, and two urban Indian health centers. The large number of tribal health care facilities and programs is a strong reflection of the partnership and cooperation to fulfill the existing health care needs of the population.

Although health disparities continue, the American Indian and Alaska Native (AI/AN) population in Oklahoma has seen a number of improvements in health indicators. The rates of death due to stroke and kidney disease have seen statistically significant decreases over the past five years. Additionally, there have been decreases in the rates of death due to heart disease, cancer, diabetes mellitus, and influenza and pneumonia. Although these specific leading causes of death do not demonstrate statistically significant decreases, there is good potential for continued improvements. The Oklahoma Indian health system is also prioritizing the identification and treatment of Hepatitis C.

In 2013 there were nearly 140,000 uninsured Native Americans, representing nearly 22% of the state's uninsured population.[20] However, Tribal Premium Sponsorship programs, whereby Tribes sponsor (pay) the individual's net premium after federal subsidies is contributing to an increased number of citizens receiving health insurance coverage on the individual market. These programs are mostly in the starting phase as pilot programs, but it is anticipated that they will continue to grow and increase the number of insured AI/ANs. Additionally, Oklahoma submitted a Sponsor's Choice Waiver, authorized under section 1115, which if approved would provide Medicaid funding for tribal premium assistance. This waiver would support the goals of the 1332 Waiver by promoting individual insurance coverage, and thus it makes sense to have these two waivers approved together. The state intends to make two changes to the Sponsor's Choice Waiver to ensure it aligns with the 1332 waiver:

- Change income eligibility from 0-200% to 0-300% FPL to align with the 1332 Waiver eligibility
- Withdraw the Amendment submitted to CMS on October 3, 2016 which limited the provider network to in or through an I/T/U

Indian Health Systems and the Affordable Care Act

In 2010, the ACA permanently reauthorized the IHCIA within Section 10221, which was first enacted in 1976. Therefore, changes to the ACA or repeal of the ACA can impact the IHCIA. The IHCIA serves as the backbone legislation for I/T/U health systems and provides the foundational authority for the IHS to be reimbursed by Medicare, Medicaid, and third party insurers; to make grants to Indian Tribes and Tribal organizations; and to run programs designed to address specific, critical health concerns for Native Americans, such as substance abuse, diabetes, and suicide. The preservation of the IHCIA and its permanency are essential for the continued provision of health care to the AI/AN population, as well as the preservation of previously mentioned ACA provisions for $0 copays for preventive services, guaranteed issue, and dependent coverage up to age 26.

[20] 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.

Furthermore, there are a number of provisions within the ACA separate from the IHCIA that have significant implications for the Indian health system. Those include, but may not be limited to:

- ✓ Special Enrollment Periods (Section 1311) – Provides for special monthly enrollment periods for Indians.
- ✓ Cost Sharing Reductions (Section 1402(d)) – AI/ANs who are members of federally recognized Tribes and whose household income is below 300 percent FPL are protected from paying *any* cost sharing when receiving essential health benefits from any provider, I/T/U or non-I/T/U, under Exchange QHPs. This coverage is identified in the Exchange plan offerings as the "zero cost sharing" plan variation. Also under Exchange QHPs, members of federally-recognized Tribes who are above 300 % FPL or whose income is not determined are not required to pay cost-sharing at I/T/U facilities or when referred for services by an I/T/U. This coverage is identified in the Exchange plan offerings as the "limited cost sharing" plan variation.
- ✓ Exemptions (Section 1501) – Exempts members of Indian tribes from the shared responsibility penalty for failure to comply with the requirement to maintain minimum essential coverage.
- ✓ Payer of Last Resort (Section 2901) – Establishes that 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.
- ✓ 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.
- ✓ Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics (Section 2902)– Makes permanent reimbursement for all Medicare Part B services furnished by Indian Health hospitals and clinics.

1332 Waiver Considerations

In consideration of these provisions, the following recommendations have been developed related to certain strategies proposed in this paper:

- ✓ Quality Measures Related to Chronic Disease

  The I/T/U system currently reports on a number of quality measures, one example being those required under the Government Performance and Results Act (GPRA). Quality measures for providers overall should align with these measures to eliminate duplication and limit the administrative burden on I/T/U providers. Additionally, baseline measures for these providers need to take into account that populations served by the I/T/U system are not currently included in statewide baseline data and health outcomes and status are statistically different for this population.

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

  Changes to special enrollment requests need to take into account that AI/ANs currently can enroll on a monthly basis. Section 1311 will continue to be effective in the 1332 Waiver application. If this population were restricted to the open enrollment period, Tribal Premium Sponsorship would be significantly impacted. Additionally, preserving the monthly enrollment periods for AI/AN will facilitate the 1332 Waiver working more seamlessly with the 1115 Sponsor's Choice Waiver.

Requirements related to premium payment for past months of non-payment when an individual re-enrolls in a plan must exempt the Tribal Sponsorship program to ensure tribes are not restricted in helping individuals access coverage through this program. Insurer processes regarding invoicing and covered lives rosters should be evaluated alongside these changes to ensure the timing of payments and continuation of coverage are reasonable. In addition, for individuals, payment of past month's premiums should include a limit to avoid the amount in arrears becoming a permanent barrier to re-enrollment.

✓ APTC and CSR Eligibility and Distribution

If eligibility for APTCs is shifted to 0-300% of the FPL, 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.

Assuming that AI/AN continue to be exempted from all cost sharing as provided in section 1402(d), consideration would need to be given to distribution of CSRs to a consumer health account.

✓ Consumer Health Accounts

The administration of consumer health accounts need to consider the current Tribal Sponsorship program operations and ensure that the program can continue to support access to coverage for the AI/AN population. Tribal Sponsorship programs currently have assurance that the federal portion of the premium payment has been made on behalf of the individual and that the tribal contribution completes the total payment. This ensures the individual indeed receives health insurance coverage. The consumer health account should also provide direct payments to insurers, continuing the assurance to Tribal Sponsorship programs that insurance coverage is paid in full. Finally, enrollment and purchasing insurance should be a prerequisite to access the consumer health account.

✓ Exploration of Reinsurance and High-Risk Pools

Reinsurance mechanisms should include the AI/AN population, since they would support carriers to cover those with high utilization costs but would not require consumers to pay a higher premium. If the state should choose to employ a high-risk pool, however, enrollment of AI/AN individuals should be a last resort after all other potential eligibility avenues have been exhausted. If an AI/AN receives coverage through Medicaid, their continuation with the Medicaid program (or Medicaid-funded participation in tribal premium assistance) should be permitted.

✓ 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. These provisions include the requirement that insurers must contract with I/T/Us using the CMS Model Indian Addendum to ensure that service provision is not interrupted, as well as utilizing the encounter rate as the payment rate to I/T/U providers.

✓ Core Health Benefits

The Essential Health Benefits required to be included in QHPs should retain Preventive Health and Behavioral Health Services, which are high priorities for Tribes. The Indian health system is a

very comprehensive system of care, and I/T/Us provide these services as well as public health and sanitation facilities in addition to clinical services. There is strong research support that investments in Preventive Health and Behavioral Health result in better health outcomes.

