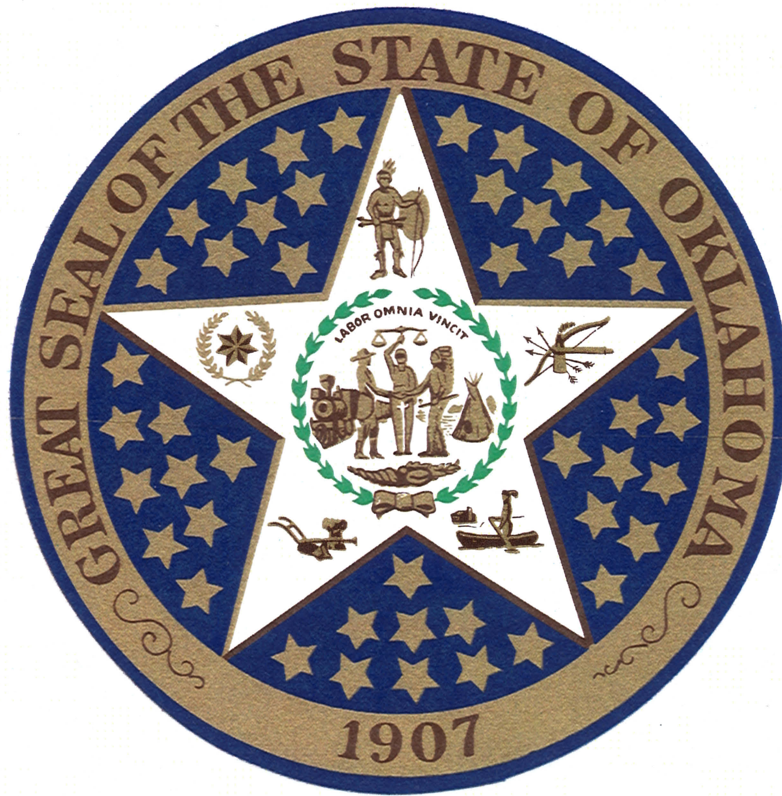
Final Report

HEALTH CARE REFORM TASK FORCE

Oklahoma House of Representatives



Representative Doug Cox, M.D., Co-Chairman

Representative Kris Steele, Co-Chairman

January 2009

Final Report

HEALTH CARE REFORM TASK FORCE

Oklahoma House of Representatives

Submitted: January 2009

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Health Care Reform Task Force Members

Representative Doug Cox, *Task Force Co-Chairman*
Representative Kris Steele, *Task Force Co-Chairman*
Representative Lisa Billy
Representative Wes Hilliard
Representative Pam Peterson
Representative Ron Peterson
Representative Ben Sherrer

Advisory Committee Members

Lt. Governor Jari Askins
Marianne Bacharach, Emergency Room Physician
David Blatt, Chair of the Alliance for Oklahoma's Future and Director of Policy for the Oklahoma Policy Institute
Kevin Blaylock, CEO of the Oklahoma Spine Hospital
Richard Boone, President of St. John Medical Center Foundation
Laura Brookins, Executive Director of the Oklahoma Association of Health Plans
Dr. Mike Crutcher, Commissioner of the Oklahoma State Department of Health
Rick Ferguson, CEO of the Oklahoma Surgical Hospital
Mike Fogarty, CEO of the Oklahoma Health Care Authority
Melissa Gower, Group Leader for Health Services for the Cherokee Nation
Heather Griffin, Executive Director for the Center for Legislative Excellence
John Harvey, CEO of the Oklahoma Heart Hospital
Jake Henry, CEO of the St. Francis Health System
Joe Hodges, President of St. Anthony Hospital
Oklahoma Insurance Commissioner Kim Holland
Stan Hupfeld, CEO of Integris Health
Craig Jones, President of the Oklahoma Hospital Association
Phil Lakin, Executive Director for the Tulsa Community Foundation
Bert Marshall, Group Vice President of Blue Cross Blue Shield of Oklahoma
Larry Mocha, President of APSCO, Inc. and Chairman, Center for Legislative Excellence
Dr. Judy Goforth-Parker, a Chickasaw legislator
Anne Roberts, Executive Director of the Oklahoma Institute for Child Advocacy
Matt Robison, Vice President of Small Business and Workforce Development for The State Chamber
Mark Rogers, CEO of Pushmataha Hospital
Dean Schirf, Vice President of Governmental Relations for the Oklahoma City Chamber of Commerce
Barry L. Smith, Attorney-at-Law with Barkley Law
Hopper Smith, President of the Oklahoma Council of Public Affairs
Steve Turnbo, Executive Committee Member of the Tulsa Metro Chamber of Commerce
Ron Webb, CEO of Valley View Regional Hospital
Brent Wilborn, Policy Liaison for the Oklahoma Primary Care Association
Terri White, Oklahoma Department of Mental Health and Substance Abuse Services

Staff

Dante Giancola, Director of Committee Staff-Research
Marcia Goff, Committee Staff-Research
Arnella Karges, Committee Staff-Research
Sarah Brune, Committee Staff-Legal
Melanie Pouncey, Committee Staff-Legal
John McPhetridge, Committee Staff-Fiscal
Mark Newman, Committee Staff-Fiscal
Craig Perry, Deputy Leadership Assistant to the Speaker
Regina Birchum, Special Projects Coordinator
Jessica Russell, Research Specialist
Liz Young, Legislative Assistant to Rep. Kris Steele

National and State Health Care Experts
Testifying to the Health Care Reform Task Force

July 24, 2008

- Commissioner Kim Holland – Oklahoma Insurance Department
- Nico Gomez – Director of Communication Services, Oklahoma Health Care Authority
- Catherine Denwalt-Graham – Chief Operating Officer, American Fidelity Health Services Administration (an affiliate of American Fidelity Assurance Company)

August 12, 2008

- Grace-Marie Turner – Founder and President, Galen Institute and Facilitator of the Health Policy Consensus Group. The Galen Institute is a public policy research organization that promotes informed debate of free-market ideas for health reform. The Health Policy Consensus Group serves as a forum for analysts from market-oriented think tanks to analyze and develop health policy recommendations.
- J.T. Petherick – Health Legislative Officer, Cherokee Nation

August 26, 2008

- Laura Tobler – Program Director for the Primary Care and Rural Health Project, National Conference of State Legislatures (NCSL)
- Christie Raniszewski Herrera – Health and Human Services Task Force Director, American Legislative Exchange Council (ALEC)

September 9, 2008

- Mitch Roob – Secretary, Indiana Family and Social Services Administration
- Enrique Martinez-Vidal – Vice President, Academy Health, and Director, Robert Wood Johnson Foundation's State Coverage Initiatives program. The State Coverage Initiatives program works with state policy leaders to develop strategies to improve insurance coverage and foster broad health care reform. Oklahoma is one of twelve states involved in the State Coverage Initiatives program, with a grant from the Robert Wood Johnson Foundation.
- Brent Wilborn – Director of Public Policy, Oklahoma Primary Care Association. The Oklahoma Primary Care Association is Oklahoma's federally-designated, federally-funded trade association for community health centers and other community-based health care providers.

September 23, 2008

- Sheryl McLain – Executive Director, Oklahoma Health Care Workforce Center. The Oklahoma Health Care Workforce Center is a public-private partnership to coordinate statewide efforts to meet supply and demand needs for Oklahoma's health care system.
- Kathleen Stoll – Director of Health Policy, Families USA. Families USA is a national nonprofit organization that is dedicated to the achievement of high-quality, affordable health care for all Americans.
- Tom Daxon – Certified Public Accountant, presented for the Oklahoma Council of Public Affairs (OCPA)

October 14, 2008

- Mike Fogarty – Chief Executive Officer, Oklahoma Health Care Authority
- Anne Winter – Senior Consultant, Burns & Associates, Inc. Burns & Associates, Inc. is a health care consulting firm that specializes in assisting state governments and private entities develop customized, innovative approaches to the financing and delivery of health care and human services.

October 28, 2008

- Dr. Marianne Ingles Bacharach –Emergency Room Physician, Oklahoma City VA Medical Center
- Melissa Gower – Group Leader for Health Services, Cherokee Nation
- Craig Jones – President, Oklahoma Hospital Association
- David Blatt – Director of Policy, Oklahoma Policy Institute
- Brent Wilborn – Policy Liaison, Oklahoma Primary Care Association
- Commissioner Kim Holland – Oklahoma Department of Insurance / Oklahoma State Coverage Initiative Team
- Barry L. Smith – Attorney-at-Law, Barkley Law
- Greg Burn – Division Vice President, Marketing and Sales, Blue Cross Blue Shield of Oklahoma
- Mike Fogarty – Chief Executive Officer, Oklahoma Health Care Authority
- Terri White – Commissioner, Oklahoma Department of Mental Health and Substance Abuse Services
- Dr. James H. Crutcher – Secretary of Health and Commissioner of Health, Oklahoma State Department of Health
- Matt Robison – Vice President Small Business and Workforce Development, State Chamber of Oklahoma
- Dr. Judy Goforth-Parker – Legislator, Chickasaw Nation
- Dean Schirf – Corporate Secretary and Vice President of Government Relations, Oklahoma City Chamber of Commerce
- Jake Henry, Jr. – President and CEO, Saint Francis Health System

November 13, 2008

- Representative Ben Sherrer – District 8 (Chouteau)
- Representative Pam Peterson – District 67 (Tulsa)
- Representative Ron Peterson – District 80 (Broken Arrow)
- Representative Doug Cox, M.D. – District 5 (Grove), Chairman of House Public Health Committee
- Representative Kris Steele – District 26 (Shawnee), Chairman of House Health Subcommittee

Introduction

In June 2008, the Speaker of the House, Chris Benge, announced the creation of a special legislative Health Care Reform Task Force and an advisory committee.

The Speaker charged the task force with examining Oklahoma's health care system, the causes behind the increase in the number of uninsured Oklahomans, the costs associated with the uninsured to Oklahoma taxpayers, reforms and incentives in other states, and gathering testimony from national and state experts in the health care field. The advisory committee, which included consumer advocates, business people, medical officials and industry representatives from across the state, provided information, assistance and recommendations to the members of the task force in this comprehensive study of increasing access to health care.

Finally, this report includes input from the task force to the House that will create a marketplace in Oklahoma for quality, affordable health care with an emphasis on encouraging competition, innovation, entrepreneurship and private sector health care solutions.

Background

In 2008, a Centers for Disease Control and Prevention survey found that one in three Oklahomans under the age of 65 do not have health insurance – a larger percentage than any other state in the nation. According to the Oklahoma Insurance Department, 18.48 percent of Oklahomans, totaling 661,499 people are without health insurance. Studies show that this uninsured population includes workers transitioning between jobs, small business employees, workers in low-wage employment and their dependents, and young adults. Nearly two-thirds of uninsured adults in Oklahoma make less than $31,200 (which is 300 percent of the 2008 federal poverty level), while about 20 percent of these individuals earn above this margin. Over half of the uninsured adults making less than $31,200 are ages 19 to 34, while 40 percent are 35 to 54 years of age.

Though Oklahomans earn less than the average individual in other states, health insurance costs are above average. Oklahoma's median annual income is approximately $40,000, whereas nationally the median annual income is $46,000. Nationally, the average individual health insurance policy costs $148 a month, whereas an Oklahoman's cost is $200 a month for a $3,000 deductible policy or as much as $400 a month for a preferred provider organization (PPO) with a $1,000 deductible.

Since November 2005, Oklahoma's Employer/Employee Partnership for Insurance Coverage (O-EPIC), now known as Insure Oklahoma, has offered health insurance to small employers. This program helps qualified workers and spouses buy health insurance through their employer and provides an option for those who are not eligible for employer-sponsored insurance. Insure Oklahoma currently has more than 14,000 employees, spouses, and individuals enrolled in small group or individual plans, but less than a third of enrollees are in the Insure Oklahoma Individual Plan.

Guiding Principles

From July to November of 2008, the task force held eight meetings at the state capitol. At the first meeting the task force distributed a list of proposed guiding principles that were subsequently adopted.

The guiding principles for the efforts of the Health Care Reform Task Force as adopted, follows:

- Consumer empowerment\Consumer choice;
- Encourage personal responsibility;
- Incentives to carefully utilize health care resources, with an emphasis on primary care;
- Fair compensation for providers;
- Efficient, effective administration;
- Effective use of technology;
- Improved health outcomes;
- Effective communication;
- Efficient use of resources; and
- Increase access to quality, affordable private health insurance.

General Findings of the Task Force

- Oklahoma's population without health insurance equals 18.48 percent. Nationally, 14.6 percent of citizens are without health insurance.

- Oklahoma ranks fifth in the percentage of total citizens without health insurance. Neighboring states ranking higher include Texas, New Mexico and Louisiana.

- Roughly one-third of uninsured people's costs for uncompensated care is reimbursed by a number of government programs and the remaining two-thirds is paid through higher premiums by people with health insurance.

- Insured Oklahomans pay for the otherwise uncompensated care of the unisured in the form of higher premiums – $680 of an insured Oklahoman's annual premium goes to cover the cost of uninsured persons within the state.

- For insured Oklahoma families the cost of covering uncompensated care is $1,781 per year. Nationally, the average annual cost to cover the uninsured is $922 per family.

- The cost of covering uncompensated care in Oklahoma is projected to increase rapidly – within two years costs to cover the uninsured will increase to $1,127 per insured person per year and the costs for insured families will also nearly double to $2,911 per year.

- Only two states have a higher cost shift of uncompensated care than Oklahoma – New Mexico and West Virginia.

- Oklahoma ranks 48th in the number of insured adults, aged 18 to 84.

- Young adults are the fastest growing segment of the uninsured, as they age out of their parents' health insurance coverage.

- Oklahoma has 36 insurance coverage mandates. It is estimated that mandated benefits currently increase the cost of basic health care coverage from a little less than 30 percent to more than 50 percent, depending on the state and its mandates.

- Eighteen states require mandated insurance benefit reviews, which legislate that any proposed insurance mandate benefit requiring coverage for a particular procedure or treatment first undergo a medical efficacy and cost/benefit analysis, most conducted by a state's Department of Insurance. Some states require a certain percentage of existing mandates to be reviewed annually, while others allow mandated benefits to expire unless specifically studied or reauthorized by the legislature.

- Nationally, more than 80 percent of health care spending is on behalf of people with chronic conditions.

- Oklahoma's High Risk Insurance Pool covers approximately 2,400 Oklahomans with pre-existing conditions that have been denied by insurance companies.

- Oklahoma's High Risk Insurance Pool is funded by insurer assessments and premiums.

- The premiums for high risk Oklahomans are up to 50 percent higher than the average Oklahoman's insurance.

- Federally Qualified Health Centers (FQHC) provide care for nearly sixteen million people in 5,000 locations across the United States. More than 40 percent of the patients are unisured, another 36 percent are Medicaid recipients.

- Oklahoma's FQHCs serve 107,000 people among fourteen organizations in twenty-seven comprehensive locations across the state.

- By 2012, Oklahoma is projected to have a shortage of 3,135 registered nurses, 606 medical lab technicians, 432 physical therapists, 303 surgical technicians and 171 occupational therapists.

- Health care is the second largest employing industry in Oklahoma with 198,636 direct jobs totaling 14 percent of Oklahoma's total employment. This sector creates nearly 150,000 indirect jobs in other industries.

- Oklahoma's health care work force contributes $6.5 billion to the gross state product.

- Oklahoma is one of ten states with a premium assistance program for small employers.

- National experts use Oklahoma's employer-sponsored insurance program, Insure Oklahoma, as an example of a model for other states to help small businesses offer health insurance to employees.

- As of October 2008, Insure Oklahoma has 10,401 people enrolled in the employer-sponsored insurance and 4,467 people enrolled in the individual plan.

- Insure Oklahoma has twenty-seven health care carriers with 187 health care plan options.

Health Care Reform Task Force Recommendations

Recommendation 1: Allow Consumer Choice
Oklahoma should allow insurance providers to offer basic preventive plans with catastrophic coverage by relaxing mandates so more, low-cost choices can be offered to small businesses and uninsured Oklahomans. At least thirteen states have allowed such plan options, resulting in a reduction of health insurance premiums by 5 to 9 percent due to decreasing the number of required, covered services.

Recommendation 2: Point of Service Enrollment
Oklahoma should encourage enrollment in a health insurance plan by requiring a commitment to find health insurance at the time of receiving uncompensated care. This reform could help eliminate the "hidden tax" on insured Oklahomans in the form of higher premiums that cover uncompensated care and emergency room use.

Recommendation 3: Create an Insurance Exchange
Oklahoma should help connect people to appropriate and affordable health insurance plans, whether Insure Oklahoma or a non-subsidized private plan. Oklahoma should offer customer support to assist people in finding, understanding and applying for health insurance.

Recommendation 4: Encourage Personal Responsibility
Oklahoma should encourage people to be responsible for their own health care by incentivizing personal wellness and preventive care. Such a reform can help contain chronic diseases such as diabetes, smoking-related illnesses and obesity that worsen a person's and family's health and drive up health care costs for everyone.

Recommendation 5: Increase Portability of Health Insurance
Oklahoma should offer reforms in the individual market, create improved options in Insure Oklahoma, and enable people to retain their coverage despite changes in occupation. The offerings in the Insure Oklahoma individual plans could be improved by allowing private companies to offer low-cost options, such as a mandate-free policy and high deductible plans with health savings accounts.

Recommendation 6: Reform High Risk Pool Act
A high percentage of health care costs in general, and care for which providers are not compensated in particular, are incurred by a relatively small percentage of people with chronic health problems. These people very often cannot obtain insurance in the private market. The state's current high risk pool, intended to offer insurance to those who cannot purchase it privately, does not adequately address these problems. The program should be reformed both by lowering the cost of insurance to those who cannot purchase private insurance and by providing subsidies for those with lower incomes. The insurance plans offered should include the provision of a primary care physician who will supervise the patient's care and provide effective disease management programs for the chronically ill. Such a cost-sharing plan will reduce even larger, unnecessary and uncompensated costs to insured Oklahomans.

Recommendation 7: Maximize Current Services
Oklahoma should work together with Federally Qualified Health Centers and tribal health facilities and providers to insure maximum utilization of those services to eligible Oklahomans by facilitating enhanced cooperation and expanding the number of Federally Qualified Health Centers in more communities.

Recommendation 8: Create an Environment for Affordable Health Care
Oklahoma should work to decrease the costs of medical care by educating providers on actual costs to consumers, fostering cooperation between insurance companies and providers, facilitating the electronic recording of medical history, and requiring pricing transparency.

Recommendation 9: Expand the Use of IRS Section 125 Plans
Oklahoma should encourage employers to expand the use of federal IRS, Section 125 plans, also known as "cafeteria plans," that allow employees to utilize pre-tax dollars to purchase health insurance. Employees in other states have been known to save up to 26 percent and employers are able to save on their annual FICA taxes.

Recommendation 10: Increase Access to Health Care with Health Care Workforce Development
Oklahoma should encourage the development of health care providers across the state by attracting more students to needed professions, attracting providers to the state, and cutting the cost of providing services so more Oklahomans can have access to quality, affordable health care.

Recommendation 11: Provide Adequate Support
Oklahoma currently has nearly 15,000 people enrolled in Insure Oklahoma. The current funding stream generated by tobacco tax revenues and matching federal funds would support up to 40,000 enrollees. As the state encourages personal responsibility and funds smoking cessation programs, it is likely that the revenues from tobacco sales will decrease. A dedicated funding stream should be examined to cover the number of Oklahomans who will be eligible for Insure Oklahoma pending federal approval.

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Appendix M: State Coverage Initiatives Response to Questions raised at September 9, 2008, meeting

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Appendix A

Health Care Reform Task Force
Meeting Dates

- Thursday, July 24, 9am-12pm – House Chamber
- Tuesday, August 12, 9am-12pm – House Chamber
- Tuesday, August 26, 9am-12pm – House Chamber
- Tuesday, September 9, 9am-12pm – House Chamber
- Tuesday, September 23, 9am-12pm – 432A
- Tuesday, October 14, 9am-12pm – House Chamber
- Tuesday, October 28, 9am-12pm – House Chamber
- Thursday, November 13, 9am-12pm – House Chamber

Appendix B

Oklahoma House of Representatives

Meeting Notice

July 9, 2008

TO: Health Care Reform Task Force

DATE: Thursday, July 24, 2008

TIME: 9:00 A.M. – 12:00 NOON

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Welcome and Introductions
2. Organizational Discussion of Meeting Dates and Times
3. Economic Overview of Data Concerning Uninsured in Oklahoma
   a. How do the uninsured affect quality of life, health care costs, costs associated with doing business and health indicators for the state?
   b. Identify people who are not covered and who do not have access to affordable health care.
4. Programs Currently Available
   a. Medicaid – Who is eligible and how does it work? Update on Medicaid Reform Plan.
   b. Insure Oklahoma/All Kids – Who is eligible and how does it work? Update on pending Federal waiver regarding expansion.
   c. Health Savings Accounts/Flexible Spending Accounts/High Deductible Health Plans Who is eligible and how does it work? Update on development and implementation.
5. Proposed Guiding Principles
6. Advisory Committee Comments
7. Other Business and Adjournment

Rep. Doug Cox , Co-Chair
Rep. Kris Steele, Co-Chair

Members:
Rep. Lisa Billy
Rep. Wes Hilliard
Rep. Pam Peterson
Rep. Ron Peterson
Rep. Ben Sherrer

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Oklahoma House of Representatives

MEETING NOTICE

August 4, 2008

TO: Health Care Reform Task Force

DATE: Tuesday, August 12, 2008

TIME: 9:00 A.M. – 12:00 NOON

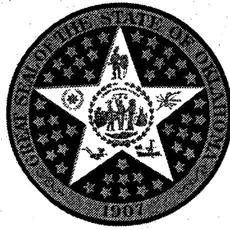
PLACE: House Chamber, State Capitol Building

AGENDA:

1. Welcome and Introductions
2. Oklahoma and Health Reform Presentation – Grace-Marie Turner, founder and president of the Galen Institute/founder and facilitator of the Health Policy Consensus Group
3. Indian Health System Overview – JT Petherick, Health Legislative Officer, Cherokee Nation
4. Discussion/Adoption of Guiding Principles
5. Advisory Committee Comments
6. Other Business and Adjournment

Rep. Doug Cox, Co-Chair
Rep. Kris Steele, Co-Chair

Members:
Rep. Lisa Billy
Rep. Wes Hilliard
Rep. Pam Peterson
Rep. Ron Peterson
Rep. Ben Sherrer



Oklahoma House of Representatives

meeting notice

August 14, 2008

TO: Health Care Reform Task Force

DATE: Tuesday, August 26, 2008

TIME: 9:00 A.M. – 12:00 NOON

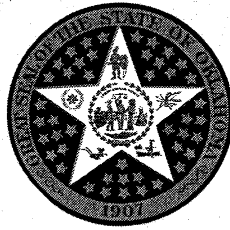
PLACE: House Chamber, State Capitol Building

AGENDA:

1. Welcome and Introductions
2. State Health Reform Efforts – Laura Tobler, Director of the Health Program at The National Conference of State Legislatures
3. State Health Reform Efforts – Christie Raniszewski Herrera, Director of the Health and Human Services Task Force at the American Legislative Exchange Council
4. Advisory Committee Comments
5. Other Business and Adjournment

Rep. Doug Cox, Co-Chair
Rep. Kris Steele, Co-Chair

Members:
Rep. Lisa Billy
Rep. Wes Hilliard
Rep. Pam Peterson
Rep. Ron Peterson
Rep. Ben Sherrer



Oklahoma House of Representatives

MEETING NOTICE

September 2, 2008

TO: Health Care Reform Task Force

DATE: Tuesday, September 9, 2008

TIME: 8:30 A.M. – 12:00 P.M.

PLACE: House Chamber, State Capitol Building

AGENDA:

1. Welcome and Introductions
2. Indiana Healthcare Program - Mitch Roob, Secretary, Indiana Family and Social Services Administration
3. Massachusetts Healthcare Program - Enrique Martinez-Vidal, Vice President, Academy Health, Director, Robert Wood Johnson Foundation's State Coverage Initiatives program
4. Federally Qualified Health Centers - Brent Wilborn, Director of Public Policy, Oklahoma Primary Care Association
5. Oklahoma Health Care Workforce Center - Sheryl McLain, Executive Director, Oklahoma Health Care Workforce Center
6. Advisory Committee Comments
7. Other Business and Adjournment

Rep. Doug Cox, Co-Chair
Rep. Kris Steele, Co-Chair

Members:
Rep. Lisa Billy
Rep. Wes Hilliard
Rep. Pam Peterson
Rep. Ron Peterson
Rep. Ben Sherrer

Oklahoma House of Representatives

Meeting Notice

MEETING NOTICE

September 22, 2008

TO: Health Care Reform Task Force

DATE: Tuesday, September 23, 2008

TIME: 9:00 A.M. – 12:00 NOON

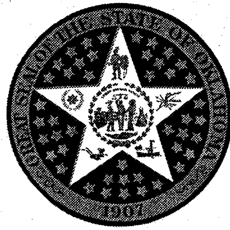
PLACE: House Chamber, State Capitol Building

AGENDA:

1. Welcome and Introductions
2. Oklahoma Health Care Workforce Center – Sheryl McLain, Executive Director, Oklahoma Health Care Workforce Center
3. Health Care Reform – Kathleen Stoll, Director of Health Policy, Families USA
4. Comprehensive Health Independence Plan (O-CHIP) – Tom Daxon, CPA
5. Advisory Committee Comments
6. Other Business and Adjournment

Rep. Doug Cox, Co-Chair
Rep. Kris Steele, Co-Chair

Members:
Rep. Lisa Billy
Rep. Wes Hilliard
Rep. Pam Peterson
Rep. Ron Peterson
Rep. Ben Sherrer



Oklahoma House of Representatives

Meeting Notice

October 3, 2008

TO: Health Care Reform Task Force

DATE: Tuesday, October 14, 2008

TIME: 9:00 A.M. – 12:00 NOON

PLACE: House Chamber, State Capitol Building

AGENDA:

1. Welcome and Introductions
2. Matt Robison, Vice President Small Business and Workforce Development, Oklahoma State Chamber
3. Mike Fogarty, Chief Executive Officer of the Oklahoma Health Care Authority
4. Anne Winter, Senior Consultant, Burns & Associates, Inc., Health Policy Consulting
5. Advisory Committee Comments
6. Other Business and Adjournment

MEETING NOTICE

Rep. Doug Cox, Co-Chair
Rep. Kris Steele, Co-Chair

Members:
Rep. Lisa Billy
Rep. Wes Hilliard
Rep. Pam Peterson
Rep. Ron Peterson
Rep. Ben Sherrer

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Oklahoma House of Representatives

Meeting Notice

REVISED

October 27, 2008

TO: Health Care Reform Task Force

DATE: Tuesday, October 28, 2008

TIME: 9:00 A.M. – 12:00 NOON

PLACE: House Chamber, State Capitol Building

AGENDA:

1. Welcome and Introductions

2. Advisory Committee Recommendations:
   Dr. Marianne Ingles Bacharach, Oklahoma City VA Medical Center
   Melissa Gower, Cherokee Nation
   Craig Jones, Oklahoma Hospital Association
   David Blatt, Oklahoma Policy Institute
   Brent Wilborn, Oklahoma Primary Care Association
   Commissioner Kim Holland, Oklahoma Department of Insurance / Oklahoma State Coverage Initiative Team
   Barry L. Smith, Barkley Law
   Greg Burn, Blue Cross Blue Shield of Oklahoma
   Mike Fogarty, Oklahoma Health Care Authority
   Terri White, Oklahoma Department of Mental Health and Substance Abuse Services
   Dr. James H. Crutcher, Oklahoma State Department of Health
   Matt Robison, State Chamber of Oklahoma
   Dr. Judy Goforth-Parker, Chickasaw Nation Legislator
   Dean Schirf, Oklahoma City Chamber of Commerce

3. Other Business and Adjournment

Rep. Doug Cox, Co-Chair
Rep. Kris Steele, Co-Chair

Members:
Rep. Lisa Billy
Rep. Wes Hilliard
Rep. Pam Peterson
Rep. Ron Peterson
Rep. Ben Sherrer

MEETING NOTICE

Oklahoma House of Representatives

Meeting Notice

November 10, 2008

TO: Health Care Reform Task Force

DATE: Thursday, November 13, 2008

TIME: 9:00 A.M. – 12:00 NOON

PLACE: House Chamber, State Capitol Building

AGENDA:

1. Welcome and Introductions
2. Health Care Reform Task Force Recommendations – Legislative Members
3. Other Business and Adjournment

Rep. Doug Cox, Co-Chair
Rep. Kris Steele, Co-Chair

Members:
Rep. Lisa Billy
Rep. Wes Hilliard
Rep. Pam Peterson
Rep. Ron Peterson
Rep. Ben Sherrer

MEETING NOTICE

Appendix C

Health Policy Initiatives

Commissioner Kim Holland

Oklahoma Insurance Department

2007 United Health Rankings

DETERMINANTS

Personal Behaviors

National Rank

47

Prevalence of Smoking
(Percent of population)
Value: 25.1

National Rank

44

Prevalence of Obesity
(Percent of population)
Value: 28.8

2007 United Health Rankings

DETERMINANTS

Clinical Care

National Rank

50

Primary Care Physicians
(Number per 100,000 population)
Value: 79.7

National Rank

45

Preventable Hospitalizations
(Number per 1,000 Medicare enrollees)
Value: 95.9

2007 United Health Rankings

HEALTH OUTCOMES

National Rank

50

Cardiovascular Deaths
(Deaths per 100,000 population)
Value: 412.1

National Rank

43

Cancer Deaths
(Deaths per 100,000 population)
Value: 215.2

2007 Commonwealth Fund Rankings

ACCESS — RANK 49

National Rank

48

2004-05 Percent of adults
(Ages 18-84) insured
State Rate: 74.5%

National Rank

44

2004-05 Percent of children
(Ages 0-17) insured
State Rate: 86.1%

2007 Commonwealth Fund Rankings

QUALITY — RANK 43

National Rank

48

Percent of adults age 50 and older received recommended screening and preventive care
State Rate: 34.5%

National Rank

44

Percent of children with both a medical and dental preventive care visit in the past year
State Rate: 49.2%

2007 F as in Fat Rankings

QUALITY — RANK 43

National Rank

39

Percent of adult diabetics received recommended preventive care
State Rate: 49.2%

National Rank

45

Percent of adults under age 65 limited in any activities because of physical, mental or emotional problems
State Rate: 18.4%

2007 F as in Fat Rankings

F as in FAT 2007 Key Facts

National Rank

42

Obesity Rates, % Adults (2004-06 average)
State Rate: 26.8%

Hypertension Rates, % Adults
(2001-05 average)
State Rate: 28.8%

National Rank

42

2007 F as in Fat Rankings

F as in FAT 2007 Key Facts

National Rank

44

Diabetes Rates, % Adults (2004-06 average)
State Rate: 9.0%

Adult Physical Inactivity
(2001-05 average)
State Rate: 29.4%

National Rank

44

2007 F as in Fat Rankings

F as in FAT 2007 Key Facts

Medical Costs of Obesity, Per Capita (2003)

$243

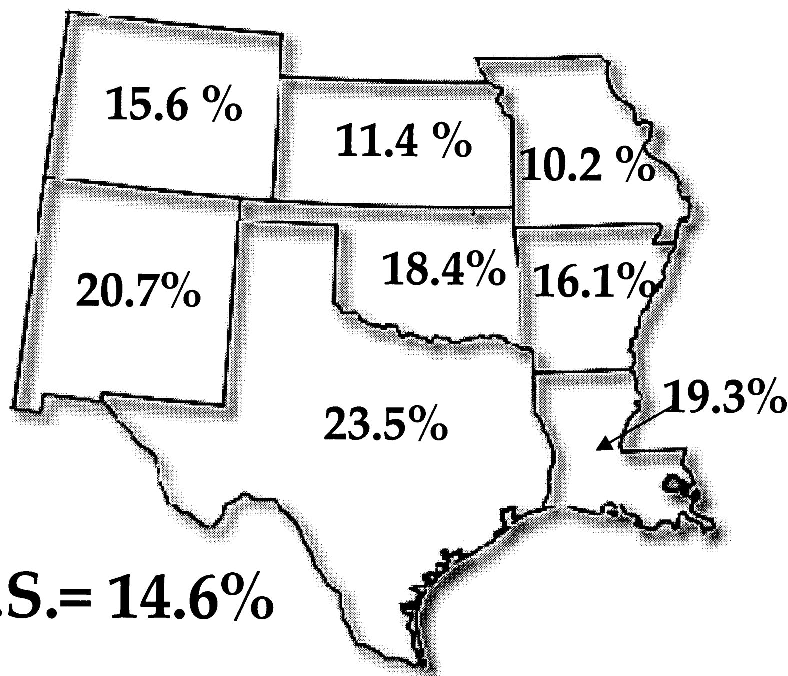
Overall Rankings

Commonwealth Fund and United Health Foundation

Overall Rank:

50

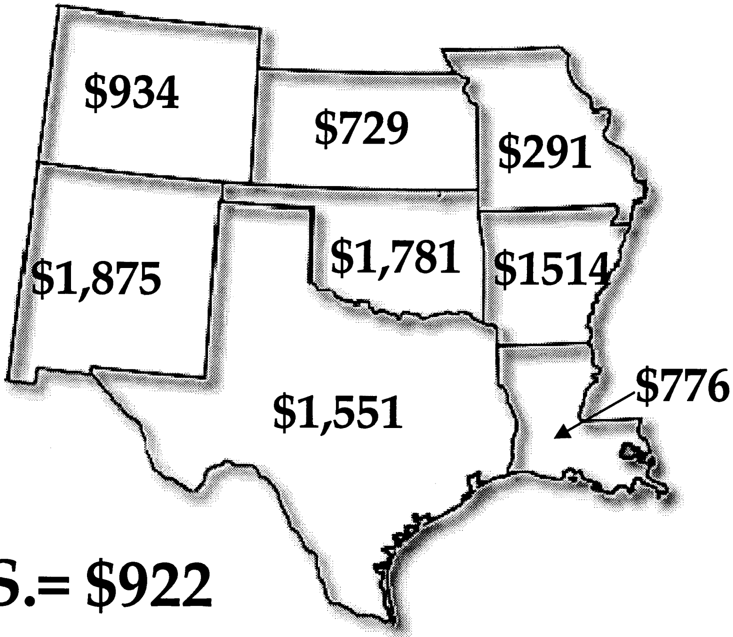
Percentage of Citizens Without Health Insurance



Source: U.S. Bureau of the Census

State	Rank
Texas	1
New Mexico	2
Louisiana	4
Oklahoma	5
Arkansas	10
Colorado	15
Kansas	30
Missouri	36

Increase in Premiums Due to Health Care for the Uninsured



Source: Families U.S.A., June 2005

Insured Oklahomans pay to cover cost of uninsured

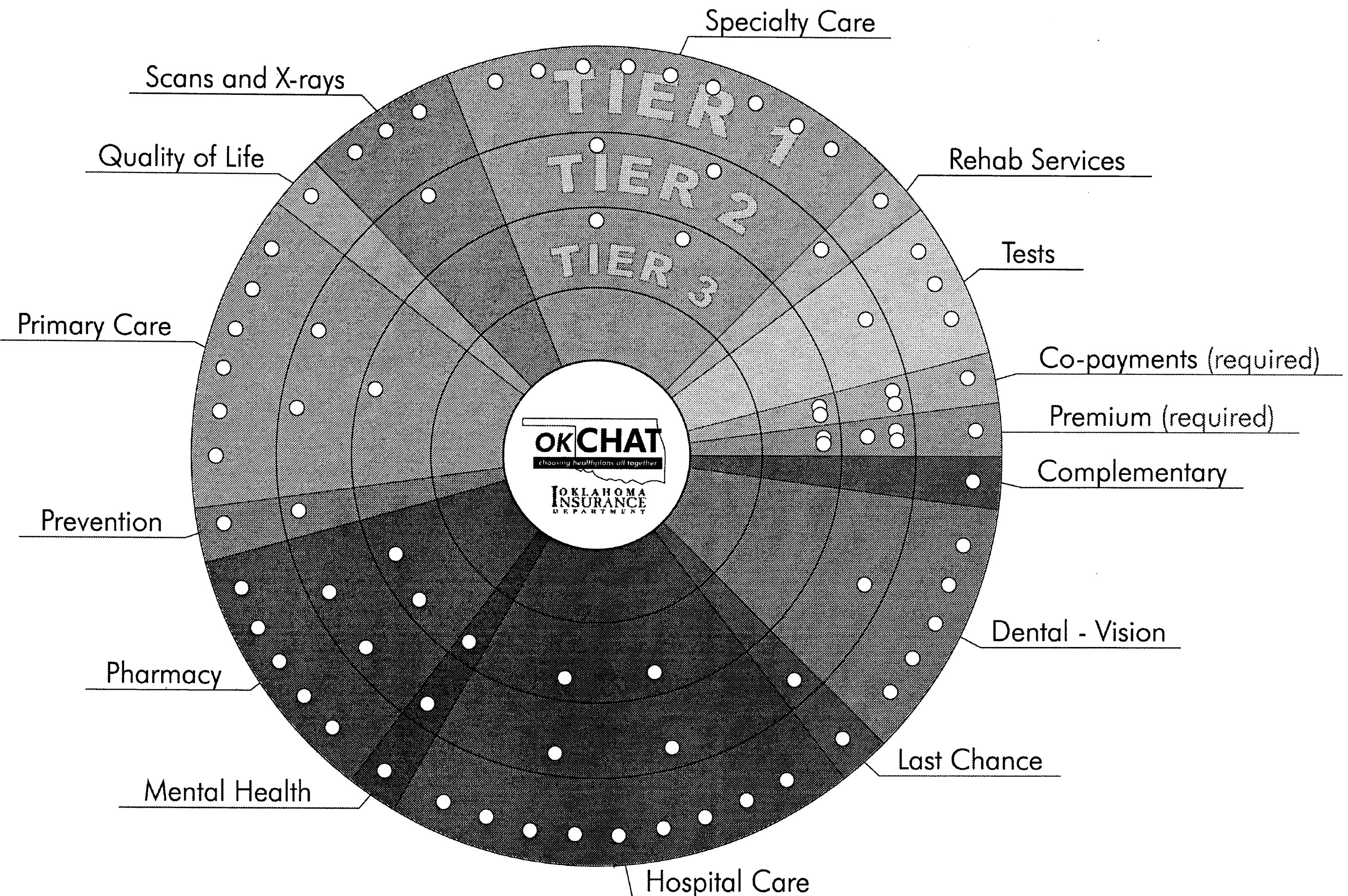
- $1,781 per family per year
- $680 per person per year

By 2010, costs will expand

- $2,911 per family per year
- $1,127 per person per year

Choosing Healthplans All Together (OK CHAT)

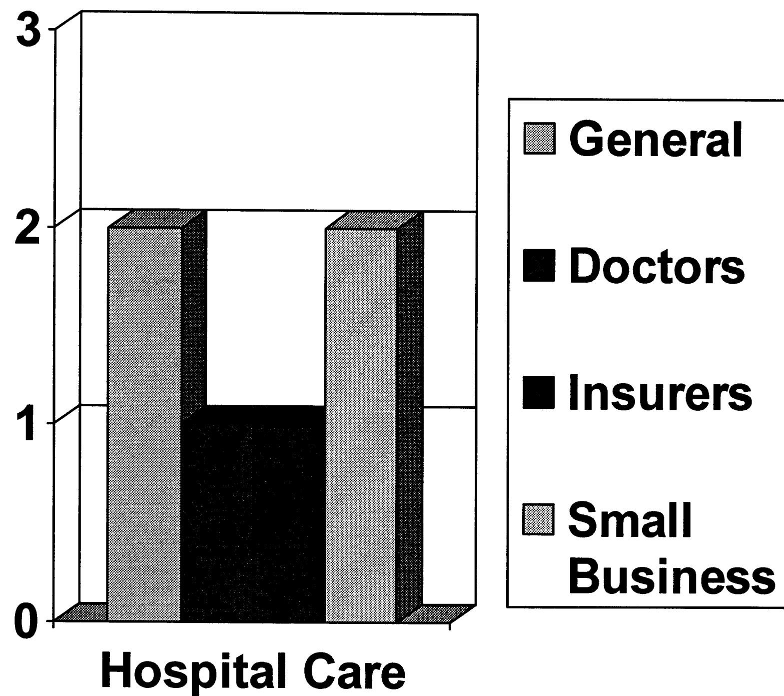
- Builds consensus about a health coverage priorities with limited resources
- More than 40 sessions in 31 Oklahoma communities
  - Six Town Hall discussions
  - More than 400 citizens input gathered
  - Cross-section of community
  - Ran for six weeks August through October
- Information to Core Health Benefit Task Force


Specialty Care
Scans and X-rays
Quality of Life
Primary Care
Prevention
Pharmacy
Mental Health
Hospital Care
Last Chance
Dental - Vision
Complementary
Premium (required)
Co-payments (required)
Tests
Rehab Services
TIER 1
TIER 2
TIER 3
OK CHAT
OKLAHOMA INSURANCE DEPARTMENT

Utilizing Round 3 Consensus Data

- General – 400+ members of 31 statewide communities
- Doctors – 16 practicing physicians
- Insurers – 9 members of Oklahoma Association of Health Plans
- Small Business – 14 State Chamber members

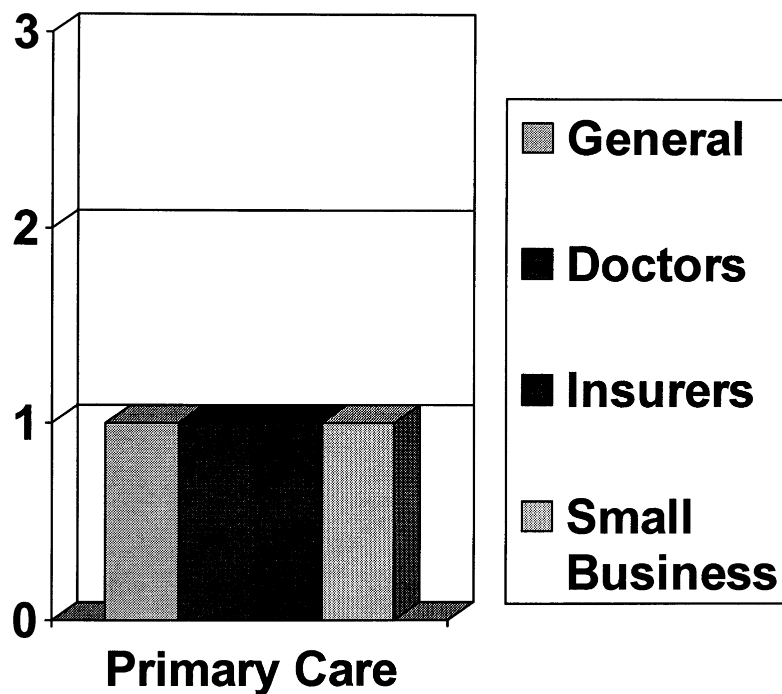
Group Comparisons



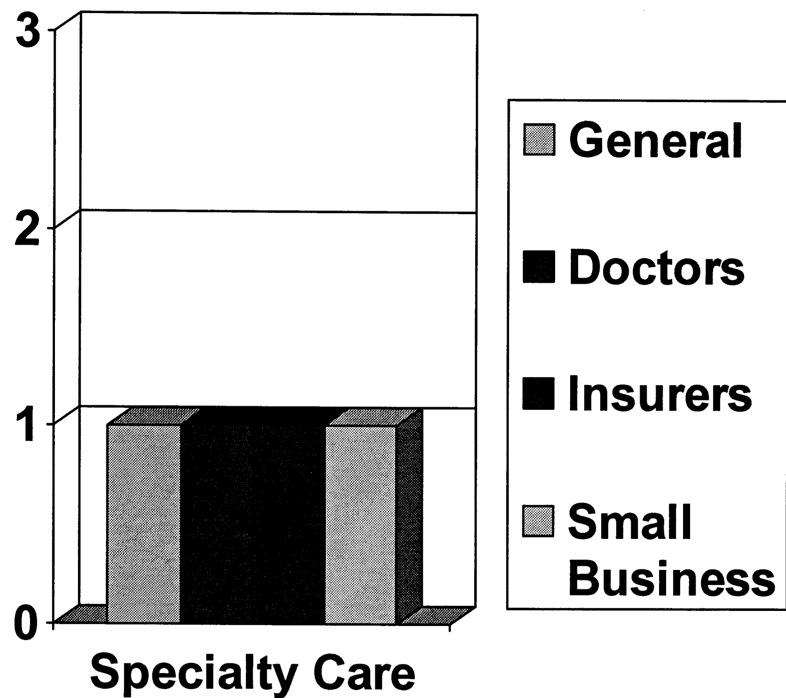
- Increase in Tier indicated desire to have more “choice” of access to hospitals

Group Comparisons

- Increase in Tier would indicate a greater “choice” in selecting a primary care physician



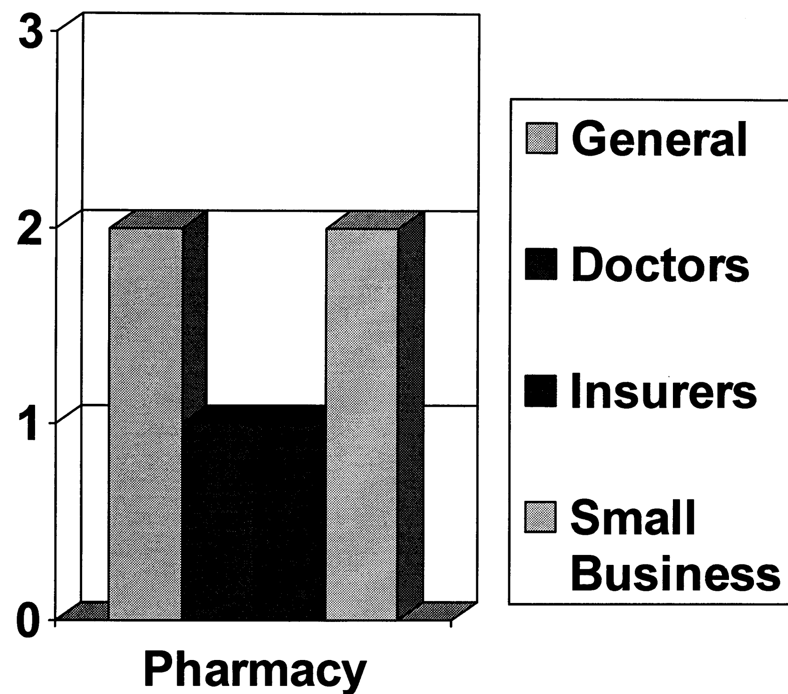
Group Comparisons



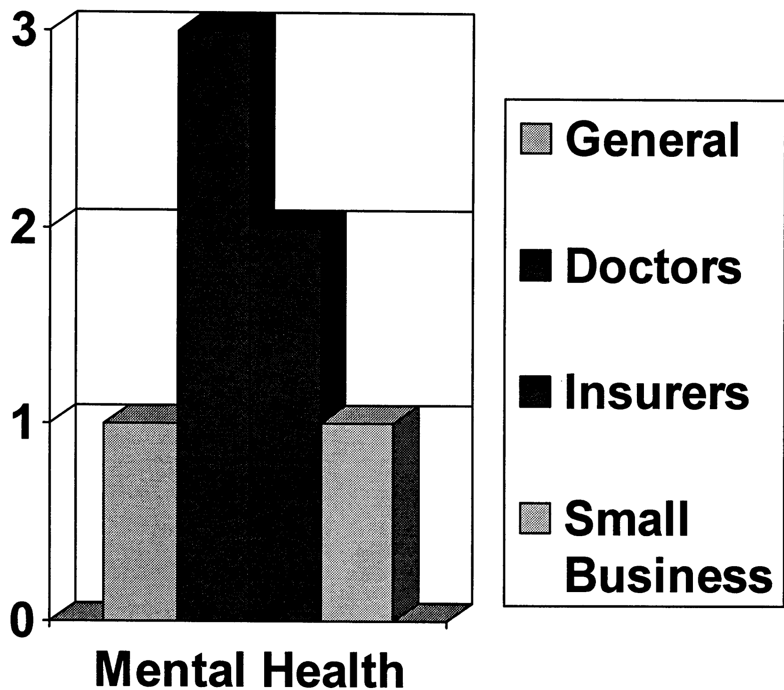
- Increase in Tier would give insured lower wait times and increased access via referral

