



Mary Fallin
Office of the Governor
State of Oklahoma

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The Honorable Kevin McCarthy
Majority Leader
United States House of Representatives
H-107, U.S. Capitol Building
Washington D.C., 20515

Dear Majority Leader McCarthy:

Thank you for the opportunity to provide feedback and recommendations as Congress considers necessary repeal and replacement of major provisions of the Affordable Care Act (ACA). In Oklahoma, the implementation of the ACA, as currently written, has decreased competition among insurance providers, dramatically increased premiums for individuals, and created unnecessary regulations for businesses. The one size fits all policy framework stemming from the ACA has undeniably provided fewer consumer choices and less affordability in our health insurance marketplace.

In response to the challenges our health insurance market has faced, the Oklahoma legislature passed SB1386 authorizing the exploration of a 1332 State Innovation Waiver. With staff support from the Oklahoma Insurance Department and Health and Human Services Cabinet, a multi-sectoral task force has been convening for six months to create a pathway to a more sustainable health insurance marketplace. The 1332 Task Force, comprised of private businesses, insurance providers, insurance brokers, navigators, healthcare providers, and tribal governments, has assisted the state in developing the following global tenets for health reform:

- Healthcare insurance and provision of services is local and states should be given the flexibility to determine what will best meet the needs of their populace. This includes returning health insurance regulatory authority to state insurance regulators and providing flexibility in federal funding for healthcare.
- Equal emphasis must be placed on improving health outcomes and controlling costs as we work together to reduce the number of uninsured. The current trajectory of healthcare expenditures is unsustainable and the system, as it exists today, is not yielding necessary health improvements.
- Reducing unnecessary administrative burden on businesses, individuals, insurance carriers, and state government can dramatically reduce complexity, overhead, administrative costs, and create a more sustainable system.
- Continuation of policies that have a track record of success - including coverage for individuals with pre-existing conditions, dependent insurance coverage of children up to age 26, and no-cost access to preventive services - should be considered in any replacement proposal.
- The rapid development and implementation of state directed health reforms must be balanced with appropriate state developed risk mitigation and insurance pool stabilization policies.

More detailed information on the work of Oklahoma's 1332 Task Force, including meeting agendas and materials, and a draft of Oklahoma's 1332 State Innovation Waiver concept paper can be found at the following website:

Oklahoma intends to submit the concept paper after public comment and legislative review in February 2017.

With regard to the specific questions you have posed, the following are the responses from the State of Oklahoma:

1. What changes should Congress consider to grant more flexibility to states to provide insurance options that expand choices and lower premiums?
 - Encourage the new administration to immediately repeal sub-regulatory guidance for 1332 State Innovation Waivers.
 - Return regulatory authority to states through permissive Congressional language so they may determine how to best meet their unique circumstances. For example, setting maximum age ratios for rating purposes and allowing the state to establish their most efficient ratio.
 - Provide flexible federal funding streams that acknowledge each of the insurance pools (Medicaid, marketplace plans, etc.) are receiving federal and/or state funding support and allowing pooling or integration of covered lives in a way that is rational. For example, the Medicaid CHIP maintenance of effort prevents states from integrating healthy covered lives into the marketplace as an attempt to help stabilize the pool. As we move forward and create quality insurance programs in the marketplace that can protect these vulnerable populations, pooling them into sustainable insurance markets can help stabilize premiums and return children into the same insurance package as their family.
 - Allow the elimination of tiered metal plans with complicated actuarial ranges.
 - Allow the inclusion of high deductible health plans coupled with a health savings account (HSA).
 - Create flexibilities in the way states can choose to deliver healthcare subsidies, including allowing HSA-like accounts and basing premiums and subsidies on factors other than income (including age).
 - Create flexibility in the population to be covered using federal healthcare subsidies including the potential to shift subsidies from higher income populations to those between 0% - 100% of the federal poverty level (FPL).
 - Provide federal funding for market stabilization activities at the discretion of the state including high-risk pools, reinsurance or hybrid mechanisms.
 - Allow states to implement incentives for continuous coverage.
 - Allow states to create insurance plan incentives for achieving health outcomes and controlling costs or individual incentives for maintaining longevity of uninterrupted coverage.

