1332 State Innovation Task Force Meeting Agenda

April 18, 2017
1:30 p.m.-3 p.m.
Oklahoma Hospital Association
4000 N. Lincoln Blvd., Seminar Room
Oklahoma City, OK 73105

Section	Time		Presenter
Welcome and Introductions	**1:30**	**5 min**	**Julie Cox-Kain, Deputy Secretary of Health and Human Services**
Federal Updates	**1:35**	**10 min**	**Julie Cox-Kain**
Discussion of Reinsurance and High Risk Pools	**1:45**	**30 min**	**Julie Cox-Kain; Buffy Heater, HHS Project Lead**
Preliminary Impact Assessment of Concept Paper Strategies	**2:15**	**30 min**	**Erik Krisle, Leavitt Partners** **Austin Bordelon, Leavitt Partners**
Timeline and Next Steps	**2:45**	**15 min**	**Julie Cox-Kain, Buffy Heater**

- **2018 Annual Open Enrollment Period**:
  - The final rule adjusts the annual open enrollment period for 2018 to more closely align with Medicare and the private market. The next open enrollment period will start on November 1, 2017, and run through December 15, 2017, encouraging individuals to enroll in coverage prior to the beginning of the year.

- **Increased Special Enrollment Verification**:
  - The final rule promotes program integrity by requiring all individuals to submit supporting documentation for special enrollment periods and ensures that only those who are eligible are able to enroll. Verification for states served by the Healthcare.gov platform is increasing from 50% to 100% of new consumers applying for a special enrollment period.

Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-04-13-2.html

- **Payment of Past Due Premiums**:
  - The final rule allows issuers to require individuals to pay back past due premiums before enrolling into a plan with the same issuer the following year. This is intended to address gaming and encourage individuals to maintain continuous coverage throughout the year, which will have a positive impact on the risk pool.

- **Actuarial Value Flexibility:**
  - For the 2018 plan year and beyond, the final rule allows issuers additional actuarial value flexibility within the metal tier system to develop more choices with lower premium options for consumers, and to continue offering existing plans.

Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-04-13-2.html

- **Network Adequacy**:
  - The final rule reduces waste of taxpayer dollars by eliminating duplicative review of network adequacy by the federal government. The rule returns oversight of network adequacy to states that are best positioned to evaluate network adequacy.

- **Essential Community Providers**:
  - The final rule allows issuers to continue to identify essential community providers who are not on the HHS list through a write-in process.
  - It also lowers the essential community provider standard to 20% instead of 30% for the 2018 plan year. This rule is designed to make it easier for issuers to build provider networks that comply with the standard.

Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-04-13-2.html

1332 State Innovation Task Force Meeting Agenda

April 18, 2017
1:30 p.m.-3 p.m.
Oklahoma Hospital Association
4000 N. Lincoln Blvd., Seminar Room
Oklahoma City, OK 73105

Section	Time		Presenter
Welcome and Introductions	**1:30**	**5 min**	**Julie Cox-Kain, Deputy Secretary of Health and Human Services**
Federal Updates	**1:35**	**10 min**	**Julie Cox-Kain**
Discussion of Reinsurance and High Risk Pools	**1:45**	**30 min**	**Julie Cox-Kain; Buffy Heater, HHS Project Lead**
Preliminary Impact Assessment of Concept Paper Strategies	**2:15**	**30 min**	**Erik Krisle, Leavitt Partners** **Austin Bordelon, Leavitt Partners**
Timeline and Next Steps	**2:45**	**15 min**	**Julie Cox-Kain, Buffy Heater**

Reinsurance and High Risk Pools

- A high-risk pool and/or reinsurance program is a potential tool to quickly stabilize the market so that participating carrier's financial risks are mitigated and Oklahomans can continue to use their tax credits to purchase coverage on healthcare.gov.
- In reinsurance programs, insurance carriers are paid part of a high-cost and/or high-need individual's claims over a specified amount. The individuals remain in the total pool.
- Alaska and Minnesota are working to implement a reinsurance program through a 1332 Waiver as a way to encourage market competition and keep premium cost growth down.

Reinsurance and High Risk Pools

- Another way to stabilize public investment is to utilize a high-risk pool design, where high-cost individuals are offered coverage in a separate pool. Taking high-risk people out of the conventional market can help keep premiums lower for those remaining in the market.
- Wisconsin is touted as having a successful state-run high risk pool program with high per capita enrollment.
- Congress is looking at a high-risk pool/reinsurance hybrid as a possible amendment to the ACA. Congress has used Maine's approach as an example model.

Risk Management for the Individual Market

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

High-Risk Pools

Segmenting the highest risk populations into a separate pool.

Pros:

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

Cons:

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

Hybrid Program

Health care condition used as triggering event for state responsibility.

Pros:

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

Cons:

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

Reinsurance

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

Pros:

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

Cons:

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

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

Options for Individual Eligibility

Cost-based

- Rather than setting up a separate high-risk pool, one approach is to use funds to reimburse health plans a portion of the claims costs of their high-cost enrollees. (MN example) High cost individuals would remain in the private individual market. States establish the definition of “high-cost” as an attachment point and claims cap.

Condition-based

- As an alternative, reimbursements could be based on an enrollee having one or more specified high-risk conditions. (AK or AZ example)

Hybrid

- Both cost and condition based (ME example)

Wisconsin High Risk Pool

- Wisconsin's Health Insurance Risk-Sharing Plan (HIRSP) ran from 1979 – 2014
- Funded through premiums, insurance company assessments and reduced payments to providers
- Statutes required policyholder premiums to fund 60% of estimated operating and administrative costs of the state-based HIRSP Plan.
- Variety of plan choices at varying levels of premium to meet the needs of individuals with pre-existing conditions.

Wisconsin High Risk Pool

- Premium, deductible and drug out-of-pocket maximum discount if applicant's household income was below $34,000/year
- Individuals had maximum annual individual out-of-pocket costs from $2,000 to $8,500
- Monthly premiums ranged from $158 for someone under age 18 to $1,500 for a male over age 60
- HIRSP premiums varied by as much as 15% per year

Alaska Reinsurance Program

- Only funded for 2017, the state has drafted a 1332 waiver proposal that seeks 5 years of federal funding
- The program will use $55 million of the $64 million that was collected in 2015 to cover claims for high-cost insured lives in the individual market
- Funding generated by a 2.7% premium tax on all insurers in AK

Maine Invisible High Risk Pool (Hybrid)

- Helped cover claim costs for individuals with high medical claims in the market (reinsurance)
- Targeted a subset of individuals based on specific conditions (high-risk pool)
- Did not move individuals with pre-existing conditions out of the traditional market
- Individuals were charged the same premium as everyone else

Maine Invisible High Risk Pool (Hybrid)

- Age rating bands were expanded from 1.5-to-1 to 3-to-1
- Helped drive premiums down, increasing the number of younger, healthier people purchasing insurance
- Two primary funding sources:
  - 90% of pool premiums were transferred to the high risk pool (known as the Maine Guaranteed Access Reinsurance Association), which covered 42% of all claim expenses
  - $4 per member per month assessment on all policies, which raised nearly $28 million

Considerations for Oklahoma:

- Need authorizing legislation and 1332 waiver approval
- Need upfront funding, via an insurance plan assessment
- Need to identify administering entity and infrastructure
- The federal government will reimburse a majority of the costs via pass through funding
- The remaining state funds necessary will be a portion of the total funding
- Timing and coordination of multiple activities occurring simultaneously

1332 State Innovation Task Force Meeting Agenda

April 18, 2017
1:30 p.m.-3 p.m.
Oklahoma Hospital Association
4000 N. Lincoln Blvd., Seminar Room
Oklahoma City, OK 73105

Section	Time		Presenter
Welcome and Introductions	**1:30**	**5 min**	**Julie Cox-Kain, Deputy Secretary of Health and Human Services**
Federal Updates	**1:35**	**10 min**	**Julie Cox-Kain,**
Discussion of Reinsurance and High Risk Pools	**1:45**	**30 min**	**Julie Cox-Kain; Buffy Heater, HHS Project Lead**
Preliminary Impact Assessment of Concept Paper Strategies	**2:15**	**30 min**	**Erik Krisle, Leavitt Partners Austin Bordelon, Leavitt Partners**
Timeline and Next Steps	**2:45**	**15 min**	**Julie Cox-Kain, Buffy Heater**

Oklahoma 1332 Task Force: Modeling Overview

LEAVITT PARTNERS

April 18, 2017

Modeling Overview

Leavitt Partners worked closely with Oklahoma Health Department staff to prioritize the following solutions from the Modernized Marketplace concept paper for comprehensive modeling and impact analysis:

- **Impact of a High-Risk Pool or Reinsurance Program –** Introducing new stability funding—whether through a reinsurance program or high-risk pool—has the ability to directly reduce the underlying cost of a risk pool and, in turn, lower premiums and slow cost growth.

- **Effects of Moving to a Wider Age Band –** Allowing greater variance to the age bands for underwriting insurance may support greater participation among younger age, and lower risk, Oklahomans.

