



*1332 State Innovation Waiver Application
for the State of Oklahoma*

TERRY L. CLINE, PH.D.
SECRETARY OF HEALTH AND HUMAN SERVICES

AUGUST 7, 2017

Table of Contents

Executive Summary	4
Assurances	5
Summary of Oklahoma’s Waiver Proposal.....	6
Impact if Waiver is Not Granted.....	7
Characteristics of Oklahoma’s Health Insurance Market.....	7
Characterization of Defined Population.....	10
Description of Waiver Program	12
Waivers Requested.....	14
Pass-Through Funding	14
Tax Credit Proposal.....	14
Affected Populations and Demographics.....	15
Effect on Residents’ Ability to Get Care Out of State	17
Description of Post-Waiver Insurance Market.....	17
Individual Market	17
Small and Large Employers	17
Medicare	18
Medicaid (SoonerCare).....	18
Number of Employers Offering Coverage Pre/Post Waiver	18
Impact on Insurance Coverage in the State.....	18
Administrative Burden	18
Effects on Sections of ACA Not Waived.....	19
Comparability.....	19
10-Year Waiver (Budget Neutrality)	24
Ensuring Compliance, Reducing Waste and Fraud	24
Implementation Timeline and Process.....	26
Reporting Responsibilities.....	28
Waiver Development Process	28

Appendices

A. Enacted Legislation.....	30
B. Oklahoma Reinsurance Program Regulation.....	41
C. Actuarial Analyses and Certifications.....	46
D. Economic Analyses.....	77
E. Assumptions and Methodology.....	88
F. Reporting Targets.....	92
G. 1332 State Innovation Waiver Task Force Meetings.....	95
H. Public Notice of Hearing-Press Release.....	96
I. Online Public Notice of Public Hearings and Tribal Consultation.....	98
J. Slides from Public Hearings.....	100
K. Issues Raised during Public Notice and Public Comment Process.....	116
L. Tribal Consultation and Issues Raised.....	121
M. State and Federally Mandated Benefits.....	126
N. Waivable Sections.....	130
O. Section-by-Section Consideration.....	131
P. Letters of Support.....	134

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 subsidy eligible individuals for the last full plan year.¹ Enrollment on the Federally Facilitated Marketplace (FFM) has stagnated, with effectuated enrollment of approximately 130,000 for both 2016 and 2017 – while over half a million Oklahomans remained uninsured.² While there have been slight decreases in the uninsured, largely as a result of the newfound coverage made available through the FFM since 2014, Oklahoma's uninsured population continues to be of significant size, adding stresses to the health care system overall.

To address these challenges, the Oklahoma Legislature passed Senate Bill 1386 in 2016 with strong bipartisan support to explore possible solutions utilizing the 1332 State Innovation Waiver process as an option. Following the passage of SB 1386, Governor Mary Fallin established the 1332 State Innovation 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, brokers, consumer advocates, and tribal nations, with support from state agencies. As a result of meeting regularly since August of 2016, specific participant input, data collection and analysis, the Task Force identified a number of recommendations that form the basis for a comprehensive set of solutions to stabilize the individual market in the state.

While the Task Force developed a number of strategies to increase enrollment and stabilize the individual market, the first priority is to implement the Oklahoma Individual Health Insurance Market Stabilization Program (OMSP) for plan year 2018. The OMSP, authorized by House Bill 2406 (see Appendix A) on June 6, 2017, proposes to utilize federal pass-through funding and state-based assessments to create a reinsurance program for carriers operating on the Federally Facilitated Marketplace (FFM). As stated in the legislation, the purpose of the OMSP is "to provide payments to health insurance plans with respect to claims for eligible individuals for the purpose of lowering premiums for health insurance coverage offered in the individual market." Oklahoma anticipates that an adequately funded reinsurance program will:

- ✓ Reduce premiums by providing carrier safeguards for high-cost individuals
- ✓ Increase enrollment, which will further diffuse risk and reduce premiums
- ✓ Increase carrier competition, resulting in more choice for consumers and more competitive premium prices

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>

² Milliman. (2017). Assess the Market Effects of Healthcare Transformation.

Independent actuarial analysis estimates premium reductions of approximately 34% in 2018 and increased enrollment of 28,000 individuals by the third year of the program.

Oklahoma proposes to waive Section 1312 (c)(1) related to risk pooling in order to implement the state-based reinsurance program. This section requires issuers to “consider all enrollees in all health plans...to be members of a single risk pool.” Oklahoma requests that the waiver be effective January 1, 2018 with an initial approval of five years and the ability to renew for another five years.

Assurances

Oklahoma’s proposed waiver represents an opportunity for the state to develop its own unique program that is responsive to the needs of the state’s residents, while increasing the number of individuals with healthcare coverage and reducing the financial burden for residents and employers seeking affordable healthcare coverage. By adopting a state-based reinsurance program, meaningful impacts would be made by lowering premium prices for the individual market and would likely result in enrollment gains. The State of Oklahoma provides the following assurances that the proposed waiver aligns with required guardrails set forth in the ACA:

Scope of Coverage

The proposed waiver meets the scope of coverage guardrail, as coverage on the individual market will be available to a comparable number of people as would have been covered in the absence of the waiver. Oklahoma anticipates that more people will be insured on the individual market with the implementation of the waiver than without it in each year of the waiver. We estimate the reductions in the uninsured population will occur primarily in the population with income above 400% of the federal poverty level (FPL), as non-group (individual market) premium rates will be more affordable under the OMSP.³

There are no anticipated decreases in coverage for vulnerable populations by coverage category, health status, age, geographic location, or any other demographic characteristic as a result of the waiver. The waiver will also prevent gaps or discontinuations in service in at least the same degree as would be prevented without the waiver.

Affordability

The proposed waiver meets the affordability guardrail, with coverage as affordable as Marketplace coverage and comparable cost sharing and out-of-pocket protections. Implementation of the reinsurance program is dependent upon reduced premiums in the individual market that will produce federal savings that are passed through to the state. Therefore, it should increase affordability for certain groups in the individual market, both with and without federal premium assistance.

The OMSP is not estimated to materially impact premium rates for employer-sponsored insurance, nor change costs for public programs. For the non-group market, the OMSP is estimated to reduce premium rates by approximately 34%. The waiver will not decrease cost sharing protections against excessive out-of-pocket spending or decrease affordability for any vulnerable or at-risk populations.

³ In 2017, the FPL is approximately \$12,000 for a single household and \$25,000 for a family of four. 400% FPL would reflect income levels of \$48,000 and \$100,000, respectively. Please see <https://aspe.hhs.gov/poverty-guidelines> for more information.

Comprehensiveness

The proposed waiver meets the comprehensiveness guardrail, with coverage as comprehensive as the benchmark in all ten Essential Health Benefit categories that are provided under the current Marketplace program. The proposed waiver does not make any changes to Essential Health Benefits or impact benefits currently provided by Medicaid or employers. The scope of benefits will not be impacted as a result of the waiver.

Deficit Neutrality

The proposed waiver will not increase the federal deficit; any additional spending and administrative costs will meet the deficit neutrality requirement of Section 1332 (b)(1)(D). An explanation of expenditures and revenue is accounted for and explained in the economic and actuarial analysis in Appendix C and D.

Pass-Through Funding

The proposed pass-through funding represents savings to the Federal government from the reduction in premiums and associated reductions in advance premium tax credits.

Effect on Federal Operations

The proposed waiver requires federal premium tax credits to be passed through to the state. It does not require any other operational changes from the federal government. The waiver is not requesting state-specific changes to the federally-facilitated exchange.

Public Input

The state of Oklahoma has provided the opportunity for public input for the proposed waiver by means of public hearing, formal consultation and listening sessions with tribal representatives, legislative briefings, Task Force meetings, and a 30-day notice and comment period in compliance with 31 CFR 33.112 and 45 CFR 155.1312. See Appendices H, J, K and L for details on public comment.

Summary of Oklahoma’s Waiver Proposal

Between 2015 and 2017, Oklahoma’s individual market premiums have doubled in price and the number of carriers participating on the Marketplace has decreased from five companies to one. In fact, Oklahoma had the fourth highest average APTC amount in the nation in 2017, at \$551 per month. This amount represents a \$250 increase from the previous year.⁴

This market response emphasizes the necessity of market stabilization efforts to improve insurance affordability for all consumers by addressing the underlying costs of a high-risk enrollee population. By reducing premiums for all, a state-based reinsurance program will encourage enrollment and create a more attractive environment for other carriers to enter into the market.

⁴ CMS. (June 12, 2017). 2017 effectuated enrollment snapshot. <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf>

Benefits of Reinsurance in Oklahoma

2018	Without OMSP	With OMSP	Net Change	Net Percentage Change
2018 Premiums PMPM* (Figures I-5A)	\$668	\$440	\$228	34.1%
2018 Enrollment (Figure 1)	150,000	172,000	22,000	14.7%

*Values are rounded to nearest whole dollar.

The state will utilize federal pass-through funding combined with state assessments on fully-funded insurers and self-funded health insurers (with stop loss coverage) to sustain the program, with a targeted total funding amount of \$325 million. The federal funding will be derived from the reduction in APTCs as a result of the waiver. As the APTC amounts are based on the second lowest-cost silver plan in the market, lowering premiums across the board will save the federal government money on subsidies while also making premiums more affordable for non-subsidized individuals.

With approval of this waiver, the Oklahoma Insurance Department will assume rate review and plan certification functions beginning in plan year 2019.

Impact if Waiver is Not Granted

If the OMSP is not implemented, premiums will continue to rise, which will in turn reduce enrollment as more individuals are priced out of the market. Increased premiums also will likely promote adverse selection, as the individuals who continue to purchase increasingly expensive coverage will likely be those who utilize a higher number of health care services. Without a reinsurance program, the federal government will continue to pay high APTC amounts; with lower premiums Oklahoma can make coverage accessible to more residents for the same amount of federal dollars absent the waiver.

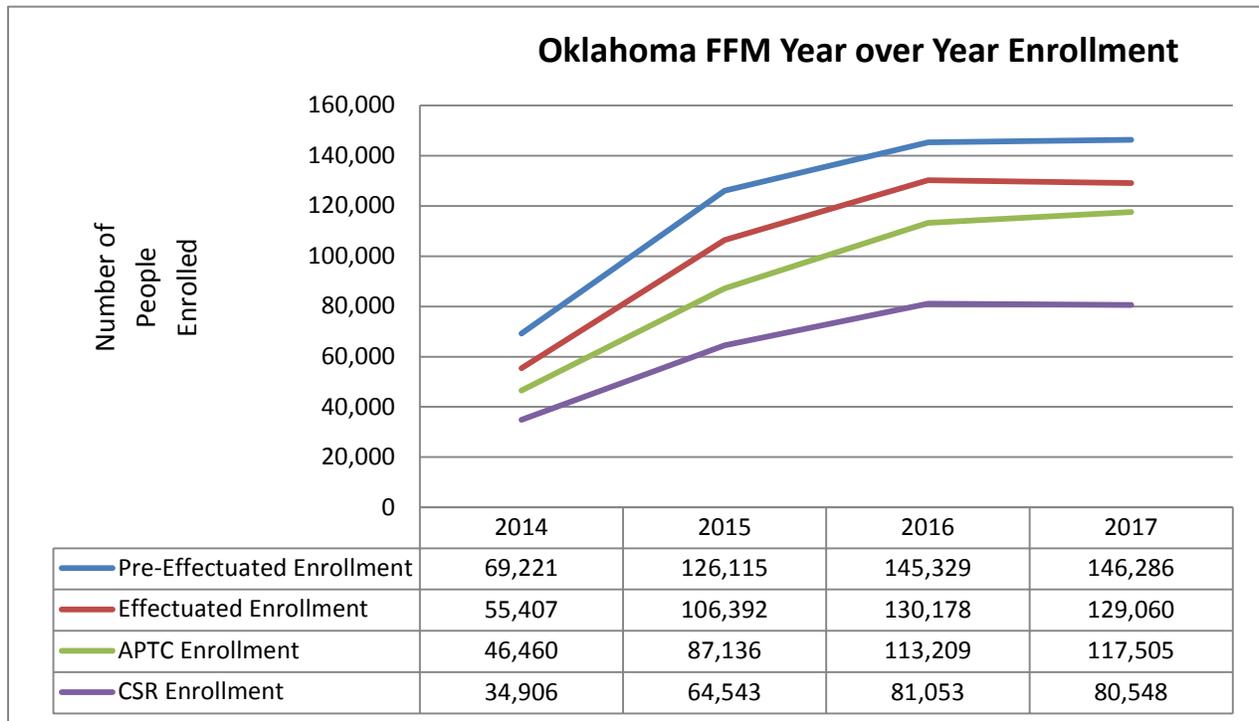
Because of Oklahoma’s budget crisis, federal funds are necessary to sustain the program. Pursuant to Oklahoma House Bill 2406 (2017 legislative session), the implementation of the program is contingent upon approval of Oklahoma’s 1332 State Innovation Waiver and receipt of federal funding. Additionally, lack of intervention will result in continued volatility in the market, which will make it less attractive for insurers, with the potential for there to be no insurers offering insurance on the market and therefor no access to available tax credits and subsidies for Oklahomans. This has the potential to increase Oklahoma’s uninsured rate.

Characteristics of Oklahoma’s Health Insurance Market

While the uninsured rate in the state materially decreased from 2013 (24%) to 2015 (20%), further improvement in the uninsured rate has not occurred in 2016 or 2017. Insurance take-up rates for the population eligible for premium assistance has not materially improved in the last two years as evidenced by 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.⁵ Premiums also continue to rise and options

⁵ The Henry J. Kaiser Family Foundation. (2016). Op. cit.

continue to dwindle, with only one carrier in Oklahoma offering plans on the FFM in 2017. Additionally, the volume of plan choice options into which consumers choose to enroll has also decreased significantly. There has been a 67% reduction in plan options (consumer choices) between 2015 and 2017.



Source: CMS Enrollment Reports

Oklahoma’s Challenges

Low Enrollment and High Costs

With only a portion 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 insurers. These individuals include young adults aged 19 to 34, whose enrollment in the individual market in 2017 was approximately 10,000 less than individuals aged 50 to 64. These young adults have an uninsured rate of 26%, which is higher than any other age group.⁶ And while over a quarter of the 550,000 uninsured in Oklahoma earn income over 250% of the FPL, only about 25,000 individuals in that income bracket are accessing coverage on the FFM.^{6,7} Low participation of this group is presumably due in part to diminishing subsidies as income levels increase.

In 2017, 91% of Oklahomans who purchased health insurance on the FFM received APTCs, with an average monthly premium of \$78 after APTC.⁸ While net premiums (post subsidy) have increased modestly since 2013, how consumers evaluate products also likely depends on out-of-pocket expenses (e.g., co-pays and deductibles). While over 60% of FFM enrollees receive cost-sharing reductions (CSRs), they are limited to silver plans and may not be enough to encourage certain individuals to enroll.

⁶ Millman. (2017). Op. cit.

⁷ CMS. (2017). 2017 Open Enrollment Period State-Level Public Use File. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html

⁸ CMS. (June 12, 2017). Op. cit.

2017 Oklahoma Average Cost Sharing Summary (In Network)			
	Bronze	Silver	Gold
Average Deductible (Single/Family)	\$6,400/ \$13,800	\$2,000/ \$5,700	\$1,100/ \$3,400
Average OOP Max (Single/Family)	\$6,900/ \$13,800	\$3,700/ \$7,900	\$4,300/ \$11,800

Source: HIX Compare Dataset.

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. Stabilizing the market and reducing total premiums will result in a per-person reduction in federal dollars for APTCs.

Federal Financial Assistance Averages in Oklahoma: Advance Premium Tax Credit Changes 2015-2017

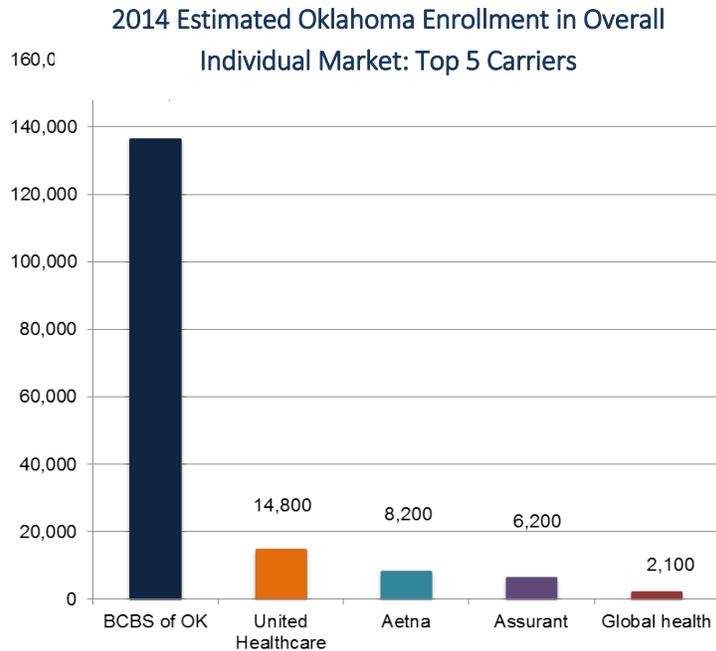
Oklahoma Averages	2015	2016	2017	Percent Change, 2015 to 2017	Percent Change, 2016 to 2017
Average Monthly Premium (APTC Eligible, all Metal Tiers)	\$292	\$375	\$629	115%	68%
Average Monthly APTC	\$208	\$299	\$551	165%	84%
Average Monthly Premium after APTC	\$83	\$76	\$78	-6%	3%
Total Federal APTC (Millions)	\$200	\$366.5	\$760.4	280%	107%

Source: Milliman. (2017). Assess the Market Effects of Healthcare Transformation.

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. The figure below indicates that in 2014, the year Oklahoma had the most robust plan participation in the FFM, market share continued be dominant by one carrier. This characteristic continues. However, with FFM enrollment declining slightly the State aims to prevent further erosion of plan participation and overall enrollment.

Payer representatives on the State’s 1332 Waiver 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. As can be seen in the figure below, the erosion of plan participation in Oklahoma’s FFM has been evident since 2014.



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

Oklahoma FFM Qualified Health Plan Participation, 2014-2017

Oklahoma Health Insurance Carrier	2014	2015	2016	2017
Aetna	X	-	-	-
Blue Cross and Blue Shield of Oklahoma	X	X	X	X
CommunityCare of Oklahoma	X	X	-	-
Coventry Health and Life	X	-	-	-
GlobalHealth	X	X	-	-
UnitedHealthcare of Oklahoma, Inc.	-	-	X	-

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

Characterization of Defined Population

American Indian and Alaska Native Populations

The American Indian and Alaska Native population in Oklahoma is estimated at approximately 360,968⁹ and is comprised of 39 tribal governments, 38 of which are federally recognized. In 2013 there were nearly 140,000 uninsured American Indians and Alaska Natives, representing nearly 22% of the state’s uninsured population.¹⁰ Of the total American Indians and Alaska Natives in the state, approximately 10,200 selected a FFM plan during 2017.¹¹ Special provisions are contained in the ACA for American

⁹ US Census Bureau, 2016

¹⁰ 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.

¹¹ CMS. (June 12, 2017). Op. cit.

Indians and Alaska Natives, including special monthly enrollment periods, no cost sharing for those that fall below 300% FPL, and no cost sharing for those who receive health services from an Indian Health Service/Tribal and Tribal Organization/Urban Indian Organization (I/T/U) with no deduction in payment to the I/T/U. Tribal members are also exempt from maintaining minimum essential coverage. The waiver will not make any changes to these exemptions and special provisions.

Section 1402(d)(1) permits tribal members with income between 100% and 300% of the FPL to have no cost sharing requirements for any insurance plan purchased through the insurance marketplace. Based on observed enrollment data, we estimate that the majority of tribal members purchasing coverage in the FFM have chosen Bronze level coverage (with zero cost sharing requirements), as these plans are less expensive than Silver or Gold plans. Under the ACA's premium assistance structure, it is possible for Marketplace enrollees to select Bronze level coverage with a \$0 premium. The likelihood of this occurring is greatest as income decreases, age increases, and premium rates rise. With significant premium increases occurring in Oklahoma's insurance Marketplace from 2014 to 2017 (approximately 145% over the four year period for a common plan), the income level at which a \$0 bronze plan may be purchased with federal assistance has also risen.

The following impacts are noted for American Indian and Alaska Native Populations:

- For Tribal Premium Sponsorship programs, additional financial resources may be needed for certain tribal members purchasing Bronze level coverage with federal premium assistance, as additional out-of-pocket premium payments may be required as a result of the premium rate decrease attributable to the OMSP.
 - This is expected to impact 6,000 total Marketplace enrollees (among all races) with income between 300% and 400% of the FPL.
- Minimal out-of-pocket premium changes are estimated for members purchasing Silver level coverage with federal premium assistance.
- Tribal members not qualifying for federal premium assistance may directly benefit from the reduction in market premiums resulting from OMSP. Premium sponsorship needs may diminish for tribal members not eligible for premium assistance.
- For Indian Health Service providers, a reduction in uncompensated care may occur as previously uninsured individuals purchase coverage as a result of lower premium rates under the OMSP.
- For Tribal members enrolled in other health insurance outside of the individual market, we do not estimate any material impacts from the OMSP.

Individuals Enrolled in Medicaid

More than 822,000 Oklahomans were enrolled in Medicaid health coverage through Oklahoma's SoonerCare program in May of 2017, making up nearly 21% of the state population.¹² The majority of participants (over 500,000) are children.¹³ To be eligible for the program, a person must be both low-income and fit into one of the following categories: children, pregnant women, seniors and disabled

¹² US Census Bureau. (January 12, 2017). Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2016

<https://www.census.gov/data/tables/2016/demo/popest/nation-total.html>

¹³ Oklahoma Health Care Authority (May 2017). SoonerCare Fast Facts. <http://www.okhca.org/research.aspx?id=87>

adults, and very low-income parents with dependent children. Oklahoma did not expand Medicaid eligibility to individuals between 0-138% of the FPL who do not qualify within these categories.

Description of Waiver Program

On May 16, 2016 Governor Mary Fallin signed Senate Bill 1386, authorizing Oklahoma to explore and pursue a 1332 waiver aimed at making improvements to the state's individual health insurance marketplace. Since that time, a task force comprised of industry experts, consumers, providers, businesses, tribes, and state-agency conveners has been meeting on a near monthly basis to identify and recommend innovative strategies for improvement. The recommendation-development process has been informed by several state-procured consultants: Evolve for a business survey and consumer focus group study, Milliman for a Marketplace analysis, Leavitt Partners for strategy impact modeling and Health Management Associates for technical advisement and reporting on the effort. On March 1, 2017 Oklahoma released a 1332 Concept Paper documenting the multi-faceted, multi-year, sequential approach to pursuing the identified strategies through a series of 1332 waivers or other means. Reinsurance and risk mitigation programs were identified early as having a high likelihood of success in terms of ease to implement, immediate effect upon premiums and being minimally disruptive to consumers as a single risk pool is maintained.

On June 6, 2017 Governor Mary Fallin signed House Bill 2406, authorizing the establishment of the Oklahoma Individual Health Insurance Market Stabilization Program, the authority for the state to pursue 1332 waivers as well as receive federal funds, a governing Board of Directors appointed by the Oklahoma Insurance Commissioner, a revenue source through assessments on Oklahoma health insurers, and administrative policies and processes overseeing the state's reinsurance program.

Oklahoma proposes to implement a reinsurance program beginning 1/1/2018 and continuing into future years in order to rapidly reduce premiums for consumers purchasing coverage on the individual market. The state plans to utilize federal pass through funds, coupled with amounts generated by an assessment on health insurers (see Attachment A for House Bill 2406 which defines the insurers to be assessed), to fully or partially reimburse qualified insurers for the claims experience of their high-cost enrollees. The high-cost enrollees are defined as those whose total claims experience in a one year period reaches \$15,000, as the state's attachment point. The state plans to reimburse plans for 80% of the enrollees costs between the attachment point and the cap of \$400,000. Enrollee costs above the cap, as well as the administration of all claims, will be the responsibility of the insurer. Enrollee costs are determined on an annual, calendar year basis corresponding to the plan year.

The State engaged the expertise of an actuarial firm, Milliman, who analyzed the population's utilization characteristics to determine the program parameters (e.g. attachment point, cap, co-insurance) as well as the total reinsurance investment necessary for average Oklahoma individual insurance market premiums to decrease to a sustainable 2016 level. Milliman determined that a \$325 million total reinsurance program would likely generate premium savings in excess of 30 percent from 2017 average rates. Of the \$325 million total, \$16 million is expected to come from Oklahoma's assessment on health insurers in 2018. Figure 3 describes estimated federal pass-through funding and estimated state-based assessment amounts.

Figure 3 Oklahoma Department of Health Estimated Available Pass-Through Funding and State-Based Assessment					
Calendar Year	Reinsurance Funding Level (\$ Millions)	Federal Pass-through Funding (\$ Millions)	State-Based Assessment (\$ Millions)	Estimated Assessment Enrollment Base	State-Based Assessment PMPM
2018	\$ 325	\$ 309	\$ 16	1,780,000	\$0.76
2019	\$ 325	\$ 262	\$ 63	1,790,000	\$2.96
2020	\$ 325	\$ 274	\$ 51	1,790,000	\$2.38
2021	\$ 325	\$ 282	\$ 43	1,800,000	\$2.00
2022	\$ 325	\$ 269	\$ 56	1,800,000	\$2.59
2018 to 2022 Totals	\$ 1,625	\$ 1,395	\$ 230	8,970,000	5 year average: \$2.14
2023	\$ 325	\$ 272	\$ 53	1,810,000	\$2.46
2024	\$ 325	\$ 269	\$ 56	1,810,000	\$2.59
2025	\$ 325	\$ 270	\$ 55	1,820,000	\$2.51
2026	\$ 325	\$ 272	\$ 53	1,830,000	\$2.43
2027	\$ 325	\$ 274	\$ 51	1,830,000	\$2.31

Notes:

1. State-based assessment PMPM does not include cost of administering reinsurance fund. Approximately \$0.05 PMPM generates an estimated \$1 million in state-based revenue per year.
2. State-based assessment PMPM values are for illustrative purposes only. The Board will determine the final assessment PMPM for each year.
3. Values are estimates. Actual Federal pass-through funding will be determined based on premium rates filed for each year.
4. Values are rounded.
5. The 2018 assessment base may be lower than the values illustrated to the extent employer-sponsored plans do not begin paying the assessment until the beginning of their plan year in 2018 (which may be on a non-calendar year basis).

The only insurer in Oklahoma’s Marketplace for 2017 and 2018 is BlueCross BlueShield of Oklahoma (BCBSOK). As the sole qualified health plan, BCBSOK has been asked to provide amended rates for the 2018 plan year, including the effects of a state-operated reinsurance program.

The Oklahoma Individual Health Insurance Market Stabilization Program, administered by the Board of Directors, will receive and distribute the reinsurance funding on a periodic basis, maintain oversight, monitoring and audit responsibilities of the program and direct program parameters. For the initial 2018 plan year, the total reinsurance investment will be \$325 million. After plan year 2018, the Board of Directors will propose the total investment and payment parameters each year. The yearly determination will consider available funding, stabilized premium targets (which for the 2018 plan year are sustainable 2016 premium rates), increased enrollment (which for the 2018 plan year are the addition of up to 30,000 covered lives), improved competition and consumer choice, and overall mitigation of the impact of high-need, high-cost, high-risk enrollees. The Board of Directors may also evaluate future federal funding opportunities that become available for the operation of the program and may modify elements of the program in consideration of additional funding based on that evaluation.

Analysis supporting this waiver proposal (found in Appendix C) assume similar scope and parameters for each of the 5 waiver-period years. For each year of the waiver-period, the program will aim to maximize the re-investment of reinsurance funding back into the market. In the event of a surplus, payment parameters will likely be modified in the subsequent year to achieve this aim. The Board of Directors, through their routine monitoring of the program parameters and payments, will be responsible to ensure an unlikely deficit scenario is avoided. As a result of the reinsurance program a reduction in premiums

and premium tax credits will occur, which will generate the necessary, federal pass-through funding that the state will apply towards the reinsurance program payments to qualified plans.

Waivers Requested

The State of Oklahoma seeks to waive Section 1312 (c)(1) for the individual market single risk pool in connection with a Section 1332 waiver to implement a state-operated reinsurance program for 2018 and future years. Currently, Section 1312(c)(1) requires a health insurance issuer to consider “all enrollees in all health plans...offered by such issuer in the individual market...to be members of a single risk pool.” To maximize the rate-lowering impact of the reinsurance program the state seeks to waive this single risk pool provision at 45 CFR 156.80 to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market wide index rate. The state requests that with the waiver, the single risk pool still include: adjustment for the risk adjustment program, Marketplace user-fee adjustment, and adjustment for the state-based reinsurance program. The Oklahoma Insurance Department will communicate with current Marketplace issuers to include state-operated reinsurance dollars when rate setting. The reinsurance program will result in a reduction in premiums and premium tax credits which the state believes will result in pass-through funding that the state can use towards the reinsurance program. The implementation of this waiver will be straightforward, as claims for enrollees through the reinsurance program will still be collected and other programs such as MLR will be unaffected.

Pass-Through Funding

The State of Oklahoma proposes to utilize the federal funding that would be paid to qualified, Oklahoma individual market enrollees absent the reinsurance program. This funding will be combined with funds generated from an assessment on health insurers to further stabilize the individual market. The implementation of Oklahoma’s reinsurance program directly affects the cost of the “applicable second lowest cost silver plan” in Section 36B (b)(3)(B) of the Internal Revenue Code. Due to the state’s investment in the stabilization of the individual market, the resulting premiums are less than they would be absent the program. Because the premium amounts are less, the federal premium tax credits are also less than they would be absent the program. The state proposes to receive the federal passthrough funding as described in the December 11, 2015 guidance provided by the Centers for Medicare and Medicaid Services. The federal funding, coupled with state revenues from the health insurer assessment, are used to stabilize premium rates.

Figure II-1 of the economic analysis, under the waiver scenario, illustrates that Oklahoma’s reinsurance program is anticipated to save the federal government approximately \$320 million in APTC expenditures during 2018. Based on the economic analysis considerations, the total savings to the federal government are \$309 million.

Tax Credit Proposal

Due to Oklahoma’s reinsurance program, the federal government will realize significant savings from the reduced premium tax credits since a significant share of Oklahoma’s individual health insurance market consumers are eligible for subsidies. The formula for a consumer’s premium tax credit is the cost of the second lowest cost silver plan minus the household’s required contribution which depends on the percentage of Federal Poverty Level (FPL). With a decrease in premiums, the cost of a second lowest cost silver plan is less; therefore, the amount of APTC provided to the household is also decreased. Oklahoma

proposes in this waiver that the savings to the federal government from the reinsurance program are provided to the state as pass-through funding to be used as dedicated revenue to the reinsurance account. The reinsurance funding will help to mitigate financial losses currently borne by the single, qualified health plan participating in Oklahoma’s individual health insurance market, as well as help to attract additional insurers to the market.

Affected Populations and Demographics

Anticipated Coverage Distribution by Age

2018	Without OMSP (Thousands)	With OMSP (Thousands)	Net Change
17 and Under	14	16	2
18 to 25	24	26	2
26 to 34	19	21	3
35 to 44	20	24	3
45 to 54	37	43	6
55 to 64	35	40	5
65 and Over	1	1	0
Total	150	172	22

As shown in Figure I-4D(iii), additional incremental non-group enrollment is estimated to occur across each age group due to OMSP.

Figure I-4D(iii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Age Group: 2017 through 2027 (Thousands) Net Enrollment Change Resulting from Waiver											
Age Group	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
17 and Under	0	2	2	2	2	2	2	2	2	2	2
18 to 25	0	2	3	3	3	2	2	2	2	2	1
26 to 34	0	3	5	5	5	4	3	2	2	2	2
35 to 44	0	3	4	4	4	4	3	3	3	3	3
45 to 54	0	6	7	7	7	7	7	6	6	6	6
55 to 64	0	5	6	6	6	6	5	5	5	4	4
65 and Over	0	0	1	1	1	1	1	1	1	0	0
Total	0	22	27	28	27	26	23	22	21	19	18

Anticipated Coverage Distribution by Income to Poverty Ratio

2018	Without OMSP (Thousands)	With OMSP (Thousands)	Net Change
0% - 99%	5	5	0
>=100% to <=150%	43	43	0
>150% to <=200%	32	32	0
>200% to <=250%	19	19	0
>250% to <=300%	11	11	0
>300% to <=400%	10	10	0
>400%	30	52	22
Total	150	172	22

Figure I-4A(iii) illustrates the estimated net non-group market enrollment change resulting from the implementation of the OMSP from 2018 through 2027. For 2017, the baseline year, no change occurs since OMSP begins in 2018. Enrollment figures include all comprehensive non-group coverage, including transitional and grandfathered coverage. See Appendix C, Section I-3-A for more information.

Figure I-4A(iii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Household Income: 2017 through 2027 (Thousands) Net Enrollment Change Resulting from Waiver											
Income Level % of FPL	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0% - 99%	0	0	0	0	0	0	0	0	1	1	1
>=100% to <=150%	0	0	0	0	0	0	0	0	0	0	0
>150% to <=200%	0	0	0	0	0	0	0	0	0	0	0
>200% to <=250%	0	0	0	0	0	0	0	0	0	0	0
>250% to <=300%	0	0	0	0	0	0	0	0	0	0	0
>300% to <=400%	0	0	3	3	3	3	1	1	1	1	1
>400%	0	22	23	24	23	22	20	19	18	17	16
Total	0	22	27	28	27	26	23	22	21	19	18

Note: Values are rounded.