2. What legislative and regulatory reforms should Congress and the incoming administration consider to stabilize your individual, small group, and large group health insurance market?
 - Immediately repeal the sub-regulatory guidance related to 1332 State Innovation Waivers and extend the deadline for insurance carriers to file rates beginning with plan year 2018.
 - Immediately return rate review, network adequacy, plan qualification, and other insurance regulatory functions to state regulators and create a fast track 1332 State Innovation Waiver pathway for states that do not have effective rate review for ACA products to assume regulatory authority.
 - Continue or create funding mechanisms for risk mitigation, at the state's discretion, during the transition from ACA to the replacement product. This may include fully funded reinsurance programs, high-risk pools, or hybrid mechanisms.
 - Return authority for small insurance markets to the states.
 - Broaden the maximum age ratio but allow subsidies to factor age to ensure young people are incentivized to enter the market and older people are protected from being priced out of insurance coverage.
 - Reduce the grace period for non-payment of premiums.
 - Reduce reasons for special enrollment and allow validation of special enrollment conditions.

- Allow integration of certain Medicaid populations into the marketplace, with Medicaid funded premium subsidies, to infuse healthy lives. This may include healthy women and children above 138% of the FPL or small business focused Medicaid programs like Insure Oklahoma.
 - Prohibit entities with a pecuniary interest from paying individual premiums. Require any non-profit paying premiums for individuals to do so for a minimum of twelve months.
 - Establish incentives (or exclusions) for continuous coverage.
 - Allow employers to continue their grandmothers plans.
 - Relax or eliminate federal plan design elements such as complicated metal tiers (and their underlying actuarial value ranges), essential health benefits, age-rating, community-rating areas, and multiple risk mitigation methods. Instead, allow state control of a minimum core set of operating principles including insurance plan actuarial values, benefits, rating, and risk mitigation methods.
 - Review and reduce regulatory requirements, taxes, and fees that add costs to implementation or are overly burdensome for the benefit received. These may include carrier fees, business reporting requirements, or conditions around the delivery of subsidies through heavily regulated exchange mechanisms.
3. What are key administrative, regulatory, or legislative changes you believe would help you reduce costs and improve health outcomes in your Medicaid program, while still delivering high quality care for the most vulnerable?
- Oklahoma is continuing to create innovative programs in Medicaid (SoonerCare) and has set a goal that 80% of all payments will be value based by 2020. SoonerCare is using a multi-payer, collaborative approach to transforming the payment system to ensure progress on outcomes and a consistent approach for the health provider community. Unfortunately, Medicare and Medicaid systems continue to operate in silos, implementing multiple projects that are not coordinated and create a complex web of regulations and guidelines. Emphasis should be focused on better federal coordination.
 - Create flexible funding mechanisms for states that acknowledge population growth, health burden, and reasonable cost growth. Flexibility should be granted to states as long as health outcomes, quality of care, and the cost of providing care are improved.
 - Reduce waiver approval timelines and requirements for submission, and create timelines for CMS response and action.
 - Allow fast track approval for state waivers that are substantially the same as approved waivers from other states, as well as for state waivers that continue programs that have been in operation for several years and are effective.
 - Lengthen waiver renewal periods to eliminate uncertainty for states and Medicaid participants.
 - Allow innovative programs that reward and incentivize healthy behavior and beneficiaries seeking services in the appropriate location (i.e., emergency room diversion). Continue existing innovation programs that move state Medicaid programs toward payment reform.
 - Give states flexibility to determine managed care rules and processes.
 - Adopt a mechanism for determining Federal Medical Assistance Percentages (FMAP) that consider a state's current economic climate in order to support states and their safety net during recessionary periods.
 - Repeal of hospital presumptive eligibility requirements, particularly in states with real time eligibility determination.
4. What can Congress do to preserve employer-sponsored insurance coverage and reduce costs for the millions of Americans who receive health coverage through their jobs?
- Return authority for small group market to the states.
 - Allow states to disallow marketplace subsidies and coverage to employees with subsidized employer coverage.
 - Eliminate burdensome reporting requirements on employer sponsored insurance.
 - Allow for long term continuation of programs like Insure Oklahoma, a public private partnership that assists small businesses in providing insurance to qualified employees using Medicaid subsidies. Insure Oklahoma requires participation from the employer, employee, the state and federal governments and allows employees to purchase commercial insurance products.