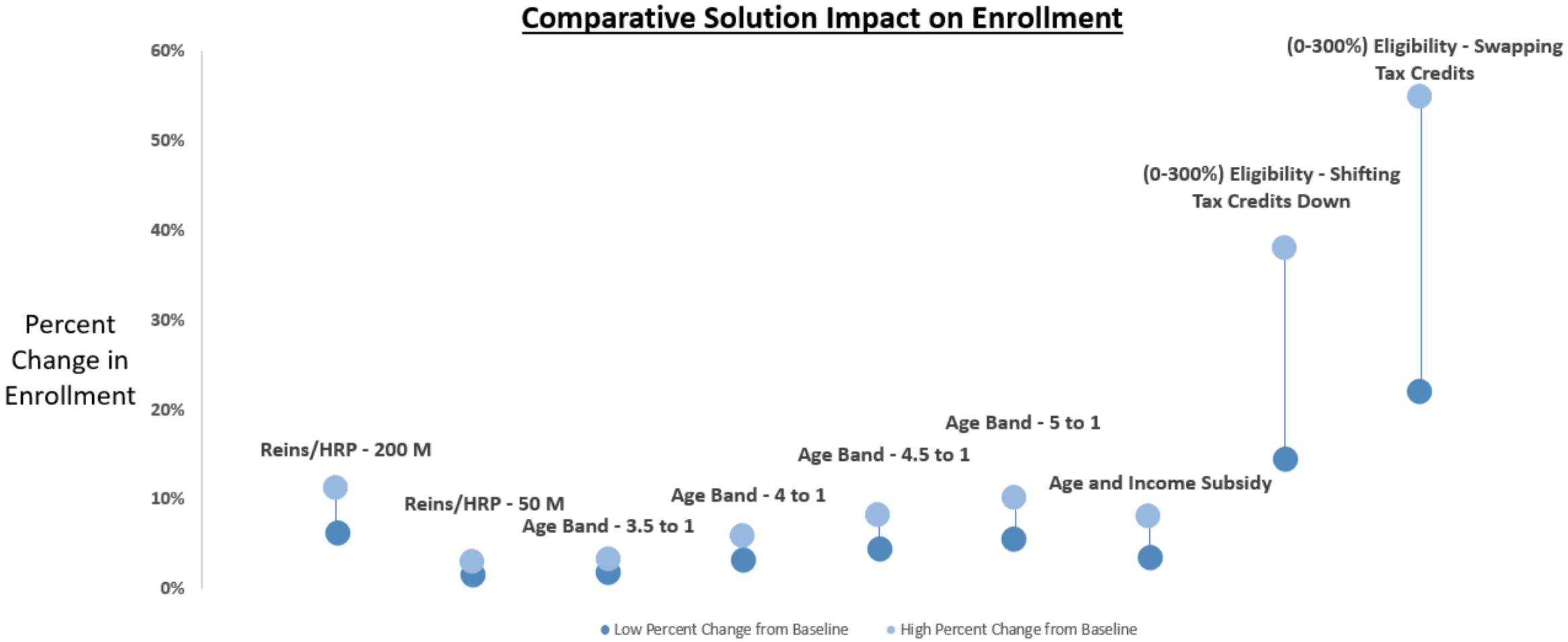
- **Standardizing Subsidies Based on Age and Income –** With the goal of providing additional support to younger populations and moving to a subsidy structure that also places more downward pressure on premiums, the State will evaluate calculating insurance subsidies based on age and income.

- **Reallocating Subsidies for 0-300% FPL Population –** With a significant population lacking coverage below the Federal Poverty Line (FPL), Oklahoma would also like to evaluate the effects of moving eligibility for premium assistance down to 0-300$ FPL (adjusting from 100-400% FPL today).

The results of this analysis are preliminary and additional refinements to the model are predicted. Leavitt Partners and the Oklahoma team also expect to model a handful of select combinations of the solutions listed above.

Modeling Overview

The various solutions are likely to have different affects on total enrollment. Subsidizing the gap population (Solution 5) has the largest effect on total enrollment driven by large increases in spending for a new population.



Modeling Overview

Summary of the analysis and composite score for each proposed solution:

Methodology
Leavitt Partners utilized the following data and research in modeling the proposed solutions: – Secondary research and literature review – Time series modeling – CMS enrollment and premium data – MLR, NAIC, and U.S. Census market data – Price elasticity modeling – Regulatory research

	Legislative		Impact			Budget	Operations	
	Federal	State	Enrollment	Premiums	Market Stability	Financial Commitment	Implementation	Composite
Solution 1: Reinsurance / High Risk Pool	●	◐	◐	◕	◐	◔	◐	◐
Solution 2: Wider Age Band	◔	◕	◐	◐	◐	●	●	◕
Solution 3: Age + Income Subsidies	◕	◐	◔	◐	◐	◕	◔	◔
Solution 4: Moving Eligibility to 0-300% FPL	◐	◔	●	◔	◐	○	○	◐

○ ◔ ◐ ◕ ●

Unfavorable → Favorable

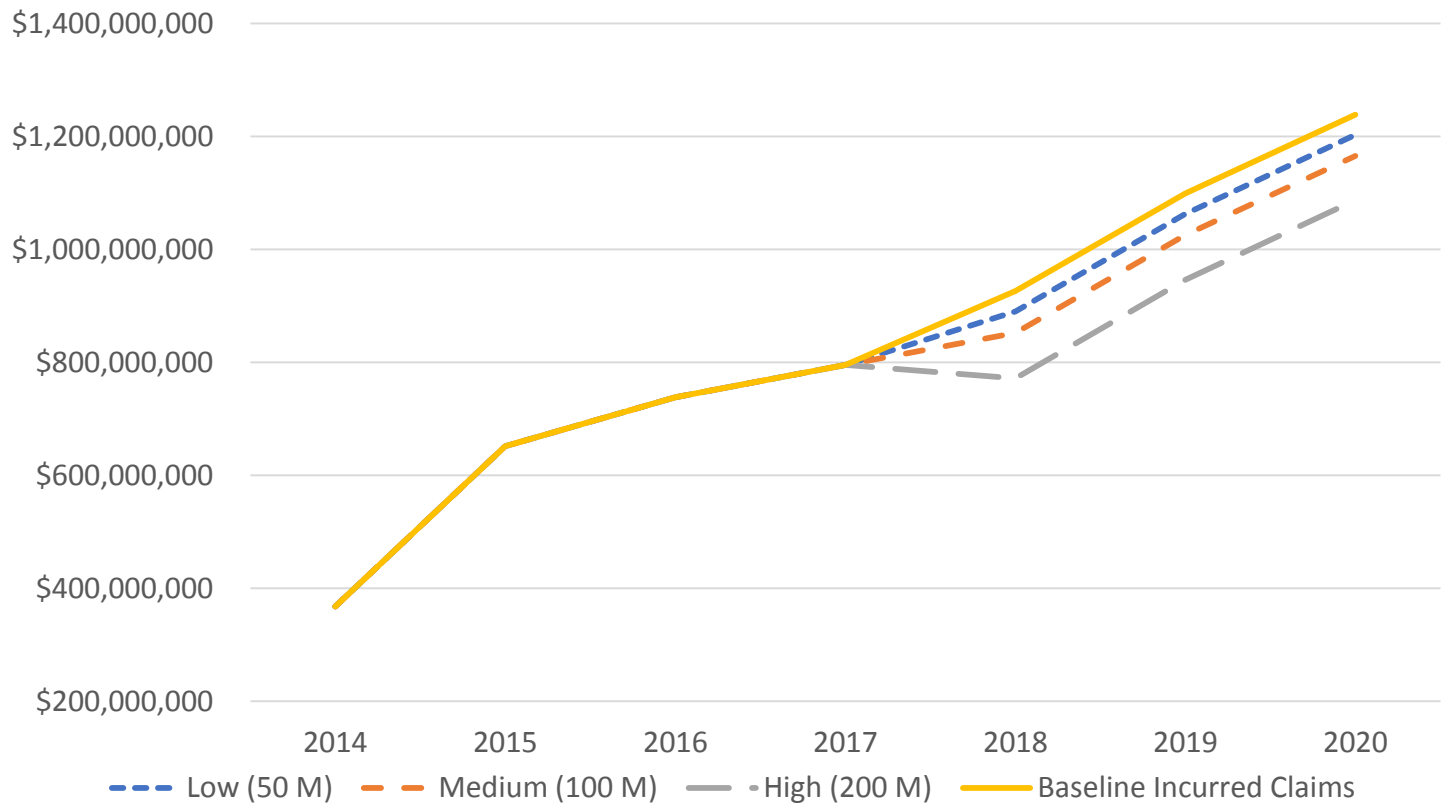
LEAVITT PARTNERS

Solution 1: Impact of a High-Risk Pool or Reinsurance Program

Solution 1: Impact of a High-Risk Pool or Reinsurance Program

The introduction of stability funding—through a reinsurance program or high-risk pool—has the ability to directly reduce the underlying cost of a risk pool and, in turn, lower premiums and slow cost growth .