As observed in Figure I-4A(iii), enrollment increases resulting from the OMSP are estimated to be primarily from the population not eligible for premium assistance (i.e., those with household income either greater than 400% FPL or less than 100% FPL). As this population is not eligible for premium assistance under the ACA, these households realize the full impact of the OMSP’s premium reduction (rather than all or a portion of the savings accruing to the Federal government). Out-of-pocket premium costs for the vast majority of the population eligible for premium assistance are not estimated to be reduced by the OMSP. For young adults with income approaching 400% FPL, we estimate the premium savings achieved through the OMSP may result in persons no longer being eligible for premium assistance (as the cost of the second lowest cost silver plan decreases below the maximum permitted under the ACA), while still decreasing out-of-pocket premiums. Therefore, we estimate individual market enrollment increases may also occur for persons with household income between 300% and 400% FPL under the waiver.

Anticipated Coverage Distribution by Health Status

As discussed in Appendix E, health status is defined based on an individual’s estimated risk score relative. Figure I-4E illustrates estimated non-group market acuity (i.e., morbidity) under the status-quo ACA (without waiver) and under the OMSP during the baseline year (2017), and from 2018 through 2027.

Figure I-4E Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees Acuity: 2017 through 2027											
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Acuity Change	0.0%	(2.9%)	(2.3%)	(2.4%)	(2.3%)	(2.3%)	(1.8%)	(1.8%)	(1.7%)	(1.5%)	(1.4%)

As the OMSP is estimated to result in greater enrollment from the population with income above 400% FPL, the acuity of the non-group risk pool is estimated to improve under the waiver. The percentage changes in Figure I-4E are representative of the entire non-group ACA-compliant risk pool. The market impact of the improved acuity in the population with income above 400% FPL, is dampened by minimal expected acuity changes for the population qualifying for APTC.

Effect on Residents’ Ability to Get Care Out of State

Oklahoma’s proposed waiver will not affect residents’ ability to get care outside of the state. The proposed waiver does not impact or change benefits or provider networks.

Description of Post-Waiver Insurance Market

Individual Market

This waiver will not impact the operations of the individual Marketplace. Oklahoma residents will have the same access (other than increased affordability) to coverage on the Marketplace as they would absent the waiver, including access to the FFM, brokers and insurers. Assistance with plan selection is not affected by this waiver and may be provided by an agent, broker, navigator, or other in-person assister. The waiver will not affect residents’ ability to obtain tribal assistance or sponsorship for coverage on the individual market. Residents will not be aware of whether or not their utilization of health care services results in reinsurance payments to their insurer.

Small and Large Employers

The waiver will not affect the small or large group insurance market. It will affect employers who offer self-funded plans with stop loss coverage in that they will be assessed a small PMPM fee to help fund the reinsurance program. Employers who offer commercial insurance may see a slight increase in premiums due to the assessment. However, it is not anticipated that this assessment will impact employers’ decision to offer coverage to their employees.

Medicare

This waiver will not affect Medicare or Medicare Supplement coverage.

Medicaid (SoonerCare)

This waiver will not affect Oklahoma Medicaid (SoonerCare) coverage.

Number of Employers Offering Coverage Pre/Post Waiver

It is not anticipated that the waiver will have any effect on the number of employers who offer coverage in the state.

Impact on Insurance Coverage in the State

Based on actuarial analyses by Milliman, the OMSP will decrease premiums and increase enrollment. These results will help stabilize the market, making it more amenable for other carriers to offer plans and thereby increasing competition and consumer choice.

While the reinsurance program will reduce premiums on the individual market and will potentially increase plan options for consumers, it will otherwise not impact coverage. That is, the reinsurance program will not make any changes to Essential Health Benefits or state-mandated benefits, provider networks, metal tiers, actuarial value requirements, or plan design.

The state's insurance coverage will continue to meet the requirements of federal law under this waiver.

Administrative Burden

Oklahoma expects that the proposed waiver will not result in any additional burden to consumers. Insurers and the State of Oklahoma will assume minimal administrative burden due to the implementation of a state-based assessment and additional reporting requirements to the federal government related to the waiver. The federal government will expect additional administrative requirements due to pass-through funding processes.

For Individuals and Families

This waiver will have no administrative impact to individuals and families related to this waiver. All individuals will continue to purchase plans in the same method utilized today – through the FFM at www.healthcare.gov, or through a broker, agent, navigator, or by directly contacting an insurance provider outside the exchange.

For Insurers

The additional administrative burden on health plans as a result of this waiver will be minimal. Oklahoma insurers will be required to provide information on levels of coverage and provide assessment payments to fund the state's portion of the reinsurance program. Insurers will periodically report on reinsurance-related population experiences and payments. The state will aim to mirror administrative processes in similar manner to those utilized previously for the Federal Transitional Reinsurance Program operating

from 2014 – 2016; as well as for former Oklahoma risk mitigation programs. The state will seek consultation with federal partners to determine the specific processes. The Oklahoma Insurance Department, following 1332 reinsurance waiver approval, will assume plan certification and rate review responsibilities. Opportunities for reducing administrative burden will be considered throughout the implementation process by the OMSP Board. Insurers will continue to manage enrollment, marketing, and other operations in the same way as they would absent the waiver.

For State Agencies

This waiver will require the Board of Directors, through administrative support of the Oklahoma Insurance Department, to submit reports, actuarial work, and other documents justifying the amount of pass-through funding received from the federal government. The waiver also requires the Board of Directors to provide all state administration and oversight of collecting assessment and pass through revenues, making reinsurance payments to qualified health plans, and independently auditing transactions and records. Specific duties of the Board, as well as the Insurance Commissioner and Department, may be found in enacted House Bill 2406 in Appendix A.

For Federal Agencies

Under this waiver, the impact on federal agencies is limited to determining waiver funding values related to the individual market and transferring pass-through funds to the state. The waiver does not affect the calculation of APTC or the reconciliation of premium tax credits in terms of tax filings.

Effects on Sections of ACA Not Waived

No other section of the ACA will be affected by Oklahoma’s proposed waiver.

Comparability

The actuarial and economic analyses provided by Milliman indicate that the proposed waiver will not affect comprehensiveness or federal deficit neutrality. Federal operations also will remain unaffected with the exception of processes for pass-through funds.

The waiver will have a positive impact on coverage comparability and affordability as a result of increased enrollment and decreased premium costs.

Coverage Comparability

The proposed waiver meets the scope of coverage guardrail requirement, as coverage will be available to a comparable number of people as would have been covered in the absence of the waiver. Actuarial analyses indicate that more people will be insured on the individual market with the implementation of the waiver than without it. There are no anticipated decreases in coverage for vulnerable populations by coverage category, health status, age, geographic location, or any other demographic characteristic as a result of the waiver. The waiver will not affect group coverage or the provision of publicly funded insurance programs.

During the course of the five-year initial waiver period and the ten-year projection period, Milliman estimates the OMSP will result in a lower number of uninsured Oklahomans each year than without the

waiver. We estimate the reductions in the uninsured population will occur primarily in the population with income above 400% of the federal poverty level (FPL), as non-group (individual market) premium rates will be more affordable under the OMSP.¹⁴

As the population with income between 100% and 400% FPL is eligible for Federal premium assistance, out-of-pocket premium rate changes have been limited since the ACA-reformed rating rules were implemented in January 2014. While premium rates for plans offered through the FFM have increased significantly from 2014 (approximately 145% for the subsidy benchmark plan in Oklahoma City), these increases have largely been borne by additional Federal premium assistance for the population with income between 100% and 400% FPL qualifying for premium assistance.

We estimate the OMSP will not have any material impacts to the number of Oklahomans covered under employer-sponsored plans, Medicaid, Medicare, or other public programs. Figure 1 illustrates separately changes in the number of Oklahomans uninsured and purchasing coverage in the non-group market under the OMSP relative to if the program was not implemented.

Figure 1 Oklahoma Department of Health Changes in Uninsured and Non-Group Market Resulting from OMSP Implementation						
Calendar Year	Uninsured			Individuals Insured in Non-Group Market		
	Without OMSP	With OMSP	Change	Without OMSP	With OMSP	Change
2017	590,000	590,000	-	150,000	150,000	-
2018	592,000	570,000	(22,000)	150,000	172,000	22,000
2019	601,000	574,000	(27,000)	144,000	171,000	27,000
2020	604,000	576,000	(28,000)	144,000	172,000	28,000
2021	607,000	580,000	(27,000)	144,000	171,000	27,000
2022	610,000	584,000	(26,000)	144,000	170,000	26,000
2023	613,000	590,000	(23,000)	144,000	167,000	23,000
2024	617,000	595,000	(22,000)	144,000	166,000	22,000
2025	620,000	599,000	(21,000)	144,000	165,000	21,000
2026	624,000	605,000	(19,000)	144,000	163,000	19,000
2027	627,000	608,000	(19,000)	144,000	163,000	19,000

From 2016 to 2017, we estimate approximately 30,000 Oklahomans exited the non-group market. We estimate the vast majority of these individuals did not qualify for premium assistance in the federally-facilitated marketplace (FFM) and were adversely impacted by a more than 70% premium rate increase from 2016 to 2017. Under the OMSP, we estimate a large portion of the cohort that exited the non-group market will re-enter the market in 2018 as a result of lower premium rates. The additional 22,000 non-group enrollees estimated to purchase coverage in 2018 as a result of the OMSP may increase the size of Oklahoma’s non-group market to 172,000.

For the duration of the projection period, we estimate 19,000 to 28,000 additional annual non-group enrollees relative to without the waiver. The enrollment impact from the waiver is estimated to grow in 2019 as a result of persons with transitional/grandfathered (non-ACA compliant) coverage having a

¹⁴ In 2017, the FPL is \$12,060 for a single household and \$24,600 for a family of four. 400% FPL would reflect income levels of \$48,240 and \$98,400, respectively. Please see <https://aspe.hhs.gov/poverty-guidelines> for more information.

greater likelihood of entering the ACA-compliant market, rather than becoming uninsured (transitional / grandfathered coverage is assumed to end after 2018). Based on this projected reduction in uninsured on an annual basis, we believe that the OMSP meets the coverage requirement for approval of the Section 1332 Waiver.

With or without OMSP, we estimate a decline in non-group coverage over the course of the ten-year projection period. While the OMSP is estimated to materially reduce premiums in 2018, premiums are still estimated to increase over the course of the projection period, resulting in higher costs for the population not qualifying for premium assistance.

Affordability of Coverage

Actuarial modeling indicates that the waiver will decrease premiums on the individual market for both subsidized and non-subsidized consumers. The waiver will not decrease cost sharing protections against excessive out-of-pocket spending or decrease affordability for any vulnerable or at-risk populations. It does not change the federal thresholds for affordability.

The OMSP is not estimated to materially impact premium rates for employer-sponsored insurance, nor change costs, eligibility parameters, or enrollment levels for public programs such as Medicaid and Medicare. A state-based assessment on commercial insurers and self-funded insurers with stop loss coverage is being implemented to fund the non-Federal portion of the reinsurance fund. It is possible that this additional cost will be passed-through to employees in the form of slightly higher plan contributions or additional cost sharing requirements. However, we estimate the assessment for the OMSP will be less than 1% of an average employer's premium costs.

For the non-group market, the OMSP is estimated to reduce premium rates by more than 30% in 2018 (relative to without the waiver). This is achieved through the \$325 million reinsurance fund that subsidizes insurer paid claim expenses for members with annual healthcare expenses meeting the reinsurance parameters defined by the OMSP. To the extent there are reductions in non-claims expenses relative to those without the waiver, premium savings for a given year may be greater than the reinsurance fund by itself. There is significant uncertainty regarding how the insurers will modify non-claims expense assumptions for premium rate development purposes; however, we believe the relationship between the OMSP and the ACA's minimum medical loss ratio requirements may result in a reduction in amounts attributable to non-claims expenses in premium rates.

During each year, the impact to consumers will vary significantly within the non-group market based on the consumer's household income and its interaction with the ACA's premium assistance program. Under the ACA's premium assistance program, qualifying households with income between 100% and 400% FPL have out-of-pocket premium expenses capped to a specified percent of income. In 2017, we estimate approximately 80% of Oklahomans purchasing coverage in the ACA-compliant individual market received Federal premium assistance. To a large degree, we estimate the vast majority of individuals receiving premium assistance without the waiver will also receive premium assistance under the OMSP. For these individuals, the premium savings will accrue to the federal government, as it reduces the amount of premium assistance necessary to ensure the out-of-pocket cost of coverage does not exceed the maximum specified by the ACA. It is possible that some young adults and other persons with income approaching 400% FPL receiving premium assistance without the waiver will see out-of-pocket premiums fall below the maximum specified by the ACA under the OMSP. In these cases, only partial premium savings accrue to the Federal government, while the consumer also directly benefits from the premium reduction.

For households not eligible for premium assistance, the full amount of premium rate reduction will be realized under the OMSP, with the federal government not accruing any savings. As premium rates are estimated to be more affordable under the OMSP, this should provide financial incentive for some of the uninsured individuals in the absence of the waiver to purchase health insurance. Figure 2 illustrates premium rate reductions for a 21-year old and a 64-year old for the second lowest cost silver plan (the benchmark plan that is used to determine available premium assistance).

Figure 2 Oklahoma Department of Health Changes in Second Lowest Cost Silver Plan Monthly Premium from OMSP Implementation						
	21-Year Old Monthly Premium			64-Year Old Monthly Premium		
Calendar Year	Without OMSP	With OMSP	Change	Without OMSP	With OMSP	Change
2017	\$405	\$405	\$0	\$1,215	\$1,215	\$0
2018	\$441	\$290	(\$150)	\$1,322	\$870	(\$451)
2019	\$437	\$311	(\$126)	\$1,310	\$933	(\$377)
2020	\$458	\$327	(\$131)	\$1,375	\$981	(\$394)
2021	\$472	\$337	(\$135)	\$1,415	\$1,011	(\$404)
2022	\$500	\$371	(\$129)	\$1,499	\$1,113	(\$387)
2023	\$529	\$401	(\$128)	\$1,588	\$1,203	(\$385)
2024	\$561	\$434	(\$127)	\$1,682	\$1,302	(\$381)
2025	\$591	\$463	(\$128)	\$1,774	\$1,390	(\$383)
2026	\$624	\$496	(\$127)	\$1,871	\$1,489	(\$382)
2027	\$658	\$530	(\$128)	\$1,973	\$1,589	(\$384)

Notes:

1. Values are rounded.
2. Values do not reflect available premium assistance for qualifying individuals.
3. Premiums are for non-tobacco user and assume Federal default 3:1 age rating.

Based on the above summary of Milliman’s analysis, we believe the OMSP meets the affordability requirement for approval of the Section 1332 Waiver.

Scope and Comprehensiveness of Coverage

As required under 45 CFR 155.1308(f)(3)(iv)(A), a State’s proposed waiver must provide coverage that is at least as comprehensive as the coverage defined in Section 1302(b) of the ACA. As described in CMS-9936-N, comprehensiveness refers to the scope of benefits provided by the coverage as measured by the extent to which coverage meets the requirements for essential health benefits (EHBs). The OMSP makes no changes to EHB requirements in the individual market, nor is it estimated to have any effect on other health insurance programs and populations within the State of Oklahoma. Additionally, the OMSP makes no changes to state-mandated benefits. As the OMSP is estimated to increase enrollment in the non-group market relative to projections absent the waiver, it increases the number of Oklahomans with insurance coverage that meets the EHB requirements, fulfilling the comprehensiveness requirements of 45 CFR 155.1308(f)(4)(iv)(A).

Federal Deficit Neutrality

The proposed waiver will not increase the federal deficit; potential reductions in federal revenue due to decreases in individual responsibility payments will be offset by the reduction in the amount of APTCs provided to consumers.

By reducing non-group premiums, the OMSP is estimated to result in Federal savings on premium assistance provided through the FFM. We also evaluated changes in Federal revenue related to individual shared responsibility payments (individual mandate), FFM user fees, health insurance providers fee (HIF), and the Patient-Centered Outcomes Research Trust Fund (PCORI). Note, we do not estimate any material changes to Federal cost-sharing reduction (CSR) payments, as the OMSP does not impact eligibility for CSR plans, estimated CSR plan enrollment, or CSR benefit design.

- *Shared responsibility payments:* Additional revenue is estimated to be collected from shared responsibility payments, as the decline in premiums from the OMSP is estimated to result in fewer Oklahomans being eligible for affordability exemptions, offsetting a reduction in shared responsibility payments from newly insured individuals.
- *FFM user fees:* As a result of reducing premiums in the individual market, we estimate the Federal government will collect a decreased amount of revenue related to the FFM user fee (assumed to be 3.5% of FFM premium).
- *HIF:* As national collected revenue amounts for the HIF are prescribed in 2018 (premium volume changes do not impact the collected amount), we do not estimate any change in HIF revenue as a result of the OMSP for 2018. Thereafter, the national HIF collection amount is estimated to be indexed by changes in per capita employer-sponsored insurance premiums. As the OMSP does not materially impact employer-sponsored insurance, we do not estimate any impacts to the national HIF amounts during the remainder of the ten-year projection period.
- *PCORI:* As additional persons are estimated to be insured under the OMSP, we estimate a slight increase in PCORI revenue in 2018. Insurers are not subject to the PCORI fee for policy years ending after September 30, 2019. Therefore, we do not estimate any change in PCORI revenue resulting from the OMSP during the remainder of the projection period.

It is possible that the OMSP may impact other federal revenue items, such as federal income taxes paid by insurers. However, quantifying these items is beyond the scope of our analysis.

The combination of Federal premium assistance savings plus the sum of revenue changes from the other described Federal revenue sources comprise the estimated Federal pass-through funding available to Oklahoma under Section 1332 Waiver regulations. Figure 3 illustrates the division of state and Federal funding for the ten-year projection period and the state-based assessment amount.

Figure II-1 Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Federal Government Expenditures Changes: 2018 through 2027 (in Millions)										
Revenue / (Expense) Item	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Federal APTC Expenditures	\$ 320	\$ 271	\$ 284	\$ 292	\$ 278	\$ 281	\$ 278	\$ 279	\$ 280	\$ 282
Aggregate Shared Responsibility Payments	\$ (1)	\$ (2)	\$ (2)	\$ (2)	\$ (1)	\$ (1)	\$ (1)	\$ (0)	\$ (0)	\$ 0
Exchange User Fee	\$ (10)	\$ (8)	\$ (8)	\$ (9)	\$ (8)	\$ (8)	\$ (8)	\$ (8)	\$ (8)	\$ (8)
PCORI	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Health Insurer Fee	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Net Change in Federal Expenditures	\$ 309	\$ 262	\$ 274	\$ 282	\$ 269	\$ 272	\$ 269	\$ 270	\$ 272	\$ 274

Note: We estimate a PCORI revenue increase of \$53,000 in 2018.

Federal Operational Considerations

The proposed waiver will require that APTC savings experience by the federal government be passed through to the State of Oklahoma. It does not require any other operational changes from the federal government.

10-Year Waiver (Budget Neutrality)

As shown in Figure II-1 above, the OMSP is estimated to have a significant impact on the Federal government APTC expenditures for Oklahomans purchasing health insurance coverage through the FFM. As permissible under Section 1332 of the ACA, Oklahoma seeks to apply the Federal savings on APTC expenditures to support the OMSP. To fulfill the Section 1332 Waiver neutrality requirements, Oklahoma seeks Federal pass-through funding equal to Federal APTC savings, less other changes to Federal government expenses. Figure II-1 provides a summary of estimated Federal expenditure changes during the ten-year projection period. More detailed information can be found in Appendix D.

Ensuring Compliance, Reducing Waste and Fraud

The Oklahoma Insurance Department has responsibility for regulating and ensuring compliance and solvency of health insurers, performing market conduct analysis and examinations, conducting investigations, and providing consumer outreach. The Department investigates complaints that fall within the division’s regulatory authority and monitors all issuers’ accreditation, quality, and network adequacy.

Sections 6530.1-6530.10 of Title 36 within Oklahoma Statute established the Oklahoma Individual Health Insurance Market Stabilization Program, its administering Board of Directors, and provided authority for the operational and financial processes necessary to support Oklahoma’s reinsurance program. The Board of Directors, with support from the Oklahoma Insurance Department, shall be responsible for all oversight and administration of the reinsurance program. The Board of Directors will establish a set of

bylaws, as well as a plan of operation, and submit such to the Insurance Commissioner for approval, prior to implementation of the program on 1/1/18.

The plan of operations shall contain forms, policies and procedures that address, at minimum, the following areas:

- Purpose and Name of Program
- Plan of Operation Justification
- Definitions
- Grievances
- Powers of the Board
- Other Powers
- Assessments
- Reports, Records, Accounting
- Staffing and Contractors
- Eligibility
- Program Parameters and Targets
- Termination
- Amendments (if applicable)

The Board of Directors, appointed by the Oklahoma Insurance Commissioner, is responsible for accounting and conducting periodic independent audit of the reinsurance program to assure accuracy of the data and finances of the program. The Board of Directors, as well as the Department of Insurance, as a state entity, adheres to sound accounting practices. All forms, policies and procedures shall conform to the requirements set forth in this waiver and shall be approved by the Insurance Commissioner. The Board of Directors is responsible for documenting such and will be detailed in the bylaws and the Plan of Operations a draft of which may be found in Appendix B.

The reinsurance program shall have an annual audit of its operations including, but not limited to, the funds, accounts and fiscal affairs of the program by an independent certified public accountant or a licensed public accountant. The Board shall maintain an account with an approved and insured bank or financial institution, and an amount which will be sufficient at all times to pay claims under the program. ToThe Board of Directors shall submit to the Insurance Commissioner an annual report of all income and disbursements prepared by an accountant firm. The auditor shall answer to and report to the Board of Directors and the Insurance Commissioner its findings pertaining to the audit. One copy of the annual audit shall be filed with the State Auditor and Inspector, and one copy shall be presented to the Board not more than one hundred twenty (120) days following the close of each fiscal year.

The Board of Directors will prepare annual financial statements and reports, and prepare quarterly projection reports. The state's financial statements are audited annually, beginning 1/1/2018. Federal staff are responsible for determining the savings calculations related to this waiver and ultimately ensuring that there are no increases to federal spending related to this waiver.

Implementation Timeline and Process

The State of Oklahoma anticipates an effective date for the waiver of January 1, 2018, with anticipated waiver approval by September 30, 2017. The Board of Directors is expected to meet regularly once the application is approved. The Board of Directors will implement, monitor, and manage the program in partnership with the Oklahoma Insurance Department, including the collection of claims information and the provision of reinsurance payments. The 1332 Task Force will also continue to meet during the application process as well as after the program is implemented.

The state plans to utilize federal pass through funds, coupled with amounts generated by an assessment on health insurers (see Attachment A for House Bill 2406 which defines the insurers to be assessed), to fully or partially reimburse qualified insurers for the claims experience of their high-cost enrollees. The high-cost enrollees are defined as those whose total claims experience in a one year period reaches \$15,000, as the state’s attachment point. The state plans to reimburse plans for 80% of the enrollees costs between the attachment point and the cap of \$400,000. Enrollee costs above the cap, as well as the administration of all claims, will be the responsibility of the insurer. Enrollee costs are determined on an annual, calendar year basis corresponding to the plan year. On an annual basis, the aggregate dollar amount of the reinsurance fund will be distributed to qualifying insurers offering coverage in the non-group market. To the extent the initial reinsurance parameters for the year result in a shortage of payments to insurers relative to the aggregate fund amount, the reinsurance insurance parameters will be adjusted to increase insurer payments to the aggregate fund amount on a retrospective basis. Conversely, the OMSP’s Board will monitor payments and adjust the reinsurance parameters as necessary to avoid a funding deficit.

Figure I-1B provides several examples of reinsurance payments in 2018 for claimants with varying annual medical expenses.

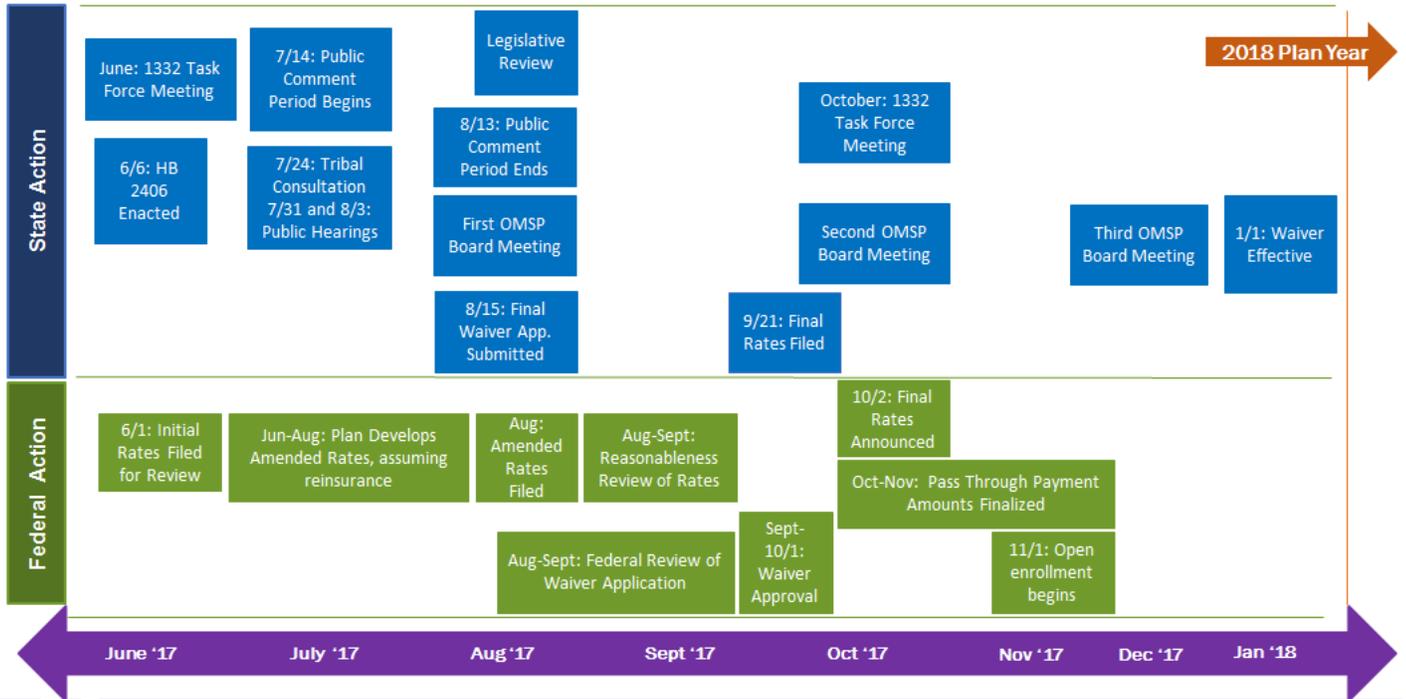
Figure I-1B Oklahoma Department of Health Individual Health Insurance Market OMSP Calendar Year 2018 Reinsurance Payment Examples				
Person	Annual Medical Expense	Reinsurance Eligible Medical Expense	Coinsurance Percentage	Reinsurance Payment
A	\$20,000	\$5,000	80%	\$4,000
B	\$100,000	\$85,000	80%	\$68,000
C	\$500,000	\$385,000	80%	\$308,000

By virtue of the coinsurance percentage not being 100%, as well as having a reinsurance cap, we believe insurers continue to have a financial incentive to manage health care costs and utilization for insured individuals meeting the payment criteria for the reinsurance program. From the consumer and provider perspective, the reinsurance program is expected to have no material impact on incentives to manage health care costs and utilization relative to the ACA’s current structure.

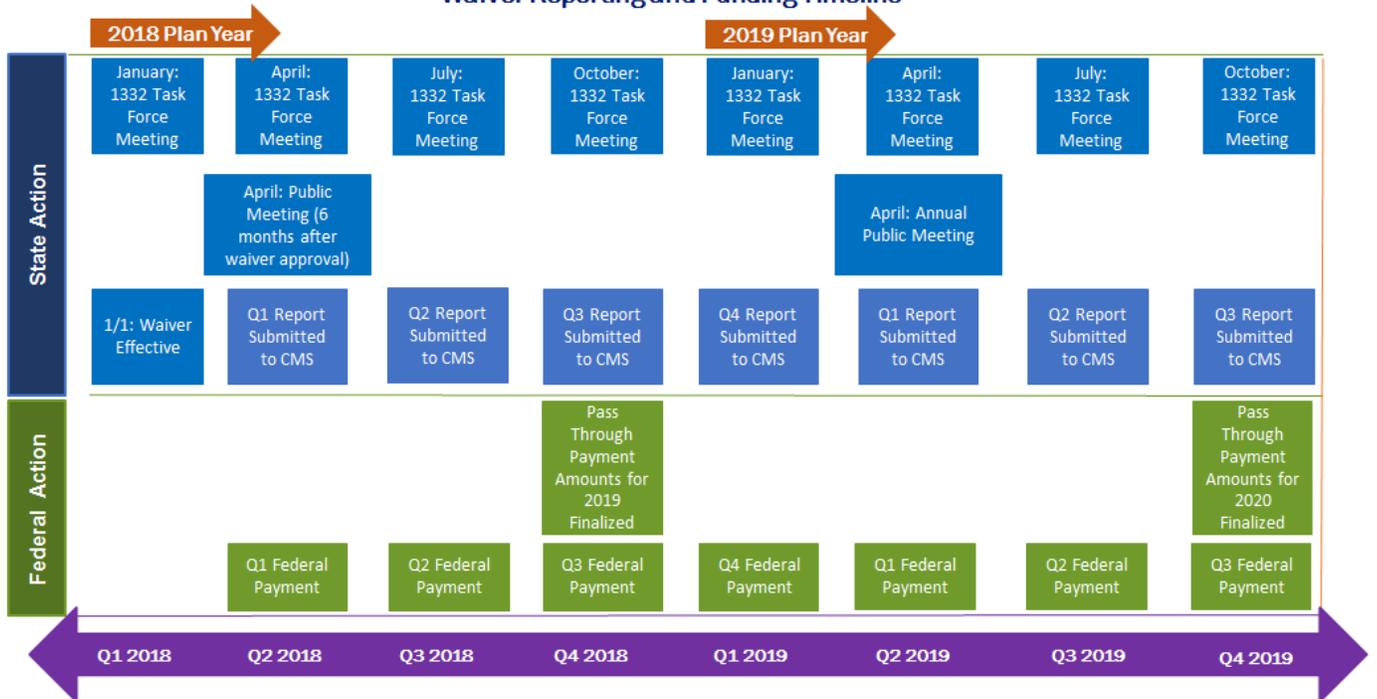
The federal pass through funds are calculated in quarter 4 of the preceeding year (2017), and paid to the Board of Directors on a quarterly basis over the course of the program year. Quartely reports will be submitted by the state to CMS, and public meetings will be held six months after waiver approval and annually thereafter.

Timelines for implementation, reporting, and funding are provided below.

Waiver Application and Implementation Timeline



Waiver Reporting and Funding Timeline



Reporting Responsibilities

Per 45 CFR 155.1308(f)(4), the Board of Directors, with administrative support from the Oklahoma Insurance Department, will submit the required quarterly, annual and cumulative targets for the scope of coverage requirement, the affordability requirement, the comprehensive requirement, and the federal deficit requirement. As required, Oklahoma will hold public meetings six months after the proposed waiver is granted and annually thereafter. The date, time, and location of each forum will be posted on the Oklahoma Insurance Department website. The department will also notify consumer and business advocacy organizations. Each meeting will be conducted at a site that allows both in-person and telephonic attendance to accommodate residents across the state.

Waiver Development Process

As required under 1332(a)(1)(B)(i), the Oklahoma state legislature passed House Bill 2406 (see Appendix A) that authorized the submission and implementation of a Section 1332 Waiver, as well as the implementation of necessary funding mechanisms and a non-profit entity (OMSP Board) to oversee the program. The bill was signed into law on June 6, 2017. Previous to the enactment of the bill, nine monthly Task Force meetings were held, during which market recommendations, which included the exploration of state-operated reinsurance and high risk pool programs, were developed (see Appendix G). The Task Force was also apprised of initial reinsurance modeling and preliminary data from the actuarial consultant. The draft waiver application was posted publicly on the Oklahoma State Department of Health website on July 14, 2017, with the public comment period running from that date until August 13, 2017. In addition to tribal listening sessions held on June 22, 2017 and July 10, 2017, formal tribal consultation took place on July 24, 2017. A summary of comments from these meetings is provided in Appendix L. Public hearings were held on July 31, 2017 and August 3, 2017. Public comments were accepted via e-mail, mail, phone, and in-person. Public notice and comment procedures were completed in accordance with 31 CFR 33.112 and 45 CFR 155.1312. A summary of public comments received is provided in Appendix K.