Next Steps

These recommended strategies are an initial proposal designed to convey the state's overarching approach to redesign the individual market and to elicit further feedback from a variety of stakeholders. In particular, it will be essential that the state legislature and state agency officials review the proposal and provide input on whether the strategies will meet the desired goals of increasing access to coverage will minimizing costs and improving quality. The proposal will likely evolve as more comprehensive information, perspectives, and analysis are gathered and integrated into the ultimate 1332 State Innovation Waiver submission.

While changes to policies and regulation are uncertain at the federal level, Oklahoma's market pain points and barriers will remain constant. This paper is a first look at how the state can fix the problems that persist and work with federal authorities to explore flexibilities or changes that will support the state's goals. As transitions to a new administration occur and future changes are identified, their impacts on Oklahoma's solutions will be evaluated.

While SB 1386 only requires legislative review for the waiver application, it is understood that legislative input and engagement throughout the process is crucial. Without active state legislative buy-in, it would be impossible for Oklahoma to achieve its policy goals, which may have impacts and require changes to the health insurance regulatory structure and state statutes. With that understanding, there will be an opportunity for legislators to be briefed, ask questions, and provide comment into the concept paper. The legislative review process is envisioned to include a briefing for all interested legislators on the concept paper by Health and Human Services project staff, followed by questions and comments. Invitations to the briefing and convening members would be led by House and Senate leadership. After the briefing, requested follow up meetings will be accommodated by HHS project staff. These activities will occur in the 2017 legislative session, with input to be incorporated into the final report, as well as identification of necessary modifications to statute or regulations.

Additionally, the Task Force will continue to meet regularly with dates secured for April and June of 2017, and state leaders will engage national experts and contractors to further refine and operationalize the strategies into a more detailed plan. By June 2017, the Task Force will produce a report that outlines this plan with more robust data and information currently being sought from surveys, focus groups, and contractors.

Conclusion

While the ACA provided additional avenues for individuals to obtain health insurance coverage, it did so with a national framework that provided limited flexibility to states and sacrificed the focus on health outcomes and cost. Oklahoma is faced with identifying opportunities to make the law more responsive to the needs of Oklahomans while addressing the challenges that persist related to consumer choice, competition, and cost. The state anticipates that changes in administration at the federal level will produce opportunities for states to communicate what has and has not worked and be given the

authority to respond to those realities. Oklahoma is well positioned to leverage existing assets and has a long history of developing innovative, state-based solutions that, with latitude at the federal level, will catalyze the establishment of a stable health insurance market and a sustainable health care system.

At the crux of this proposal is the philosophy that states can most effectively make decisions about how the health insurance market should be regulated and designed, and that families can most effectively decide what coverage options are best for them. If more flexibility is given to Oklahoma, the state can design, implement, and assess new and creative strategies that will ultimately promote lower costs, better care, and healthier people.

Appendix A: Proposed Solutions

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

Pain Point Addressed: Each solution is designed to address one or more of Oklahoma's five individual insurance market pain points:

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

Level of Impact:

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

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

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

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

Continued State Support					
Solution	**Pain Point Addressed**	**Level of Impact**	**Waiver- Relevant ACA Section**	**Justification**	**Effective Plan Year**
Tribal Considerations					
Retain ACA provisions related to AI/AN populations and the Indian Health Care Improvement Act; ensure the special protections and provisions, exemptions, as well as special enrollment period for the American Indian/Alaska Native populations are retained	Low Enrollment	Low	Retain: Section 1311(c)(6)(d); Section 1402(d)(1); Section 1402(d)(2); Section 1402(d)(3); Section 1411(b)(5)(A); Section 1501/5000(e)(3); Section 2901(a); Section 2901(b)	OK proposes to retain these provisions and continue use of effective policies.	2017
Consumer Outreach					
Provide clarity and assistance to families to access financial tools and understand coverage	Low Enrollment	Low	None – no federal authority needed to pursue	OK proposes, on a continual basis after individual insurance market improvements are realized, to engage plans, advocates, etc. to reach and educate consumers on health insurance options.	2018 – for transition planning; 2019 - for implementation after marketplace improvements are made
Increase marketing and outreach efforts	Low Enrollment	Low	None – no federal authority needed to pursue	OK proposes to encourage plans to deliver marketing campaigns, networking with community supports.	2018

Improved Plan Design					
Maintain $0 co-pays for certain preventive services, guaranteed issue, and dependent coverage up to age 26	Plan Design	Moderate	Section 2704; Section 2711; Section 2714; Section 2713	OK proposes to retain these provisions and continue use of effective policies.	2018
Encourage the use of telehealth	Plan Design	Moderate	None – no federal authority needed to pursue	OK proposes to encourage plans and providers to utilize telehealth where appropriate and effective.	2018

State Regulation and Federal Flexibility					
Solution	**Pain Point Addressed**	**Level of Impact**	**Waiver- Relevant ACA Section**	**Justification**	**Effective Plan Year**
Tribal Considerations					
Retain ACA provisions related to AI/AN populations and the Indian Health Care Improvement Act; ensure the special protections and provisions, exemptions, as well as special enrollment period for the American Indian/Alaska Native populations are retained	Low Enrollment	Low	Retain: Section 1311(c)(6)(d); Section 1402(d)(1); Section 1402(d)(2); Section 1402(d)(3); Section 1411(b)(5)(A); Section 1501/5000(e)(3); Section 2901(a); Section 2901(b)	OK proposes to retain these provisions and continue use of effective policies.	2017
Improved Plan Design					
Encourage plans to offer additional value-added benefits (e.g., dental and vision)	Plan Design	Moderate	None – no federal authority needed to pursue	OK proposes to give preference to plans whose qualification criteria include additional services being offered alongside mandated benefits	2018

Eliminate metal plan AV criteria and replace them with a standard minimum AV of 80% for all traditional plans (non-HDHP) with simplified, fixed-cost benefits descriptions	Low Enrollment Plan Design	Moderate	Section 1301: Definition of QHP Section 1302: EHB Requirements	OK proposes to waive the requirement for at least 1 silver plan and waive the definition of metal tier by AV	2019
State-Controlled Plan Regulation					
Have the Oklahoma Insurance Department assume rate review and plan certification	State Oversight	High	None - federal authority provided outside 1332 waiver	OK proposes to change its federal oversight status and assume state responsibility	2018
Qualify plans that incorporate value-based payments	Plan Design State Oversight	Moderate	Section 1301: Definition of QHP; Section 1311(c) and 1311(d)(4)(A)	OK proposes to waive the definition of QHPs to include a VBP provision.	2018
Implement quality measures related to chronic disease	Plan Design State Oversight	Moderate	Section 1301: Definition of QHP; Section 1311(d)(4)(D)	OK proposes to waive the definition of QHPs to include quality measure reporting and associated payments for improvements related to chronic disease	2018
Ensure plans implement case management/care coordination	Plan Design State Oversight	Moderate	Section 1301: Definition of QHP; Section 1311(c) and 1311(d)(4)(A)	OK proposes to waive the definition of QHPs to include a provision for required case management/care coordination activities and responsibilities by plans	2018
Ensure qualified plan process includes validation of AV calculations	Plan Design State Oversight	Low	Section 1301: Definition of QHP Section 1302: EHB Requirements	OK proposes to waive the definition of metal tiers by AV and require validation of QHPs AV by the state	2018