Group Comparisons

- Increase in Tier indicated desire for greater access to "name brand" prescription drugs

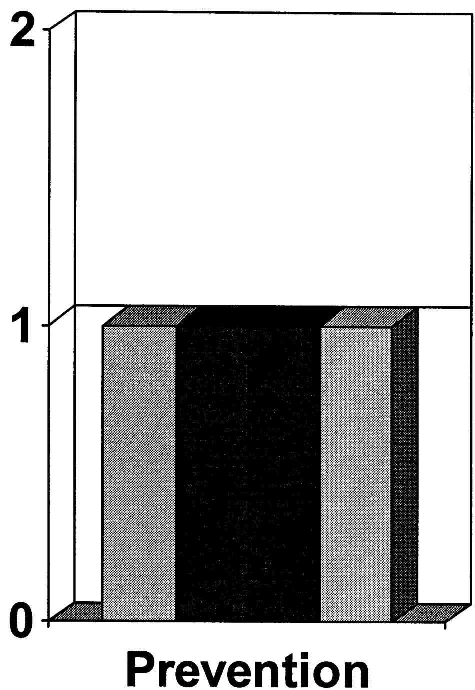


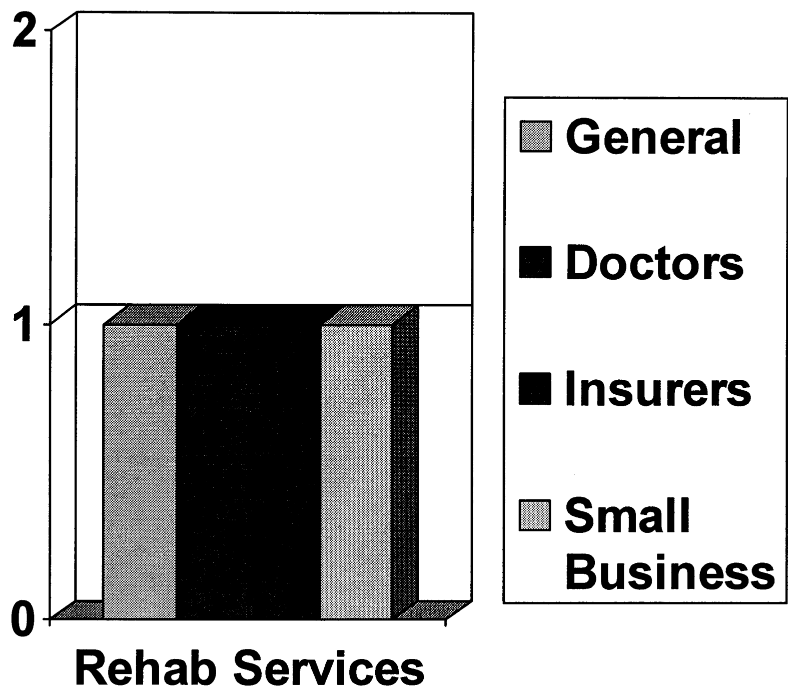
Group Comparisons



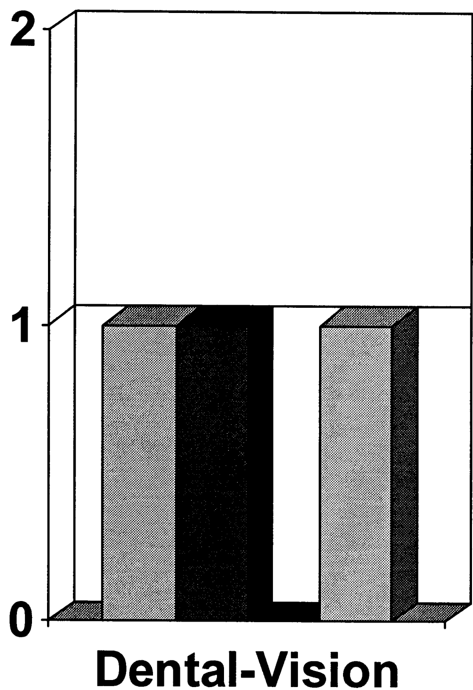
- Increase in Tier indicated expansion of services to include (Tier 2) behavioral addictions and (Tier 3) long-term therapy

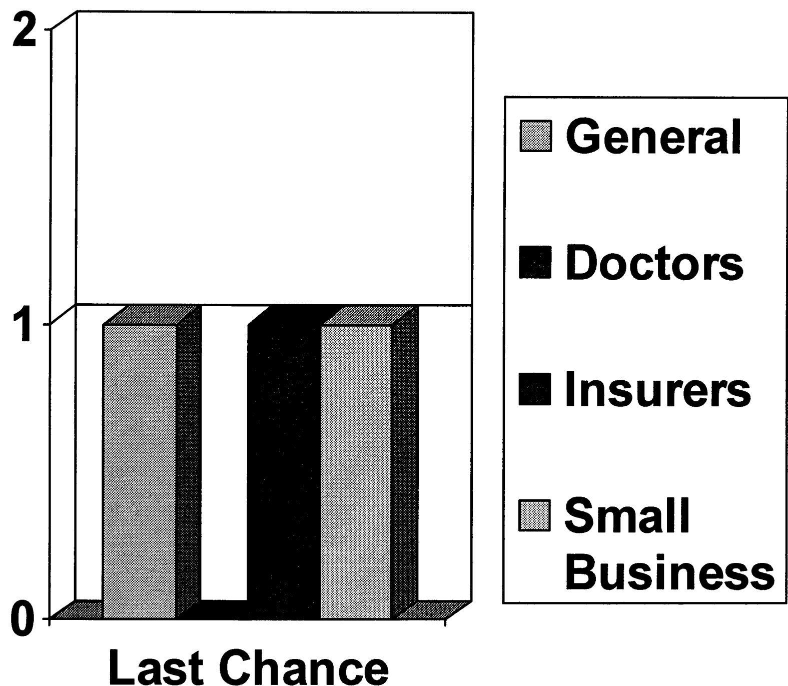
Group Comparisons



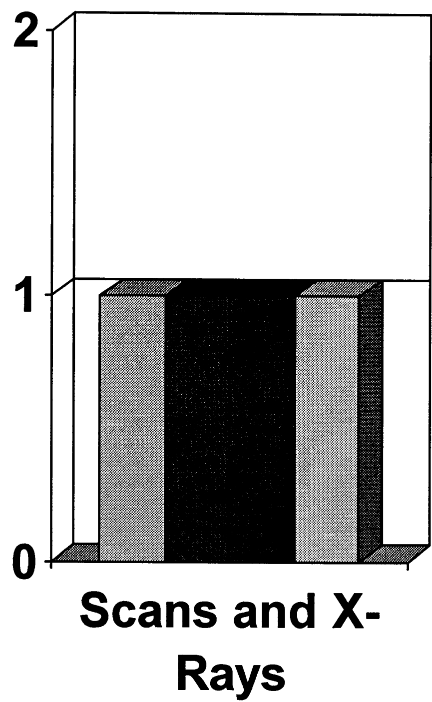


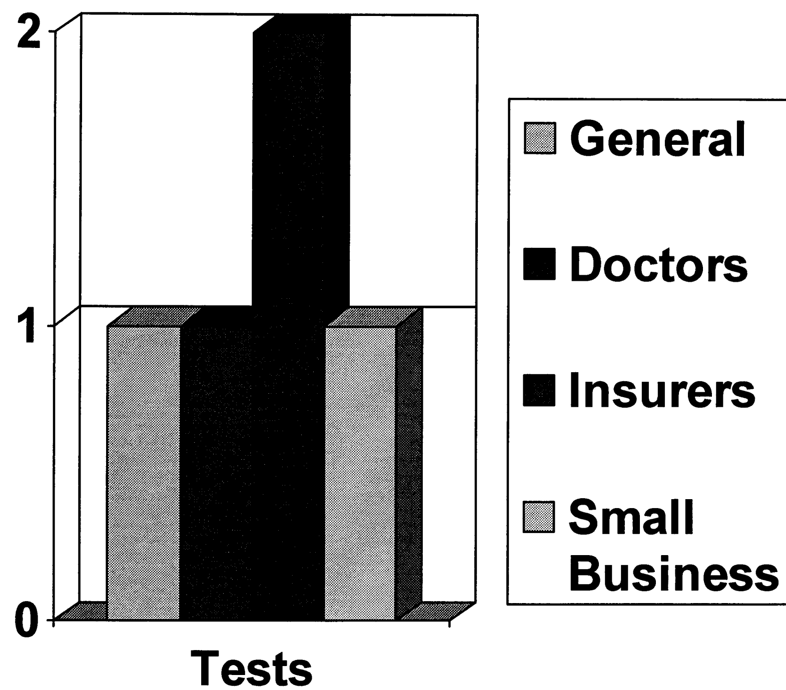
Group Comparisons



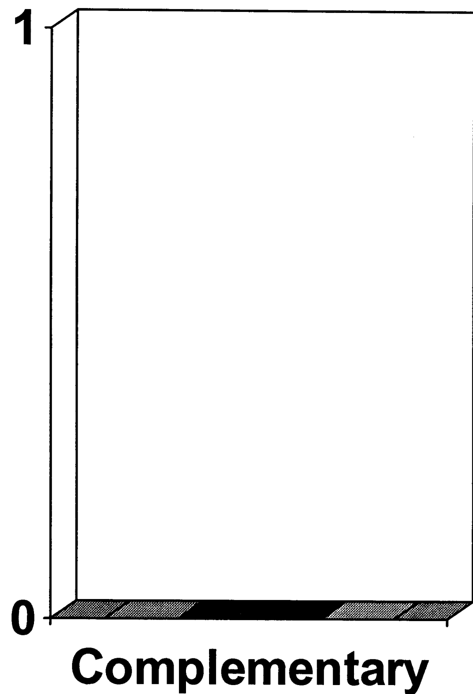


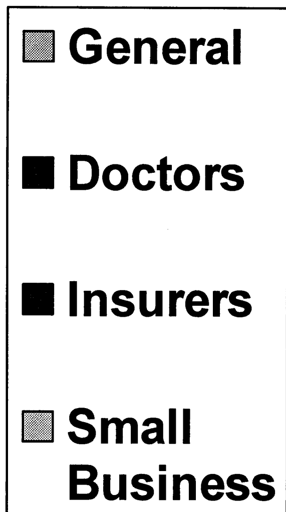
Group Comparisons

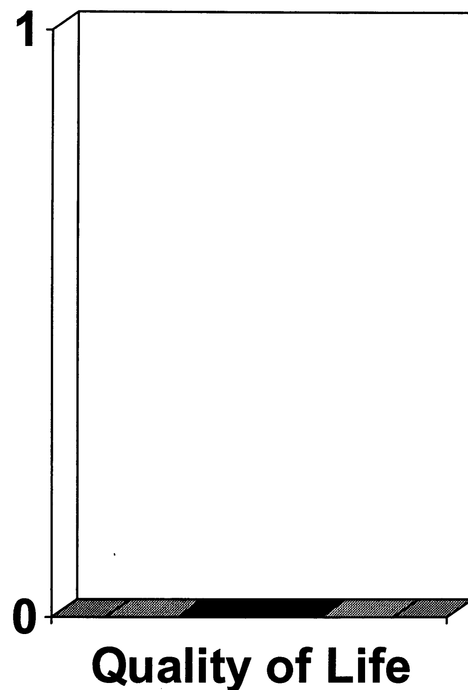


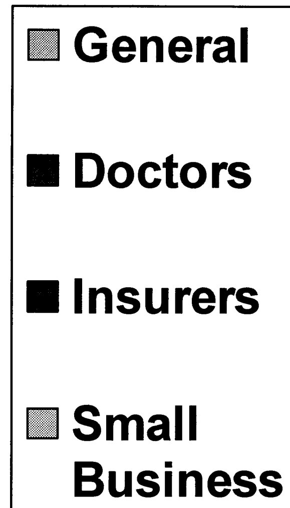


Group Comparisons

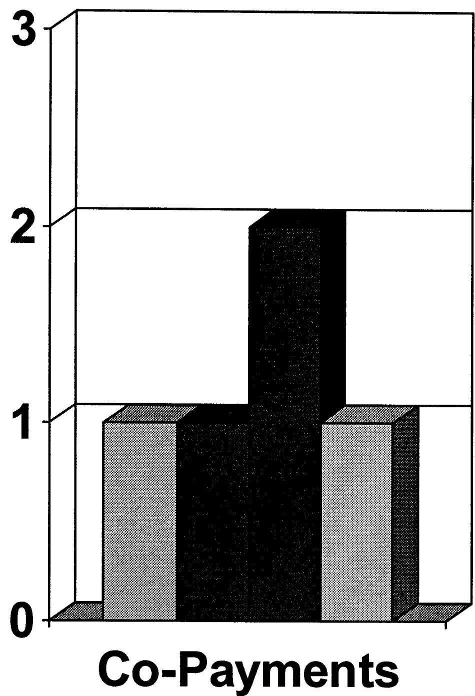


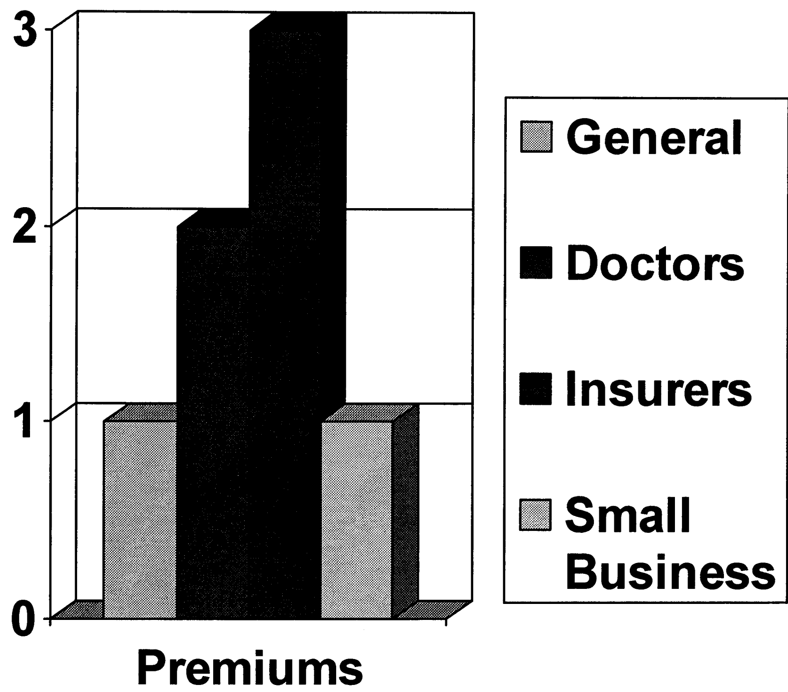






Group Comparisons





HCR 1010 Recommendations

- **IOM Principles of Health** – safe, effective, patient-centered, timely, efficient and equitable
- **Study** – expand CHAT, identify uninsured, determine affordability, review current healthcare expenditures, cost of defensive medicine

HCR 1010 Recommendations

- **Leverage Resources** – federal funds, state purchasing dollars
- **Promote** – patient-centered medical homes, health information technology, evidence-based medical protocols

Task forces working towards construction of plan

State Coverage Initiatives Grant

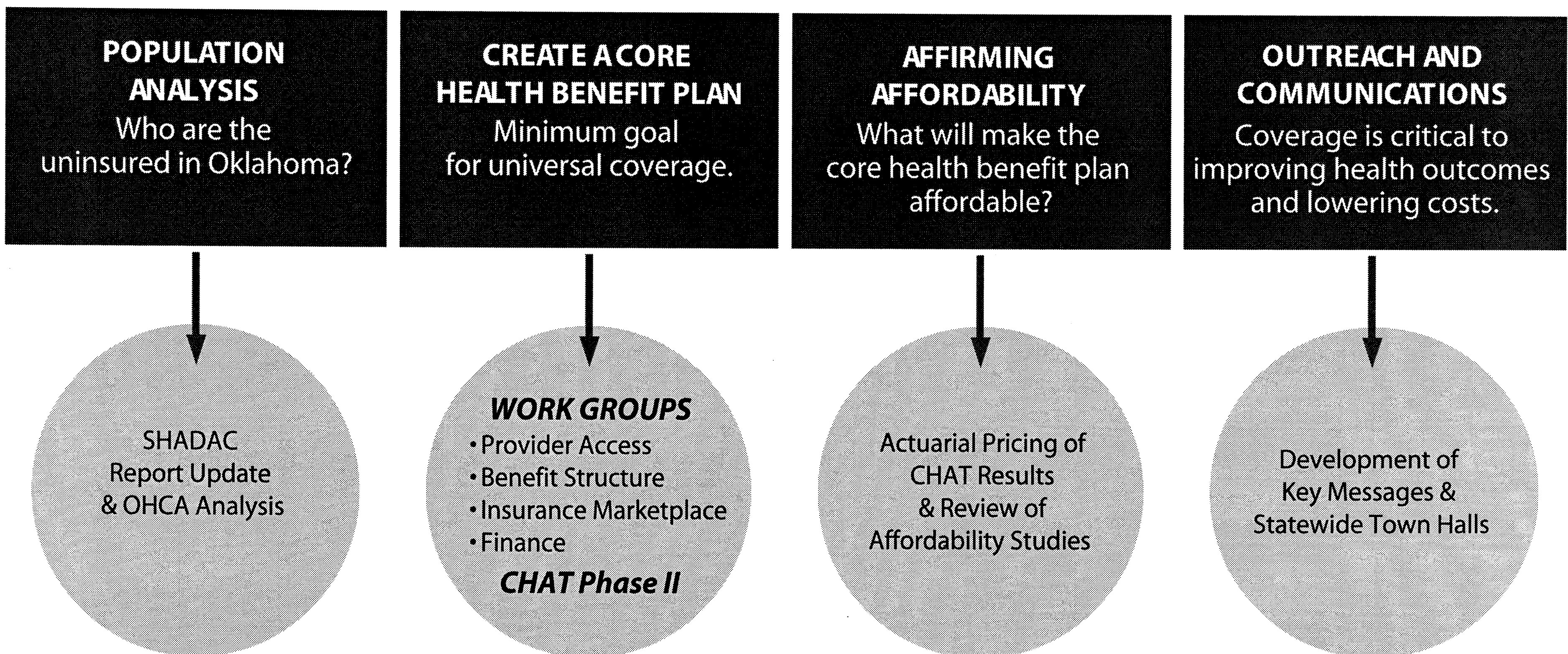
- One of 14 states selected to participate in the SCI program
- State teams will meet with experts from the Robert Wood Johnson Foundation to assess current challenges, analyze strategic policy options and refine current state-specific plans
- $200,000 development grant received

SCI Team Vision

- All Oklahomans should have access to high quality health care and affordable health insurance through a private/public partnership in 3-5 years

Robert Wood Johnson Foundation
SCI (State Coverage Initiatives)

Grant total is $200,000 from February 1, 2008 to July 31, 2009



Health Policy Initiatives

Commissioner Kim Holland

Oklahoma Insurance Department

Appendix D

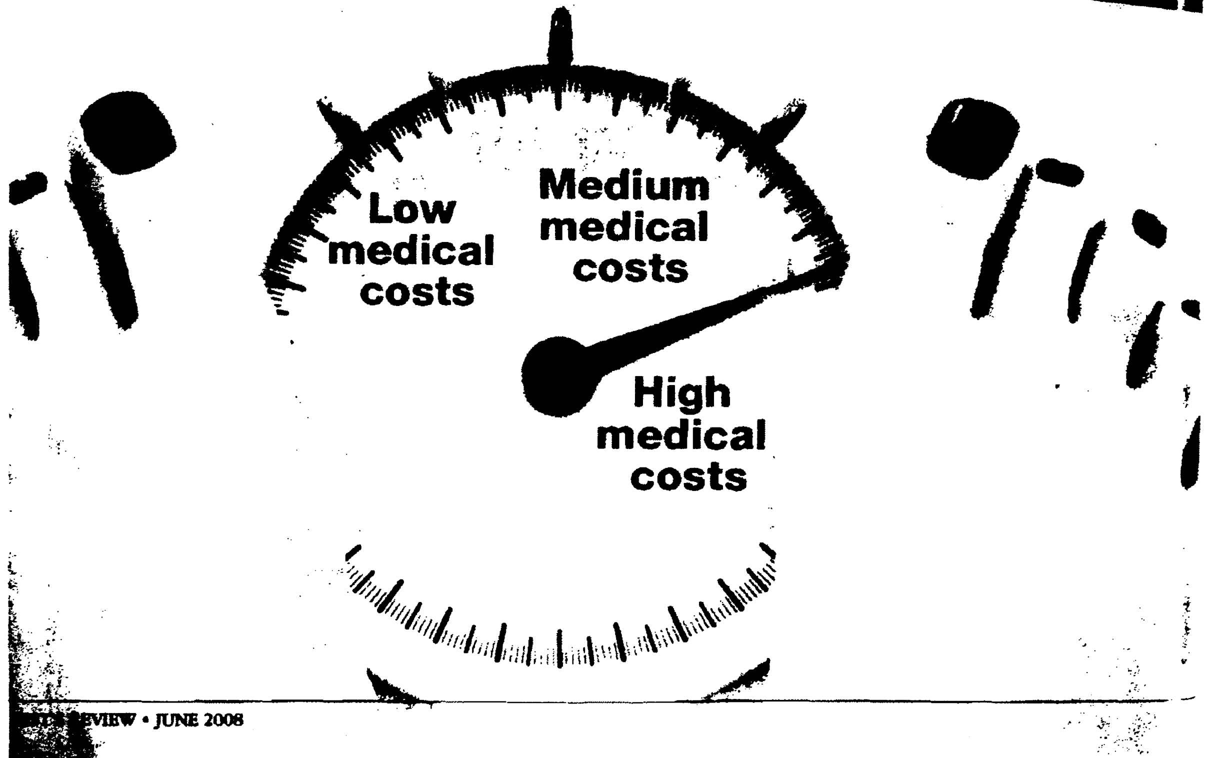
A Weighty Issue

Increasing obesity is placing a heavy burden on U.S. workers' compensation claims.

by Meg Green

The statistics are staggering: Not only are obese workers more likely to file workers' compensation claims, but those claims are likely to be more costly.

A Duke University Medical Center study found that obese workers filed twice the number of workers' compensation claims; had seven-times higher medical costs from those claims; and lost 13-times more days of work from work injuries or work illnesses than did non-obese workers.



Given the strong link between obesity and workers' compensation costs, maintaining healthy weight is not only important to workers but also should be a high priority for employers, said Truls Ostbye, M.D., Duke professor of community and family medicine and one of the study's authors.

Woody Dwyer, senior ergonomics consultant with Travelers, couldn't agree more. He talks about obesity and health in every loss review presentation he does with employers, and with good reason.

"Obesity is a real risk management issue. The rate of growth in obesity has been enormous from 1997 to 2002," Dwyer said.

"I think corporations are starting to recognize it."

A Growing Problem

According to the U.S. Centers for Disease Control and Prevention, one in four Americans in some 22 states were obese in 2006. In two of those states—Mississippi and West Virginia—one in nearly every three people were considered obese.

It's not simply that there are more obese people today. It's that obesity puts additional stress and strain on the body, so obese workers are more likely to wind up injured.

"Obese people already have additional stress on their joints and backs," said Mike Lemrick, senior vice president of Managed Care Services at Cambridge Integrated Services. "In some cases, the workers' comp claim is a direct result of the strain of the obesity. Say a worker was walking and their knee gave out. If it happens at work, it's a workers' comp claim because most states are no fault, when in truth, it was the obesity."

The Duke study examined the medical records of 11,700 Duke University workers who had a least one medical checkup between 1997 and 2004. During the study, workers filed 2,539 workers' comp claims totally $5 million in medical claims and another $5 million in indemnity claims.

▶ The News: Obese workers cost employers significantly more in workers' compensation claims.

▶ The Background: One study found obese workers generate twice the number of claims, along with skyrocketing treatment costs and lost workdays, compared to workers at healthy weights.

▶ The Payoff: Insurers and claims professionals are encouraging employers to help workers maintain a healthy weight.

Researchers examined workers' body mass index data, which indicates whether one's weight is "recommended," or higher than it should be. A BMI score of 18.5 to 24.9 is considered a healthy weight; 25 to 29.9 is considered overweight; and 30 and above is considered obese.

The Duke study found that workers with BMIs of 40 or higher also racked up the highest costs stemming from their injuries. Medical claims alone per 100 workers ranged from an average $7,500 for claimants with a healthy BMI, to more than $13,300 for overweight workers and more than $51,000 for severely obese workers.

According to the Duke study, the body parts most prone to injury among obese workers were the lower extremities, wrist or hand, and back. The most common causes of these injuries were slips, falls and lifting, the study said.

Lemrick noted that when obese workers are injured, it generally takes them longer to heal.

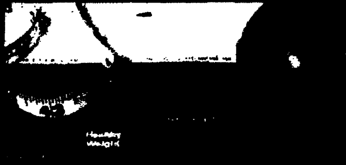
"One of the biggest issues you have to deal with is typically that someone who is defined as obese is a lot more sedentary," he said.

"For wound recovery, for instance, you need people to be up and mobile, to have their circulation moving so their wound can heal properly. The more sedentary an injured worker is, the more complications there are. The body just cannot heal as efficiently as it would if you were mobile."

Obese Workers

- Weight puts additional strain on back and joints (wrist, knees, hand)
- Most common causes of injuries—slips, falls and lifting
- File twice the number of workers' compensation claims
- Lose 13 times more days of work from job-related injuries or illnesses than non-obese workers

Source: Duke University



What Is Obesity?

A person is considered obese when his weight is 20% or more above normal weight. The most common measure of obesity is the body mass index or BMI. BMI is a measure of an adult's weight in relation to his height—specifically, the weight in pounds multiplied by 703, then divided by the square of his height in inches.

BMI categories are:

Underweight: BMI score of less than 18.5

Normal weight: BMI score of 18.5 to 24.9

Overweight: BMI of 25 to 29.9

Obese: BMI of 30 or greater

Doctors term a person "morbidly obese" if that person is either:

50% to 100% over normal weight

More than 100 pounds over normal weight

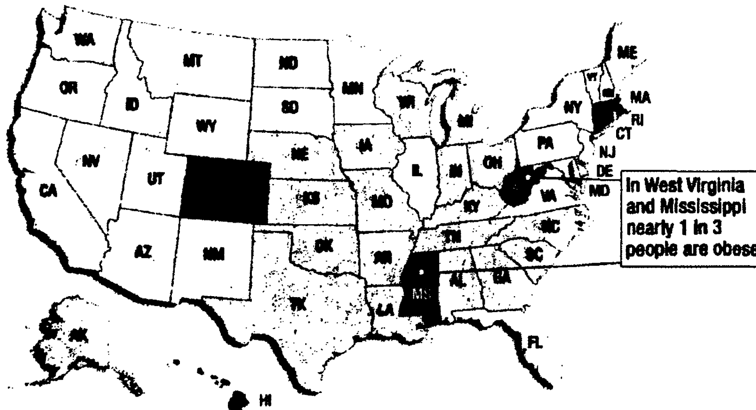
Has a BMI of 40 or higher

Is sufficiently overweight to severely interfere with health or normal function.

Source: National Heart, Lung and Blood Institute

Percent of U.S. Adult Population That Is Obese (BMI 30 and Above)

15%-19% | 20%-24% | 25%-29% | More than 30%



Source: U.S. Centers for Disease Control and Prevention

Also, since obesity itself puts unnatural strain on the body, strains and sprains can be especially difficult injuries to overcome. "Not only does the injury have to heal, but if it's a strain or a sprain of a joint, the joint has to heal enough not just to support a normal weight, but get further in the healing process so that it can support more weight, which also takes longer," Lemrick said.

There may also be complications, Lemrick added, when obese employees undergo gastric bypass surgery to shrink the stomach and induce significant weight loss.

"In some cases, depending on how the surgery is done, it can create weaknesses in the muscles," Lemrick said. "We had one case with an injured worker who went through two surgeries of gastric bypass, and ended up injured at work from lifting a toaster. We had a difficult time separating the occupational injury from the personal injury."

There may be complications when obese employees undergo gastric bypass surgery.

—Mike Lemrick, Cambridge Integrated Services

Weight Lifters

Hospitals are becoming focal points for obesity-related injuries to medical workers who must lift and move ever-heavier patients.

Dwyer noted that one major study, which was examining the risks of lifting patients, found a hospital where, in a five-day period, 20 patients weighing over 300 pounds each were treated. Several weighed close to 400 pounds each, he added.

"Obese patients are increasing the potential risk to [hospital workers] and many hospitals aren't ready for it," Dwyer said. "One hospital had a 700-pound patient. I asked them what their policy was, and they said they called the fire department. So, basically, they transferred the risk to the fire department."

He said 94% of nurses in the United States are women, and the average age is 45 to 46.

"Women tend to have a lower level of strength, and compound that with them trying to move heavier patients each year," Dwyer said. "It's a real concern."

Hospital can use machines to help move obese patients, but some are only rated to handle up to 400 pounds. "So if a patient comes in at 480, and your lift is 400, you are at risk because your

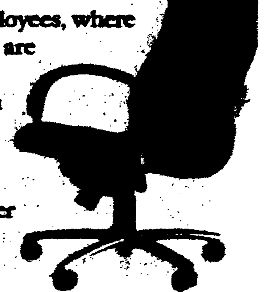
Take a Seat

Obese workers also are an issue when it comes to seating, said Woody Dwyer, senior ergonomics consultant with Travelers.

Employers need to make sure their equipment matches the needs of their employees. For example, a chair rated for up to 275 pounds will not be adequate for an employee who weighs more than that.

"If you are not aware of that, a person can break the chair back and fall out," Dwyer said. This can be an issue in a call center with hundreds of employees, where there might be 20% to 30% who are obese.

There can also be issues with obese people not being able to physically fit into a standard work space. For example, think of a mechanic having to maneuver under the hood of a car, Dwyer said.



equipment isn't designed to handle them," he said.

Hard to Talk About

There's no question that obese workers who are injured on the job are causing more expensive workers' comp claims, but it's something companies can be reluctant to address.

For instance, it can be socially awkward, Dwyer acknowledged, to answer an obese worker who asks how they should be placing their hands on the keyboard.

"If you are fairly wide through the shoulders and chest, you might have to reach around to reach the keyboard. In some cases, we've had to get people a split keyboard," Dwyer said.

Both Dwyer and Lemrick said some companies are taking proactive steps to address their workers' weight issues by trying to make it convenient to live healthier lives at work. This can include gyms and exercise space at work, flex time, and offering healthy lunch alternatives.

"We see companies that have wellness programs, beautiful fitness centers and a dining department with healthy choices. We also see companies where the main source of food is the lunch truck that drives up to the facilities. We see a huge continuum of what people provide," Dwyer said.

Lemrick said companies tend to focus more on meeting the U.S. Occupational Safety and Health Administration standards than on whether or not workers are obese.

"It's not something you see prevalent education for in the workplace yet," he said. "We need to take the stigma of it not being politically correct, and somehow address it matter-of-factly. For any employer, their employees are their most valuable resource."

Who Is Obese?

Sample BMI ranges for a person who is 5 feet 9 inches tall:

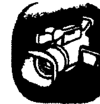
Weight Range	BMI	Considered
124 lbs or less	Below 18.5	Underweight
125 lbs to 168 lbs	18.5 to 24.9	Healthy weight
169 lbs to 202 lbs	25.0 to 29.9	Overweight
203 lbs or more	30 or higher	Obese

Source: U.S. Centers for Disease Control and Prevention

Learn More

Travelers Insurance Cos.
A.M. Best Company # 58470
Distribution: Independent agencies

For ratings and other financial strength information visit www.ambest.com.



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Appendix E

Health Care Reform Task Force
July 24, 2008

Nico Gomez
Communications Director
Oklahoma Health Care Authority
www.okhca.org

What is SoonerCare?

- Oklahoma's Medicaid Program
  - **Primary Care Case Management**
  - **Comprehensive Fee-for-Service Plan**
  - **Medicare Supplemental Plan**

Who qualifies for SoonerCare?

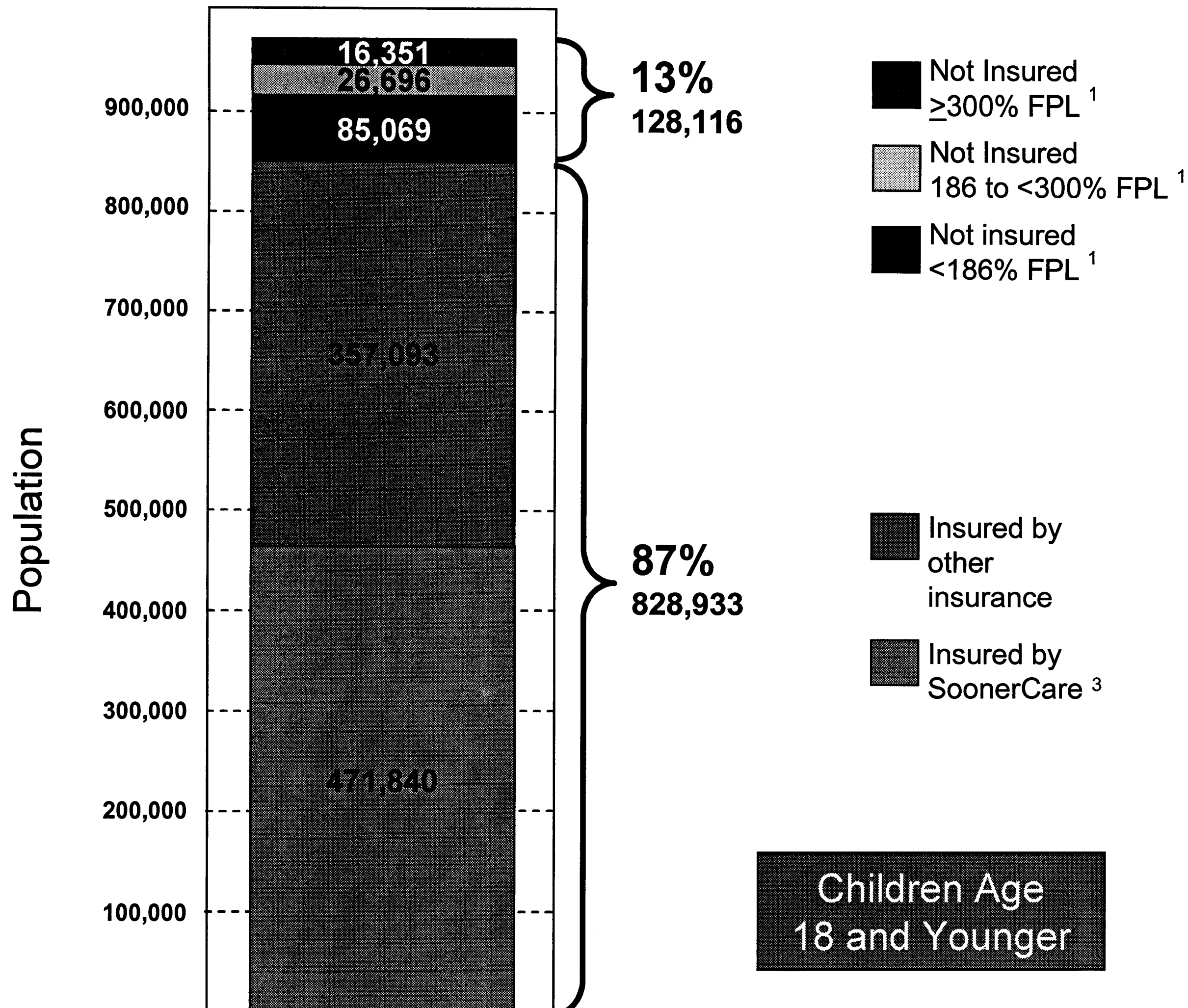
- Primarily:
  - **Low-income pregnant women**
  - **Low-income children**
  - **Low-income individuals who are aged, blind or disabled**

Many low-income workers are not eligible for Medicaid.

What is Insure Oklahoma?

- Oklahoma's Premium Assistance Program
  - **O-EPIC, Oklahoma's Employer/Employee Partnership for Insurance Coverage**
  - **Helps qualified workers and spouses buy health insurance through their employer**
  - **Option available for qualified Oklahomans who are not eligible for employer-sponsored insurance**

Oklahoma Children's Health Insurance Profile - 2006



Total Children's Population = 957,049 [1]

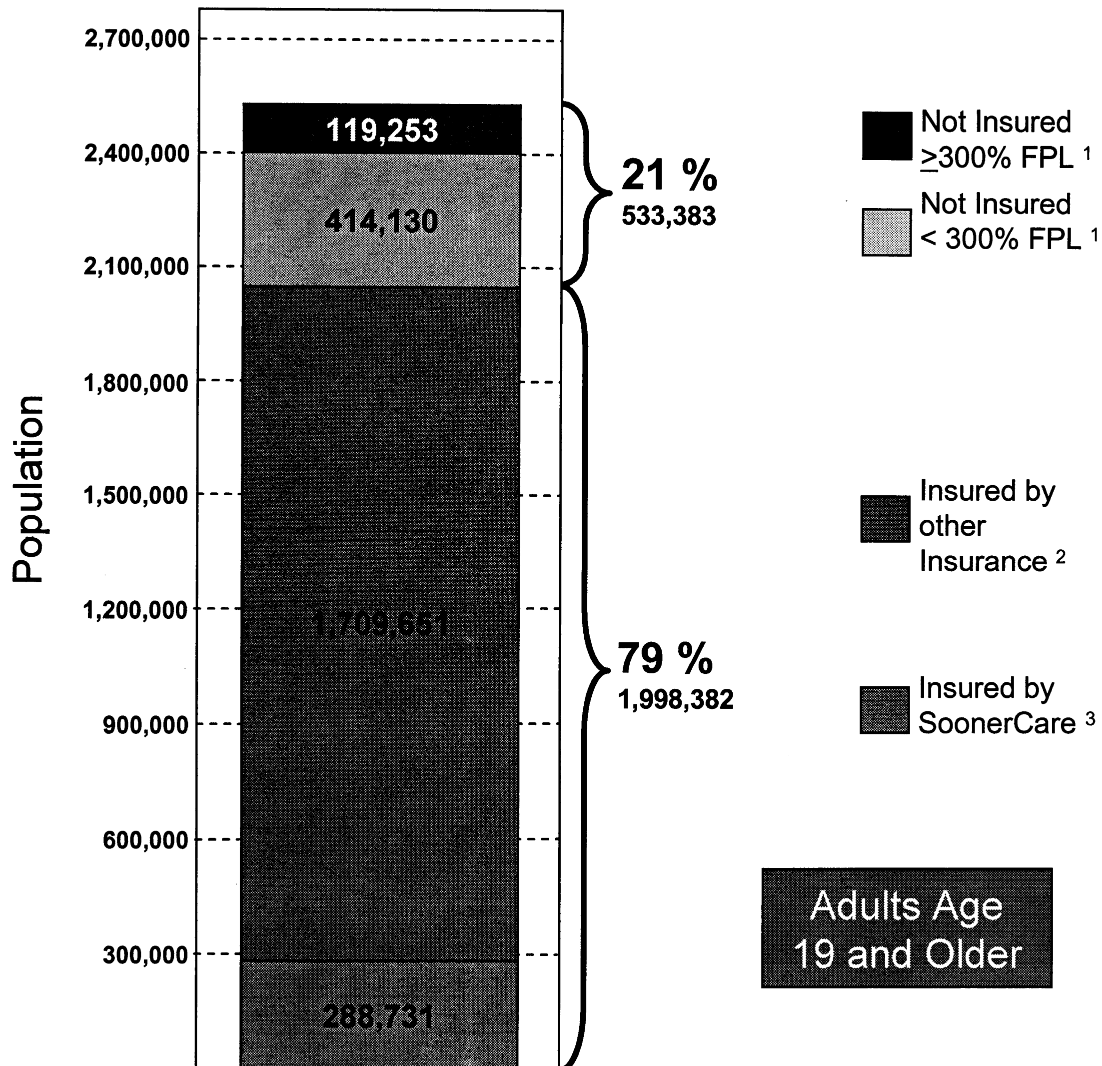
Sources:

1 US Census Bureau, Current Oklahoma Population Survey, Annual Social and Economic Supplement, 2007 Table Creator I, 2006 data collected in 2007, CPS Perso Poverty Universe. Excludes unrelated individuals under the age of 15. http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

2 Includes Insure Oklahoma O-EPIC ESI members, CY 2006

3 Unduplicated OHCA Annual Enrollment, CY 2006

Oklahoma Adults' Health Insurance Profile - 2006



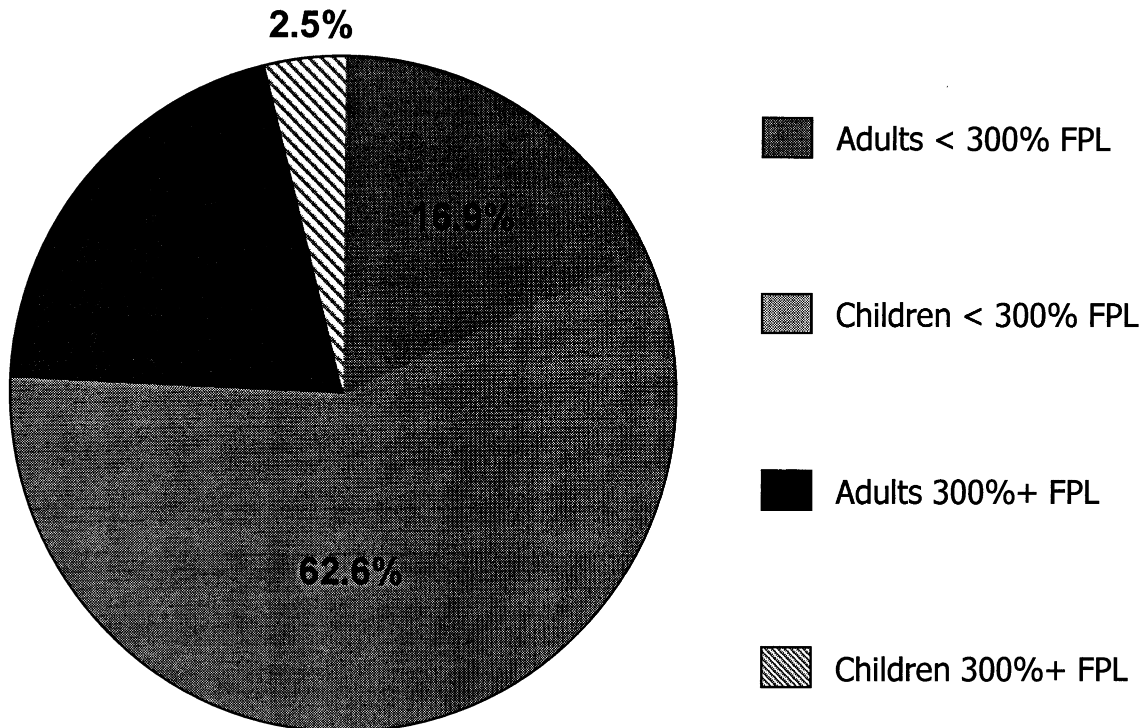
Total Adult Population = 2,531,765 [1]

Sources:

1. US Census Bureau, Current Oklahoma Population Survey, Annual Social and Economic Supplement, 2007 Table Creator II, 2006 data collected in 2007, CPS Persons in Poverty Universe. Excludes unrelated individuals under the age of 15. http://www.census.gov/hhes/www/cpstc/apm/cpstc_altpov.html
2. Includes Insure Oklahoma O-EPIC ESI members, CY 2006
3. Unduplicated OHCA Annual Enrollment, CY 2006

Oklahoma's Uninsured
"Who Are We Talking About?"

Distribution of Oklahoma's Uninsured Children and Adults by FPL (2006)



Source: US Census Bureau, CPS Table Creator. http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

A Matter of Affordability "Where's the Cliff?"