Appendices

Appendix A: Enacted Legislation

An Act

ENROLLED HOUSE
BILL NO. 2406

By: Osborn (Leslie) and
Wallace of the House

and

David and Fields of the
Senate

An Act relating to insurance; creating the Oklahoma Individual Health Insurance Market Stabilization Act; providing payments to health insurance plans; providing market stabilization activities; providing legislative intent; defining terms; providing Individual Health Insurance Market Stabilization Program eligibility requirements; establishing the Oklahoma Individual Health Insurance Market Stabilization Program; providing Board of Directors membership; providing Board member reimbursement; requiring adoption of plan of operation, bylaws and rules; requiring administrative rules be promulgated and revoked under certain circumstances; authorizing hiring of Executive Director; providing administrative and operational support to the Program; requiring annual audit; providing certain duties of the Board; requiring sunset of the Program under certain conditions; granting certain powers to the Program; providing assessment of insurers and reinsurers; requiring participation be determined annually; prohibiting certain tax credit under certain circumstances; allowing the Board to abate or defer assessment under certain circumstances; providing certain actions shall not violate certain laws; authorizing the Secretary of Health and Human Services to apply for certain waiver; providing for codification; and declaring an emergency.

SUBJECT: Oklahoma Individual Health Insurance Market Stabilization Act

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 6530.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Oklahoma Individual Health Insurance Market Stabilization Act". It is the intent of the Legislature to provide payments to health insurance plans with respect to claims for eligible individuals for the purpose of lowering premiums for health insurance coverage offered in the individual market. Market stabilization activities shall include establishment of a high-risk pool, reinsurance, hybrid programs or any combination thereof. It is the further intent of the Legislature to bestow upon the Oklahoma Insurance Commissioner the authority to appoint a Board of Directors which shall create, implement, oversee and monitor the high-risk pool, reinsurance or hybrid programs under provisions of this act. The Board of Directors and the Oklahoma Secretary of Health and Human Services are authorized to apply for, accept and receive federal funds to implement and sustain market stabilization programs. Preliminary planning and analysis shall continue under the direction of the Oklahoma Insurance Commissioner. The onset of market stabilization implementation shall be contingent upon Oklahoma's approval for and receipt of federal funds to implement and sustain market stabilization programs.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6530.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Oklahoma Individual Health Insurance Market Stabilization Act:

1. "Agent" means any person who is licensed to sell health insurance in this state;
2. "Board" means the Board of Directors of the Oklahoma Individual Health Insurance Market Stabilization Program;
3. "Health insurance" means any individual or group hospital or medical-expense-incurred policy or health care benefits plan or

contract providing insurance against loss through illness or injury of the insured. The term does not include any policy governing short-term accidents only, a fixed indemnity policy, a limited benefit policy, a specified accident policy, a specified disease policy, a Medicare supplement policy, a long-term care policy, medical payment or personal injury coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, a disability policy or workers' compensation;

4. "High-risk pool" means specially designated health insurance plans organized by federal or state entities, or a combination of federal and state entities, to serve high-risk, high-cost or both high-risk and high-cost individuals who meet enrollment criteria and do not have access to group insurance. They are organized as independent entities governed by their own boards and administrators and supported by the state's department of insurance;

5. "Insurer" means any individual, corporation, association, partnership, fraternal benefit society or any other entity engaged in the health insurance business, except insurance agents and brokers. This term shall also include not-for-profit hospital service and medical indemnity plans, health maintenance organizations, preferred provider organizations, prepaid health plans, the State and Education Employees Group Health Insurance Plan, stop-loss insurance plans and any reinsurer reinsuring health insurance in this state, which shall be designated as engaged in the business of insurance for the purposes of the Oklahoma Individual Health Insurance Market Stabilization Act;

6. "Market" means the individual health insurance market in Oklahoma, wherein income-eligible individuals may receive federal financial assistance for the purchase of qualified health plans as provided by Section 36B of Title 26 of the United States Code and Section 1301 of the federal Patient Protection and Affordable Care Act;

7. "Market stabilization activities" means a high-risk pool, reinsurance, hybrid programs or any combination thereof authorized by this act;

8. "Plan" means any of the comprehensive health insurance benefit plans as approved by the Board of Directors of the Oklahoma Individual Health Insurance Market Stabilization Program or qualified for participation in the market or by rule;

9. "Program" means the Oklahoma Individual Health Insurance Market Stabilization Program;

10. "Reinsurer" means any insurer from whom any insurer providing health insurance to Oklahomans procures insurance for itself with respect to all or part of the health insurance risk of the person; and

11. "Reinsurance" means the contract made between an entity providing insurance coverage and a third party to protect the insurer from losses. The contract provides for the third party to pay for the loss sustained by the insurer when the insurer makes a payment on the original contract. Reinsurance lets insurers cover a portion of their financial risks by recovering some or all of the claimed amounts they pay.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6530.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

Except as otherwise provided in this section, any person who is qualified for and enrolled in coverage through the market and is a permanent resident of the State of Oklahoma shall be eligible for coverage under the Oklahoma Individual Health Insurance Market Stabilization Program except that:

1. No person who is currently receiving or is entitled to receive health care benefits under any other federal or state program providing financial assistance or preventive and rehabilitative social services is eligible for coverage under the Program; and

2. No inmate incarcerated in any state penal institution or confined to any narcotic detention, treatment and rehabilitation facility shall be eligible for coverage under the Program.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6530.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. There is hereby created a nonprofit legal entity to be known as the "Oklahoma Individual Health Insurance Market Stabilization Program".

B. 1. The Program shall operate under the management of a nine-member Board of Directors appointed by the Insurance Commissioner. The Board shall consist of:

- a. two representatives of domestic insurance companies licensed to do business in this state,
- b. one member from the general public who is a member of the class of individuals to which the program would apply,
- c. one representative of a health maintenance organization,
- d. one member from a health-related profession,
- e. one member from the general public who is not associated with the medical profession, a hospital or an insurer,
- f. one representative of reinsurers, and
- g. two representatives from the providers of individual plans licensed to do business in this state.

2. The original Board shall be appointed for the following terms:

- a. three members for a term of one (1) year,
- b. three members for a term of two (2) years, and
- c. three members for a term of three (3) years.

3. All terms after the initial term shall be for three (3) years.

4. The Board shall elect one of its members as chairperson.

5. Members of the Board may be reimbursed from monies of the Program for actual and necessary expenses incurred by them in the performance of their official duties as members of the Board but shall not otherwise be compensated for their services.

6. The Board shall adopt a plan of operation and submit its articles, bylaws and operating rules to the Insurance Commissioner for approval. If the Board fails to submit a suitable plan of operation, articles, bylaws and operating rules within one hundred eighty (180) days, then the Insurance Commissioner shall promulgate rules governing the operation of the Program. If the Board subsequently adopts and submits any plan of operation, articles, bylaws or operating rules that are approved by the Commissioner, then the Commissioner shall revoke prior adopted administrative rules that the Commissioner determines to be inconsistent with the approved plan of operation, articles, bylaws or operating rules.

7. The Board shall have the authority to hire an Executive Director of the Program.

8. The Oklahoma Insurance Department shall provide administrative and operational support to the Program and to the Board. The Board shall reimburse the Insurance Commissioner for any direct and actual administrative costs associated with administering the provisions of this act from monies collected by the Board.

C. The Board shall cause an audit to be made of, including, but not limited to, the funds, accounts and fiscal affairs of the Program which shall be prepared by an independent certified public accountant or a licensed public accountant. One copy of the annual audit shall be filed with the State Auditor and Inspector, and one copy shall be presented to the Board not more than one hundred twenty (120) days following the close of each fiscal year. In the event that a copy of the audit as required by this section is not filed with the State Auditor and Inspector within the time herein provided, the State Auditor and Inspector is authorized to either commence an audit or employ a certified public accountant or licensed public accountant to make the audit herein required at the cost and expense of the Program.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6530.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Board of Directors of the Oklahoma Individual Health Insurance Market Stabilization Program shall:

1. Develop, implement and administer the Program. Implementation of the Program shall be contingent upon Oklahoma's

approval for and receipt of federal funds to implement and sustain the Program;

2. Levy and collect all assessments from all health insurers and reinsurers;

3. Make payments to provide for the market stabilization activities authorized by this act and for administrative expenses incurred or estimated to be incurred during the period for which assessment is made;

4. Establish administrative and accounting processes and procedures for the operation of the Program and create operating rules to effectuate the provisions of this act including but not limited to:

- a. determine eligibility of individuals to receive coverage under the Program,
- b. establish standards for qualification based upon health status, health conditions, prior or current insurance coverage status, health costs as a result of utilization of consuming health care,
- c. determine amount of the assessment and the amount or percentage of the premiums paid to health insurance plans for health insurance coverage by eligible individuals, that shall be collected and deposited to the credit of, and available for use by, the Program,
- d. establish the dollar amount of claims for eligible individuals after which the Program will provide payments to health insurance plans and the proportion of such claims above such dollar amount that the Program will pay,
- e. establish the rate at which the Program will reimburse a health insurance plan for claims incurred for an enrolled individual's claims, above the attachment point and below the reinsurance cap,
- f. determine the threshold amount for claims costs incurred by a health insurance plan for an enrolled individual's claims, after which the claims costs for

benefits are no longer eligible for reinsurance payments, and

- g. determine the diagnosed health condition of an eligible individual for which the Program will provide payments to health insurance plans for claims incurred after such diagnosis is made; and

5. Apply for, accept and receive federal funding for the operation of the Program, including the following:

- a. approval of a waiver provided by Section 1332 of the Patient Protection and Affordable Care Act, "1332 State Innovation Waiver", authorizing federal funding to support market stabilization program payments,
- b. Oklahoma's participation in any federal grant program or programs, or
- c. any combination of the above approaches.

B. In the event Oklahoma is unable to secure federal approval of a 1332 State Innovation Waiver or secure funding from federal grant programs within two (2) years from the effective date of this act, the Oklahoma Individual Health Insurance Market Stabilization Program shall sunset, and any remaining monies shall be returned to insurers on a pro rata basis based on the amount each insurer has paid in assessments since the creation of the Program.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6530.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Board may:

- 1. Exercise powers granted to insurers under the laws of this state;
- 2. Sue or be sued;
- 3. In addition to imposing assessments under Sections 5 and 7 of this act, levy interim assessments against insurers and reinsurers to ensure the financial ability of the Program to cover the market stabilization activities authorized by this act and any administrative expenses incurred or estimated to be incurred in the

operation of the Program prior to the end of a calendar year. Any interim assessment shall be due and payable within thirty (30) days of the receipt of the assessment notice by the insurer. Interim assessments shall be credited against the insurer's and reinsurer's annual assessment; and

4. Request the Insurance Commissioner to check the reports, records, books and papers of the Insurance Department to determine the financial condition of an insurer for purposes of Section 8 of this act.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6530.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. For the purpose of providing the funds necessary to carry out the provisions of this act, each insurer and each reinsurer shall be assessed by the Board of Directors of the Oklahoma Individual Health Insurance Market Stabilization Program according to such assessment methodology and at such time and for such amount as the Board finds necessary.

B. Each insurer's or reinsurer's proportion of participation in the Program shall be determined annually by the Board based on annual statements and other reports deemed necessary by the Board and filed with it by the insurer.

C. An insurer or reinsurer which has paid an assessment levied pursuant to this section shall not take a credit on the premium tax return for that insurer or reinsurer but may include the assessment amount in the insurer's or reinsurer's claims cost calculation for the purpose of determining the insurer's or reinsurer's rates for premiums charged for insurance policies to which the act applies. The rates shall not be deemed excessive for the sole reason of including in the calculation an amount reasonably calculated to recoup the assessment amount paid by the insurer or reinsurer.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6530.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Board may abate or defer, in whole or in part, the assessment of any insurer or reinsurer if determined by the Commissioner and the Board, payment of the assessment would place the insurer or reinsurer at an action control level as defined in

subparagraph a, b, c or d of paragraph 11 of Section 1522 of Title 36 of the Oklahoma Statutes or prevent the insurer or reinsurer from fulfilling the contractual obligations of the insurer or reinsurer.

B. In the event that an assessment against an insurer or reinsurer is abated or deferred, in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other insurers or reinsurers in a manner consistent with the basis for assessments set forth in Sections 5 and 7 of this act, and the insurer or reinsurer receiving the abatement or deferment shall remain liable to the Program for the deficiency for four (4) years.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6530.9 of Title 36, unless there is created a duplication in numbering, reads as follows:

It shall constitute an unfair practice for the purposes of Sections 1201 through 1220 of Title 36 of the Oklahoma Statutes for an insurer, insurance agent, insurance broker or third-party administrator to refer an individual employee to the Program or arrange for an individual employee to apply for the Program, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6530.10 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Secretary of Health and Human Services may apply to the United States Secretary of Health and Human Services for a waiver pursuant to Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C., Section 18052), "1332 State Innovation Waiver", with respect to health insurance coverage in the state for a plan year beginning on or after January 1, 2018. The Secretary may implement a state plan meeting the waiver requirements in a manner consistent with state and federal law and as approved by the United States Secretary of Health and Human Services.

SECTION 11. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the House of Representatives the 24th day of May, 2017.

Presiding Officer of the House
of Representatives

Passed the Senate the 26th day of May, 2017.

Presiding Officer of the Senate

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____
day of _____, 20_____, at _____ o'clock _____ M.
By: _____

Approved by the Governor of the State of Oklahoma this _____
day of _____, 20_____, at _____ o'clock _____ M.

Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____
day of _____, 20_____, at _____ o'clock _____ M.
By: _____

Appendix B: Oklahoma Reinsurance Program Regulation

Oklahoma Statute: Title 36, Sections 6530.1-6530.10

§ 6530.1. Short Title - Legislative Intent

This act shall be known and may be cited as the "Oklahoma Individual Health Insurance Market Stabilization Act". It is the intent of the Legislature to provide payments to health insurance plans with respect to claims for eligible individuals for the purpose of lowering premiums for health insurance coverage offered in the individual market. Market stabilization activities shall include establishment of a high-risk pool, reinsurance, hybrid programs or any combination thereof. It is the further intent of the Legislature to bestow upon the Oklahoma Insurance Commissioner the authority to appoint a Board of Directors which shall create, implement, oversee and monitor the high-risk pool, reinsurance or hybrid programs under provisions of this act. The Board of Directors and the Oklahoma Secretary of Health and Human Services are authorized to apply for, accept and receive federal funds to implement and sustain market stabilization programs. Preliminary planning and analysis shall continue under the direction of the Oklahoma Insurance Commissioner. The onset of market stabilization implementation shall be contingent upon Oklahoma's approval for and receipt of federal funds to implement and sustain market stabilization programs.

§ 6530.2. Definitions

As used in the Oklahoma Individual Health Insurance Market Stabilization Act:

1. "Agent" means any person who is licensed to sell health insurance in this state;
2. "Board" means the Board of Directors of the Oklahoma Individual Health Insurance Market Stabilization Program;
3. "Health insurance" means any individual or group hospital or medical-expense-incurred policy or health care benefits plan or contract providing insurance against loss through illness or injury of the insured. The term does not include any policy governing short-term accidents only, a fixed indemnity policy, a limited benefit policy, a specified accident policy, a specified disease policy, a Medicare supplement policy, a long-term care policy, medical payment or personal injury coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, a disability policy or workers' compensation;
4. "High-risk pool" means specially designated health insurance plans organized by federal or state entities, or a combination of federal and state entities, to serve high-risk, high-cost or both high-risk and high-cost individuals who meet enrollment criteria and do not have access to group insurance. They are organized as independent entities governed by their own boards and administrators and supported by the state's department of insurance;
5. "Insurer" means any individual, corporation, association, partnership, fraternal benefit society or any other entity engaged in the health insurance business, except insurance agents and brokers. This term shall also include not-for-profit hospital service and medical indemnity plans, health maintenance organizations, preferred provider organizations, prepaid health plans, the State and Education Employees Group Health Insurance Plan, stop-loss insurance plans and any reinsurer reinsuring health insurance in this state, which shall be designated as engaged in the business of insurance for the purposes of the Oklahoma Individual Health Insurance Market Stabilization Act;
6. "Market" means the individual health insurance market in Oklahoma, wherein income-eligible individuals may receive federal financial assistance for the purchase of qualified health plans as provided by Section 36B of Title 26 of the United States Code and Section 1301 of the federal Patient Protection and Affordable Care Act;
7. "Market stabilization activities" means a high-risk pool, reinsurance, hybrid programs or any combination thereof authorized by this act;
8. "Plan" means any of the comprehensive health insurance benefit plans as approved by the Board of Directors of the Oklahoma Individual Health Insurance Market Stabilization Program or qualified for participation in the market or by rule;

9. "Program" means the Oklahoma Individual Health Insurance Market Stabilization Program;

10. "Reinsurer" means any insurer from whom any insurer providing health insurance to Oklahomans procures insurance for itself with respect to all or part of the health insurance risk of the person; and

11. "Reinsurance" means the contract made between an entity providing insurance coverage and a third party to protect the insurer from losses. The contract provides for the third party to pay for the loss sustained by the insurer when the insurer makes a payment on the original contract. Reinsurance lets insurers cover a portion of their financial risks by recovering some or all of the claimed amounts they pay.

§ 6530.3. Eligibility Limitations

Except as otherwise provided in this section, any person who is qualified for and enrolled in coverage through the market and is a permanent resident of the State of Oklahoma shall be eligible for coverage under the Oklahoma Individual Health Insurance Market Stabilization Program except that:

1. No person who is currently receiving or is entitled to receive health care benefits under any other federal or state program providing financial assistance or preventive and rehabilitative social services is eligible for coverage under the Program; and

2. No inmate incarcerated in any state penal institution or confined to any narcotic detention, treatment and rehabilitation facility shall be eligible for coverage under the Program.

§ 6530.4. Creation and Administration of the Board of Directors

A. There is hereby created a nonprofit legal entity to be known as the "Oklahoma Individual Health Insurance Market Stabilization Program".

B. 1. The Program shall operate under the management of a nine-member Board of Directors appointed by the Insurance Commissioner. The Board shall consist of:

- a. two representatives of domestic insurance companies licensed to do business in this state,
- b. one member from the general public who is a member of the class of individuals to which the program would apply,
- c. one representative of a health maintenance organization,
- d. one member from a health-related profession,
- e. one member from the general public who is not associated with the medical profession, a hospital or an insurer,
- f. one representative of reinsurers, and
- g. two representatives from the providers of individual plans licensed to do business in this state.

2. The original Board shall be appointed for the following terms:

- a. three members for a term of one (1) year,
- b. three members for a term of two (2) years, and
- c. three members for a term of three (3) years.

3. All terms after the initial term shall be for three (3) years.

4. The Board shall elect one of its members as chairperson.

5. Members of the Board may be reimbursed from monies of the Program for actual and necessary expenses incurred by them in the performance of their official duties as members of the Board but shall not otherwise be compensated for their services.

6. The Board shall adopt a plan of operation and submit its articles, bylaws and operating rules to the Insurance Commissioner for approval. If the Board fails to submit a suitable plan of operation, articles, bylaws and operating rules within one hundred eighty (180) days, then the Insurance Commissioner shall promulgate rules governing the operation of the Program. If the Board subsequently adopts and submits any plan of operation, articles, bylaws or operating rules that are approved by the Commissioner, then the Commissioner shall revoke prior adopted administrative rules that the Commissioner determines to be inconsistent with the approved plan of operation, articles, bylaws or operating rules.

7. The Board shall have the authority to hire an Executive Director of the Program.

8. The Oklahoma Insurance Department shall provide administrative and operational support to the Program and to the Board. The Board shall reimburse the Insurance Commissioner for any direct and actual administrative costs associated with administering the provisions of this act from monies collected by the Board.

C. The Board shall cause an audit to be made of, including, but not limited to, the funds, accounts and fiscal affairs of the Program which shall be prepared by an independent certified public accountant or a licensed public accountant. One copy of the annual audit shall be filed with the State Auditor and Inspector, and one copy shall be presented to the Board not more than one hundred twenty (120) days following the close of each fiscal year. In the event that a copy of the audit as required by this section is not filed with the State Auditor and Inspector within the time herein provided, the State Auditor and Inspector is authorized to either commence an audit or employ a certified public accountant or licensed public accountant to make the audit herein required at the cost and expense of the Program.

§ 6530.5. Duties of the Board

A. The Board of Directors of the Oklahoma Individual Health Insurance Market Stabilization Program shall:

1. Develop, implement and administer the Program. Implementation of the Program shall be contingent upon Oklahoma's approval for and receipt of federal funds to implement and sustain the Program;

2. Levy and collect all assessments from all health insurers and reinsurers;

3. Make payments to provide for the market stabilization activities authorized by this act and for administrative expenses incurred or estimated to be incurred during the period for which assessment is made;

4. Establish administrative and accounting processes and procedures for the operation of the Program and create operating rules to effectuate the provisions of this act including but not limited to:

a. determine eligibility of individuals to receive coverage under the Program,

b. establish standards for qualification based upon health status, health conditions, prior or current insurance coverage status, health costs as a result of utilization of consuming health care,

c. determine amount of the assessment and the amount or percentage of the premiums paid to health insurance plans for health insurance coverage by eligible individuals, that shall be collected and deposited to the credit of, and available for use by, the Program,

d. establish the dollar amount of claims for eligible individuals after which the Program will provide payments to health insurance plans and the proportion of such claims above such dollar amount that the Program will pay,

e. establish the rate at which the Program will reimburse a health insurance plan for claims incurred for an enrolled individual's claims, above the attachment point and below the reinsurance cap,

- f. determine the threshold amount for claims costs incurred by a health insurance plan for an enrolled individual's claims, after which the claims costs for benefits are no longer eligible for reinsurance payments, and
- g. determine the diagnosed health condition of an eligible individual for which the Program will provide payments to health insurance plans for claims incurred after such diagnosis is made; and

5. Apply for, accept and receive federal funding for the operation of the Program, including the following:

- a. approval of a waiver provided by Section 1332 of the Patient Protection and Affordable Care Act, "1332 State Innovation Waiver", authorizing federal funding to support market stabilization program payments,
- b. Oklahoma's participation in any federal grant program or programs, or
- c. any combination of the above approaches.

B. In the event Oklahoma is unable to secure federal approval of a 1332 State Innovation Waiver or secure funding from federal grant programs within two (2) years from the effective date of this act, the Oklahoma Individual Health Insurance Market Stabilization Program shall sunset, and any remaining monies shall be returned to insurers on a pro rata basis based on the amount each insurer has paid in assessments since the creation of the Program.

[§ 6530.6. Powers of the Board](#)

The Board may:

- 1. Exercise powers granted to insurers under the laws of this state;
- 2. Sue or be sued;
- 3. In addition to imposing assessments under Sections 5 and 7 of this act, levy interim assessments against insurers and reinsurers to ensure the financial ability of the Program to cover the market stabilization activities authorized by this act and any administrative expenses incurred or estimated to be incurred in the operation of the Program prior to the end of a calendar year. Any interim assessment shall be due and payable within thirty (30) days of the receipt of the assessment notice by the insurer. Interim assessments shall be credited against the insurer's and reinsurer's annual assessment; and
- 4. Request the Insurance Commissioner to check the reports, records, books and papers of the Insurance Department to determine the financial condition of an insurer for purposes of Section 8 of this act.

[§ 6530.7. Insurer and Reinsurer Assessment](#)

A. For the purpose of providing the funds necessary to carry out the provisions of this act, each insurer and each reinsurer shall be assessed by the Board of Directors of the Oklahoma Individual Health Insurance Market Stabilization Program according to such assessment methodology and at such time and for such amount as the Board finds necessary.

B. Each insurer's or reinsurer's proportion of participation in the Program shall be determined annually by the Board based on annual statements and other reports deemed necessary by the Board and filed with it by the insurer.

C. An insurer or reinsurer which has paid an assessment levied pursuant to this section shall not take a credit on the premium tax return for that insurer or reinsurer but may include the assessment amount in the insurer's or reinsurer's claims cost calculation for the purpose of determining the insurer's or reinsurer's rates for premiums charged for insurance policies to which the act applies. The rates shall not be deemed excessive for the sole reason of including in the calculation an amount reasonably calculated to recoup the assessment amount paid by the insurer or reinsurer.

[§ 6530.8. Abatement or Deference of Assessment](#)

A. The Board may abate or defer, in whole or in part, the assessment of any insurer or reinsurer if determined by the Commissioner and the Board, payment of the assessment would place the insurer or reinsurer at an action control level as defined in subparagraph a, b, c or d of paragraph 11 of [Section 1522 of Title 36](#) of the Oklahoma Statutes or prevent the insurer or reinsurer from fulfilling the contractual obligations of the insurer or reinsurer.

B. In the event that an assessment against an insurer or reinsurer is abated or deferred, in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other insurers or reinsurers in a manner consistent with the basis for assessments set forth in Sections 5 and 7 of this act, and the insurer or reinsurer receiving the abatement or deferment shall remain liable to the Program for the deficiency for four (4) years.

[§ 6530.9. Unfair Practices](#)

It shall constitute an unfair practice for the purposes of [Sections 1201](#) through [1220 of Title 36](#) of the Oklahoma Statutes for an insurer, insurance agent, insurance broker or third-party administrator to refer an individual employee to the Program or arrange for an individual employee to apply for the Program, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

[§ 6530.10. Application for Federal Waiver](#)

The Oklahoma Secretary of Health and Human Services may apply to the United States Secretary of Health and Human Services for a waiver pursuant to Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C., Section 18052), "1332 State Innovation Waiver", with respect to health insurance coverage in the state for a plan year beginning on or after January 1, 2018. The Secretary may implement a state plan meeting the waiver requirements in a manner consistent with state and federal law and as approved by the United States Secretary of Health and Human Services.

Appendix C: Actuarial Analyses and Certifications

Milliman Client Report



Section 1332 State Innovation Waiver Actuarial Analyses and Certification and Economic Analyses

Oklahoma State Department of Health

Prepared for:
Terry L. Cline, Ph.D.
Secretary of Health and Human Services

Prepared by:
Paul R. Houchens
FSA, MAAA
Principal and Consulting Actuary

Bradley A. Teach
FSA, CERA, MAAA
Actuary

Zachary J. Fohl
FSA, MAAA
Actuary

Jason P. Melek
ASA, MAAA
Associate Actuary

10 West Market Street
Suite 1600
Indianapolis, IN 46204 USA

Tel +1 317 639-1000
Fax +1 317 639-1001

milliman.com

EXECUTIVE SUMMARY

Milliman, Inc. (Milliman) has been retained by the Oklahoma State Department of Health (OSDH) to provide actuarial and consulting services related to its proposed Section 1332 State Innovation Waiver Application (Section 1332 Waiver). This Section 1332 Waiver seeks federal pass-through funding to implement the Oklahoma Individual Health Insurance Market Stabilization Program (OMSP) beginning in calendar year 2018. This report provides the required actuarial analysis and certification, and economic analyses supporting the State's determination that the OMSP meets the requirements for Federal pass-through funding.

Legislation authorizing the OMSP was signed on June 6, 2017 by Governor Mary Fallin.¹ As stated in the legislation, the purpose of the OMSP is “to provide payments to health insurance plans with respect to claims for eligible individuals for the purpose of lowering premiums for health insurance coverage offered in the individual market.” For the State's Section 1332 Waiver application, it seeks to implement a reinsurance program for the individual market (also known as “non-group” coverage) beginning on January 1, 2018.

The OMSP is intended to reduce premiums in the individual market by subsidizing insurer paid claims for high cost members. For the portion of claims expenditures within the parameters defined by the OMSP, insurers offering comprehensive individual market coverage meeting requirements under the Affordable Care Act (ACA) in Oklahoma's insurance market will be eligible for reimbursement under the OMSP. Reimbursement will be available regardless of whether the coverage is sold inside or outside the federally-facilitated insurance marketplace (FFM). For 2018, the State is targeting a reinsurance fund of \$325 million. During the remainder of the initial five-year waiver period and subsequent waiver periods, the OMSP's Board of Directors (Board) will evaluate the reinsurance parameters and estimated impact to Oklahoma's individual health insurance market. For purposes of the projections shown in this report, we have assumed the annual reinsurance fund will remain at \$325 million per year through the end of the projection period (2027). Insurance coverage that is considered transitional or grandfathered as defined by the ACA and other regulations will not be eligible for payments from the OMSP.

For the OMSP to meet the Federal requirements for Section 1332 Waivers, it must be deficit neutral to the Federal government and meet the following standards:

- *Coverage*: The Section 1332 Waiver must provide health insurance to *at least* as many people as would be projected under the status-quo ACA (without waiver).
- *Affordability*: The Section 1332 Waiver must provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver.
- *Comprehensiveness*: The Section 1332 Waiver must provide coverage at least as comprehensive (as defined by the ACA's essential health benefits) as would be projected without the waiver.

It should be stressed that these requirements are in relation to coverage, affordability, and comprehensiveness without the waiver. For example, a Section 1332 Waiver is not required to result in more insured individuals relative to a period before its implementation. Rather, it must be estimated to insure at least as many during the projection period relative to if the Section 1332 Waiver was not implemented.

Our analysis indicates that all the Federal requirements cited above are met by the OMSP.

Coverage

During the course of the five-year initial waiver period and the ten-year projection period, we estimate the OMSP will result in a lower number of uninsured Oklahomans each year than without the waiver. We estimate the reductions in the uninsured population will occur primarily in the population with income above 400% of the federal poverty level (FPL), as non-group (individual market) premium rates will be more affordable under the OMSP.²

As the population with income between 100% and 400% FPL is eligible for Federal premium assistance, out-of-pocket premium rate changes have been limited since the ACA-reformed rating rules were implemented in January 2014.³ While

¹ <https://legiscan.com/OK/text/HB2406/2017>

² In 2017, the FPL is \$12,060 for a single household and \$24,600 for a family of four. 400% FPL would reflect income levels of \$48,240 and \$98,400, respectively. Please see <https://aspe.hhs.gov/poverty-guidelines> for more information.

³ For example, see slide 28: https://www.ok.gov/health2/documents/1332%20Task%20Force%20Meeting_2.21.pdf.

premium rates for plans offered through the FFM have increased significantly from 2014 (approximately 145% for the subsidy benchmark plan in Oklahoma City), these increases have largely been borne by additional Federal premium assistance for the population with income between 100% and 400% FPL qualifying for premium assistance.

We estimate the OMSP will not have any material impacts to the number of Oklahomans covered under employer-sponsored plans, Medicaid, Medicare, or other public programs. Figure 1 illustrates separately changes in the number of Oklahomans uninsured and purchasing coverage in the non-group market under the OMSP relative to if the program was not implemented.

Figure 1 Oklahoma Department of Health Changes in Uninsured and Non-Group Market Resulting from OMSP Implementation						
Calendar Year	Uninsured			Individuals Insured in Non-Group Market		
	Without OMSP	With OMSP	Change	Without OMSP	With OMSP	Change
2017	590,000	590,000	-	150,000	150,000	-
2018	592,000	570,000	(22,000)	150,000	172,000	22,000
2019	601,000	574,000	(27,000)	144,000	171,000	27,000
2020	604,000	576,000	(28,000)	144,000	172,000	28,000
2021	607,000	580,000	(27,000)	144,000	171,000	27,000
2022	610,000	584,000	(26,000)	144,000	170,000	26,000
2023	613,000	590,000	(23,000)	144,000	167,000	23,000
2024	617,000	595,000	(22,000)	144,000	166,000	22,000
2025	620,000	599,000	(21,000)	144,000	165,000	21,000
2026	624,000	605,000	(19,000)	144,000	163,000	19,000
2027	627,000	608,000	(19,000)	144,000	163,000	19,000

From 2016 to 2017, we estimate approximately 30,000 Oklahomans exited the non-group market. We estimate the vast majority of these individuals did not qualify for premium assistance in the federally-facilitated marketplace (FFM) and were adversely impacted by a more than 70% premium rate increase from 2016 to 2017. Under the OMSP, we estimate a large portion of the cohort that exited the non-group market will re-enter the market in 2018 as a result of lower premium rates. The additional 22,000 non-group enrollees estimated to purchase coverage in 2018 as a result of the OMSP may increase the size of Oklahoma’s non-group market to 172,000.

For the duration of the projection period, we estimate 19,000 to 28,000 additional annual non-group enrollees relative to without the waiver. The enrollment impact from the waiver is estimated to grow in 2019 as a result of persons with transitional/grandfathered (non-ACA compliant) coverage having a greater likelihood of entering the ACA-compliant market, rather than becoming uninsured (transitional / grandfathered coverage is assumed to end after 2018). Based on this projected reduction in uninsured on an annual basis, we believe that the OMSP meets the coverage requirement for approval of the Section 1332 Waiver.

With or without OMSP, we estimate a decline in non-group coverage over the course of the ten-year projection period. While the OMSP is estimated to materially reduce premiums in 2018, premiums are still estimated to increase over the course of the projection period, resulting in higher costs for the population not qualifying for premium assistance.

Affordability

The OMSP is not estimated to materially impact premium rates for employer-sponsored insurance, nor change costs, eligibility parameters, or enrollment levels for public programs such as Medicaid and Medicare. A state-based assessment on commercial insurers and self-funded insurers with stop loss coverage is being implemented to fund the non-Federal portion of the reinsurance fund. It is possible that this additional cost will be passed-through to employees in the form of slightly higher plan contributions or additional cost sharing requirements. However, we estimate the assessment for the OMSP will be less than 1% of an average employer’s premium costs.

For the non-group market, the OMSP is estimated to reduce premium rates by more than 30% in 2018 (relative to without the waiver). This is achieved through the \$325 million reinsurance fund that subsidizes insurer paid claim expenses for members with annual healthcare expenses meeting the reinsurance parameters defined by the OMSP. To the extent there are reductions in non-claims expenses relative to those without the waiver, premium savings for a given year may be greater than the reinsurance fund by itself. There is significant uncertainty regarding how the insurers will modify non-claims expense assumptions for premium rate development purposes; however, we believe the relationship between the OMSP and the ACA’s minimum medical loss ratio requirements may result in a reduction in amounts attributable to non-claims expenses in premium rates.