Implement state-assessed incentives and/or penalties on plans for failure to comply with regulations	State Oversight	Moderate	Section 1311; state regulations	OK proposes to design criteria to assess incentives and/or penalties (financial, administrative, etc.) on plans when appropriate.	2018
Reduced administrative burden on plans related to reporting, risk mitigation, eligibility, and enrollment	Competition	Low	Section 1311	OK proposes modification to federal regulations)and processes (as provided by plans allowing administrative simplification for plans	2018-for reporting and risk mitigation 2019-for eligibility and enrollment alongside the use of the Insure Oklahoma platform
Allow greater variance to the rating windows for age	Plan Design	Moderate	Section 2701(a)(1)(A)(iv)	Ok proposes modification to federal regulations allowing flexible age rating up to a 5:1 ratio	2018
Improved Risk Management					
Adopt Medicare Advantage-like risk mitigation models and plan quality rating programs	Competition	Low	Section 1343 and the Annual Notice of Benefit and Payment Parameters	OK proposes modifications to allow MA-like risk mitigation and rating programs	2019
Encourage plans to reinsure themselves and/or participate in continued federal reinsurance program	Competition	Moderate	Section 1341	OK proposes federal continuation of reinsurance program; and state flexibility to prefer QHPs whose carriers have secured adequate reinsurance policies	2018

Continue to explore federally-funded, state-administered high-risk pools, reinsurance, and hybrid programs for high cost enrollees and to provide temporary coverage for those who fail to join during open enrollment	Competition	Moderate	None- federal authority provided outside 1332 waiver	OK proposes to develop and implement a state-run and regulated risk mitigation program as a means to limit premium increases due to churn and exceptional needs consumers, as federal funds become available	2018
Modified Enrollment Procedures					
More robust verification of special enrollment requests	Churn	Low	Section 1311: Providing consumers a health insurance exchange; Section 2702(b)(3); 45 CFR 155.420 and 45 CFR 147.104; other federal authority outside 1332 waiver	OK proposes modifications to federal regulations allowing state verification of SEPs as a condition of individual insurance market eligibility through the Insure Oklahoma platform	2019
Require premium to be paid before policy is issued for re-enrollment	Churn	Low	Section 1311: Providing consumers a health insurance exchange; Section 1412(c)(2)(B)(iii)(II); Section 2703; other federal authority outside 1332 waiver	OK proposes modifications to federal regulations allowing state designed premium payment policies as a condition of individual insurance market eligibility through the Insure Oklahoma platform	2019

Limit number of special enrollment periods and requests	Churn	Low	Section 1311: Providing consumers a health insurance exchange; other federal authority outside 1332 waiver	OK proposes modifications to federal regulations allowing elimination of SEP reasons (exceptional circumstance, attested Medicaid denial) as a condition of individual insurance market eligibility through the Insure Oklahoma platform .	2019
Reduce to 30-day grace period for premium payments	Churn	Moderate	Section 1311: Providing consumers a health insurance exchange; Section 1412(c)(2)(B)(iii)(II); other federal authority outside 1332 waiver	OK proposes modifications to federal regulations allowing state designed premium payment policies as a condition of individual insurance market eligibility through the Insure Oklahoma platform	2019

Oklahoma's Modernized Market					
Solution	**Pain Point Addressed**	**Level of Impact**	**Waiver- Relevant ACA Section**	**Justification**	**Effective Plan Year**
Tribal Considerations					
Retain ACA provisions related to AI/AN populations and the Indian Health Care Improvement Act; ensure the special protections and provisions, exemptions, as well as special	Low Enrollment	Low	Retain: Section 1311(c)(6)(d); Section 1402(d)(1); Section	OK proposes to retain these provisions and continue use of effective policies.	2017

enrollment period for the American Indian/Alaska Native populations are retained			1402(d)(2); Section 1402(d)(3); Section 1411(b)(5)(A); Section 1501/5000(e)(3); Section 2901(a); Section 2901(b)		
Consumer Outreach					
Allow plans to direct market, solicit clients, assist in enrolling	Low Enrollment	High	Section 1312: Consumer Choice to enroll via exchange and agents; Section 1311(d)(4)(F) - requirement for Exchange to determine eligibility and enroll	OK proposes to waive the FFM allowing plans and their agents to directly market to and enroll consumers; plans are expected to work in conjunction with community-based resources who are already serving vulnerable populations	2019
State-Controlled Plan Regulation					
Tighten exemption criteria and allow fewer exemptions	Churn	Low	Section 1311: Providing consumers a health insurance exchange; other federal authority outside 1332 waiver	OK proposes modification allowing elimination of exemptions for affordability, financial hardship and coverage gap, as a condition of eligibility through the Insure Oklahoma platform	2019