Adults and Children Uninsured Rates by Federal Poverty Level in Oklahoma (2006)

25.0%
20.0%
15.0%
10.0%
5.0%
0.0 %

19.4%
9.7%
13.9%
5.2%

■ ≥300%
■ 200 to <300%

Adults
Children

Source: US Census Bureau, CPS Table Creator. http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Adult Uninsured Rate by Age Range Under 300% FPL

Uninsured Rate

Age	Rate
19-34	48%
35-54	37%
55-64	30%
65-80	2%

Source: US Census Bureau, CPS Table Creator.
http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Distribution of Uninsured Adults Under 300% FPL

Source: US Census Bureau, CPS Table Creator.
http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Pending Federal Approval

- Insure Oklahoma
  - **Children up to 300% FPL (All Kids Act)**
  - **Working adults up to 250% FPL**
  - **Employers with up to 250 employees**
  - **College students up to age 23**
  - **Next waiver request**
    - Foster care parents
    - Not-for-profit employers with up to 500 employees

Medicaid Reform Act of 2006

E-Prescribing

Health Management

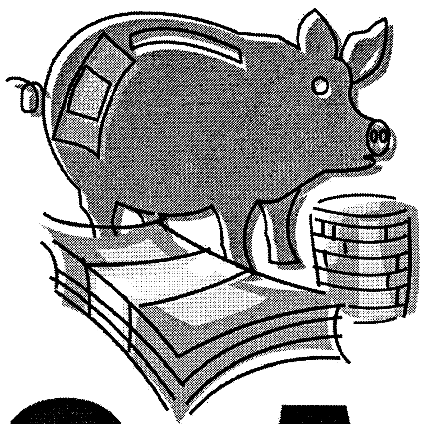
Focus on Excellence

Appropriate ER Use

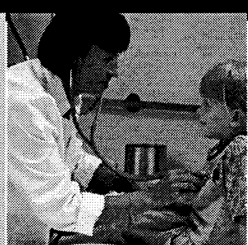
Health Care Reform Task Force
July 24, 2008

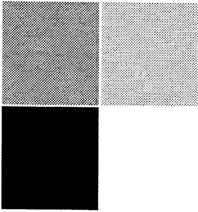
Nico Gomez
Communications Director
Oklahoma Health Care Authority
www.okhca.org

Appendix F



HEALTH SAVINGS ACCOUNT





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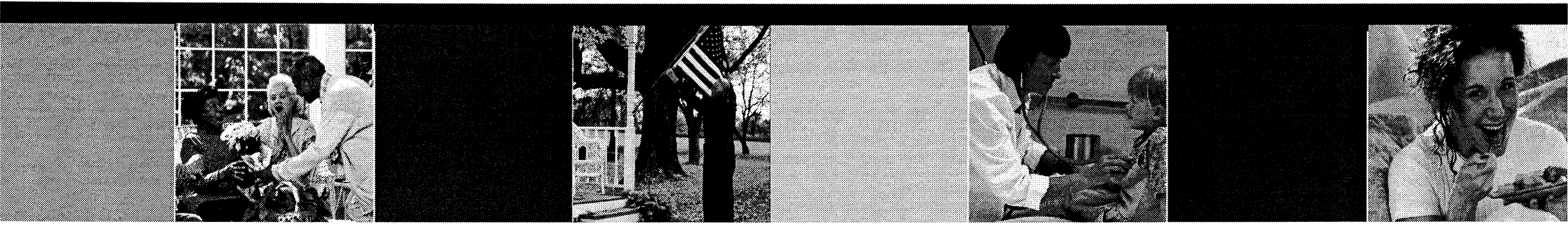
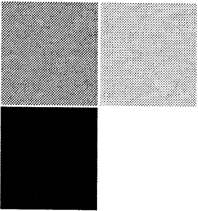
- 5 Strategic Business Units
- K-12 Schools
- Associations (Auto Dealers)

Products & Services

- Disability, Cancer, Accident Only, Hospital Indemnity, Life, Supplemental Medical
- S125/Flex/HRA/**HSAs**
- Annuities





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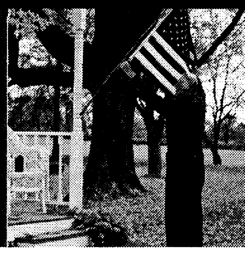
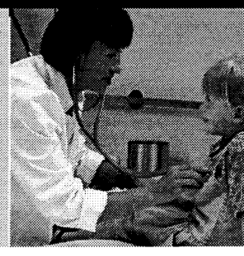
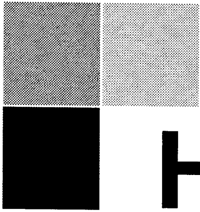
Two Components

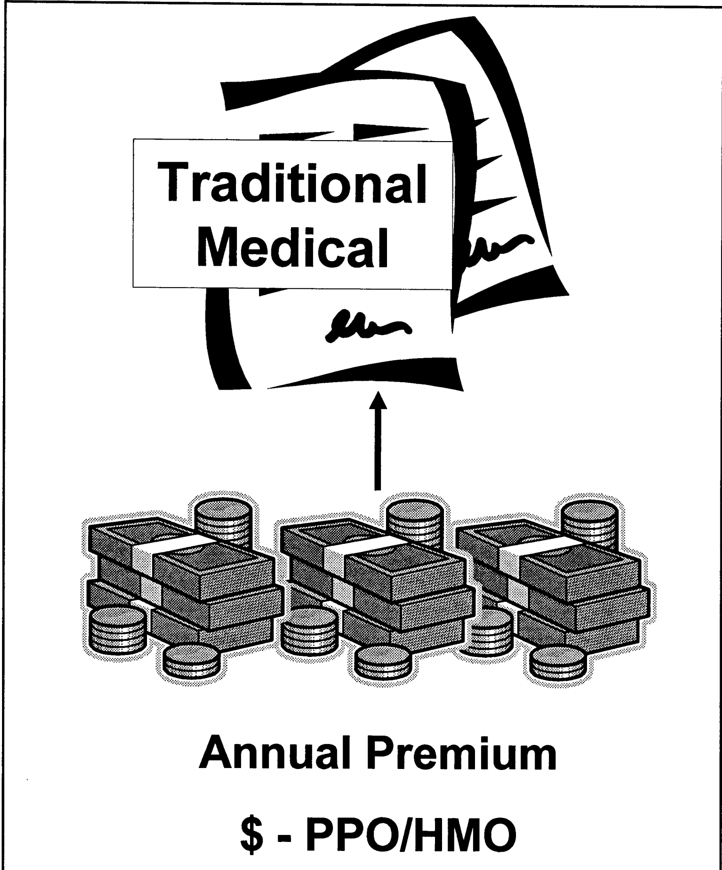
Qualified
High Deductible
Health Plan

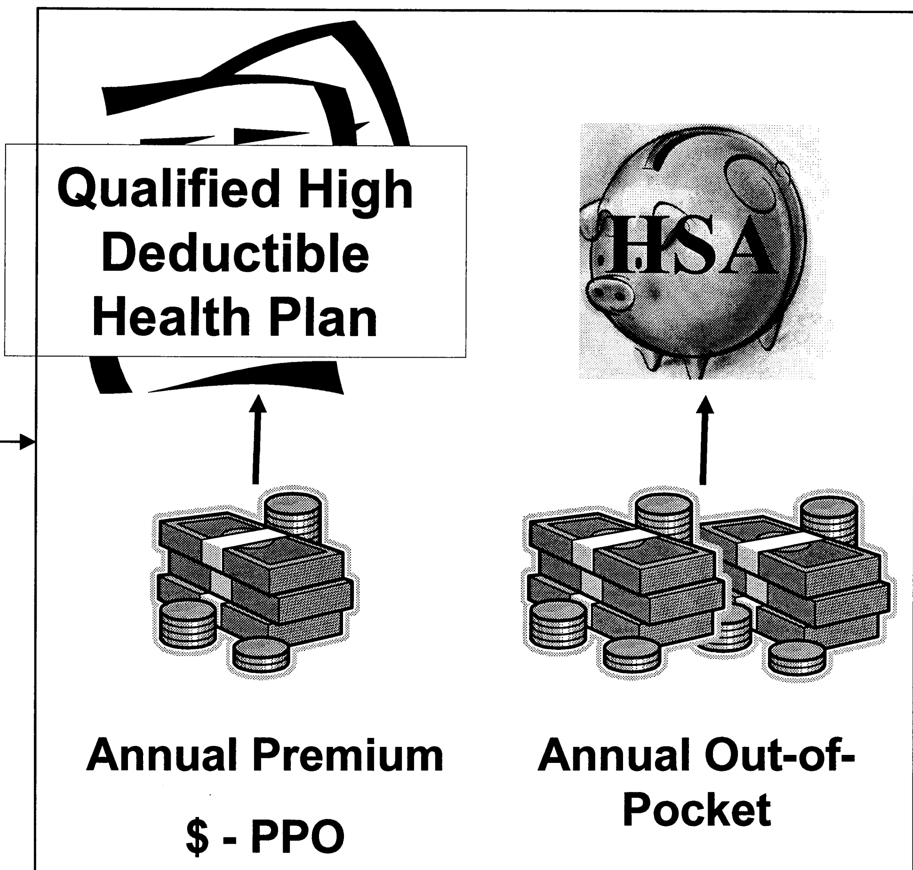
Health Savings
Account

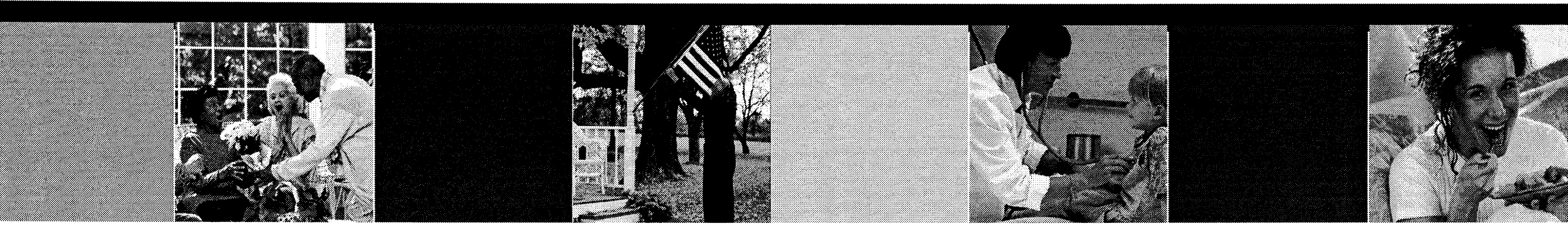



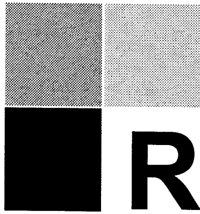
How it Works











Reasons for CDHP

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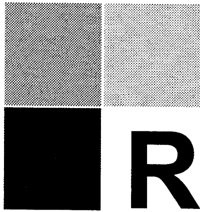
- Reduce medical spending
- EE/Individuals must take responsibility for their health & the cost attached to their health care decisions
- Interest in tax advantages



Reasons for CDHP

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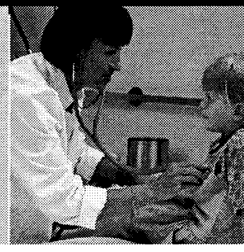
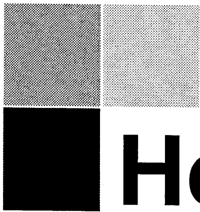
- Potential to offer employees trade -- higher premium & annual increases for lower rates on both -- seed money
- Transparency of medical costs
- Patients become empowered when they realize that they can take charge of their healthcare





Health Savings Accounts

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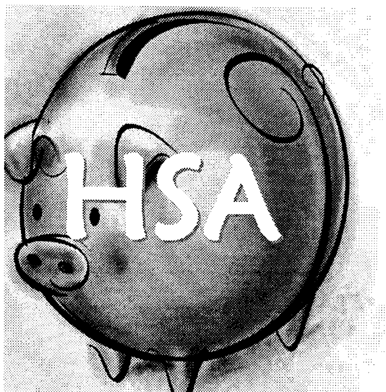
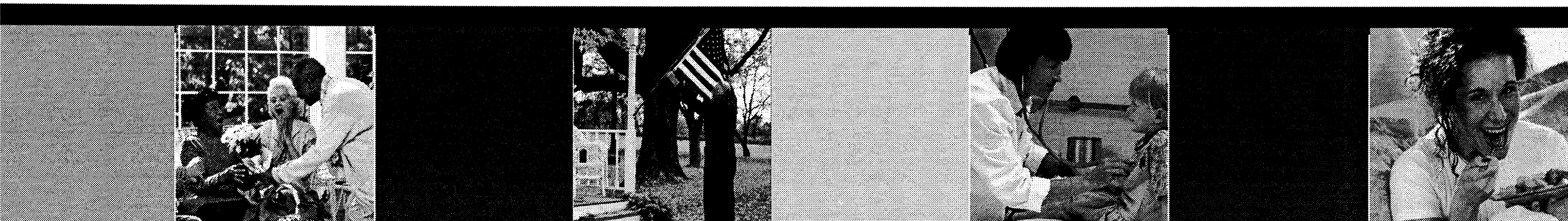
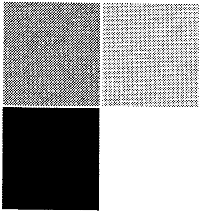


- Individually owned savings account
- Contributions, distributions, interest earnings – tax free
- No maximum on amount on accumulation
- Pay for qualified medical expense for spouse & tax dependants
- Portable





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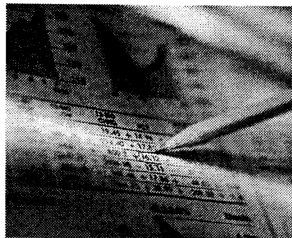
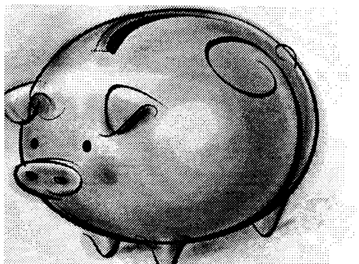
AF Health Services Administration



Strong offering of mutual funds that cross all investment risk tolerances.

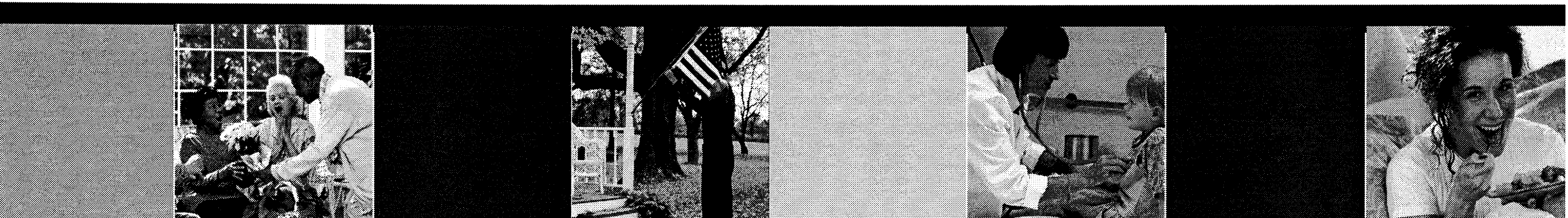
$2,500 Minimum Requirement

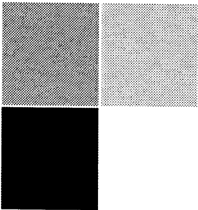


Accounts are invested in money market funds.

Total interest passed on to the account holder.

One monthly fee.





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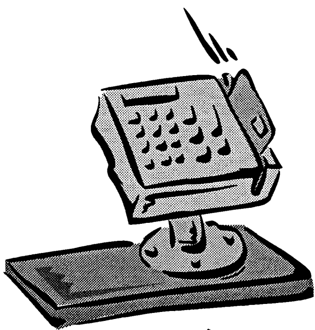
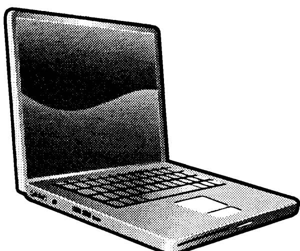
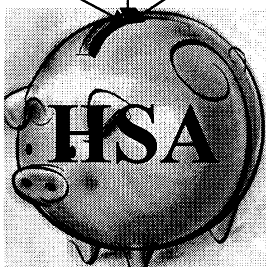
AF Health Services Administration







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HEALTH SAVINGS ACCOUNT
Distribution Request Form

A. General Information			
Name		Social Security #	
Employer Name (if applicable)		Address	
Employer Address (if applicable)		City, State, Zip	
Daytime Phone	( )	Home Phone	( )

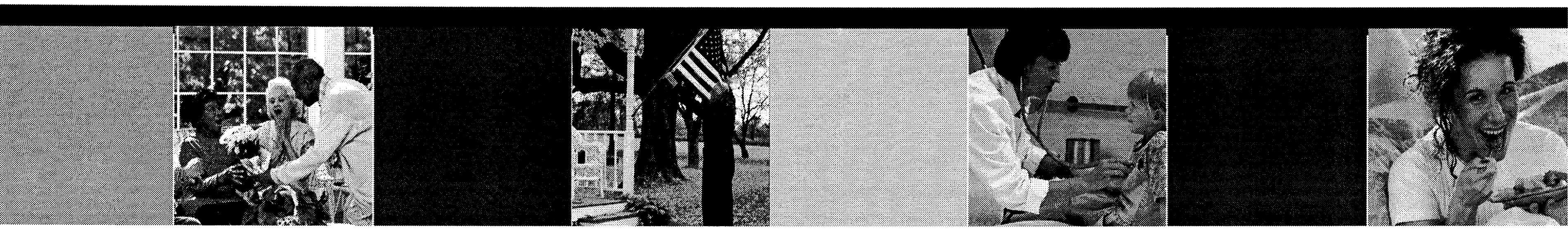
B. Distribution Information			
Distribution amount	$	☐ Check ☐ Direct Deposit	Method of distribution (For direct deposit, complete Section C)
Reason for distribution	☐ Eligible Medical Expense ☐ Excess Contribution Removal ($20 fee) ☐ Ineligible Medical Expense	☐ Yes ☐ No	Will this distribution close the account? ($20 closing fee)

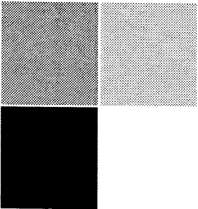
C. Direct Deposit Information (if applicable)			
Bank Name		Bank Phone	( )
Deposit Account	☐ Checking ☐ Savings	Bank Routing Number	
		Bank Account Number	

ATTACH COPY OF VOIDED CHECK/SAVINGS WITHDRAWAL FORM HERE

Signature of Accountholder — Date

FOR OFFICE USE ONLY	RECEIVED BY	PROCESSED ON	PROCESSED BY





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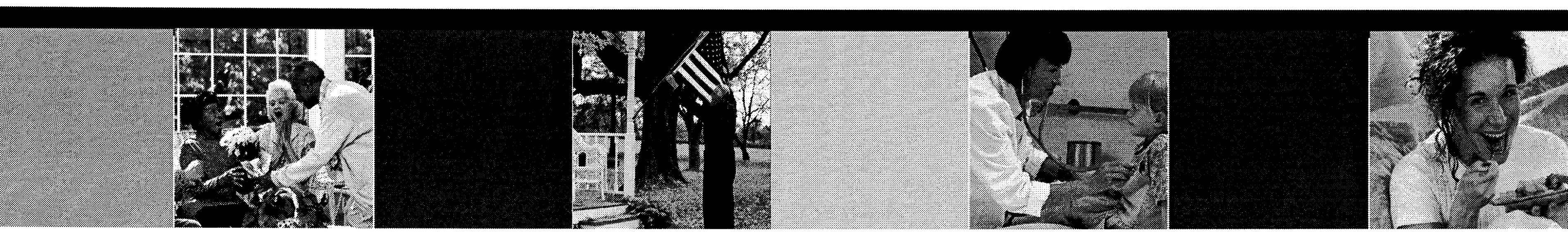
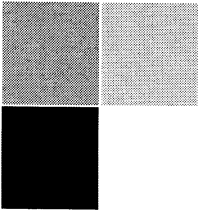
AF Health Services Administration

	2005	2006	2007	2008 (as of June)
Employers	7	18	24	29
Account Holders	68	124	421	639
% Increase		8.2%	239%	52%
Annual Contribution	$60,678.31	$163,137	$244,872	$763,578
Avg Mo Contribution	$204	$140	$257	$194





American Fidelity Health Services Administration
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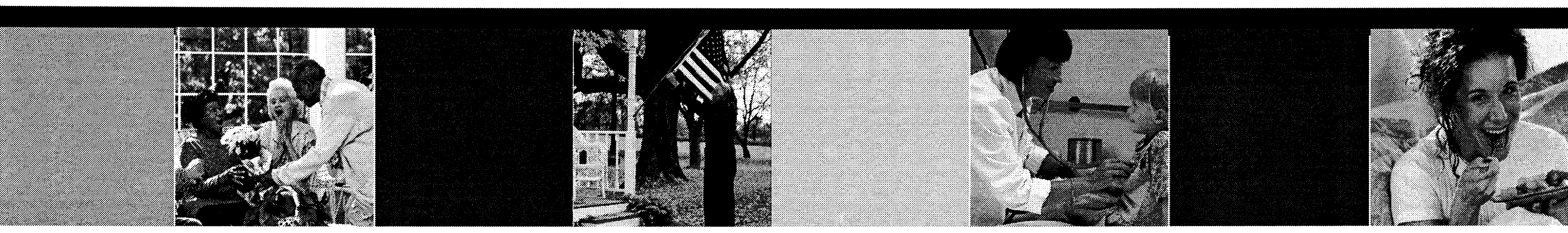
AF Health Services Administration

	2005	2006	2007	2008 (as of June)
Account Holders	68	124	421	639
Total To Date Contributions	$60,678.31	$223,815	$468,687	$1,645,388
Avg Mo Contribution	$204.19	$140	$257	$194
% Left on Deposit	96%	87.1%	62.9%	54%
Withdrawals w/Debit Card			89%	91.6%



American Fidelity Health Services Administration
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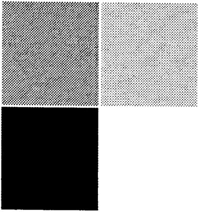
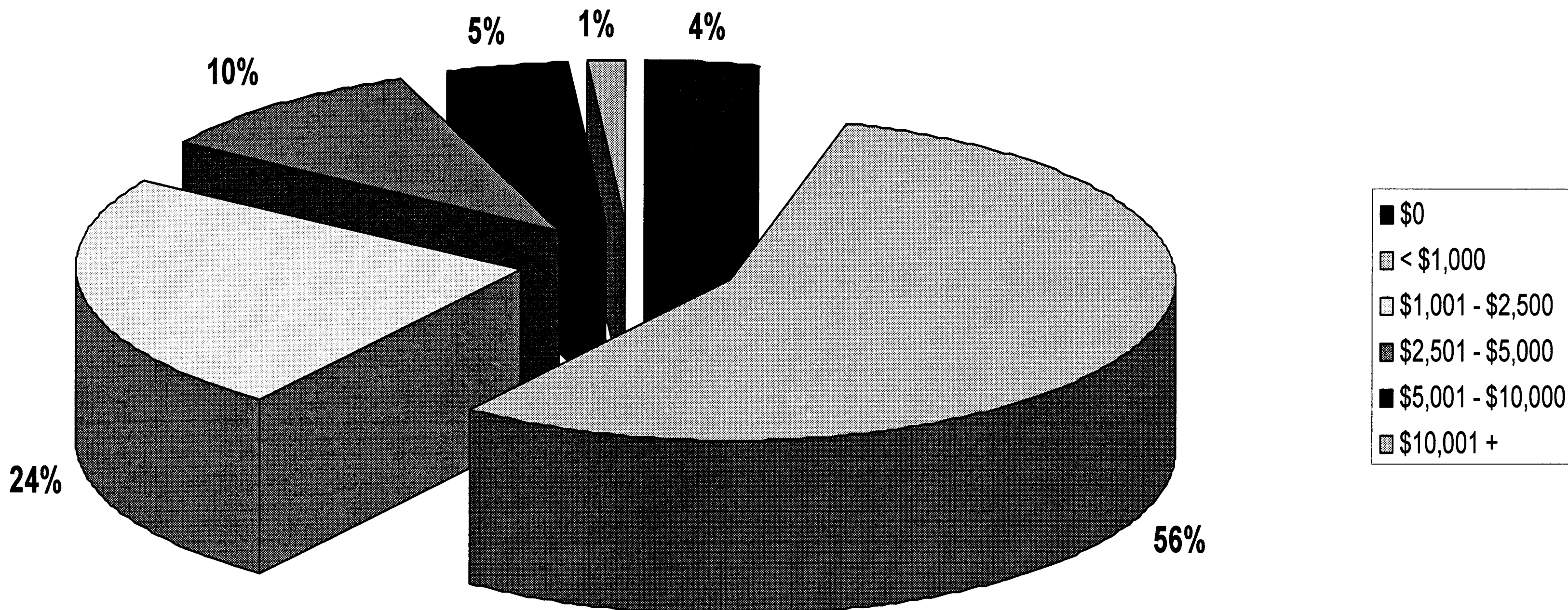
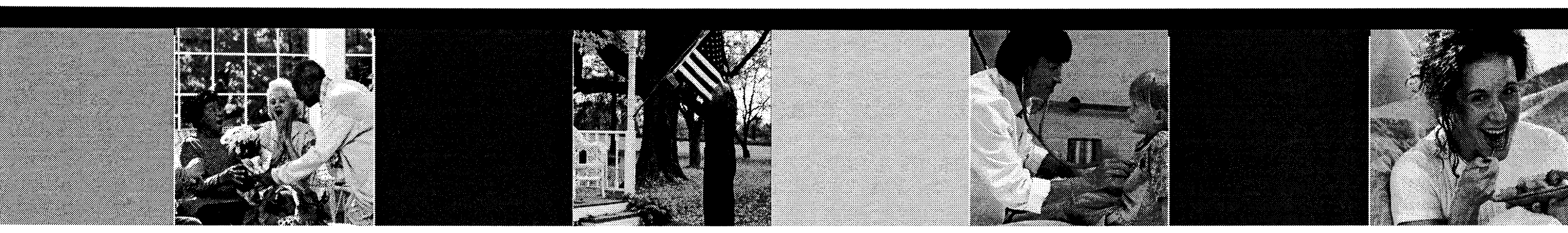
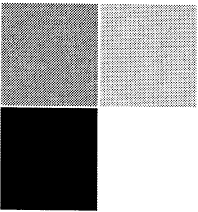
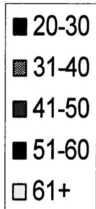


AF Health Services Administration

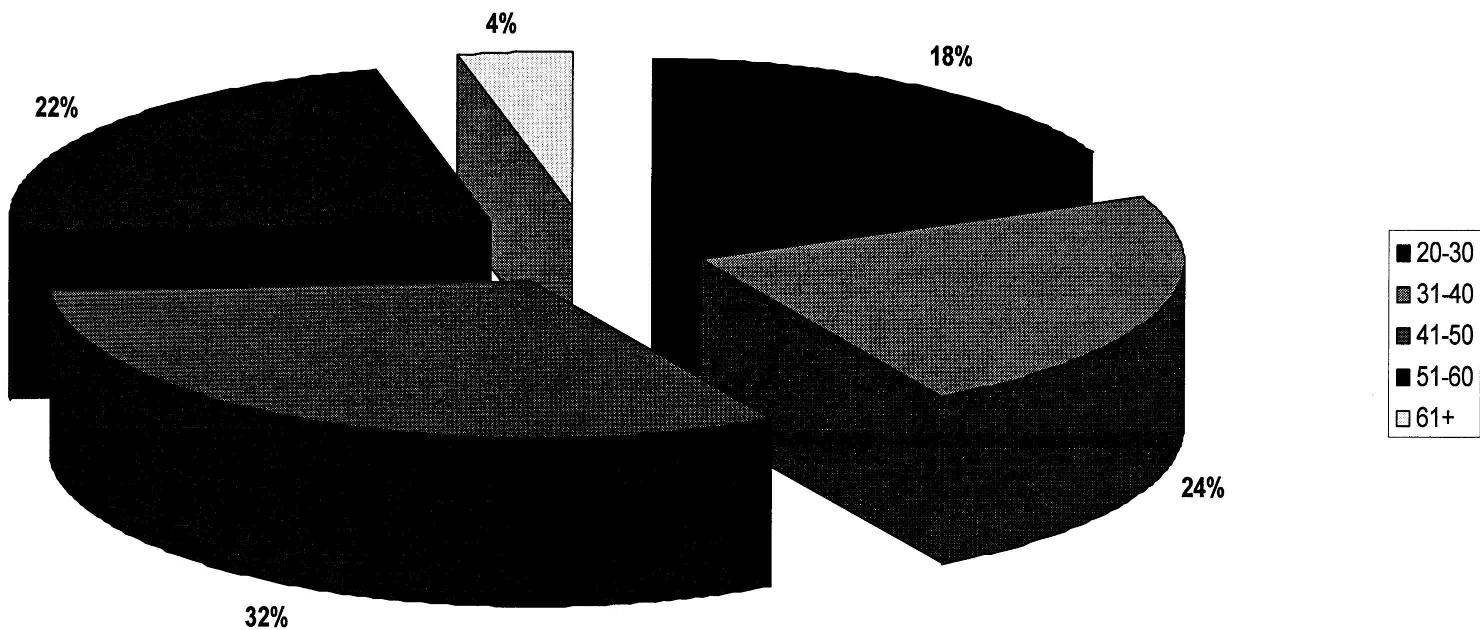


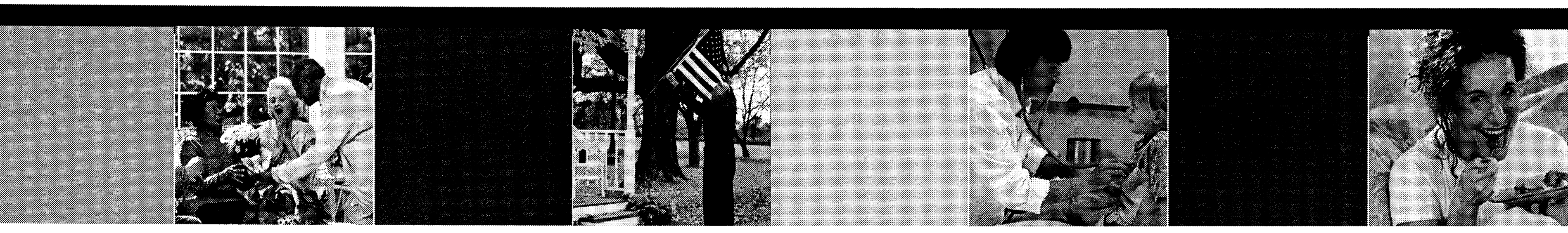


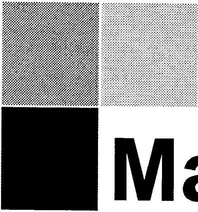




AF Health Services Administration







Market Approach

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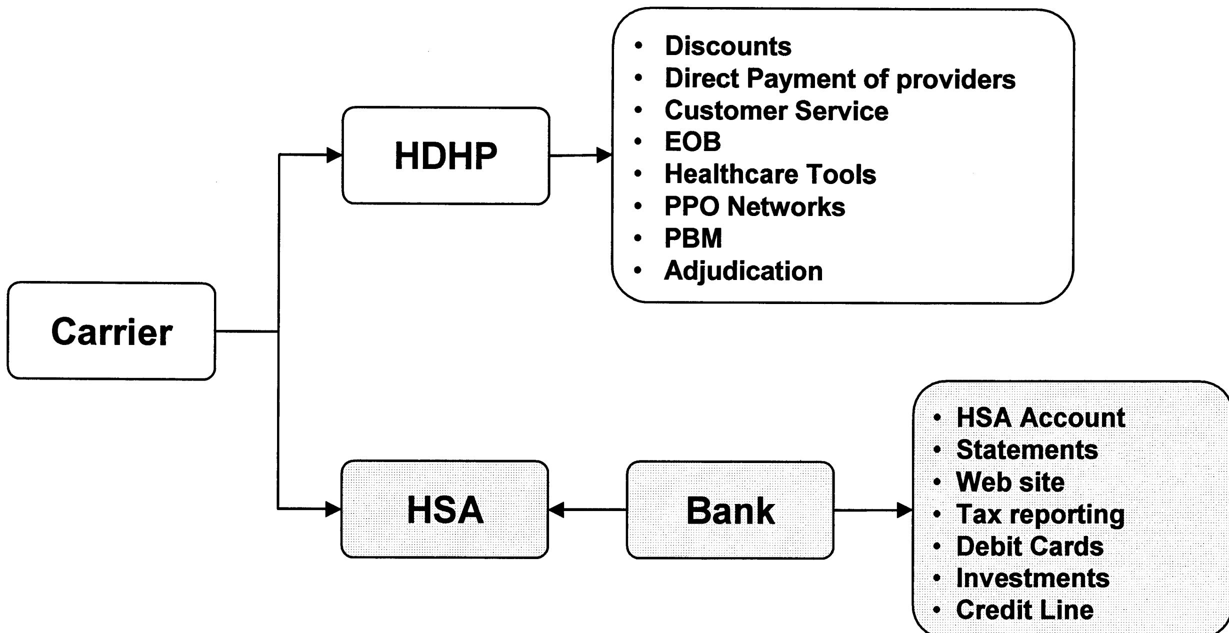

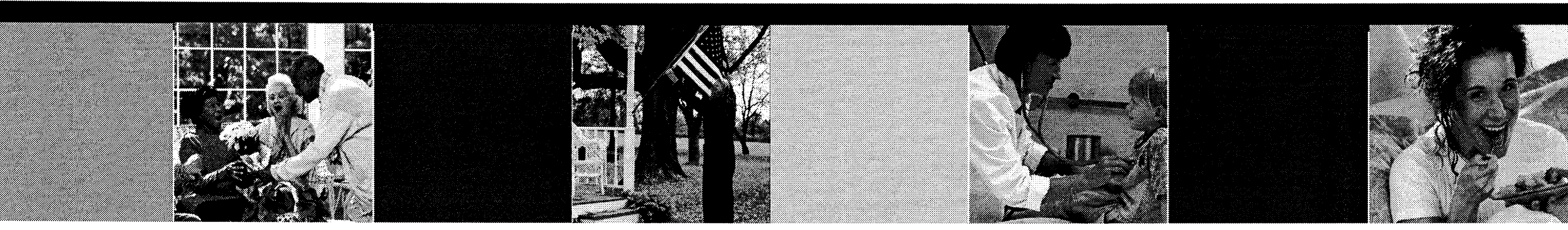

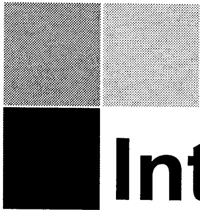

Integrated Approach

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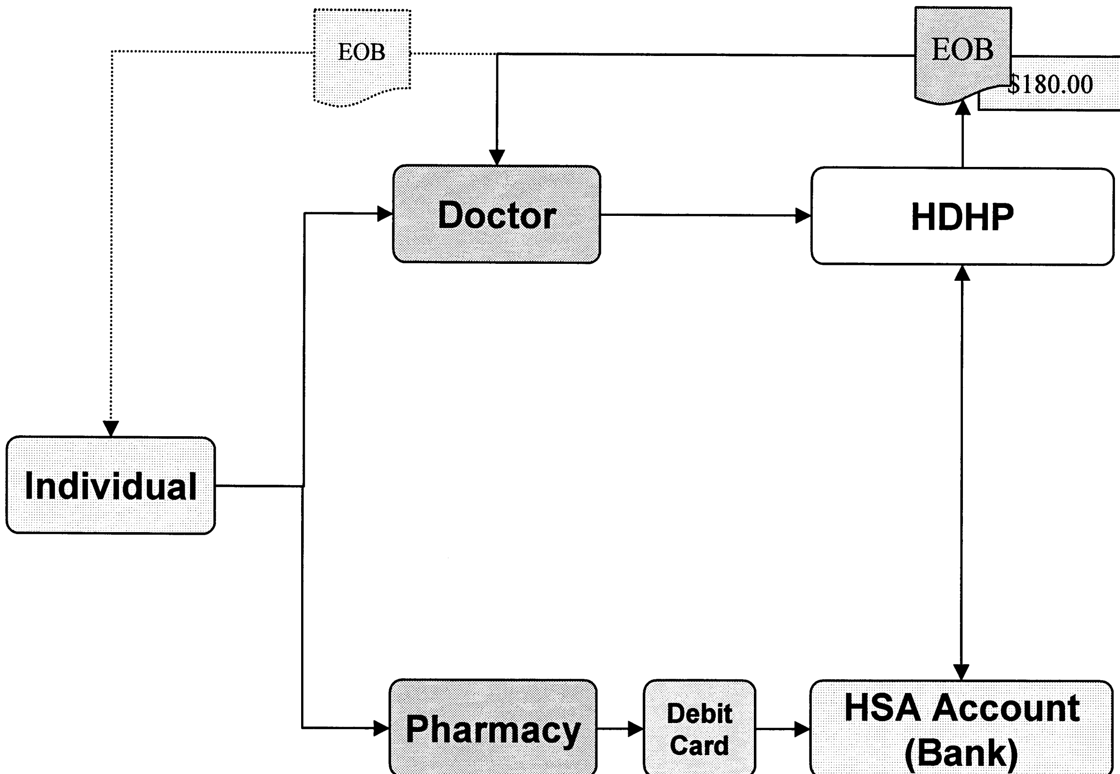
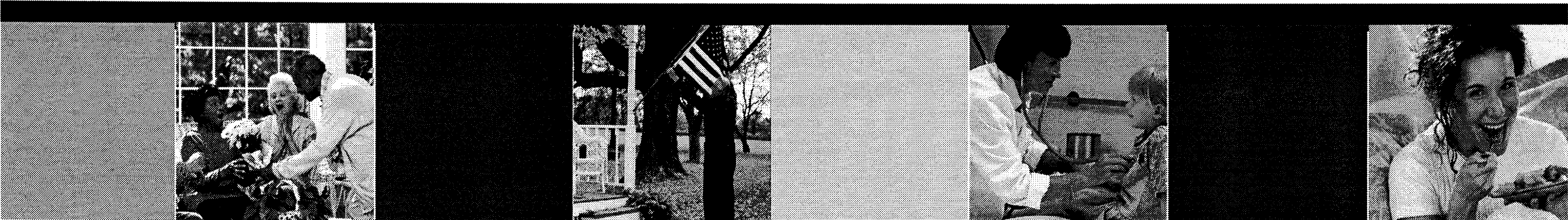


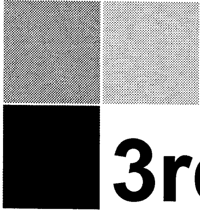
$ 300.00 Provider Bill

$ 180.00 40% Discount (120.00)

$ 144.00 80% Insurance Pays

$ 36.00 20% Insured Pays





3rd Party Administration Approach

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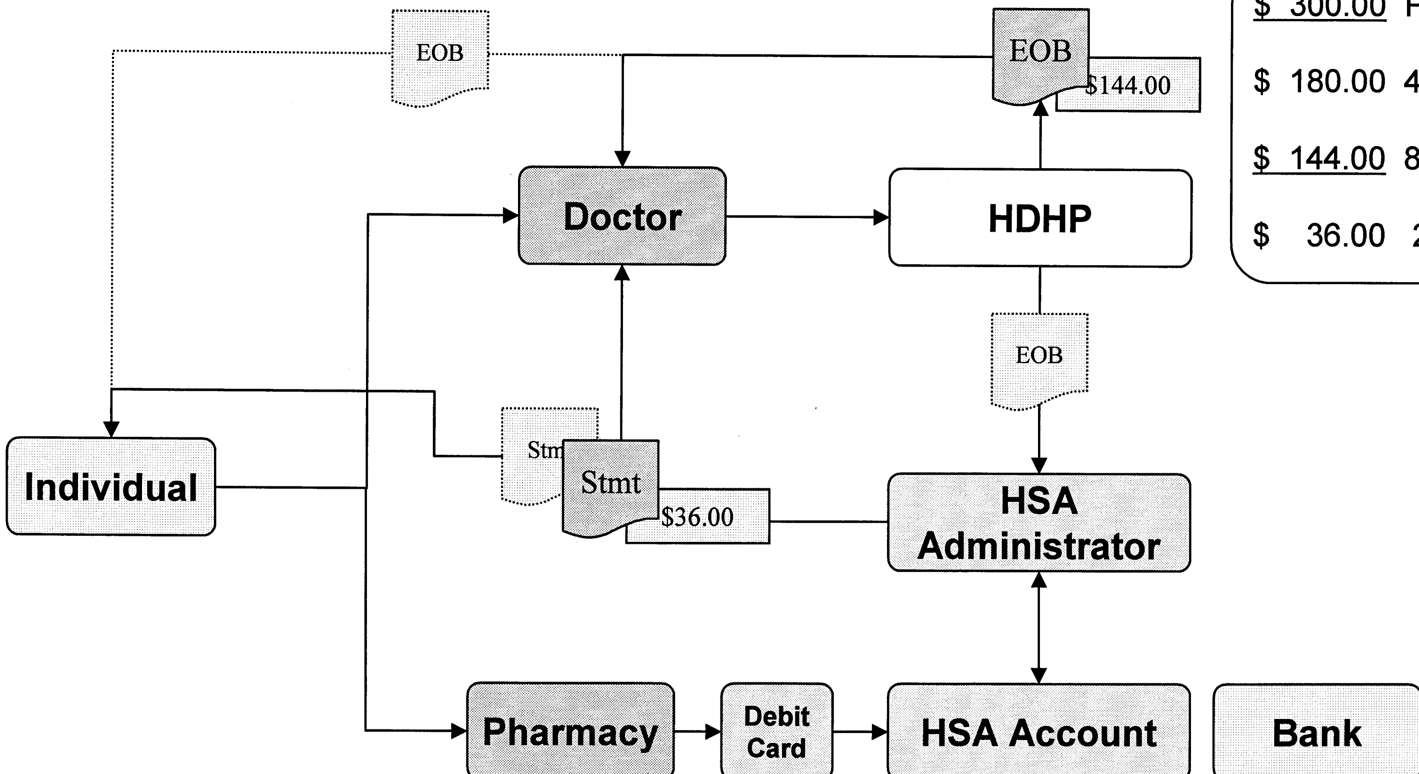

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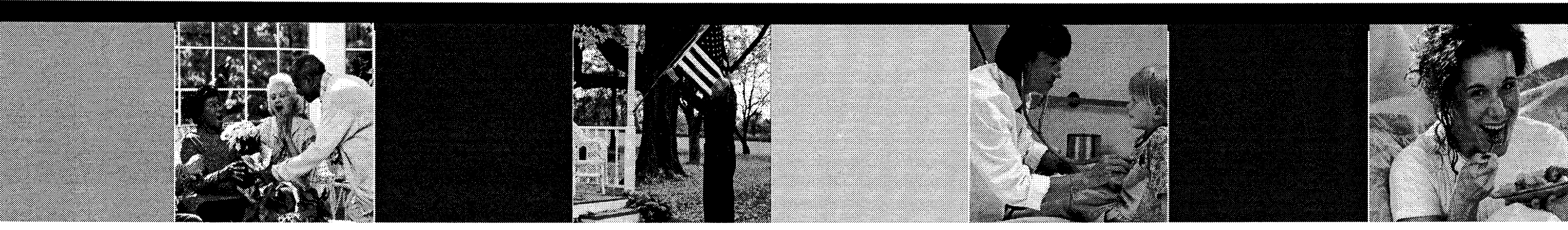
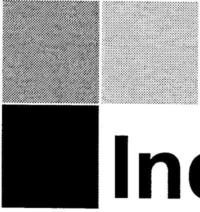


Independent Approach



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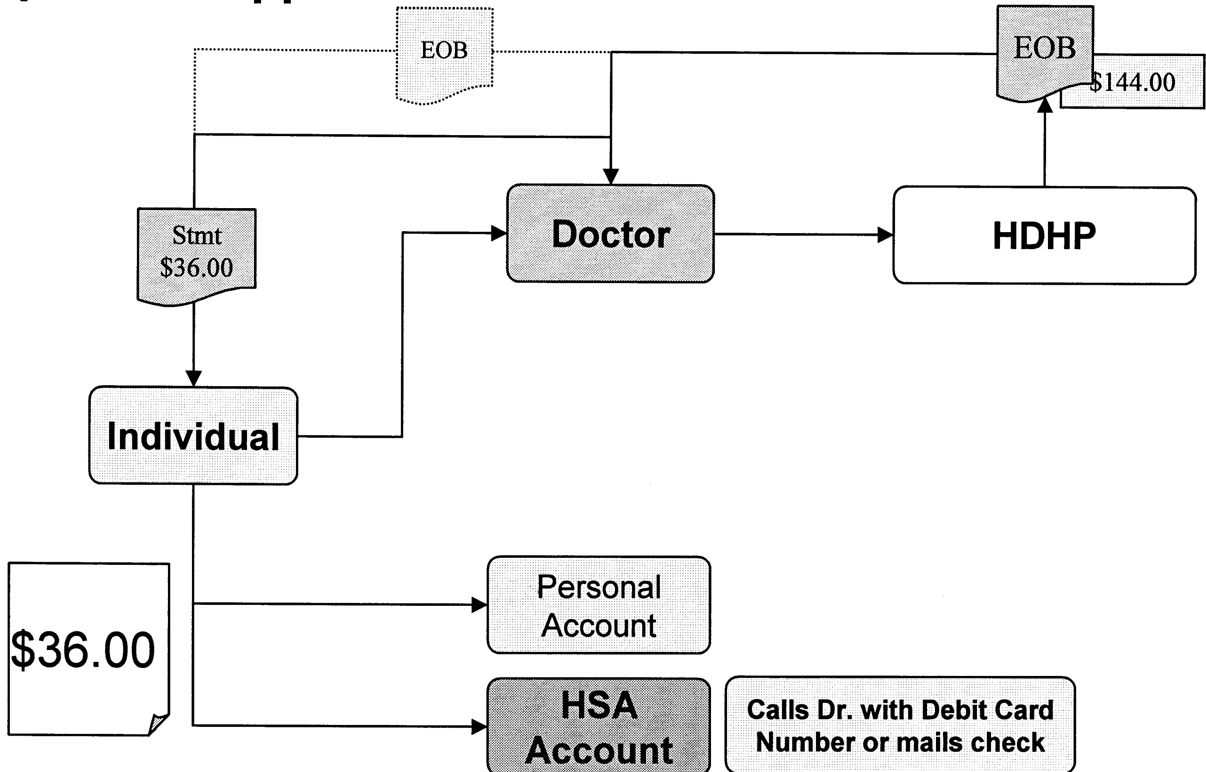
Independent Approach



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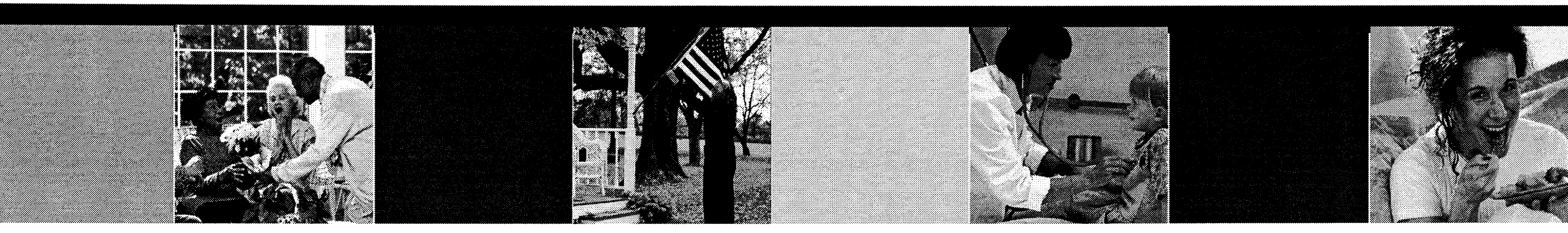


Appendix G

Oklahoma and health reform

Grace-Marie Turner
Galen Institute

August 12, 2008

Who are the uninsured?

- Workers transitioning between jobs
- Small business employees
- Workers in low-wage jobs and their dependents
- Young adults
- Minorities, especially Hispanics
- Undocumented workers

Uninsured rates in 2006

	Number	**Percent**
Wisconsin*	481,000	8.8
Oklahoma	661,000	18.9
Texas	5,704,000	24.5
United States	46,995,000	15.8

*According to the U.S. Census Bureau press release on the Current Population Survey, "the rates for Minnesota, Hawaii, Iowa, Wisconsin and Maine were lower than the rates of the other 45 states and the District of Columbia. The rates for these five states were not statistically different from one another."