Aggregate Incurred Claims under Varying Amounts of Stability Funding



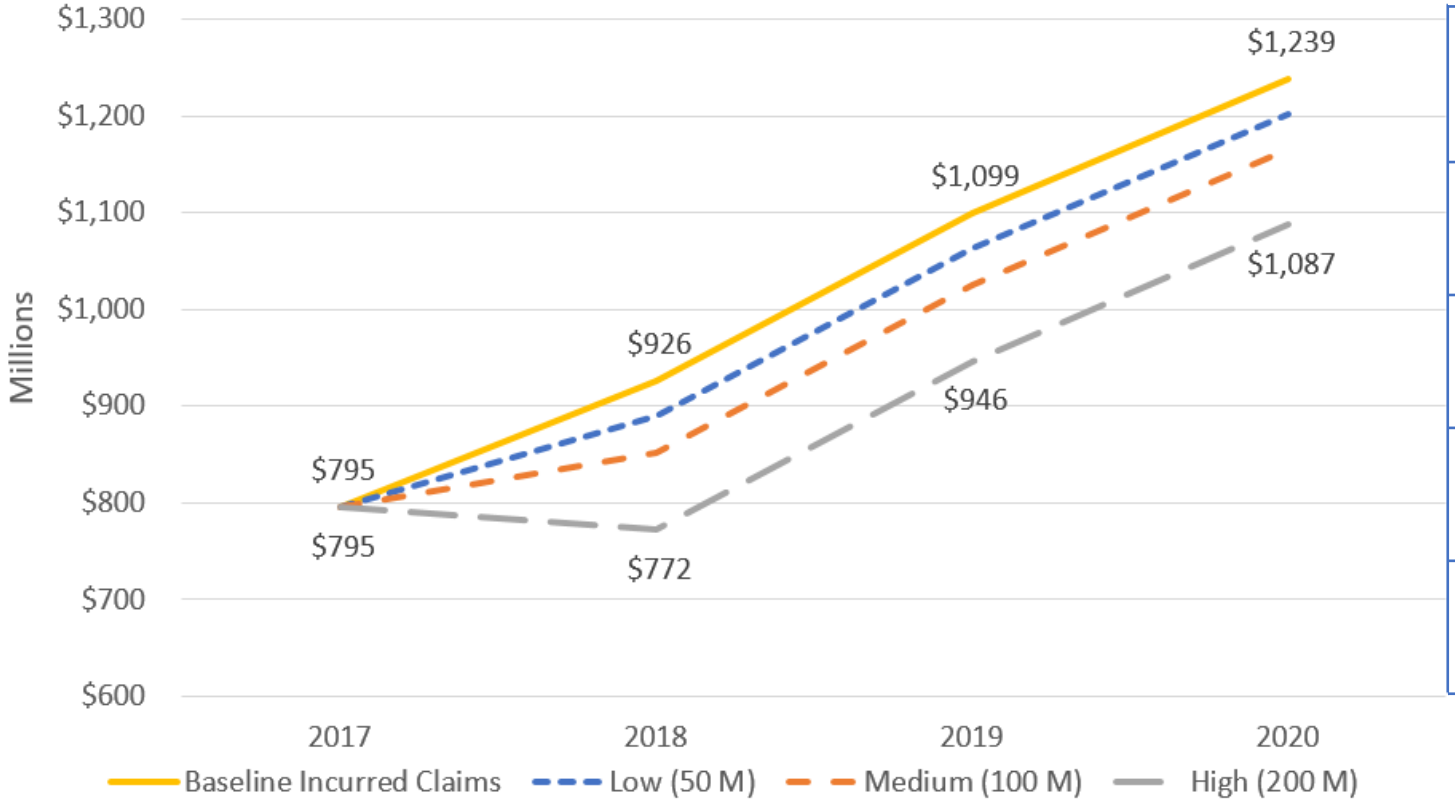
Leavitt Partners modeled the influence of reinsurance program or high-risk pool funding of $50M, $100M, and $200M. These amounts were determined as a function of 5%, 10% and 20% of the aggregate individual market incurred claims amount.

Source: Market data obtained through Leavitt Partners analysis of CMS Medical Loss Ratio (MLR) data

Solution 1: Impact of a High-Risk Pool or Reinsurance Program

The introduction of stability funding—through a reinsurance program or high-risk pool—has the ability to directly reduce the underlying cost of a risk pool and, in turn, lower premiums and slow cost growth.

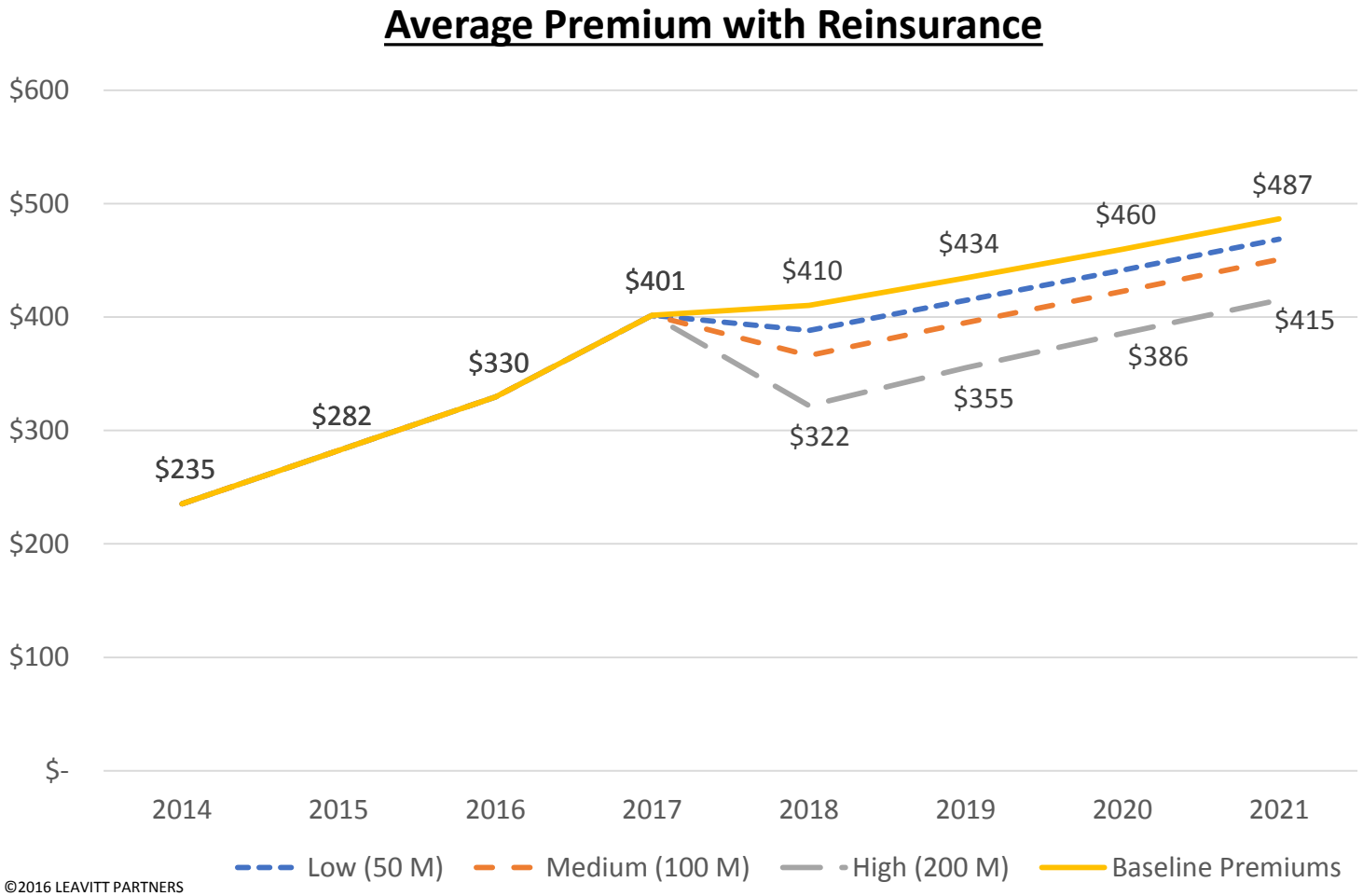
Aggregate Incurred Claims under Varying Amounts of Stability Funding



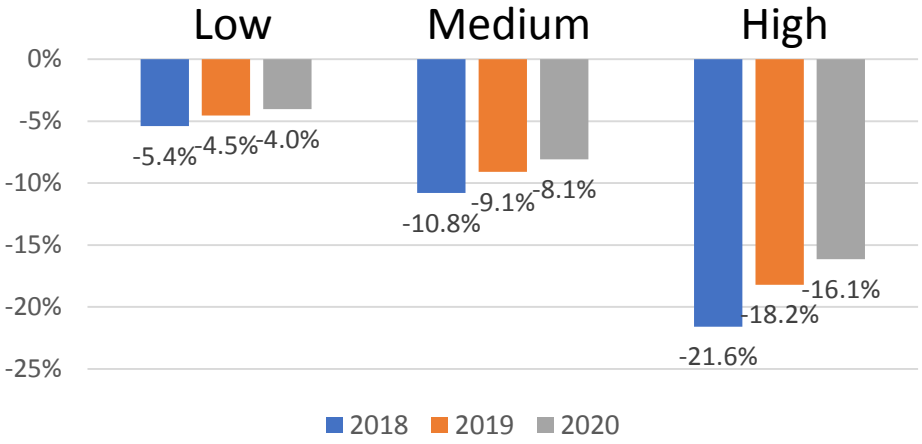
Year	Baseline Incurred Claims	Low (50 M)	Medium (100 M)	High (200 M)
2017	$795	$795	$795	$795
2018	$926	$890	$852	$772
2019	$1,099	$1,063	$1,025	$946
2020	$1,239	$1,203	$1,165	$1,087

Solution 1: Impact of a High-Risk Pool or Reinsurance Program

Directly subsidizing the individual market risk pool has an immediate affect on premiums for the state. Based on the subsidy amount, premiums are estimated to drop 5% (50 M), 11% (100 M), and 22% (200 M).