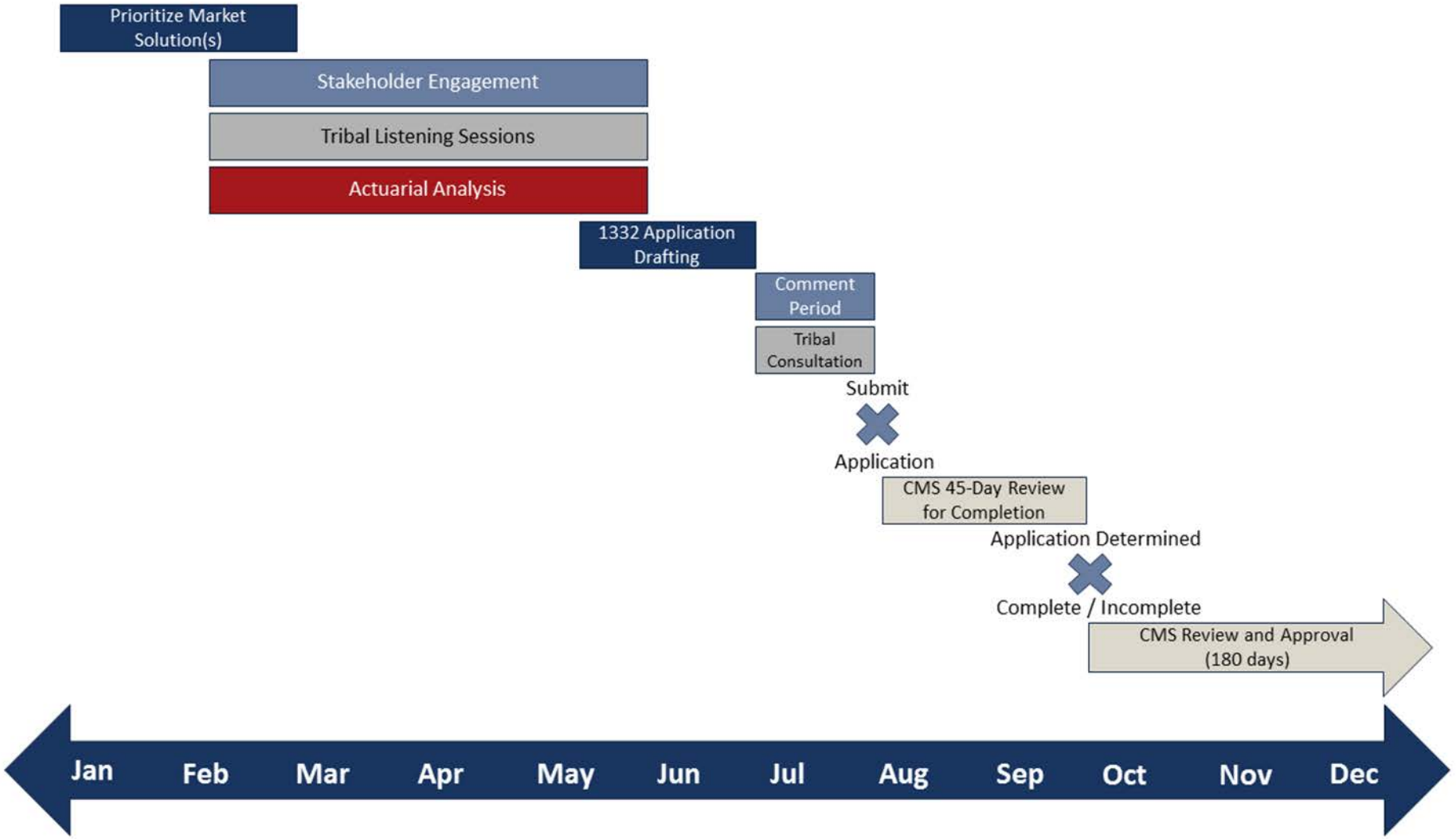
Allow the state to determine benefits; identify a core set and/or provide flexibility depending on consumer needs	State oversight; competition	Moderate	Section 1301(a)(1): Definition of QHP; Section 1302: EHB Requirements	OK proposes to re-evaluate the benefits package. Where appropriate, the state will consider refinements to the benefit package that optimize access and ensure affordability for consumers.	2019
Modified Enrollment Procedures					
Promote continuous coverage, enrollment longevity, and healthy behaviors through reductions in premiums or loyalty incentives	Churn	Moderate	Section 1402/36B: Provisions and eligibility for APTC & CSR	OK proposes to waive APTC & CSR provisions to include financial incentives for consumers who maintain continuous coverage and demonstrate healthy behaviors	2018
Eligibility Changes					
Broaden APTC and CSR eligibility to include gap populations (income less than 100% of the FPL)	Low Enrollment	High	Section 1402/36B: Provisions and eligibility for APTC & CSR	OK proposes to waive current APTC & CSR eligibility and calculation provisions allowing their redistribution and use for gap populations	2019
Upon CHIP maintenance of effort expiring or failed reauthorization at the federal level, allow CHIP members to enter individual insurance market pool as a means to keep family coverage together	Low Enrollment	High	Section 1402/36B: Provisions and eligibility for APTC & CSR	OK proposes to waive APTC & CSR provisions allowing their use for populations who previously were subject to the CHIP MOE	2020 – effective 10/1/19 with expiration of MOE or upon failure of CHIP reauthorization and sunset of

					the program
Modified Subsidy Processes					
Shift APTCs and CSRs from higher incomes (e.g., 300-400% of FPL) to uninsured individuals (less than 100% of the FPL)	Low Enrollment	High	Section 1402/36B: Provisions and eligibility for APTC & CSR	OK proposes to waive APTC & CSR provisions allowing reduction of subsidies for consumers with incomes between 300-400% FPL	2019
Standardize subsidies based on age and income	Low Enrollment	Moderate	Section 1402/36B: Provisions and eligibility for APTC & CSR	OK proposes to waive provisions allowing subsidy amounts to be based upon income and age on a sliding scale	2019
State-Owned Platform					
In lieu of FFM, leverage Insure Oklahoma eligibility and subsidy platform	State Oversight	High	Section 1311: Providing consumers a health insurance exchange; Section 1312: Consumer Choice; other federal authority outside 1332 waiver	OK proposes to waive federal exchange systems and processes, replacing them with the Insure Oklahoma platform overseen by the state. The state-designed, subsidy leveraging, eligibility infrastructure will utilize regulations and processes controlled by the state.	2019

Utilize automatic enrollment of certain individuals into the lowest cost plan (e.g., for consumers determined ineligible for Medicaid)	Low enrollment	Moderate	Section 1311: Providing consumers a health insurance exchange; Section 1312: Consumer Choice	OK proposes to waive initial plan selection by certain individuals who have sought other public coverage but have been denied. The state will proactively enroll and notify individuals of their enrollment in alternative coverage. In return, individuals will be educated by plans on the available benefits, fixed-dollar costs, and options available as a way to demonstrate the value of maintaining coverage.	2019
State-Designed HSA-like Accounts					
Establish HSA-like consumer health accounts funded by redirecting APTCs and CSRs for consumers to purchase coverage and pay for out-of-pocket expenses	State Oversight	High	Section 1311: Providing consumers a health insurance exchange; Section 1402/36B: Provisions and eligibility for APTC & CSR; Section 1301(a)(1)(C)(ii) – req. to offer one silver and one gold; Section 1302(d), 1302(e), and 1302(f): AV levels, catastrophic plans, child-only plans	OK proposes to waive federal exchange systems and processes, replacing them with the Insure Oklahoma platform overseen by the state, and utilizing HSA-like accounts managed by consumers. The state-designed, subsidy leveraging, eligibility infrastructure will utilize regulations and processes controlled by the state. APTC and CSR funds will be combined and repurposed to fund the HSA-like consumer health accounts.	2019

Establish two simple options for consumers to use their accounts: 1) purchase a traditional plan (non-HDHP) with at least 80% AV or 2) purchase a high-deductible plan and keep remaining subsidy dollars for health expenses	Plan Design State Oversight	High	Section 1301: Definition of QHP; Section 1302: EHB Requirements Section 1312: Consumer Choice; Section 1301(a)(1)(C)(ii) – req. to offer one silver and one gold; Section 1302(d), 1302(e), and 1302(f): AV levels, catastrophic plans, child-only plans; Section 1402/36B: Provisions and eligibility for APTC & CSR	OK proposes to waive the metal tier AV definitions; the metal tier plan qualifications; and the consumer choice provisions allowing instead two simple plan design options. The state establishes a minimum AV floor of 80% for traditional (non-HDHP) individual insurance market plans. A transition period of one year will allow for current metal plans to migrate to a single AV floor. A lower AV option will also be available through the HDHP, but will be coupled with HSA-like consumer health accounts to allow consumers the option of directly purchasing needed services.	2018 – transition to a consistent AV floor among plans begins 2019 – establishment of the 80% AV floor, coupled with offering HDHP coupled with HSA-like accounts