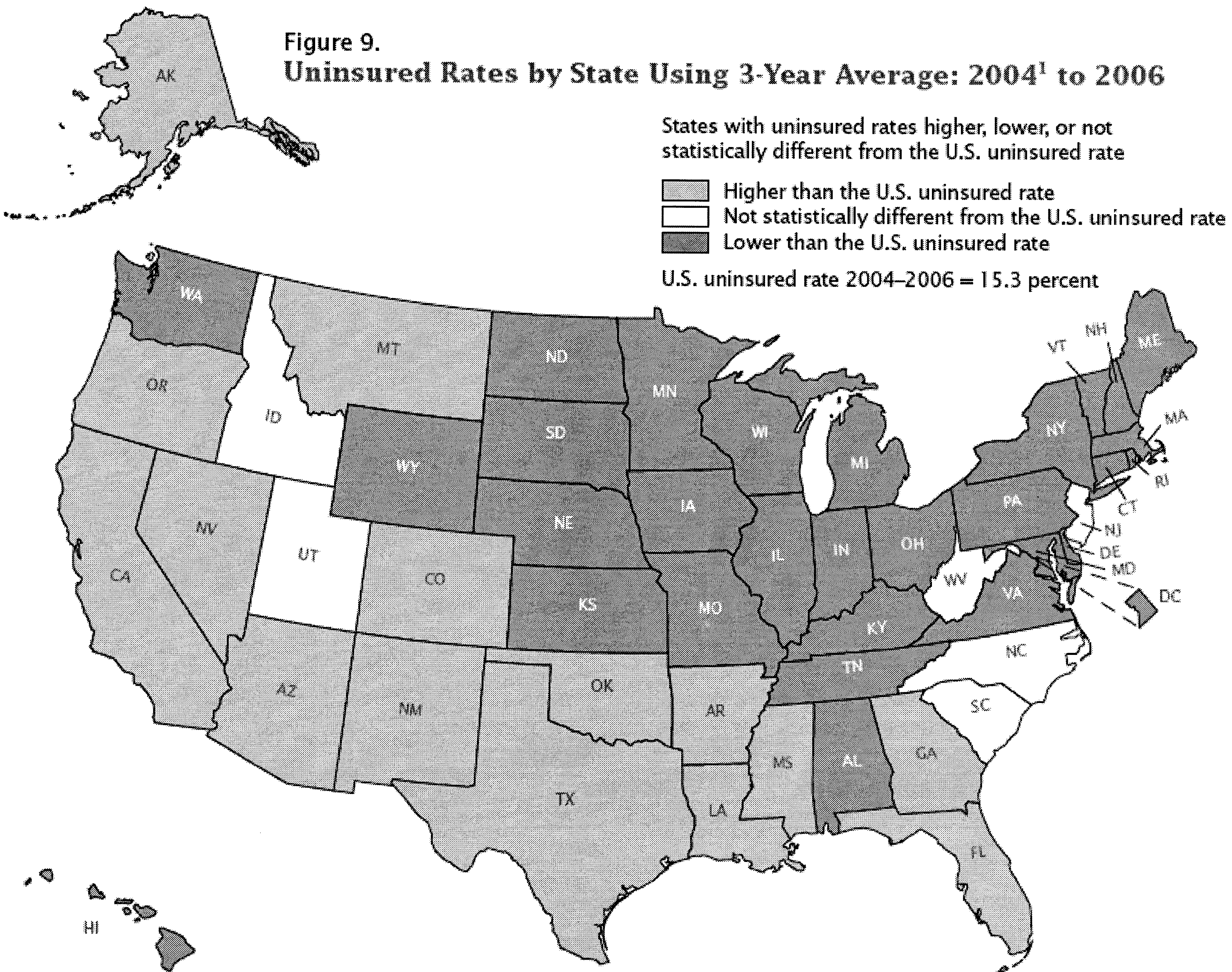
Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Last revised: August 28, 2007. http://pubdb3.census.gov/macro/032007/health/h06_000.htm.

Income distribution

State	Median Annual Income
Wisconsin	$48,874
Oklahoma	**$40,001**
Texas	$43,425
U.S.	$46,071

Figure 9.

Uninsured Rates by State Using 3-Year Average: 2004[1] to 2006



[1] The 2004 and 2005 data have been revised since originally published. See <www.census.gov/hhes/www/hlthins/usernote/schedule.html>.

Source: U.S. Census Bureau, Current Population Survey, 2005 to 2007 Annual Social and Economic Supplements.

Oklahoma's health insurance market

- 36 coverage mandates. (Idaho has the fewest with 14. Maryland the most w/ 60)*
- Oklahoma does not require guarantee issue. ME, MA, NV, NJ, NY, VT require all health plans to guarantee issuance to individuals **
- Oklahoma has modified community rating in the individual market; NJ, NY, VT require full community rating for all individual policies

* http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf
**Summary of State Guarantee Issue and Rating Requirements. America's Health Insurance Plans. December 2007.

Cost of mandates

- Mandated benefits currently increase the cost of basic health coverage from a little less than 20% to more than 50%, depending on the state and its mandates.*
- Numerous mandates and heavy regulations drive up costs. New Yorkers pay on average 3.5 times as much as residents of Iowa for insurance. ($98 vs. $338)**

*"Health Insurance Mandates in the States 2008," Council for Affordable Health Insurance, January 2008. www.cahi.org

**"The Cost and Benefits of Individual Health Insurance Plans: 2007" Forrester Research based upon eHealthInsurance data

Cost of individual insurance

- I could buy a $3,000 deductible policy in Oklahoma City for $200/mo. on eHealthInsurance.com* The most expensive is $400/mo. for a PPO with a $1,000 deductible. Choice of 10 plan options. Someone 20 years younger would pay $100/mo. for a higher deductible plan and $275/mo. for a lower-deductible policy.
- eHealthInsurance says the average individual policy nationwide costs $148 a month.

* http://www.ehealthinsurance.com

Costs of Job-Based Insurance

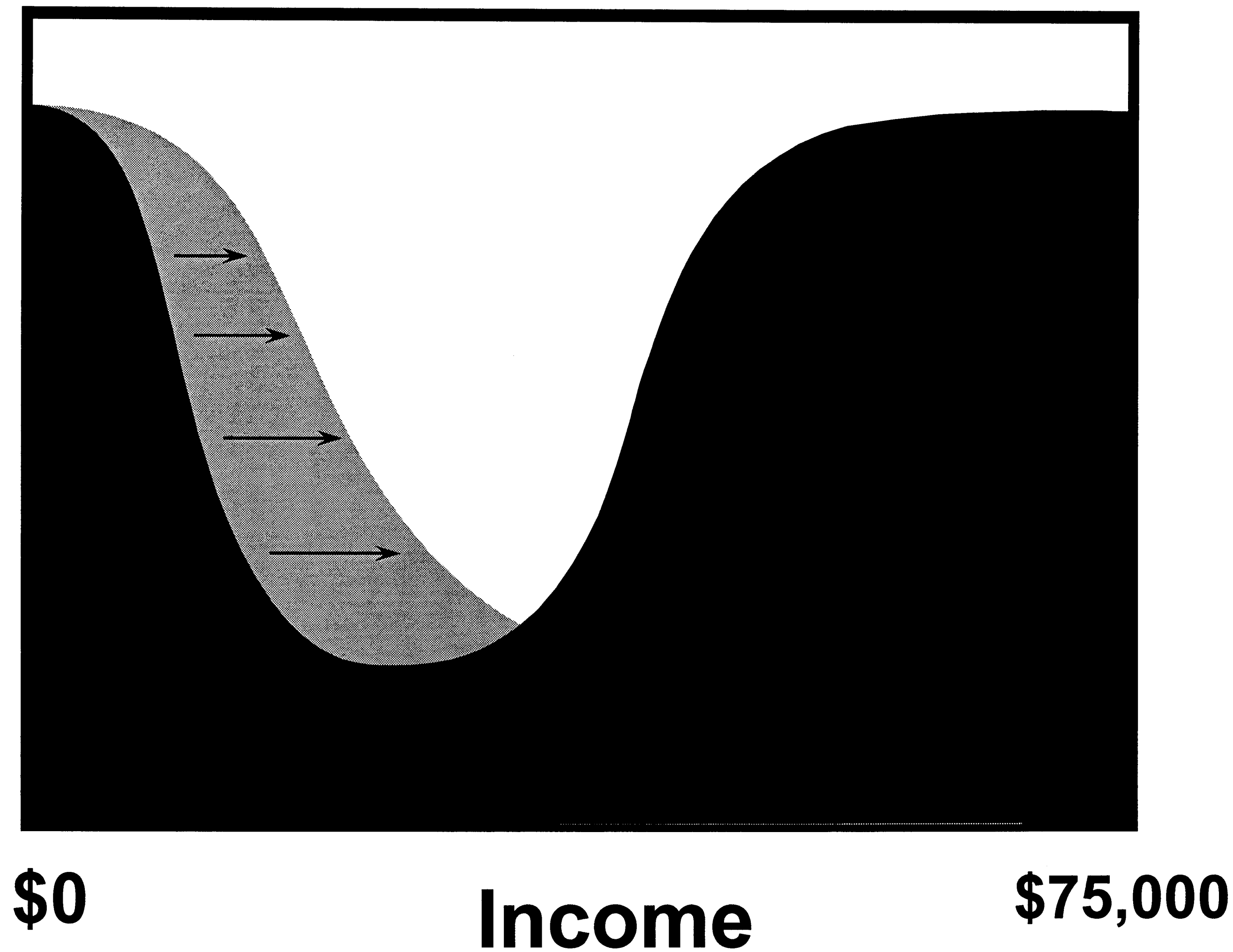
- Individual
  - Oklahoma $4,088
  - U.S. $3,991

- Family
  - Oklahoma $10,985
  - U.S. $10,728

Kaiser Family Foundation, State Health Facts 2005. www.statehealthfacts.org

Many states believe that a high uninsured rate impacts the business climate and quality of life for citizens.

Pressure for government to fill the gap:



Massachusetts and universal coverage

- Former Gov. Mitt Romney worked with Democratic legislators to pass sweeping health reform

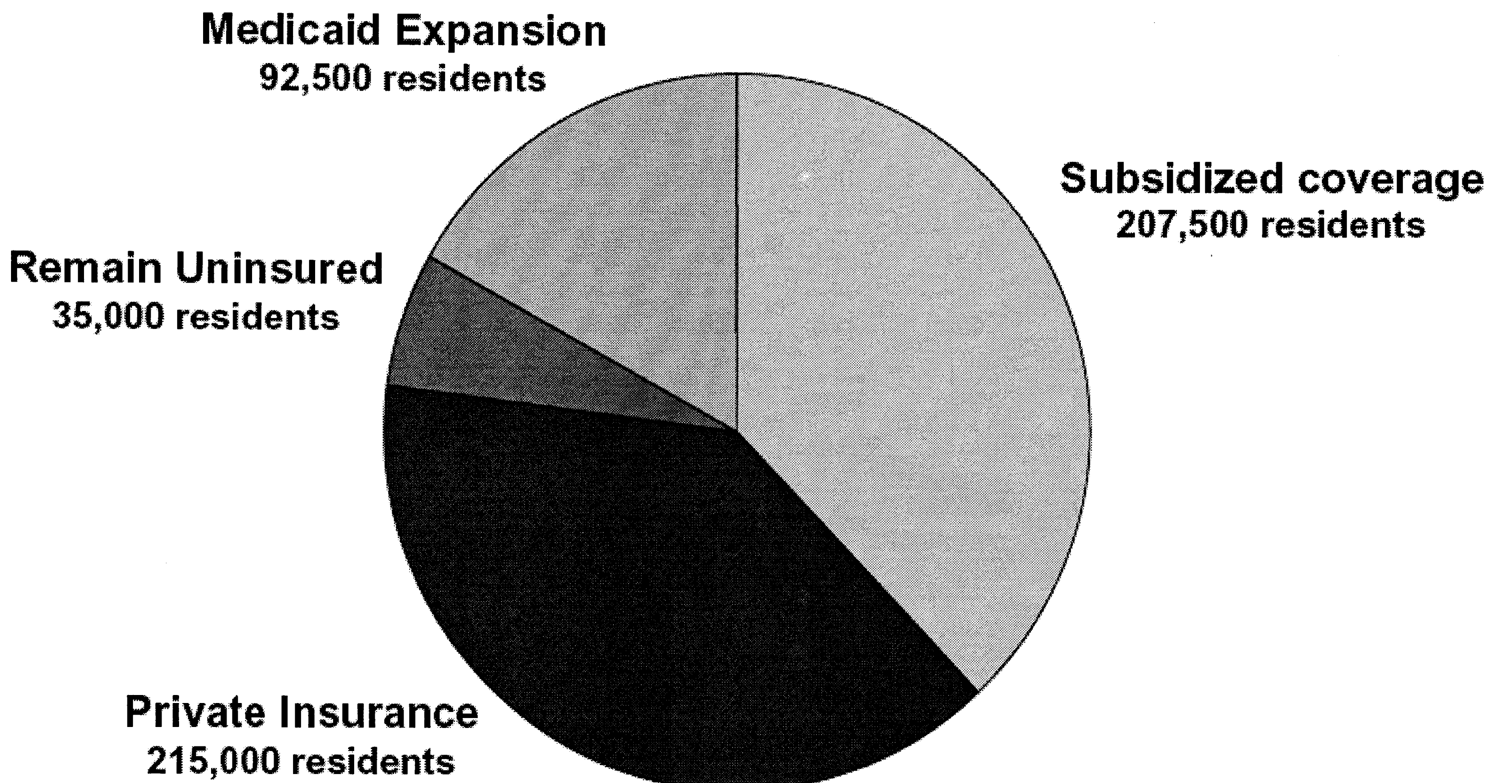
- How is it working out?

Massachusetts Healthcare Reform

- Medicaid money was the impetus for creating the MA Health Reform Plan
- The state stood to lose $385 million in uncompensated care funds if it didn't take action on reform
- Therefore, the Republican governor, Democratic legislature, hospitals, businesses and other interest groups were highly motivated to develop a plan

Figure 1

How Uninsured Are Covered Under the Massachusetts Health Care Reform Plan



Total Uninsured – 550,000

Source: Massachusetts Senate

KAISER COMMISSION ON
Medicaid and the Uninsured

Positive aspects of the MA plan

- The health insurance “Connector” allows workers to purchase insurance from competing private insurers
- Those with incomes up to 300% of poverty receive subsidies to buy coverage
- Employees can purchase health insurance with pre-tax dollars
- Insurance is portable and can move with a worker from job to job
- The plan addresses the “free rider” problem by mandating that everyone must be in the system

Danger points of Massachusetts' plan

- The state has imposed a mandate on individuals to purchase insurance while leaving in place rules and mandates that have driven out competition and driven up costs, such as guaranteed issue and more than 40 coverage mandates.

- The only policies that will be offered through the state program to those under 300% of poverty eligible for a new state subsidy have no deductible and must cover all mandates. Only offered by Medicaid HMOs.

Dangers for companies

- Employers face stiff penalties if they do not offer access to insurance.

- The legislature inserted in the law a provision that forces employers with 11 or more employees to pay a $295 per-employee fine if they don't *offer* access to health insurance and to pay health costs above $50,000 for their uninsured workers who seek free care.

- Individual mandates quickly become employer mandates. Employers must pay at least one-third of premium costs, and legislators are considering boosting their required share

Bureaucracy and enforcement

- The law requires every employer and employee in the state to sign "under oath" a Health Insurance Responsibility Disclosure form.
- It creates at least 10 new boards and commissions, such as the Health Care 10 Quality and Cost Council, the Payment Policy Advisory Board, and the Health Access Bureau.
- New and existing state agencies will be checking on individuals' insurance status, monitoring their income to see if they qualify for subsidies, and tracking individual health habits (like smoking and wellness activities).

Pushback from individual mandate

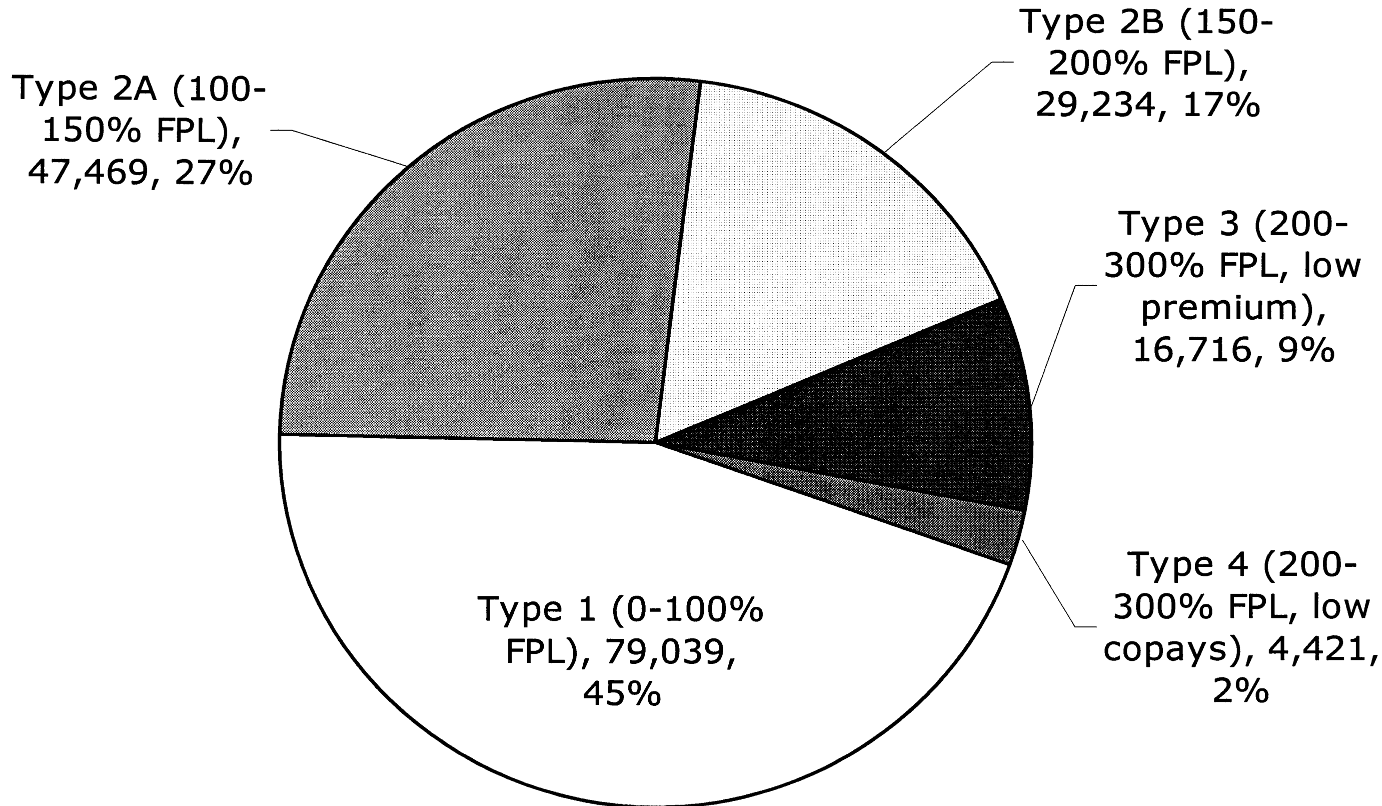
- “The dreaded Individual Mandate Call (IMC) usually begins, ‘I’m uninsured. I heard that a new law says that everyone in Massachusetts has to have health insurance by July 1st or they could get fined on their taxes.’
- “People are angry and, at times, very angry. Earlier today, a caller responded, ‘So you mean to tell me that I’m punished even though I only have $10 left each month for food after I pay my bills?’ Then she violently hung up on me…We hear this story often.”

Massachusetts’ Health Care for All Helpline blogger
Kate Bicego

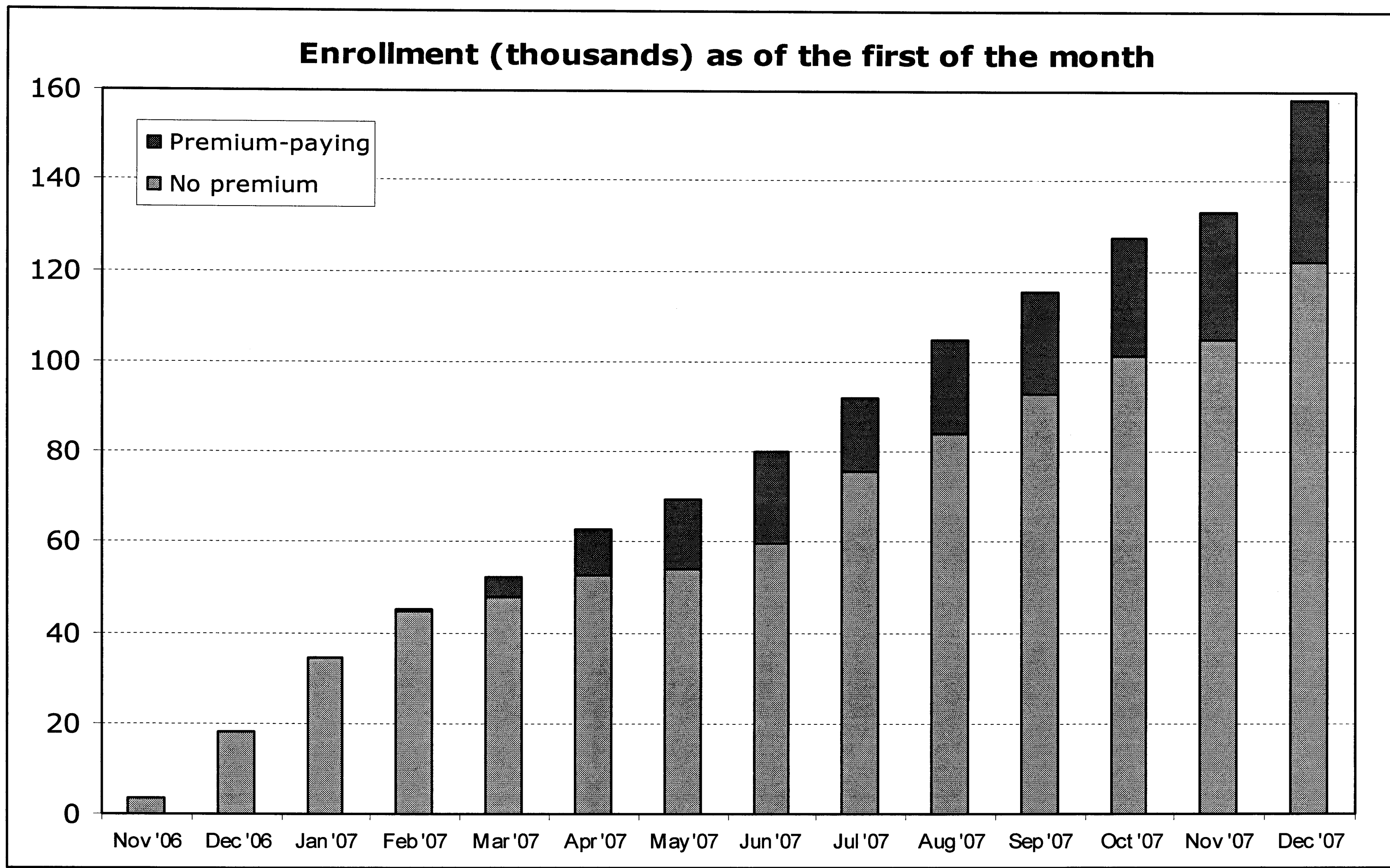
Massachusetts Connector

- Four premium levels for same coverage through the subsidized Commonwealth Care program
- Six health insurance plans offer coverage through the unsubsidized Commonwealth Choice plan
- Many continue to be covered under job-based plans

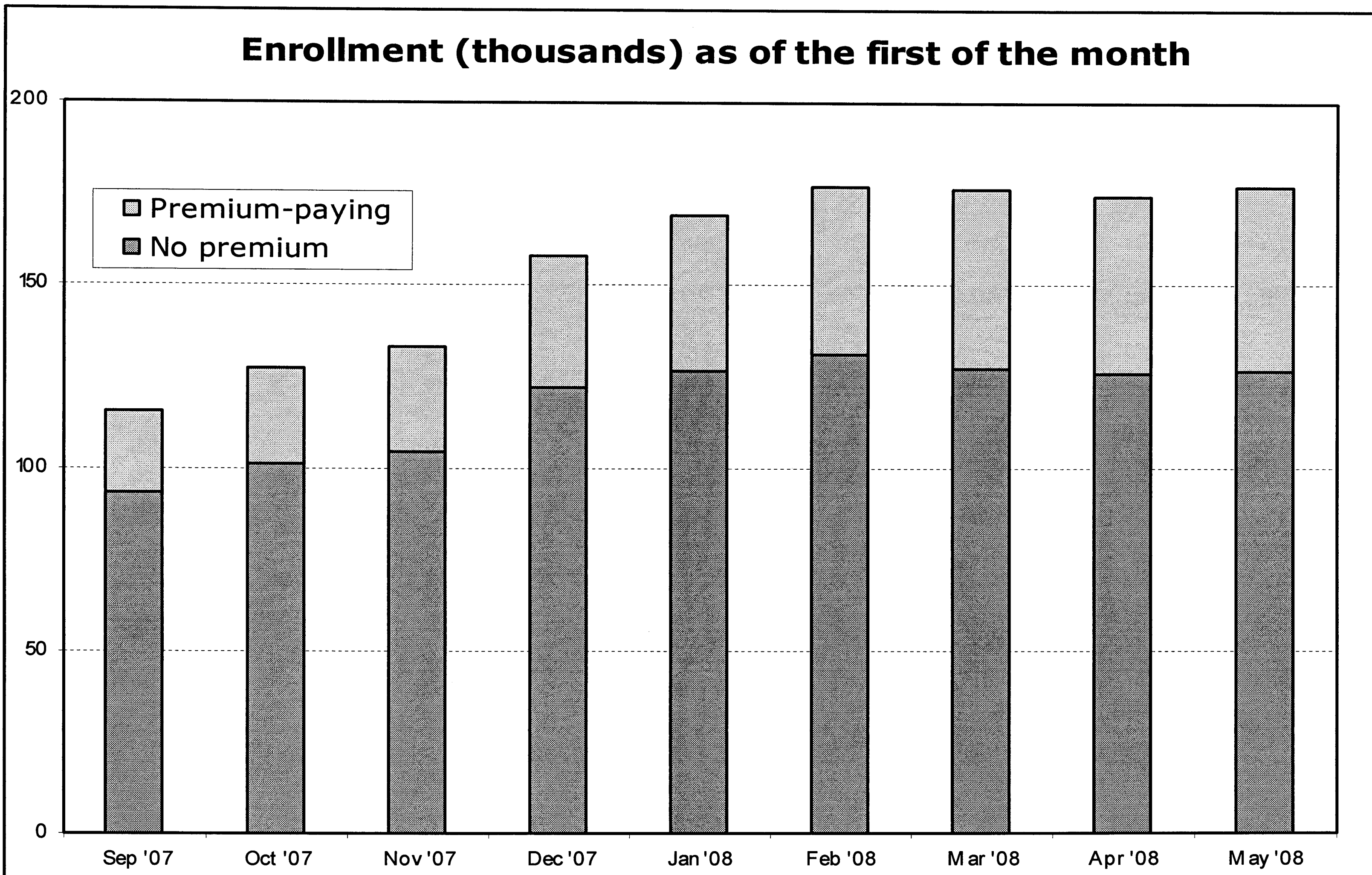
Largest enrollment in no-cost plans



Commonwealth Care Enrollment Nov '06 – Dec '07



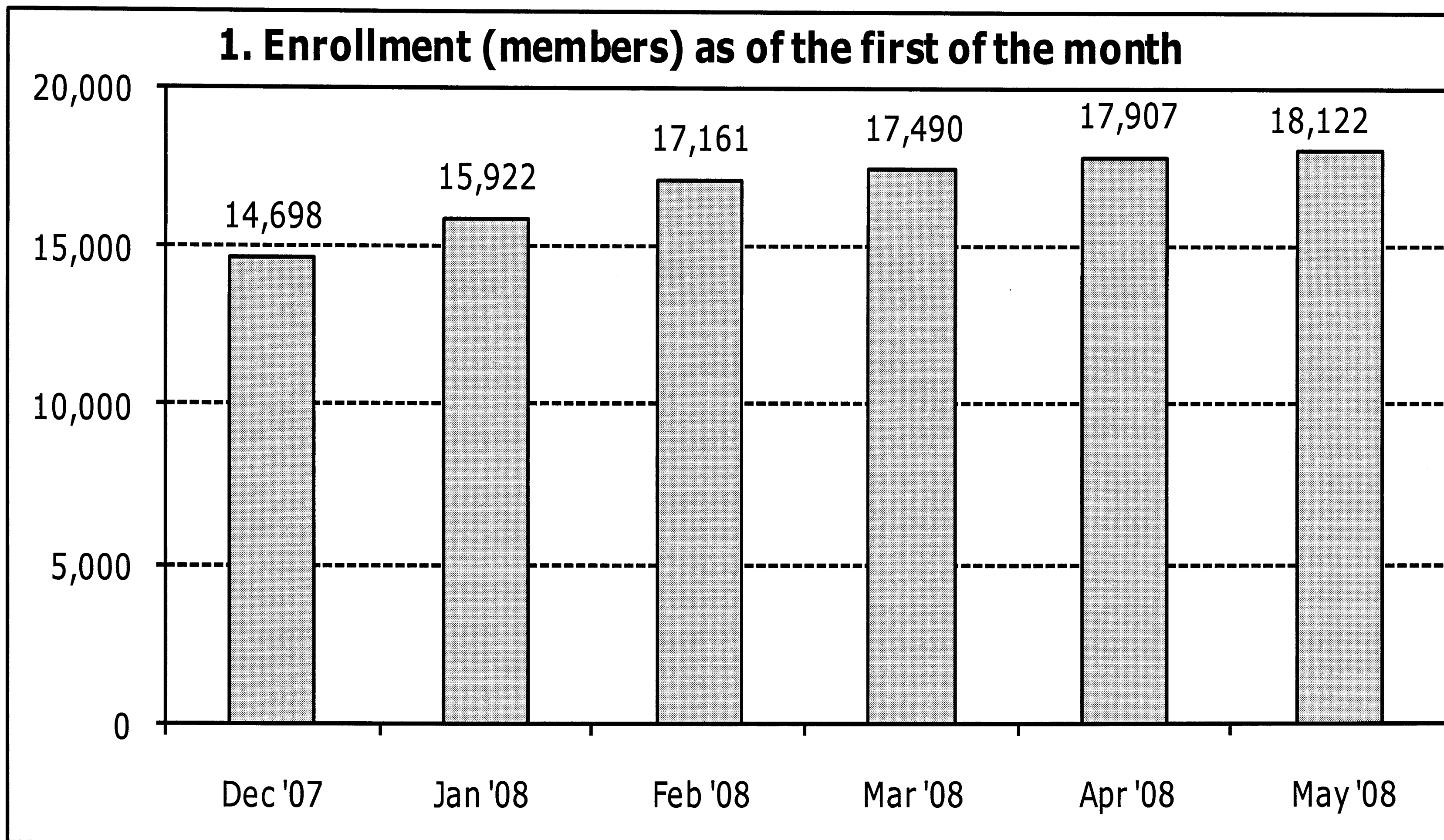
Commonwealth Care Enrollment Sept '07 – May '08



Summary of Costs by Plan Type

	Plan 1	Plan 2	Plan 3	Plan 4
Monthly Premium	$0	$0-$35	$70-$105	Depends upon plan choice
Max OOP (Med/Rx)	$36 / $200	$250 / $250	$500 / $500	Phased out 7/1

Enrollment in Commonwealth Choice



Typical connector prices

	Coverage	Annual premium
Young adult	$2,000 deductible	$2,280
	HMO/ no ded.	$6,096
Young family	$1,500/$3,000 ded.	$7,200
	HMO/ low ded.	$18,300
Empty-nest couple	$2,000/$4,000 ded.	$7,800
	HMO/ no ded.	$21,804

Risks moving forward

- For consumers…
  - State approved a 12% insurance rate increase for next year
  - Fines to individuals continue to rise
    - $219 in first year
    - Up to $912 this year; $1,824 for uninsured couples
  - Shortage of doctors in some areas taking new patients
- Rising costs for taxpayers
- Crowd-out of job-based insurance

Taxpayer costs are rising

- State budget calls for $869 million in fiscal 2009, but the bill could be closer to $1.1 billion
- About 330,000 Massachusetts residents are newly enrolled in coverage, but at least 263,000 are in free or subsidized plans
- A new study shows that mandates add $1.3 billion to the cost of health insurance a year

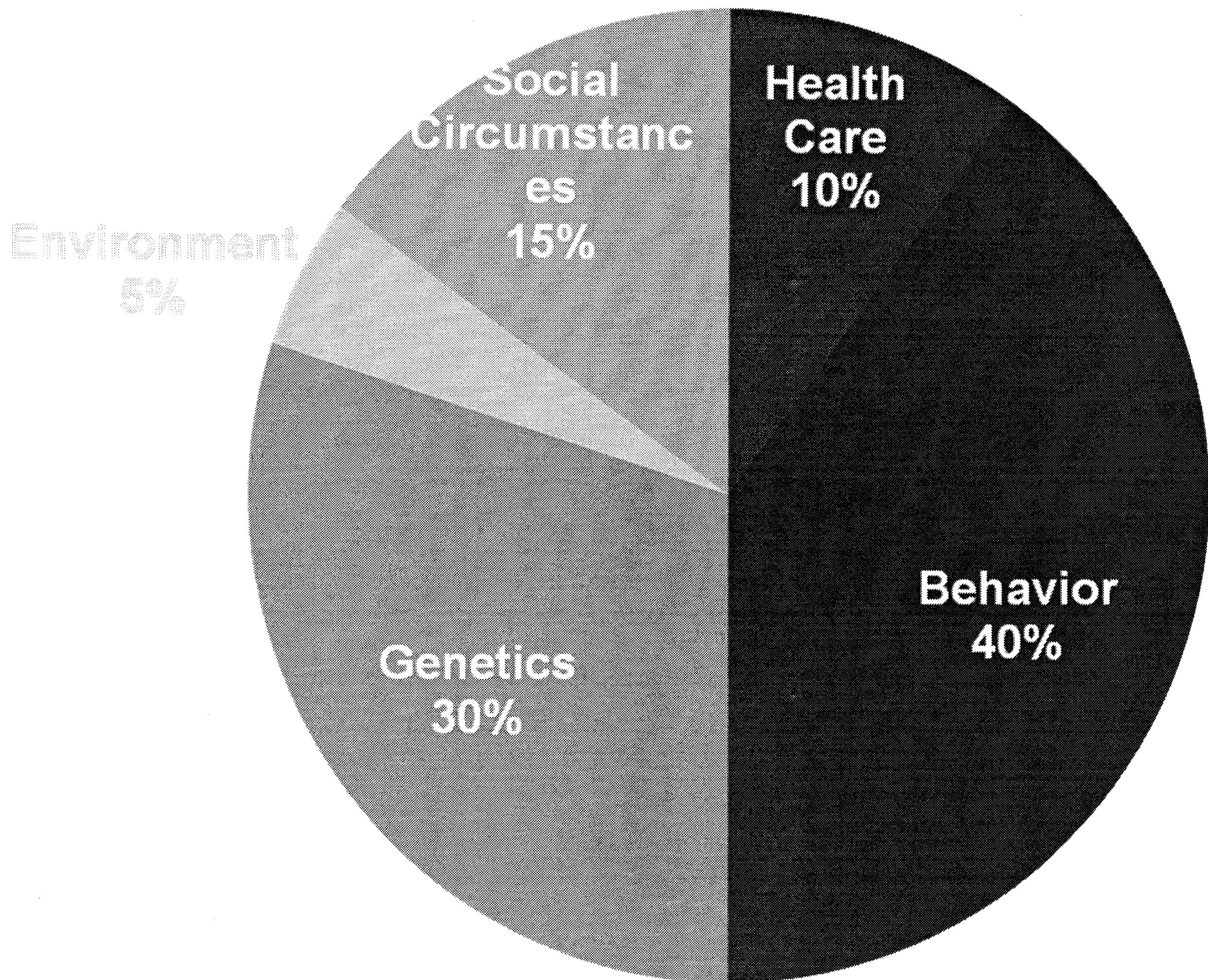
CommonwealthConnector

2008 Draft Affordability Schedule Proposed March 20th

Individuals		Couples		Families	
Annual Gross Income Range	2008 Proposed	Annual Gross Income Range	2008 Proposed	Annual Gross Income Range	2008 Proposed
$0 - $15,612 (150%)	$0	$0 - $21,012 (150%)	$0	$0 - $26,412 (150%)	$0
$15,613 - $20,808 (200%)	$39	$21,013 - $28,008 (200%)	$78	$26,413 - $35,208 (200%)	$78
$20,809 - $26,016 (250%)	$77	$28,009 - $35,016 (250%)	$154	$35,209 - $44,016 (250%)	$154
$26,017 - $31,212 (300%)	$116	$35,017 - $42,012 (300%)	$232	$44,017 - $52,812 (300%)	$232
$31,213 - $37,500 (360%)	$165	$42,013 - $52,500 (375%)	$297	$52,813 - $70,000 (398%)	$352
$37,501 - $42,500 (408%)	$220	$52,501 - $62,500 (446%)	$396	$70,001 - $90,000 (511%)	$550
$42,501 - $52,500 (505%)	$330	$62,501 - $82,500 (589%)	$550	$90,001 - $110,000 (625%)	$792
>$52,501	n/a	>$82,501	n/a	>$110,001	n/a

So what is the alternative?

Determinants of Health



The Vision:

- Engaging consumers as partners in managing health costs and getting the best <u>value</u> for health care dollars

Common themes

Focus on:

- Personal responsibility by recipients
- Incentives for patient participation
- Wellness and prevention services
- Better coordination of care
- Greater focus on disease management
- Data collection and outcomes reports

Some tools available now

- **Flexible Spending Accounts**
  - available since the mid ‘80s
  - “Use it or lose it” flaw
- **Health Reimbursement Arrangements**
  - Created in 2002
- **Health Savings Accounts**
  - Available since 2004

Top three priorities for reform

- Lighten the regulatory burden on health insurance and services to boost competition
- Allow greater portability of health insurance
- Provide new subsidies for the uninsured

An innovative program: The Healthy Indiana Plan

- A novel way of increasing access to health insurance for the uninsured
- A jointly-funded POWER account -- $1,100
- Medicaid coverage for medical costs above that, including preventive care
- Unused POWER balances roll over to help fund next year's account

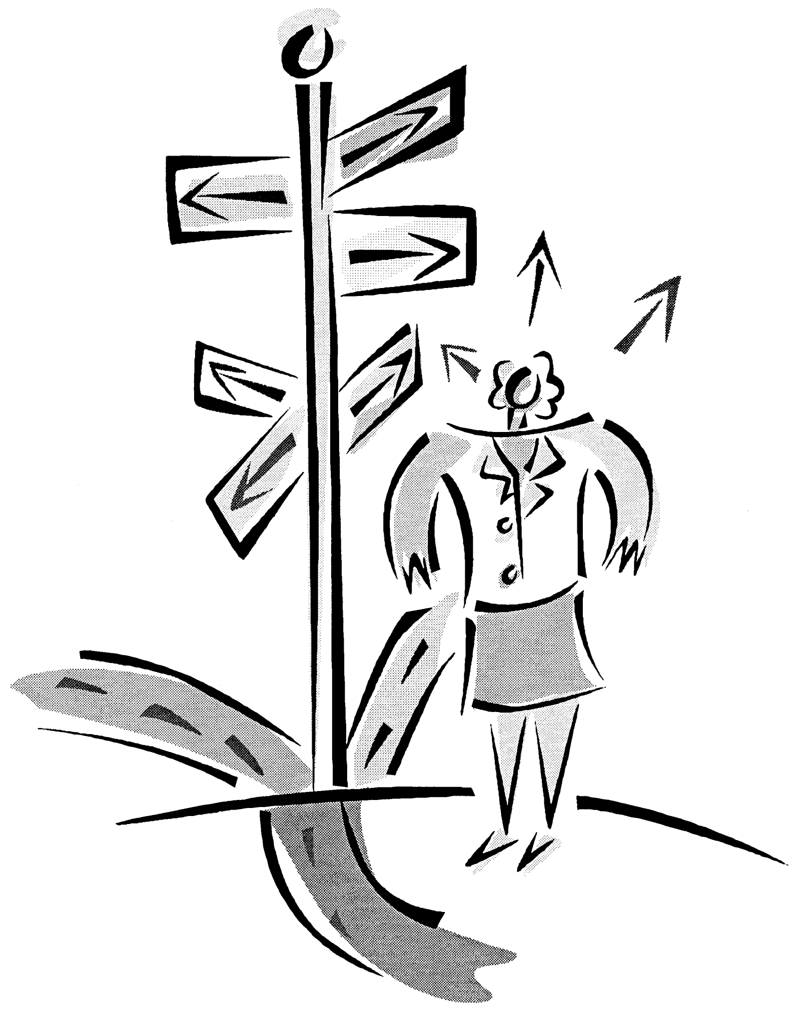
Georgia's new law

- Allow individuals to deduct HSA premiums from state taxes
- $250 annual tax credit to small businesses to enroll employees in HSA plans
- Allow insurance companies to reward people for healthy behavior

Federal proposals

- Give individuals and families tax deductions or credits to purchase private health insurance
- Allow people to buy health insurance from other states
- Create more options for people to use SCHIP and Medicaid dollars for private coverage

What will the future hold?



Elections will determine the direction of change. *But…*

- The new president will definitely determine the direction of reform, toward a greater role for government in our health sector or a much more functional private and competitive market for health insurance and health care

Appendix H

Overview of the Indian Health System

Melissa Gower
Group Leader for Health Services
Cherokee Nation

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Recognition of Inherent Tribal Powers

- The presence of Tribal Governments predates both the formation of the United States (U.S.) and the State of Oklahoma and interact on a government-to-government basis
- As sovereign nations, Tribal Governments exercise inherent sovereign powers over their citizens, territory and lands.
- Tribal citizens have a ***unique legal and political status which is based on Tribal citizenship rather than a racial category***
- Tribal Governments have an inalienable and inherent right to self-governance, meaning governance in which decisions are made by the people who are most directly affected by the decisions

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Codification of the Federal Responsibility to Provide Health Services to AI/ANs

- Snyder Act of 1921 (P.L. 67-85)
- Indian Self-Determination and Education Assistance Act (P.L. 93-638, as amended)
- Indian Health Care Improvement Act (P.L. 94-437)

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Indian Health Service (IHS)

- IHS is charged with the Federal Government's obligation to provide health services to American Indians and Alaska Natives (AI/AN)
- Currently, the IHS provides health services to approximately **1.9 million** AI/ANs belonging to over 557 federally recognized Tribes in 35 states
- According to the 2000 U.S. Census, AI/AN alone or in combination with one or more other races population exceeds **4.1 million (391,949 in Oklahoma)**

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The Indian Health System

- Services are provided through facilities of the Indian Health Service (IHS), facilities operated by a Tribe or Tribal organization authorized by the Indian Self Determination and Education Assistance Act (P.L. 93-638), and Urban Indian programs authorized under Title V of the Indian Health Care Improvement Act (P.L. 94-437). **Collectively, the facilities comprise what is known as the I/T/U**

Oklahoma City Area IHS

- The Oklahoma City Area (OCA) IHS oversees the provision of health services to Tribal citizens in Oklahoma, Kansas, and portions of Texas
- Of the 40 facilities throughout the OCA, 26 are operated by Tribes, 12 are operated directly by the IHS, and 3 clinics are operated in urban settings

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Cherokee Nation Health System Snapshot

The 14-county service area of Cherokee Nation (CN) includes:

- 6 CN clinics
- 2 CN satellite clinics, 1 student/employee clinic, and
- 2 Indian Health Service (IHS) operated hospitals
- A CN managed, 20-bed co-educational facility for treatment of chemical dependency in AI adolescents
- A number of CN field-service sites for auxiliary health programs such as WIC, Early Cancer Detection and Health Promotion/Disease Prevention, and other public health activities
- CN Emergency Medical Services (EMS) accredited by Commission on Accreditation of Ambulance Services
- Serves more than 127,000 eligible patients throughout the 14-county service area

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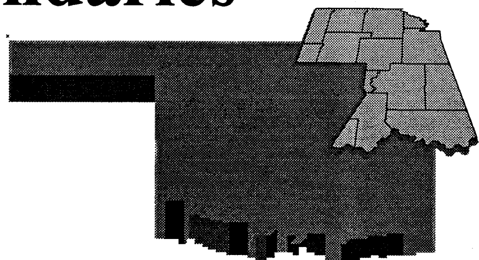
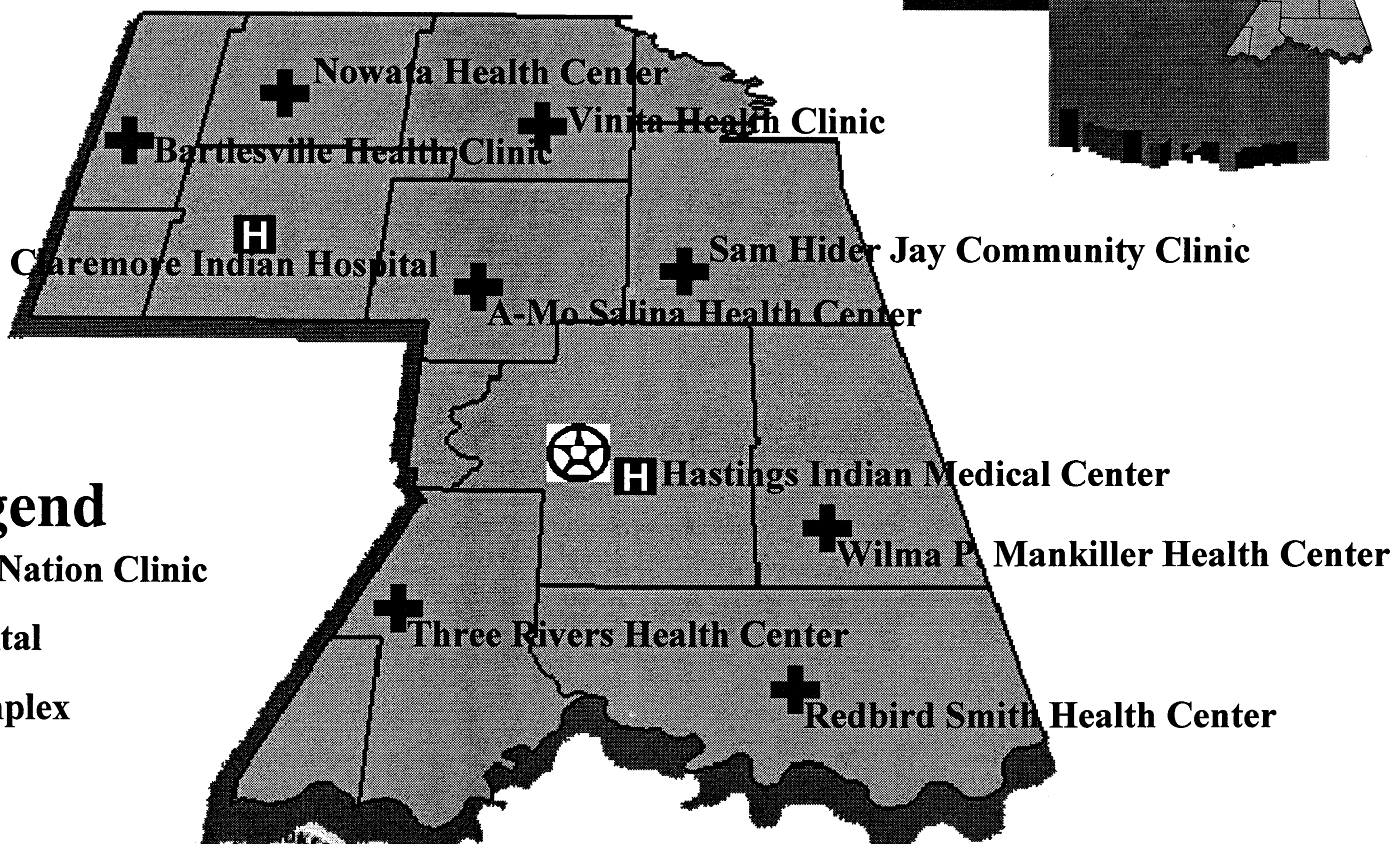
14 County Jurisdictional Boundaries





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Why does the IHS provide services to less than ½ of the AI/AN population?

- Inadequate funding - IHS funding is discretionary and competes with all other discretionary programs – national defense, emergency preparedness, etc.
- The per capita personal health care expenditures for the IHS population are significantly less that the general population (In 2003, **$1,914 compared to $5,085**). The Oklahoma City Area receives only **$976** per capita, which represents only **44%** of the actual need according to the Federal Disparity Index
- As a result, services are very basic and limited, extremely long waiting periods for appointments, reduced hours of operation, inadequate staffing, lack of facilities, overburdened facilities

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Why does the IHS provide services to less than ½ of the AI/AN population?