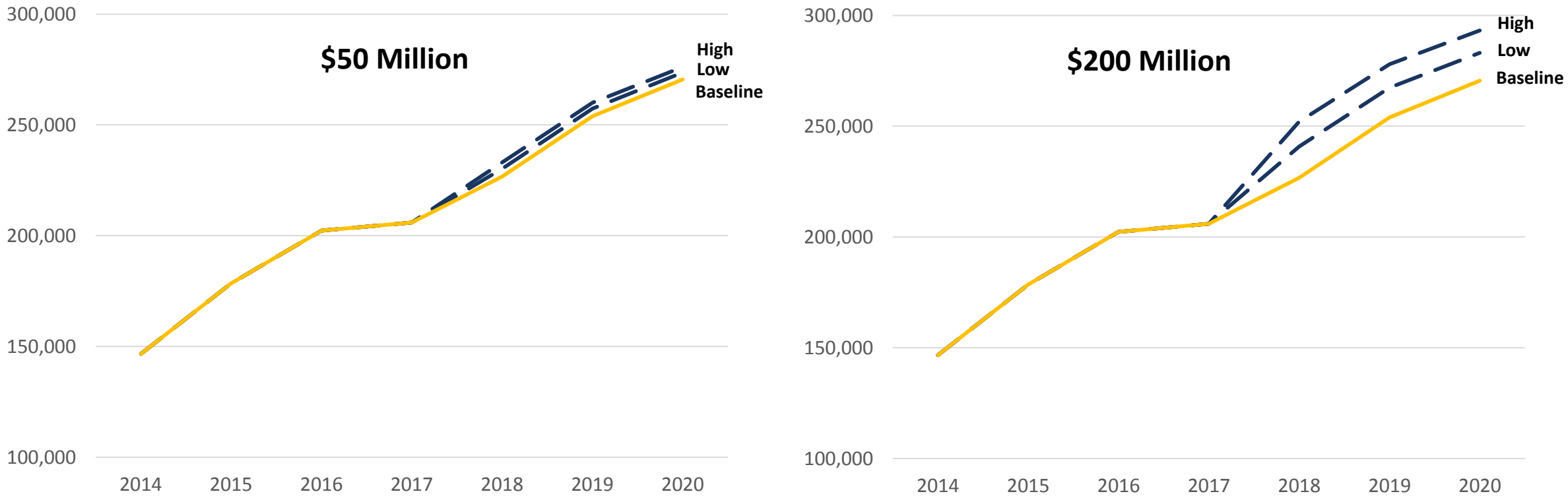
Percent Premium Change			
Year	Low (50 M)	Medium (100 M)	High (200 M)
2018	-5.4%	-10.8%	-21.6%
2019	-4.5%	-9.1%	-18.2%
2020	-4.0%	-8.1%	-16.1%



Solution 1: Impact of a High-Risk Pool or Reinsurance Program

Individual market enrollment could increase between 1.5% to 3% under $50M of stability funding for the state or 6.2% to 11.2% with $200M of new funding.

Total Individual Market Enrollment with Reinsurance



Note: High and low enrollment estimates reflect varied assumptions for consumer sensitivity to changes in price

Source: Market data obtained through Leavitt Partners analysis of CMS Medical Loss Ratio (MLR) data; Consumer elasticity data estimated through Literature Review

Solution 1: Impact of a High-Risk Pool or Reinsurance Program

As premium's are reduced, savings to the federal government from lower subsidy payments are realized and may be eligible to be collected for future program funding

		Baseline APTC Subsidy	New APTC Subsidy (low)	New APTC Subsidy (high)	Potential APTC Savings[1]	Original Funds Eligible for Pass-Through Savings (%)
$50 Million in Program Funding	2018	$ 828.92 M	$ 784.19 M	$ 806.25 M	$ 22.67 M - $ 44.74 M	45.3% - 89.5%
	2019	$ 1002.55 M	$ 956.93 M	$ 979.66 M	$ 22.89 M - $ 45.61 M	45.8% - 91.2%
	2020	$ 1139.88 M	$ 1093.87 M	$ 1116.94 M	$ 22.95 M - $ 46.02 M	45.9% - 92.0%
$100 Million in Program Funding	2018	$ 828.92 M	$ 739.45 M	$ 780.95 M	$ 47.97 M - $ 89.48 M	48.0% - 89.5%
	2019	$ 1002.55 M	$ 911.32 M	$ 954.47 M	$ 48.08 M - $ 91.23 M	48.1% - 91.2%
	2020	$ 1139.88 M	$ 1047.85 M	$ 1091.89 M	$ 48.00 M - $ 92.03 M	48.0% - 92.0%
$200 Million in Program Funding	2018	$ 828.92 M	$ 649.97 M	$ 722.84 M	$ 106.08 M - $ 178.95 M	53.0% - 89.5%
	2019	$ 1002.55 M	$ 820.10 M	$ 897.62 M	$ 104.92 M - $ 182.45 M	52.5% - 91.2%
	2020	$ 1139.88 M	$ 955.82 M	$ 1036.01 M	$ 103.87 M - $ 184.06 M	51.9% - 92.0%

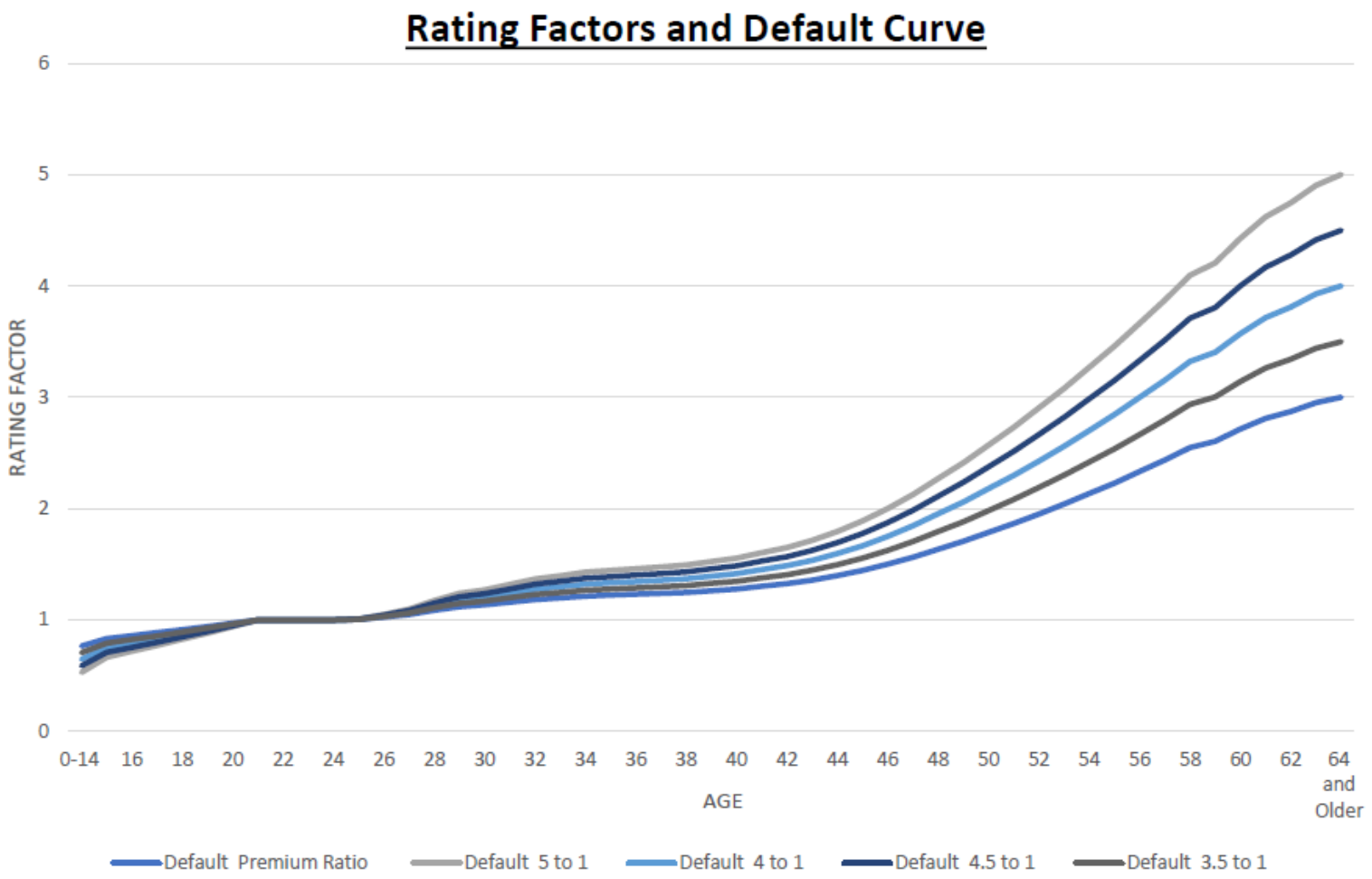
[1] **Note:** Savings reflect APTC reduction only. Does not reflect mandate penalties or FFM user fee adjustment.