During each year, the impact to consumers will vary significantly within the non-group market based on the consumer’s household income and its interaction with the ACA’s premium assistance program. Under the ACA’s premium assistance program, qualifying households with income between 100% and 400% FPL have out-of-pocket premium expenses capped to a specified percent of income. In 2017, we estimate approximately 80% of Oklahomans purchasing coverage in the ACA-compliant individual market received Federal premium assistance. To a large degree, we estimate the vast majority of individuals receiving premium assistance without the waiver will also receive premium assistance under the OMSP. For these individuals, the premium savings will accrue to the federal government, as it reduces the amount of premium assistance necessary to ensure the out-of-pocket cost of coverage does not exceed the maximum specified by the ACA. It is possible that some young adults and other persons with income approaching 400% FPL receiving premium assistance without the waiver will see out-of-pocket premiums fall below the maximum specified by the ACA under the OMSP. In these cases, only partial premium savings accrue to the Federal government, while the consumer also directly benefits from the premium reduction.

For households not eligible for premium assistance, the full amount of premium rate reduction will be realized under the OMSP, with the federal government not accruing any savings. As premium rates are estimated to be more affordable under the OMSP, this should provide financial incentive for some of the uninsured individuals in the absence of the waiver to purchase health insurance. Figure 2 illustrates premium rate reductions for a 21-year old and a 64-year old for the second lowest cost silver plan (the benchmark plan that is used to determine available premium assistance).

Figure 2
Oklahoma Department of Health
Changes in Second Lowest Cost Silver Plan Monthly Premium from OMSP Implementation

Calendar Year	21-Year Old Monthly Premium			64-Year Old Monthly Premium		
	Without OMSP	With OMSP	Change	Without OMSP	With OMSP	Change
2017	\$405	\$405	\$0	\$1,215	\$1,215	\$0
2018	\$441	\$290	(\$150)	\$1,322	\$870	(\$451)
2019	\$437	\$311	(\$126)	\$1,310	\$933	(\$377)
2020	\$458	\$327	(\$131)	\$1,375	\$981	(\$394)
2021	\$472	\$337	(\$135)	\$1,415	\$1,011	(\$404)
2022	\$500	\$371	(\$129)	\$1,499	\$1,113	(\$387)
2023	\$529	\$401	(\$128)	\$1,588	\$1,203	(\$385)
2024	\$561	\$434	(\$127)	\$1,682	\$1,302	(\$381)
2025	\$591	\$463	(\$128)	\$1,774	\$1,390	(\$383)
2026	\$624	\$496	(\$127)	\$1,871	\$1,489	(\$382)
2027	\$658	\$530	(\$128)	\$1,973	\$1,589	(\$384)

Notes:

1. Values are rounded.
2. Values do not reflect available premium assistance for qualifying individuals.
3. Premiums are for non-tobacco user and assume Federal default 3:1 age rating.

Based on the above summary of our analysis, we believe the OMSP meets the affordability requirement for approval of the Section 1332 Waiver.

Comprehensiveness

As the OMSP makes no change to insurer benefit requirements for plans offered in Oklahoma's health insurance markets, the OMSP meets the comprehensiveness requirements required for a Section 1332 Waiver. The OMSP makes no changes to essential health benefit (EHB) or state-mandated benefit requirements in the individual market. Therefore, the focus of the actuarial analysis was related to coverage and affordability requirements for this Section 1332 Waiver, as presented above and discussed in greater detail later in this report.

Economic Analyses

A Section 1332 waiver application must demonstrate it will not increase the Federal deficit. By reducing non-group premiums, the OMSP is estimated to result in Federal savings on premium assistance provided through the FFM. We also evaluated changes in Federal revenue related to individual shared responsibility payments (individual mandate), FFM user fees, health insurance providers fee (HIF), and the Patient-Centered Outcomes Research Trust Fund (PCORI). Note, we do not estimate any material changes to Federal cost-sharing reduction (CSR) payments, as the OMSP does not impact eligibility for CSR plans, estimated CSR plan enrollment, or CSR benefit design.

- *Shared responsibility payments:* Additional revenue is estimated to be collected from shared responsibility payments, as the decline in premiums from the OMSP is estimated to result in fewer Oklahomans being eligible for affordability exemptions, offsetting a reduction in shared responsibility payments from newly insured individuals.
- *FFM user fees:* As a result of reducing premiums in the individual market, we estimate the Federal government will collect a decreased amount of revenue related to the FFM user fee (assumed to be 3.5% of FFM premium).
- *HIF:* As national collected revenue amounts for the HIF are prescribed in 2018 (premium volume changes do not impact the collected amount), we do not estimate any change in HIF revenue as a result of the OMSP for 2018. Thereafter, the national HIF collection amount is estimated to be indexed by changes in per capita employer-sponsored insurance premiums. As the OMSP does not materially impact employer-sponsored insurance, we do not estimate any impacts to the national HIF amounts during the remainder of the ten-year projection period.
- *PCORI:* As additional persons are estimated to be insured under the OMSP, we estimate a slight increase in PCORI revenue in 2018. Insurers are not subject to the PCORI fee for policy years ending after September 30, 2019. Therefore, we do not estimate any change in PCORI revenue resulting from the OMSP during the remainder of the projection period.

It is possible that the OMSP may impact other federal revenue items, such as federal income taxes paid by insurers. However, quantifying these items is beyond the scope of our analysis.

The combination of Federal premium assistance savings plus the sum of revenue changes from the other described Federal revenue sources comprise the estimated Federal pass-through funding available to Oklahoma under Section 1332 Waiver regulations. Figure 3 illustrates the division of state and Federal funding for the ten-year projection period and the state-based assessment amount.

Figure 3 Oklahoma Department of Health Estimated Available Pass-Through Funding and State-Based Assessment					
Calendar Year	Reinsurance Funding Level (\$ Millions)	Federal Pass-through Funding (\$ Millions)	State-Based Assessment (\$ Millions)	Estimated Assessment Enrollment Base	State-Based Assessment PMPM
2018	\$ 325	\$ 309	\$ 16	1,780,000	\$0.76
2019	\$ 325	\$ 262	\$ 63	1,790,000	\$2.96
2020	\$ 325	\$ 274	\$ 51	1,790,000	\$2.38
2021	\$ 325	\$ 282	\$ 43	1,800,000	\$2.00
2022	\$ 325	\$ 269	\$ 56	1,800,000	\$2.59
2018 to 2022 Totals	\$ 1,625	\$ 1,395	\$ 230	8,970,000	5 year average: \$2.14
2023	\$ 325	\$ 272	\$ 53	1,810,000	\$2.46
2024	\$ 325	\$ 269	\$ 56	1,810,000	\$2.59
2025	\$ 325	\$ 270	\$ 55	1,820,000	\$2.51
2026	\$ 325	\$ 272	\$ 53	1,830,000	\$2.43
2027	\$ 325	\$ 274	\$ 51	1,830,000	\$2.31

Notes:

6. State-based assessment PMPM does not include cost of administering reinsurance fund. Approximately \$0.05 PMPM generates an estimated \$1 million in state-based revenue per year.
7. State-based assessment PMPM values are for illustrative purposes only. The Board will determine the final assessment PMPM for each year.
8. Values are estimates. Actual Federal pass-through funding will be determined based on premium rates filed for each year.
9. Values are rounded.
10. The 2018 assessment base may be lower than the values illustrated to the extent employer-sponsored plans do not begin paying the assessment until the beginning of their plan year in 2018 (which may be on a non-calendar year basis).

The required state-based assessment amount is estimated based on the difference between the reinsurance funding level (\$325 million for each year) and the estimated Federal pass-through funding. The estimated state-based assessment varies by year as a result of premium rate differentials between the without waiver and with waiver scenarios that differ over the course of the projection period. For the state-based assessment amount, the State of Oklahoma proposes to assess a PMPM fee on health insurance coverage meeting one of the following requirements:

- Fully insured, comprehensive non-group coverage;
- Fully insured, comprehensive group coverage (small and large group);
- Governmental entities providing employer-sponsored insurance that is not considered an Employee Retirement Income Security Act (ERISA) plan, including the Oklahoma Employees Group Insurance Division (EGID); and,
- ERISA plans purchasing stop-loss coverage.

ERISA plans not purchasing stop-loss coverage are exempted from paying the OMSP assessment. The 'Estimated Assessment Enrollment Base' column in Figure 3 reflects estimated average monthly enrollment for Oklahomans enrolled in health insurance coverage meeting the described assessment criteria. The enrollment estimates reflect projected changes in non-group and employer-sponsored coverage during the ten-year projection period. *Based on information provided by the State, we have assumed that 90% of self-funded employer-sponsored plans (excluding the EGID population) purchase stop-loss coverage.*

For the initial 2018 assessment amount, the State has elected to collect an assessment of \$2.14 PMPM, based on the five year average assessment for the initial waiver period. This is based on the estimated state-based assessment funding that will be required, on average, during the initial five-year waiver period (2018 through 2022) and the estimated assessment enrollment base. For 2018, the State believes the assessment revenue will be sufficient to cover any nominal administrative expenses associated with the reinsurance fund. For 2019 and thereafter, the Board will determine the annual assessment amount.

Sensitivity of Results

It should be noted there is significant uncertainty surrounding future enrollment and premiums in health insurance programs, particularly the individual market. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. *As final Federal pass-through funding will be based on actual premiums filed by insurers offering coverage in Oklahoma's non-group market, final funding amounts may differ significantly from the estimates provided in this report. It is our assumption that insurers will re-file rates to reflect the estimated impact of the OMSP in 2018.*

The actuarial and economic analyses presented in this report solely reflect the estimated incremental impact of the OMSP. Other state or Federal policy changes may impact actual amounts presented in this report.

We specifically note that our projections of enrollment and premium rates in the individual market assume Federal funding of cost sharing reduction (CSR) subsidies continue, the individual mandate is enforced in a manner similar to the 2014 through 2016 time period, and insurer pricing assumptions do not materially deviate from 2017 assumptions. To the extent judicial, legislative, or regulatory changes are made to the ACA, the values presented in this report may be impacted by a significant degree. Actual insurer premiums in 2018 and beyond may contain additional margin related to these contingencies to provide the insurer financial protection. As we have evaluated Oklahoma's Section 1332 Waiver under current law and regulations, we have not made adjustments for these contingencies in the estimates provided in this report.

SECTION I. ACTUARIAL ANALYSIS

This section provides the required actuarial analysis for Oklahoma's Section 1332 Waiver application. Appendix 1 contains the actuarial certification for the Section 1332 Waiver.

A description of the actuarial analysis meeting the requirements under 45 CFR 155.1308(f)(4)(i) and other applicable information as requested in the Checklist for Section 1332 Innovation Waiver Applications has been provided in this section. For purposes of this analysis, calendar year 2017 serves as the baseline year for the ten-year required projections.

As discussed in the Assumptions and Methodology section of this report, we utilized a combination of census bureau survey and projection data, publicly available health insurance enrollment and premium data, modeling of the ACA's premium assistance structure, and proprietary data to model the estimated impact of the OMSP during the ten-year projection period. Our analysis reflects the estimated demographics of Oklahomans during the projection period and models insurance purchasing behavior based on changes in premium rates and Federal premium subsidies. Our modeling allows for the summarization of projected enrollment and premium information by age, gender, health status, household income, and insurance market.

Prior to performing any projections, we calibrated our projection model's census, premium, claims expense, and other assumptions to reflect Oklahoma's insurance markets. As the OMSP is estimated to primarily impact Oklahoma's individual health insurance market and uninsured population, the focus of our modeling efforts were on the interaction between these populations under both the status-quo ACA and the Section 1332 Waiver.

1. REINSURANCE PARAMETERS

Oklahoma has elected to implement an attachment point reinsurance model under its 1332 waiver application for 2018. The design of the reinsurance program is not intended to replace private reinsurance that Oklahoma insurers may purchase, as it does not eliminate insurance risk for insured members with claims in excess of \$400,000 during the year. Rather, the program is intended to subsidize insurers' claim expenses for high cost claimants, while maintaining an insurer's incentive to manage the costs associated with these claimants. Figure I-1A illustrates the reinsurance parameters for the program.

Figure I-1A Oklahoma Department of Health Individual Health Insurance Market OMSP Calendar Year 2018 Reinsurance Parameters	
Parameter	Parameter Value
Attachment Point	\$15,000
Reinsurance Cap	\$400,000
Coinsurance Percentage	80%

Attachment Point: The reinsurance program will begin making payments to an insurer when an individual's accumulated claims incurred during the calendar year exceed the attachment point. For 2018, the proposed attachment point is \$15,000. For claimants with annual expenses not exceeding \$15,000, insurers will not receive any payments from the reinsurance fund. To the extent a claimant's medical⁴ expenses exceeds \$15,000, the insurer will receive a payment from the reinsurance fund.

Reinsurance Cap: The reinsurance program will not make payments to insurers for a claimant's medical expenses exceeding the reinsurance cap. For 2018, the proposed reinsurance cap is \$400,000. For claimants with annual medical expenses above the reinsurance cap, the insurer will be compensated for the covered claim value above the attachment point and below the reinsurance cap.

⁴ Includes amounts for all services and materials covered under the health care plans, including medical services, prescription drugs, and medical equipment and supplies.

Coinsurance Percentage: For eligible claimants, the insurer will be reimbursed for a percentage of the medical expense between the attachment point, and the lesser of the reinsurance cap or annual medical expense. In equation form, the insurer will receive a payment from the reinsurance fund equal to:

Reinsurance Payment

$$= \text{Maximum}[0, [\text{Minimum}(\text{Reinsurance Cap}, \text{Annual Medical Expense}) - \text{Attachment Point}] \times \text{Coinsurance Percentage}]$$

Figure I-1B provides several examples of reinsurance payments in 2018 for claimants with varying annual medical expenses.

Figure I-1B Oklahoma Department of Health Individual Health Insurance Market OMSP Calendar Year 2018 Reinsurance Payment Examples				
Person	Annual Medical Expense	Reinsurance Eligible Medical Expense	Coinsurance Percentage	Reinsurance Payment
A	\$20,000	\$5,000	80%	\$4,000
B	\$100,000	\$85,000	80%	\$68,000
C	\$500,000	\$385,000	80%	\$308,000

By virtue of the coinsurance percentage not being 100%, as well as having a reinsurance cap, we believe insurers continue to have a financial incentive to manage health care costs and utilization for insured individuals meeting the payment criteria for the reinsurance program. From the consumer and provider perspective, the reinsurance program is expected to have no material impact on incentives to manage health care costs and utilization relative to the ACA's current structure.

2. PROJECTED REINSURANCE FUNDING LEVELS

For calendar year 2018, the State is targeting a reinsurance fund of \$325 million. The \$325 million excludes costs associated with administering and operationalizing the reinsurance program. The above parameters are estimated to generate this level of insurer payments in 2018. As individual market member level data were not available, we relied on historical transitional reinsurance payments (TRP) that were made to insurers participating in Oklahoma's ACA-compliant individual health insurance market from 2014 through 2016 to estimate reinsurance distributions to Oklahoma's individual market population.⁵ Additionally, we received insurer information validating our modeled estimates.

On an annual basis, the aggregate dollar amount of the reinsurance fund will be distributed to qualifying insurers offering coverage in the non-group market. To the extent the initial reinsurance parameters for the year result in a shortage of payments to insurers relative to the aggregate fund amount, the reinsurance insurance parameters will be adjusted to increase insurer payments to the aggregate fund amount on a retrospective basis. Conversely, the OMSP's Board will monitor payments and adjust the reinsurance parameters as necessary to avoid a funding deficit.

Figure I-2A illustrates the estimated aggregate reinsurance funding, insurer paid claim expenses (prior to reinsurance), and reinsurance funding as a percent of insured paid claim expenses during the ten-year projection period. On an annual basis, the Board will evaluate the reinsurance parameters and estimated impact to Oklahoma's individual health insurance market. For purposes of this actuarial analysis, we have maintained the 2018 aggregate reinsurance funding amount of \$325 million throughout the projection period, with the assumption the reinsurance parameters will be adjusted on an annual basis to maintain this funding level. As illustrated in Figure I-2A, as a result of health care inflation, the \$325 million reinsurance fund decreases from an estimated 39% of insurer paid claims expense in 2018, to an estimated 21% in 2027.

⁵ For annual data on TRP payments made to Oklahoma insurers, please see <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/>.

Figure I-2A Oklahoma Department of Health Section 1332 Waiver Application Estimated Reinsurance Payments and Aggregate Insurer Paid Claims Expenses (\$ Millions)			
Calendar Year	Reinsurance Payments(\$ Millions)	Insurer Paid Claims Expenses Prior to Reinsurance(\$ Millions)	Ratio: Reinsurance Payments to Paid Claims Expense
2018	\$ 325	\$ 833	39%
2019	\$ 325	\$ 956	34%
2020	\$ 325	\$ 1,041	31%
2021	\$ 325	\$ 1,110	29%
2022	\$ 325	\$ 1,183	27%
2023	\$ 325	\$ 1,250	26%
2024	\$ 325	\$ 1,332	24%
2025	\$ 325	\$ 1,407	23%
2026	\$ 325	\$ 1,489	22%
2027	\$ 325	\$ 1,581	21%

Note: Reinsurance payments funded through a combination of Federal and state dollars. Insurer paid claims reflect estimated enrollment changes. Values are rounded.

3. ESTIMATED PREMIUM IMPACT FROM REINSURANCE PROGRAM

In modeling the impact of the reinsurance program, we have assumed reinsurance funding will result in a dollar-for-dollar reduction in individual market insurer paid claims expense. We have also considered the impact of the reinsurance program on insurer's non-benefit expenses, primarily administrative expenses and margin. Per instructions from the Centers for Medicare & Medicaid Services (CMS), insurers will be instructed to deduct reinsurance funds received from the OMSP in reporting claims expense in required annual medical loss ratio (MLR) reporting. Additionally, insurers will report ceded premium (or reinsurer assessments) with state taxes and assessments (resulting in a reduction to insurer premiums for purposes of the MLR calculation).⁶

The ACA requires insurers offering health insurance coverage in the individual market to maintain an annual minimum MLR of 80%.⁷ As defined in 45 CFR 158.220, the MLR for a commercial health insurance business is calculated based on a rolling three-year period.⁸ For example, an insurer's MLR for 2017 for purposes of determining if policyholders are owed a rebate will be evaluated based on experience from 2015 through 2017. To the extent an insurer had very unfavorable experience in 2015 and 2016, and had MLRs well above the 80% minimum, the insurer may operate at a MLR below 80% in 2017 and not owe a rebate to consumers.

As the OMSP is estimated to reduce per capita claims expenses in the individual market by around 40% relative to without the program in 2018, it is also estimated to reduce the premium amount on a per member per month (PMPM) basis that can be allocated to non-claims expenses under the ACA's minimum MLR requirements. Under the status-quo ACA, we estimate Oklahoma's individual health insurance market will have a medical loss ratio of 66% in 2018. This percentage does not reflect adjustment for taxes and assessments or quality improvement expenses that are reflected in the MLR calculation for purposes of determining if an MLR rebate is owed to consumers. Based on observed industry data, we estimate a standard 66% MLR would be the equivalent of an approximately 71% MLR under the CMS rules.⁹ As stated in the executive summary, we believe a portion of the 2018 premium rates may be attributable to contingencies for CSR payments and

⁶ Instructions provided by CMS to OSDH in a July 24, 2017 email.

⁷ http://www.naic.org/cipr_topics/topic_med_loss_ratio.htm

⁸ <https://www.law.cornell.edu/cfr/text/45/158.220>

⁹ Estimated developed from commercial MLR data. Please see <http://www.milliman.com/uploadedFiles/insight/2017/2015-commercial-health-insurance.pdf> for more information.

individual mandate enforcement. Our projections assume insurers receive 100% of expected CSR payments and the individual mandate is enforced in a similar manner to 2014 through 2016. We have assumed that uncertainty related to the CSR payments does not continue indefinitely, resulting in a reduction in non-claims expenses during the first several year of the projection period.

Figure I-3A illustrates the estimated non-claims expense PMPM and corresponding MLR (without adjustment for taxes and assessments or quality improvement expenses) under both the status-quo ACA and under the Section 1332 Waiver.

Figure I-3A Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Claims Expenses and Individual Market Medical Loss Ratio				
Calendar Year	Without Waiver		With Waiver	
	Non-Claims Expense PMPM	MLR	Non-Claims Expense PMPM	MLR
2017	\$ 216	65%	\$ 216	65%
2018	\$ 228	66%	\$ 180	59%
2019	\$ 185	72%	\$ 165	65%
2020	\$ 174	75%	\$ 149	70%
2021	\$ 157	78%	\$ 128	75%
2022	\$ 160	79%	\$ 141	75%
2023	\$ 163	80%	\$ 146	76%
2024	\$ 165	81%	\$ 151	77%
2025	\$ 168	81%	\$ 155	78%
2026	\$ 172	82%	\$ 158	79%
2027	\$ 175	82%	\$ 161	80%

Notes:

1. Values have been rounded.
2. MLR have not been adjusted for fees and taxes or quality improvement expenses.

- *Without waiver:* we have assumed a gradual return to an MLR above minimum Federal requirements by 2021. Thereafter, we have assumed annual growth in non-claims expense PMPM costs of 2%.
- *With waiver:* Under the Section 1332 Waiver, we assumed a more significant decrease in non-claims expense PMPM during the 2018 through 2021 time period. For 2021 and 2022, we assumed an MLR of approximately 75% to meet Federal minimum MLR requirements (assuming an unadjusted MLR of 75% is equivalent to a CMS adjusted MLR of 80%). Thereafter, we assumed an annual increase in MLR, resulting in estimated non-claims expense PMPM being slightly below the without waiver scenario at the end of the projection period. It is possible that additional competition induced by the creation of the OMSP could further reduce non-claims expenses and thereby increase the MLRs illustrated in Figure I-3A.

There is significant uncertainty regarding insurer pricing assumptions with or without the implementation of the OMSP. Insurer competition, regulatory changes, and other unknown factors may result in actual non-claims expenses varying materially from the above values. Changes in non-claims expense may have a significant impact on premium rates and resulting Federal pass-through funding. It should be noted that under both the without and with waiver scenarios, the non-claims expense PMPM is estimated to be greater than industry norms. Based on an analysis for 2015 insurer financial data, insurers participating in the individual market had a \$62 non-claims expense PMPM (excluding underwriting margin).¹⁰ Based on 2016 insurer financial data, our projections for 2018 assume insurer expenses for non-claims expenses (excluding

¹⁰ <http://www.milliman.com/uploadedFiles/insight/2017/2015-commercial-health-insurance.pdf>, Figure 4. Values reflects the sum of fees, taxes, and total administrative expenses.

underwriting margin) are approximately \$75 to \$85 PMPM under both the baseline and with waiver scenario. We do not believe the OMSP limits or constrains insurers from offering coverage at sustainable margins during the projection period.

4. COVERAGE REQUIREMENTS

As required under 45 CFR 155.1308(f)(3)(iv)(C), a State's proposed waiver must provide coverage to at least a comparable number of its residents as the provisions of Title I of the ACA. Under Oklahoma's OMSP, we estimate an additional number of individuals will have health insurance. This is a result of OMSP reducing premiums in the individual market, which we estimate will incentivize additional individuals to purchase health insurance relative to without the waiver.

By making premium rates more affordable, we estimate the average member persistency (number of months during the year coverage is maintained/in force) under the Section 1332 Waiver may improve, reducing the potential for gaps in insurance coverage. As discussed throughout this report, we estimate individuals not qualifying for the Advanced Premium Tax Credit (APTC) in absence of the waiver will see the greatest reduction in out-of-pocket premiums, and therefore may have more significant changes in coverage relative to the population qualifying for APTCs.

Funding for the OMSP will be through a combination of federal pass-through funding (as a result of reducing the federal government's expenditures on premium tax credits) and a state-based assessment on comprehensive commercial health plan coverage. Insurers, third-party administrators, and other self-funded employer plans with stop loss coverage will be assessed on a PMPM amount to generate the targeted state-based revenue needed for the reinsurance fund. We estimate that the cost of the assessment will be less than 1% of an average employer's total health insurance costs (including employee contributions). While a new assessment for the OMSP may marginally increase the cost of offering employer-sponsored insurance, we do not estimate the assessment amounts are large enough to result in a material change in the likelihood of employers offering health insurance coverage relative to current law. As observed in the Agency for Health Care Quality & Research's Medical Expenditure Panel Survey (MEPS), the percentage of private sector establishments with fifty or more employees offering coverage has remained at approximately 96% since the late 1990's, despite significant cost increases for employer-sponsored insurance during that timeframe.¹¹ While more significant changes have occurred for establishments with fewer than fifty employees, we do not estimate the assessment, by itself, will result in a material change in the likelihood of such an employer offering health insurance to its employees. It is possible that a small number of employers may elect to terminate coverage as a result of the OMSP assessment.

The following paragraphs detail 2017 (baseline year) health insurance coverage in the non-group market, as well as estimated coverage changes during the ten-year projection period, 2018 through 2027

A. NON-GROUP MARKET ENROLLEES BY HOUSEHOLD INCOME

Figure I-4A(i) illustrates estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2017), and from 2018 through 2027 by household income, as measured as a percentage of the federal poverty level (FPL). Enrollment figures include all comprehensive non-group coverage, including transitional and grandfathered coverage.

¹¹ Agency for Healthcare Research and Quality. *Percent of private-sector establishments that offer health insurance by firm size and selected characteristics* (Table I.A.2), year 1996-2015. Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. (July 11, 2017)

Figure I-4A(i) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Household Income: 2017 through 2027 (Thousands) Without Waiver											
Income Level % of FPL	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0% - 99%	5	5	5	5	5	5	5	5	4	4	4
>=100% to <=150%	43	43	43	43	43	43	44	44	44	44	44
>150% to <=200%	32	32	32	32	32	32	32	32	32	33	33
>200% to <=250%	19	19	19	19	19	19	19	19	19	19	19
>250% to <=300%	11	11	10	10	10	10	10	10	10	10	10
>300% to <=400%	10	10	9	9	9	9	9	9	9	9	9
>400%	30	30	26	26	26	25	25	25	25	24	24
Total	150	150	144								

Note: Values are rounded to the nearest thousand. Total values are rounded separately.

As shown in Figure I-4A(i), the greatest concentration of non-group market enrollment in the 2017 baseline year and ten-year projection period has household income ranging from 100% to 250% FPL, representing more than half of market enrollment in each year. It is assumed that the vast majority of these households are receiving federal premium assistance to purchase health insurance coverage in the FFM. The structure of the ACA's premium subsidy has resulted in minimal out-of-pocket premium rate increases for households purchasing coverage with federal premium assistance in the FFM.¹²

The population with household income above 400% FPL or below 100% FPL is not eligible for premium assistance under the ACA. As a result of additional premium rate increases, we estimate the number of individuals purchasing coverage in the non-group market declines during the ten-year projection period. At the end of 2018, we assume transitional/grandfathered coverage will end, with a portion of these individuals electing to become uninsured in 2019. From 2020 through the end of the projection period, we estimate a slow erosion of enrollment from the population not qualifying for premium assistance.

Figure I-4A(ii) illustrates estimated non-group market enrollment in thousands under the OMSP (with waiver) during the baseline year (2017), and from 2018 through 2027. Enrollment figures include all comprehensive non-group coverage, including transitional and grandfathered coverage.

Figure I-4A(ii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Household Income: 2017 through 2027 (Thousands) With Waiver											
Income Level % of FPL	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0% - 99%	5	5	5	5	5	5	5	5	5	5	5
>=100% to <=150%	43	43	43	43	43	44	44	44	44	44	44
>150% to <=200%	32	32	32	32	32	32	32	32	33	33	33
>200% to <=250%	19	19	19	19	19	19	19	19	19	19	19
>250% to <=300%	11	11	11	11	11	11	11	11	11	11	11
>300% to <=400%	10	10	12	12	12	12	10	10	10	10	10
>400%	30	52	50	50	48	47	46	44	43	41	41
Total	150	172	171	172	171	170	167	166	165	163	163

Note: Values are rounded.

¹² <https://www.ok.gov/health2/documents/1332%20June%20Task%20Force%20Meeting%20Presentation.pdf>, Slide 11.

Figure I-4A(iii) illustrates the estimated net non-group market enrollment change resulting from the implementation of the OMSP from 2018 through 2027. For 2017, the baseline year, no change occurs since OMSP begins in 2018. Enrollment figures include all comprehensive non-group coverage, including transitional and grandfathered coverage.

Figure I-4A(iii)											
Oklahoma Department of Health											
Individual Health Insurance Market OMSP											
Estimated Non-Group Market Enrollees by Household Income: 2017 through 2027 (Thousands)											
Net Enrollment Change Resulting from Waiver											
Income Level % of FPL	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0% - 99%	0	0	0	0	0	0	0	0	1	1	1
>=100% to <=150%	0	0	0	0	0	0	0	0	0	0	0
>150% to <=200%	0	0	0	0	0	0	0	0	0	0	0
>200% to <=250%	0	0	0	0	0	0	0	0	0	0	0
>250% to <=300%	0	0	0	0	0	0	0	0	0	0	0
>300% to <=400%	0	0	3	3	3	3	1	1	1	1	1
>400%	0	22	23	24	23	22	20	19	18	17	16
Total	0	22	27	28	27	26	23	22	21	19	18

Note: Values are rounded.

As observed in Figure I-4A(iii), enrollment increases resulting from the OMSP are estimated to be primarily from the population not eligible for premium assistance (i.e., those with household income either greater than 400% FPL or less than 100% FPL). As this population is not eligible for premium assistance under the ACA, these households realize the full impact of the OMSP's premium reduction (rather than all or a portion of the savings accruing to the Federal government). Out-of-pocket premium costs for the vast majority of the population eligible for premium assistance are not estimated to be reduced by the OMSP. For young adults with income approaching 400% FPL, we estimate the premium savings achieved through the OMSP may result in persons no longer being eligible for premium assistance (as the cost of the second lowest cost silver plan decreases below the maximum permitted under the ACA), while still decreasing out-of-pocket premiums. Therefore, we estimate individual market enrollment increases may also occur for persons with household income between 300% and 400% FPL under the waiver.

B. NON-GROUP MARKET ENROLLMENT BY PREMIUM TAX CREDIT ELIGIBILITY

The next series of figures illustrate the impact to non-group market enrollment resulting from the OMSP based on enrollee advanced premium tax credit (APTC) eligibility status. Under the ACA, qualifying households with income between 100%¹³ and 400% of the FPL are eligible for an APTC that may be used to purchase health insurance coverage in the FFM. Figure I-4B(i) illustrates estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2017), and from 2018 through 2027, while Figure I-4B(ii) illustrates the same information under the OMSP (with waiver). Figure I-4B(iii) illustrates the net change in enrollment by APTC status resulting from the OMSP. Enrollment figures include all comprehensive non-group coverage, including transitional and grandfathered coverage.

Figure I-4B(i) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Premium Tax Credit Status: 2017 through 2027 (Thousands) Without Waiver											
APTC Status	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Eligible	110	111	113	113	114	114	114	114	115	115	116
Not Eligible	40	40	31	31	30	30	30	29	29	29	29
Composite	150	150	144	144	144	144	144	144	144	144	144

Note: Values are rounded.

As shown in Figure I-4B(i), more than 70% of individual market enrollees are estimated to receive an APTC to purchase health insurance coverage during the 2017 baseline year. During the ten-year projection period, the percentage of market enrollees estimated to receive an APTC increases to approximately 80% by 2027.

Figure I-4B(ii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Premium Tax Credit Status: 2017 through 2027 (Thousands) With Waiver											
APTC Status	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Eligible	110	111	114	114	115	117	115	116	117	117	117
Not Eligible	40	61	57	58	56	53	51	50	48	46	46
Composite	150	172	171	172	171	170	167	166	165	163	163

Note: Values are rounded.

Figure I-4B(iii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Premium Tax Credit Status: 2017 through 2027 (Thousands) Net Enrollment Change Resulting from Waiver											
APTC Status	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Eligible	0	1	1	1	1	3	1	1	2	2	2
Not Eligible	0	21	26	27	26	23	22	21	19	18	17
Composite	0	22	27	28	27	26	23	22	21	19	18

Note: Values are rounded.

As the OMSP is estimated to have the greatest consumer premium impact to the population not eligible for Federal premium assistance (APTC), the majority of coverage gains in the individual market are estimated to occur from persons not eligible for APTC. Under the waiver, it is possible that a small number of APTC-enrollees without the waiver may no longer qualify

¹³ Legal aliens with income below 100% FPL may also receive a premium tax credit.

for APTC upon OMSP implementation. As the OMSP is estimated to reduce the cost of the second lowest cost silver plan, young adults with income near 400% FPL may have the value of available premium assistance reach \$0. However, to the extent that healthcare inflation assumptions outstrip income growth, over time, some of these persons are modeled to regain APTC-eligibility during the course of the projection period.

C. NON-GROUP MARKET ENROLLMENT BY PLAN

This section provides the estimated impact to non-group market enrollment by plan level resulting from the OMSP. Under the ACA, households may purchase a non-group plan in one of four metallic tiers: bronze, silver, gold, or platinum.¹⁴ However, insurers participating in Oklahoma’s non-group market do not currently offer platinum level coverage. For individuals under 30 or persons qualifying for an unaffordability or hardship exemption, a catastrophic plan may also be purchased.