- Geographic Limitations – Because of limited funding, facilities are typically located in areas with high AI/AN populations (in turn causing the facilities to be severely overburdened)
- A substantial number of AI/ANs do not live in close proximity to I/T/U facilities and/or do not have adequate transportation to reach the facilities, therefore it is not a viable option

Defining "Insured"

- The U.S. Census Bureau's Current Population Survey (CPS) is the most commonly used data source for estimating the rates of health insurance coverage nationally and across states
- According to the CPS, individuals who report Indian Health Services (IHS) and no other coverage are classified as **uninsured**.

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Efforts to Address Funding Deficiencies

- While Tribes continue to push for adequate funding to carry out the federal government's trust responsibility, the reality exists that Tribes must provide additional Tribal resources in an attempt to meet the health care needs of their people. The amount of funding and the manner in which funds are allocated for healthcare purposes varies among Tribes, but examples of the utilization of funds include:
  - ✓ Supplementing the IHS Contract Health Services (CHS) Program, used in instances where the I/T/U is unable to provide services, a patient may receive care outside of the I/T/U
  - ✓ Direct Care
  - ✓ Facility Construction/Expansion
  - ✓ Leveraging federal resources

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Efforts to Address Under Funding: Maximizing Third Party Collections

- Another resource Tribes have utilized to address the funding gap are third party resources. Over the past several years, Tribes in Oklahoma have put forth much effort to stretch limited health resources by maximizing third party collections such as Medicare, Medicaid, and private insurance.
- Increased third party collections have been achieved through close collaboration with Tribes and the Indian Health Service (IHS), Centers for Medicare & Medicaid Services (CMS) the Oklahoma Health Care Authority (OHCA), the Oklahoma Insurance Department (OID), and private insurance providers
- However, barriers exist to increasing participation by American Indians and Alaska Natives in the Medicare, Medicaid, and private insurance. A perception exists that enrollment (and the payment of any premiums, co-pays, etc.) in Medicare, Medicaid, and private insurance is not necessary because the patient is seeking care in an Indian health facility.
- Many Tribes in Oklahoma, as well as IHS operated facilities, undertake great effort to ensure third party payers are utilized when possible

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Efforts to Address Under Funding: Collaboration

- Tribes recognize the need to partner with local health providers, such as municipal hospitals, clinics, etc. Partnerships have occurred for various purposes to reduce the duplication of services, increase emergency medical services, and to establish specialty care in rural communities
- Many Tribes are supportive of their local communities and offer many programs/services that do not differentiate between Tribal citizens and non-citizens, to the extent allowable by law.
- Tribes are often viewed as valuable community partners and offer many unique opportunities due to sovereign status, flexibility, etc.

GWY.Ꮷ DᏣᎵ Cherokee Nation
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Tribal Considerations when Collaborating

- In Oklahoma, I/T/U facilities are paid according to what is referred to as the ***"all-inclusive," or "OMB" rate***, which is established annually by the federal government. The flat daily rate per encounter is calculated based on various cost factors and eases the administrative burden on both the OHCA and the I/T/U facilities.
- In HB 2842, language was included authorizing the OHCA to develop mechanisms to allow Tribally operated facilities that elect to provide services to beneficiaries other than American Indians or Alaska Natives beneficiaries (non-AI/ANs) to receive reimbursement for such services. If a Tribe elects to serve non-AI/ANs under such an arrangement:
  - ✓ The Tribal facility would be paid at the all-inclusive rate
  - ✓ The Tribal facility would then remit the state share collected (approximately 32%) to the OHCA when providing care to non-AI/ANs
- The purpose of the language was to benefit from the favorable reimbursement rates through the all-inclusive rate.
- However, when considering providing services to non-AI/ANs, Tribes must carefully consider any potential impacts on individual Tribal health systems

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Tribal Considerations when Collaborating

- Some of the practical considerations a Tribal facility must consider include:
  - ✓ **Patient load** – as previously discussed, many Tribal facilities do not have the capacity to serve the current AI/AN patient load, therefore extending services to non-AI/ANs is not a practical option
  - ✓ **Applicability of the Federal Tort Claims Act (FTCA)** – Tribes (and its employees) are deemed to be employees of the Federal government while performing work under ISDEAA Compacts. However, such FTCA coverage only extends to the provision of care to eligible beneficiaries under the ISDEAA Compact (AI/ANs and in very limited circumstances, non-AI/ANs)

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Tribal Considerations when Collaborating

- Continued:
  - ✓ **Federal supply sources** – In addition to FTCA coverage, Tribes can also access federal supply sources through ISDEAA Compacts. However, federal supply sources can only be accessed when providing care to care to eligible beneficiaries
  - ✓ **Federal Scrutiny** – Given the lack of available federal resources for health care and routine scrutiny of federal spending involving Tribes, the Federal government could view the expanded use of the all-inclusive rate negatively and remove the authority for Tribal facilities to utilize the all-inclusive rate

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100 % Federal Medical Assistance Percentage (FMAP)

- I/T/U facilities are authorized under federal law to be reimbursed at ***100% of the federal medical assistance percentage (FMAP)*** when providing services to AI/AN Medicaid recipients
- The 100% FMAP reimbursement greatly benefits both the State of Oklahoma and the I/T/U because the State does not have to fund the state match (currently at 32.09%) and the I/T/U is able to conserve woefully under funded Indian Health Service dollars by accessing Medicaid funds instead.
- What is the fiscal impact to the State of Oklahoma because of the 100% FMAP? For the 2005 calendar year, nearly $85 million in health services was provided to AI/AN Medicaid enrollees in I/T/U facilities in Oklahoma. As a result of 100% FMAP, ***the State saved over $27 million in matching funds during this period***

GWYꮓꭷ DꮜP Cherokee Nation
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Questions/Comments?

- Melissa Gower –
  melissa-gower@cherokee.org
- J.T. Petherick
  jt-petherick@cherokee.org
- Rachel McAlvain
  rachel-mcalvain@cherokee.org

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Appendix I

State Premium Assistance Programs and More

A presentation for the
Oklahoma House of Representatives
Health Care Reform Task Force
By

Laura Tobler
NCSL - Denver
303-856-1545, laura.tobler@ncsl.org

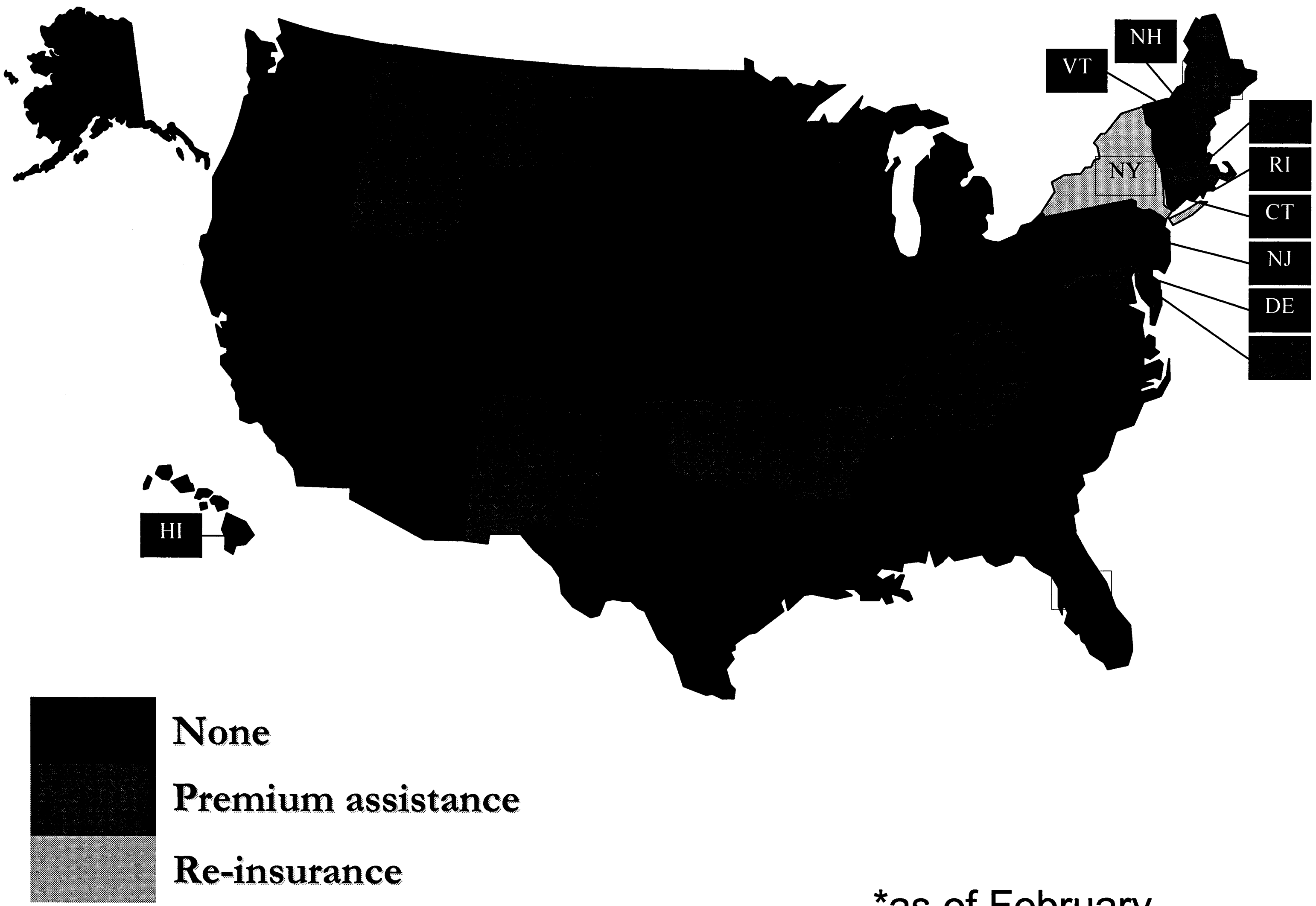
Health care costs rank near the top of Americans' personal economic concerns, outranked only by paying for gas and finding a good paying job.   28% of respondents said that they or their families have had serious problems paying for health care or health insurance premiums.

- Source: Kaiser Family Foundation *Health Tracking Poll: Election 2008* (conducted April 3-13, 2008).

Topics:

- State Premium Assistance Programs for Small Business.
- Other examples of public/private partnerships.
- Private market strategies to make insurance more affordable and reduce the number of uninsured.
  - Individual mandate
  - Insurance connector or exchange.
  - Limited benefit plans.
  - Others.

Premium Assistance Programs for Small Employers, 2008 *



*as of February

2008 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,400	$13,000	$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

SOURCE: ***Federal Register*, Vol. 73, No. 15, January 23, 2008, pp. 3971–3972**

Cover TN

Eligibility

- Employer eligibility: 50 or fewer FTE equivalents, 50% employees earn less than $43,000 or less, health insurance offered to all employees, must pay 1/3 premium. Employees who work at least 20 hrs/wk, 19 yrs or older are eligible.
- Self-employed: 6 mth residency, 20 hrs/wk, $43,000 or less, agree to pay 2/3 of the premium.
- Employees from non-participating employers: 6 mth residency, work at least 20 hrs/wk, 19 or older, earn $43,000 or less, agree to pay 1/3 of the premium.
- Between jobs: Unemployed last 6 mths, worked at least one 20 hr/wk in the last six mths or had work hours reduced by employer, earn(ed) $43,000 or less, agree to pay 2/3 premium
- Spouse: agree to pay up to 2/3 premium, (the employee must pay whatever portion of the spouse's premium that the employer does not cover)

Cover TN

Benefits: basic, limited coverage with a yearly max of $25,000.

- Plan A-basic benefits, with more comprehensive prescription drug benefits.
- Plan B-basic benefits, with coverage for more physician office visits and hospital stays.

Enrollment:

- As of June 2008 (started April 2007) about 15,000 employees from 6,196 small businesses are enrolled. The state has not sold out the program as it has money available for 19,000 enrollees through the end of this fiscal year.

Premiums:

- Premiums range between $112 a month for an under 30, non-smoker, normal weight individual or as much as $327 for a smoking, obese 65-year old. Other cost sharing.

ARHealth Network

<u>Eligibility:</u>

- Employer eligibility: not offered group health plan within past 12 mth, 2 to 500 employees (at least 30 hrs/wk). All full-time employees must participate in ARHealth Networks coverage or have documented coverage under another group or individual health plan.   At least one employee must qualify for subsidized premiums by having an annual household income at or below 200% of the FPL.
- Employee: work at least 30 hrs/wk, eligible for subsidy if income is at or below 200% FPL.

ARHealth Network

Benefits: limited coverage with a yearly max of $100,000.

- Per year the plan will cover: 7 inpatient days, 2 major outpatient services (including emergency room and major services performed in the office), 6 physician office visits
- Two prescriptions per month
- $1,000 out of pocket cap
- Renewable each 12 months

Enrollment: 3,703 as of July 31st, average group size is around 4 employees, with around 890 employers participating.

Premiums/Cost sharing:

- Premiums for employees with incomes less than 200 percent of FPL are $25/mth and $200/month for employees with higher incomes. Maximum annual out-of-pocket costs are $1,000 per individual.

KY I-Care Program

Eligibility for employers:

- Employ 2-25 people (full-time or full-time equivalent)
- Pay at least 50 percent of the employee premium for single coverage
- Pay an average annual salary of no more than $51,510 (300 % FPL) for a family of three. Salaries of any owners and employees who are ineligible are not included in this average.

Employer incentive payments:

- $40 per eligible employee/mth if the employer has not offered health insurance for the past 12 months. The monthly amount decreases by $10 each subsequent year of the program.
- $60 per eligible employee/mth for an employer group if at least one employee has a defined high-cost condition. The monthly amount decreases by $15 each subsequent year of the program.

KY I-Care Program

Benefits: basic, limited coverage with a yearly max of $25,000.

- Plan A-basic benefits, with more comprehensive prescription drug benefits.
- Plan B-basic benefits, with coverage for more physician office visits and hospital stays.

Enrollment:

- As of June 2008 (started April 2007) about 15,000 employees from 6,196 small businesses are enrolled. The state has not sold out the program as it has money available for 19,000 enrollees through the end of this fiscal year.

Premiums:

- Premiums range between $112 a month for an under 30, non-smoker, normal weight individual or as much as $327 for a smoking, obese 65-year old. Other cost sharing.

New Mexico's State Coverage Insurance

<u>**Eligibility:**</u>

- **Employer eligibility**: Does not offer health insurance and has 50 or fewer eligible employees. (Eligible: Otherwise eligible for employers health insurance; not otherwise covered by Medicare or through spousal coverage)
- **Employees:** working residents between the ages of 19-64 years with household income of up to 200% of FPL; no current health insurance coverage; no voluntary cancellation of health insurance in the last six months; not eligible for certain government health insurance benefits.

New Mexico

Benefits: benefits comparable to private market. Limited to a yearly max of $100,000.

Enrollment: 16,528 employees, 700 employers.

Premiums:

- Employer and employee monthly premiums. The premium is about $355.00. The state pays the difference with federal and state money.

FPL	0-100%	101-150%	151-200%
Employer Contribution	$ 0.00	$75.00	$75.00
Employee Contribution	$0.00	$20.00	$35.00

Insure Montana

Eligibility

- **Employer eligibility**: Does not offer health insurance, has 2 to 9 employees working 30 hrs/wk. All employees must earn less than $75,000 gross/yr.

Benefits: Blue Cross/Blue Shield full comprehensive coverage.

Enrollment: 4,000 lives covered. There is a waiting list of 550 businesses.

Premium only program: State contracts with a management company to administer a premium only flexible benefits program at no cost to employer.

Healthy Wonders: Pregnancy management program.

Insure Montana

Premiums

- Each employee receives a monthly Premium Assistance Payment; amounts range from 20%-90% depending on family annual income
- Employer receives a premium incentive payment of 25% of the employee premium (after incentive) for each employee covered.

Other

- Tax credits to small businesses currently offering health insurance.
- Program is funded by a tobacco tax.

Example
Employee-only coverage (family income $14,355-$19,140)

Monthly Premium: $346.00
Employer contribution: $173.00
Employer Incentive: $73.00*
Net Employer portion: $100.00

Monthly Premium: $346.00
Employee contribution: $173.00
Employee Assistance: $102.20*
Net Employee portion: $70.80

Other example: PA adultBasic

Eligibility: Uninsured with family income below 200% FPL. 90 day residency requirement.

Benefits: hospitalization, primary care, specialists, diagnostics, ER, maternity, rehab, skilled care.

Enrollment: About 51,300. There is a waiting list of 106,000 people.

Premiums: Each enrollee pays a monthly premium of $30.00 plus co-payments.

Other: Created in June 2001 by the Health Investment Insurance Act (Act 77 of 2001). Funded by tobacco settlement, general fund and community health reinvestment funds (BC/BS).

Other examples: Indiana Plan

- Expand Medicaid to adults up to 200 percent of the FPL ($20,800 for an individual, $42,400 for family of four) with a health plan based on the Health Savings Account model:
  - Receive $500 in free preventive care; a $1,100 health savings account (state and individual); up to $300,000 of annual coverage from a private insurer- enrollee must pay 50% of premium.
  - ESI program for those under 200% FPL.
- <u>Premiums</u>: 2 to 5 % of adjusted gross income.
- <u>Other provisions</u>: increased eligibility for children/pregnant women; young adults up to age 24 stay on parent's plan, pool for small businesses, tax incentives for employers, premium assistance.
- Financed with cigarette tax increase-$0.44 to $0.995.

Limited benefits for public or publicly subsidized plans

One way to control expense but offer access to preventive services with Medicaid or other public programs.

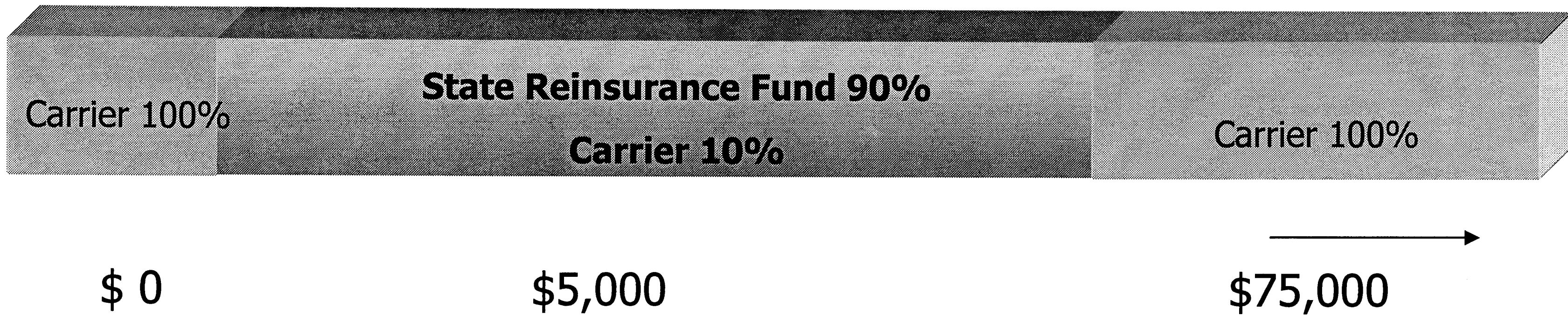
- Utah Primary Care Network
- Arkansas' ARHealthNet
- Indiana
- PA AdultBasic
- MD Primary Care Program

Reinsurance

Subsidized

- **Example: Healthy New York**
  - Provide publicly-funded reinsurance for private coverage to assume a portion of insurer's high-cost claims.
  - State subsidizes costs for expensive people with the goal of lowering premiums for all -- 20% of people account for 80% of health spending.
  - State requires all HMOs to offer product.
  - Small firms w/ low-wage workers, low income self-employed, uninsured workers w/o access to employer sponsored insurance may enroll.

How the reinsurance is subsidized



- Results in about a 17% savings for small business and between 50 to 70% savings for individuals.
- 130,000 covered (Nov 06). 56.6% working individuals, 18% sole proprietors, and 25.4% small groups.

Reinsurance

Not subsidized

Example: Healthcare Group of Arizona (Began in 1986)

- In 2000, state subsidized with $8 million of general funds. Subsidy cut and program now financially self-sufficient as of July 1, 2005.
- Employers and employees pay entire cost of the product.
- Carriers protected using aggregate stop-loss reinsurance.
- Close to 30,000 enrollees (over 8,500 small business groups). 90% have three employees or less.
- Open to small business, the self-employed, and political subdivisions. No income limits apply. Employee participation requirements and firms must not have offered group insurance for six months.
- HCG benefit packages and premiums are comparable and very competitive for groups under five employees.

Private Market Initiatives

- Individual Mandate
- Employer Assessments
- Exchanges/Connectors and Section 125 plans
- Expand age for coverage of dependent
- Health Savings Accounts and other consumer directed initiatives.
- Examine health insurance mandates/Mandate light plans
- High Risk Pools (at least 33 states)

Require all residents to buy health insurance…

- Massachusetts requires every resident to have health insurance as of July 1, 2007 with some exceptions.
  - Affordability waiver; hardship waiver
- Question of affordability for individuals and employers- 7.5% income (Lewin, CO) up to 8% (MA). Employer costs will go up as more employees enroll in ESI.
- Many states are discussing the feasibility of an individual mandate.
- Increases the pool of people in coverage=more stable, predictable (not always cheaper, unless more healthy are included)
- Reduce uncompensated care costs (often high-cost emergency room services) -by moving everyone (possible) into coverage status.

"Moderating costs is only possible if everyone is in the pool."

- Jon Kingsdale, Executive Director, Commonwealth Connector Authority. July 2007

Employer Fiscal Responsibility/Assessments

- MA and VT are implementing employer assessments to help finance reforms. $295 and $365 per uninsured employee annually.
- Maryland law to impose a payroll tax for large employers not meeting a minimum requirement for employee health insurance was struck down on the basis of ERISA in 2007.
- Challenges
  - ERISA
  - Political feasibility
  - Supermajority required in eight states for new taxes

The "Connector"/Health Insurance Exchanges

- Exchanges/Connectors and Section 125 plans
  - MA, WA, MN - Exchange or connector
  - FL: Florida Health Choices Corporation, a centralized clearinghouse or "marketplace," where small businesses with less than 50 employees may offer employees a chance to choose from a variety of health care plans and services.
- Central part of the Massachusetts 2006 health reform.
- Concept: provide a single place for persons to purchase insurance coverage (also very involved in the regs and implementation).
- Allows for greater transparency or competition
- A number of states continue to examine this strategy.

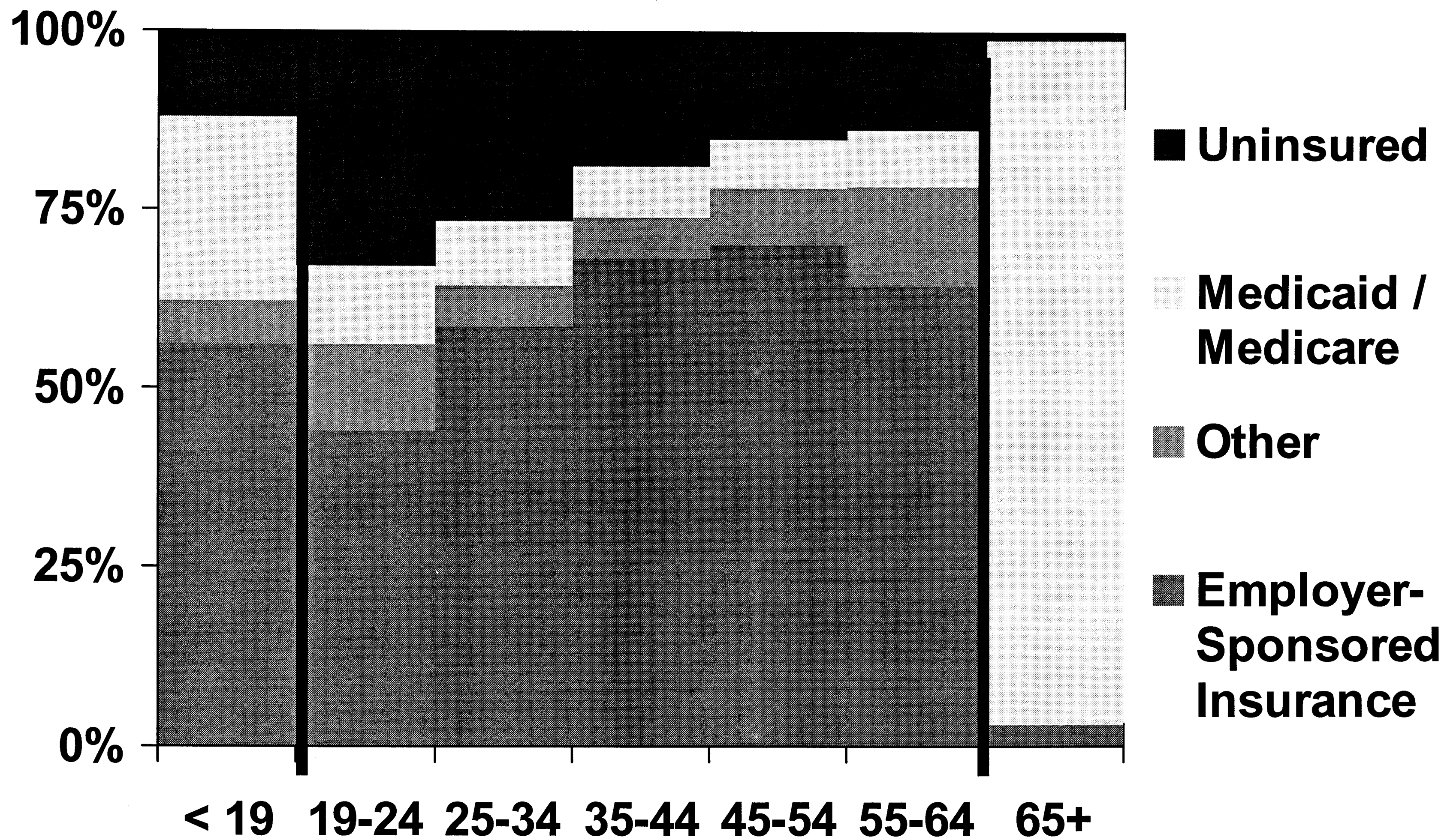
MA Connector

- 15,000 new purchasers via the Connector
- 165,000 newly insured (net growth in 6 plans)
- Insurers pay a premium fee of 4% to the Connector
- Market reforms: merger of small group and individual markets
  - 15% (minimum) decrease for individual plans
  - 1.4 % increase in small group premium cost

Expanded use of "Cafeteria Plans"

- Expand or require use of federal IRS (Section 125) "cafeteria plans" that allow full tax deduction for health premiums.
  - Employee saves 26%
    Employers will save 1.86% *(Mass. Calculation, 2007)*
    Employee earning $50,000 in employer's Plan has annual tax savings of $796; employer saves $161 in annual FICA taxes.
- KS, MA, MO, MN, RI, WA,

Distribution of Health Insurance Coverage by Age



Source: 2006 CPS

Allow young adults to remain on their parent's insurance longer …

- Fastest growing segment of the uninsured.
- Beyond the typical age-out of 19. Most laws cover up to age 25. NJ and FL go up to 30.
- Impact on employers?
- State examples include CO, CT, DE, FL, ID, IN, IA, KY, ME, MA, MD, MN, MO, MT, NH, NJ, NM, RI, TN, TX, UT, WA, WV.

"Consumer Directed Health Care" and Health Savings Accounts

- Health Savings Accounts established in federal law 12/8/03. They are tax-free financial accounts designed to help individuals save for future health care expenses.
- According to an industry survey, 40% of new HSA buyers had incomes of $50,000 or less and at least 30% were previously uninsured.
- <u>Growing enrollment and use</u>; Premium savings: HDHP total premium about 16 to 20% lower. (save. $640 below HMO for an individual; $1,700 for family)
- For more information go to http://www.ncsl.org/programs/health/hsa.htm

Limited-Benefit Plans

- At least 13 states have enabling legislation.
- Referred to as bare-bones, mandate-light, mandate-free, limited benefit, minimum benefit, etc.
- Reduce premiums by decreasing the number of covered services.
- To encourage small employers to buy health insurance.
- May reduce the premium between 5 to 9%.
- Trade-offs.

Examine Insurance Mandates

- State coverage mandates add to costs, but repeals do not assure cheaper premiums.
  - No simple answers.
  - Most existing state mandate laws are stable.
  - New mandates have virtually disappeared.
- Required mandate reviews, now in 18 states
  - MA universal law retains, freezes mandates, old & new.
  - Mandate exemptions for defined groups growing. HSAs.
- Iowa study a useful example in contrasts
  - Chiropractors add 1.49% but may save on surgery or bone specialists?
  - Diabetes self-management adds 3.63% but may be a major savings v. hospitalization.

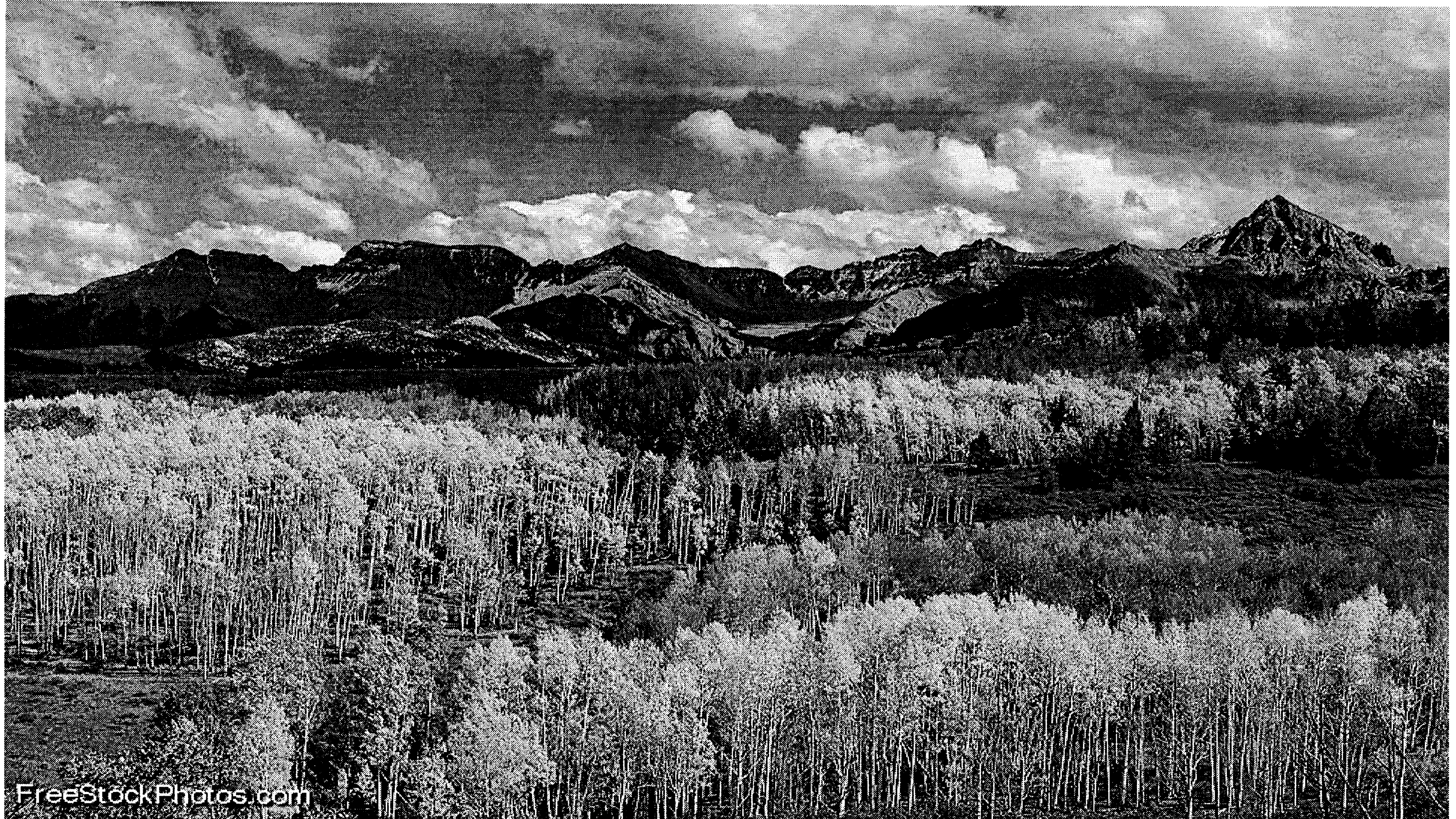
Access to health care isn't just an insurance card: Supporting community providers.

- Community Health Centers provide care for some 15 million people at 5,000 locations.
- More than 40 % of patients uninsured/36 %Medicaid recipients.
- In 2008, 35 states + DC directly funded health centers= $590 million. (2006 = $365 million)
  - KS '08 law increased funding for clinics caring for low-income people.
  - IN and NE are among the states that use tobacco settlement funds to support health centers. Other states, such as CA, CO, MI, WA earmark some state tobacco tax $ for public health programs, including health centers.
  - NJ funds health centers through a hospital assessment fund.
  - WA '07 provide grants to CHC that work with local hospitals to reduce ER use.

Other initiatives that impact access…

- Patient-centered care model/medical home model initiatives. (e.g. Iowa in '08)
- State-wide initiative to improve care for people with chronic disease.
- Workforce initiatives (examining scope of practice and distribution of providers) - PA
- HIT
- Quality initiatives

Questions?



Appendix J

The Good, Bad, and Ugly

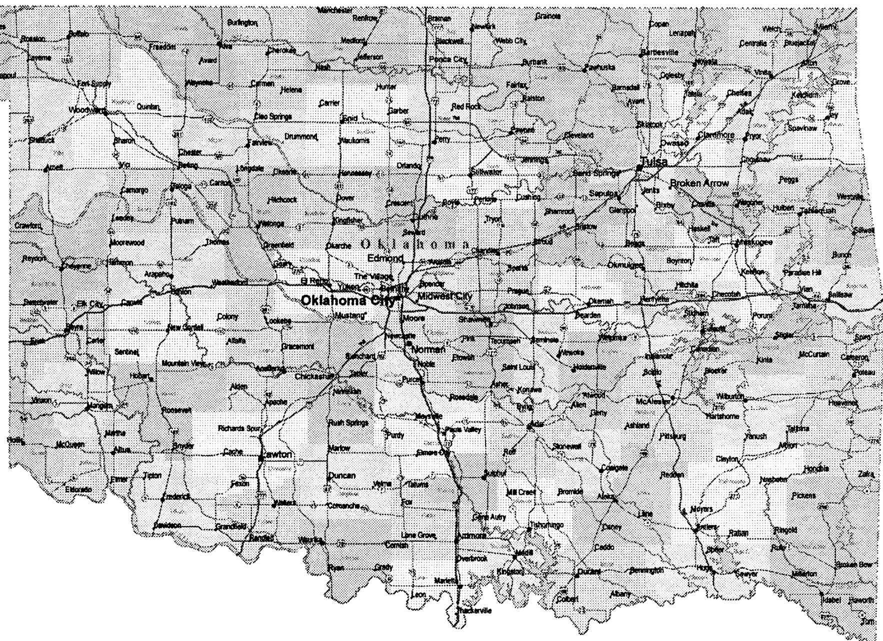
State Efforts to Address Rising Health Insurance Costs

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council
Testimony before the Oklahoma House Health Care Reform Task Force
Tuesday, August 26, 2008

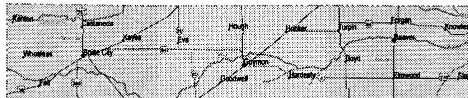
About ALEC

- ALEC is the nation's largest, nonpartisan membership association of state legislators.
- ALEC's membership boasts 2,000 legislators across the country, which is about 1/3 of all legislators nationwide. ALEC also has 87 "alumni" members in Congress.
- ALEC's mission is to promote Jeffersonian principles in the states: free markets, individual liberty, limited government, and federalism.
- Since 2005, 21 states have enacted model legislation drafted by ALEC's Health and Human Services Task Force.

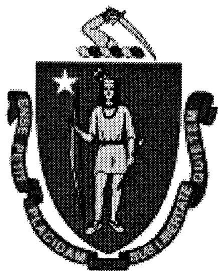
Roadmap



- **Discuss** the "good, bad, and ugly" of state health reform plans:
  - **Massachusetts**
  - **California**
  - **Wisconsin**
  - **Indiana**
  - **Florida**
  - **Maine**
  - **Tennessee**
- **Highlight** ALEC model bills to expand access to coverage: *Mandated Benefits Review Act*, *Health Care Choice Act for States*, and the *Affordable Health Insurance Act*.



Massachusetts: The Goals



- **Universal coverage** for the uninsured.
- **Elimination of the "free-rider problem,"** where those with insurance subsidize those without insurance.
- **"Appropriate care in the appropriate setting"**—keeping people out of the ER and with their primary care doctors.
- Access to a wide range of **affordable, portable, tax-free health insurance policies** for individuals.
- Successful implementation of the plan . . . with **no new taxes nor a "single-payer" financing system.**

Massachusetts: The Plan

INDIVIDUAL MANDATES

- As of July 1, 2007, every Massachusetts resident was required to have health insurance—either through their employers, through Medicaid/Medicare, or by purchasing it on the individual market.
- Every Massachusetts taxpayer must indicate on his state income tax return that he, and his dependents, had health insurance during the previous year, with no lapse longer than 63 days.
- Failure to comply results in a penalty equal to 50% of the lowest-cost insurance policy available for each month without coverage.
- This year, the mandate penalty is $219. Next year, it could rise to $912, due to proposed regulations that would set new minimum "standards" for coverage, which drives up the cost of insurance.

Massachusetts: The Plan

SUBSIDIES AND MEDICAID EXPANSION

- Uninsured individuals with incomes under 100% FPL get fully-subsidized health insurance. They pay no premiums.
- Families with incomes up to 300% FPL—that's a family of four making $60,000—get sliding-scale subsidies for premiums.
- Massachusetts expanded Medicaid eligibility for children in working families with incomes up to 300% FPL. Massachusetts is undergoing aggressive efforts to sign up the 106,000 uninsured (almost 25% of its uninsured) who already qualify for Medicaid.
- Increased Medicaid spending will lead to a 50% match from the federal government. This "new money" will be used to, in part, fund the program.

Massachusetts: The Plan

THE "CONNECTOR"

- The Massachusetts Health Care Connector combined the individual and small group markets under a single set of regulations. This allows both groups to take advantage of "economies of scale" (in administration and risk pooling) available to large businesses.

- Any individual can purchase coverage through the Connector with pre-tax dollars. The insurance is portable from job to job.

- Any business with fewer than 50 workers can choose the Connector as their insurance plan. Multiple employers can pay into the Connector on behalf of a single employee.

- Starting in 2009, Medicaid will designate the Connector as its "insurance plan."

Massachusetts: The Plan

EMPLOYER MANDATES

- Employers with more than 11 workers must pay a $295 "Fair Share" contribution if they do not make a contribution to their workers' health insurance that is "fair and reasonable."

- "Fair and Reasonable": An employer must offer a group plan and pay at least 1/3 of the cost, or an employer must offer a group plan and make any contribution as long as 25% of full-time workers are enrolled.

- Employers more than 11 workers must also establish a Section 125 "cafeteria plan" so that their employees can pay their share of insurance premiums with pre-tax dollars. Businesses that do not comply face a "free rider surcharge" if the state pays more than $50,000 for care provided to that company's employees.

Massachusetts: The Plan

"When you come to a celebration of a signing and Mitt Romney and Ted Kennedy and The Heritage Foundation are all together, it's clear one of us didn't read the bill." – *U.S. Senator Ted Kennedy*

Massachusetts: The Good

- **Preserving tax breaks:** The Connector extends generous federal tax breaks for employer-sponsored insurance to individuals.
- **Establishing portability:** The Connector makes coverage easier to purchase and maintain for part-time and temporary workers.
- **"Funding people, not providers":** Massachusetts is converting federal uncompensated care funds for hospitals into a premium assistance program for low-income individuals, administered by the Connector—a good alternative to wholesale Medicaid expansion.
- **Addressing the "free-rider" issue . . .** although uncompensated care amount to only 3-5% of health care spending.
- **Addressing the uninsured . . .** although Massachusetts had the 8th-lowest uninsured rate—and the number of uninsured dropped by 19% before the plan's implementation.

Massachusetts: The Bad and Ugly

INDIVIDUAL MANDATES

- **Represents government intrusion at its finest.** By virtue of living in Massachusetts, residents will be forced to purchase a government-defined product—whether they want it or not.

- **Compliance is futile.** Mandating health insurance is often compared to mandating car insurance. But states that mandate car insurance typically still have 15 percent of their drivers uninsured—the same percentage as states that don't mandate car insurance.

- **Impossible enforcement.** Using state income tax filings for enforcement will make it hard to track down the low-income, the elderly, immigrants, the homeless, the mentally-ill, (and even some state legislators) who don't file state income tax returns.

- **Weak penalties** that are often cheaper than purchasing coverage.

Massachusetts: The Bad and Ugly

INDIVIDUAL MANDATES

- **Red tape** like guaranteed issue, modified community rating, and 43 mandated benefits keeps the market distorted and increases the price of the mandate for the young, healthy, and "rich" (incomes greater than $55,000, which are 35% of Massachusetts' uninsured).

- **Forcing purchase of a government-defined benefits package will ratchet up spending.** Special interests will lobby (and win) for inclusion in the "standard package"—thus increasing the price of coverage and subsidies to help keep up with the cost of care.

- **Religious concerns.** Current mandated benefits in Massachusetts include IVF and contraceptives—and future mandates could include other "religiously-objectionable" practices. Also, non-traditional "insurance," such as medical bill sharing in churches, was not originally deemed by Massachusetts as acceptable coverage.

Massachusetts: The Bad and Ugly

SUBSIDIES AND MEDICAID EXPANSION

- **Expansion of government welfare programs well into the middle class.** All means-tested government programs tend to discourage work, family formation, and wealth accumulation.
- **"Crowd out"**—when the government begins to provide a service, it crowds out private-sector or charitable alternatives. For every 10 people that join a government-run health program, six of them leave the private market.

Massachusetts: The Bad and Ugly

THE "CONNECTOR"

- **Can have regulatory powers.** Vague implementing language says that Connector can determine which plans have "high quality and good value."

- "High Quality": Individuals below 300% FPL get a "Medicaid plus" plan; those above 300% FPL get capped deductibles and mandate-rich benefit packages.

- "Good Value": Was originally intended to mean monthly premiums of no more than $200/month, but regulation has ratcheted up monthly premium costs to $380. High premiums caused Massachusetts to exempt 20% of the low-income uninsured (who do not qualify for subsidies) from purchasing coverage. Those already in the small group market will also see their premiums rise 2-8%.

Massachusetts: The Bad and Ugly

THE "CONNECTOR"

- **Can become "single-seller" health insurance.** When subsidies and tax advantages are available only through the Connector, it can squeeze out other market activity. Other "Connector" states have proposed mandating that residents drop existing coverage and enroll in one of the Connector's plans.

- **Is the Connector like a benign "farmers market"?** As intended, yes. But if the Connector flexes its regulatory muscle, the "farmers market" can devolve into one in which a regulatory body determines which farmers can participate in the market, which vegetables participating farmers can sell at pre-determined prices, and which residents can receive subsidies to buy vegetables. The farmers market will become the sole place to buy vegetables in the state, thus eliminating Kroger and Costco.

Massachusetts: The Bad and Ugly

EMPLOYER MANDATES

- **Compliance is futile.** In 1974, Hawaii became the first state that required employers to provide health insurance for their workers. 30+ years later, Hawaii's uninsured rate still hovers at 10%. Many Hawaiian employers escaped the mandate by shifting work to (exempt) part-time employees.

- **Weak penalties**—"pay," at $295/worker, is cheaper than "play."

- **Cost-shifting from businesses to their workers.** Businesses faces with "Fair Share" fees will absorb those costs with higher prices or by cutting workers' pay, benefits, or jobs.

- **"Fair Share" runs afoul of ERISA** and previous Court rulings that strike down state laws mandating specific health benefits. Avoiding an ERISA lawsuit means getting a Congressional exemption (see Hawaii).

Massachusetts: The Bad and Ugly

EMPLOYER MANDATES

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Massachusetts: The Bad and Ugly

TWO YEARS LATER . . .

- **Massachusetts still hasn't achieved 100% coverage.**
  - –O f its 600,000 uninsured residents, half of them still don't have health coverage.
  - –Many were exempt because coverage was too expensive.
- **Those who did get coverage got free, or nearly-free, plans.**
  - –37% are getting fully-subsidized coverage
  - –25% w ere enrolled in employer-sponsored plans
  - –17% w ere enrolled in Medicaid
  - –14% are getting partially-subsidized coverage
  - –7% paid for coverage completely out-of-pocket
- **The number of those in subsidized plans is expected to double over the next three years; as such, the "Connector" will barely be used as people flood the low- and no-cost insurance options.**

Massachusetts: The Bad and Ugly

TWO YEARS LATER . . .

- **Massachusetts'man dated benefits account for 12 cents of every health insurance dollar, and cost $1.3 billion annually.** Massachusetts also recently lifted the new mandate moratorium.
- **Provider shortage: 42% of patients were able to see their PCP within one week, compared with 53% before the plan.**
  - The newly-insured must make appointments 2-3 months in advance; some report waiting lists of 150-200 patients.
  - The Progressive States Network reports that some previously-insured residents are still visiting the ER despite having coverage.
- **Premiums are rising . . . for everyone.**
  - Premiums for fully-subsidized coverage increased 9.4%.
  - Premiums for partially-subsidized coverage increased 5.1%.

Massachusetts: The Bad and Ugly

TWO YEARS LATER . . .

- **The plan exceed original costs estimates by $153 million last year, and by $144 million next year. The plan will double in size and cost over the next three years, and produce a $2-$4 billion shortfall over the next decade.**
  - $174 million: $1 per pack increase in the tobacco tax.
  - $33 million: Taxing insurers' reserve accounts.
  - $28 million: "Contributions" from hospitals.
  - (Proposed) $45 million: Penalties for businesses who do not provide coverage for at least 25% of employees AND do not contribute at least 1/3 of premiums.
  - (Proposed): Reduced payments to doctors and hospitals.

California: The Plan

- **Coverage for ¾ of California's 6.5 million uninsured.** California has the fifth-highest uninsured population in the country.
- **Elimination of the "hidden tax"** of higher premiums through uncompensated care and ER use.
- **Containment of chronic diseases** like diabetes, smoking, and obesity that worsen health and drive up health costs.
- **Enactment of a reform plan in which individuals, businesses, doctors, hospitals, insurers, and the government (aka taxpayers) "chip in" to pay for rising health costs.**

California: The Goal

California: The Plan

INDIVIDUALS

- Would be required to have health insurance; a minimum coverage plan would have a $5,000 deductible.

- SCHIP would be expanded to children, regardless of residency, for children in families up to 300% FPL; Medicaid would be expanded for childless adults (who are legal residents) with incomes below 100% FPL. Medicaid would also have "Healthy Action Rewards," which are incentives for healthy living.

- Uninsured legal residents with incomes between 100-250% FPL will be eligible for coverage through a state purchasing pool; uninsured legal residents with incomes above 250% FPL will receive subsidies.

- Undocumented immigrants with incomes below 250% FPL will receive coverage through county and UC hospitals via DSH.

California: The Plan

EMPLOYERS

- Employers with 10 or more workers must pay the state 4% of payroll if they do not offer health insurance. Companies with less than 10 employees are exempt.
- The 4% tax will "discourage employers from dropping coverage."