Source: Market data obtained through Leavitt Partners analysis of CMS Medical Loss Ratio (MLR) data

LEAVITT PARTNERS

Solution 2: Effects of Moving to a Wider Age Band

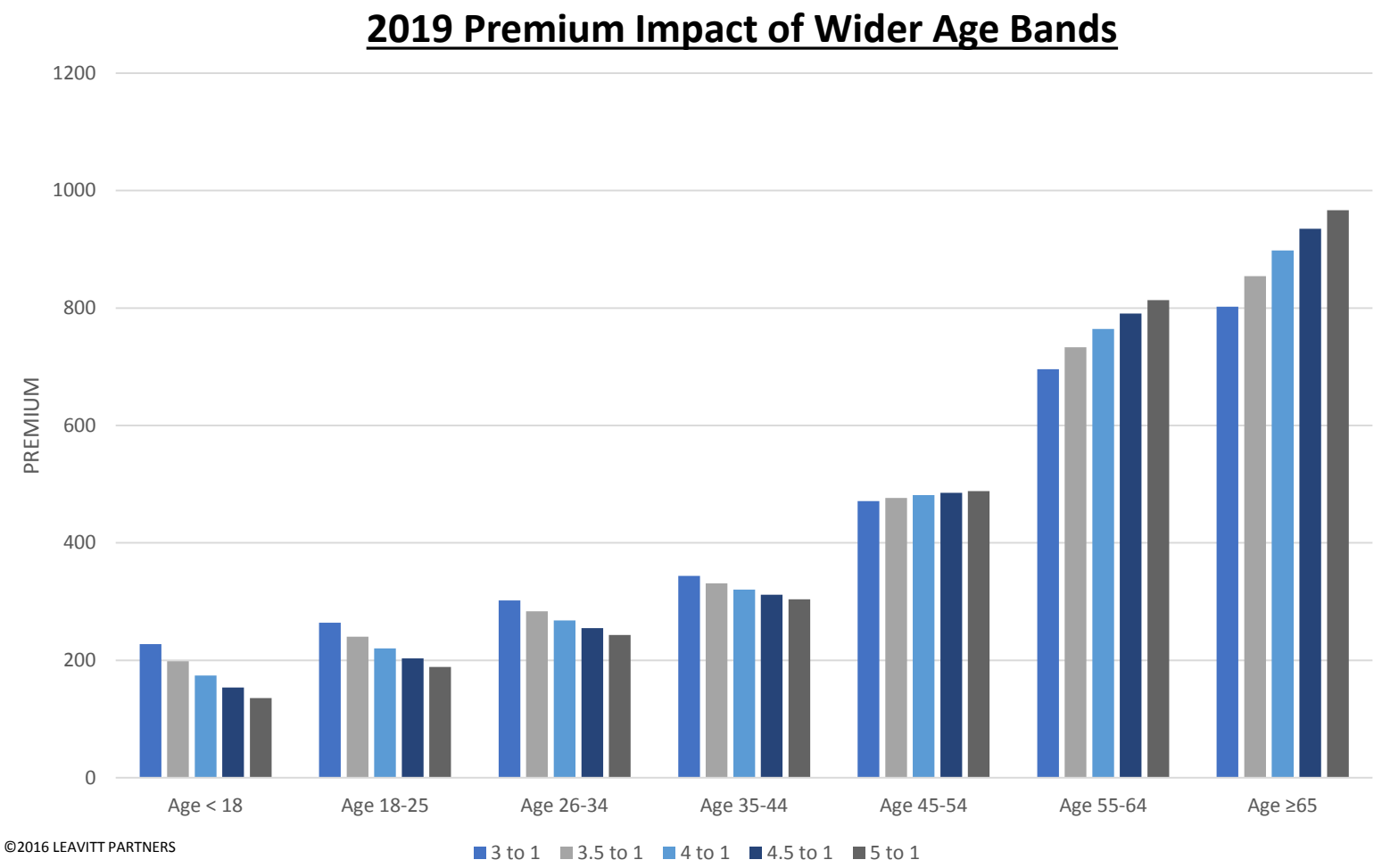
Solution 2: Effects of Moving to a Wider Age Band



- The current, 3:1 ratio for Age Banding means that insurers cannot charge seniors more than three times what younger patients pay in premium value.
- These rating rules attempt to strike a balance between promoting market stability and sound risk pools, while at the same time assuring that younger, healthier individuals can participate in the coverage marketplace.
- These age band curves reflect the “default” slope for reaching the upper band. However, states do have the option to customize.

Solution 2: Effects of Moving to a Wider Age Band

Widening the age band is likely reduce premiums for young enrollees and increase them for older populations. A 5:1 age band could reduce young adult premiums as much as 29% and increase them by 21% for older enrollees.

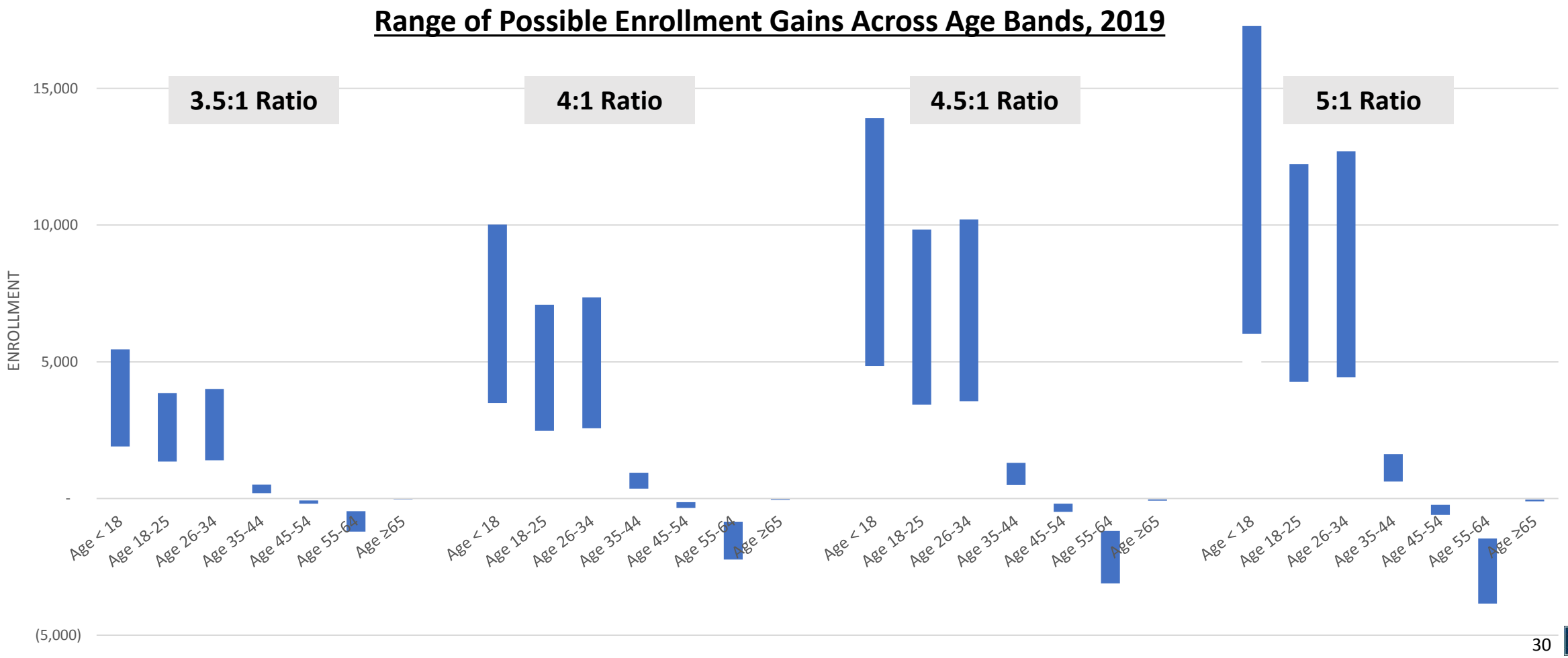


Avg. Monthly Premiums ($'s)					
Age Bands	3 to 1	3.5 to 1	4 to 1	4.5 to 1	5 to 1
Age < 18	228	199	174	154	136
Age 18-25	264	240	220	203	189
Age 26-34	302	284	268	255	243
Age 35-44	344	331	321	312	304
Age 45-54	471	477	481	485	488
Age 55-64	696	733	764	791	813
Age ≥65	802	854	898	935	967

	Percent Change from 3:1 Age Band (2019)				
Age Bands	3 to 1	3.5 to 1	4 to 1	4.5 to 1	5 to 1
Age < 18	0%	-13%	-23%	-32%	-40%
Age 18-25	0%	-9%	-17%	-23%	-29%
Age 26-34	0%	-6%	-11%	-16%	-19%
Age 35-44	0%	-4%	-7%	-9%	-12%
Age 45-54	0%	1%	2%	3%	4%
Age 55-64	0%	5%	10%	14%	17%
Age ≥65	0%	6%	12%	17%	21%

Solution 2: Effects of Moving to a Wider Age Band

Lower premiums are likely to encourage new enrollment among younger populations while "pricing out" a subset of the older population.