Additionally, there is a relatively small portion of the non-group market that has maintained grandfathered or transitional coverage that was first purchased prior to the ACA’s reformed rating rules implemented in 2014. We assume this type of coverage will end or lapse after 2018.¹⁵ Figure I-4C(i) illustrates estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2017), and from 2018 through 2027, while Figure I-4C(ii) illustrates the same information under the OMSP (with waiver). Figure I-4C(iii) illustrates the net change in enrollment by plan level resulting from the OMSP.

Figure I-4C(i) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Plan Level: 2017 through 2027 (Thousands) Without Waiver											
Plan Level	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Catastrophic	<1	<1	<1	<1	<1	<1	<1	<1	<1	<1	<1
Bronze	48	48	51	51	51	51	51	51	51	51	51
Silver	84	85	87	87	87	87	87	87	88	88	88
Gold	5	5	6	5	5	5	5	5	5	5	5
Platinum	0	0	0	0	0	0	0	0	0	0	0
Non-ACA	13	12	0	0	0	0	0	0	0	0	0
Composite	150	150	144	144	144	144	144	144	144	144	144

Note: Values are rounded.

Figure I-4C(ii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Plan Level: 2017 through 2027 (Thousands) With Waiver											
Plan Level	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Catastrophic	<1	<1	<1	<1	<1	<1	<1	<1	<1	<1	<1
Bronze	48	61	66	66	65	65	63	62	62	61	60
Silver	84	92	95	95	95	95	94	94	94	94	94
Gold	5	9	10	10	10	10	9	9	9	8	8
Platinum	0	0	0	0	0	0	0	0	0	0	0
Non-ACA	13	9	0	0	0	0	0	0	0	0	0
Composite	150	172	171	172	171	170	167	166	165	163	163

Note: Values are rounded.

¹⁴Please see <https://www.healthcare.gov/choose-a-plan/plans-categories/> for more information.

¹⁵ Based on current CMS guidance, transitional coverage must end by December 31, 2018: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Extension-Transitional-Policy-CY2018.pdf>. For modeling purposes, we have also assumed grandfathered business transitions to the ACA-compliant market in 2018.

Figure I-4C(iii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Plan Level: 2017 through 2027 (Thousands) Net Enrollment Change Resulting from Waiver											
Plan Level	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Catastrophic	0	<1	<1	<1	<1	<1	<1	<1	<1	<1	<1
Bronze	0	13	15	15	14	14	12	11	11	10	10
Silver	0	7	8	8	8	8	7	7	6	6	6
Gold	0	5	5	5	5	4	4	4	4	3	3
Platinum	0	0	0	0	0	0	0	0	0	0	0
Non-ACA	0	(3)	0	0	0	0	0	0	0	0	0
Composite	0	22	27	28	27	26	23	22	21	19	18

Note: Values are rounded.

As shown in Figure I-4C(iii), the majority of enrollment increases resulting from the OMSP are estimated to occur in the Bronze metallic tier. While FFM enrollment is weighted heavily towards Silver coverage (as a result of CSR subsidies being tied to the purchase of Silver coverage), individual market coverage outside of the FFM is estimated to have a higher concentration of Bronze level coverage. As the OMSP has the greatest premium effect on consumers not eligible for premium assistance, we estimate Bronze coverage will experience the greatest enrollment increase as a result of the waiver.

D. NON-GROUP MARKET ENROLLMENT BY AGE

This section provides the estimated impact to non-group market enrollment by age group from the OMSP. Figure I-4D(i) illustrates the estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2017), and from 2018 through 2027, while Figure I-4D(ii) illustrates the same information under the OMSP (with waiver). Figure I-4D(iii) illustrates the net change in enrollment by plan level resulting from the OMSP.

Figure I-4D(i) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Age Group: 2017 through 2027 (Thousands) Without Waiver											
Age Group	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
17 and Under	14	14	13	13	13	13	13	13	13	13	13
18 to 25	24	24	23	23	23	22	22	22	22	22	22
26 to 34	18	19	18	18	18	18	18	18	18	18	18
35 to 44	20	20	20	20	20	20	20	21	21	21	21
45 to 54	38	37	35	35	35	35	35	35	35	35	35
55 to 64	35	35	34	34	34	34	34	34	34	33	33
65 and Over	1	1	1	1	1	1	1	1	1	1	1
Total	150	150	144								

As shown in Figure I-4D(i), approximately 50% of individual market enrollees are estimated to be 45 years or older during the 2017 baseline year. For comparative purposes, this age group only represents 35% of covered members in a standard employer-sponsored insurance health plan.¹⁶

Figure I-4D(ii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Age Group: 2017 through 2027 (Thousands) With Waiver											
Age Group	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
17 and Under	14	16	16	16	16	15	15	15	15	15	15
18 to 25	24	26	25	25	25	25	25	25	24	24	24
26 to 34	18	21	23	23	23	23	21	21	20	20	20
35 to 44	20	24	24	24	24	24	24	24	24	24	24
45 to 54	38	43	42	42	42	42	42	41	41	41	41
55 to 64	35	40	40	40	40	39	39	39	38	38	38
65 and Over	1	1	1	1	1	1	1	1	1	1	1
Total	150	172	171	172	171	170	167	166	165	163	163

¹⁶ 2017 Milliman Health Cost Guidelines

Figure I-4D(iii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees by Age Group: 2017 through 2027 (Thousands) Net Enrollment Change Resulting from Waiver											
Age Group	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
17 and Under	0	2	2	2	2	2	2	2	2	2	2
18 to 25	0	2	3	3	3	2	2	2	2	2	1
26 to 34	0	3	5	5	5	4	3	2	2	2	2
35 to 44	0	3	4	4	4	4	3	3	3	3	3
45 to 54	0	6	7	7	7	7	7	6	6	6	6
55 to 64	0	5	6	6	6	6	5	5	5	4	4
65 and Over	0	0	1	1	1	1	1	1	1	0	0
Total	0	22	27	28	27	26	23	22	21	19	18

As shown in Figure I-4D(iii), additional incremental non-group enrollment is estimated to occur across each age group due to OMSP.

E. NON-GROUP MARKET ENROLLMENT BY HEALTH STATUS

This section provides the estimated impact to non-group market enrollment by health status from the OMSP. As discussed in the methodology section of this report, health status is defined based on an individual's estimated risk score relative. Figure I-4E illustrates estimated non-group market acuity under the status-quo ACA (without waiver) and under the OMSP during the baseline year (2017), and from 2018 through 2027.

Figure I-4E Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Market Enrollees Acuity: 2017 through 2027											
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Acuity Change	0.0%	(2.9%)	(2.3%)	(2.4%)	(2.3%)	(2.3%)	(1.8%)	(1.8%)	(1.7%)	(1.5%)	(1.4%)

As the OMSP is estimated to result in greater enrollment from the population with income above 400% FPL, the acuity (i.e., morbidity) of the non-group risk pool is estimated to improve under the waiver. The percentage changes in Figure I-4E are representative of the entire non-group ACA-compliant risk pool. The market impact of the improved acuity in the population with income above 400% FPL is dampened by minimal expected acuity changes for the population qualifying for APTC.

5. AFFORDABILITY REQUIREMENTS

As required under 45 CFR 155.1308(f)(3)(iv)(B), a State’s proposed waiver must provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable under Title I of the ACA. As described in CMS-9936-N, increasing the number of state residents with large health care spending burdens relative to their incomes would result in a waiver proposal failing to meet the affordability requirement of the 1332 waiver application.¹⁷ Additionally, regulations state an evaluation of the affordability requirement will take into account the impact of the waiver proposal to “vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues”.

Under Oklahoma’s OMSP, we estimate premium rates in the non-group market will be reduced as a result of the reinsurance fund. For the majority of the APTC-eligible population, this will not impact out-of-pocket premium costs for the second-lowest cost Silver plan (subsidy benchmark plan). These households will continue to pay up to a maximum percentage of their household income for the subsidy benchmark plan. A portion of consumers receiving an APTC in the absence of the OMSP will no longer be eligible for the subsidy after the reinsurance program is implemented due to the premium expense not exceeding the maximum percentage of household income as defined under the ACA. These consumers will realize out-of-pocket premium savings as a result of OMSP. Finally, for consumers purchasing coverage in the FFM without an APTC or outside the FFM, premium savings will be realized from the OMSP. Consumers not receiving an APTC under current law will realize the greatest savings from the OMSP, as 100% of premium savings are accrued, whereas for APTC consumers, a large portion of savings are retained by the Federal government (which will be re-distributed in the form of pass-through funding).

For persons qualifying for APTC that are purchasing Bronze level coverage, it is possible that out-of-pocket premiums may increase as a result of OMSP. As the OMSP is estimated to reduce the dollar amount of the APTC for qualifying individuals, the available financial assistance that can be applied to the purchase of Bronze level coverage is reduced. However, we estimate the number of low income persons impacted by this effect is minimal for the following reasons:

- Based on 2017 open enrollment marketplace selection data, only 26% of plan selections with household income under 250% are purchasing bronze level coverage. As these persons qualify for cost sharing reduction payments if a Silver plan is purchased¹⁸, there is a strong financial incentive to purchase Silver coverage.
- For low income individuals, the ACA’s subsidy structure may create the availability of a \$0 out-of-pocket premium for Bronze coverage.¹⁹ In 2017, we estimate that nearly all persons with income under 200% FPL qualifying for premium assistance are eligible to purchase a \$0 Bronze plan. Due to the ACA’s permissible 3:1 age rating factor, some older adults are eligible for \$0 Bronze plan at income levels above 300% FPL. As the OMSP is estimated to reduce premiums, it is likely the number of marketplace enrollees qualifying for a \$0 Bronze plan will decrease to some degree. However, for enrollees with income under 200% FPL, we estimate a large portion of marketplace enrollees will continue to have access to a Bronze plan with \$0 out-of-pocket premium.

Based on marketplace selection data and estimated effectuation rates in 2017, we estimate 6,000 enrollees with household income between 300% and 400% purchasing Bronze coverage may experience an increase in out-of-pocket premiums from the reduction in available APTC amounts.

Premium savings from the OMSP will vary by allowable rating factors under the ACA and the APTC structure: age, tobacco-use, geographic location, plan metallic level, and household income. Vulnerable residents will realize out-of-pocket premium savings consistent with their demographics as they relate to these factors. The OMSP does not make any changes to required insurer plan design, cost sharing limitations, or cost sharing assistance in the non-group market. For persons not eligible for APTC, it may be possible the OMSP allows the consumer to purchase a richer benefit plan (e.g., a Silver instead of a Bronze plan), which may result in lower out-of-pocket cost sharing expenses.

¹⁷ <https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf>

¹⁸ Native Americans qualify for a zero cost sharing plan if income is between 100% and 300% FPL, regardless of metal level purchased.

¹⁹ See <https://www.ok.gov/dcs/solicit/app/viewAttachment.php?attachmentID=67716>, page 9 for an illustration of Bronze out-of-pocket premiums by FPL and age in 2017.

As discussed previously, funding for the OMSP will be through a combination of federal pass-through funding (as a result of reducing the federal government's expenditures on premium tax credits) and a state-based assessment on comprehensive commercial health insurance coverage. Insurers, third-party administrators, and other self-funded employer plans with stop loss coverage will be assessed a PMPM amount to generate the targeted state-based revenue for the reinsurance fund. It is theoretically possible that the assessment will result in small modifications to offered benefit designs (deductible, coinsurance, copays) or increased employee contributions in order for the employer to offer coverage that is financially sustainable within its overall expense structure.

However, as the cost of the reinsurance fund assessment is estimated to be less than 1% of the total cost of employer-sponsored insurance in Oklahoma, we do not estimate a material change in employee contributions or cost sharing requirements resulting from the OMSP. Additionally, it is possible the OMSP, through insuring additional persons, will result in providers having lower amounts of uncompensated care. This may result in lower healthcare unit cost increases in the commercial health insurance market, offsetting the assessment.

The following sections provide estimates of changes in market premiums and APTC amounts resulting from the OMSP.

A. NON-GROUP MARKET PER MEMBER PER MONTH PREMIUM

The following tables illustrate estimated non-group PMPM premium for 2017 and the ten-year projection period without the waiver, under the waiver, and the net change in per member per month premium. We have illustrated premiums separately for ACA-compliant coverage (ACA) and transitional/grandfathered coverage (Non-ACA). ACA coverage reflects premiums attributable to coverage purchased in the FFM, as well as coverage outside the FFM that is compliant with ACA rating rules. Note, drivers of premium rate changes resulting from the waiver include the reinsurance program, as well as age and plan mix changes. Non-ACA coverage is assumed to end after 2018.

Figure I-5A(i) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Premium PMPM by Plan Type: 2017 through 2027 Without Waiver											
Plan Type	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
ACA	\$ 614	\$ 668	\$ 662	\$ 695	\$ 716	\$ 758	\$ 803	\$ 850	\$ 897	\$ 946	\$ 997
Non-ACA	\$ 309	\$ 333	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Composite	\$ 588	\$ 641	\$ 662	\$ 695	\$ 716	\$ 758	\$ 803	\$ 850	\$ 897	\$ 946	\$ 997

Note: Values are rounded to the nearest whole dollar.

ACA-compliant premium rates have increased significantly since 2015, increasing from \$284 PMPM to approximately \$600 PMPM in 2017.²⁰ 2018 premium rate changes are based on the current rate filing submitted by Blue Cross Blue Shield of Oklahoma. Premium rates for ACA-compliant coverage are estimated to marginally increase from 2019 through 2021 due to our assumption of the medical loss ratio returning to industry norms. After 2021, premium rates are estimated to trend at 5% to 6% per year.

Figure I-5A(ii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Premium PMPM by Plan Type: 2017 through 2027 With Waiver											
Plan Type	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
ACA	\$ 614	\$ 440	\$ 472	\$ 496	\$ 511	\$ 562	\$ 608	\$ 658	\$ 703	\$ 753	\$ 804
Non-ACA	\$ 309	\$ 333	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Composite	\$ 588	\$ 435	\$ 472	\$ 496	\$ 511	\$ 562	\$ 608	\$ 658	\$ 703	\$ 753	\$ 804

Note: Values are rounded to the nearest whole dollar.

Figure I-5A(iii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Premium PMPM by Plan Type: 2017 through 2027 Net PMPM Dollar Change											
Plan Type	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
ACA	\$ 0	\$(228)	\$(191)	\$(199)	\$(204)	\$(196)	\$(195)	\$(192)	\$(194)	\$(193)	\$(194)
Non-ACA	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Composite	\$ 0	\$(207)	\$(191)	\$(199)	\$(204)	\$(196)	\$(195)	\$(192)	\$(194)	\$(193)	\$(194)

Note: Values are rounded to the nearest whole dollar.

²⁰ <https://www.ok.gov/health2/documents/1332%20June%20Task%20Force%20Meeting%20Presentation.pdf>, Slide 11.

As observed in the above figures, the OMSP is estimated to result in a PMPM premium decrease for ACA compliant coverage of \$191 to \$228 PMPM during the ten year projection period relative to estimated premium levels without the waiver. The OMSP is estimated to result in a premium decrease in 2018 relative to the prior year rates; however, premium rates are estimated to increase thereafter under both scenarios due primarily to healthcare expense inflation, while still being lower than if the waiver was not implemented.

Under the OMSP, premium rates are estimated to trend higher during 2022 through 2027 relative to in absence of the waiver. As the reinsurance funding is assumed to be held constant at \$325 million, there is a leveraging impact on premium rates, resulting in annual premium increases of 8% to 10% relative to 5% to 6% without the waiver.

B. NON-GROUP MARKET AGGREGATE PREMIUM

The following tables illustrate estimated non-group aggregate premium for 2017 during the ten-year projection period without the waiver, under the waiver, and the net change in aggregate premium. We have illustrated premiums separately for ACA-compliant coverage (ACA) and transitional/grandfathered coverage (Non-ACA). ACA coverage reflects premiums attributable to coverage purchased in the FFM, as well as coverage outside the FFM that is compliant with ACA rating rules.

Figure I-5B(i) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Aggregate Premium by Plan Type: 2017 through 2027 (\$ Millions) Without Waiver											
Plan Type	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
ACA	\$ 1,013	\$ 1,108	\$ 1,144	\$ 1,199	\$ 1,236	\$ 1,309	\$ 1,386	\$ 1,468	\$ 1,547	\$ 1,634	\$ 1,728
Non-ACA	\$ 48	\$ 48	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Composite	\$ 1,061	\$ 1,156	\$ 1,144	\$ 1,199	\$ 1,236	\$ 1,309	\$ 1,386	\$ 1,468	\$ 1,547	\$ 1,634	\$ 1,728

Note: Dollar amounts are rounded to the nearest million.

As illustrated in Figure I-5B(i), aggregate ACA-compliant premiums in 2017 are estimated to be nearly \$1.1 billion. Non-ACA compliant premiums are estimated to represent less than 5% of 2017 aggregate individual market premiums without the waiver, totaling less than \$50 million in 2017. During the projection period, individual market premium volume is estimated to increase to approximately \$1.7 billion.

Figure I-5B(ii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Aggregate Premium by Plan Type: 2017 through 2027 (\$ Millions) With Waiver											
Plan Type	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
ACA	\$ 1,013	\$ 862	\$ 971	\$ 1,023	\$ 1,047	\$ 1,144	\$ 1,217	\$ 1,308	\$ 1,388	\$ 1,473	\$ 1,570
Non-ACA	\$ 48	\$ 35	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Composite	\$ 1,061	\$ 897	\$ 971	\$ 1,023	\$ 1,047	\$ 1,144	\$ 1,217	\$ 1,308	\$ 1,388	\$ 1,473	\$ 1,570

Note: Dollar amounts are rounded to the nearest million.

Figure I-5B(iii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Non-Group Aggregate Premium by Plan Type: 2017 through 2027 (\$ Millions) Net Change											
Plan Type	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
ACA	\$ 0	\$ (246)	\$ (174)	\$ (177)	\$ (188)	\$ (165)	\$ (169)	\$ (160)	\$ (159)	\$ (160)	\$ (158)
Non-ACA	\$ 0	\$ (13)	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Composite	\$ 0	\$ (259)	\$ (174)	\$ (177)	\$ (188)	\$ (165)	\$ (169)	\$ (160)	\$ (159)	\$ (160)	\$ (158)

Note: Dollar amounts are rounded to the nearest million.

The above figures illustrate a significant decrease to aggregate ACA premiums resulting from the implementation of the OMSP in 2018, even with the migration of some uninsured people to the non-group market under the OMSP. For non-ACA coverage, we estimate reduction in premium volume in 2018, as we estimate a greater likelihood of migration from non-ACA to ACA coverage under the waiver.

C. SECOND-LOWEST-COST SILVER PLAN PREMIUM – 40 YEAR OLD

The following tables illustrate the estimated second-lowest-cost silver plan PMPM premium (also referred to as the “subsidy benchmark plan”) for a single, 40 year old, non-tobacco user by Oklahoma’s five rating areas.²¹ The vast majority of enrollment is estimated to be in Rating Areas 3 through 5, representing 95% of statewide individual market enrollment. We have assumed variation by rating area during the projection period is consistent with the observed variation in the baseline year. As shown in Figure-5C(i), Rating Areas 1 and 5 have premium rates that are approximately 6% to 7% higher than the statewide average, while Rating Areas 2 and 3 have premium rates approximately 5% lower than the statewide average.

Figure I-5C(i) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Second Lowest Cost Silver Plan PMPM Premium, Single 40 Year Old: 2017 through 2027 Without Waiver											
Rating Area	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
1	\$ 552	\$601	\$ 596	\$ 625	\$ 644	\$ 682	\$ 722	\$ 765	\$ 806	\$ 851	\$ 897
2	\$ 492	\$ 536	\$ 531	\$ 558	\$ 574	\$ 608	\$ 644	\$ 682	\$ 719	\$ 758	\$ 800
3	\$ 493	\$ 537	\$ 532	\$ 558	\$ 575	\$ 609	\$ 645	\$ 683	\$ 720	\$ 760	\$ 801
4	\$ 515	\$ 561	\$ 556	\$ 584	\$ 601	\$ 636	\$ 674	\$ 714	\$ 753	\$ 794	\$ 837
5	\$ 550	\$ 599	\$ 593	\$ 623	\$ 641	\$ 679	\$ 719	\$ 762	\$ 803	\$ 847	\$ 894
Composite	\$ 517	\$ 563	\$ 558	\$ 586	\$ 603	\$ 639	\$ 677	\$ 717	\$ 756	\$ 797	\$ 841

Notes:

1. Values have been rounded to the nearest whole dollar.
2. Premiums reflect non-tobacco user.

Figure I-5C(ii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Second Lowest Cost Silver Plan PMPM Premium, Single 40 Year Old: 2017 through 2027 With Waiver											
Rating Area	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
1	\$ 552	\$396	\$ 424	\$ 446	\$ 460	\$ 506	\$ 547	\$ 592	\$ 632	\$ 677	\$ 723
2	\$ 492	\$ 353	\$ 378	\$ 398	\$ 410	\$ 451	\$ 488	\$ 528	\$ 564	\$ 604	\$ 644
3	\$ 493	\$ 353	\$ 379	\$ 398	\$ 411	\$ 452	\$ 488	\$ 529	\$ 565	\$ 605	\$ 645
4	\$ 515	\$ 369	\$ 396	\$ 416	\$ 429	\$ 472	\$ 510	\$ 552	\$ 590	\$ 632	\$ 675
5	\$ 550	\$ 394	\$ 423	\$ 444	\$ 458	\$ 504	\$ 545	\$ 589	\$ 630	\$ 674	\$ 720
Composite	\$ 517	\$ 371	\$ 397	\$ 418	\$ 431	\$ 474	\$ 512	\$ 554	\$ 592	\$ 634	\$ 677

Notes:

1. Values have been rounded to the nearest whole dollar.
2. Premiums reflect non-tobacco user.

²¹ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/ok-gra.html>

Figure I-5C(iii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Second Lowest Cost Silver Plan PMPM Premium, Single 40 Year Old: 2017 through 2027 Net Change											
Rating Area	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
1	\$ 0	\$ (205)	\$ (172)	\$ (179)	\$ (184)	\$ (176)	\$ (175)	\$ (173)	\$ (174)	\$ (174)	\$ (174)
2	\$ 0	\$ (183)	\$ (153)	\$ (160)	\$ (164)	\$ (157)	\$ (156)	\$ (154)	\$ (155)	\$ (155)	\$ (156)
3	\$ 0	\$ (183)	\$ (153)	\$ (160)	\$ (164)	\$ (157)	\$ (156)	\$ (155)	\$ (156)	\$ (155)	\$ (156)
4	\$ 0	\$ (191)	\$ (160)	\$ (167)	\$ (171)	\$ (164)	\$ (164)	\$ (162)	\$ (163)	\$ (162)	\$ (163)
5	\$ 0	\$ (204)	\$ (171)	\$ (179)	\$ (183)	\$ (175)	\$ (174)	\$ (172)	\$ (174)	\$ (173)	\$ (174)
Composite	\$ 0	\$ (192)	\$ (161)	\$ (168)	\$ (172)	\$ (165)	\$ (164)	\$ (162)	\$ (163)	\$ (163)	\$ (163)

Notes:

1. Values have been rounded to the nearest whole dollar.
2. Premiums reflect non-tobacco user.

As shown in Figure I-5C(iii), each rating area is estimated to experience a reduction in the premium amount for the subsidy benchmark plan under the “with waiver” scenario. We have assumed the baseline premium rates accurately reflect the underlying insured population in each rating region. Therefore, on a PMPM basis, rating areas with higher baseline premiums are estimated to have a greater PMPM reduction relative to rating areas with less expense premiums.

D. ADVANCED PREMIUM TAX CREDIT

The following tables illustrate the estimated number of average monthly enrollees receiving an APTC through the FFM, the average APTC PMPM amount, and aggregate APTC expenditures for 2017 and the ten-year projection period without the waiver, under the waiver, and the net change for these values resulting from waiver implementation. From 2015 to 2017, aggregate APTC payments made to Oklahomans are estimated to have increased from \$200 million to \$725 million, corresponding to the significant increases in FFM premiums for the second-lowest cost silver plan. Without the waiver, aggregate APTC expenditures are estimated to increase to over \$1 billion by 2023.

Figure I-5D(i) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Premium Tax Credit Enrollment and Expenditures: 2017 through 2027 Without Waiver											
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
APTC Enrollees ¹	110	111	113	113	114	114	114	114	115	115	116
APTC PMPM ²	\$ 550	\$ 607	\$ 599	\$ 629	\$ 647	\$ 690	\$ 734	\$ 782	\$ 827	\$ 875	\$ 926
Aggregate APTC ³	\$ 725	\$ 805	\$ 812	\$ 854	\$ 881	\$ 942	\$ 1,006	\$ 1,073	\$ 1,138	\$ 1,210	\$ 1,286

Notes:

1. Values for APTC enrollees are rounded to the nearest thousand and reflect average monthly effectuated enrollment.
2. Values for APTC PMPM have been rounded to the nearest whole dollar.
3. Values for Aggregate APTC have been rounded to the nearest million.

Figure I-5D(ii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Premium Tax Credit Enrollment and Expenditures: 2017 through 2027 With Waiver											
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
APTC Enrollees ¹	110	111	114	114	115	117	115	116	117	117	117
APTC PMPM ²	\$ 550	\$ 364	\$ 395	\$ 415	\$ 428	\$ 474	\$ 524	\$ 573	\$ 613	\$ 663	\$ 713
Aggregate APTC ³	\$ 725	\$ 485	\$ 541	\$ 570	\$ 589	\$ 664	\$ 725	\$ 796	\$ 859	\$ 929	\$ 1,003

Notes:

1. Values for APTC enrollees are rounded to the nearest thousand and reflect average monthly effectuated enrollment.
2. Values for APTC PMPM have been rounded to the nearest whole dollar.
3. Values for Aggregate APTC have been rounded to the nearest million.

Figure I-5D(iii) Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Premium Tax Credit Enrollment and Expenditures: 2017 through 2027 Net Change											
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
APTC Enrollees ¹	0	1	1	1	1	3	1	1	2	2	2
APTC PMPM ²	\$ 0	\$ (243)	\$ (204)	\$ (213)	\$ (219)	\$ (215)	\$ (210)	\$ (208)	\$ (214)	\$ (212)	\$ (214)
Aggregate APTC ³	\$ 0	\$ (320)	\$ (271)	\$ (284)	\$ (292)	\$ (278)	\$ (281)	\$ (278)	\$ (279)	\$ (280)	\$ (282)

Notes:

1. Values for APTC enrollees are rounded to the nearest thousand and reflect average monthly effectuated enrollment.
2. Values for APTC PMPM have been rounded to the nearest whole dollar.
3. Values for Aggregate APTC have been rounded to the nearest million.

As shown in Figure I-5D(iii), while the OMSP is estimated to slightly increase the number of APTC enrollees, it is estimated to have a much greater effect on the per capita APTC amount, decreasing it by 40% in 2018. The per capita APTC savings translate to significant aggregate savings on APTC expenditures. These savings, net of other applicable Federal revenue changes, are estimated to become available pass-through funding for the OMSP. In 2018, net changes in APTC expenditures approach the \$325 million for the reinsurance program. This is primarily the result of additional non-claims expense reductions attributable to the OMSP, as discussed in Section I-3.

6. COMPREHENSIVENESS REQUIREMENTS

As required under 45 CFR 155.1308(f)(3)(iv)(A), a State's proposed waiver must provide coverage that is at least as comprehensive as the coverage defined in Section 1302(b) of the ACA. As described in CMS-9936-N, comprehensiveness refers to the scope of benefits provided by the coverage as measured by the extent to which coverage meets the requirements for essential health benefits (EHBs). The OMSP makes no changes to EHB requirements in the individual market, nor is it estimated to have any effect on other health insurance programs and populations within the State of Oklahoma. Additionally, the OMSP makes no changes to state-mandated benefits. As the OMSP is estimated to increase enrollment in the non-group market relative to projections absent the waiver, it increases the number of Oklahomans with insurance coverage that meets the EHB requirements, fulfilling the comprehensiveness requirements of 45 CFR 155.1308(f)(4)(iv)(A).

**Oklahoma State Department of Health
Section 1332 Waiver Application
Oklahoma Individual Health Insurance Market Stabilization Program
Actuarial Certification**

I, Paul R. Houchens, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the Oklahoma State Department of Health to perform an actuarial analysis and certification regarding the State's Section 1332 Innovation Waiver proposal that seeks Federal funding for implementation of the Oklahoma Individual Health Insurance Market Stabilization Program (OMSP). I am generally familiar with the federal requirements for Section 1332 waiver proposals, commercial health insurance rating rules, insurance exchanges, the Affordable Care Act's premium assistance structure, rules surrounding individual shared responsibility payments, and other components of the Affordable Care Act relevant to this Section 1332 State Innovation Waiver proposal.

As required under 45 CFR 155.1308 (f)(4)(i), this certification provides documentation that my actuarial analyses supports the State of Oklahoma's finding that the OMSP complies with the following requirements for Section 1332 waivers as defined under 45 CFR 155.1308 (f)(3)(iv)(a)-(c):

- The proposal will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver;
- the proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver; and,
- the proposal will provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver

The assumptions and methodology used in the development of the actuarial certification has been documented in my report provided to the State of Oklahoma. The actuarial certification provided with this report is for the period from January 1, 2018 through December 31, 2022. To the extent state or federal regulations are modified through the end of the waiver period, it may be necessary for this actuarial certification and corresponding analyses to be amended.

The actuarial analyses presented with this certification is based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the analyses.

In developing the actuarial certification, I have relied upon data and information provided by the State of Oklahoma, publicly available Federal government data sets and reports, and statutory financial statement data downloaded through S&P Global Market Intelligence. I have relied upon these third parties for audit of the data. However, I did review the data for reasonableness and consistency.

 Electronic
Signature

Paul R. Houchens, FSA
Member, American Academy of Actuaries

August 7, 2017

Date

Appendix D: Economic Analyses

SECTION II. ECONOMIC ANALYSIS

45 CFR 155.1308(f)(4)(ii) requires the Section 1332 waiver application to provide economic analyses to support the State's estimates that the proposed waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement and the Federal deficit requirement. Analyses related to the estimated impact of the OMSP to health insurance coverage in Oklahoma has been provided within the actuarial certification. This section addresses the deficit neutrality requirements of the waiver application, providing a ten-year budget plan that includes all costs under the waiver, including administrative and other costs to the Federal government.

As shown in the actuarial analysis, Figure I-4D(iii), the OMSP is estimated to have a significant impact on the Federal government APTC expenditures for Oklahomans purchasing health insurance coverage through the FFM. As permissible under Section 1332 of the ACA, Oklahoma seeks to apply the Federal savings on APTC expenditures to support the OMSP. To fulfill the Section 1332 Waiver neutrality requirements, Oklahoma seeks Federal pass-through funding equal to Federal APTC savings, less other changes to Federal government expenses. Figure II-1 provides a summary of estimated Federal expenditure changes during the ten-year projection period.

Figure II-1 Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Federal Government Expenditures Changes: 2018 through 2027 (in Millions)										
Revenue / (Expense) Item	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Federal APTC Expenditures	\$ 320	\$ 271	\$ 284	\$ 292	\$ 278	\$ 281	\$ 278	\$ 279	\$ 280	\$ 282
Aggregate Shared Responsibility Payments	\$ (1)	\$ (2)	\$ (2)	\$ (2)	\$ (1)	\$ (1)	\$ (1)	\$ (0)	\$ (0)	\$ 0
Exchange User Fee	\$ (10)	\$ (8)	\$ (8)	\$ (9)	\$ (8)	\$ (8)	\$ (8)	\$ (8)	\$ (8)	\$ (8)
PCORI*	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Health Insurer Fee	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Net Change in Federal Expenditures	\$ 309	\$ 262	\$ 274	\$ 282	\$ 269	\$ 272	\$ 269	\$ 270	\$ 272	\$ 274

Note: We estimate a PCORI revenue increase of \$53,000 in 2018.

Federal APTC Expenditures: As the OMSP is estimated to reduce the cost of the second lowest cost silver plan (subsidy benchmark plan) during the projection period, the Federal government's expenditures on APTC for Oklahomans is estimated to be reduced. Further detail on APTC savings is provided in Section I-5D of the actuarial certification.

Aggregate Shared Responsibility Payments: Under 26 U.S. Code § 5000A, a taxpayer must maintain minimum essential coverage for his or herself, as well as dependents, or otherwise be subject to a penalty for failure to maintain coverage.²² This provision is commonly referred to as the "individual mandate". Under the OMSP, we estimate federal revenue associated with shared responsibility payments will decrease from individuals gaining insurance, but increase from a lower likelihood of individual mandate affordability exemptions.

Exchange User Fee: For states electing to use the FFM, the federal government requires a 3.5% assessment on insurance marketplace coverage to support the operation of the FFM. As the OMSP is estimated to reduce premium rates for non-group coverage, purchased both on and off the marketplace, it is also estimated to reduce the revenue generated by the 3.5% premium assessment on insurance purchased through the FFM.

Patient-Centered Outcomes Research Trust Fund (PCORI): The PCORI fee is an assessment on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans that helps to fund the Patient-Centered

²² <https://www.law.cornell.edu/uscode/text/26/5000A>

Outcomes Research Institute (PCORI).²³ PCORI fees are assessed to health insurance policies that have plan years ending before October 1, 2019.²⁴ As a result of insuring more Oklahomans, the OMSP is estimated to increase PCORI fee revenue during 2018. We have assumed the fee is not applicable for later years, as non-group coverage purchased for calendar year 2019 will have a plan year ending December 31, 2019, after the expiration of the fee.