DOCTORS, HOSPITALS, AND INSURERS

- Doctors will be taxed 2% of revenues, and hospitals will be taxed 4% of revenues, in order to get federal matching funds back in the form of increased reimbursements.
- Guaranteed issue will be imposed on the individual insurance market. Insurers must reduce administrative costs to 15% and offer incentives for healthy behaviors.

California: The Plan

GOVERNMENT ("TAXPAYERS")

- **The $12.1 billion plan maximizes federal matching funds. California contributes $1.3 billion in new money to its plan; taxpayers in other states would contribute $4.5 billion.**

- The plan would increase reimbursements to providers and hospitals, which triggers federal matching funds.

- Providers and hospitals are then taxed (2% and 4%, respectively), which allows the state to "make up" for increased provider/hospital reimbursements.

- Medicaid expansion for childless adults below 100% FPL triggers a 50% federal match; SCHIP expansion for families below 300% FPL triggers a 65% federal match.

California: The Plan

HOW IT'S FINANCED

Federal Matching Funds from Increased Provider/Hospital Reimbursements

+

State Funds from the 2% Provider Tax/4% Hospital Tax

+

Federal Matching Funds from Medicaid/SCHIP Expansion and Subsidies

+

State Funds from 4% Employer Tax

+

State Funds/Federal Matching Funds from Existing Medicaid/SCHIP Spending

California: The Good

- **HSA tax parity.** California is one of the few remaining states that taxes HSA contributions. The plan would eliminate the HSA "tax."
- **Encouraging "minute clinics"** by deregulating laws governing oversight of nurse practitioners.
- **"Healthy Action Rewards" for Medicaid** that incentivize healthy behaviors—thus lowering costs and improving quality of life.
- **Addressing the "free-rider" issue . . .** although uncompensated care amount to only 3-5% of health care spending.
- **At least California doesn't standardize a benefit package … and it does include a high-deductible health plan.**
- **The legislature has not yet introduced Schwarzenegger's plan.**

California: The Bad and Ugly

INDIVIDUALS

- **Represents government intrusion at its finest.**
- **Compliance is futile—despite an auto insurance mandate, 25% of California drivers are uninsured.**
- **Impossible (and vague) enforcement.**
- **Medicaid/SCHIP expansion will incentivize low-paid workers to drop coverage—thus extending welfare into the middle class.**
- **Lower wages** for workers when they're on the receiving end of the 4% employer tax, and **more expensive care** when patients are on the receiving end of the 2% provider tax and the 4% hospital tax.

California: The Bad and Ugly

EMPLOYERS

- **Compliance is futile**—see the Hawaii example.
- **Cost-shifting from businesses to their workers.**
- **"Fair Share" runs afoul of ERISA.**
- **Weak penalties that don't stop "crowd-out"**—"pay," at 4% of payroll, can be cheaper than play.

California: The Bad and Ugly

DOCTORS, HOSPITALS, AND INSURERS

- **Even with increased reimbursements, providers and hospitals will still be subject to, on net, a $700,000 tax.**

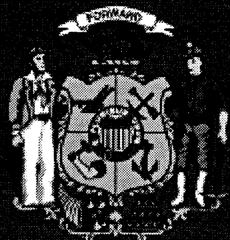
- **Overregulation** (like guaranteed issue or pay-for-performance) **can cause insurers to leave the state and can cause doctors to stop seeing patients.**

GOVERNMENT ("TAXPAYERS")

- **Higher taxes for Californians**—gaming the federal match means gaming California taxpayers, who pay federal, state, and local taxes.

- **Higher taxes for Americans**—who will foot the bill for over ¾ of the program's new spending.

Wisconsin: The Goals



- **Health cost stability and predictability** for businesses.
- **Less employee turnover; healthy/productive employees.**
- **Higher salaries and more jobs** through health cost savings.

- **Opportunity for citizens to have the same health benefits as legislators,** with mental health parity and preventive dental for kids.
- **$1 billion state and local property tax** cut from savings.
- **"Everybody pays their fair share."**

ALEC
American Legislative Exchange Council

Wisconsin: The Plan

WHO'S COVERED

- **All Wisconsin residents and workers**, unless otherwise covered by Medicaid, Medicare, BadgerCare, or the FEHBP.

WHAT'S COVERED

- **Comprehensive benefits** included in the State Employee Uniform Benefits plan, including mental health and prescription coverage.
- **Cost-sharing:** $300-$600 yearly deductible; $20 "soft" copay for office/ER visits ($60 "soft" copay for frivolous ER use); $5 copay for generic drugs, $15 for brand-name drugs; $40 for non-formulary drugs. There is no cost-sharing for preventive care, chronic disease management, or for children under 18.
- **Out-of-pocket expenses capped** at $2,000 per adult and $3,000 per family.

Wisconsin: The Plan

HOW IT WORKS

- **"Health Care Networks" comprised of providers and hospitals** will submit per-person premium bids to the Plan.
- **The Plan determines which Networks are of "low cost and high quality"—and the state will pay the full cost for these plans.** Residents that don't choose these plans will pay the difference in cost.
- **The Plan will also establish a statewide, fee-for-service plan that anyone can choose at no cost,** unless a Plan-deemed "low cost and high quality" Network exists in the area.
- **Residents must choose a Network (or the fee-for-service option)** and must choose a primary care doctor.

Wisconsin: The Plan

WHO PAYS

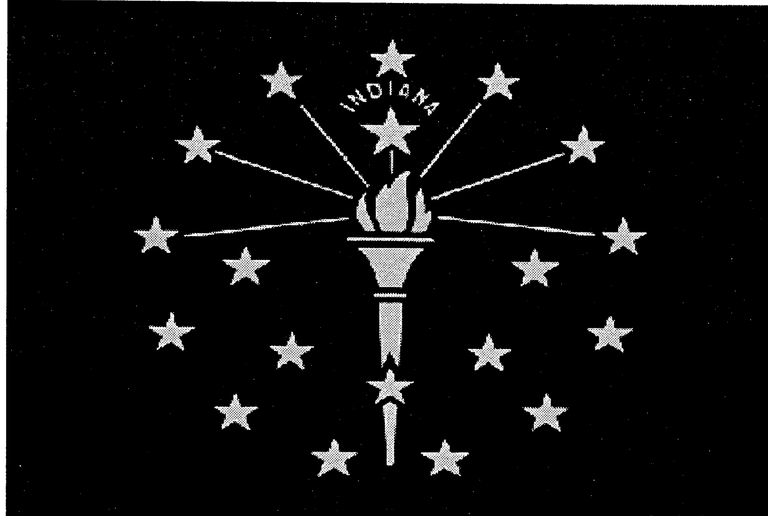
- **All employers would be required to pay the Plan 9-12% of Social Security wages,** instead of paying the employer's share of workers' health insurance. The Plan estimates the average tax to be about 10%, or an average of $370 per month per worker.
- Depending on income, **all employees would be required to pay the Plan 4% of Social Security wages,** instead of paying the individual's share of health insurance. The Plan estimates the average tax to be $140 per month per individual.
- **Self-employed persons, and those with income but no wages, would be required to pay the Plan 10% of their income.**
- "Social Security Wages": Maximum amount of your annual earnings subject to OASDI taxes, indexed yearly. In 2007: $97,500 per individual.

Wisconsin: The Good

Wisconsin: The Bad and Ugly

- **Financing the Plan would mean a $15.2 billion dollar tax increase—the largest tax increase ever enacted by any state.**
- **Wisconsin's tax burden is already the 7th-highest in the country. The 14.5% payroll tax would bump Wisconsin to #1—bringing the state tax burden to 20% of income.**
- Enacting the Plan would represent **the first time any state has voted to double its tax collections in a single year.**
- Enacting the Plan would represent **the first time any state has passed a tax increase equivalent to 50% of general revenues.**
- Enacting the Plan would represent **the first time any state has passed a tax increase equal to 6% of its GDP**—more than 13 times bigger than any state other state tax increase, ever.

Indiana: The Plan



- **Expand Medicaid for pregnant women and children up to 200% FPL.**
- **Expand SCHIP** to children in **families up to 300% FPL.**
- **Allow small businesses to join a health insurance pool.**
- **Establish a Small Employer Wellness Tax Credit** for 50% of the cost of a wellness program for employees.
- **Provide up to a $2,500 tax credit for previously-"bare" employers that establish a Section 125 benefit plan.**
- **Institute a "slacker mandate"** requiring insurers to allow "children" to remain on their parents' policies up to age 24.

Indiana: The Plan

- **Create the "Indiana Check-Up Plan" which subsidizes insurance for all uninsured up to 200% FPL.** Participants must be uninsured for more than six months and without access to ESI.

PersOnal WEllness Responsibility (POWER) ACCOUNTS

- **Indiana will provide each eligible person a "POWER Account" to pay for medical costs and prescription drugs.**

- **Indiana will deposit the first $500 into the Account for preventive care** (physicals, mammograms, smoking cessation, etc.).

- **Each Account owner must make a monthly contribution** on a sliding-scale basis, up to 5% of gross family income.

- **Employers are eligible to contribute to the Account** if they have not offered insurance to their employees for six months or more.

Indiana: The Plan

- **Indiana will "make up the difference" to ensure there is a total of $1,100 per person in the Account.** For example, if the contribution from the participant and/or employer is $600, Indiana will contribute $500. Indiana's contribution will be deposited at the time of enrollment to ensure that funds are available right away.

- **Account owners can use the funds to purchase a standard benefits plan from private insurance carriers** who compete on the basis of participating providers and customer service options. **When Account funds are exhausted, participants will receive a maximum insurance benefit of $300,000** or a lifetime benefit of $1 million.

- **At the end of the year, the Account owner can roll over $600 or withdraw those funds for any purpose. If the Account owner is no longer eligible for the Plan, they get back their share of the funds in the Account.** For example, if the Account balance is $300, and the participant contributed $100, he would receive $100 back.

Indiana: The Plan

HOW IT'S FINANCED

Cigarette Tax Increase of 44.5 cents per pack

+

State Funds for Medicaid and SCHIP Expansion

+

Federal Matching Funds from Medicaid Expansion (62%) and SCHIP Expansion (73%)

+

Mandatory Participant Contribution and/or Optional Employer Contribution in POWER Account

Indiana: The Good

- **Funding people, not providers.**
- **Preserving federal tax breaks** by encouraging (not requiring) employers to establish Section 125 plans.
- **Allowing small businesses to pool together to purchase health insurance.**
- **"A for Effort"—introducing an HSA-like concept for the uninsured** (although it is government-administered).
- **It's not an entitlement (although it may become one).**

Indiana: The Bad and Ugly

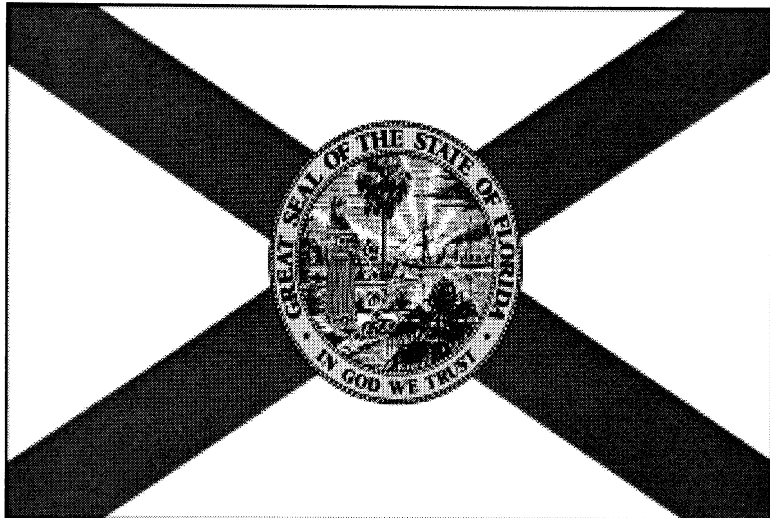
- **Although the program is not, technically, an entitlement now, political pressure will move it in that direction.**
- **A state-funded HSA is NOT an HSA.**
- **Taxpayers outside of Indiana will foot more than 2/3 of the bill.**
- **Standardized benefits mean a costly, one-size-fits-all package for everyone.**
- **"Slacker mandate"**—are 24-year-olds really "children"?
- **The cigarette tax is an regressive, unstable funding source.** Taxes discourage less of the taxed activity. If people stop smoking, how will Indiana fund the plan? Also, smokers tend to be low-to-moderate-income—the target group for the Indiana plan.

Indiana: The Bad and Ugly

ONE YEAR LATER . . .

- **40,000 Indianans have applied for the program. Of those, 11,000 were deemed ineligible and only 6,700 have coverage.**
  - The maximum plan enrollment is 130,000 – 37,000 childless adults and 90,000 parents.
- **Legislators are considering rescinding the six-month waiting period and other measures designed to stop HIP from becoming an entitlement program.**
- **"Interest in the plan is high and it is likely that the amount of the cigarette tax may need to be revisited."** – Indiana FSSA Secretary Mitch Roob in *Health Affairs*

Florida: The Plan



- **SCHIP "buy-in" for all families, regardless of income.**
- **Tougher burden of proof for a hospital to use CON** to prevent competition; **"loser pays."**
- **"Slacker mandate"** requiring insurers to allow "children" to remain on their parents' policies up to age 30.
- **Provide coverage for 4 million uninsured Floridians.**
- **Comprised of two components: "Cover Florida"** (Governor's plan) **and "Florida Health Choices Corporation"** (House plan).

Cover Florida: The Plan

THE PLAN

- Cover Florida will provide "mandate-lite" coverage that, at a minimum, covers preventive care, inpatient hospital, emergency care, prescription drugs, durable medical equipment, and diabetic supplies.

- Catastrophic and non-catastrophic coverage will be available. It's estimated that some plans will cost as little as $150/month.

- All Cover Florida plans will be guaranteed issue.

WHO IS ELIGIBLE?

- People aged 19-64 who have been uninsured for at least six months; those who have lost health coverage due to job loss, COBRA exhaustion, death/divorce.

Cover Florida: Good, Bad, or Ugly?

- **Will it work?** It's doubtful that the state can attract insurance products that are $150/month while mandating preventive care AND guaranteed issue.

- **Will there be political pressure to add special interest mandates to the "basic" plan?** Will special interests lobby (and win) for inclusion in the "standard package"—thus increasing the price of coverage?

- **Are 30-year-old non-students really "children"?** "You can vote at 18, but you're not competent to buy a health plan until you're 30." – John Graham, Pacific Research Institute

Florida Health Choices Corporation: The Plan

WHAT IS IT?

- **A state-administered "public/private employer marketplace" for small businesses seeking coverage for their workers.** The Corporation will sell traditional plans, "mandate-lite" plans as prescribed in Cover Florida, and other products (Flexible Spending Accounts, alternative medicine, etc.).
- **A *de facto* human resources department/third-party administrator** for participating small businesses.
- **Participating businesses will get tax breaks for using the Corporation.**
- **The Corporation, which is comprised of 15 political appointees, will also:**
  - Decide which products are sold; "choice counseling."
  - Collect and distribute premiums, as well as manage individual benefit accounts.

Florida Health Choices Corporation: The Plan

WHO IS ELIGIBLE?

- **The plan is targeted to small businesses with fewer than 50 workers. Other populations can also participate, including:**
  - State workers not otherwise eligible for health benefits
  - State retirees
  - Small city governments
  - Medicaid "opt-out" population

HOW DOES IT WORK?

- **Participating employers will use pre-tax dollars** to contribute to the Corporation on behalf of their workers.
- **Participating individuals can contribute to the Corporation either by using pre-tax dollars or payroll deduction.**
- **Workers choose a plan. The Corporation pays the premium.**

Florida Health Choices Corporation: The Bad and Ugly

"MASSACHUSETTS REDUX"

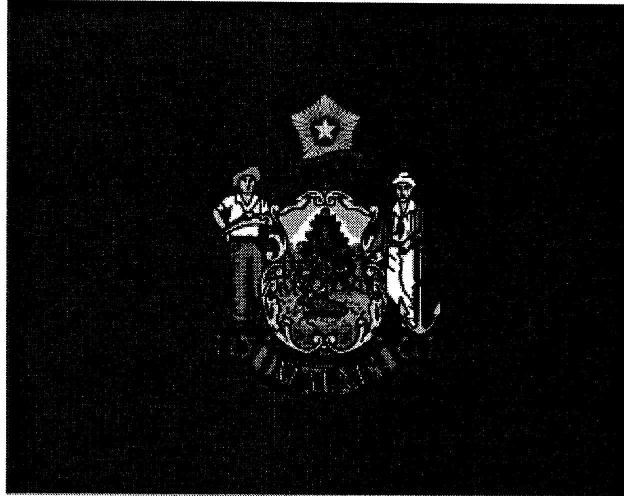
- **The Corporation: More "Checkpoint Charlie" than "Farmers Market."** Vague implementing language allows the Corporation to accept "recommendation[s] that a risk-bearing [insurance] product should not be available in the marketplace." Political pressure will likely force the Corporation to flex its regulatory muscle.

- **Can become "single seller insurance."** When tax breaks are available only through the Corporation, it can squeeze out other market activity.

- **Coverage is "portable" only if workers move from small business to small business, or go on Medicaid.**

- **Unelected, unaccountable political appointees running health care for small businesses.**

Maine: The Goals and the Plan



- **Eliminate all 135,000 uninsured within five years (2009).**
- **Be self-supporting with no new taxes or state funds (beyond first year).**
- **Stabilize health insurance premiums and cost increases.**
- Medicaid expansion.
- New state health care and health insurance regulations: minimum loss ratios, expanded CON, limits on private health care investment, evidence-based medicine, limits on hospitals' operating margins; new boards and commissions.
- **"DirigoChoice," a subsidized insurance product for individuals and small businesses.**

DirigoChoice: The Plan

Health Care Simplification?
Navigating the 24 Different DirigoChoice Plans for Employees
2005 Family Income Eligibility

<table>
<tr><th></th><th colspan="5">Annual household income can be no more than:</th><th>Annual household income over</th></tr>
<tr><td>1 person family
2 person family
3 person family
4 person family
5 person family
6 person family</td><td>$9,570
$12,830
$16,090
$20,110
$22,610
$25,870</td><td>$14,355
$19,245
$24,135
$30,165
$33,915
$38,805</td><td>$19,140
$25,660
$32,180
$40,220
$45,220
$51,740</td><td>$23,925
$32,075
$40,225
$50,275
$56,525
$64,675</td><td>$28,710
$28,490
$48,270
$60,330
$67,830
$77,610</td><td>$28,710
$38,490
$48,270
$60,330
$67,830
$77,610</td></tr>
<tr><td>% of federal poverty limit</td><td>0-100%</td><td>125-150%</td><td>150-200%</td><td>200-250%</td><td>250-300%</td><td>300+%</td></tr>
<tr><td>Adults Without Minor Children*</td><td rowspan="3">Category A: $0/$0 deductible, currently Medicaid eligible</td><td>Category B: $250/$500 deductible</td><td>Category C: $500/$1,000 deductible</td><td rowspan="3">Category D: $750/$1,500 deductible</td><td rowspan="3">Category E: $1,000/$2,000 deductible</td><td rowspan="3">Category F: $1,250/$2,500 deductible</td></tr>
<tr><td>Parents*</td><td rowspan="2">Category A: $0/$0 deductible, currently Medicaid eligible OR Category B: $250/$500</td><td>Category A: $0/$0 deductible, May 2005 Medicaid eligible OR Category C: $500/$1,000 deductible</td></tr>
<tr><td>Children*</td><td>Category A: $0/$0 deductible, currently Medicaid eligible OR Category C: $500/$1000 deductible</td></tr>
</table>

* The first number is the individual deductible; the second is the family deductible.
Source: Information compiled by author from Dirigo Health Agency, Web site, at www.dirigohealth.com (May 17, 2005).

PLAN OPTIONS

- **Dirigo has four different coverage options** (employee only, employee and spouse, employee and child, and family coverage).
- **Dirigo also has six different categories of premium assistance** (Categories A-F, where A=most state aid and F=least state aid).

DirigoChoice: The Plan

ELIGIBILITY: EMPLOYERS

- **Must only offer Dirigo to employees.**
- **Must pay the same portion of Dirigo premiums for all employees—at minimum, 60% of the employee's premium. Employers are expected to "voluntarily" pay the same premium for Medicaid-eligible employees.** Premiums are then sent to the Maine Department of Human Services to be used as seed money for Medicaid match.

ELIGIBILITY: EMPLOYEES

- **Can apply for a Medicaid or premium subsidy.**
- **Can just pay the Category F premiums and deductibles.**
- **Employees purchase coverage from Anthem BCBS.**

DirigoChoice: The Plan

PREMIUM SUBSIDY AS PERCENTAGE OF ENROLLMENT

Family Income (% of FPL)	Category	Premium Subsidy Deductible – Ind./Family	% Total Dirigo Enrollment
Medicaid Eligible <200% families, <100% childless adults	**A**	**100%** **$0/$0**	**1%**
<150%	**B**	**80%** **$250/$500**	**51%**
150-200%	**C**	**60%** **$500/$1,000**	**16%**
200-250% ($40,000 family of four)	**D**	**40%** **$750/$1,500**	**9%**
250-300%	**E**	**20%** **$1,000/$2,000**	**4%**
>300% ($60,000 family of four)	**F**	**0%** **$1,250/$2,500**	**19%**

DirigoChoice: The Plan

IMPACT ON EMPLOYERS

- **Complexity:** Employers will have to determine which of the 24 eligibility levels to apply to employees; must explain the system to all new hires and existing employees when they enroll in Dirigo.
- **One-Size-Fits-All:** Dirigo encourages employers to minimize their share of premium payments, as all employees must be treated the same.
- **Why would employers pay the state so that a Medicaid-eligible employee can go on Medicaid when that same employee can go on Medicaid without cost to the employer?**

IMPACT ON EMPLOYEES

- **"Fertility Bonus":** Under Dirigo, the more children you have, the less premium you pay. In contrast, private health insurance plans would typically charge the same premium regardless of the number of children covered.

ALEC American Legislative Exchange Council

DirigoChoice: The Plan

HOW IT'S FUNDED

- **Employer contributions** (made by businesses that uses DirigoChoice as their health insurance plan) **that trigger matching federal Medicaid dollars.**
- **"Savings Offset Payment" (SOP): Because Dirigo was to eliminate all of the uninsured within five years, the State calculated the "savings" (on bad debt and charity care) that Dirigo would bring to insurers—and then forced insurers to remit most of those "savings" back to the state.**
- **Maine didn't actually have to show any "savings" in order to claim the SOP.**
- **"Savings"= Slowed growth of health insurance premiums or health care costs.**

DirigoChoice: The Bad and Ugly

ENROLLMENT

- **No One's Signing Up:** Complexity to employers and individuals means that Dirigo covers only about 12,000 individuals, which is 1% of the state's population and 3.2% of the state's uninsured population.

- **Most Enrollees Are Already Insured:** Only 31% of Dirigo's enrollees were previously uninsured, causing "crowd out" in the remaining 70% of Dirigo enrollees.

- **Many Enrollees Are Dropping Out:** One in eight Dirigo enrollees dropped the plan within the first eight months of coverage.

- **At this rate, it would take Maine 108 years to cover all 135,000 uninsured.**

DirigoChoice: The Bad and Ugly

COSTS

- **Cost to Taxpayers:** Dirigo costs taxpayers $2,977 per enrollee per year just for the premium subsidy. Dirigo's administrative costs are about $4 million annually. **The Dirigo experiment has cost Mainers over $100 million since 2005.**

- **More Tax Increases:** Despite initial promises that Dirigo would be self-sustaining, the Maine legislature instituted the following taxes, which cost the average family $210 per year:
  - **$4/gallon tax on soda syrup**
  - **42¢/gallon tax on bottled sodas**
  - **Doubling of the beer and wine tax**
  - **New 1.8% claims tax on all health insurance claims**

- **At this rate, it would cost Maine $1.5 billion to cover all 135,000 uninsured.**

DirigoChoice: The Bad and Ugly

new_index - Windows Internet Explorer

http://www.dirigohealth.maine.gov/

Maine.gov Agencies | Online Services | Help

State Search:

We are rebuilding our website as part of the transition of DirigoChoice to Harvard Pilgrim Health Care. Please check back soon.

We are not offering subsidized coverage to new members at this time due to lack of funding.

As your elected representatives discuss the future of Dirigo in Augusta, it is important that you let them know what you think of the DirigoChoice program. Let your Legislator know if this program is working for you.

Office of the Governor
1 State House Station
Augusta, ME 04333-0001
(207) 624-7447
governor@state.me.us

The Maine Senate
3 State House Station
Augusta, ME 04333-0003
(207) 287-1540
webmaster_senate@legislature.maine.gov

Maine House of Representatives
2 State House Station
Augusta, ME 04333
(207) 287-1400
webmaster_House@legislature.maine.gov

For more information about DirigoChoice, or to be notified when subsidized coverage is available, please call toll free:

(877) 892-8391

Dirigo Health Board of Trustees Meeting Minutes and Documentation

Dirigo Health Agency 2006 Annual Report

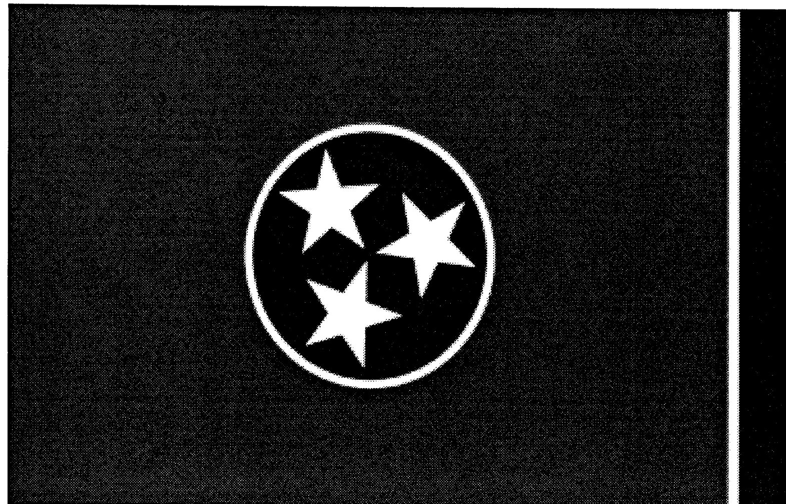
Savings Offset Payment FAQ

Harvard Pilgrim Health Care

Maine Quality Forum

Year 4 Aggregate Measurable Cost Savings Adjudicatory Hearing

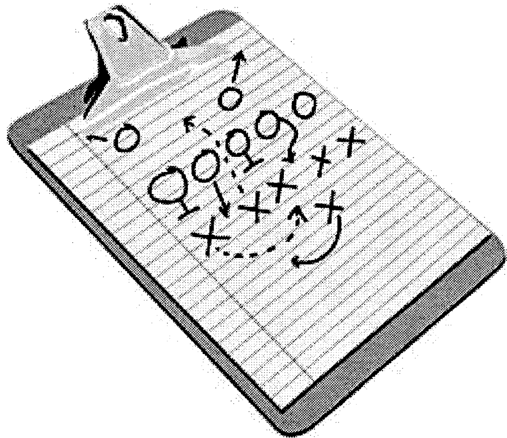
State to Watch: Tennessee



- **BCBS-designed insurance for small businesses who don't offer coverage and have at least half of employees earning $43,000/year or less.**
- **"Three Share":** Individuals, employers, and businesses all pay 1/3 of the premium.

- **Coverage:** No deductible, $15/copay, but a $25,000 maximum benefit—only $15,000 of which can pay for hospital costs.
- **The Question: Would CoverTN's enrollees be better off in HSAs, where coverage is cheaper** (thus eliminating taxpayers' 1/3 "share") **and lifetime benefit limits are typically $5 million?**

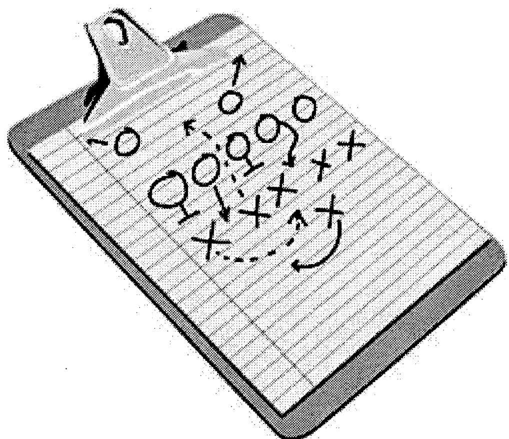
Mandated Benefits Review Act



- **Requires that any proposed mandated benefit, mandated offering, or mandated coverage first undergo a medical efficacy and cost/benefit analysis** by the state Department of Insurance.

- Option #1: Can require a certain percentage (usually 20%) of existing mandates be annually reviewed in the same manner.
- Option #2: Can require a certain percentage of existing mandates to annually expire unless specifically studied/reauthorized by the legislature.
- The *Mandated Benefits Review Act* serves as an "institutional check" on fiscally-disastrous mandates that interest groups often steamroll into existence. Think "concentrated benefits vs. diffuse costs."

Health Care Choice Act for States



- Despite the failure of Shadegg's "Health Care Choice Act" (H.R. 2355), **states may form voluntary agreements allowing consumers to purchase health insurance across state lines, as long as the insurance product is licensed/domiciled in the "agreement" state.**

- Mandating benefits for health insurance is like saying to someone in the market for a new car . . . "If you can't afford a Lexus loaded with options, you have to walk." *(HT: Council for Affordable Health Insurance)*

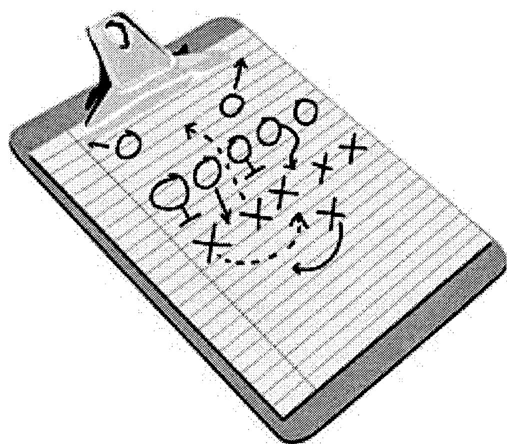
- Critics say that competition between states and insurance providers will yield a "race to the bottom" in health care. Although consumers may purchase basic policies with as few as 14 mandates (ID), they can also choose to purchase gold-plated coverage (for example, in MN, which has 63 mandates).

Health Care Choice Act for States

HOW WOULD IT WORK?

- **Private entities (like *Consumer Reports*) would advertise the extent of each state's regulations.** "This Plan Licensed in Idaho" would have the same branding as "100% Florida Orange Juice."
- **How would an Oklahoman get care if they purchase coverage in Idaho?** Provider networks would be established via private contract.
- **Where would disputes be settled?** Consumers would be bound by the regulatory protections of the state in which the plan originates.
- **What about premium taxes?** Premium taxes would be allocated to the state in which the plan originates. Because of this, states would offer favorable business climates so that insurers would domicile in their state. This not only would help states gain more premium tax revenue, it would also increase plan choice for their own citizens.

Affordable Health Insurance Act



- **The *Act* recognizes that the uninsured are a diverse group—and targets large segment of the uninsured who can afford coverage, but don't think it's a good "deal."**
  - The "Uninsurable: Homeless, mentally-ill.
    - –Me dicare-/Medicaid-Eligible: 25% of uninsured.

– **"Invincibles":** 30.6% of the uninsured are young-and-healthy "invincibles" between the ages of 18-24; 26.4% of the uninsured are between the ages of 25-34.

– **Opt-Out with Good Incomes:** 20% of the uninsured have good incomes, but voluntarily opt-out of coverage. The fastest-growing segment of this "opt-out" population is the nine million uninsured who have incomes above $75,000/year.

Affordable Health Insurance Act

HOW WOULD IT WORK?

- **Allows HDHP insurers to lawfully establish wellness incentives.**
- **Allows HRAs to be sold with individual health insurance policies.**
- **Gives a 100% state income tax deduction for HDHP premiums** when used with an HSA.
- **Provides a $250 small business tax credit for spending at least that amount for each employee enrolled in an HDHP with an HSA.**
- **Exempts HDHPs** (when sold with an HSA) **from premium taxes.**
- **Conducts a study of HSA-eligible plans in other states and establishes a "fast track" process so that those plans can be made available in the state.**

Contact Us!

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council
1101 Vermont Avenue, N.W., 11th Floor
Washington, D.C. 20005
(202) 466-3800
christie@alec.org
http://www.alec.org

ALEC
American Legislative Exchange Council

Appendix K

Healthy Indiana Plan

HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

30,000 more insured!

- ✓ As of September 6, 2008, 75,367 applications have been received.
  - Of those, 75,367 applications have been processed.
    - 14,056 Pending
      - Awaiting additional information, particularly the necessary verification documents.
    - 22,578 Denied
      - Due to existing insurance coverage (either have access to health insurance, have had insurance within last 6 months, etc.)
    - 29,925 Eligible
      - 5,782- Conditionally Eligible (still awaiting payment)
      - 24,143- Fully Eligible (receiving HIP coverage)
- ✓ Monitoring Daily

Our Bad Value

- ✓ “Payin’ for a Caddy, Gettin’ a Chevy”
- ✓ High Total Expenditure:
  - US spends 15.2% GDP on Healthcare
  - The US spends the most in the world, and this percentage of spending is only increasing.
  - Headlines: “US Healthcare spending to double by 2017”
- ✓ Poor Health Outcomes:
  - The US ranks 20th and 19th respectively for male and female life expectancy.
  - Despite the investment made into the health system, the outcomes are some of the worst among major industrialized nations.

How have we evolved to this point?

We Can't Handle the Truth

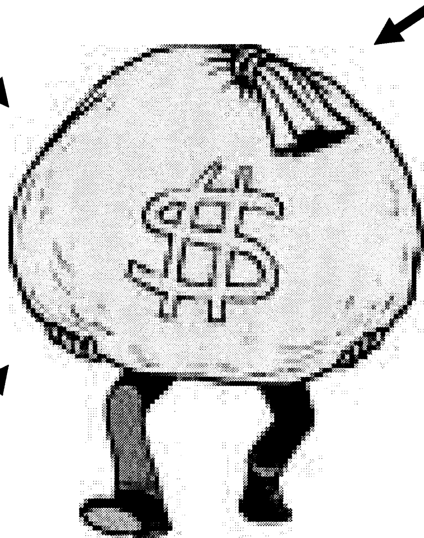
- ✓ We have universal healthcare!
  - We just won't admit it
- ✓ Use hospitals to mediate our two colliding American values
  - Rugged Individualism
    - American society is based on equal opportunity, and with that, personal responsibility to reap one's own rewards or consequences based on actions.
  - Judeo-Christian Ethic
    - Its' not in society's interest to allow the poor, ill, disabled, and elderly to die in the streets.
- ✓ Conflict not in Consort

Financing the Care of the Uninsured

Higher Health Care Premiums
Family = **+$950/year**
Individual = **+$375/year**

"Tax Effect" of Employer Sponsored Health Insurance = **Undetermined**

Out-of-Pocket Expenses paid by the Uninsured = **$503M**



Government payments to hospitals (DSH, UPL, HCI) = **$426M**

Federally Qualified & Rural Health Centers = **$40M**

Charity Care & Community Outreach = **Unknown & often Not Recorded**

Total Cost:
Over $2 billion

Health Care System & the Free Market

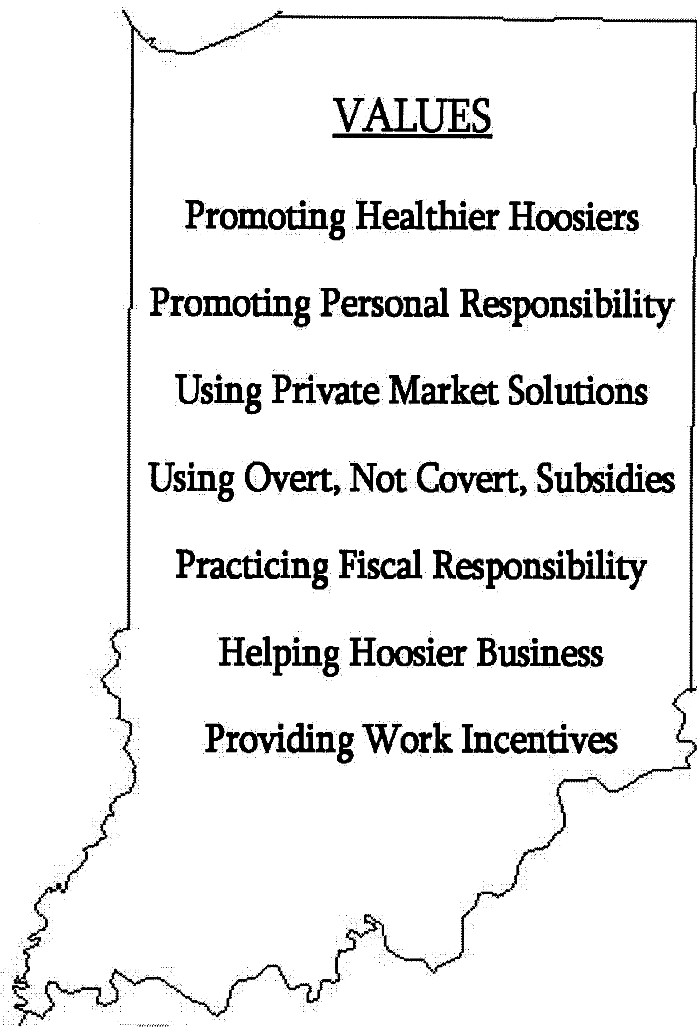
- ✓ Americans use markets
  - Markets are the worst possible way to provide healthcare…EXCEPT for the rest
- ✓ Consumers (Patients), Producers (Physicians) and the Third Party (Uninsured)
- ✓ Imbalance in Consumer/ Producer Relationship
  - Cost-shifting to the insured requires opaque pricing
  - Institutional entitlements
    - Government Subsidies
    - Disproportionate Share Hospitals, Health Centers etc.

Inaction is not a market solution.

Market Forces Only Work

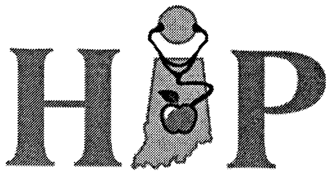
$$\frac{P}{Q} = V$$

Indiana's Healthcare Value and Vision



Indiana's Healthcare Challenges

- ✓ Since 1990, the uninsured population in Indiana has increased by 30%
- ✓ 67% of Indiana's uninsured are below 200% FPL
- ✓ Indiana's Medicaid coverage level for non-disabled adults ranks 47th in the nation (22% FPL)
  - No awareness of cost or incentive to consider costs
  - No incentive for health lifestyles



Filling the Coverage Gap

FPL

250%
200%
150%
133%
100%
70% - 80%*
23%

SCHIP 2
SCHIP 1
Standard Medicaid
Pregnancy Services Only
THE GAP IN COVERAGE
Ages 19 - 64
Medicare
Medicare/ Medicaid Dual
MEDWorks Buy-in
MEDWorks

Age <1 | 1-5 | 6-18 | Pregnant | 19 - 64 | *65+ | Disabled Blind*

The Gap in Coverage shown in Orange

Current Medicaid population shown in blue.

*Aged, Disabled and Blind income eligibility is driven by SSI standards rather than FPL

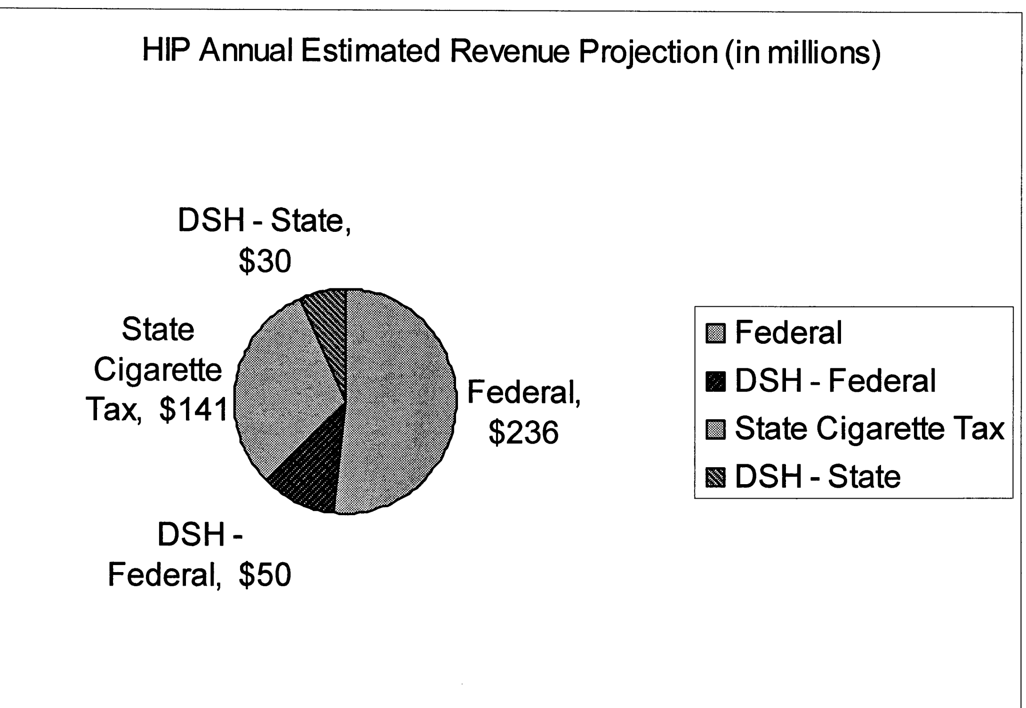
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

HIP Target Group

- ✓ Non-Disabled Adults Ages 19-64:
  - **Caretaker Relatives** of dependent children with family incomes from 22% to 200% FPL
  - **Childless adults** with family incomes under 200% FPL
    - Enrollment Cap: 34,000 childless adults each year

- ✓ An estimated 375,000 Hoosiers are chronically uninsured under 200% FPL
  - HIP has funding to cover approximately 130,000 Hoosiers a year

HIP Annual Estimated Revenue Projection



Fiscal Responsibility

✓ Program needed budget neutrality
- Funded primarily by increase in cigarette tax
- Anti-entitlement provision in legislation prevents an open ended obligation

✓ "Skin in the game" for participant
- Participant must contribute financially
- Sliding scaled contribution
- Health Savings Account structure

Health Savings Accounts & High Deductible Health Plans

✓ Benefits:

- Encourage healthy lifestyles
- Engages consumer to make cost and value based health care decisions (Invisible Hand)
- Promotes price transparency
- Promotes competition and quality

✓ Criticisms:

- Deductible too high for low income population
- Discourage needed health care services
- Tax benefits are not applicable to low income

Plan Structure

Preventive Services
$500 for Preventive Care Services
Amount in addition to POWER Account funds

POWER Account
$1,100
Individual & State Contributions
Controlled by participants to cover initial medical expenses

Insurance Coverage
$300,000 Annual Coverage
$1 Million Lifetime Coverage

COVERED SERVICES:

Physician Services
Prescriptions
Diagnostic Exams
Disease Management
Hospital

Individual POWER Account contribution will not exceed 5% of gross annual income – approximately $200 - $900 annually

Encouraging Healthy Behaviors

✓ Creates financial incentives for preventive services through POWER Account roll-over

- If all age, gender, and pre-existing condition appropriate preventive service goals are met, *all* account funds (state and individual) roll over to offset the following year's contribution
- If not, only the individual's prorated contribution to the account rolls over

HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

Personal Responsibility

- ✓ Terminations
  - Proportional share of individuals contribution returned
  - No State dollars paid out
- ✓ Disenrolled Due to Failure to Pay Contribution
  - Receives 75% of their proportional contribution
- ✓ Emergency Room Co-payments

Supporting a Private Market

- ✓ Anti-Crowd Out Provisions
  - Participants must be uninsured for at least 6 months
  - Participants must not be eligible for employer-sponsored health insurance offered through their individual employer
- ✓ Contracting with Private Plans
  - Anthem Blue Cross Blue Shield
  - MDwise with AmeriChoice
- ✓ Buy-In Option

Market Concept at Work

Both Insurers are:

- ✓ Providing **free unlimited preventive care services** rather than the minimum $500 required by the legislation
- ✓ Sending detailed monthly statements to members to monitor POWER Account balances, which are also accessible on the internet

HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

Cutting Deals

- ✓ Cigarette Tax- 44¢ compromise
- ✓ Providers paid at Medicare (not Medicaid) rates
- ✓ Mental health parity
- ✓ No vision or dental coverage

HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

Implementation Timeline

- ☑ November 2006- Governor Daniels announces plan
- ☑ April 2007- General Assembly passes HEA 1678
- ☑ May 2007- Submit RFP for Health Plans
  - Five health plans submit proposals
- ☑ June 2007- Begin Regular Waiver Negotiations with CMS and OMB
- ☑ August 2007- Health Plans Selected
  - Anthem Blue Cross Blue Shield
  - MDwise and United Healthcare were asked to come together to offer HIP (Subcontracting relationship)
  - Enhanced Services Plan- ICHIA

HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

Implementation Timeline

- ☑ September 2007- Conceptual Agreement with CMS
- ☑ November 2007- Contract signed with health plans
- ☑ December 14, 2007- Official Waiver Approval
  - Funding for 130,000
  - Limits on Childless Adults
  - Eligibility Begins at Age 19 not 18
  - No Dental or Vision Coverage
  - No Plan Involvement in Enrollment
  - Must Allow Legal Aliens to Participate
  - Moved Contribution for 150-200% from 5% to 4.5% for parents

Although, the waiver process made some small changes, the basic structure for HIP including benefit package and POWER Account remained unchanged

Implementation Timeline

- ☑ December 10, 2007- Statewide Media Campaign Begins
  - "We've Got you Covered"- TV, Radio, Billboard, Transit
  - Direct Marketing to S-CHIP Parents
- ☑ December 17, 2007- Begin Accepting Applications
  - On the internet at www.hip.in.gov
  - Request by phone at 1-877-GET-HIP-9
  - Pick up at local DFR office or Hoosier Healthwise Enrollment Center
- ☑ January 1, 2008- HIP Fully Implemented
  - Nearly 7,000 applications received by start of program

Daily Dashboard

HIP WEEKLY DASHBOARD

Tuesday September 2, 2008 Day 263 of the program

GREEN: Stay the course – progressing accord to plan
YELLOW: Caution – Issues needing corrective action exist
RED: Urgent – Corrective action required immediately

Applied

Applications
To Date: 73,976
Exported: 65,175
Queue: 8,810

Last Week
Received: 2,081
Exported: 1,574
Change: 516
Avg Received: 281*
Avg Exported: 248*

* Averages are based on calendar days

Eligibility Status

Pending
Active: 14,249

Denied
Total: 21,782
Rate: 42.8%

Conditional
Active: 8,193

Fully
Total: 22,951

Conditional Breakdown

- Anthem Total: 3,553
- MDW/ AC Total: 2,474
- ESP Total: 166

Milliman
Total Cases: 952
Total Adjudicated: 741
Active Cases: 211
Assigned to ESP: 175
Assigned to Plan: 566

Cancer: 136 (77.7%)
Blood Disorders: 6 (3.4%)
HIV/AIDS: 16 (9.1%)
Other: 3 (1.7%)
Transplant: 14 (8.1%)