LEAVITT PARTNERS

Solution 3: Standardizing Subsidies Based on Age and Income

Solution 3: Standardizing Subsidies Based on Age and Income

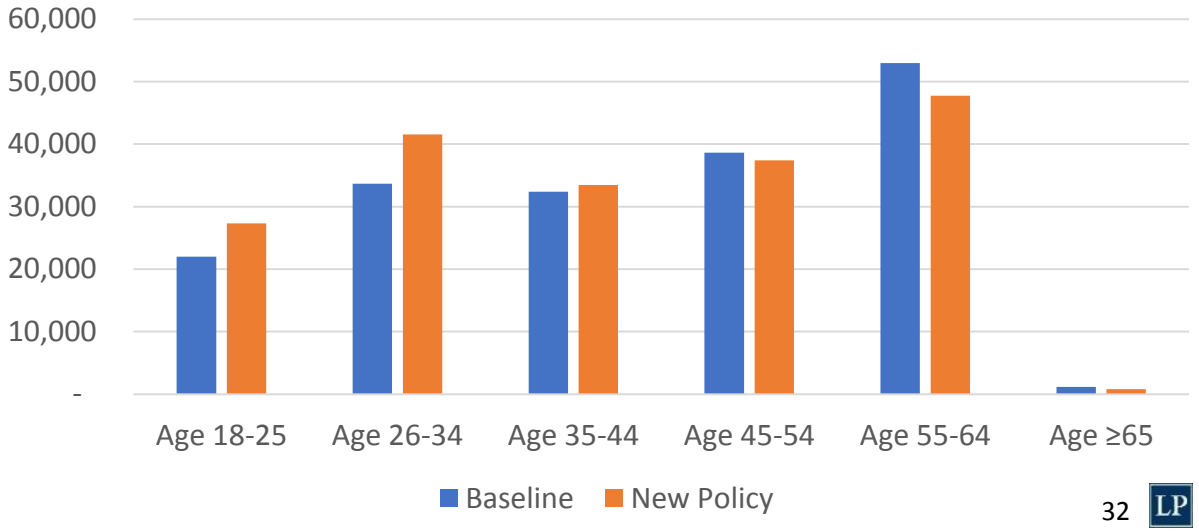
Guiding principles for developing a new subsidy structure based on "age" and "income:"

1. Should make coverage more affordable to younger populations
2. Total subsidies will be budget neutral relative to anticipated APTC funding
3. Spread across ages should still require some 'skin in the game' for enrollees
4. Cost-sharing reduction (CSR) are assumed to remain in place
5. Only available to plans purchased on marketplace

New Subsidy Amount

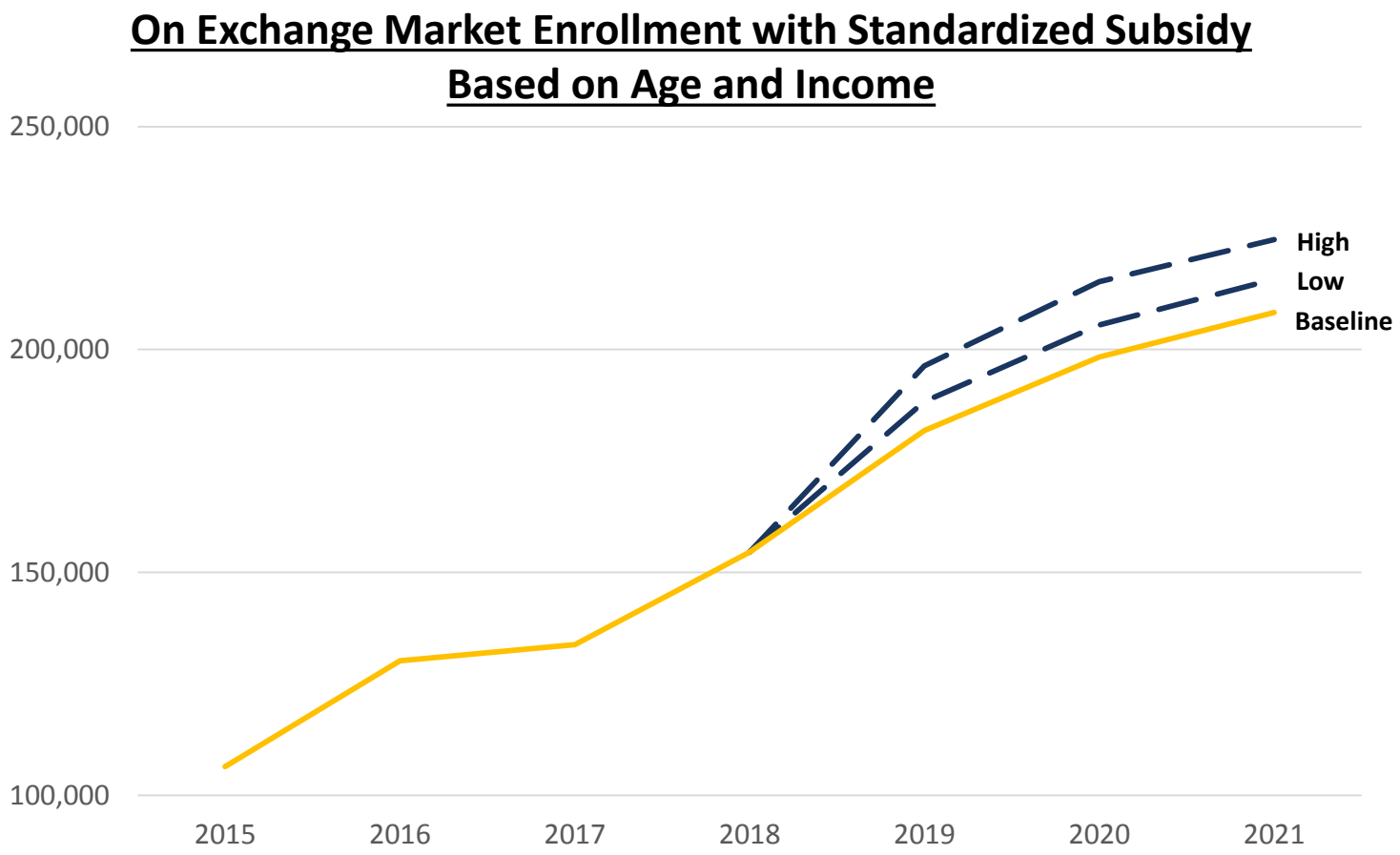
Federal Poverty Level	**100-138% (Old)**	**100-138% (New)**	139-200%	201-250%	251-400%	400%+
Age 18-25	**$ 383**	**$ 395**	$ 371	$ 296	$ 217	$ -
Age 26-34	**$ 441**	**$ 454**	$ 427	$ 341	$ 250	$ -
Age 35-44	**$ 506**	**$ 514**	$ 483	$ 385	$ 282	$ -
Age 45-54	**$ 703**	**$ 691**	$ 650	$ 518	$ 380	$ -
Age 55-64	**$ 1,050**	**$ 1,027**	$ 965	$ 770	$ 565	$ -
Age ≥65	**$ 1,214**	**$ 1,106**	$ 1,040	$ 830	$ 608	$ -

Possible Enrollment Impact of New Subsidy Structure in Year 1



Solution 3: Standardizing Subsidies Based on Age and Income

Older populations have much lower demand elasticity for health care services and are less sensitive to changes in price. Thus, moderate reductions in premium to young enrollees and slight increases to older enrollees have the potential to increase aggregate enrollment for the market (shown at left).



Year	Exchange Enrollment (baseline)	Solution Low	Solution High
2016	130,000	-	-
2017	134,000	-	-
2018	155,000	-	-
2019	182,000	188,000	196,000
2020	198,000	205,000	215,000
2021	208,000	214,000	225,000

Note: High and low enrollment estimates reflect varied assumptions for consumer sensitivity to changes in price

Source: Market data obtained through Leavitt Partners analysis of CMS Medical Loss Ratio (MLR) data; Consumer elasticity data estimated through Literature Review

LEAVITT PARTNERS

Solution 4: Reallocating Subsidies for 0-300% FPL Population

Solution 4: Reallocating Subsidies for 0-300% FPL Population

As a potential way to cover the Medicaid "gap population," we considered the effects of lowering subsidy eligibility below 100% and two possible methods for subsidy calculation. Concerns of Medicaid enrollees cannibalization warranted a second scenario (at right) with higher member cost-sharing.