5. What key long-term reforms would improve affordability for patients?
- The key to addressing affordability in the long term is to focus on health outcome improvement, reducing the burden of chronic disease, investing more in prevention and shifting payment and delivery systems to address performance and accountability. These concepts will continue to be the focus in Oklahoma and embedded in all programs developed and delivered for state constituents. Federal funding flexibility and innovation funding to ensure proper implementation and transition of the delivery system are key to success.
 - As repeal of the ACA is contemplated, public health funding for prevention programs that has transitioned into the Prevention and Public Health Fund needs to be considered and sustained. Prevention programs improve health outcomes, yield the largest return on investment and need to be implemented concurrent with health reform.
 - The State of Oklahoma is preparing a 1332 Concept Paper for submission in February that will address issues of affordability. The following are the main areas of concern and key policy reforms that will be explored throughout the development of the waiver in order to positively impact health outcomes and affordability:
 - i. Increase pool of covered lives to ensure a healthy, stable and sustainable insurance pool:
 1. Eliminate complicated metal tiers and actuarial value ranges so that insurance plans can create consumer directed health plans
 2. Allow high-deductible plan with a health savings account
 3. Shift Advanced Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSR) into a streamlined, standardized subsidy
 4. Redeploy subsidies from the upper end of the income spectrum into lower incomes
 5. Waive the federally facilitated marketplace and allow plans to directly market, enroll consumers or use private exchanges
 - ii. Increase plan competition and choice:
 1. Adopt Medicare Advantage risk adjustment models and ratings, re-establish state operated high risk pools or extend temporary federal reinsurance program during transition
 2. Reduce administrative burden on plans (e.g. risk management, reporting, enrollment and subsidy administration)
 - iii. Modify plan design:
 1. Allow variance to age rating ratios from 3:1 to 5:1 and use age as a basis for subsidy amount
 2. Implement quality and outcome measures related to chronic disease
 - iv. Increase accountability of plans:
 1. Qualify plans that incorporate value-based payment mechanisms
 2. Implement outcome measures in qualification process
 3. Rate plans in accordance with performance across quality measures and provide incentives for high performing plans
 4. Disconnect subsidy growth from second lowest silver plan, incorporate a reasonable inflationary factor and provide benefits to plans achieving cost, quality and outcome measures
6. Does your state currently have or plan to enact authority to utilize a Section 1332 Waiver for State Innovation beginning January 1, 2017?
- If allowed, would your state utilize a coordinated waiver application process for both 1115 Medicaid and 1332 State Innovation Waivers for benefit year 2017?
 - If allowed, would your state utilize a model waiver for expedited review and approval similar to the Medicare Part D transition and assistance for Hurricane Katrina evacuees?
 - If allowed, which requirements would your state seek to waive under a 1332 waiver?
 - If allowed – and if applicable – what changes would be necessary to current guidance to accelerate your state’s ability to pursue a 1332 waiver?

Yes, the State of Oklahoma has legislative authority for a State Innovation Waiver, but given the necessary transition time for any significant change, the state is not planning a submission for benefit year 2017. A phased approach will be used to request and implement reforms for plan year 2018 and 2019, or beyond if local circumstances and federal policy reforms are favorable.

The State of Oklahoma would welcome the flexibility to couple a 1115 Medicaid waiver with a 1332 State Innovation Waiver for purposes of budget neutrality and to ensure a sustainable insurance pool. Given the state's initial approach includes redeployment of subsidies from the upper income spectrum (300-400% FPL) to those with lower income (0-100% FPL), the intersections of 1332 and 1115 waiver approaches need to be flexible to allow comprehensive, high quality and affordable coverage pathways for Oklahoma's uninsured population.