Health Insurer Fee: Section 9010 of the ACA mandates a national assessment on health insurers of \$14.3 billion in 2018. Thereafter, the national assessment amount is index based on the “premium growth rate” as defined under the ACA. For 2018, the Internal Revenue Services (IRS) will target collecting \$14.3 billion, regardless of changes in premium volume. Therefore, the OMSP has no impact on estimated HIF revenue in 2018. As the premium growth rate is calculated based on changes per capita costs for employer-sponsored insurance, we do not believe the OMSP materially impacts the premium growth rate calculation. Therefore, the OMSP is not estimated to result in any changes to Federal revenue from the HIF.

The remainder of this section provides more detailed discussion on the components of Federal revenue changes, excluding APTC expenditures, which are discussed in detail within the actuarial certification.

²³ <https://www.irs.gov/uac/patient-centered-outcomes-research-trust-fund-fee-questions-and-answers>

²⁴ Same link as above.

1. AGGREGATE SHARED RESPONSIBILITY PAYMENTS

As stated above, under 26 U.S. Code § 5000A, a taxpayer must maintain minimum essential coverage for him or herself, as well as dependents, or otherwise be subject to a penalty for failure to maintain coverage. This provision is commonly referred to as the “individual mandate”. The individual mandate penalty in 2017 is the lesser of²⁵:

- 2.5% of modified adjusted gross income less the sum of the standard exemption amount and basic standard deduction (not to exceed the annual premium for the national average price of a Bronze plan sold through the insurance marketplace)
- \$695 per adult, \$347.50 per child under 18, up to a maximum of \$2,085 for a household

The individual mandate does not apply to individuals who fail to maintain minimum essential coverage meeting one of several requirements²⁶, including:

- Households with gross income below the tax return filing threshold²⁷
- Health insurance coverage is deemed unaffordable under the ACA
- The person went less than three consecutive months without minimum essential coverage
- Members of Federally-recognized Indian Tribes
- Incarcerated individuals
- Members of a health care sharing ministry
- Non-citizens not lawfully present in the United States
- General hardship²⁸
- Household income is below 138% of the FPL in a state that does not participate in Medicaid expansion under the ACA

Qualitative Analysis

With regard to the impact of the OMSP on shared responsibility payments, it is important to consider how each insurance market in Oklahoma will be impacted, as well as the variance of impacts by income cohorts within each market.

Employer-sponsored insurance: We do not anticipate any material change in employer-sponsored coverage resulting from OMSP, and therefore, do not expect any change in shared responsibility payments from individuals who are eligible, but not enrolling in coverage.

Government programs: We do not expect any change in health insurance coverage for individuals enrolled in Medicaid, Medicare, or other government programs. Therefore, we assume no change in shared responsibility payments resulting from the OMSP for persons eligible for these types of coverage.

Non-group market: For individuals who are not eligible for health insurance through a government program or employer-sponsored plan, health insurance must be purchased in the non-group market or the person will remain or become uninsured. The impact of the OMSP as it relates to shared responsibility payments varies significantly for the population that is uninsured or purchasing coverage in the non-group market based on the ACA’s premium assistance structure and individual mandate exemption criteria.

Exemption population: Because Oklahoma has not expanded Medicaid under the ACA, uninsured households with income below 138% FPL are automatically exempted from the individual mandate. Additionally, Oklahomans belonging to a Federally-recognized Indian Tribe are exempted from the individual mandate. These exemptions

²⁵ <https://www.healthcare.gov/fees/fee-for-not-being-covered/>

²⁶ <https://www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-exemptions>

²⁷ For 2016 values, see <https://www.irs.gov/pub/irs-pdf/p501.pdf>, Table 1.

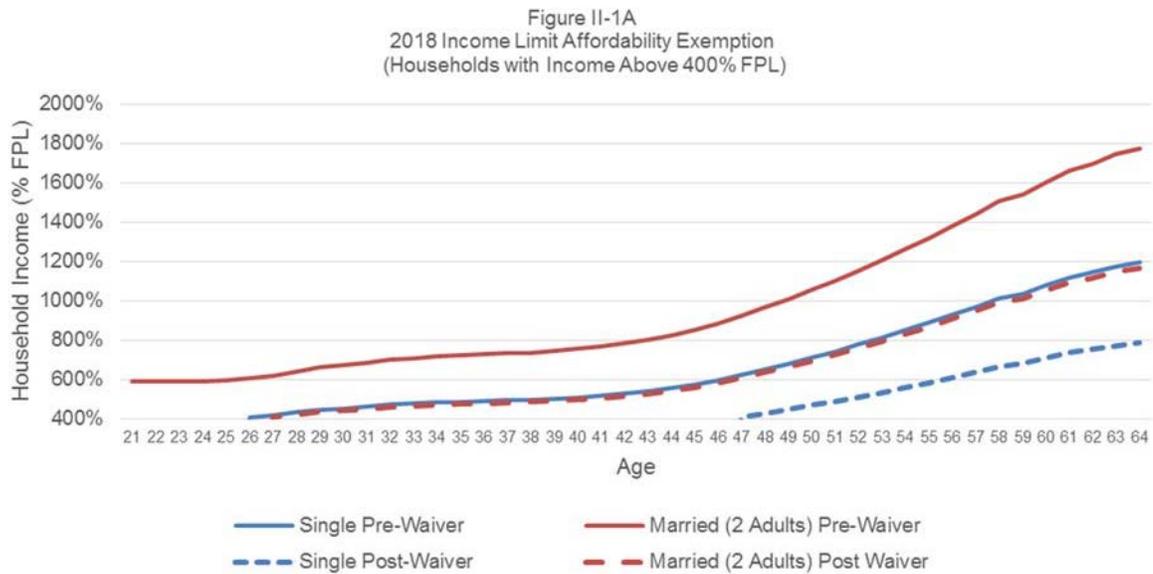
²⁸ <https://www.healthcare.gov/health-coverage-exemptions/hardship-exemptions/>

are not impacted by the OMSP, and therefore, we assume no change in shared responsibility payments from these individuals under the OMSP.

Households with income between 139% and 400% FPL eligible for federal premium assistance: Households in this income range eligible for APTC receive a guarantee the household will not spend more than a specified percentage of their household income for the second-lowest-cost silver plan. The individual mandate's affordability exemption applies only if the cost of bronze level coverage exceeds 8.05% (2018, values indexed each year).²⁹ For reference, in 2018, qualifying households with income up to approximately 250% FPL have the cost of the second lowest cost Silver plan capped below 8.05%. However, Bronze level coverage, through application of federal premium assistance, may be purchased at a significantly lower percentage of household income. For example, in 2017, a single 21-year old, non-tobacco user in Oklahoma City with income at 400% FPL (the income cut-off for subsidy eligibility) is eligible to receive premium assistance resulting in the out-of-pocket premium for the lowest cost bronze plan equaling 6.83% of household income. For a similarly situated 64-year old, the lowest cost bronze plan is only 1.12% of household income.

Because the ACA's premium subsidy structure results in Bronze coverage being affordable, as defined by the ACA, persons in this income cohort are, and will continue to be, subject to the individual mandate under the OMSP (subject to other available exemptions). Therefore, we estimate any changes in health insurance coverage at these income levels will have a direct impact on revenue associated with shared responsibility payments.

Households with income above 400% FPL: Households with income above 400% FPL are subject to the individual mandate unless the cost of Bronze coverage is deemed unaffordable by the ACA (in excess of 8.05% of household income in 2018). As illustrated in Figure II-1A, by virtue of reducing the cost of bronze level coverage, the OMSP is estimated to reduce the income level at which households are exempted from the individual mandate due to the affordability provision.



For example, we estimate a single 50-year old with income up to approximately 710% FPL would qualify for an affordability exemption without the waiver in 2018. By reducing premium costs under the waiver, a single 50-year old would only be exempted from the individual mandate if income was below approximately 470% FPL. Similarly, for a married couple (2 adults, age 50), the affordability exemption is estimated to be reduced from approximately 1055% FPL to 700% FPL.

²⁹ <https://www.gpo.gov/fdsys/pkg/FR-2016-12-22/pdf/2016-30433.pdf>, page 94133.

To the extent no individuals purchased coverage in the non-group market as a result of the OMSP, we would estimate it would result in increased shared responsibility payments to the Federal government, as it reduces the population exempt from the individual mandate penalties.

Modeling Approach

As we estimate the OMSP is most likely to reduce out-of-pocket premiums and reduce the uninsured rate for Oklahomans with income near or above 400% FPL, we have focused our modeling of shared responsibility payments on higher income households. This approach is dependent upon the following key assumptions:

1. The average responsibility payment per uninsured person making a payment with income near or above 400% FPL.
2. The likelihood of an uninsured individual making a responsibility payment with income near or above 400% FPL.
3. The change in likelihood of an uninsured individual making a responsibility payment with income above 400% FPL as a result of a reduction in the income threshold for affordability exemptions from the individual mandate.

For calendar year 2014 (data have not been published for 2015 at the time of this analysis), the Internal Revenue Service (IRS) published statistics on the number of tax returns with individual responsibility payments by the size of adjusted gross income (AGI) on the return.³⁰ We believe tax returns with adjusted gross income in excess of \$50,000 are most representative of the population that will be impacted by the OMSP, as this income level would equate to a household income above 400% for single individuals. The IRS data provided the following statistics related to 2014 shared responsibility payments at this income level (tax returns exceeding \$50,000 AGI):

- Total returns: 55,948,480
- Number of returns with responsibility payment: 1,249,521
- Total amount of responsibility payments: \$694,211,000
- Average penalty per return (calculated): \$556

Based on the 1% penalty³¹ in 2014, this would indicate the average adjusted taxable income above the tax filing threshold for tax returns with shared responsibility payments was \$55,600 ($\$556 \div 1\%$). To estimate the average shared responsibility payment during the ten-year projection period for this income cohort, we inflated the income amount by observed and projected changes in the federal poverty level (2014 through 2027), and assumed a penalty amount equal to 2.5% above the estimated tax filing threshold. Figure II-1B illustrates the estimated shared responsibility payments for tax returns in this income cohort (2014, AGI \$50,000 and over).

³⁰ <https://www.irs.gov/pub/irs-soi/14in27aca.xls>

³¹ For higher income levels, it is likely that the 1% penalty would apply rather than the flat \$95 amount in 2014. Please see figures 3 and 4 in <http://www.milliman.com/uploadedFiles/insight/health-published/measuring-strength-individual-mandate.pdf> for more information.

Figure II-1B Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Individual Mandate Penalty 2017 through 2027 Households with Income >\$50,000 (CY 2014)			
Calendar Year	Estimated Income Above Tax Filing Threshold¹	Individual Mandate Penalty Amount Per Assessed Tax Return	Penalty Per Uninsured
2017	\$57,415	\$1,435	\$718
2018	\$58,908	\$1,473	\$736
2019	\$60,439	\$1,511	\$755
2020	\$62,011	\$1,550	\$775
2021	\$63,623	\$1,591	\$795
2022	\$65,277	\$1,632	\$816
2023	\$66,974	\$1,674	\$837
2024	\$68,716	\$1,718	\$859
2025	\$70,502	\$1,763	\$881
2026	\$72,335	\$1,808	\$904
2027	\$74,216	\$1,855	\$928

Notes:

1. Average adjusted taxable income after adjustment for personal exemption amount and standard deduction.

A key aspect of modeling the shared responsibility payments is estimating the percentage of the uninsured population making shared responsibility payments. As we discussed above, a significant portion of the population is exempted from the individual mandate due to having income at or below 138% FPL. Additionally, there exists a material portion of the population with income above 400% FPL that is also exempted from the mandate due to the affordability exemption. To estimate the likelihood of an uninsured individual making a shared responsibility payment for our projections, we compared the estimated national uninsured population in 2014 with household income of \$50,000 or more from the American Community Survey (ACS)³² relative to the 2014 tax return data published by the IRS. Based on these data sources, we estimate approximately 17% of uninsured individuals with income at or above \$50,000 in 2014 made a shared responsibility payment. Details of the estimate are provided below:

- Total uninsured population with household income of \$50,000 or more (ACS Data): 15.0 million
- Number of returns with responsibility payment with AGI of \$50,000 or more (IRS): 1.25 million
- Estimated uninsured individuals per tax return: 2.0³³
- Estimated uninsured individuals making shared responsibility payment: 2.5 million
- Estimated percentage of 2014 uninsured individuals making shared responsibility payment: 17%

There are several sources of uncertainty regarding the actual rate of shared responsibility payments for the uninsured population:

- There is variance in the definition of household income reported in the ACS vs. AGI reported to the IRS.
- The figures are from 2014, the first year the individual mandate requirements were in effect. Federal enforcement of individual mandate, mandate exemption criteria, and reporting on tax return filings may impact payment rates in future years. While detailed statistics have not been published for 2015 tax returns, it has been announced across all income levels only 6.5 million tax returns reported a shared responsibility payment for 2015, relative to 8.0 million returns for the 2014 tax filing year.³⁴
- Values are based on national figures, Oklahoma experience will vary to an unknown degree. It should be noted Oklahoma has a substantially larger proportion of its population that is a member of a federally recognized Indian

³² https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_S2702&prodType=table

³³ 68% of tax returns in this income cohort were filed by married individuals, <https://www.irs.gov/pub/irs-soi/14in12ms.xls>. The exact number of uninsured individuals per household is uncertain.

³⁴ <https://www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf>

Tribe. Based on the 2010 census, Oklahoma had 9% of the national population reporting themselves as an American Indian or Alaska Native (AIAN)³⁵, relative to only 1% of the United States population as a whole.³⁶

- Premium rate changes that have occurred since 2014 and in the future will impact the income levels that are eligible for the individual mandate’s affordability exemption.

For purposes of the modeling the change in shared responsibility payments for our analysis, we have made the following assumptions:

- There is a 17% likelihood the individual gaining insurance as a result of the OMSP would make a shared responsibility payment in absence of the waiver.
- The forgone shared responsibility payment is equal to the ‘Penalty per Uninsured’ column in Figure II-1B for the given calendar year.

Based on our analysis of the Current Population Survey and ACS data, we estimate 35% to 50% of the uninsured population with income above 400% FPL has income less than 500% FPL. This would suggest the potential for a material change in the likelihood of the residual uninsured population making shared responsibility payments as a result of the OMSP. In consideration of other individual mandate exemptions, we have assumed the population with income above 400% FPL that remains uninsured under the OMSP will have a 22% likelihood of making a shared responsibility payment (with the 5% increase attributable to fewer affordability exemptions). While there is a high degree of uncertainty regarding the actual percentage of uninsured Oklahomans making a shared responsibility payment with or without the OMSP, we believe the materiality of the modeled changes for the affordability exemption, as modeled in Figure II-1A, warrants reflection in financial estimates of shared responsibility payments.

Figure II-1C Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Aggregate Shared Responsibility Payments: 2018 through 2027 (in Thousands)						
Calendar Year	Uninsured Entering Non-Group Market	Reduction in Shared Responsibility Payments ¹	Residual Uninsured Population Income >400% FPL	Additional Uninsured Making Shared Responsibility Payments ²	Gain in Shared Responsibility Payments ³	Net Change in Shared Responsibility Payments ⁴
2018	21,731	\$ (2,720)	48,174	2,409	\$1,774	\$ (947)
2019	27,495	\$ (3,531)	50,247	2,512	\$1,898	\$ (1,633)
2020	28,098	\$ (3,703)	50,409	2,520	\$1,954	\$ (1,749)
2021	26,803	\$ (3,624)	52,218	2,611	\$2,076	\$ (1,547)
2022	25,624	\$ (3,554)	54,039	2,702	\$2,205	\$ (1,350)
2023	22,915	\$ (3,261)	55,875	2,794	\$2,339	\$ (922)
2024	21,845	\$ (3,190)	57,723	2,886	\$2,479	\$ (711)
2025	20,761	\$ (3,110)	59,585	2,979	\$2,626	\$ (485)
2026	19,170	\$ (2,947)	61,530	3,077	\$2,782	\$ (165)
2027	18,455	\$ (2,910)	62,866	3,143	\$2,916	\$ 6

Notes:

1. The product of the number of uninsured entering the non-group market, 17% (estimated likelihood of the uninsured otherwise making a shared responsibility payment), and the estimated penalty per uninsured.
2. The product of 5% (22% vs. 17% rate of penalty payment) and the residual uninsured population with income >400% FPL.
3. The product of the additional uninsured making shared responsibility payments and the estimated penalty per uninsured.
4. The sum of the reduction in shared responsibility payments from persons entering the non-group market and the additional payments from the residual uninsured not eligible for the affordability exemption as a result of the OMSP.

³⁵ <https://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf>, see Figure 3.

³⁶ <https://www.census.gov/2010census/popmap/>

2. EXCHANGE USER FEE

Section 1311(d)(5)(A) of the ACA allows an Exchange (also referred to as a marketplace) to charge assessments or user fees to participating health insurers to generate funding to support the operation of the Exchange. In the 2018 Notice of Benefit and Payments parameters, the Federal government set the 2018 user fee for insurers offering coverage in the FFM at 3.5% of charged premium.³⁷ For purposes of our ten-year projection, we have assumed that Oklahoma will continue to utilize the FFM and the 3.5% user fee will continue through the course of the projection period.

FFM user fee revenue may change as a result of the following impacts under the OMSP:

- The OMSP is estimated to result in a decrease in per capita premiums charged by insurers in the ACA-compliant non-group market, both within the FFM and in the outside market.
- To the extent persons receive an APTC without the OMSP, but no longer receive an APTC under the waiver (as a result of premium rate decreases rendering the APTC worth \$0), the financial incentive to purchase coverage through the FFM is removed. FFM data through 2017 indicate that nearly 90% of Oklahomans purchasing coverage in FFM qualify for an APTC.³⁸ Therefore, it is possible that a small portion of the APTC population in the absence of the waiver will shift to purchasing coverage outside of the FFM as a result of the OMSP. These households are most likely to consist of young adults, with income above 300% FPL, as these persons receive a lower amount of APTC relative to older and/or lower income households.
- Additional persons entering the non-group market as a result of the OMSP are more likely to not qualify for an APTC, as the reinsurance program's premium reduction will primarily accrue to consumers with income above 400% FPL who do not qualify for APTC. However, as approximately 10% of Oklahomans making a selection in the FFM during the 2017 open enrollment period did not qualify for APTC³⁹, we estimate a similar proportion of individuals entering the non-group market as a result of the OMSP will purchase coverage in the insurance marketplace without an APTC.

Figure II-2A illustrates the estimated change in FFM premium revenue during the projection period, as well as corresponding change in the collected FFM user fee, based on 3.5% of premium revenue.

³⁷ <https://www.gpo.gov/fdsys/pkg/FR-2016-12-22/pdf/2016-30433.pdf>, page 94138.

³⁸ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2017_OEP_State-Level_Public_Use_File.zip, worksheet (5) by Premium and FA

³⁹ Same as prior reference.

Figure II-2A Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Change in FFM Insurer Assessment Revenue 2018 through 2027 3.5% Premium Assessment Assumed (in Thousands)		
Calendar Year	Change in FFM Premium Revenue	Change in Federal Assessment
2018	\$ (288,670)	\$ (10,103)
2019	\$ (230,287)	\$ (8,060)
2020	\$ (238,729)	\$ (8,356)
2021	\$ (247,738)	\$ (8,671)
2022	\$ (230,739)	\$ (8,076)
2023	\$ (238,249)	\$ (8,339)
2024	\$ (233,096)	\$ (8,158)
2025	\$ (233,214)	\$ (8,162)
2026	\$ (235,848)	\$ (8,255)
2027	\$ (236,780)	\$ (8,287)

3. HEALTH INSURANCE PROVIDERS FEE

The Health Insurer Providers Fee (HIF), mandated by Section 9010 of the ACA is applicable to qualifying health insurance premiums earned by for-profit and a portion of non-profit insurers. The annual fee amount required for an insurer is based on its premium volume in proportion to premium volume of other health insurers subject to the HIF during the prior year. Nonprofit insurers who receive more than 80% of their premium revenue from Medicare, Medicaid, CHIP, and dual eligible plans are exempted from the fee. Other nonprofit insurers will be able to exclude 50% of their premium revenue from the health insurer fee calculation. In 2018, the national HIF charge is \$14.3 billion. In 2019 and thereafter, the HIF charge is increased by the rate of premium growth relative to the preceding year (as defined in Section 36B(b)(3)(A)(ii) by the IRS).⁴⁰

As the required HIF charge of \$14.3 billion in 2018 is a prescribed amount, changes in Oklahoma's health insurance premium volume as a result of the OMSP would not change the aggregate amount collected (it may change the allocation of the HIF amongst assessed insurers). In the remainder of the ten year projection period, the national HIF charge will be indexed based upon the premium growth rate. As the OMSP is not estimated to materially change employer-sponsored insurance premiums in Oklahoma, we do not estimate the OMSP will impact CMS' projection of per enrollee employer-sponsored insurance premiums. In the absence of other information and based on current regulations, we assume that CMS will continue to calculate the premium growth rate based on projected changes in employer-sponsored insurance premiums.

Since the ACA's implementation, the Centers for Medicare & Medicaid Services (CMS) has used a methodology based on the most recent National Health Expenditures Accounts projection of per capita employer-sponsored insurance premiums to develop the above referenced premium growth percentage.⁴¹ As discussed in the 2018 Notice of Benefit and Payment Parameters, CMS is considering future rulemaking to adjust the methodology of the premium growth rate calculation.⁴² However, it is uncertain to what degree (if any) changes would be made this calculation in the future.

Based on this set of assumptions, we do not estimate the OMSP will have any material impact on HIF charges during the ten-year projection period. To the extent the state-based assessments supporting the OMSP result in higher per capita employer-sponsored insurance premiums in Oklahoma, the OMSP would actually result in greater HIF revenue for the Federal government based on the current indexing methodology.

It is possible that the share of HIF payments made attributable to Oklahoma health insurance premiums may vary as a result of the OMSP. As the OMSP is estimated to reduce insurer premium volume, it may result in a slight increase in required payments from insurers not participating in Oklahoma's individual health insurance market (as well as APTC expenditures in other states). However, based on IRS data published for 2016, the estimated premium volume reduction from the OMSP will be less than 0.1% of national premiums subject to the HIF.⁴³ Additionally, it is possible that the OMSP may incentivize new insurers to enter the market that may or may not be subject to the HIF. This may change the amount of HIF revenue collected from Oklahoma insurers, but will not change the national assessment amount.

⁴⁰ Please see <https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010> for more information related to the HIF.

⁴¹ <https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2016-fact-sheets-items/2016-12-16.html>, see paragraph entitled "Premium Adjustment Percentage".

⁴² <https://www.gpo.gov/fdsys/pkg/FR-2016-12-22/pdf/2016-30433.pdf>, page 94133

⁴³ <https://www.irs.gov/pub/irs-utl/form8963finalfeeyear2016.xlsx>

4. PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND FEE

The Patient-Centered Outcomes Research Trust Fund (PCORI) fee is an assessment on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans that helps to fund the Patient-Centered Outcomes Research Institute (PCORI).⁴⁴ PCORI fees are assessed to health insurance policies that have plan years ending before October 1, 2019.⁴⁵ Therefore, with respect to the 2018 to 2027 projection period, non-group health insurance policies will only be subject to the PCORI fee for 2018 coverage years (as it is assumed 2019 policies will be purchased with a plan year ending December 31, 2019). The PCORI fee rate for policy years ending between October 1, 2016 and September 30, 2017 is \$2.26 (annual per member assessment).⁴⁶ The fee is indexed based on changes in the projected per capita National Health Expenditures.⁴⁷ For purposes of modeling the PCORI fee amounts for non-group coverage during for the 2018 time period, we have assumed an annual per person PCORI fee amount of \$2.45 (the estimated effective rate for policies ending between October 1, 2018 and September 30, 2019). This estimate assumes a \$0.09 annual increase relative to the \$2.26 rate that is effective for policies ending between October 1, 2016 and September 30, 2017. Figure II-4A illustrates the estimated change in PCORI fee revenue resulting from OMSP. The estimate is based on the additional individuals insured in the non-group market (21,700), multiplied by the estimated fee of \$2.45.

Figure II-4A Oklahoma Department of Health Individual Health Insurance Market OMSP Estimated Change in PCORI Fee Revenue 2018 through 2027	
Calendar Year	Revenue Change (\$ Thousands)
2018	\$ 53
2019	\$ 0
2020	\$ 0
2021	\$ 0
2022	\$ 0
2023	\$ 0
2024	\$ 0
2025	\$ 0
2026	\$ 0
2027	\$ 0

⁴⁴ <https://www.irs.gov/uac/patient-centered-outcomes-research-trust-fund-fee-questions-and-answers>

⁴⁵ Same link as above.

⁴⁶ <https://www.irs.gov/affordable-care-act/patient-centered-outreach-research-institute-filing-due-dates-and-applicable-rates>

⁴⁷ <https://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf>, 72722

Appendix E: Assumptions and Methodology

SECTION III. ASSUMPTIONS AND METHODOLOGY

1. MARKET CALIBRATION

A key aspect of modeling healthcare reform proposals is establishing a status quo set of assumptions for the population being modeled. For the State of Oklahoma insurance markets, we developed estimates for the number of Oklahomans insured through each insurance market (or uninsured) in 2017 by age, gender, household income, health status, metallic level (if applicable for the market), premium rates, and other factors to establish baseline assumptions for Oklahoma's population. We developed our starting census and premium rate assumptions for each insurance market from a number of publicly available data sources. The assumptions in the model related to insurance take-up rates and market migration have been calibrated based on observed insurance market experience during calendar years 2014 through 2016. This calibration was based on publicly available data related to insurance marketplace enrollment, as well as proprietary data that we received from Oklahoma insurers and OSDH, along with other sources Milliman has gathered and developed. Data from insurers included estimated 2017 enrollment and claims projections. Proprietary data received from OSDH included Medicaid enrollment by household income, aid category, and age group. Public data sources used in our census and assumption calibration process include:

- **Oklahoma Census Projections** – To project statewide census changes by age and gender, we utilized population projections from 2010 through 2075 published by the Oklahoma Department of Commerce. Population estimates are provided in five year increments from 2010 through 2027. By interpolating between the five year increments, we established estimated population changes by age and gender through the end of the ten year projection period.
- **Current Population Survey (CPS) data** – These data, which are updated monthly, provided us with demographic information by insurance coverage, age, FPL, and health status. While CPS data offer a smaller sample size relative to other sources of population survey data, the survey includes self-reported health status information which was critical in understanding the relationship between Oklahoma's uninsured and non-group market by age and income level. To obtain a credible sample size, three years of CPS data were reviewed. In situations where CPS sample size credibility was a concern, state data were evaluated alongside national data to further enhance credibility in modeling results.
- **American Community Survey (ACS) data** – Due to the large sample size, ACS data were used to provide estimated enrollment distributions by insurance coverage, age, gender, FPL, and marital status. Adjustments were made to the ACS data to reflect an over-reporting of non-group coverage relative to actual insurer data, and corresponding under-count of Medicaid enrollment.
- **Medical Loss Ratio Reporting Form data (MLR) data** – MLR data are required to be submitted by carriers offering fully-insured commercial products for the purpose of complying with federal MLR reporting requirements. Publicly available MLR information from 2014 through 2015 was used to evaluate historical changes in the number of covered lives by insurance segment and market per capita premium. This source of information includes a more credible source of insured lives relative to population survey data for non-group and fully insured group markets.
- **Marketplace Enrollment Reports** – We utilized publicly available data provided by the United States Department of Health and Human Services (HHS) to understand the enrollment of the Individual Health Insurance Marketplace during 2014 through 2017 at the county level. While the total size of the individual market can be observed using carrier financial reporting information, HHS marketplace enrollment reports include information related to the size of the FFM. Combining this with insurer financial data enabled us to fully understand the portion of the individual market that is on-FFM vs. off-FFM.
- **Marketplace Publicly Available Files (PUFs)** - The Marketplace PUFs include plan and issuer level information for certified Qualified Health Plans (QHPs) and stand-alone dental plans (SADPs) offered to individuals and small businesses through the Health Insurance Marketplace. The Marketplace PUFs include data from states participating in the Federally Facilitated Marketplaces (FFM), which include State Partnership Marketplaces (SPMs), and states whose State-based Marketplaces rely on the federal information technology platform for QHP eligibility and enrollment functionality. We used the Marketplace PUF to estimate the distribution of insurance marketplace enrollment by metal level, rating area, household income, age, and premium assistance levels.
- **Statutory Financial Statement Data** – As MLR data are not available for 2016 or 2017, we believe it is also important to incorporate more recent financial information into our census estimates. For this project, we also

reviewed calendar year 2016 and first quarter 2017 statutory statement information for insights into Oklahoma's insurance markets.

Based on actual insurance enrollment from insurer financial data and public programs, we estimated 2017 enrollment counts for each insurance market. The ACS demographic distributions were used to allocate enrollment in each market by age, gender, and income level. Adjustments were made to demographic distributions to reflect changes in insurance market enrollment since 2015. For example, there has been a material decline in non-group enrollment for the population with income above 400% FPL.

2. POPULATION MODELING

Based on the Oklahoma census projections, we estimated enrollment in each insurance market from 2018 through 2027 by assuming the distribution of insurance market enrollment by age, gender, and income level would remain constant relative to 2017. Changes in insurance market enrollment during the projection period are a result of changes in the estimated number of Oklahomans by age and gender in the census projections. For example, the census projections estimate the number of Oklahomans age 65 and over will increase from approximately 590,000 in 2015 to 775,000 by 2027. This results in a corresponding increase in the number of estimated Medicare enrollees during the same time period. We evaluated this methodology on a national basis and observed growth in the number of Medicaid, Medicare, and employer-sponsored insurance enrollees consistent with CMS projections.⁴⁸

For the uninsured and non-group market, further adjustments were made to enrollment projections based on the census projections. We have observed a significant decline in non-group market enrollment in Oklahoma from 2015 through 2017. Approximately 192,000 Oklahomans enrolled in non-group coverage in 2015, while we estimate only 150,000 Oklahomans have purchased non-group coverage in 2017.

In our projections, we have estimated immaterial changes in non-group coverage for the population eligible for APTC. As the structure of the APTC calculation caps a consumer's out-of-pocket premium, we have assumed little enrollment changes (other than those driven by census projections), for the population eligible for APTC. This assumption is supported by the stability in APTC enrollment between 2016 and 2017, despite significant premium rate increases occurring in the market. As discussed in this report, the OMSP is not estimated to have a material impact on out-of-pocket premiums for the population eligible for the APTC. Therefore, under both the without waiver and waiver scenarios, we projected relatively similar APTC enrollment.

For the uninsured and non-group markets, we divided enrollment into risk quintiles, and assigned an acuity factor to each quintile. Acuity factors were developed based on a review of insurer diagnosis data and actuarial judgment. Separate acuity factors were developed by age group and gender for individuals with income below 250% FPL, 250% FPL to 400% FPL, and with income above 400% FPL. Individuals in high risk quintiles were assumed to have a greater likelihood of maintaining insurance (current non-group) or entering the market (current uninsured) relative to enrollees in lower risk quintiles.

For the population not eligible for APTC, largely Oklahomans with income above 400% FPL, we have assumed further attrition in market enrollment will occur if premium rate growth exceeds income growth. As a result of the OMSP, we estimate enrollment attrition is halted for several years for Oklahomans currently purchasing coverage in the non-group market. Additionally, the decrease in premiums is estimated to incent currently uninsured individuals to purchase coverage in 2018.

For the population that is estimated to enter the non-group market as a result of the OMSP program, we anticipate that subsequent premium rate increases will result in enrollment attrition. Note, under the without waiver scenario, we do not assume a net population movement from the uninsured market to the non-group market, as premium rates increases are estimated to exceed income growth.

3. PREMIUM AND CLAIMS EXPENSE PROJECTIONS

Premium and claims expenses estimated in the non-group market are based on a combination of the following factors:

- Estimated healthcare inflation (assuming no change in benefit levels or insured demographics);
- Changes in population acuity (as measured by the assigned acuity factors to each risk quintile);
- Estimated changes in non-claims expenses (administrative costs, fees and taxes, insurer margin); and,

⁴⁹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2016Tables.zip>, Table 17.

- Changes in composite benefit level (the mix of coverage by metallic tier in the non-group market).

Health care inflation assumptions were developed based on Milliman's Health Cost Guidelines – Commercial Rating Structures™, with adjustments during the projection period based on CMS's projected per capita change in direct insurance costs.⁴⁹ Population acuity changes were developed based on the composite mix of acuity scores for the population estimated to purchase non-group coverage in a given year. As stated previously in this report, we believe the current market premium rates potentially contain contingencies for CSR payments and the enforcement of the individual mandate. Under the without waiver scenario, we assumed a gradual reduction in non-claims expenses until the projected medical loss ratio that exceeds the ACA's minimum medical loss ratio requirement. Thereafter, we assumed non-claims expenses would grow by approximately 2% annually on a PMPM basis. For the with waiver scenario, we assumed the combination of the reduction in premium rates and the ACA's minimum medical loss ratio requirements would initially result in declining non-claims expenses on a PMPM basis relative to the without waiver scenario. By the end of the ten year projection period, we assumed only minimal differences in non-claims PMPM expense assumptions between the two modeled scenarios.

For individuals estimated to enroll or maintain non-group coverage, a metallic tier plan is assigned based on the distribution of metallic plans in the 2017 FFM⁵⁰ and income level. For example, based on FFM data, individuals qualifying for CSR payments between 100% and 250% FPL have a much greater likelihood of purchasing a Silver plan, relative to households at higher income levels.