Scenario #1: ACA subsidy shifted downward

	Gap Population (<100%)	100-138%	139-200%	201-250%	251-300%	301-400%
Individual FPL Guidelines (monthly):	$ 661	$ 1,211	$ 1,724	$ 2,294	$ 2,803	$ 3,565
Income Limit for Premium	2%	3-5.9%	6-7.85%	7.86-9.10%	9.11-9.69%	0%
Average Premium	$ 13.49	$ 49.39	$ 120.70	$ 197.83	$ 269.87	$ 419.23
Avg. Change in Premium	$ (405.74)	$ 24.69	$50.35	$ 37.26	$ 34.98	$ 117.68
Low Enrollment Projection	47,682	(10,494)	(7,980)	(1,760)	(788)	(143)
High Enrollment Projection	118,352	(26,024)	(19,789)	(2,056)	(878)	(304)

Net New Enrollment (2019): 26,500 – 69,000 individuals

Net New Spend (2019): $194 – $499 million

Scenario #2: ACA subsidy swapped from upper end

	Gap Population (<100%)	100-138%	139-200%	201-250%	251-300%	301-400%
Individual FPL Guidelines (monthly):	$ 661	$ 1,211	$ 1,724	$ 2,294	$ 2,803	$ 3,565
Income Limit for Premium	9.11-9.69%	2%	3-5.9%	6-7.85%	7.86-9.10%	0%
Average Premium	$ 64.07	$ 24.69	$ 70.35	$ 160.57	$ 234.89	$ 419.23
Avg. Change in Premium	$ (355.16)	$ -	$ -	$ -	$ -	$ 117.68
Low Enrollment Projection	39,616	-	-	-	-	(143)
High Enrollment Projection	98,746	-	-	-	-	(304)

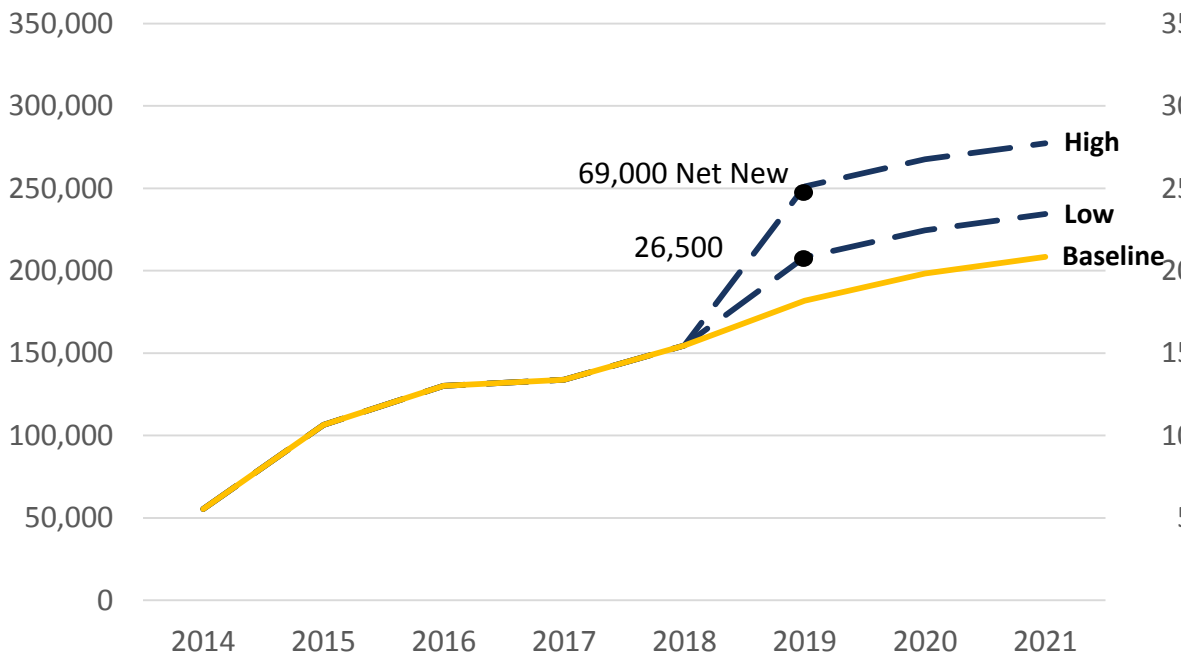
Net New Enrollment (2019): 39,500 – 98,500 individuals

Net New Spend (2019): $150 – $387 million

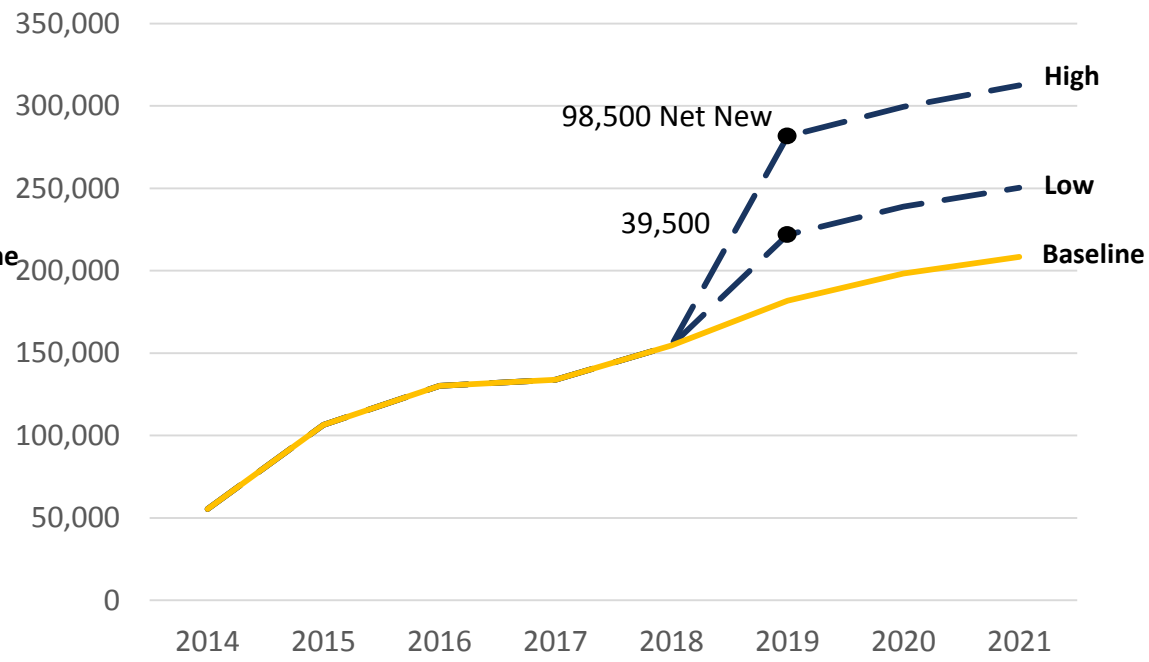
Solution 4: Reallocating Subsidies for 0-300% FPL Population

Based on these parameters, the "gap population" is likely to see greater enrollment due to the significantly lower premiums. However, a key factor for total enrollment gains is the degree of premium change for the other low income populations (i.e., 100-300% FPL).

Total Exchange Enrollment (Scenario 1- Shifting)



Total Exchange Enrollment (Scenario 2- Swapped)



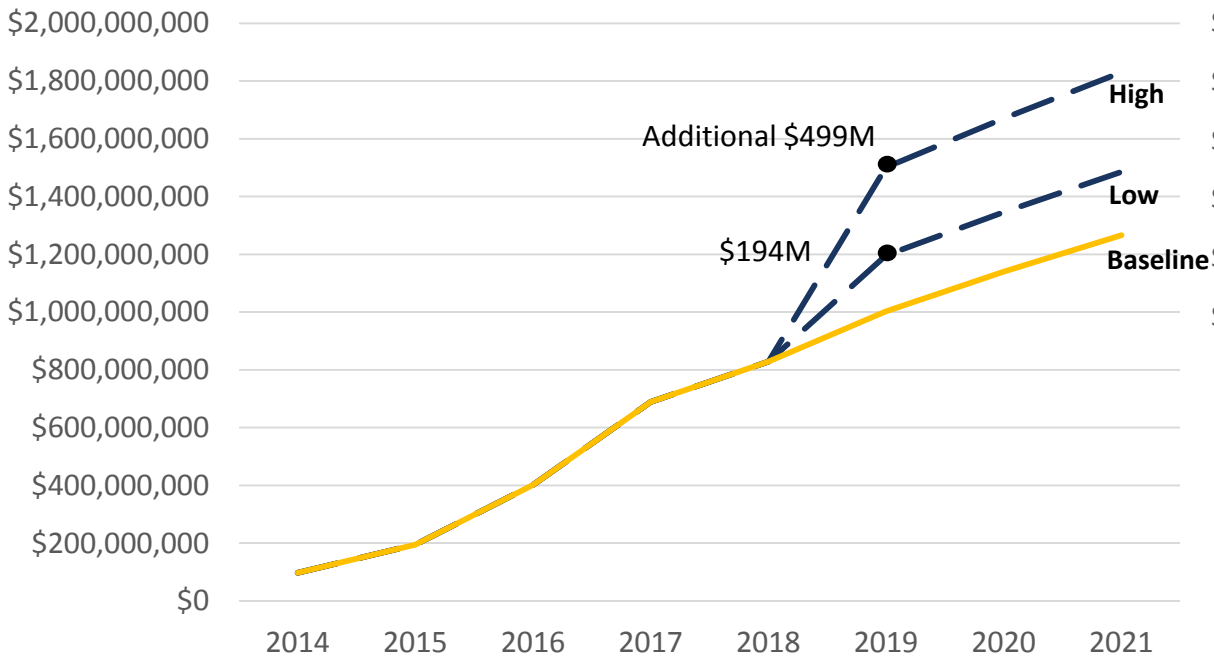
Note: High and low enrollment estimates reflect varied assumptions for consumer sensitivity to changes in price