Appendix B: 1332 Waiver Application and Approval Tentative Timeline



Appendix C: State Innovation Task Force Timeline

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

Appendix D: State Innovation Task Force Invitation Letter

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

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

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

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

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

Sincerely,

Mary Fallin

Mary Fallin
Governor

STATE CAPITOL BUILDING • 2300 N. LINCOLN BLVD., SUITE 212 • OKLAHOMA CITY, OKLAHOMA 73105-4801 • (405) 521-2342 • FAX (405) 521-3353

Appendix E: State Innovation Task Force Members and Data Workgroup Members

State Innovation Task Force Members

Stakeholder Type	Organization	Designee
Private Payers	Oklahoma Association of Health Plans	Laura Brookins-Fleet, Executive Director
	Blue Cross Blue Shield of Oklahoma	Stephania Grober, VP of Sales
	United Health Care	Jeff Hudson, Public Exchange Leader
Tribal Nations	Chickasaw Nation	Melissa Gower, Senior Advisor, Policy Analyst
	Cherokee Nation	Mitch Thornbrugh, COO Hastings Hospital
Providers	Oklahoma Hospital Association	Craig Jones, President
	Oklahoma State Medical Association	Melissa Johnson, Healthcare Policy Director
	Oklahoma Osteopathic Association	Duane Koehler, DO, Assistant to the Dean of Rural Health, Oklahoma State University
	INTEGRIS Health	Greg Meyers, VP of Revenue Integrity
	St. John Medical Center	Richard Todd
Brokers	Oklahoma Association of Health Underwriters	Roger Flippo, President
Consumer Advocacy Groups	Community Service Council	Jan Figart, RN, Associate Director, member of the Oklahoma Nurses Association
	Health Alliance for the Uninsured	Pam Cross, Executive Director
	Opportunities, Inc.	Keri Divis, Facility Manager
Self-insured Businesses	Devon	Jeremy Colby, VP of Benefits
	Oklahoma State Chamber	Jennifer Lepard, VP of Government Affairs
	HealthSmart	Eric Wright, Sr. Vice President

State Innovation Data Workgroup Members

Data Workgroup	Organization	Designee
Health Plan	Blue Cross Blue Shield of Oklahoma	Stephania Grober, VP of Sales
	United Health Care	Jeff Hudson, Public Exchange Leader
	Global Health	David Thompson, SVP and Chief Operating Officer
	Global Health	Dee Delapp, VP of Business Development
	Community Care	Greg Burn, Director of Marketing
	Oklahoma Insurance Department	Mike Rhodes, Deputy Commissioner of Health Insurance
	Oklahoma Insurance Department	Rebecca Ross, Liaison
	Oklahoma Association of Health Plans	Laura Brookins-Fleet, Executive Director
	Employees Group Insurance Department	Diana O'Neal, Deputy Administrator
	Oklahoma Health Care Authority	Becky Pasternik-Ikard, Chief Executive Officer
	Oklahoma Health Care Authority	Melissa McCully, Insure Oklahoma Administrator
	Oklahoma State Department of Health	Derek Pate, Director of Center for Health Statistics
Provider	Oklahoma Hospital Association	Rick Snyder, VP Finance and Information Services
	Oklahoma State Medical Association	Melissa Johnson, Healthcare Policy Director
	Oklahoma Osteopathic Association	Duane Koehler, DO, Assistant to the Dean of Rural Health, Oklahoma State University
	Chickasaw Nation	Melissa Gower, Senior Advisor, Policy Analyst
	Cherokee Nation	Mitch Thornbrugh, COO Hastings Hospital
	INTEGRIS Health	Greg Meyers, VP of Revenue Integrity
	St. John Medical Center	Richard Todd
	Oklahoma Health Care Authority	Becky Pasternik-Ikard, Chief Executive Officer
	Oklahoma State Department of Health	Derek Pate, Director of Center for Health Statistics
Business	Devon Energy	Jeremy Colby, VP of Benefits
	State Chamber of Commerce	Jennifer Lepard, VP of Government Affairs and Executive Director

	Oklahoma Association of Health Underwriters	Roger Flippo, President
	HealthSmart	Eric Wright, Sr. Vice President
	Oklahoma Health Care Authority	Becky Pasternik-Ikard, Chief Executive Officer
	Oklahoma Health Care Authority	Melissa McCully, Insure Oklahoma Administrator
	Oklahoma State Department of Health	Derek Pate, Director of Center for Health Statistics
Consumer	Community Service Council	Jan Figart, RN, Associate Director, member of the Oklahoma Nurses Association
	Opportunities Inc., Navigator grantee for Community Action Agency	Keri Divis, Facility Manager
	Health Alliance for the Uninsured	Pam Cross, Executive Director
	Oklahoma Health Care Authority	Becky Pasternik-Ikard, Chief Executive Officer
	Oklahoma Health Care Authority	Melissa McCully, Insure Oklahoma Administrator
	Oklahoma Department of Human Services	Mark Jones, Director, Community Living and Support Services
	Oklahoma Department of Mental Health and Substance Abuse Services	Traylor Rains-Sims, Senior Director, Policy and Provider Regulation
	Oklahoma Department of Mental Health and Substance Abuse Services	Carrie Hodges, Deputy Commissioner Treatment and Recovery Services
	Oklahoma State Department of Health	Derek Pate, Director of Center for Health Statistics

Appendix F: Senate Bill 1386

An Act

ENROLLED SENATE
BILL NO. 1386

By: David of the Senate
and
Mulready of the House

An Act relating to health insurance; creating the State Innovation Waiver; allowing for multiple waiver submissions; establishing certain procedures for development; requiring certain entities to submit information for approval; authorizing the Insurance Department to review health insurance market after waiver implementation; providing for codification; and providing an effective date.

SUBJECT: State Innovation Waiver

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1416 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. There is hereby authorized the creation and submission of a State Innovation Waiver for the purpose of creating Oklahoma health insurance products that improve health and healthcare quality while controlling costs.

B. The State Innovation Waiver may include multiple waiver submissions under federal waiver authorities, including:

1. Waivers as provided in Section 1332 of the federal Affordable Care Act for the purpose of waiving certain federal

insurance and tax regulations to create more state flexibility within the health insurance market; and

2. Waivers as provided in Section 1115 of the federal Social Security Act for the purpose of participating in the Delivery System Reform Incentive Payment Program or uncompensated care pools or both the Delivery System Reform Incentive Payment Program and uncompensated care pools with the aim of incentivizing providers through payment for achieving better health outcomes.