Federal premium assistance was estimated based on premium rate changes for the second-lowest cost Silver plan available in the FFM, projected household income by FPL, and the indexing of the premium tax credit expenditures. For each enrollee cohort, a rating factor corresponding to the default Federal age curve was assigned.⁵¹ For the 2017 baseline year, we confirmed that our model produced an estimated, aggregate, Federal premium assistance amount that closely corresponds to the estimated number of APTC enrollees and the average APTC per month for qualifying enrollees published by CMS (\$550).⁵²

4. REINSURANCE PAYMENT MODELING

In the absence of enrollee level claims expense information, we calibrated our model to the estimated cost distribution of the ACA-compliant non-group market using reported experience from the Transitional Reinsurance Program (TRP) for Oklahoma insurers and Milliman's Health Cost Guidelines. We discussed the reasonableness of reinsurance parameters with the participating insurer, validating consistency with their internal projections for 2017 enrollees.

⁵⁰ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2016Tables.zip>, Table 17.

⁵¹ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2017_OEP_State-Level_Public_Use_File.zip

⁵² <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Guidance-Regarding-Age-Curves-and-State-Reporting-12-16-16.pdf>, page 4.

⁵³ <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf>, Average Advanced Premium Tax Credit by State, February 2017, page 6

LIMITATIONS

The services provided for this project were performed under the contract between Milliman and Oklahoma State Department of Health (OSDH) dated June 8, 2017.

The information contained in this report has been prepared for OSDH and their consultants and advisors to provide actuarial certification and economic analyses related to the State of Oklahoma's Section 1332 Waiver application that seeks Federal funding for the OMSP. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this letter will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for OSDH by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the premium rates, insurance market population estimates, trend rates, and other assumptions.

Milliman has relied upon certain data and information provided by OSDH and the Oklahoma Insurance Department (OID). Additionally, we relied on statutory financial statement information downloaded from S&P Global Market Intelligence (formerly SNL Financial), Federal government reports related to insurance marketplace enrollment and premiums, proprietary insurer financial data, and Federal economic and healthcare expenditure forecasts. Milliman has relied upon these third parties for the accuracy of the data and accepted it without audit. To the extent that the data provided are not accurate, the estimates provided in this report would need to be modified to reflect revised information.

It should be noted there is significant uncertainty surround future enrollment and premiums in health insurance programs, particularly the individual market. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

We specifically note our projections of enrollment and premium rates in the individual market assume Federal funding of cost sharing reduction (CSR) subsidies continue, the individual mandate is enforced in a manner similar to the 2014 through 2016 time period, and insurer pricing assumptions do not materially deviate from 2017 assumptions. It is certain that values presented in this report will deviate from actual amounts. However, to the extent judicial, legislative, or regulatory changes are made to the ACA, the values presented in this report may be impacted by a significant degree. Actual insurer premiums in 2018 and beyond may contain additional margin related to these contingencies to provide financial protection for these occurrences.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

Appendix F: Reporting Targets

Per 45 CFR 155.1308(f)(4)(vi) Oklahoma will submit quarterly, annual, and cumulative targets related to the guardrails of scope of coverage, affordability, and comprehensiveness, as well as the federal deficit requirement. Specifically, Oklahoma proposes to provide the following data regarding the guardrails:

Scope of Coverage/Comparability

The proposed waiver meets the scope of coverage guardrail, as coverage on the individual market will be available to a comparable number of people as would have been covered in the absence of the waiver. Oklahoma anticipates that more people will be insured on the individual market with the implementation of the waiver than without it. There are no anticipated decreases in coverage for vulnerable populations by coverage category, health status, age, geographic location, or any other demographic characteristic as a result of the waiver.

Enrollment Projections (per Figure 1 in Actuarial Analysis)

Total Non-Group Market: Enrollment Projections					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018	172,000	172,000	172,000	172,000	172,000
2019	171,000	171,000	171,000	171,000	171,000
2020	172,000	172,000	172,000	172,000	172,000
2021	171,000	171,000	171,000	171,000	171,000
2022	170,000	170,000	170,000	170,000	170,000

Affordability

The proposed waiver meets the affordability guardrail, with coverage as affordable as Marketplace coverage and comparable cost sharing and out-of-pocket protections. Therefore, it should increase affordability for certain groups in the individual market, both with and without federal premium assistance. The waiver will not decrease cost sharing protections against excessive out-of-pocket spending or decrease affordability for any vulnerable or at-risk populations.

Premium Projections (per Figure I-5A(ii) in Actuarial Analysis)

Total Non-Group Market: Premium PMPM Projections					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018	\$ 440	\$ 440	\$ 440	\$ 440	\$1,760
2019	\$ 472	\$ 472	\$ 472	\$ 472	\$1,888
2020	\$ 496	\$ 496	\$ 496	\$ 496	\$1,984
2021	\$ 511	\$ 511	\$ 511	\$ 511	\$2,044
2022	\$ 562	\$ 562	\$ 562	\$ 562	\$2,248

Comprehensiveness

Oklahoma’s proposed waiver does not amend any aspects of the ACA that pertain to comprehensiveness of benefits.

Deficit Neutrality

The proposed waiver will not increase the federal deficit; any additional spending and administrative costs will meet the deficit neutrality requirement of Section 1332 (b)(1)(D).

APTC Spending Projections (per Figure II-1 in Economic Analysis)

Federal APTC Spending Projections (Millions)					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018	\$80	\$80	\$80	\$80	\$ 320
2019	\$67.75	\$67.75	\$67.75	\$67.75	\$ 271
2020	\$71	\$71	\$71	\$71	\$ 284
2021	\$73	\$73	\$73	\$73	\$ 292
2022	\$69.5	\$69.5	\$69.5	\$69.5	\$ 278

Proposed Report

In addition, the State proposes to include the following information within its reports:

1. Evidence of compliance with public forum requirements (within six-months after waiver implementation and annually thereafter), including date, time, place, description of attendees, the substance of public comment and the State’s response, if any.
2. Information about any challenges the State may face in implementing and sustaining the waiver program and its plan to address the challenges.

3. A description of any substantive changes in Oklahoma's insurance market such as the number of carriers serving the individual market or benefits.
4. Modifications, if any, which have been made in plans resulting from changes in federal or state law.
5. Any other information consistent with the terms and conditions in the State's approved waiver.

Appendix G: 1332 State Innovation Task Force Meetings

Meeting Date	Agenda Topics
August 30, 2016	<ul style="list-style-type: none"> • 1332 Task Force Purpose & Charge • Roles and Ground Rules for Discussion • 1332 Overview, Guiding Principles & Goals • 1332 Considerations, Current Insurance Market Issues • Discuss Task Force Perspectives on Pain Points of Market • Waiver Timeline & Next Steps
September 26, 2016	<ul style="list-style-type: none"> • Oklahoma Marketplace Overview • 1332 Policy Levers • Data Workgroup Discussions • FFM Problems, Data, and Policy Levers Discussion • FFM Special Enrollment Guidance Update • Waiver Timeline & Next Steps
October 18, 2016	<ul style="list-style-type: none"> • Data Workgroup Discussions • FFM Problems, Data, and Policy Levers Discussion • Consultant Support and Survey Data • Waiver Timeline & Next Steps
November 15, 2016	<ul style="list-style-type: none"> • Overview of Provider Survey Results • Discussion of Marketplace Pain Points and Possible Solutions • Next Steps
December 12, 2016	<ul style="list-style-type: none"> • Overview of Consumer and Business Surveys • Overview of Task Force Responses to Proposed Solutions • Discussion of Marketplace Options • Next Steps
January 24, 2017	<ul style="list-style-type: none"> • Update on Consumer and Business Surveys • Review of FFM and Uncompensated Care Data • Discussion of Concept Paper and Alignment with Federal Proposals • Discussion of Proposal Timing and Feasibility • Analytical Approach for Impact Analysis • Next Steps
February 21, 2017	<ul style="list-style-type: none"> • Consumer and Business Surveys: Initial Results • Insurance Market Analysis: Initial Results • Review of Public Comments on Concept Paper • Overview of Tribal Considerations • Discussion of Additional Strategies • Next Steps
April 18, 2017	<ul style="list-style-type: none"> • Federal Updates • Discussion of Reinsurance and High Risk Pools • Preliminary Impact Assessment of Concept Paper Strategies • Timeline and Next Steps
June 29, 2017	<ul style="list-style-type: none"> • Results of Solution Modeling • Next Steps

Appendix H: Public Notice of Hearing-Press Release



Oklahoma State Department of Health
Creating a State of Health

July 14, 2017

Notice of Public Comment Period for Oklahoma Section 1332 State Innovation Waiver

Draft of Oklahoma’s Section 1332 State Innovation Waiver to Ensure Access to Coverage, Create a Sustainable Insurance Market and Reduce Health Insurance Premiums for Consumers

FOR IMMEDIATE RELEASE:

The Oklahoma Health and Human Services Cabinet Secretary (HHS), in conjunction with the Oklahoma Insurance Department (OID), has developed a 1332 State Innovation Waiver pursuant to House Bill 2406 to create a Market Stabilization Program to waive certain provisions of the Affordable Care Act (ACA), assume state control and regulation of the Oklahoma individual health insurance market, increase competition, reduce healthcare premiums and protect coverage for approximately 130,000 Oklahomans. This waiver was produced in collaboration with a 1332 Task Force established by Governor Mary Fallin to recommend solutions to the State of Oklahoma to improve its health insurance market (see link below for a full list of Task Force members).

HHS and OID will conduct two informational meetings and provide opportunity for public comment on a Section 1332 “State Innovation” Waiver. The meetings will consist of a presentation about the waiver followed by time for questions and comments from the public. The public comment period will officially begin on July 14th and will end on August 13th. A draft waiver application will be available on the [Oklahoma State Department of Health website](#). Following the public comment period the Section 1332 Waiver will be submitted to the US Department of Health and Human Services for review and approval to implement the Oklahoma Individual Health Insurance Market Stabilization Program, a state-operated reinsurance program.

Moving forward, the State of Oklahoma will continue engaging with the public as it looks to implement additional reforms to the ACA.

The 1332 State Innovation Waiver is available online at:
[https://www.ok.gov/health/Organization/Center for Health Innovation and Effectiveness/1332 State Innovation Waiver /index.html](https://www.ok.gov/health/Organization/Center%20for%20Health%20Innovation%20and%20Effectiveness/1332%20State%20Innovation%20Waiver/index.html)

Public Comment

Comments may be submitted in writing, online, or in person at the public information meetings. Please submit comments no later than August 13, 2017 via mail or email to:

1332Waiver@health.ok.gov



Oklahoma State Department of Health
Creating a State of Health

Buffy Heater
HHS Strategy Officer
Commissioner's Office, Oklahoma State Department of Health
1000 NE 10th Street
Oklahoma City, Oklahoma 73117

Public Information Meetings

The Oklahoma State Department of Health will conduct two public information meetings regarding the Section 1332 Waiver application. The meetings will consist of a presentation about the waiver followed by time for questions and comments from the public. The meeting date, time, and location are as follows:

Date	Location	Time
July 31, 2017	Oklahoma State Capitol, Room 535 2300 N. Lincoln Blvd. Oklahoma City, OK 73105	3:30 pm-4:30 pm
August 3, 2017	Tulsa City-County Library, Central Library Downtown, Aaronson Auditorium, L01 400 Civic Center Tulsa, OK 74103	1:00 pm-2:00pm

Appendix I: Online Public Notice of Public Hearings and Tribal Consultation

OSDH Home > Organization > Center for Health Innovation and Effectiveness > 1332 State Innovation Waiver

[email](#) | [print](#)

1332 State Innovation Waiver

Oklahoma Senate Bill 1386, enacted during the 2016 legislative session, was created to explore potential methods to increase healthcare coverage in Oklahoma and reduce the financial burden for Oklahoma residents and employers seeking affordable coverage. The goal is to create an alternative pathway for affordable, high quality healthcare coverage in Oklahoma's commercial insurance market that meets the needs of Oklahomans. As a result of this legislation, a task force comprised of numerous Oklahoma stakeholders is investigating and analyzing the options for Oklahoma pursuing a 1332 State Innovation Waiver.

The 1332 Waiver task force is exploring what Oklahoma needs to ensure affordable and robust healthcare coverage for its residents and, with public input, decide how best to address our state's needs and whether the development of a 1332 Waiver is advantageous to the state.

Download the 1332 Waiver Application here:
[Oklahoma 1332 State Innovation Waiver DRAFT](#)

Public Comment Information:
The public comment period for the 1332 Waiver will run from July 14, 2017 - August 13, 2017.

Submit Comments Online:
[Submit comments for the 1332 Waiver Application](#)

Attend a Public Hearing

Upcoming Meetings

Public Hearing - Oklahoma City
July 31st 3:30 - 4:30 pm
Oklahoma State Capital Building, Room 535
2300 N. Lincoln Blvd. OKC, OK

Public Hearing - Tulsa
August 3rd 1:00 - 2:00 pm
Tulsa City-County Library
Central Library Downtown
400 Civic Center Tulsa, OK

Download the 1332 Waiver Task Force Concept Paper Here:
[Oklahoma 1332 Task Force Concept Paper](#)

1332 Waiver: Tribal Listening Session

Formal Tribal Consultation – 1332 Waiver

July 24th – 1:30 pm to 3:30 pm
Indian Health Care Resource Center of Tulsa
550 S Peoria Ave, Tulsa, OK 74120

The OSDH conducted a tribal listening session on Monday February 13th regarding the 1332 state innovation waiver. For reference and review, these documents are listed below.

[1332 Listening Session Agenda](#)

[1332 Listening Session Minutes](#)

During the listening session the 1332 Waiver Concept Paper was discussed as well as possible tribal considerations. For reference and review, these documents are listed below.

[1332 Waiver Concept Paper Draft](#)

[Tribal Considerations 1332 Concept Paper](#)

[PowerPoint 1332 Concept Paper](#)

The OSDH would like to solicit feedback about the concept paper. Please take a moment to review the questions posed in the document below and submit responses to SallyC@health.ok.gov. Any additional questions, comments, suggestions and revisions should also be emailed to SallyC@health.ok.gov or call the Office of the Tribal Liaison at (405) 271 5170. We respectfully ask that all comments and questions be submitted by February 23rd, 2017.

[Questions Handout](#)



Appendix J: Slides from Public Hearings



Public Hearing: 1332 Waiver For Reinsurance Program Agenda

Oklahoma State Capitol, Room 535
 2300 N Lincoln Blvd
 Oklahoma City, OK 73105
 July 31, 2017
 3:30 pm. - 4:30 pm.

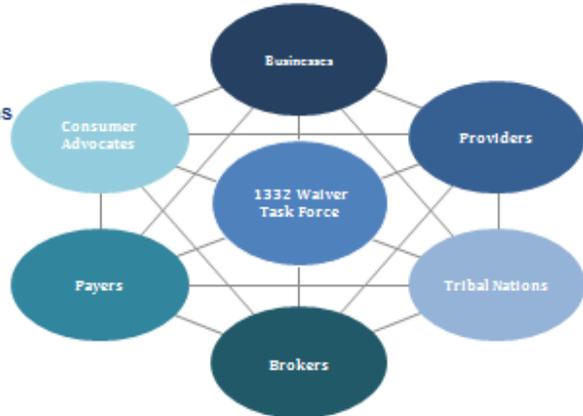
Section	Time	Presenter
Welcome & Opening Remarks	3:30 - 5 min	Julle Cox-Kain, Deputy Secretary, Oklahoma Health and Human Services
History of the 1332 Waiver and Concept Paper	3:35 - 10 min	Buffy Heister, HHS Strategy Officer
Overview and Discussion: State-Based Reinsurance Programs and Oklahoma's 1332 Waiver Application	3:45 - 30 min	Attendees, Buffy Heister
Overview and Discussion: 1332 Waiver Timeline and Next Steps	4:15 - 10 min	Attendees, Julle Cox-Kain
Closing Remarks and Adjournment	4:25 - 5 min	Julle Cox-Kain

1332 Waiver Task Force

- **SB1386:** Explore the potential development of new Innovation Waivers for the purpose of creating Oklahoma health insurance products that improve health and healthcare quality while controlling costs:
 - 1332 State Innovation Waiver
 - 1115 Delivery System Reform Incentive Payment (DSRIP)

- **Stakeholder Input:**
 - Advisory Task Force to assist in investigating / analyzing options for an Oklahoma 1332 “State Innovation” Waiver
 - Individual and group meetings
 - Public comment period
 - Transparency requirements

- **Task Force Goals:**
 - Explore potential methods to reduce the financial burden for Oklahoma residents and employers seeking affordable, quality healthcare coverage.
 - Develop innovative, state-based solutions to address its healthcare coverage needs.
 - Promote competition and choice.



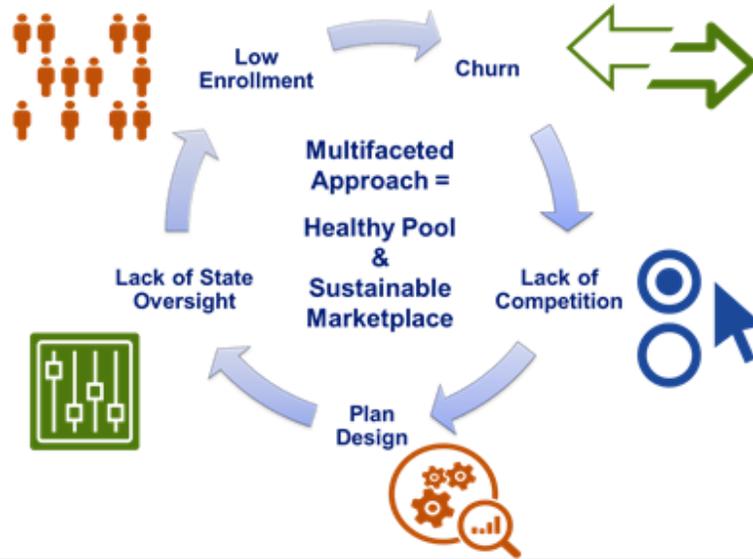
▪ **Required Legislative Review**

1332 Waivers: Four Areas of Innovation

States may propose innovations and alternatives to four pillars of the ACA.

<p>1 Individual Mandate</p> <p>States can modify or eliminate the tax penalties that the ACA imposes on individuals who fail to maintain health coverage.</p>	<p>2 Employer Mandate</p> <p>States can modify or eliminate the penalties that the ACA imposes on large employers who fail to offer affordable coverage to their full-time employees.</p>
<p>3 Benefits and Subsidies</p> <p>States can modify the rules governing what benefits and subsidies must be provided within the constraints of section 1332's coverage requirements.</p>	<p>4 Exchanges and QHPs</p> <p>States can modify or eliminate QHP certification and the Exchanges as the vehicle for determining eligibility for subsidies and enrolling consumers in coverage.</p>

Market Pain Points



Oklahoma Marketplace Data

- Enrollment in the FFM is Low and Relatively Unhealthy
 - In 2018, only 31% of Oklahoma's eligible population was enrolled in the Federally Facilitated Marketplace (FFM)
- Competition and Consumer Choices are Shrinking
 - The FFM has gone from 5 insurance companies offering plans in Oklahoma in 2014 to 1 in 2017
 - There has been a 87% reduction in plan options (consumer choices) between 2015 - 2017
- Premiums are increasing, as are subsidies
 - As the FFM dropped to one insurer in 2017, premium rate increases of 75% were requested and granted by HHS
 - Between 2015 and 2017, premiums for all ages, individuals and families have roughly doubled in price
 - Average Silver Plan premium changes 2015 - 2017:

Covered Individuals	2015 Monthly Premium Rate	2017 Monthly Premium Rate
Individual Aged 27	\$ 227	\$ 454
Individual Aged 50	\$ 357	\$ 775
Family (Aged 50) with 2 kids (Aged 10)	\$ 788	\$ 1,555

- Average premiums due (after subsidy) for Oklahomans have increased from \$65 to \$78 (20% increase) between 2014 and 2017
- Approx. 91% of the 129,000 enrolled receive tax credits and 82% receive cost sharing reductions in 2017
- Deductibles are High
 - 2017 average deductibles for an individual ranges from \$1,125 (Gold In-Network) to \$10,200 (Bronze Out of Network)
 - 2017 average deductibles for a family ranges from \$3,575 (Gold In-Network) to \$41,957 (Bronze Out of Network)
- Some individuals are not remaining insured throughout the course of the year (lack of persistency)
 - In 2017, 17,000 Oklahomans (12% of enrollees) selected a plan but did not pay their premiums
- Of the uninsured, 39% have incomes below 100% of FPL and are ineligible for FFM subsidies

Sequential Approach to Recommendations



Why Pursue Reinsurance and Risk Pooling Programs?

Oklahoma has an opportunity to innovate and address its unstable market.

- Between 2014 and 2017, Oklahoma’s individual market premiums have almost doubled in price. Recent consumer focus groups indicate that the biggest barrier to greater health insurance enrollment is affordability.
- HHS Secretary Price recently sent a series of letters to state governors encouraging them to evaluate reinsurance or risk pooling opportunities available under the Section 1332 Innovation Waiver.
- Adopting a state-based reinsurance or risk pooling program in the State of Oklahoma would provide immediate relief to insurance premiums, encourage greater competition, and likely produce gains in enrollment.

Why Pursue Reinsurance and Risk Pooling Programs?

Oklahoma can maximize the positive impact of funding for state-based reinsurance or risk pooling programs.

- Reinsurance programs protect insurance companies from serious financial losses due to the cost of **extremely** sick people getting the healthcare services they need. 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.
- Premium savings are realized by enrollees and the federal government through reduced Advance Premium Tax Credit (APTC) subsidy payments. The federal government "passes through" these APTC savings onto states, allowing states to receive the amount of federal funding that would have been paid absent the program.



Benefits of Reinsurance Programs

For reinsurance programs, the Federal Government shares in financial risk to reduce the cost of high-risk enrollees.

Benefits of reinsurance programs:

- Equitable treatment of high-risk residents
- Invisible to the consumer
- Single risk pool maintained
- Shared risk as incentive for carriers to keep costs down
- Lower administrative cost
- Greatest financial certainty of program risk and funding



Other Reinsurance Examples

- **Alaska** submitted their 1332 waiver on January 3, 2017 in order to avoid a 45% premium increase for the 2018 plan year.
 - 20,000 covered lives; Condition based eligibility; highest premiums at \$1,191 for 2018; 1,650 more people expected to enroll
 - \$55M total investment; 2.7% premium tax on all insurers in the state
- **Minnesota** submitted their 1332 waiver on June 15, 2017 and are attempting to reduce individual insurance premiums by 20% for the 2018 plan year.
 - 275,000 covered lives; \$50,000 attachment point & \$250,000 cap; Low uninsured rate at 5.5%; 20,000 more people expected to enroll
 - \$271M total investment; funded by MN's health care access fund (3% premium tax) and general revenue
- **Federal Transitional Reinsurance Program** active during 2014-2016.
 - In its last year, \$90,000 attachment point & \$250,000 cap; 50% coinsurance
 - PMPM Assessment on all health insurers of \$5.25 in '14; \$3.67 in '15; and \$2.25 in '16



Oklahoma's Reinsurance Recommendation

Note: Milliman provided the state with detailed modeling and recommendations on reinsurance funding, to generate discussion and inform waiver development.

- **Maximum** \$350M total reinsurance investment for 2018
 - Federal portion approximately \$250M, or 70/30 share of federal pass through funding
 - *The actual share could differ and is dependent on finalized program details*
- State's portion funded by **up to** \$4.95 PMPM assessment on all health insurers
 - All commercial, comprehensive, major medical insurers; including self-funded, small group, large group, non-retiree state employee, ACA and non-ACA compliant plans
 - All funds invested into reinsurance payments, excluding nominal administrative expenses of the board (<1% of state share)
- Premium reduction of approximately 30%
 - Enrollment gains of up to 21,000 covered lives
 - Returns premium averages to sustainable 2016 rates
 - Targets a 2018 average premium of \$431.25; down from \$590.84 for 2017.



Oklahoma’s 1332 Waiver: Assurances

Scope of Coverage

Oklahoma anticipates that more people will be insured on the individual market with the implementation of the waiver than without it.

Affordability

The OMSP will increase affordability for certain groups in the individual market, both with and without federal premium assistance. The waiver will not decrease cost sharing protections.

Comprehensiveness

The scope of benefits will not be impacted as a result of the waiver.

Deficit Neutrality

The proposed waiver will not increase the federal deficit.

13



Oklahoma’s 1332 Waiver: Impact if Not Granted

- If the OMSP is not implemented, **premiums will continue to rise**, which will in turn reduce enrollment as more individuals are priced out of the market
- Increased premiums also will likely promote **adverse selection**, as the individuals who continue to purchase increasingly expensive coverage will likely be those who utilize a higher number of health care services
- Without a reinsurance program, **the federal government will continue to pay high APTC amounts**; with lower premiums Oklahoma can make coverage accessible to more residents for the same amount of federal dollars absent the waiver

14



Oklahoma’s 1332 Waiver: Description of Waiver

- **Begins 1/1/2018** and continues into future years in order to rapidly reduce premiums for consumers on the individual market
- The state plans to utilize **federal pass through funds**, coupled with amounts generated by an **assessment on health insurers**
- The State is **engaging the expertise of an actuarial firm**, Milliman, who analyzed the population’s utilization characteristics to determine the program parameters (e.g. attachment point, cap, co-insurance)
- Administered and monitored by non-profit **Board of Directors**, including the management of any excess funds
- **\$350 million investment** is targeted to get to 2016 rates/ **30% premium reduction**

15



Oklahoma’s 1332 Waiver: Description of Waiver

Waivers Requested

- The State of Oklahoma seeks to waive Section 1312 (c)(1) for the individual market single risk pool in connection with a Section 1332 waiver to implement a state-operated reinsurance program for 2018 and future years.
- Currently, that requirement at Section 1312(c)(1) requires a health insurance issuer to consider “all enrollees in all health plans...offered by such issuer in the individual market...to be members of a single risk pool.”

16



Oklahoma’s 1332 Waiver: Proposed Reinsurance Parameters

Figure I-1 Oklahoma Department of Health Individual Health Insurance Market OMSP Calendar Year 2018 Reinsurance Parameters	
Parameter	Parameter Value
Attachment Point	\$15,000
Reinsurance Cap	\$400,000
Coinsurance Percentage	90%

Note: These parameters are preliminary and could change as actuarial analysis is finalized.

17

Oklahoma’s 1332 Waiver: Actuarial Analysis

Scope of Coverage

- It is estimated that the OMSP will result in a **lower number of uninsured Oklahomans** each year. Reductions in the uninsured population are estimated to occur primarily in the population with income above 400% of the FPL
- Increases in enrollment are **estimated at 21,000** non-group enrollees
- The majority of enrollment increases resulting from the OMSP are estimated to occur in the **Bronze** metallic tier
- Enrollment in the individual market is estimated to increase **across each age group**

18

Oklahoma’s 1332 Waiver: Actuarial Analysis

Scope of Coverage

- Enrollment in the individual market is estimated to **primarily increase from individuals estimated to have excellent or good health status**. We estimate individuals with a fair or poor health status are less sensitive to premium rate changes, and have a higher likelihood of purchasing health insurance
- We estimate that the **cost of the assessment will be approximately 1%** of an average employer’s total health insurance costs (including employee contributions). We do not estimate the assessment amounts are large enough to result in a material change in the likelihood of employers offering health insurance coverage relative to current law
- By making premium rates more affordable, we estimate the average member **persistence (number of months during the year coverage is maintained/in-force) may improve**, reducing the potential for gaps in insurance coverage

19



Oklahoma’s 1332 Waiver: Actuarial Analysis

Affordability

- For the non-group market, the OMSP is estimated to **reduce premium rates by approximately 30%**
- However, the impact to consumers will vary significantly based on the consumer’s household income and its interaction with the ACA’s premium assistance program
- For the majority of the APTC-eligible population, **there will be no impact on out-of-pocket premium costs for the second-lowest cost Silver plan** (subsidy benchmark plan)
- **A portion of consumers receiving an APTC in the absence of the OMSP will no longer be eligible for the subsidy** after the reinsurance program is implemented due to the premium expense not exceeding the maximum percentage of household income as defined under the ACA. These consumers will realize out-of-pocket premium savings as a result of OMSP
- Finally, for consumers purchasing coverage in the FFM without an APTC or outside the FFM, premium savings will be realized from the OMSP. **Consumers not receiving an APTC under current law will realize the greatest savings from the OMSP**

20



Oklahoma’s 1332 Waiver: Actuarial Analysis

Affordability

- The structure of the ACA’s premium subsidy has resulted in **minimal out-of-pocket premium rate increases** for households purchasing coverage with federal premium assistance in the FFM
- For persons qualifying for APTC that are purchasing Bronze level coverage, it is possible that **out-of-pocket premiums may increase for small number of higher income individuals as a result of OMSP** (variable based on age, etc.). As the OMSP is estimated to reduce the dollar amount of the APTC for qualifying individuals, the available financial assistance that can be applied to the purchase of Bronze level coverage is reduced. Consumers can expect to experience costs very similar to what they experienced in 2016.
- While the OMSP is estimated to materially reduce premiums in 2018 and early years, **premiums are estimated to increase over later years of the projection period**. However, premiums will still be less with the OMSP than without it.

21



Oklahoma’s 1332 Waiver: Economic Analysis

- **Federal APTC Expenditures:** As the OMSP is estimated to reduce the cost of the second lowest cost silver plan (subsidy benchmark plan) during the projection period, the Federal government’s expenditures on APTC for Oklahomans is estimated to be reduced.
- **FFM User Fee:** For states electing to use the FFM, the federal government requires a 3.5% assessment on insurance marketplace coverage to support the operation of the FFM. As the OMSP is estimated to reduce premium rates for non-group coverage, purchased both on and off the marketplace, it is also estimated to reduce the revenue generated by the 3.5% premium assessment on insurance purchased through the FFM.
- **Health Insurer Fee:** Section 9010 of the ACA mandates a national assessment on health insurers of \$14.3 billion in 2018. The OMSP has no impact on estimated HIF revenue in 2018.

22



Oklahoma’s 1332 Waiver: Economic Analysis

Shared Responsibility Payments

- Exemption population: Because Oklahoma has not expanded Medicaid under the ACA, uninsured households with income below 138% FPL are automatically exempted from the individual mandate. Additionally, Oklahomans belonging to a Federally-recognized Indian Tribe are exempted from the individual mandate. These exemptions are not impacted by the OMSP.
- Households with income between 139% and 400% FPL eligible for federal premium assistance: Persons in this income cohort are, and will continue to, be subject to the individual mandate under the OMSP (subject to other available exemptions). Therefore, we estimate any changes in health insurance coverage at these income levels will have a direct impact on revenue associated with shared responsibility payments.
- Households with income above 400% FPL: Households with income above 400% FPL are subject to the individual mandate unless the cost of Bronze coverage is deemed unaffordable by the ACA (in excess of 8.05% of household income in 2018). By virtue of reducing the cost of bronze level coverage, the OMSP will reduce the income level at which households are exempted from the individual mandate due to the affordability provision.

23

HB 2406 Oklahoma Individual Health Insurance Market Stabilization Act

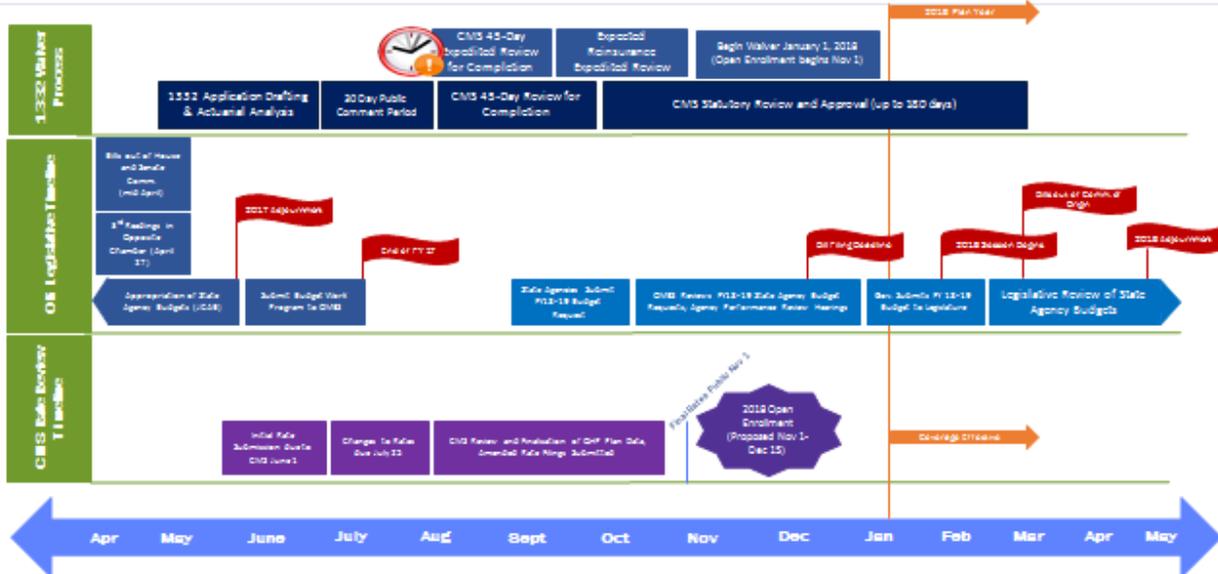
- **Language** added to Title 36
- **Creates** the Oklahoma Individual Health Insurance Market Stabilization Act
- **Establishes** the Oklahoma Individual Health Insurance Market Stabilization Program
- **Purpose**: The act shall provide for a Board to make payments to health insurance plans with respect to claims for eligible people for the purpose of lowering premiums for health insurance coverage offered in the individual market. Market stabilization activities shall include establishment of a high risk pool, reinsurance, hybrid programs or any combination thereof.