An expedited waiver approach would be welcomed for plan year 2018 changes. Under the current filing requirements, insurance plans will file 2018 plan year rates in the spring of 2017. Oklahoma may seek expedited approval to assume regulatory oversight, delay rate reporting requirements, and implement changes that would help stabilize the market and can be rapidly deployed.

The State of Oklahoma is exploring the waiver of many provisions of the ACA, some of which may require Congressional approval. Oklahoma will prepare and submit a concept paper after a public comment period and legislative review. The concept paper is scheduled to be submitted to CMS in late February 2017. The concept paper will outline a high level road map that will need actuarial analysis, modeling and detailed plan development before submission of a waiver.

At this stage in development Oklahoma is exploring a waiver of the FFM and all exchange requirements, integrating APTCs and CSRs, delivering subsidies through an HSA-like account with individual incentives, changing the basis for the subsidy amount to account for age, redeploying subsidies to the most needy, changing the current age rating by broadening the age ratio, eliminating metal tiers and establishing an actuarial floor, qualifying high deductible plans with an HSA, including outcome measures as a basis for qualifying health plans, utilizing Medicare Advantage risk adjustment and quality rating process with incentives for high performing plans and disconnecting subsidies from second lowest silver plan.

Immediate revocation of all sub-regulatory guidance is necessary for implementation of Oklahoma's 1332 waiver.

7. As part of returning more choice, control and access to the states and your constituents, would your state pursue the establishment of a high-risk pool if federal law were changed to allow one?

Yes, Oklahoma is exploring the benefits of a high-risk pool but would like to have an opportunity for quick analysis to determine if reinsurance, or a hybrid system, is a more efficient and effective way to reduce premiums.

8. What timing issues, such as budget deadlines, your legislative calendar, and any consumer notification and insurance rate and form review requirements should we consider before making changes?

Current federal schedules for rate filing do not easily accommodate transitions to new regulations and policies within one year. While Oklahoma suggests a delay of plan filings to September for the following plan year, implementing such changes must also be mindful of state budgeting processes. Oklahoma budget requests are submitted nine months prior to their implementation. The appropriation of state funds, as well as legislative authorizations, is performed annually from February through May with implementation at the onset of the state fiscal year beginning July 1.

The timing of state and federal fiscal year periods can create supplemental appropriation needs for state funds, depending on what Congress or CMS decide after Oklahoma's legislature adjourns. For example, as

Congress begins to consider what to do with CHIP enhanced funding reauthorization (expiring 10/1/2017) the state has until the end of May 2017 to decide how they will fund CHIP, although Congress might not act on the issue until later in the FFY.

Oklahoma's permanent rule making process follows the state legislative calendar and lasts for approximately 4 months. If Congress mandates new policies or changes requiring rule promulgation, the state would need ample notice and time to adhere to state rule making requirements and must allow for approval during legislative session.

9. Has your state adopted any of the 2010 federal reforms into state law? If so, which ones? What impact would repeal have on these state law changes?

Oklahoma has not adopted any of the 2010 federal reforms into state law. However, the Medicaid program has adopted several required state plan amendment and policy changes. The full list of Medicaid policy changes is included in the attached table.

Oklahoma has invested a considerable amount of state and federal dollars converting to the Modified Adjusted Gross Income (MAGI) and the single, streamlined application requirements in the ACA. Any changes considered by Congress and CMS should minimize required expenditures and significant retooling of eligibility determination processes.

We appreciate the opportunity to provide information based on our experience in Oklahoma. While we have realized multiple unintended consequences from the implementation of the ACA we understand every state has unique experiences. Given that, we urge you to create the flexibility in federal law that allows states to meet their circumstances and the distinct needs of their populace. We look forward to continuing this conversation and stand ready to assist you as we create a sustainable healthcare system focused on improved health.