C. The State Innovation Waiver shall be created consistent with the innovation design plan developed through the Oklahoma Health Improvement Plan. It shall be presented to the Oklahoma Legislature along with a summary of comments received from public hearings and shall include the identification of specific provisions of the Affordable Care Act to be waived in the State of Oklahoma.

D. Participating agencies, including but not limited to the State Department of Health, the Oklahoma Health Care Authority, the Department of Mental Health and Substance Abuse Services and the Insurance Department, shall develop the State Innovation Waiver with input from the private sector partners and various subject matter experts and submit any and all necessary information for approval to all relevant entities.

E. The Insurance Department is hereby authorized to conduct rate review for the individual and small group health insurance market upon implementation of the State Innovation Waiver under Section 1332 of the federal Affordable Care Act.

SECTION 2. This act shall become effective November 1, 2016.

Appendix G: Oklahoma Insurance Market Data

2015

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

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

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

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

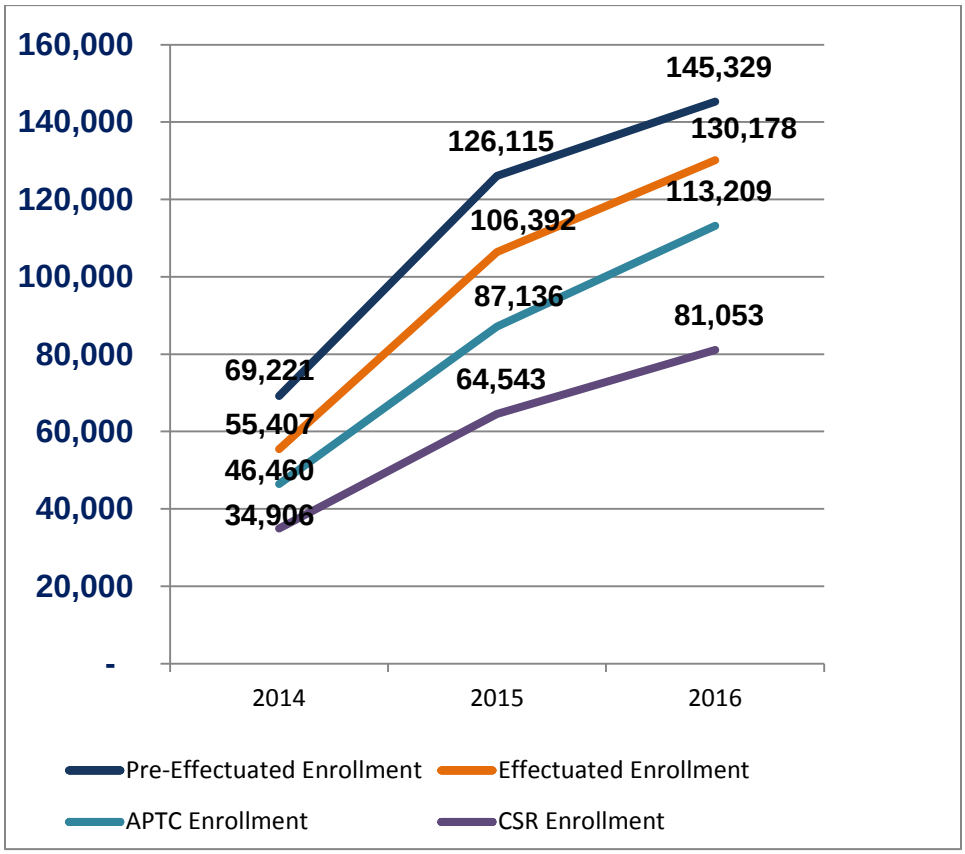
Source: Milliman. (2015). Oklahoma State Innovation Model Insurance Market Analysis.
Department of Health and Human Services (March 2016). Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: https://aspe.hhs.gov/sites/default/files/pdf/188026/MarketPlaceAddendumFinal2016.pdf

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

FFM Year over Year Enrollment*

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

*CMS has announced 146,000 plan selections for Oklahoma's FFM in 2017, an increase of approximately 700 relative to 2016.



Source: Centers for Medicare and Medicaid Services. (June 2016). March 31, 2016 Effectuated Enrollment Snapshot: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html

Centers for Medicare and Medicaid Services. (February 20176). Biweekly Enrollment Snapshot: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-02-03.html

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

Milliman

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**

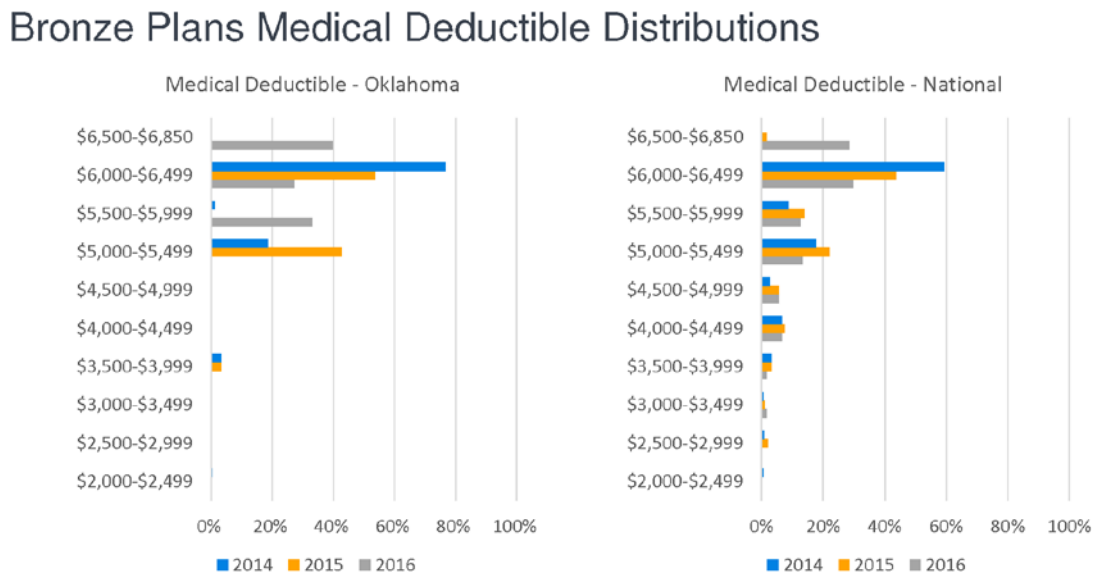
Notes:
1. Values reflect estimated market enrollment differences to the extent the ACA was not implemented.
2. Values reflect estimated average monthly effectuated enrollment.
3. Values are rounded.

- 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

Milliman

Source: Milliman. (2017). Oklahoma Federally Facilitated Marketplace Profile and Insurance Market Population Movement: Preliminary Results.