Board of Directors

The OK Insurance Commissioner appoints a nine member **Board of Directors:**

- two representatives of Oklahoma domestic insurance companies,
- one member from the general public who is a member of the class of individuals to which the program would apply,
- one member from the general public who is not associated with the medical profession, a hospital or an insurer,
- one representative of a health maintenance organization,
- one member from a health-related profession,
- one representative of reinsurers, and
- two representatives from the providers of Oklahoma individual plans

1332 WAIVER, STATE, AND CMS RATE REVIEW TIMELINES



1332 Waiver Development Next Steps

- Monitor federal developments regarding ACA amendments, CSR decision, etc.
- Finalize impact analysis assessment by consultants
- Proceed with waiver development, post updates online
- Determination of resulting premium impacts, filing revised rates
- Continued, regular dialogue with federal officials
- Hold tribal consultation and public comment period (7/14 – 8/13)
- Submit waiver (Mid-August)
- OID to pursue change to Effective Rate Review state



Comments and Questions

1332 State Innovation Waiver:

https://www.ok.gov/health2/documents/OK_1332%20Waiver_DraftForPublicComment_7.14.17.pdf

Also available on the OSDH homepage: <https://www.ok.gov/health/>

Submit written comments to: 1332waiver@health.ok.gov or

Buffy Heater, HHS Strategy Officer

Commissioner's Office, Oklahoma State Department of Health

1000 NE 10th Street

OKC, OK 73117



Additional/Amended Slides for August 3, 2017 Public Hearing

Public Hearing: 1332 Waiver For Reinsurance Program Agenda

Tulsa City-County Library- Central Library Downtown
 400 Civic Center Tulsa, OK
 August 3, 2017
 1:00 pm. – 2:00 pm.

Section	Time	Presenter
Welcome & Opening Remarks	1:00 5 min	Julie Cox-Kain, Deputy Secretary, Oklahoma Health and Human Services
History of the 1332 Waiver and Concept Paper	1:05 10 min	Buffy Heater, HHS Strategy Officer
Overview and Discussion: State-Based Reinsurance Programs and Oklahoma's 1332 Waiver Application	1:15 30 min	Attendees, Buffy Heater
Overview and Discussion: 1332 Waiver Timeline and Next Steps	1:45 10 min	Attendees, Julie Cox-Kain
Closing Remarks and Adjournment	1:55 5 min	Julie Cox-Kain

Oklahoma's Reinsurance Recommendation – 8/2/17 update

Note: Milliman provided the state with detailed modeling and recommendations on reinsurance funding, to generate discussion and inform waiver development.

- **Range of \$300M-\$350M** total reinsurance investment for 2018
 - Federal portion approximately \$291M, or 90/10 share of federal pass through funding
 - *The actual share could differ and is dependent on finalized program details*
- State's portion funded by **range of \$1.50-\$4.50 pmpm** assessment on all health insurers
 - All commercial, comprehensive, major medical insurers; including self-funded, small group, large group, non-retiree state employee, ACA and non-ACA compliant plans
 - All funds invested into reinsurance payments, excluding nominal administrative expenses of the board (<1% of state share)
- Premium reduction of approximately **38%**
 - Enrollment gains of up to **25,000** covered lives
 - Returns premium averages to sustainable 2016 rates
 - Targets a 2018 average premium of \$431.25; down from \$590.84 for 2017.

Updated Recommendations Based on New Information Received 8/2/2017

Additional data recently received by the actuarial contractor has provided more refined information about the program.

Key Updates:

- Range of \$300-\$350M target for reinsurance fund
- Estimated 90% Federal share via pass through funds
- Range of \$1.50-\$4.50 PMPM assessment
- Approximately 38% premium reduction for 2018
- Approximately 25,000 new enrollees
- 80% coinsurance, \$15k attachment point, \$400k cap

**Note: Finalized numbers are dependent upon amended rate filings received for the individual market.*

13

Oklahoma’s 1332 Waiver: Proposed Reinsurance Parameters

Figure I-1 Oklahoma Department of Health Individual Health Insurance Market OMSP Calendar Year 2018 Reinsurance Parameters	
Parameter	Parameter Value
Attachment Point	\$15,000
Reinsurance Cap	\$400,000
Coinsurance Percentage	80%

Note: Coinsurance updated 8/2/17. These parameters could change as actuarial analysis is finalized.

14

Appendix K: Issues Raised during Public Notice and Public Comment Process

Oklahoma held two formal public hearings, one in Oklahoma City and one in Tulsa. The notices of these meetings, along with instructions for submitting comments through mail or e-mail, were posted on the Oklahoma State Department of Health's website at:

[https://www.ok.gov/health/Organization/Center for Health Innovation and Effectiveness/1332 State Innovation Waiver /index.html](https://www.ok.gov/health/Organization/Center%20for%20Health%20Innovation%20and%20Effectiveness/1332%20State%20Innovation%20Waiver/_index.html)

July 31, 2017: Oklahoma City

- Commenter had wondered why a state board was appointed with 7 insurance-related members with no parameters on amounts that could be charged. Additionally the commenter asked why there were not limits on parameters and why the program was left so unstructured. In Alaska and Minnesota, there were attachment points and caps on their plans. Questioner raised concern on risk adjustment with \$15,000 attachment point and 90% coinsurance.
- The nature of the per-person per month assessment fee on the public was described as a challenge for multi-household families and small businesses.
- The questioner's understanding was that the state was seeking authorization from CMS for the waiver. Questioner asked how much money would be redirected from Medicare and Medicaid and how much would be going to set-up the waiver. Consumer was currently satisfied with their Medicare plans, and had concerns about any changes to the current program.

Response: No dollars will come from Medicaid and none from Medicare. While the same agency (CMS) and CMS gives authority to this is because the 1332 Waiver does not have the authority to alter these programs, it only has the ability to changes for the Federal Marketplace available on Healthcare.gov. The federal government offers dollars to buy insurance on this Marketplace, only for qualifying individuals. State program is saving money for the federal government and then receiving the savings to help stabilize the insurance market.

- How many additional companies are signing up for offering plans on the FFM in 2018? Commenter expressed concern about benefits of the program being focused on BCBS.

Response: None have yet offered or expressed interest for 2018.

- Will comments be made public or published, including those submitted online?

Response: All comments will be summarized and included in the waiver itself. If a specific question is asked, a response will be provided.

- If Oklahoma had better participation from younger, healthier people this program be necessary? Would a higher proportion, and greater efforts to enroll these consumers help the state?

Response: Yes – there probably would be an impact with more young, healthy lives covered on the market. The degree to which we would need an increase in this population is unknown.

- If/when healthcare laws at the federal level are changed, would this waiver be affected? Could this program be cancelled if ACA goes away?

Response: The waiver is dependent on there being federal APTC savings, so federal changes could impact the project.

- Questioner noted Alaska and Minnesota are using a premium tax on all insurers. What was the thought process for our method of assessing fees on only health plans in the waiver, and how would we explain the rationale for fees assessed on non-FFM participating health plans?

Response: One of the goals of the program was to do it with low administrative cost, so the state looked at what's been successful in the past to move things forward. Oklahoma has experienced previous high-risk pools. The methodology of the plan in our state was based on how this had previously occurred.

- Questioner had noted that the federal law allows for APTC funds, and the state is anticipating savings to deliver reduced premiums. The plan states that calculations of federal pass through dollars would be based on a lower required amount, if premiums dropped as projected. In the event that the federal government caps or reduces APTC payments, who would be then responsible for the payments? The concern of the questioner is that if there were changes in how the federal government decides to fund these payments, what assurances are there for limiting the financial liability of the assessed insurance plans to make up the differences? This also would relate to the small businesses which self-fund and/or contract with insurers. Would the premium reductions take effect in 2018 or 2019?

Response: There will be forthcoming actuarial analysis from Milliman, as soon as possible. The online website will post all changes of the current document, with 'pending' sections removed. While BCBS has submitted premiums for plan year, in the event of approval and implementation of a 1332 waiver, participating FFM insurers would have to re-file rates which would reflect changes. Upon approval, the federal government will notify state of the finite amount of federal pass through dollars. The state determines the total reinsurance funding amount, which will not be changed by the federal government. The premium reductions will take effect in plan year 2018.

- Does the board of the authority to change the parameters of the program?

Response: Yes, the board has authority.

- Did the House and Senate both vote on this bill?

Response: Yes, and signed by the Governor.

- How are we saving the federal government money?

Response: As premiums that are offered on the FFM go up and down, the APTCs also go up or down. As the state assesses fees and is able to offer reinsurance, participating insurers are able to assume greater market certainty and reduced risk. With the reduced risk, they then would be able to lower the premium amounts on the FFM. Lower premium amounts would be linked to a lower total cost to the federal government for APTCs.

- The presentation mentioned churn and other issues with consistency and length of time customers are enrolled. Will there be aspects of the plan to improve churn?

Response: There is not yet any part of the current submission addressing churn. But there would be potential for pursuing modifications in the future (2019 and beyond) to address this issue, some of which are outlined in the Concept Paper. The federal government is already taking steps to close some of the loopholes to increase persistency in the marketplace.

- Questioner noted that decreased premiums projected would benefit those above 400% FPL in the individual market. Are steps being taken to provide coverage to those who are uninsured because of not expanding Medicaid?

Response: Within the Concept Paper, there is a proposal to shift the subsidy eligibility to individuals within 0-100% of FPL. This proposal could be included in a future waiver.

- If 70% of those who meet eligibility are not enrolling, how can we encourage them to begin to make decisions on selection of plans and understand what is out there for them?

Response: OSDH partnered with EVOLVE to do a consumer survey and focus group. The results provide some insights into the concerns and barriers for consumers on selecting and understanding health plans. Many of these were related to plan complexity and uncertainty of the value/cost of insurance. With this information, more planning can be done to reduce the complexity of insurance products sold on the market. The Concept Paper includes proposals to address this concern.

- Are any of these tax credits front loaded?

Response: Premium tax credits for those that meet eligibility are advanceable and paid to the insurance carrier.

- Commenter had a concern that health care and health insurance are two separate issues. For example, health insurance has its own administrative complexity, which might potentially divert resources from needy people. Commenter would like the legislature to look at health care costs and ways to improve the health care system.

August 3, 2017: Tulsa

- How does the state get federal funding-how is it calculated?

Response: As premiums come down, there is a reduced responsibility by the federal government in APTCs. The federal government calculates what they would have paid with and without the waiver, and the difference is what is received as pass through funding. Negotiations happen in the fourth quarter. The amount is set and doesn't change for the year, and is paid quarterly.

- Explain the 38% reduction – is it compared to 2017 or 2018 rates?

Response: It's compared to 2018 filed rates.

- An attachment point of \$15,000 is rather low. Is that to attract more carriers and reduce risk?

Response: Yes, it is robust. We're hoping that signals to the market that we are dedicated to mitigating risk and draws new insurers to the pool.

- The federal reinsurance program had a timeline – does this program?

Response: The 1332 waiver is approved for 5 years. The state is proposing a 5 year program, with subsequent decisions left to Board of Directors.

- Some carriers did not receive payment from federal government for their program. What safeguards are there for this program?

Response: The federal government has confirmed that it will provide a certain amount that is determined before the waiver and that they will pay the funding quarterly.

- Will this PowerPoint presentation also be on the website?

Response: Yes.

- The assessment is in a broad range – how will it actually be determined, and is it set for the full 5 year period or does it fluctuate?

Response: When we see the amended rate filing, we can determine the actual assessment amount based on the state and federal share. We are proposing that the parameters be set on an annual basis, and this is monitored by the Board. The parameters could change, but what is presented is for 2018.

- Rates are already filed without reinsurance. We seem to have a very thin window for 2018 - is it going to be possible? Is there anything that would prevent us from rolling out a 90% reinsurance program?

Response: The federal government requires a state investment so it can't be fully funded by the federal government. We as a state can determine how big the reinsurance program should be, but we cannot forgo the state share. We are in a very short window. August 1st the rates became public for 2018, but they do not assume a reinsurance program. We are in conversations with OID and CCIIO about timing. We are looking at waiver submission in mid-August in order to give the federal government time to upload rates for the November 1st open enrollment period. On or before August 15th is when we would like to see amended rates from BCBS. We are still discussing options but everyone is committed to getting it completed for 2018.

- If rates increased by 75% from 2016 to 2017, shouldn't we need a premium reduction larger than 38%?

Response: We are trying to get the market back to a sustainable market. In 2016 insurers operated at a loss. We estimate \$300-350 million is needed to get to a premium rate for 2018 that would be on par with 2016 sustainable rates.

- Are there any guarantees or requirements for the carriers to lower their rates for 2018?

Response: None from the state, but there are medical loss ratio requirements that regulate rates.

- When you did the modeling for enrollment, did you look at deductibles and out-of-pocket costs as a factor?

Response: The primary factor for enrollment projections is based on those who exited the market – we are hopeful that a significant percentage will re-enroll in the market with lowered premiums. Increased enrollment is primarily being drawn by reduced premiums and not out-of-pocket costs.

- Insurance carriers can't reduce prices unless providers do. Where are they?

Response: We do have multiple representatives of providers on the Task Force, as well as tribal partners. We also looked at surveys and workgroups that included their input. We do acknowledge that we have to bend the health care cost curve. This is one solution to stabilize the market. If we lose our one carrier, we would likely have many uninsured individuals. We are looking at other ways to improve health outcomes.

Public Comment via E-mail/Mail

- Commenter expressed desire for speech-language pathology services to be listed within Appendix M of the waiver for habilitative and rehabilitative services.

Response: The waiver does not make any changes to benefits. We will include this clarification for habilitative and rehabilitative services within Appendix M.

- Commenter expressed desire for the implementation of the reinsurance fund and stated that a return to 2016 rates would be very beneficial for many Oklahomans.

- Commenter asked if the 1332 Waiver replaces the existing 1115 Waiver.

Response: No, the 1332 waiver is for ACA regulations, not Medicaid.

- Commenter asked if the assessment on health plans also applies to the federal employee health benefit plans.

Response: The assessment does not apply to the federal employee health benefit plan, but does apply to the state employee plan through EGID.

- Commenter expressed concern about the State's legal authority to collect assessments on self-funded plans and sovereign tribal nations, as well as administration burden for tribal entities.

Appendix L: Tribal Consultation and Issues Raised

Oklahoma held a formal Tribal Consultation on July 24, 2017 to the state's Federally-Recognized Tribal stakeholders. Tribal Listening Sessions were also held on the dates of June 22, 2017 and July 10, 2017. The notices of these meetings were posted on the Oklahoma State Department of Health's website at: https://www.ok.gov/health/Organization/Partnerships_for_Health_Improvement/Office_of_Tribal_Liaison/1332_Waiver:_Tribal_Listening_Session/index.html.

Tribal representatives asked questions and gave feedback both during and after the presentations. The presentations were presented by the Deputy Secretary of Oklahoma Health and Human Services as well as the Health and Human Services Project Lead.

Tribal participant asked questions and offered feedback during the Listening Sessions, and were responded to during each public forum. They included:

- One commenter asked if there will be only one 1332 waiver, or will more follow.

Response: A successive series of waivers will be submitted.

- One commenter asked if the state gets approval now, will it limit additional waiver submittals in the future.

Response: That it is to be determined. For reinsurance programs, they are approving waivers on a 5 year basis. The approval should cover a 5 year period. If there are substantial federal changes, it will be up to the federal government to determine the impact.

- One commenter asked if reinsurance is funded largely through APTC pass-through dollars, would changes at the federal level impact APTCs in the future.

Response: Yes, there is some uncertainty there. It could be that the mechanism of 1332 stays same, but any changes to APTCs may impact the rate at which the state can collect those dollars. We would have to evaluate it when and if it occurs.

- One commenter stated that other state reinsurance examples are very recent, and wanted to know if there are examples with longer operating histories.

Response: Alaska and Minnesota are very recent. However, reinsurance as a core function and as an element of health insurance has been around many years. Health insurance companies today, to mitigate losses, will purchase reinsurance policies from companies offering them.

- One commenter stated the importance of allowing consumers to keep existing/consistent coverage under 1332 and not being required to reapply for a different plan.

Response: The amount of federal pass-through funding is contingent upon a decrease in premiums. Plans have to have a certain actuarial value, and specific conditions were made. From a consumer perspective it should be a robust plan.

- One commenter was concerned about up front funding for the reinsurance program, asking what would happen if the numbers do not play out according to plan.

Response: In the federal transitional reinsurance program (2014 to 2016), the payments back to insurance plans came back a year later from the plan year they were calculated on. For insurance plans that have such huge capital, they were able to do it regardless of the delay. For pass through payments, we would receive them on a quarterly basis. The year proceeding the plan year, the calculation is made and the federal government alerts the state of the total amount being passed through. That number is then divided by four and payment is remitted to the state quarterly. Oklahoma has an option as to how we want to pay plans, such as once a year, twice a year, four times a year, etc. and we will need to discuss and decide.

- One commenter asked if the federal government is predicting delays due to the influx of waiver submittals.

Response: That it is a concern but we have not heard back from federal partners if they are expecting any delays or if they are ramping up on staffing.

- One commenter asked if premium decreases with reinsurance would be enough to offset the drastic rise in healthcare costs.

Response: When we prepared the concept paper, we had focus groups and asked “what is affordable?” The price point for uninsured was about \$100 to \$150 per month for their family affordability. Today’s premiums are in excess of \$400. We are trying to get to premium level similar to a 2016 rate, but there will continue to be a need for tax credits for families. This is just one tool to use to provide relief to this population.

- One commenter asked if Oklahoma can offer subsidies for low income people utilizing high risk pools.

Response: This is addressed in the concept paper and we basically have two options: moving the subsidy down to 0 – 300%, or we take that 300%-400% tax credit and put it to 0-100%. It impacts enrollment dramatically. Timing is one concern: The challenge with changing subsidies, if you do that, you have to come off the federal exchange platform. We do not have time to build a mechanism to do this. Modeling indicates while we get more enrollments, it would cost government, and we have a guardrail that we cannot increase the federal deficit. Budget neutrality in 1332 is significant if we shift subsidies down. It is not authorized in the ACA currently, and we need congress to authorize us to shift subsidies.

- Several commenters inquired how reinsurance could affect tribal health and premium sponsorship programs.

Response: Operationally, we need to make sure tribal sponsorship programs work if other plans join the exchange.

- Several commenters asked about the 1115 waiver and what impacts the waiver could have to that initiative.

Response: They do not believe the administration has been in place long enough to see if we could reconvene talks about 1115, and it can be discussed with the governor’s office.

Tribal participants asked questions and offered feedback during the Listening Consultation, and were responded to during the public forum. They included:

- One commenter asked if a reduction in premium impact is only for plans on the market place.

Response: It is targeted towards the Marketplace plans. Additionally, on and off exchange policies are following rules under Affordable Care Act and will experience premium reductions. The excluded plans are the grandfathered or transitional plans purchased prior to 2014 that a member has continued to maintain and covers about 14,000 people in state. The state anticipates significant premium reductions for included plans.

- One commenter stated that the per-month per-member fee would cost approximately \$60 per year, per employee, and would not give relief to their tribal entity because it is self-insured.

Response: The 1% fee is broad in order to be financially effective, and amounts to about \$60 per member per year.

- One commenter stated that their tribe employs approximately 20,000 people, and this fee will be a significant impact for tribal employers. Is the proposed \$4.95 per-member per-month fee expected to be static or will it fluctuate and adjust down?

Response: It will be at the discretion of the Board of Directors for the program.

- One commenter asked what additional federal funds can be used for and could they offset the costs of the reinsurance program.

Response: Uncertainty persists around what federal funds may become available to support reinsurance. HB 2406 authorizes us to accept federal grants or apply for 1332 waivers.

- One commenter stated that should the reduced value of Advanced Premium Tax Credits (APTCs) be realized by federal policy changes, it would affect the amount of federal pass through dollars the state receives. How would Reinsurance be funded in this case?

Response: We have to go forward with the path available to us now. We will have to be flexible in the future and realize that this is a fluid program based upon federal legislation.

- One commenter reiterated the significant impact for tribes of the per-member per-month fee. This could mean an additional \$500,000 for tribes each year. Will the actuary do more analysis regarding the cost increase on Bronze level plans?

Response: This could be analyzed further.

- One commenter wanted clarification about the Board of Directors. Are the insurer and HMO representatives separate? Are there separate companies that provide reinsurance?

Response: Two insurer representatives and one health maintenance organization representative are separate. There is a distinction in that insurance companies often use reinsurance companies to mitigate risk on their own. Yes, there are separate companies that do reinsurance.

- One commenter wanted clarification regarding language in the bill: “no person who is currently receiving or entitled to receive health care benefits under any other federal or state program” is eligible for coverage under this program. Tribal health systems receive federal funding and might fall into this category.

Response: It was not interpreted that way, but will note this as a possible concern.

- One commenter asked if it is possible to legislatively dictate that excess revenue from insurance companies be used to lower individual assessments instead of leaving it to the discretion of the Board.

Response: It will be at the discretion of the Board that will receive it, as they have the authority to adjust the assessment. House Bill 2406 would need to be amended in order to mandate how excess revenue would be handled.

- One commenter asked how quickly new pricing for 2018 could be implemented.

Response: There are continuing conversations regarding filing amended rates assuming reinsurance.

- One commenter reiterated that the per-member per-month fee increases are significant for tribes. As premiums continue to rise the fees increase exponentially. The Board members will be very influential. In order to keep premiums low, fees will have to rise over time. How do we keep from having another mass exodus from the Marketplace?

Response: We are trying to solve three issues: increase enrollment, increase Marketplace competition, and reduce premiums. We hope to reduce premiums and other things in the Concept Paper. There are pros and cons to all choices that have to be made. If you make one change it impacts everything else, such as age ratings. Increasing rates for older citizens will result from decreasing rates for younger ones. Reducing some of the complexity could also reduce some of the premiums.

- One commenter asked if the waiver application can include the possibility of grants awarded as a potential funding source if there were to be an increase of federal funding.

Response: We have not included any caveats regarding future possible federal changes but we can ask about this caveat.

- One responder asked how church will be handled on the Marketplace, and mentioned that tribal members enjoy this special exemption.

Response: This is not subject to waiver and we have not said anything about changing exemptions or special provisions for tribes in the Concept Paper. The waiver will not change those special provisions for tribal members. We are also hopeful that premium decreases may increase enrollment persistency.

- One commenter inquired about new administrative expenses required to oversee this program.

Response: It is a non-profit organization and the board members have other full time jobs. There is no separate facility, and the Oklahoma Insurance Department is tasked with providing administrative support. There is an estimated administrative expense of less than 1% of the state portion of the reinsurance fund, which would amount to a maximum of approximately \$1.1M.

- One commenter asked if staff be hired.

Response: Yes, the board will have the authority to hire an Executive Director.

- One commenter asked if the state health insurance plan will pay the per-member per-month fee.

Response: Yes, the state of Oklahoma is self-insured so these plans are also subject to the fee.

Appendix M: State and Federally Mandated Benefits

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 May include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.	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 May include physical and occupational therapy, speech-language pathology, and other services for people with disabilities.	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			

Appendix N: Waivable Sections under §1332

Qualified Health Plans (QHPs) and Essential Health Benefits (EHBs)

- Section 1301: Definition of QHPs
- Section 1302: EHB requirements, including
 - Identifying EHB
 - Annual limitations on cost-sharing
 - Annual limitations on deductibles for employer-sponsored plans
 - Levels of coverage as currently defined by metal levels (platinum, gold, silver, bronze)
 - Catastrophic plans
 - Child-only plans
- Section 1303: Special rules related to abortion services
- Section 1304: Definitions related to
 - Group and individual markets
 - Large and small employers and rules related to determining the size of an employer

Health Insurance Exchanges

- Section 1311: Affordable health plan choices via establishing exchanges
- Section 1312: Consumer choice
 - Employee choice
 - Single risk pool
 - Markets outside of exchanges
 - Individual choice to enroll in a QHP or participate in the exchange
 - Limitations on access to exchanges to citizens and lawful residents
 - Ability of exchanges to offer coverage to large employers starting in 2017
- Section 1313: Financial integrity expectations that exchanges will keep accurate accounts of receipts and expenditures

Premium Tax Credits and Reduced Cost-Sharing

- Section 1402: Cost-sharing reductions via enrollment in QHPs
- Section 36B of the IRS Code: Refundable credits/premium assistance for coverage in a QHP

Individual and Employer Responsibility Requirements

- Section 4980H of the IRS Code: Shared responsibility for employee health insurance
 - Penalties for large employers (more than 100 employees) if not providing coverage
 - Penalties for large employers if coverage offered but employees still access premium tax credits or cost sharing
 - Definition of Full Time Employee ("FTE") as at least 30 hours per week employment
 - Exemption for certain employees: FTEs who work seasonally or 120 or fewer days/year
 - Definition of seasonal workers
 - Rules for determining employer size
- Section 5000A of the IRS Code: Requirement to maintain minimum coverage (Section 1501)
 - Penalties
 - Exemptions
 - Definition of minimum essential coverage

Appendix O: Section by Section Consideration

Establishment of Qualified Health Plans

Section 1301: Definition of Qualified Health Plans	Oklahoma Proposal
<i>The definition of “Qualified Health Plan” including providing EHB, and offering plans conforming to metal levels with the inclusion of at least silver and gold</i>	Oklahoma proposes to retain these provisions.
<i>Inclusion of Co-Op and Multi-State Plans</i>	Oklahoma proposes to retain these provisions.
<i>Treatment of Qualified Direct Primary Care Medical Home Plans</i>	Oklahoma proposes to retain these provisions.
<i>Exceptions for Self-Insured Plans and MEWAS (multiple employer welfare arrangements)</i>	Oklahoma proposes to retain these provisions.

Section 1302: EHB Requirements	Oklahoma Proposal
<i>Defines EHB</i>	Oklahoma proposes to retain these provisions.
<i>Annual limitations on costsharing</i>	Oklahoma proposes to retain these provisions.
<i>Annual limitations on deductibles for employer sponsored plans</i>	Oklahoma proposes to retain these provisions.
<i>Definition of metal levels by actuarial value</i>	Oklahoma proposes to retain these provisions.
<i>Availability of catastrophic plans</i>	Oklahoma proposes to retain these provisions.
<i>Availability of child-only plans</i>	Oklahoma proposes to retain these provisions.
<i>Defines payment to federally qualified health centers</i>	Oklahoma proposes to retain these provisions.

Section 1303: Special Rules Related to Abortion Services	Oklahoma Proposal
<i>Details special rules related to abortion services</i>	Oklahoma proposes to retain these provisions.

Section 1304: Definitions of Markets and Rules for Large and Small Employers	Oklahoma Proposal
<i>Specifies rules for aggregation treatment of employers, employers not in existence in preceding year, and predecessor employers</i>	Oklahoma proposes to retain these provisions.
<i>Defines when a “growing” small employer that purchased employee coverage through SHOP may continue to do</i>	Oklahoma proposes to retain these provisions.

Section 1311: Providing Consumers a Health Insurance Exchange	Oklahoma Proposal
<i>Requires establishment of an American Health Benefit Exchange, and details responsibilities of the exchange</i>	Oklahoma proposes to retain these provisions.
<i>Provides for the establishment of a SHOP exchange</i>	Oklahoma proposes to retain these provisions.
<i>Specifies which entities are eligible to carry out responsibilities of the Exchange</i>	Oklahoma proposes to retain these provisions.

Section 1312: Consumer Choice	Oklahoma Proposal
<i>Details provisions for consumer choice among QHPs through an exchange</i>	Oklahoma proposes to retain these provisions.
<i>Establishes that all enrollees in the individual market are in a single risk pool</i>	Oklahoma proposes to waive this provision
<i>Establishes that all enrollees in the small group market are in a single risk pool</i>	Oklahoma proposes to retain these provisions.
<i>Allows states to merge individual and small group insurance in a single risk pool if the state deems it appropriate</i>	Oklahoma proposes to retain these provisions.
<i>Prevents state law from requiring grandfathered plans to be in the individual or small group risk pool</i>	Oklahoma proposes to retain these provisions.
<i>Allows health issuers to offer coverage outside an exchange, and allows individuals and qualified employers to purchase coverage outside an exchange</i>	Oklahoma proposes to retain these provisions.
<i>Maintains state control of plans outside of the exchange</i>	Oklahoma proposes to retain these provisions.
<i>Provides choice to qualified individuals as to whether or not to enroll via an exchange and which plan to choose</i>	Oklahoma proposes to retain these provisions.
<i>Describes health plan choices for members of Congress and Congressional staff</i>	Oklahoma proposes to retain these provisions.
<i>Ensures that individuals who cancel enrollment on the exchange in favor of employer coverage will not be penalized</i>	Oklahoma proposes to retain these provisions.
<i>Allows enrollment through agents and brokers</i>	Oklahoma proposes to retain these provisions.
<i>Limits enrollment through an exchange to citizens and lawful residents</i>	Oklahoma proposes to retain these provisions.
<i>Excludes incarcerated individuals</i>	Oklahoma proposes to retain these provisions.
<i>Allows coverage via the exchange for the large group market</i>	Oklahoma proposes to retain these provisions.
<i>Provides that access to coverage through an</i>	Oklahoma proposes to retain these provisions.

<i>exchange may be denied to those who are not lawful residents for the entire enrollment period</i>	
--	--

Section 1313: Financial Integrity	Oklahoma Proposal
<i>Details financial management and protections against fraud and abuse for an exchange</i>	Oklahoma proposes to retain these provisions.

Premium Tax Credits and Reduced Cost-Sharing

Sections 1402/36B – Premium Tax Credits and Cost Sharing	Oklahoma Proposal
<i>Details provisions and eligibility for reductions in cost-sharing and out-of-pocket costs for individuals who enroll in a QHP</i>	Oklahoma proposes to retain these provisions.

Individual and Employer Responsibility Requirements

IRC Sections 4980H and 5000A: Individual and Employer Responsibility	Oklahoma Proposal
<i>Defines and details requirements for offering health insurance coverage by large employers and responsibilities of employees for enrolling</i>	Oklahoma proposes to retain these provisions.

Appendix P: Letters of Support



August 3, 2017

The Honorable Steven Mnuchin, Secretary
United States Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

The Honorable Thomas E. Price, M.D., Secretary
United States Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Oklahoma Section 1332 State Innovation Waiver

Dear Secretary Mnuchin and Secretary Price:

The Oklahoma State Medical Association (OSMA) offers its support of the Oklahoma Section 1332 State Innovation Waiver application. We believe giving Oklahoma the option of developing its own unique reinsurance program that is affordable and specific to our citizens needs is the best option for our state.

As members of the Oklahoma 1332 Task Force, we were joined by representatives from the state that included consumer advocates, businesses, Tribal nations, health plans, healthcare providers, and health insurance brokers. We met nine times between August 2016 and June 2017 to collaborate and recommend improvements to Oklahoma's Individual Health Insurance Market. We were provided with a great deal of data and analysis regarding the best solutions for health care in our state. This first 1332 reinsurance waiver application being submitted by Oklahoma represents months of hard work with the best of the interest of the state in mind. We are hopeful for a successful, expedited review and approval by the federal government.

We appreciate the opportunity to express our support for the Oklahoma Section 1332 State Innovation Waiver and for all it offers the citizens of this state. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "K. E. Taubman MD". The signature is fluid and cursive, with the initials "K. E." clearly visible at the beginning.

Kevin Taubman, MD
President



OKLAHOMA DEPARTMENT OF HUMAN SERVICES
Sequoyah Memorial Office Building

P.O. BOX 25352
Oklahoma City, OK 73125-0352
(405) 521-3646 · www.okdhs.org

Ed Lake, Director

July 20, 2017



The Honorable Steven Mnuchin, Secretary
United States Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

The Honorable Thomas E. Price, M.D., Secretary
United States Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Oklahoma Section 1332 State Innovation Waiver

Dear Secretary Mnuchin and Secretary Price:

The Oklahoma Department of Human Services (DHS) offers its support to the Oklahoma Section 1332 State Innovation Waiver application. Many DHS service recipients who are ineligible for Medicaid are nevertheless experiencing difficulty accessing affordable, quality and sustainable health care coverage. With only one insurer in the market for 2017, we believe that providing Oklahoma with the option to develop an affordable reinsurance program is the best first step to improved insurance availability and affordability.

As a member of the Oklahoma 1332 Task Force, DHS assisted in conducting research and providing content on the potential impact that innovation waivers might have to improve the health and health care quality of our service recipients. We met many times between August 2016 and June 2017, to collaborate and recommend improvements to Oklahoma's Individual Health Insurance Market. The task force engaged in extensive data analysis with the goal of identifying the best solutions for health care in Oklahoma. We believe this first 1332 reinsurance waiver application does so. We support an expedited review and approval.

We appreciate the opportunity to express our support for the Oklahoma Section 1332 State Innovation Waiver and appreciate your consideration.

Sincerely,

A handwritten signature in black ink that reads "Ed Lake".

Ed Lake, Director
Oklahoma Department of Human Services

EL:dm

cc: HHS Cabinet Secretary Terry L. Cline, Ph.D.