Enrolled

Anthem
Total: 16,821

MDWise/ AmeriChoice
Total: 5,919

ESP Qualified
Total: 211

Claims	Prior Authorizations	Network Development
Anthem Received: N/A Paid: N/A Denied: N/A	Anthem Received: 14 % Denied: 7.0%	Anthem PMPs: 2,113 100% Access: Yes
MDWise Received: N/A Paid: N/A Denied: N/A	MDWise Received: 124 % Denied: 17.0%	MDWise PMPs: 808 100% Access: Yes
ESP Received: N/A Paid: N/A Denied: N/A	ESP Received: N/A % Denied: N/A	ESP PMPs: NA 100% Access: N/A

WEEKLY AS OF 08/25/2008

Notes:
For Questions/Concerns/Comments please contact:
Ryan May (ryan.may@fssa.in.gov)
or
Ted Feeney (ted.feeney@fssa.in.gov)

Lesson's Learned

- ✓ Help those who need it, but increase personal responsibility and market incentives
  - Rugged Individualism and Judeo Christian Ethic working in consort
- ✓ Fiscal responsibility
- ✓ Reach across the aisle, compromise & cut deals
- ✓ Don't let perfection be an impediment to good

The Bottom Line

- ✓ HIP will cover 130,000 Hoosiers who are currently uninsured
- ✓ **Each State is different. Do what makes sense for Oklahoma!**

For More Information

Call:**1-877-GET-HIP-9**

Or Visit: **www.hip.in.gov**

Appendix L

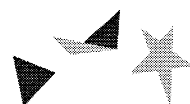
State Coverage Initiatives

Robert Wood Johnson Foundation

Massachusetts Health Care Reforms: What They Are and What They Mean

Oklahoma House Health Care Reform Task Force
Oklahoma City, OK
September 9, 2008

Enrique Martinez-Vidal
Vice President, AcademyHealth
Director, State Coverage Initiatives



AcademyHealth

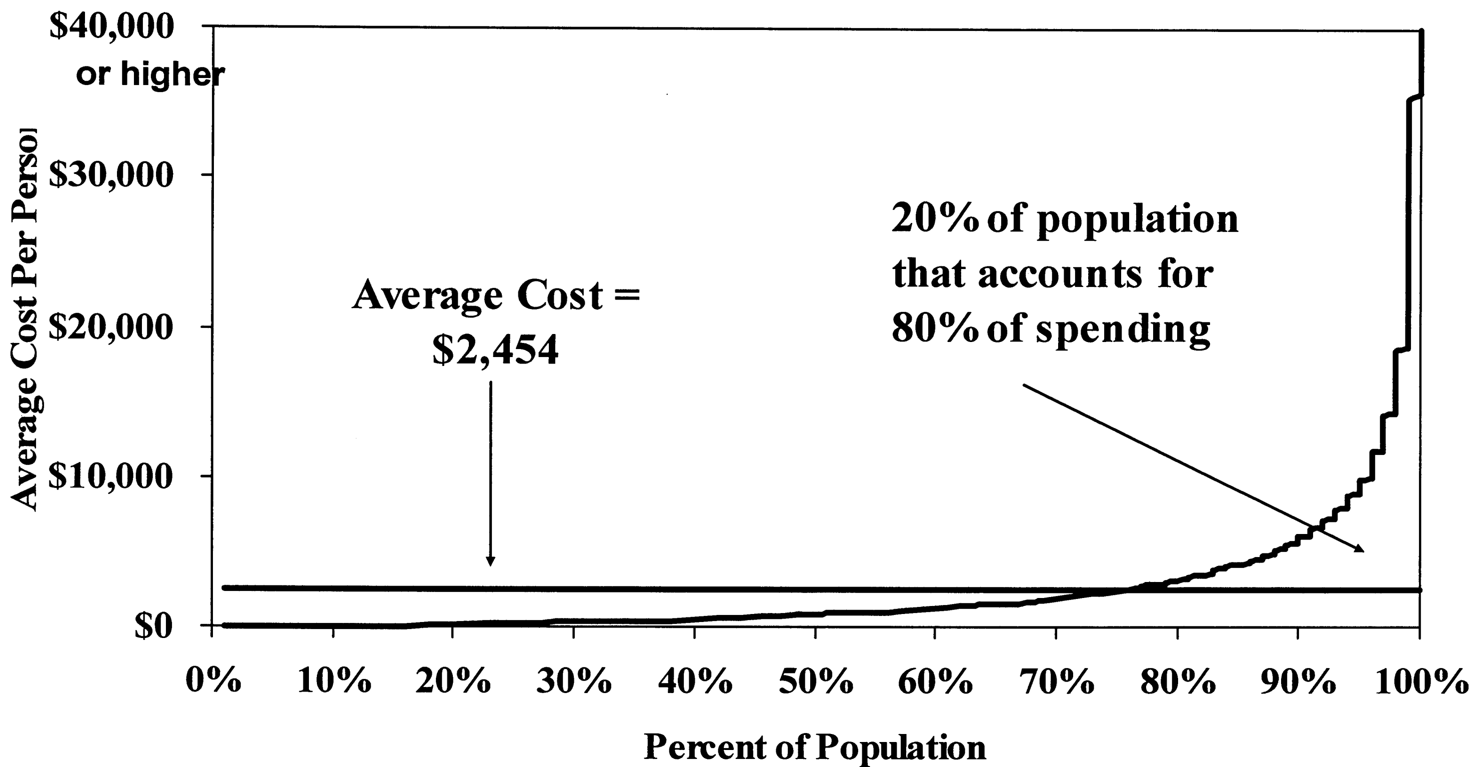
State Coverage Initiatives (SCI)

- An Initiative of the Robert Wood Johnson Foundation
- Direct technical assistance to states
  - State specific help, research on state policy makers' questions
  - Convening state officials
  - Web site: http://statecoverage.net
  - Coverage Matrix
  - Publications
  - Grant funding/Coverage Institute

Contact Information:

Enrique.Martinez-Vidal@academyhealth.org

Distribution of Health Spending Adults Ages 18-64, 2001

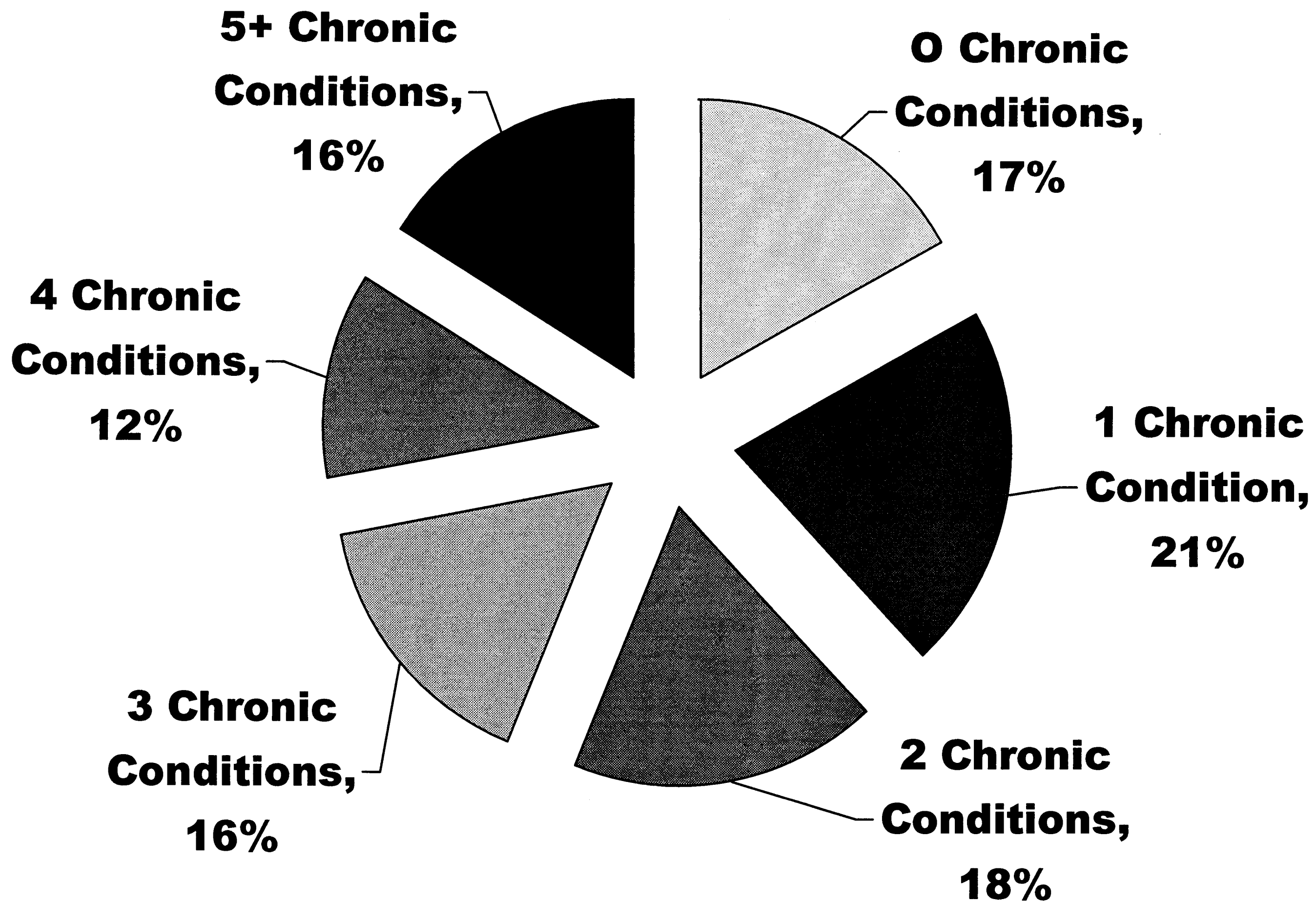


State Coverage Initiatives

Robert Wood Johnson Foundation

Source: Employee Benefit Research Institute estimates from the 2001 Medical Expenditure Panel Survey.

More than 80% of Health Care Spending on Behalf of People with Chronic Conditions



Thorpe, Kenneth E, PhD. *What Accounts for the High and Rising Costs of Health Care?* Slides presented at the State Coverage Initiatives National Meeting, Washington, DC, February 23-24, 2006

Root Problems of Cost Increases

- Inappropriate and/or overutilization of medical care/ good new technologies
- Regional variation in services and spending
- Administrative inefficiency associated with payer/provider/patient interface
- Growing uninsured population (cost-shift/hidden tax)
- Insufficient preventive services
- Patient lack of price sensitivity (3rd party payment/lack of info)
- Incentive mis-alignment (docs; hospitals; other providers)
- Under-application of current evidence base
- Too small an evidence base
- Poor lifestyle choices

Sources: Nichols, L. "Financing Health Reform: Shared Responsibility IS the American Way.", Financing Health Care Reform in New Jersey Forum, March 18, 2008; and *HCFO Hot Topics on Health Care Costs.*

Key Policy and Design Issues

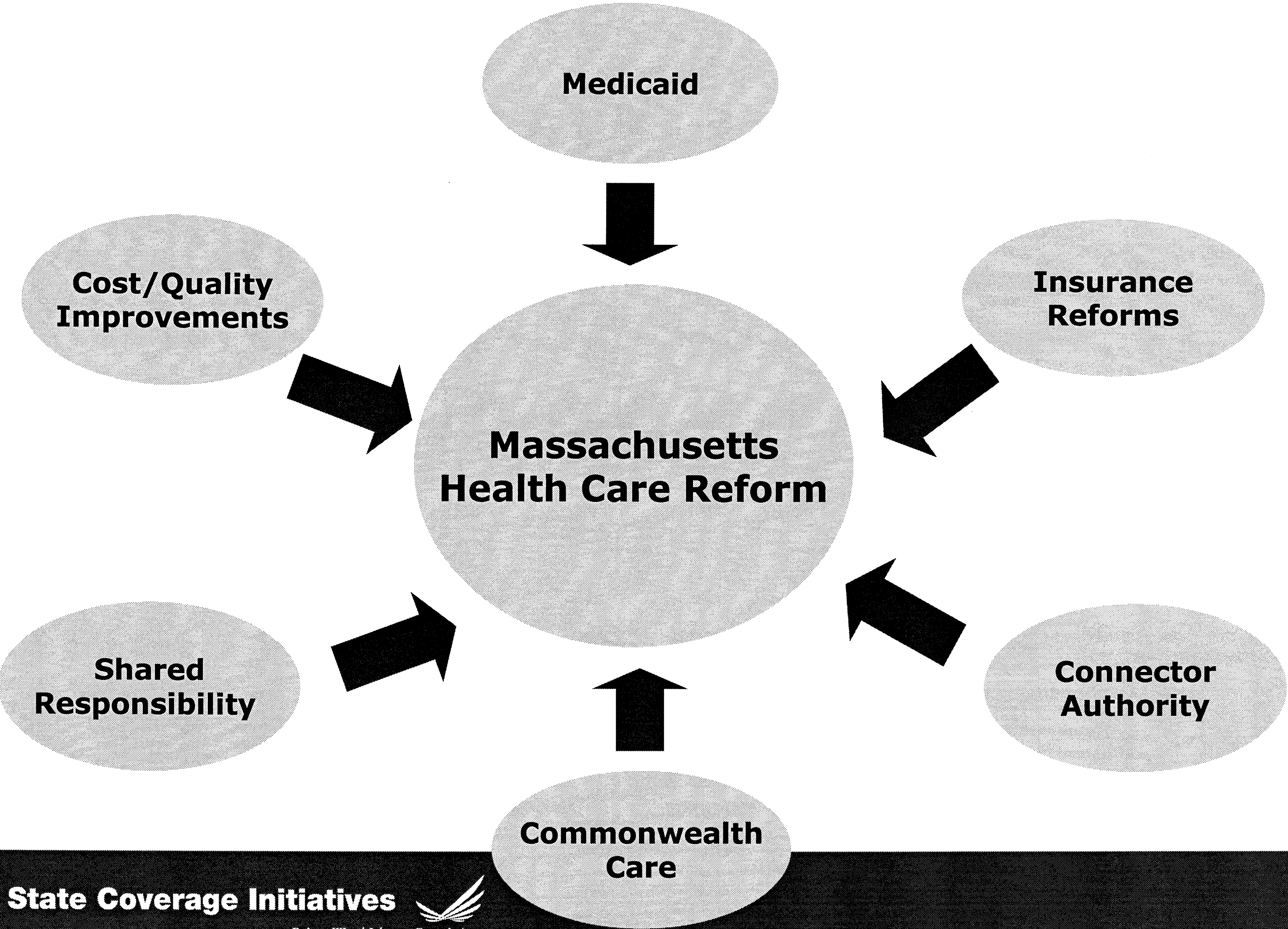
- Different Populations Require Different Solutions
- States Need Clear Vision and Prioritized Goals
- Subsidies and Financing: Who will pay? Who will benefit?
- Should Health Insurance Coverage Be Required?
- What is Affordable Coverage?
- What is the Most Appropriate Benefit Design?
- How Can Risk Be Pooled?
- Do Insurance Markets Need to be Reformed/Reorganized?
- Best Mechanisms for Cost Containment/Systems Improvement

Best Mechanisms for Cost Containment/Systems Improvement

- Big Question – relationship btw cost containment, increased access, and quality improvement
- Strategies include:
  - Prevention/primary care/wellness
  - Chronic care management and coordination
  - Public health initiatives
  - Value-based purchasing/payment reforms
  - Medical error reduction
  - Health-acquired infection reduction/patient safety
  - Price and quality transparency
  - Heath information technology and exchange
  - Administrative and regulatory efficiencies

Why Health Care Reform in Massachusetts?

- Double-digit, annual increases in insurance premiums and the highest per capita healthcare spending in the nation
- 500,000+ uninsured adults in Mass (roughly 8% of residents)
- Broad coalition of business, labor, advocates, insurers & providers
- History of creative approaches to health coverage expansions
- Bi-partisan, multi-year effort
- Limited availability of information to consumers and businesses precludes informed health insurance purchase decisions
- Potential loss of at least $385 million in federal government Medicaid funding
- Two “universal” health care ballot initiatives
- $1 billion and growing of “free-care” forcing all stakeholders to deal with costs for uninsured and under-insured


Medicaid
Cost/Quality Improvements
Insurance Reforms
Massachusetts Health Care Reform
Shared Responsibility
Connector Authority
Commonwealth Care
State Coverage Initiatives
Robert Wood Johnson Foundation

The Goal: “Near Universal” Coverage

Principles of Reform:

- Building Blocks: Use the existing system and fill in gaps
  - Not purely market-based nor purely “single-payer”
- “Shared responsibility”
  - Individuals
  - Employers
  - Government
- Shift financing from “opaque bulk payments” to safety net *providers* to health insurance for *individuals*

Health Reform's Building Blocks

- Broad Medicaid program
  - 1115 Waiver
  - High Eligibility Levels
- Uncompensated Care Pool - $$
- Highly regulated small group and non-group health insurance markets

Key Element of Reform: Share the Responsibility

Residents:
- Individual mandate

Government:
- Connector
- Regs & oversight
- Premium assistance

Employers:
- Make "fair" contribution
- Set up Section 125

Pillars of the Reform

- Employer Responsibilities
- Personal Responsibility/Individual Mandate
- Expansion of Publicly-subsidized Programs
- Major Changes to Insurance Market
  - Merged Small Group and Individual Markets
  - Raising age of dependents – up to 25
  - Connector

Employer Responsibilities

- Gives employers with 11+ full time equivalent employees a choice to make a *fair and reasonable contribution* or pay an assessment of up to $295 per employee per year:
  - Must cover 33% of the cost of the premium; OR
  - Have 25% of full-time workers enrolled in company's plan

- Requires employers to provide voluntary benefit option (§125 Plan) to most workers not offered insurance (part-time & temporary)

Employer Responsibilities (cont.)

- Non-discrimination requirement: Insurance companies may only provide group coverage to employers who offer same coverage to all full-time employees and who do not offer lower premium contributions to lower-wage employees

- Employers are required to collect Employee Health Insurance Responsibility Disclosure (HIRD) Forms from those who decline coverage and/or Section 125 participation

Overview of Section 125 Requirement

- Applies to all Massachusetts employers with 11 or more full-time equivalent employees
- Premium-only plan that allows employees to pay health insurance premiums "pre-tax"
- Eligible employees must have access to at least one health plan
- No employer contribution required

Overview of Section 125 Requirement (cont.)

- Up to two months waiting period permitted
- Advantages to designating the Connector, but not a requirement
- Penalty ("Free Rider Surcharge") may be assessed if such a plan is not established and employee(s) use state-funded health care services

Section 125 – Exclusions

Developed exclusions by working with employers:

- Employees under age 18
- Temporary employees (less than 12 consecutive weeks)
- Employees working, on average, fewer than 64 hours per month
- Wait staff, service employees or service bartenders who earn, on average, less than $400 in monthly payroll wages
- Employees covered by collectively-bargained multi-employer health benefit plan (e.g., Taft-Hartley, MEWA)
- Students employed as interns or as cooperative education student workers
- Seasonal employees (state certified) and seasonal employees who are international workers with either:
  - U.S. J-1 student visa, or
  - U.S. H2B visa and who are also enrolled in travel health insurance

Personal Responsibility/ Individual Mandate

- All adult residents of the Commonwealth required to maintain health coverage (insurance)

- Connector Board established what constitutes "minimum creditable coverage" (MCC) and "affordability"

- Tax penalty for not having insurance:
  - Indicate insurance policy number on state tax return
  - $219 (loss of personal exemption) in 2007
  - As much as $912 in 2008 (half the cost of lowest cost plan)

- Religious exemption and affordability waiver based on age and income

What is Minimum Creditable Coverage?

Effective Jan. 1, 2009, to satisfy individual mandate, health insurance must include:

- Comprehensive medical benefits, including prescription drugs
- In-network deductible capped at $2,000/$4,000
- If deductible or co-insurance, must include out-of-pocket max of $5K/$10K
- No indemnity fee schedule of benefits
- No annual or per illness maximum allowed
- Federally compliant HSA/HDHP plans qualify

2008 Affordability Schedule

Individuals		Couples		Families	
Annual Gross Income Range	2008 Proposed	Annual Gross Income Range	2008 Proposed	Annual Gross Income Range	2008 Proposed
$0 - $15,612 (150%)	$0	$0 - $21,012 (150%)	$0	$0 - $26,412 (150%)	$0
$15,613 - $20,808 (200%)	$39	$21,013 - $28,008 (200%)	$78	$26,413 - $35,208 (200%)	$78
$20,809 - $26,016 (250%)	$77	$28,009 - $35,016 (250%)	$154	$35,209 - $44,016 (250%)	$154
$26,017 - $31,212 (300%)	$116	$35,017 - $42,012 (300%)	$232	$44,017 - $52,812 (300%)	$232
$31,213 - $37,500 (360%)	$165	$42,013 - $52,500 (375%)	$297	$52,813 - $70,000 (398%)	$352
$37,501 - $42,500 (408%)	$220	$52,501 - $62,500 (446%)	$396	$70,001 - $90,000 (511%)	$550
$42,501 - $52,500 (505%)	$330	$62,501 - $82,500 (589%)	$550	$90,001 - $110,000 (625%)	$792
>$52,501	n/a	>$82,501	n/a	>$110,001	n/a

Expansion of Public Programs

- Medicaid Expansions and Restorations
- Change in Free Care Pool rules (new Health Safety Net)
- Establishment of Commonwealth Care -- subsidized health insurance for adults without access to ESI or other health coverage up to 300% FPL
- Current Eligibility Levels:
  - Children (Medicaid and SCHIP): 300% FPL
  - Pregnant Women: 200% FPL
  - Parents: 133% FPL
  - SSI Disabled: 74% FPL

Commonwealth Care - Subsidized Program

- Commonwealth Care is a government-subsidized, comprehensive health insurance for uninsured individuals with incomes up to 300 percent of the federal poverty level (FPL)

- Coverage is through a choice of four private health insurance plans – Medicaid Managed Care Organizations (MMCOS) for three years

- Sliding fee scale with least expensive enrollee contributions ranging from $0 to $105 per month:

Commonwealth Care minimum monthly premiums – effective July 1, 2007		
Income (% of FPL)	**Income ($)**	**Min. monthly premium**
0-150%	$0-$15,318	N/A
150.1%-200%	$15,319-$20,424	$35
200.1%-250%	$20,425-$25,530	$70
250.1%-300%	$25,531-$30,636	$105

Insurance Market Reforms: Non-Group Options Enhanced

- Pre-Reform: Highly regulated non-group market with two plan designs (in a death spiral):
  - High deductible ($5,000), or
  - First-dollar coverage
- July 2007: small and non-group markets merged
- 37-year-old Bostonian pre-reform
  - $5,000 deductible, no Rx
  - Monthly premium = $335
- 37-year-old Bostonian post-reform
  - $2,000 deductible with Rx
  - Monthly premium = $184
- Minimal Impact on Small Group Market – Individuals joining were young and healthy

Health Connector Authority Key Tasks

- Launch and administer Commonwealth Care program
- Launch and administer Commonwealth Choice program
- Define Minimum Creditable Coverage
- Establish Affordability standards
- Promulgate regulations on Section 125 Plan requirement for Massachusetts employers
- Administer waivers and appeals related to the individual mandate

The Connector

Insurance Connector

Non-offered Individuals

Non-working Individuals

Small Businesses

Young Adults

Blue Cross Blue Shield

Harvard Pilgrim

Tufts

Fallon

NHP

New Entrants

MMCOs

Purposes of the Connector

- Nexus between buyers and sellers
  - Premiums paid with pre-tax dollars (125 Cafeteria Plan)
  - Facilitate premium assistance for 100-300% FPL
- Organize the market
  - Facilitate choice
  - Set standards
  - Increase affordability
  - Increase competition among private plans
  - Encourage innovation

"Commonwealth Care" makes private insurance affordable for eligible individuals

- Redirects **existing** spending on the uninsured away from opaque bulk payments to providers to direct assistance to the individual
- Premium assistance up to 300% of Federal Poverty Level (FPL)
  - Zero premium for individuals under 100% FPL
  - Premiums increase with ability to pay up to 300% FPL
  - No cliff; glide-path to self-sufficiency
  - No deductibles permitted for low-income individuals
- Private insurance plans offered exclusively through Medicaid Managed Care Organizations (MMCOs) for first three years
- The Connector will serve as the exclusive administrator of Commonwealth Care premium assistance program
  - Works closely with Medicaid program to determine eligibility

Commonwealth Choice (not subsidized)

- Designed to promote choice in non-group and small group markets
- Commercial (non-subsidized) health insurance distribution system
- Four prime target markets:
  - Non-group individuals
  - Young adults not offered ESI
  - Employees not offered/eligible for group coverage
  - Small businesses

Makes the Market Work Better: Sets Standards

- Authority sets benefits "floor" for health insurance coverage
- Seal of Approval for health plans sold through Connector
- Minimum Creditable Coverage (MCC) for individual mandate

Makes the Market Work Better: Increases Affordability

- More affordable coverage options (e.g., select networks; more than 2 non-group products now)

- Increased access to Section 125 Plans (pre-tax premium payments)
  - Employer requirements
  - Online tools

Makes the Market Work Better: Increases Transparency/Simplifies Consumer Experience

- New Website: easy to shop; compare health plans online
- Easy to enroll (and soon, to pay) online.

Help | Contact Us | Mass.gov

CommonwealthConnector

Home | Find Insurance | Health Care Reform | About Us

Welcome to the Health Connector!

LEARN. COMPARE. SELECT A HEALTH PLAN.

Big changes are happening in Massachusetts health care.
Most adults must now carry health insurance. We give you the tools and the **facts** you need to **find the right health plan**.

We work to bring you health benefits at better prices. There are choices here for everyone. And if you qualify for a plan at no or low cost, we'll let you know.

Health insurance is an important decision. We are here to help.

Your Connection to Good Health

Individuals & Families Young adults too. Shop now >

Employees In an employer sponsored health plan. Shop now >

Employers Shopping for yourself and your employees. Shop now >

Brokers Exploring on behalf of your employer clients. Shop now >

Commonwealth Choice: Easy to Shop

Connector's Commonwealth Choice program has 3 tiers of health plans (Gold, Silver and Bronze, plus a 4th for Young Adults):

Tier	Benefits
Gold (1)	→ Average monthly cost = $289 to $549 → No or small payment when you go to the doctor or stay in the hospital → Choice of large number of doctors and hospitals
Silver (2)	→ Average monthly cost = $232 to $406 → $15 or more each time you go to the doctor → Additional cost-sharing required at point-of-service → Some plans may limit which doctors and hospitals you can use.
Bronze (2)	→ Average monthly cost = $148 to $256 ($167 to $280 with Rx) → $20 or more each time you go to the doctor → Highest amount of cost-sharing required at point-of-service → Some plans limit which doctors and hospitals you can use
Young Adult (age 18-26) (2)	→ Average monthly cost = $110 to $193 without Rx → Highest cost-sharing required at point-of-service → Most plans include an annual benefit maximum → Only available to people between the ages of 19 to 26, without access to employer sponsored insurance

Commonwealth Choice: Easy to Enroll

Online or by phone:

Consumer gathers information:
- Benefits options
- Cost
- Location of MDs/hospitals

Connector presents options:
- Plan A
- Plan B
- Plan C
- Plan D

Consumer:
- Selects Plan
- Completes Online Enrollment
- Picks a PCP
- Pays 1st Month Premium

Connector:
- Collects Premium
- Sends Enrollment Information to Health Plan

Health Plan:
- Processes Enrollment
- Issues ID Card & EOC
- Pays Claims

Connector Implementation Issues

- Number of plans
- Coverage requirements – rules in and out of connector
  - Benefit design
  - Underwriting/rating rules
- Risk management
- Eligibility
- Functionality
- Other thorny issues
  - COBRA, HIPAA, ERISA
  - Role of brokers

www.statecoverage.net/pdf/healthinsurance0907.pdf

New Legislation (S.2863): Signed 8.10.08

- Creates Health Payment Reform Commission
- Develops standards for uniform billing and coding
- “Never-events” and “serious reportable events”
- E-Health Institute
  - Sets goal of statewide adoption of Computerized Physician Order Entry systems (CPOE) by 2012 – required for hospital licensure
  - Sets goal of statewide adoption of electronic medical records by 2015 – required for hospital licensure
  - All physicians must demonstrate competency in EMR/HIT by 2015
- Pharmacy Academic Detailing Program
  - Educate providers who prescribe expensive brand name drugs
  - Regulates marketing practices of pharmaceutical and medical device industry companies to health care professionals
  - Public disclosure of payment/subsidy by Rx/Med Device to health care professionals
- MassHealth Medical Home demonstration project

Current State of the Commonwealth

- More than 439,000 newly-insured between June 2006 and March 31, 2008
- 191,000 more in private coverage (no public $$)
- Employer-sponsored insurance remains predominant source of coverage (82% of non-elderly): no crowd-out
- Non-group premiums are down over 40% and membership has grown over 50%

Current State of the Commonwealth

- Free Care Pool/Health Safety Net usage and spending down by over one-third

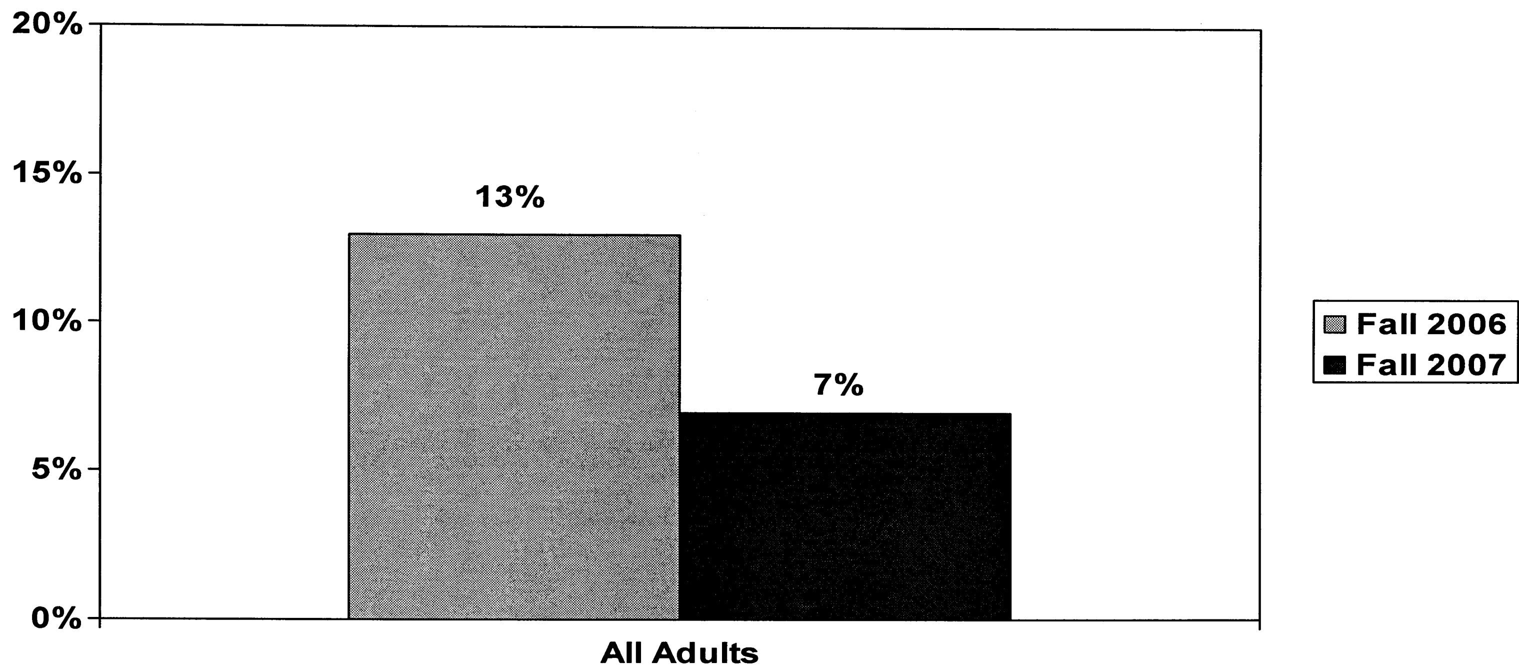
- Loan repayment initiative has resulted in 47 primary care doctors and nurse practitioners committing to practice in community health centers, providing access to primary care for 84,000 patients

- Opinion polls show plurality of voters continue to support health reform

Current State of the Commonwealth

- Program ramp-up more rapid than originally projected has created a budget shortfall:
  - Employers: $33 m.
  - Insurers: $33 m.
  - Hospitals: $28 m.
  - State Health Insurance Fund Surplus: $35 m.

Uninsurance for Working-age Adults Down by Almost 50%, Halfway through Implementation



Commonwealth Care (Subsidized Program) Spending Per Member Per Month

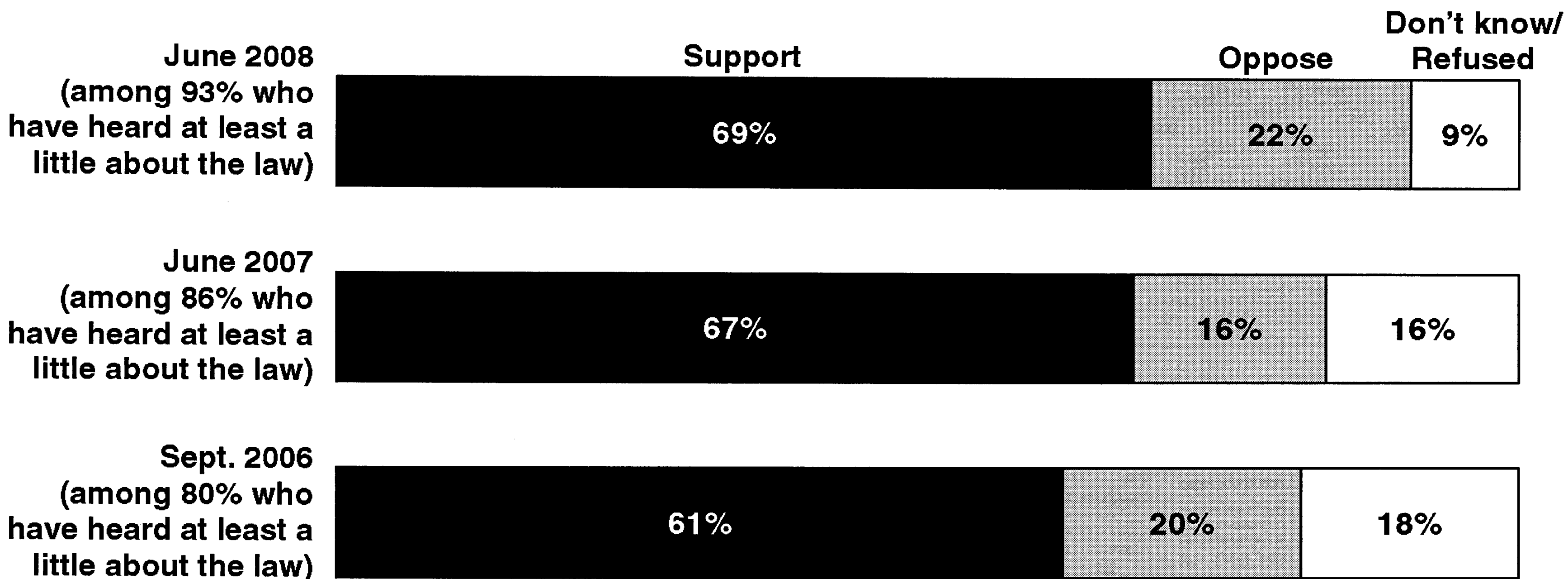
	Budgeted	Actual
FY07	$343.62	$354.07
FY08	$358.63	$351.76
FY09 (proj.)	$380.65	

Chart 2

Support for Massachusetts Health Reform Law

AMONG THOSE WHO ARE FAMILIAR WITH THE LAW:

Given what you know about it, in general, do you support or oppose the Massachusetts universal health insurance Law?

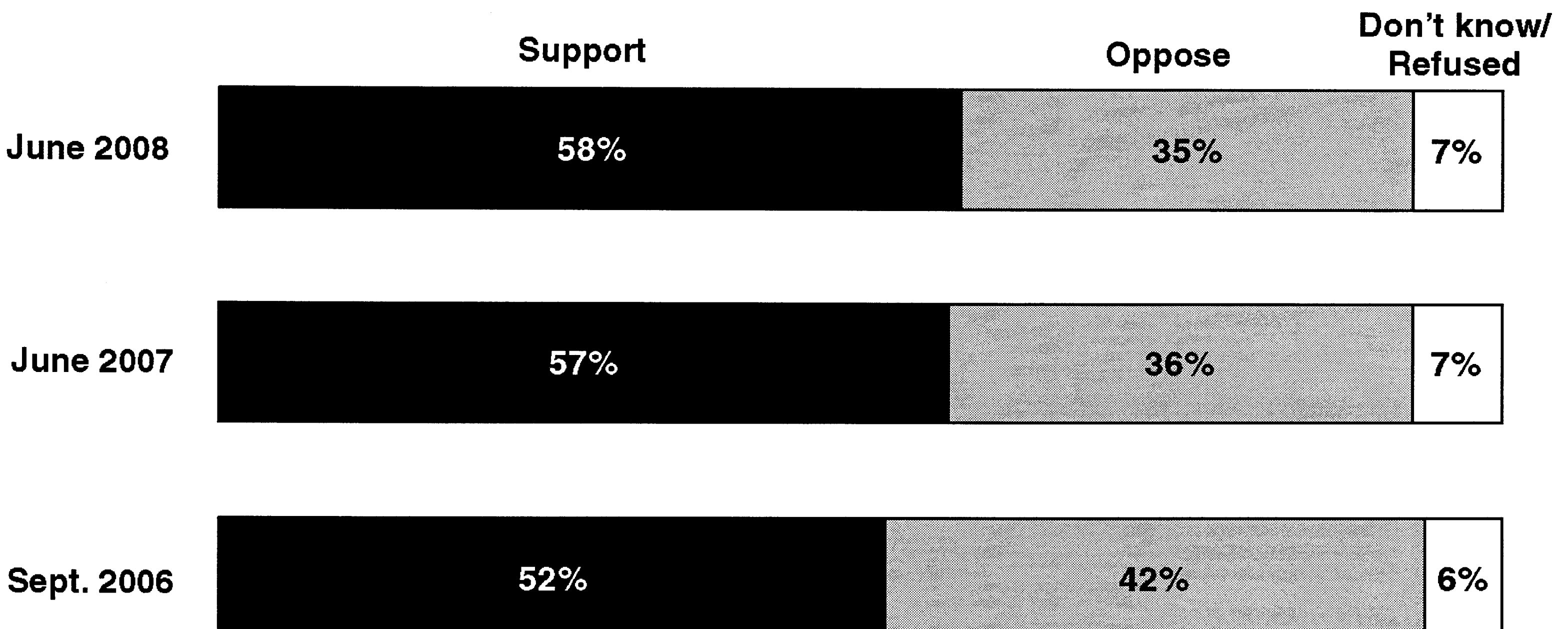


Source: Harvard School of Public Health/BCBS of Mass. Foundation/ICR *Massachusetts Health Reform Survey* (conducted June 10-23, 2008); Kaiser Family Foundation/Harvard School of Public Health/BCBS of Mass. Foundation *Massachusetts Health Reform Tracking Survey* (conducted May 29-June 10, 2007); Harvard School of Public Health/BCBS of Mass. Foundation/ICR *The Massachusetts Health Reform Law: Public Opinion and Perception* (conducted Sep. 11-18, 2006)

Chart 3

Support for Individual Mandate

The law requires that all uninsured Massachusetts residents either purchase health insurance or pay a fine of up to 50% of what health insurance would cost. If a state agency determines that a person can't afford a policy, they would not be required to buy one. People whose incomes fall below a certain level would receive help paying part or all of their insurance premiums. Do you support or oppose state government requiring uninsured residents to purchase health insurance?



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Health Care Quality and Cost Council

- Reduce the annual rise in health care costs to no more than the unadjusted growth in Gross Domestic Product (GDP) by 2012;
- Ensure patient safety and effectiveness of care;
- Improve screening for and management of chronic illnesses in the community;
- Develop and provide useful measurements of health care quality in areas of health care for which current data are inadequate;
- Eliminate racial and ethnic disparities in health and in access to and utilization of health care; health indicators will be consistent, and consistently improving, across all racial and ethnic groups; and
- Promote quality improvement through transparency.

Healthy Massachusetts Compact (HealthyMass): Nine State Agencies

- Coordinating purchasing and contracting strategies across programs, including but not limited to, shared pay for performance incentives and quality standards;
- Reducing administrative costs by encouraging the use of technology, including electronic medical records, and employing shared processes whenever possible;
- Seeking the highest quality health care standards, as defined by nationally accepted and recognized measures of quality;
- Promoting transparency in the delivery of and payment for health care services, as well as outcomes achieved;
- Using payment systems to encourage care in the most cost-efficient and effective settings, promoting wellness, the prevention and treatment of chronic diseases, including chronic mental disorders, and appropriate care for disabling conditions within primary care;

Healthy Massachusetts Compact (HealthyMass): Nine State Agencies (cont.)

- Ensuring that investments in the expansion of health care services, new technologies, new facilities and new treatments appropriately meet the current and projected needs of communities;
- Partnering with businesses, schools, and others to promote wellness and chronic disease prevention;
- Partnering with cities and towns to reduce their health care costs;
- Supporting and collaborating with communities in their efforts to promote healthy environments and individual wellness;
- Eliminating racial and ethnic health disparities through health care quality improvement; systems reform; community interventions and collaboration with communities;
- Supporting the goals of the Health Care Quality and Cost Council; and
- Educating the public to allow people seeking health care to make informed decisions about ways to maintain health and wellness and about how to use the health care system.

Lessons from Massachusetts

- Get everyone to the table – and keep them there
  - Many different tables
  - Relationships matter
- Compromise
  - Everyone got something and also gave something up
- Create shared ownership
  - Passing law is only the first step
  - Continued coalition and collaboration <u>after</u> passage
  - Stakeholders must have capacity to participate in implementation

Everyone Got Something…

- Consumers: Medicaid expansion, subsidies, employer responsibility
- Providers: Medicaid rate increases
- Business: Lower assessment than might have otherwise been, sets no precedent since based on pool, individual mandate, expanded subsidies for small employers and their low-wage workers
- Insurers: New potential members, young adult products, individual mandate

And Traded Something Off…

- Consumers: Individual mandate, potential for increased cost sharing
- Providers: More pay for performance, less money than they wanted (but still a LOT)
- Business: More assessment than they wanted
- Insurers: Subsidized plans limited to current Medicaid managed care organizations for the first three years, less flexibility on benefit design than they wanted

Challenges Ahead

- Education, outreach and enrollment
- Sustaining public support
- Ensuring access for the newly insured
- Mandate: can't exempt too many people or reform is meaningless
- Maintaining strong safety net for those who will remain uninsured
- Financing – need a strong state economy
- Continued federal support for waiver renewal
- Moderating health care cost growth

Lessons learned in state reform efforts #1

- Successful comprehensive reforms are built on previous efforts, financing mechanisms
- Need ingredients: leadership, opportunity, readiness to act, persistence
- No free solutions
- Successful efforts to enact reforms often need shared financial responsibility
- Different segments of the uninsured require different solutions
- State expansions in coverage mainly rely on private insurers to deliver care
- Voluntary strategies will not result in universal coverage - some states are beginning to recognize the need for mandatory participation

Lessons learned in state reform efforts #2

- Hard to get agreement on what is covered (benefit design/affordability)
- Little success so far in addressing underlying cost of health care but a new focus on chronic care management/preventive care holds potential
- Address access, systems improvement, cost containment simultaneously—concern about long-term sustainability of coverage programs and improved population health
- New state reforms can be fairly judged only after several years, allowing a realistic length of time to work through implementation challenges.
- Comprehensive reforms need sequencing
  - Sequential = incremental with a vision

Acknowledgments

- Robert Carey
- Kevin Counihan
- Rosemarie Day
- Sarah Iselin
- Jon Kingsdale
- Amy Lischko
- Elliot Wicks
- The Urban Institute

Contact Information

Enrique Martinez-Vidal

Enrique.Martinez-Vidal@academyhealth.org

www.statecoverage.net

202-292-6700

Appendix M

AcademyHealth
1150 17th Street, NW, Suite 600, Washington, DC 20036
Tel. 202 292 6700 Fax 202 292 6800
www.statecoverage.net

State Coverage Initiatives

Enrique Martinez-Vidal
Director

Isabel Friedenzohn
Deputy Director

To: Representatives Kris Steele and Doug Cox
From Enrique Martinez-Vidal, State Coverage Initiatives
Date: October 1, 2008
Re: Questions Raised at House Health Care Reform Task Force Meeting

Thank you again for inviting me to present information about the Massachusetts reforms to the Oklahoma House Health Care Reform Task Force. Below are answers to questions that were posed to which I did not have immediate answers.

Question 1: I believe the following question was asked by Representative Pam Peterson: She asked about the governance structure of the Connector Authority Board. The following provides information about who is required to be on the board and how they are selected. It also includes the names and positions of current members.

Answer: The Commonwealth Health Insurance Connector Authority is an independent public authority created to implement significant portions of the new landmark health care reform legislation. The Connector assists qualified Massachusetts adult residents with the purchase of affordable health care coverage if they don't already have it.

The Health Connector is operated under the Executive Office for Administration and Finance but is an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the Commonwealth except as specifically provided in any general or special law.

It is led by Jon M. Kingsdale, Executive Director, and overseen by an appointed board of 10 public and private representatives:

- The Secretary for Administration and Finance, *ex officio*, who shall serve as chairperson;
- The Director of Medicaid, *ex officio*;
- The Commissioner of Insurance, *ex officio*;
- The Executive Director of the Group Insurance Commission (state employees benefits agency), *ex officio*;
- Three (3) members appointed by the Governor: one must be a member in good standing of the American Academy of Actuaries, one must be a health economist, and one must represent the interests of small businesses; and

Robert Wood Johnson Foundation

AcademyHealth
1150 17th Street, NW, Suite 600, Washington, DC 20036
Tel. 202 292 6700 Fax 202 292 6800
www.statecoverage.net

Enrique Martinez-Vidal
Director

Isabel Friedenzohn
Deputy Director

- Three (3) members appointed by the Attorney General: one must be an employee health benefits plan specialist, one must be a representative of a health consumer organization, and one must be a representative of organized labor.

No appointee may be an employee of any licensed carrier authorized to do business in the Commonwealth.

All appointments serve a term of 3 years, but a person appointed to fill a vacancy may serve only for the unexpired term. An appointed member of the board is eligible for reappointment. The board annually elects one of its members to serve as vice-chairperson. Each member of the board serving ex officio may appoint a designee.

The current Board members are:

- Leslie Kirwan, *Ex-officio*, Chair
  Secretary, Executive Office for Administration and Finance

- Nonnie Burns, *Ex-officio*
  Commissioner, Division of Insurance

- Tom Dehner, *Ex-officio*
  Medicaid Director

- Dolores Mitchell, *Ex-officio*
  Executive Director, Group Insurance Commission

- Ian Duncan (appointed by the Governor)
  President, Solucia Inc.

- Jonathan Gruber (appointed by the Governor)
  Professor of Economics, Massachusetts Institute of Technology

- Richard Lord (appointed by the Governor)
  President and CEO, Associated Industries of Massachusetts

- Louis Malzone (appointed by the Attorney General)
  Executive Director, Massachusetts Coalition of Taft-Hartley Funds

- Nancy Turnbull (appointed by the Attorney General)
  Senior Lecturer on Health Policy and Associate Dean for Educational Programs, Harvard School of Public Health

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Enrique Martinez-Vidal
Director

Isabel Friedenzohn
Deputy Director

- Celia Wcislo (appointed by the Attorney General)
  Assistant Division Director, 1199 SEIU United Healthcare Workers East

Question 2: I believe this question was asked by Tom Daxon, who was attending the briefing in the audience: He asked about the "Young Adults Plans" (YAP) that are being offered only through the Connector to young adults ages 18-26 and how they are being rated in the insurance market.