Source: Market data obtained through Leavitt Partners analysis of CMS Medical Loss Ratio (MLR) data; Consumer elasticity data estimated through Literature Review

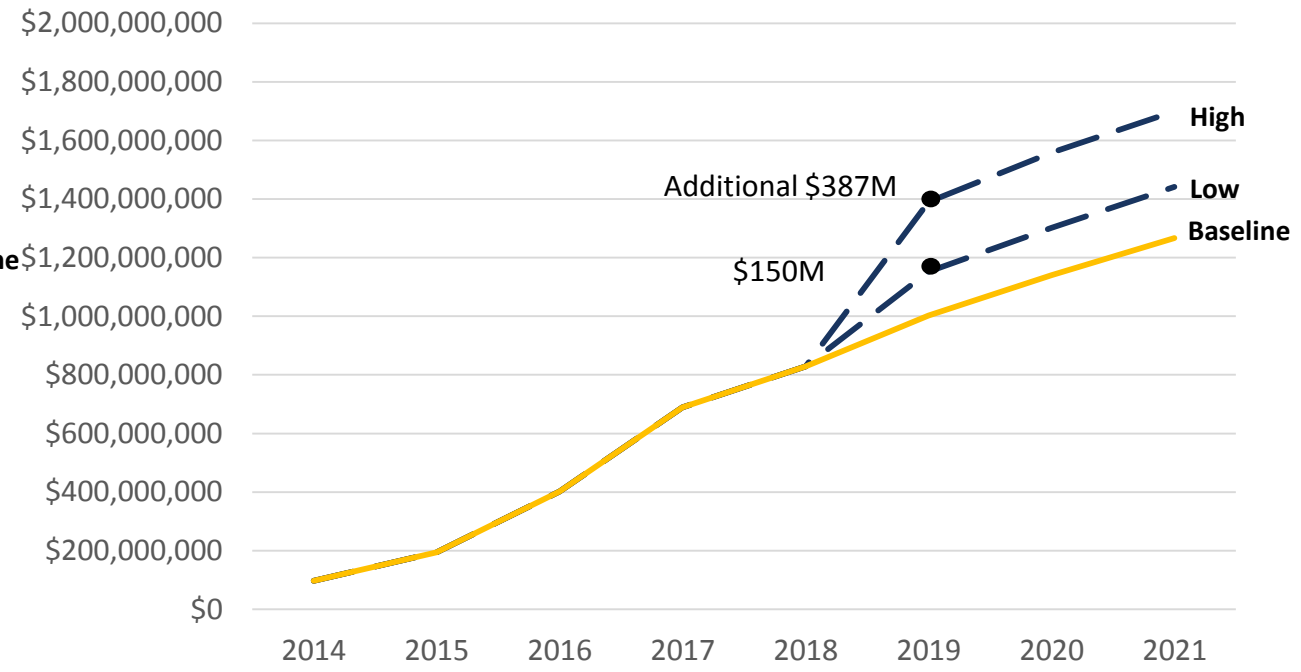
Solution 4: Reallocating Subsidies for 0-300% FPL Population

Gains in enrollment among the low income will not come cheap. The population between 300-400% FPL is much smaller than the "gap population" and the cost to subsidize their coverage is much greater.

Total Spending (Scenario 1- Shifting)



Total Spending (Scenario 2- Swapped)



Note: High and low enrollment estimates reflect varied assumptions for consumer sensitivity to changes in price

Source: Market data obtained through Leavitt Partners analysis of CMS Medical Loss Ratio (MLR) data; Consumer elasticity data estimated through Literature Review

A health care intelligence business

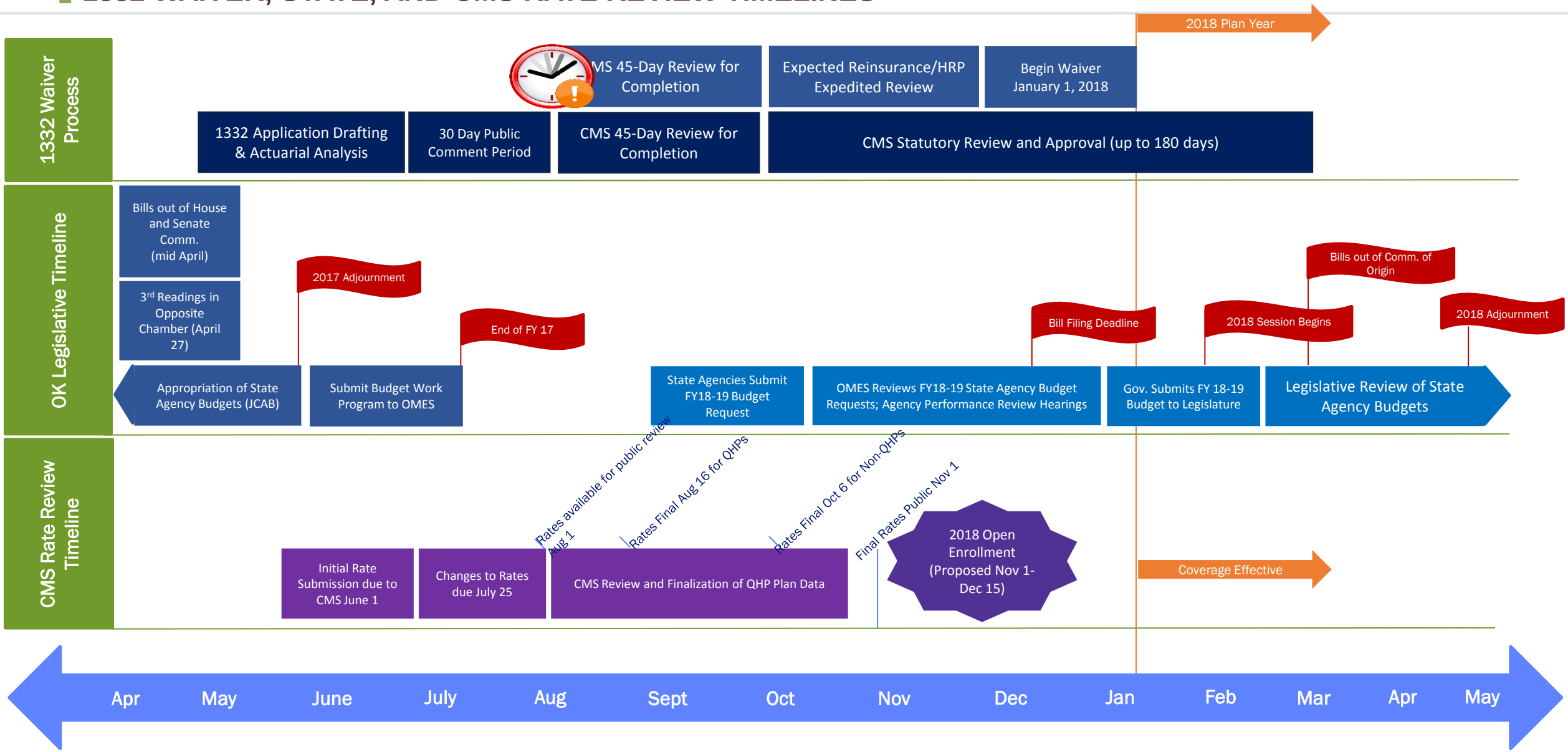
LeavittPartners.com

1332 State Innovation Task Force Meeting Agenda

April 18, 2017
1:30 p.m.-3 p.m.
Oklahoma Hospital Association
4000 N. Lincoln Blvd., Seminar Room
Oklahoma City, OK 73105

Section	Time		Presenter
Welcome and Introductions	**1:30**	**5 min**	**Julie Cox-Kain, Deputy Secretary of Health and Human Services**
Federal Updates	**1:35**	**10 min**	**Julie Cox-Kain,**
Discussion of Reinsurance and High Risk Pools	**1:45**	**30 min**	**Julie Cox-Kain; Buffy Heater, HHS Project Lead**
Preliminary Impact Assessment of Concept Paper Strategies	**2:15**	**30 min**	**Erik Krisle, Leavitt Partners** **Austin Bordelon, Leavitt Partners**
Timeline and Next Steps	**2:45**	**15 min**	**Julie Cox-Kain, Buffy Heater**

1332 WAIVER, STATE, AND CMS RATE REVIEW TIMELINES



Next Steps

- Conduct legislative review mid-April
- Continue impact analysis assessment by consultants, engagement of federal officials and stakeholders, report at June Task Force meeting
- Monitor federal developments regarding ACA amendments, CSR decision, etc.
- Secure actuarial consultant, proceed with waiver development
- Schedule tribal consultation and public comment periods
- Monitor progress on authorizing legislation and funding
- Pursue rate and form review responsibilities of OID
- Develop plans for potential administration responsibilities and infrastructure