Sincerely,



Mary Fallin

cc: The Honorable Kevin Brady, Chairman, House Committee on Ways and Means
The Honorable Fred Upton, Chairman, House Committee on Energy and Commerce
The Honorable John Kline, Chairman, House Committee on Education and the Workforce
The Honorable Greg Walden, Chair-Elect, House Committee on Energy and Commerce
The Honorable Virginia Foxx, Chair-Elect, House Committee on Education and the Workforce

ACA PROVISION	PROVISION DESCRIPTION	IMPLICATION(S)
ELIGIBILITY	1 Inclusion of Certain Waivered Services as a State Plan Benefit (eff. July 1, 2011) - Creates a state option to provide family planning services through the State Plan	The repeal of provision would require this limited benefit to be only available through a waiver option, which requires reporting and reauthorization. Having this benefit under the State Plan eliminates this undue administrative burden.
	2 Single, Streamlined Application (eff. January 1, 2014)	The State invested a significant number of planning hours and state and federal dollars to modify its MMIS to accommodate the Single, Streamlined Application requirements. The Single, Streamlined Application is interstate compatible and its repeal would eliminate the uniformity of the application process.
	3 Simplified Eligibility and Enrollment Rules (eff. January 1, 2014)	The State invested a significant number of planning hours and state and federal dollars to modify its MMIS to accommodate the Simplified Eligibility and Enrollment Rules.
	4 Hospital Presumptive Eligibility (eff. January 1, 2014) - Allows all hospitals participating in Medicaid to make presumptive eligibility determinations for all Medicaid-eligible populations	Oklahoma has a real time eligibility determination system making this requirement unnecessary.
	5 Coverage for Children in Foster Care (eff. January 1, 2014) - States must provide Medicaid coverage for children under age 26 who were in foster care when they turned 18	Oklahoma has nearly 10,000 children in foster care who often times have emotional and behavioral challenges. Maintaining medical coverage which addresses medical and mental health needs highly benefits this population of the State. Repealing coverage for foster children would eliminate this benefit.
	Modified Adjusted Gross Income (MAGI) (eff. January 1, 2014)	The State invested a significant number of planning hours and state and federal dollars to modify its MMIS to accommodate the MAGI Rules Repeal of this standardized methodology would revert back to self-declaration which puts the agency at risk of fraudulent declarations.

ACA PROVISION	PROVISION DESCRIPTION	IMPLICATION(S)
FINANCING	1 Payments for Hospital-Acquired Infections (eff. July 1, 2011) - Prohibits federal payments to states for Medicaid services related to certain hospital-acquired infections	This requirement holds hospitals accountable for hospital-acquired infections/diseases and it's repeal would put the State at risk of paying for an avoidable error in care/service.
	2 Payments for Primary Care (eff. January 1, 2013 through December 31, 2014) - Increases Medicaid payments for primary care services provided by primary care doctors to 100 percent of the Medicare payment rate for 2013 and 2014	Repeal of the payments for primary care requirement would not impact Oklahoma as the State did not continue the enhanced payment after 2014.

	3	Disproportionate Share Hospital Payments (eff. October 1, 2014) -Reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments and requires the Secretary to develop a methodology for distributing the DSH reductions	Repeal of this requirement would help state hospitals by reinstating increased Disproportionate Share Hospital allotments.
BENEFITS	1	Children Receiving Hospice Care - States providing hospice coverage can provide concurrent treatment for children receiving hospice care. Also applies to CHIP	Repeal of the hospice care requirement for children would eliminate the State's Medicaid expenditures for non-hospice care.
	2	Option to Provide Health Homes for Enrollees with Chronic Conditions (Provides states with a new Medicaid State Plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of another, or at least one serious and persistent mental health condition to designate a provider as a health home. States will receive 90 percent FMAP for two years for services including care management, care coordination, and health promotion.)	Repeal of this requirement would eliminate needed care coordination coverage for approximately 8,000 members who are severely emotionally disturbed and/or severely mentally ill.
CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)	1	Extension of Children's Health Insurance Program (CHIP) (authorization expires Fiscal Year 2013) - Extends authorization and funding for CHIP through 2015	Oklahoma is an expansion CHIP state and repeal of CHIP would have a significant budget impact to provide medical services to approximately 113,993 members.
	2	Increase Federal Match for CHIP (eff. October 1, 2015) - Provides for a 23 percentage point increase in the Children's Health Insurance Program (CHIP) match rate up to a cap of 100 percent	