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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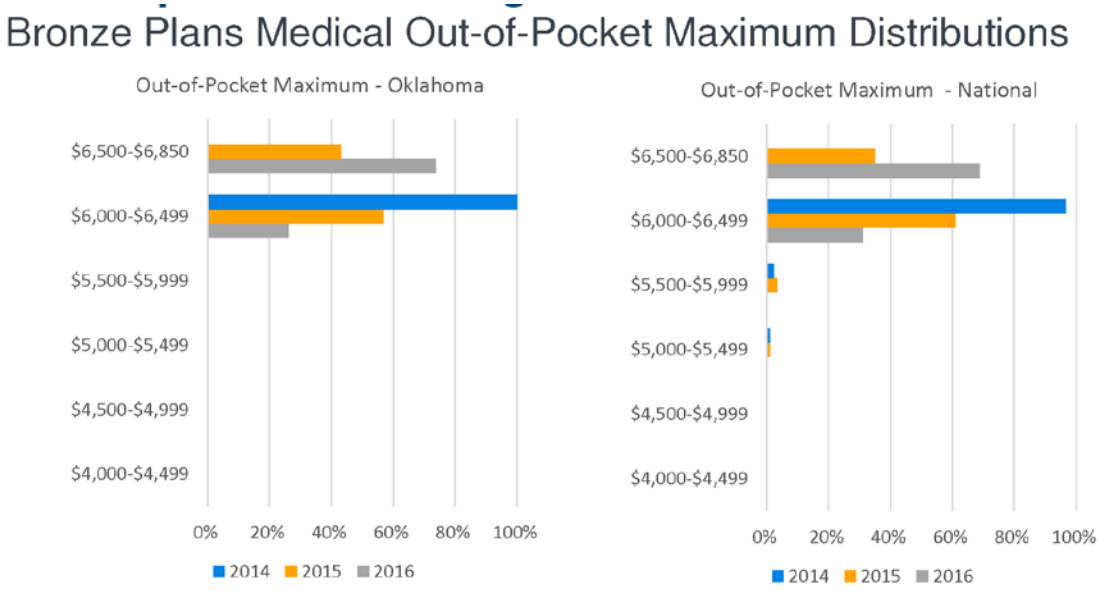
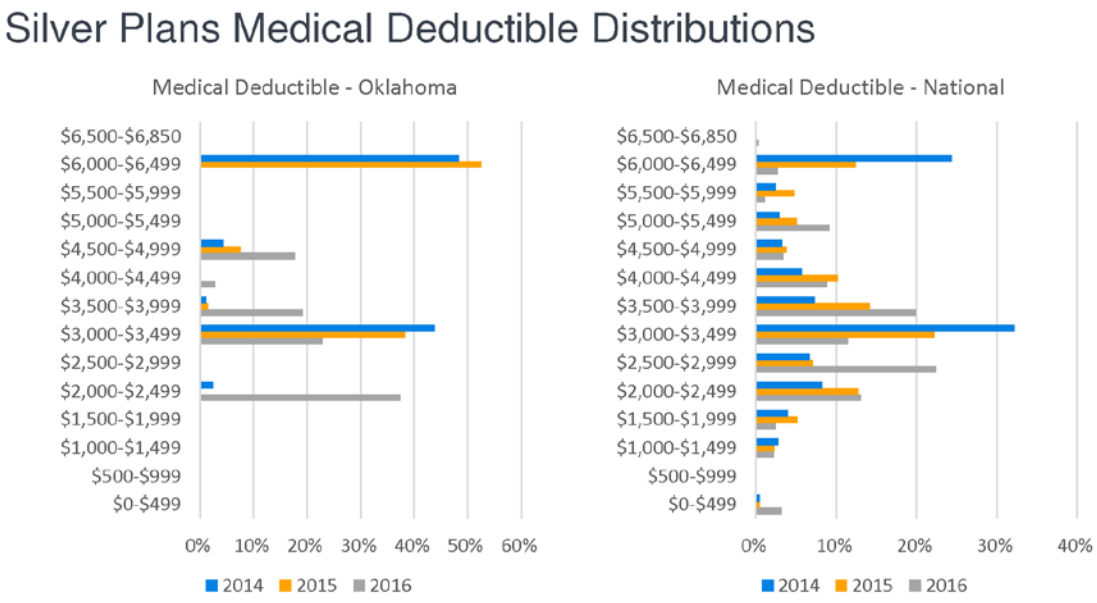


- 100% of bronze QHPs have single OOP Maximum in excess of $6,000 in Oklahoma, similar to national FFM

Milliman

Source: Milliman. (2017). Oklahoma Federally Facilitated Marketplace Profile and Insurance Market Population Movement: Preliminary Results.



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

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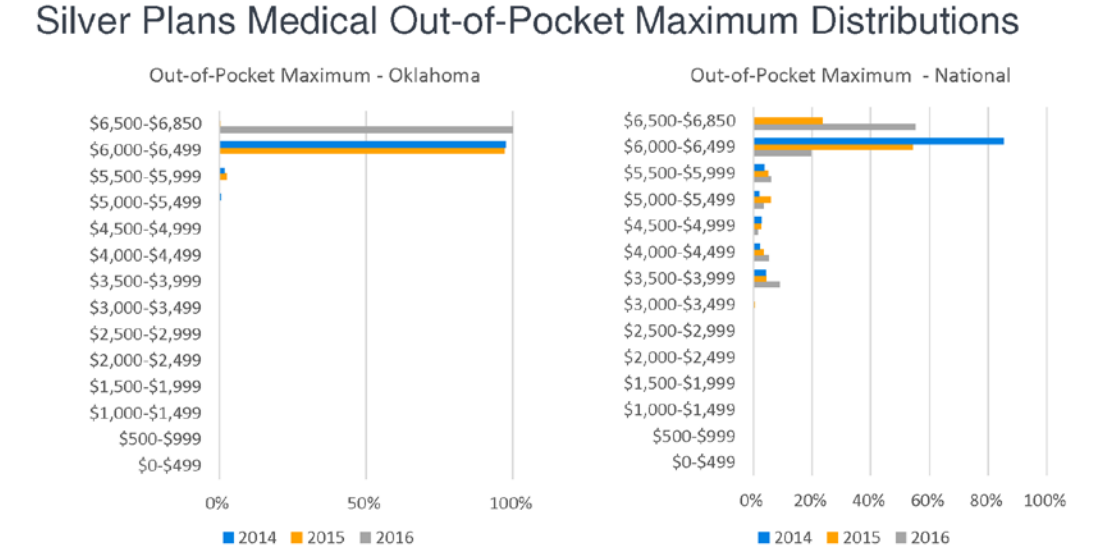

- Vast majority of single silver OOP Max exceeds $6,000 in Oklahoma and in national FFM

Milliman

Source: Milliman. (2017). Oklahoma Federally Facilitated Marketplace Profile and Insurance Market Population Movement: Preliminary Results.

Appendix H: ACA Essential Health Benefits and Oklahoma State-Mandated Benefits Comparison

Note: State mandated benefits are indicated from the perspective of the largest PPO small group product (currently BlueOptions PPO)

Benefit	EHB?	State Mandated Benefit?	Benefit Description (All benefit data corresponds to the EHB unless otherwise noted)	Quantitative Limit on Service?	Limit Quantity	Limit Unit and/or Description	Explanations
Autism Spectrum Disorder	No	Yes	Screening, diagnosis, and treatment of autism spectrum disorder in individuals under 9 years of age or for at least 6 years	Yes	25/$25,000	Hours per week/max benefit per year	For all plans issued or renewed on or after November 1, 2016
Bariatric Surgery	Yes		Bariatric Surgical Procedures	No			Only as medical necessity. Not covered when related to weight reduction.
Basic Dental Care - Child	Yes		Basic Dental Care - Child	No			Limitations, including dollar limits, may apply.
Bone Density Tests	Yes	Yes					
Breast Cancer Treatment	Yes	Yes					
Chiropractic Care	Yes	Yes	Chiropractic Manipulation	Yes	25	Visits per year	Chiropractic office Visits are not limited to 25, only PT is limited. Same benefit as combination of Physical Therapy, Occupational Therapy and Manipulative Therapy and habilitation.
Congenital Anomaly, including Cleft Lip/Palate	Yes		Congenital Anomaly, including Cleft Lip/Palate	No			
Cosmetic Surgery	Yes		Cosmetic Surgery (Medically Necessary)	No			For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless: needed to repair conditions resulting from an accidental injury; or for the improvement of the physiological functioning of a malformed body member, except for services related to Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue.
Delivery and All Inpatient Services for Maternity Care	Yes		Maternity Service	No			

Benefit	EHB?	State Mandated Benefit?	Benefit Description (All benefit data corresponds to the EHB unless otherwise noted)	Quantitative Limit on Service?	Limit Quantity	Limit Unit and/or Description	Explanations
Dental Check-Up for Children	Yes		Dental Exams	Yes	2	Visits per year	Limitations, including dollar limits, may apply. Supplemented using Oklahoma CHIP.
Dental Anesthesia	Yes	Yes	Dental Anesthesia	No			
Diabetes Care Management	Yes	Yes	Diabetes Care Management	No			
Diagnostic Test (X-Ray and Lab Work)	Yes	Yes	Diagnostic Test	No			
Durable Medical Equipment	Yes		Durable Medical Equipment	No			
Emergency Room Services	Yes	Yes	Emergency Room Visit	No			
Emergency Transportation/Ambulance	Yes		Ambulance Transportation				
Eye Care (Medically Necessary)	Yes	Yes					
Eye Exam for Children	Yes		Routine eye exam	Yes	1	Visit per year	
Eye Glasses for Children	Yes		Eye Glasses for Children	Yes	1	1 pair of glasses (lenses and frames) per year	
Generic Drugs	Yes		Generic Drugs	No			
Habilitation Services	Yes		Rehabilitation Services	Yes	25	Visits per year	Same benefit as combination of Physical Therapy, Occupational Therapy and Manipulative Therapy.
Hearing Aids	Yes		Hearing Aid	Yes	1	Hearing aid per ear every 48 months for Subscribers up to age 18.	
Hearing Exams and Aids for Children	Yes	Yes					

Benefit	EHB?	State Mandated Benefit?	Benefit Description (All benefit data corresponds to the EHB unless otherwise noted)	Quantitative Limit on Service?	Limit Quantity	Limit Unit and/or Description	Explanations
Home Health Care Services	Yes	Yes	Coordinated Home Care Program	Yes	30	Visits per Year Per benefit	
Hospice Services	Yes		Hospice Care	No			
Imaging (CT/PET Scans, MRIs)	Yes		Diagnostic Test	No			
Infertility Treatment							Diagnosis is covered, treatment is not
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Yes	Inpatient Hospital Services	No			
Inpatient Physician and Surgical Services	Yes		Inpatient Hospital Services	No			
Laboratory Outpatient and Professional Services	Yes	Yes	Laboratory Outpatient and Professional Services	No			
Major Dental Care - Child	Yes		Major Dental Care - Child	No			Limitations, including dollar limits, may apply.
Mental Health Other	Yes		Mental Health Other	No			
Mental/Behavioral Health Inpatient Services	Yes	Yes	"Severe Mental Illness Treatments" mandated	Yes	30	Days per year	
Mental/Behavioral Health Outpatient Services	Yes	Yes	20 visits mandated by the state	Yes	20	Visits per year	
Non-Preferred Brand Drugs	Yes		Non-Preferred Brand Drugs	No			
Orthodontia - Child	Yes		Orthodontia - Child	No			Limitations, including dollar limits, may apply. Medically necessary orthodontia only.
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Provider office Visit	No			
Outpatient Rehabilitation Services	Yes	Yes	Rehab. Phys Therapy a state mandated benefit	Yes	25	Visits per year	Combination of Physical Therapy, Occupational Therapy and Manipulative Therapy. Same Benefit as habilitation Chiropractic Benefit Below.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Yes	Outpatient Hospital Services	No			

Benefit	EHB?	State Mandated Benefit?	Benefit Description (All benefit data corresponds to the EHB unless otherwise noted)	Quantitative Limit on Service?	Limit Quantity	Limit Unit and/or Description	Explanations
Outpatient Surgery Physician/Surgical Services	Yes		Outpatient or ambulatory surgical procedures	No			
Postnatal Newborn Injury or Sickness	Yes	Yes	Maternity Service				
Preferred Brand Drugs	Yes		Preferred Brand Drugs	No			
Prenatal and Postnatal Care	Yes		Maternity Service	No			
Prescription Drugs Other	Yes		Prescription Drugs Other	No			
Preventive Care/ Screening/ Immunization	Yes	Yes	Colorectal Cancer Screenings, Mammography Screening, "preventative services", and	No			
Primary Care Visit to Treat an Injury or Illness	Yes		Physician Office Visits	No			
Private-Duty Nursing	Yes		Private Duty Nursing Service	Yes	85	Visits per year	
Reconstructive Surgery	Yes		Reconstructive Surgery	No			
Routine Foot Care	Yes		Routine Foot Care	No			Covered only for diabetic members.
Scalp Prosthesis	Yes	Yes					
Skilled Nursing Facility	Yes		Skilled Nursing Facility Services	Yes	30	Days per year	
Specialist Visit	Yes		Specialty Provider Visit	No			
Specialty Drugs	Yes		Specialty Drugs	No			
Substance Abuse Disorder Inpatient Services	Yes		Mental health and substance abuse services	Yes	30	Days per year	Visit Limits combined with mental health visit limits.
Substance Abuse Disorder Outpatient Services	Yes		Mental health and substance abuse services	Yes	20	Visits per year	Visit Limits combined with mental health visit limits.
Substance Abuse - Chemical Dependency-Detoxification	Yes	Yes					
Urgent Care Centers or Facilities	Yes		Urgent Care Services	No			
Weight Loss Programs							Covered under diabetes self - management.
X-rays and Diagnostic Imaging	Yes	Yes	X-rays and Diagnostic Imaging	No			