Answer: Because Massachusetts, in their health care reforms, merged their non-group (individual) and small group markets, all policyholders within a particular carrier's book of business within that merged market, including those purchasing YAP products, are being rated together whether they are sold either through the Connector or outside of the Connector in the general market.

For example: Carrier X comes up with a "core base rate" for their merged market. They can then increase or decrease that core base rate depending on the product design (e.g., what services are included; varying cost-sharing arrangement). Therefore a Gold, Silver, Bronze, and YAP product design (examples of levels of products being sold through the Connector) each will have their own "base rate" that has been calculated off of the original "core base rate." Then, within each product design (Gold, YAP, Silver, etc.), a rating band of 2:1 of highest premium to lowest premium is allowed based on age, industry code and a few other factors (however, not health status – no medical underwriting is permitted). An additional 20% is allowed for cost variation across geographic areas but the 2:1 ratio within the product design must be maintained. The premium for any particular product must be the same whether it is sold through the Connector or through the general market.

Please feel free to follow-up with any additional questions you might have about either of these questions/answers or anything else about Massachusetts or other states' health care reform activities that may come to mind as you move forward in your process. Again, thank you for the opportunity to address your Task Force as it works on this important issue.

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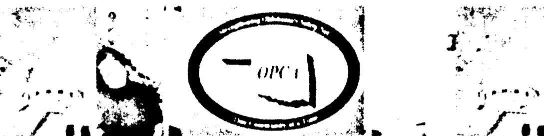
Appendix N

Section 330 Community Health Centers and State Health Policy



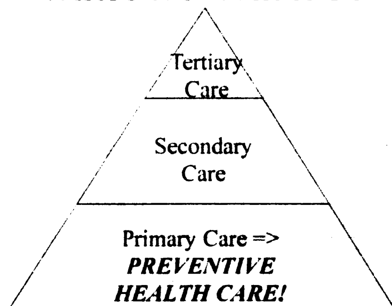
Presented by
Oklahoma Primary Care Association

September 9, 2008

Who is OPCA?

- Oklahoma Primary Care Association is Oklahoma's trade association for community health centers and other community-based safety net providers.
- OPCA is a nonprofit organization that receives a grant from the Bureau of Primary Health Care (BPHC / HRSA / DHHS) to provide training and technical assistance to BPHC grantees and other safety net providers and act as the BPHC liaison to grantees.

Where We Want to Be



What are CHCs/FQHCs?

330 Community Health Centers (CHCs), initially referred to as "Neighborhood Health Centers," are an outgrowth of President Lyndon B. Johnson's *Great Society Program,* in 1966.
CHCs, receiving Section 330 grant funds, are federally mandated by the Public Health Service Act to provide care to anyone seeking health care.

Note: FQHC is a CMS deemed reimbursement status for which Section 330 CHC grantees are eligible.

CHCs are Public/Private Partnerships

- PUBLIC – receive federal grant dollars (year after year) to help with health center funding in their role as 'safety net' providers; have other Federally supported benefits available to help them achieve their purpose
- PRIVATE – health centers are operated by a private, non-profit 501(c)3 community board to keep decisions at a local level; utilize a variety of support including local resources

Brief Timeline of CHCs

- 1960's - First neighborhood health centers – demonstration projects by Ofc. Of Econ. Opportunity – Boston and rural Mound Bayou, Mississippi
- 1975 - Health centers made permanent as "community and migrant health centers"
- 1987 – Stewart B. McKinney Homeless Assistance Act of 1987 established Health Care for the Homeless
- OBRA 1989-1990 – FQHC status enacted – cost-based reimbursement
- 1990 - Disadvantaged Minority Health Improvement Act Public Housing Primary Care - 1991 first grantee

CHC Timeline Continued

- 1996 – Health Centers Consolidation Act – combined several types of health centers under Section 330 of the Public Health Service Act – Community Health Centers are Section 330(e)
- BIPA 2000 – FQHC Medicaid Prospective Payment System
- 2001 – President Bush – Initiative to expand health centers by 1,200 new access points by thte end of 2006
- Today – 16 Million patients nationwide; >107,000 in Oklahoma (In Oklahoma 14 organizations, 27 comprehensive locations)
- Outlook – Strong bipartisan support Federally, currently pursuing reauthorization (passed by both houses); national goal to serve 30 million patients by 2015

Core Elements of 330 Grantees - Health Care Homes -

- Federal resources are targeted to communities with highest need – must serve an MUA
- Health services are available to all persons regardless of ability to pay (sliding fee scale)
- Provide comprehensive primary care and enabling services (e.g. transportation, health education, case management [facilitate continuum of care])
- Health centers must be directed by a governing board of which ≥51% are patients of the health center
- Must meet performance & accountability requirements

Must adhere to BPHC PIN 98-23 – Program Expectations

Sliding Fee Scale

#	Minimum Fee		25% Fee		50% Fee		75% Fee		Full Fee
	From	To*	From	To	From	To	From	To**	More Than
1	$0	$10,210	$10,211	$13,614	$13,615	$17,017	$17,018	$20,420	$20,420
2	$0	$13,690						$27,380	$27,380
3	$0	$17,170						$34,340	$34,340
4	$0	$20,650						$41,300	$41,300
5	$0	$24,130						$48,260	$48,260
6	$0	$27,610						$55,220	$55,220
7	$0	$31,090						$62,180	$62,180
8	$0	$34,570						$69,140	$69,140
9	$0	$38,050						$76,100	$76,100
10	$0	$41,530						$83,060	$83,060

2007 HHS Poverty Guidelines
*** 100% Federal Poverty Level**
**** 200% Federal Poverty Level**

Examples of Health Center Services

- Primary Care – All Ages
- Well Child
- Well Baby
- Lab, X-Ray
- Oral Health
- Mental Health/ Substance Abuse
- Pre- and Postnatal Care
- Family Planning
- Pharmacy
- Immunizations
- Translation
- Prevention
- Outreach
- Home Health
- Child Care
- Social Services
- Referral
- Patient Education
- School-Based Services
- Homeless Health Care
- Transportation

CHC Benefits

- Covered by Federal Tort Claims Act (FTCA)
- Enhanced Medicare Reimbursement
- Enhanced Medicaid Reimbursement — FQHC Status
- Eligible for Section 340B Drug Pricing
- Access to Vaccines for Children (VFC)
- Participation in BPHC Collaboratives
- Access to NHSC providers through scholars and loan repayment programs – existing CHCs now have automatic HPSA designation

Who Awards Federal 330 Grant Dollars?

Funds are awarded through the
U.S. Health and Human Services' (HHS)
Health Resources and Services Administration's (HRSA)
Bureau of Primary Health Care (BPHC)
by using a highly competitive grant process

New Access Points: Two Funding Approaches

- 'New Start' – a new organization applying for 330 funds that must develop CHC from the 'foundation' up
- 'Expansion' or 'Satellite' – an existing CHC grantee serving a new community, utilizing existing infrastructure
- Expansion grants are funded at a higher rate due to cost efficiencies

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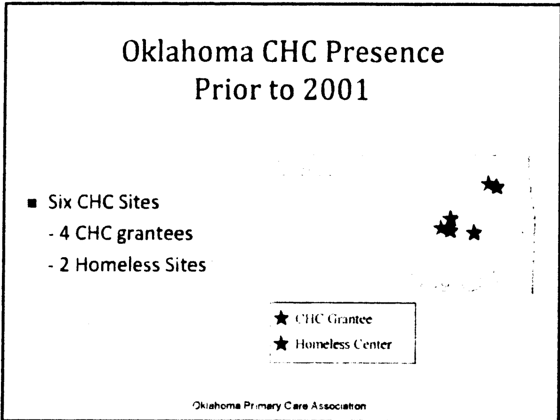
Oklahoma CHC Presence Prior to 2001

- Six CHC Sites
  - 4 CHC grantees
  - 2 Homeless Sites



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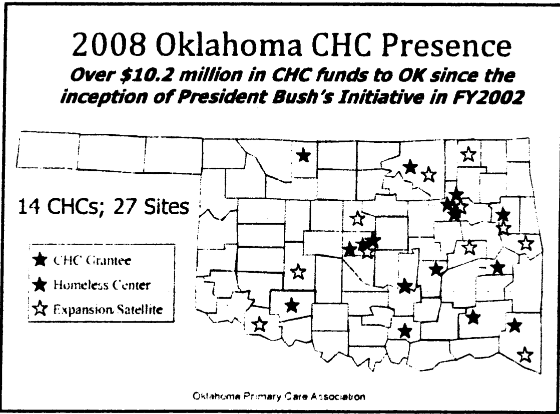
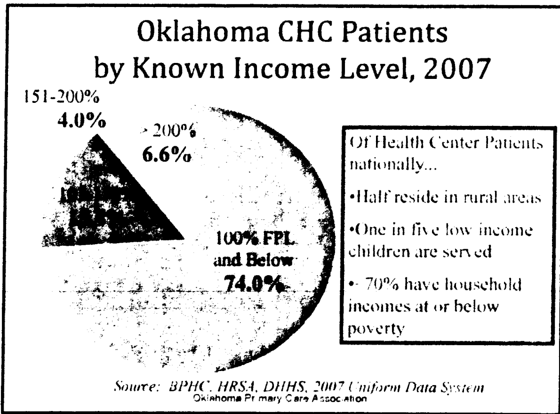
2008 Oklahoma CHC Presence

Over $10.2 million in CHC funds to OK since the inception of President Bush's Initiative in FY2002



Oklahoma Primary Care Association

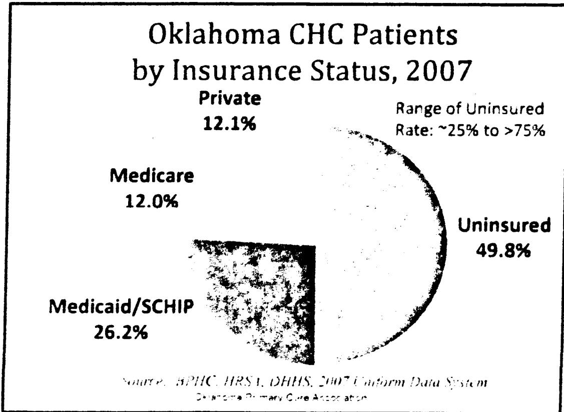
Oklahoma CHC Patients by Known Income Level, 2007



Source: BPHC, HRSA, DHHS, 2007 Uniform Data System

Oklahoma Primary Care Association

Oklahoma CHC Patients by Insurance Status, 2007



Source: BPHC, HRSA, DHHS, 2007 Uniform Data System

Oklahoma Primary Care Association

OK CHC Patients by Age

Age	OK CHC Population	% of OK CHC Population In Age Group, '07	% of Oklahoma Population In Age Group '06
0-5	9,373	8.7%	7.0%
5-14	12,442	11.6%	13.6%
15-19	6,996	6.5%	7.2%
20-44	38,406	35.8%	33.9%
45-64	28,710	26.7%	24.9%
65+	11,484	10.7%	13.3%
	107,411	100%	~ 100%

Aggregate Totals for OK CHC Grantees Varies by CHC

Source: BPHC, HRSA, DHHS, 2007 Uniform Data System

Oklahoma Primary Care Association

Costs of Delivering Care in Community Health Centers

(Per Year, CY2007)

	Oklahoma	Nationwide
Medical Cost / Medical Patient	**$270**	$416
Average encounters	2.41	3.37
Dental Cost / Dental Patient	**$442**	$344
Average encounters	2.17	2.39
Total Cost / Patient	**$464**	$561
Average encounters	3.24	3.93

Source: BPHC, HRSA, DHHS, 2007 Uniform Data System, 13 Grantees

Example Quality Factors

- Clinical quality measures monitored by Federal government
- Participation in national health disparities collaboratives (HDC) – methods for chronic disease prevention and treatment
- Accreditation
- Movement to adopt HIT

State Health Policy Considerations

(Note: OPCA does not necessarily endorse or encourage the following considerations and observations)

- Costs and Economic Impact
- Tax policy
- Program Eligibility – e.g. SoonerCare, Insure Oklahoma
- Enrollment via health centers
- Provider licensing and workforce
- Insurance regulation
- Direct funding / Contracts
  - Uninsured
  - Planning / development
  - Infrastructure / supports - HIT

Costs Effectiveness

Several studies depict savings to Medicaid programs when patients are served through health centers.

- 2000-2003 SC study – lower average annual PCP payments and lower average payment per hospitalization compared to Family Practice visits when looking at diabetic patients
- 2003-2004 MI study revealed CHC/FQHC costs/reimbursement not less expensive, but savings were found when the entire spectrum of services were considered for patients that had been served by a health center (categorically similar: non-disabled, 18-64) compared to non-FQHC patients

Economic Impact

- Spring 2008 OPCA commissioned economic impact study of CHCs in Oklahoma (annual impact, 2007 data)
  - Employment Impact - 566 directly employed health related FTE generated a total employment impact in the state of **1,063 jobs with secondary impacts** included
  - Income Impact - ~$26M in direct CHC income generated another $13M in secondary income for a **total income impact of ~$39M**.

Tax Policy

- Purchasing – sales tax relief
  - Oklahoma law currently provides health centers with a sales tax exemption (§68-1356. Exemptions - Governmental and nonprofit entities)
- Tobacco Tax related expenditures
  - CHCs not a component of the increase in OK
  - Is a component in other states e.g. CO

Program Eligibility / Insurance Coverage

- More than 25% of Oklahoma CHC patients are insured by SoonerCare
- Federal grant dollars are insufficient for the high demand placed on some mature health centers by the uninsured
- Insuring more individuals could better leverage grant dollars to meet the needs of the remaining uninsured population

Enrollment via CHCs

- Most health center patients are low income and nearly 50% are uninsured
- Health centers attempt to connect patients with existing programs for which they are eligible
- Health centers are strategically strong locations for outreach
- Outstationed eligibility worker opportunities

Provider Licensing / Workforce

- Health centers are located in areas of underservice; recruitment can be difficult
- Licensure and regulation can have an impact on health access through a variety of individual provider types
- Incentive programs for underserved areas further enhance the ability of health centers to recruit – e.g. loan repayment programs
- Tort protections e.g. volunteers

Emergency Preparedness Considerations

- BPHC Program Information Notice (PIN 2007-15) outlines health center participation in emergency situations
- Participation in statewide emergency preparedness planning and communication networks

Other Considerations

- Communication infrastructure – OK pays for rural CHC T1 or similar connection but not the service itself

  (§17-139.109 – OK Special Universal Service)

- Regulation of insurance to provide favorable treatment regarding CHC participation (obviously any requirement becomes controversial)

Direct Funding / Contracts

- OK State Assistance
  - Uninsured care: assisting with cost above federal grant dollars experienced by CHCs (formula distribution)
  - Development - Training and technical assistance e.g. finance, board training
- Other States: ≥ 35 states + DC provide some form of assistance totaling ~ $626 million

$0 > $1M	3	IA, MT, NV
$1M > $5M	13	AR, GA, MI, MN, MS, NB, NC, OH, OK, SC,UT, VA, WI
$5M > $20M	9	AZ, CT, HI, IL, NH, NM, TN, WA, VA
≥$20M	11	CA, CO, DC, FL, IN, LA, MA, MO, NM, NY, TX

Source National Association of Community Health Centers, 6th Annual Survey of Primary Care Associations on Funding Issues, July 2007

Direct Funding / Contracts

Types of Assistance

- Uninsured care / uncompensated care pools
- Development / Incubator programs / Expansions
- Capital assistance
- Services / Operations
  - – sometimes specific e.g. mammography
- Reporting - Diabetes data tracking
- HIT related
- Provider loan repayment programs
- Specialty services continuum of care

Source: National Association of Community Health Centers, "Gaining Ground II: State Funding, Medicaid Changes and Health Centers," State Policy Report #18, August 2007

Oklahoma Primary Care Association

Helpful Resources

www.okpca.org

www.bphc.hrsa.gov

www.nachc.com

For further information, contact

Brent Wilborn, Director of Public Policy
Oklahoma Primary Care Association
4300 N. Lincoln Blvd., Ste. 203
Oklahoma City, OK 73105
(405) 424-2282, Ext. 107 • Fax (405) 424-1111
bwilborn@okpca.org

Oklahoma Primary Care Association

Appendix O

Alleviating Health Care Worker Shortages – A Collaborative Model

Sheryl McLain, MS
Executive Director

What Is It?

A public/private partnership created through legislation

SB 1394 – Passed in May 2006; Effective Nov. 2006
Co-authors: Sen. Susan Paddack; Rep. Doug Cox

A private, non-profit organization dedicated to alleviating Oklahoma's health care worker shortage

With Whom Does It Collaborate?

19 Member Board

- Oklahoma State Regents for Higher Education
- Department of Career Tech
- Department of Education
- OU Health Sciences Center
- OSU Center for Health Sciences
- Governor's Council for Workforce & Economic Development
- Oklahoma State Senate (2)
- Oklahoma House of Representatives (2)
- Office of State Finance
- Secretary of Health
- Commissioner of Health
- Oklahoma Hospital Association
- Oklahoma Nurses Association
- Nursing Home Association
- State Medical Association
- State Osteopathic Association
- Lay Member Representing the General Public

Other Collaborative Partners

- OK Department of Commerce
- U.S. Department of Labor
- OESC
- OK Board of Nursing
- K-12 Teachers/Counselors
- School Nurses
- Allied Health & Nursing Faculty from Career Techs, 2 & 4-year colleges/universities
- Oklahoma Healthcare Educators Association
- Oklahoma Area Health Education Centers (AHECs)
- Workforce Investment Boards
- Physician Manpower Training Commission
- LPN, ADN & BSN Council Chairpersons
- Oklahoma Organization of Nurse Executives
- Institute for Oklahoma Nursing Education
- Oklahoma Hospital HR Association

Funding & In-Kind Support

- Oklahoma Hospital Association
- Oklahoma Hospitals
- OSRHE
- ODCTE
- OU MEDICAL CENTER
- Oklahoma Department of Commerce
- Oklahoma State Department of Health

Continue Pursuing Support from Other Stakeholders

Priorities/Goals

- Education & Training
- Recruitment
- Retention
- Data Collection/Analysis
- Funding
- Increasing Public Awareness

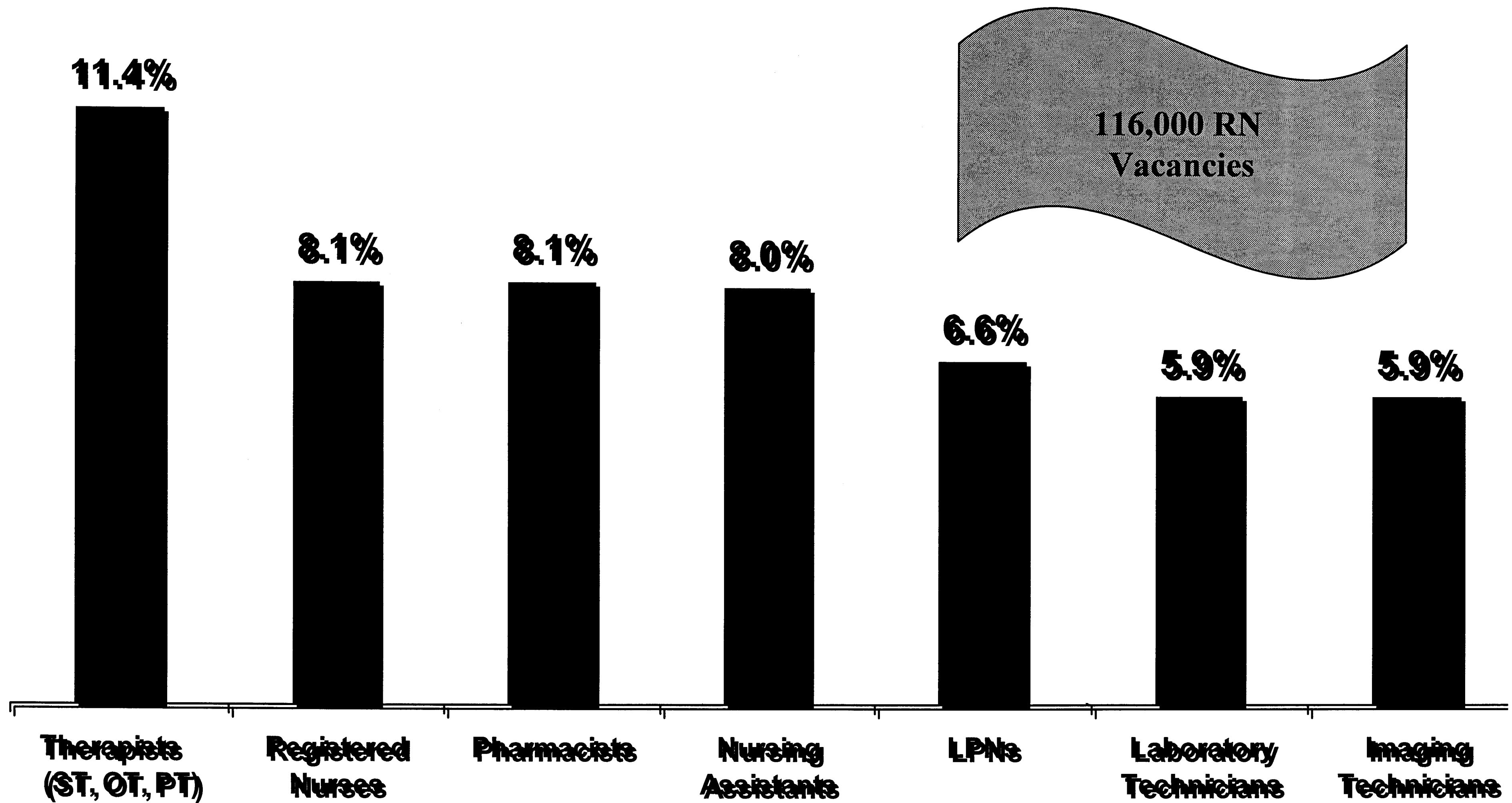
Worker Shortage Trends – United States

116,000 RN vacancies in hospitals

500,000 RN shortages by 2025

Sources: 2007 AHA Survey of Hospital Leaders; "Blowing Open the Bottleneck: Designing New Approaches to Increase Nurse Education Capacity": White Paper, May 2008.

U.S. Hospital Vacancy Rates for Key Personnel



Source: 2007 AHA Survey of Hospital Leaders;
ST: Speech Therapist, OT: Occupational Therapist, PT: Physical Therapist.

Shortage Projections—Oklahoma

Occupation	Projected Shortage in 2012	Percentage of Projected Total Employment in 2012
Registered Nurses	3,135	12%
Medical and Lab Technicians and Technologists	606	15%
Occupational Therapists	171	16%
Physical Therapists	432	20%
Surgical Technicians	303	21%

Source: Governor's Council On Workforce & Economic Development, Oklahoma's Health Care Industry Workforce: 2006 Report.

Oklahoma Ranks Lower than National Average – 100K Population

Occupation	High	U.S	Oklahoma
RNs	69.9	48.3	44.2
Medical & Lab Techs and Technologists	281.8	101.3	92.8
Occupational Therapists	59.2 (RI)	29.5	21.0
Physical Therapists	87.1 (Mass)	49.5	47.4
Respiratory Therapists	56.0	32.1	28.4
Radiologic Technologists	99.9 (SD)	62.0	55.3

Source: The U.S. Health Workforce Profile, The New York Center for Health Workforce Studies, October 2006.

Health Care – A Major Economic Engine for Oklahoma

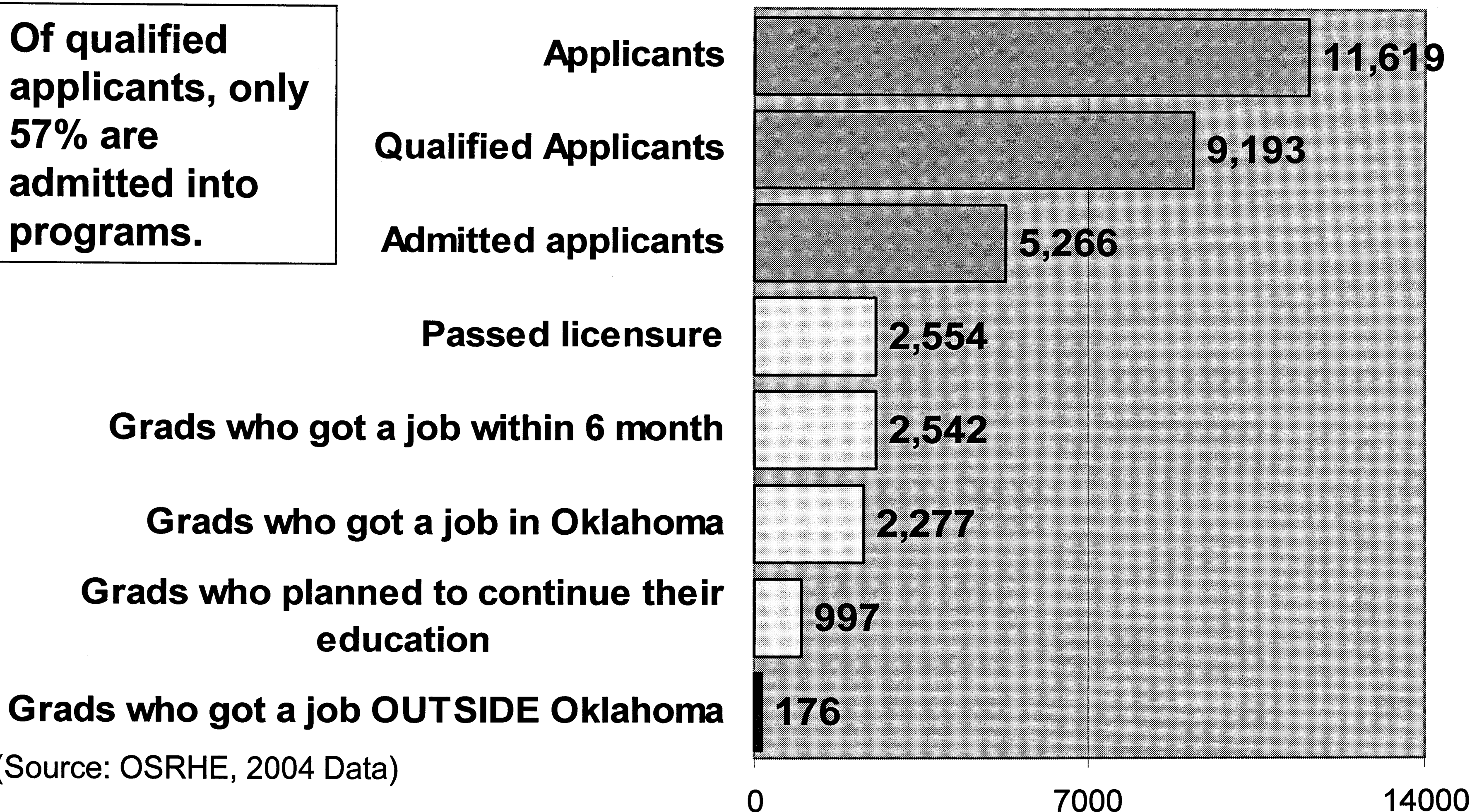
Second Largest Employing Industry

- **198,636 direct jobs**
- 14% of Oklahoma's total employment

- **141,032 indirect jobs** created in other industries
- $6.5 billion in direct contributions to Oklahoma's Gross State Product

Source: Governor's Council On Workforce & Economic Development, Oklahoma's Health Care Industry Workforce: 2006 Report.

Nursing and Allied Health Pipeline
(all Public Postsecondary)



Nursing and Allied Health Pipeline

(all Public Postsecondary)

Faculty

- Shortage in nursing and allied health faculty (156)
- Largest for RN faculty (17)
- 37 RN faculty plan to retire in the next 5 years
- Nursing faculty often leave for higher paying jobs in hospitals

(Source: OSRHE, 2004 Data)

Oklahoma State Regents for Higher Education Response

Annual earmark approved in 2006: = $4,562,646

Results annually:

- 300 more RNs
- 130 Allied Health personnel
- 20 additional MSNs

Center's Action Plan

Education & Training

#1 GOAL: Increase Educational Capacity!

Support prioritization of funds & resources to expand capacity in nursing & allied health education

Oklahoma Legislative Response

Education & Training

SB 1769 Passed & Signed by the Governor

Legislative Champions:

Sen. Susan Paddack (D-Ada) and Rep. Doug Cox (R-Grove)

Currently Unfunded

2009 – OHCWC will focus on funding to expand capacity in nursing & allied health education

Funding to Expand Capacity in Nursing & Allied Health Education

Education & Training

- Scholarships for faculty development
- Incentive matching funds for educational capacity expansion: online, distance ed, simulation, etc.
- Scholarships for high demand professions

Center's Action Plan

Education & Training

Maximizing Clinical Opportunities for Students

- Development & Launch of Online Student Affiliation Management System
  - Online Clinical Placement System
  - Mandatory Courses Required of all Students
  - Health Care Orientation/Policies

  --Seeking $70K funding to launch demonstration

Center's Action Plan

Education & Training

Explore Use of Clinical Simulation for student & staff training

oklahoma
health care
workforce
center

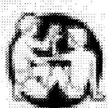
A best practices workshop...

"Using Clinical Simulation in Nursing and Allied Health Education & Staff Development"

I hear and I forget. I see and I remember. I do and I understand.
–Confucius

This best practices workshop is made possible through the generous contributions and resources provided by the following sponsors:

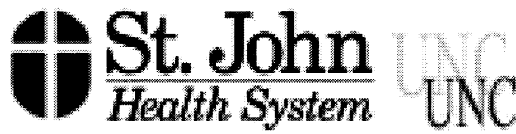
Hillcrest
HEALTHCARE SYSTEM

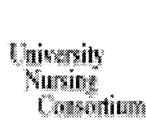


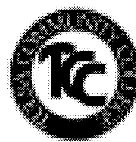
Laerdal
helping save lives

METI

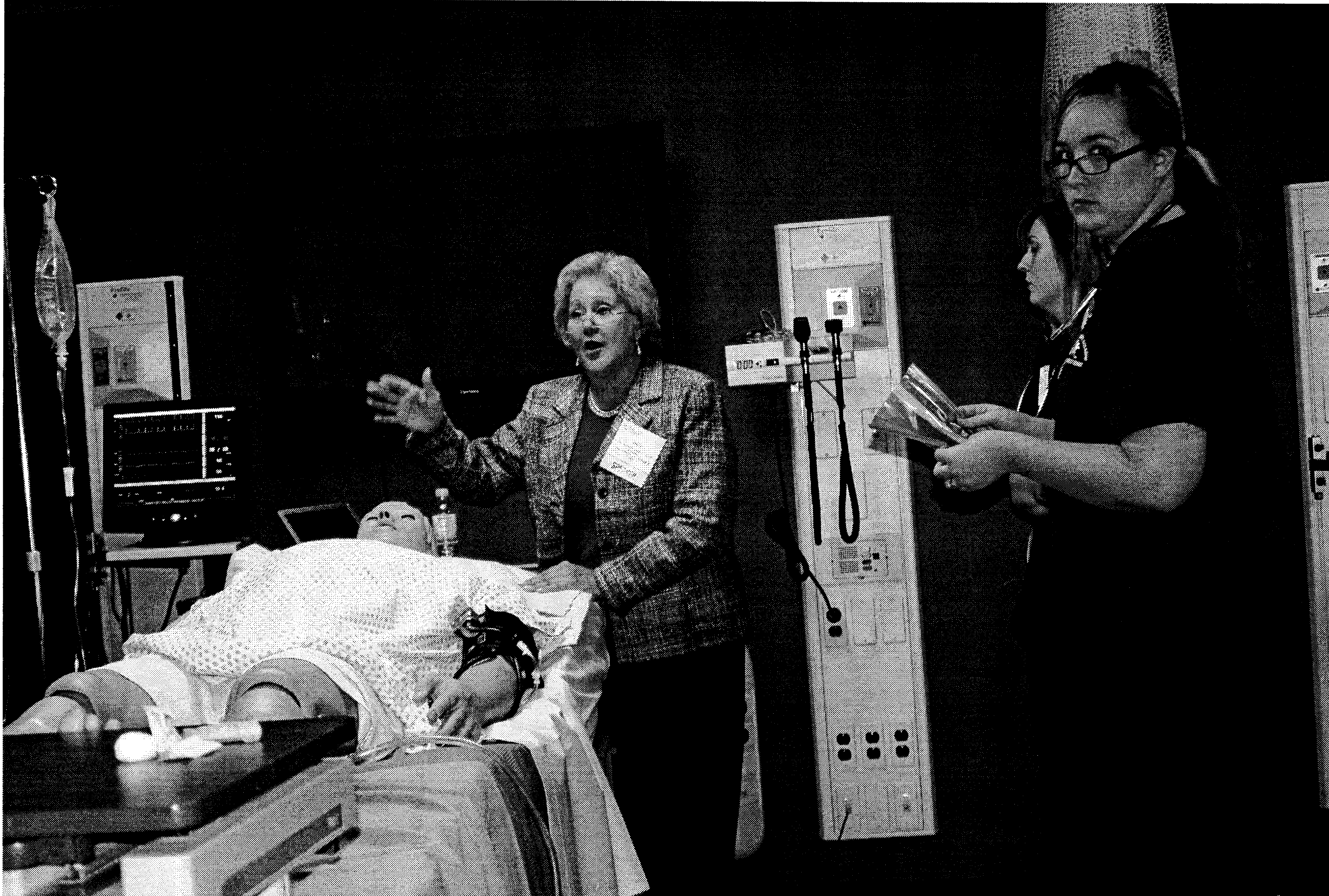
INTEGRIS
Health







Explore Clinical Simulation



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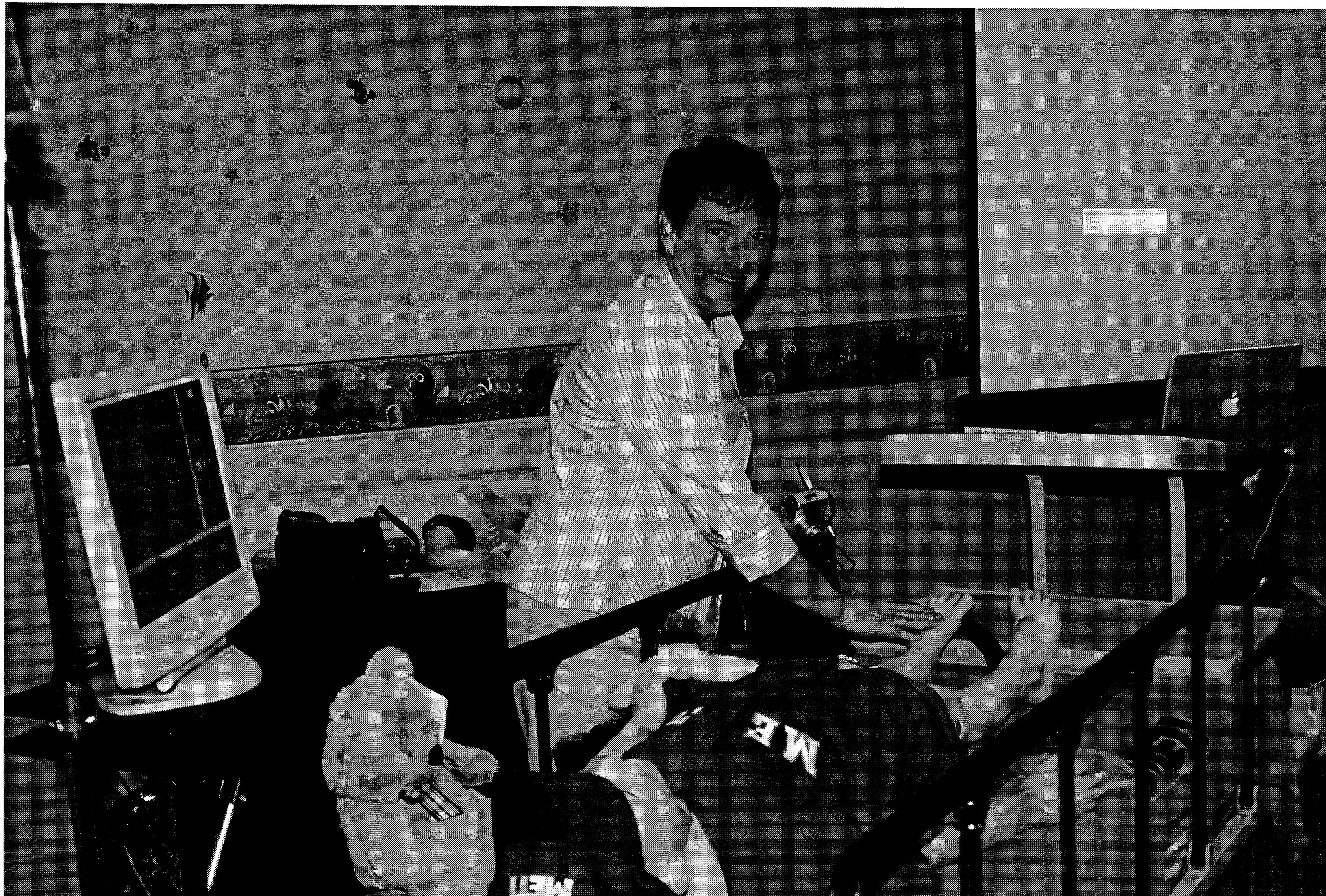
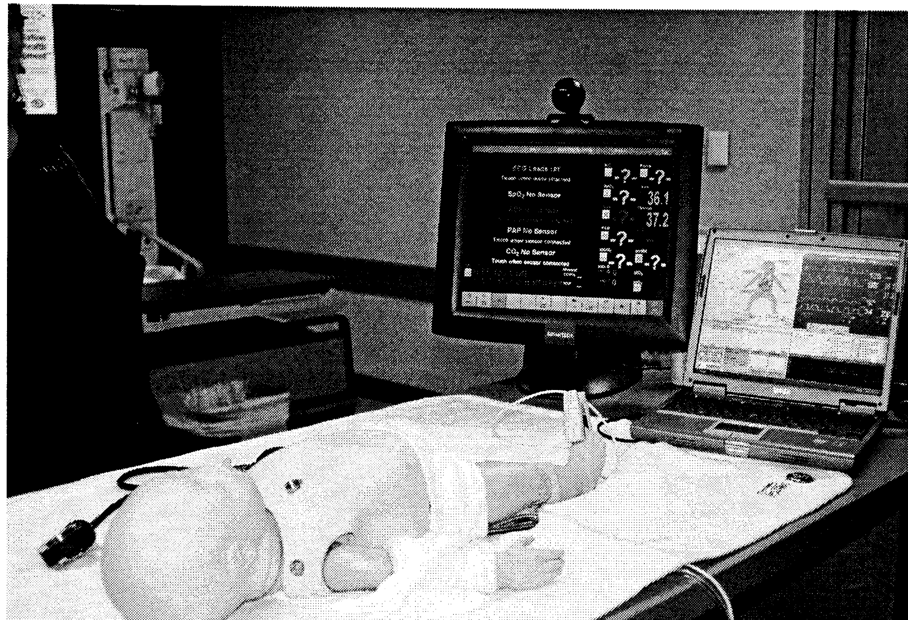


Explore "Simulation"



Part II Workshop

May 21, 2008

Oklahoma City
Community College

Center's Action Plan

Education & Training

- Part III Simulation Workshop
- May 2009
- Oklahoma City

Center's Action Plan

Education & Training

Explore Best Practices for Capacity Expansion

Explore "Best Practices" Capacity Expansion

Expanding Health Care Educational Capacity:

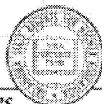
A best practices workshop...

oklahoma
health care
workforce
center

This best practices workshop is made possible through the generous contributions and resources provided by the following sponsors:

GOVERNOR'S COUNCIL FOR WORKFORCE AND ECONOMIC DEVELOPMENT
EDUCATION. ECONOMIC DEVELOPMENT. EMPLOYMENT.

OKLAHOMA STATE REGENTS FOR HIGHER EDUCATION
Improving our future by degrees



careertech

ROSE STATE COLLEGE

Explore "Best Practices" Capacity Expansion

Explore "Best Practices" Capacity Expansion

Center's Action Plan

Education & Training

Identify alternative educational delivery methods to use faculty resources efficiently – Simulation, Distance Ed. & Online

(Education & Training Subcommittee)

Center’s Action Plan

Education & Training

Eliminate educational redundancies and ensure coordination of the articulation process

(Subcommittees on Online Core Curriculum & Articulation)

Center's Action Plan

Retention

Improve job satisfaction and retention rates of Oklahoma health care employees

Share best practices which promote employee satisfaction, foster positive working environments, reduce vacancy and turnover rates and retain mature workers

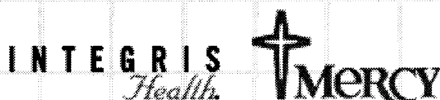
Center's Action Plan

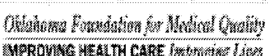
Retaining Oklahoma's Health Care Workers:

A best practices workshop...

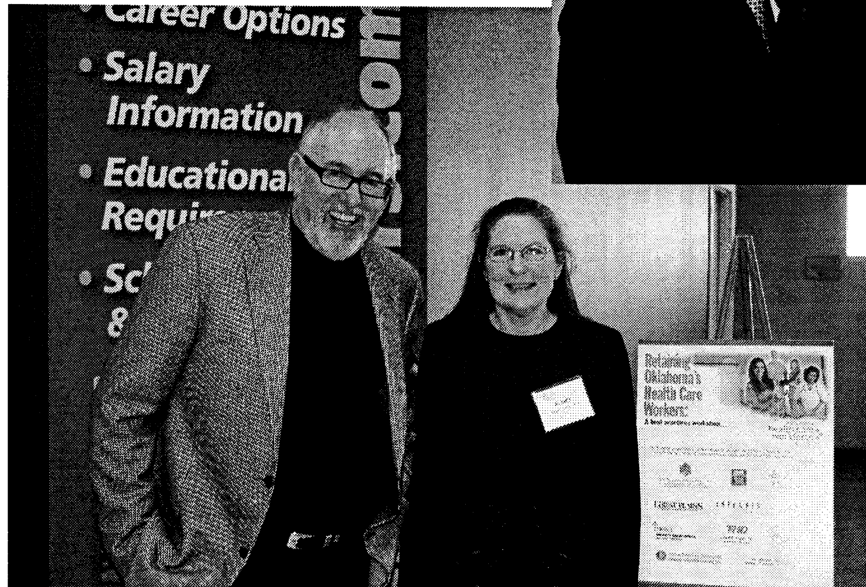
Sponsored by: oklahoma health care workforce center

Co-sponsors





Center's Action Plan



Center's Action Plan

Retention

Next Steps – Best Practices:

- Leadership & Management Training
- Coaching
- Mentoring
- Orientation/Transitioning Students & Others into Health Care Practice Settings

Tool-kits, Online & Distance Education, Face-to-Face Workshops

Bonus: RWJ/NW Health Foundation Grant

Retention

- RWJ/NW Health: $250K
- Oklahoma Funders:
  - 5 Rural Hospitals (Ada, Talihina, Tahlequah, Atoka, Stilwell)
  - $480,000 leveraged by Oklahoma Partners (Career Tech, OSRHE, OneNet, OHA, Hospitals)

Bonus: RWJ/NW Health Foundation Grant

Retention

- Provides Leadership Development & Management Training for rural nurses via online and distance education;
- Scholarships 8 educators master's in nursing education via OU online program

Center's Action Plan

Recruitment

Increase the promotion & distribution of materials used to market health careers to K-12 students, teachers, counselors, parents and others

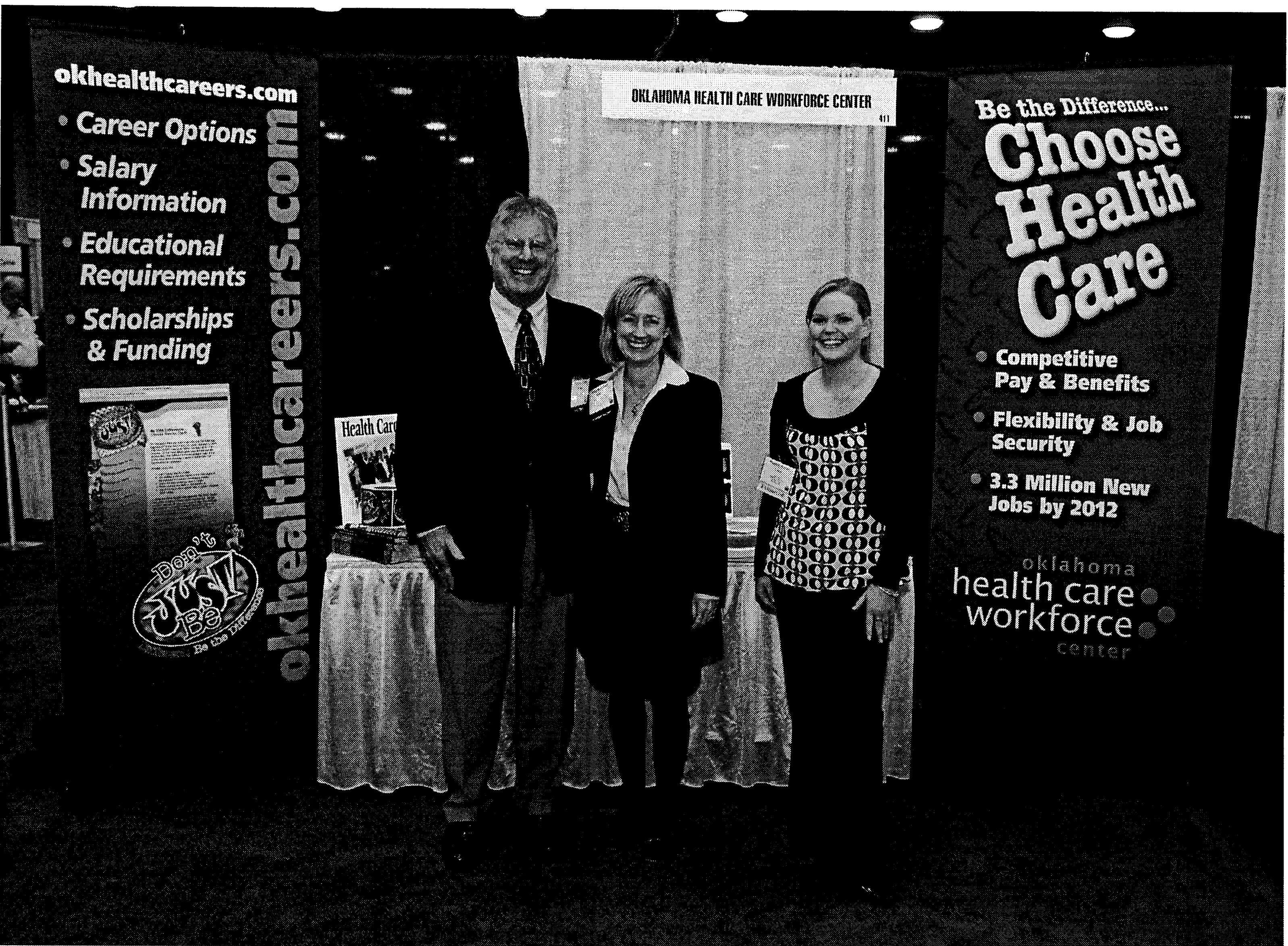
Center's Action Plan

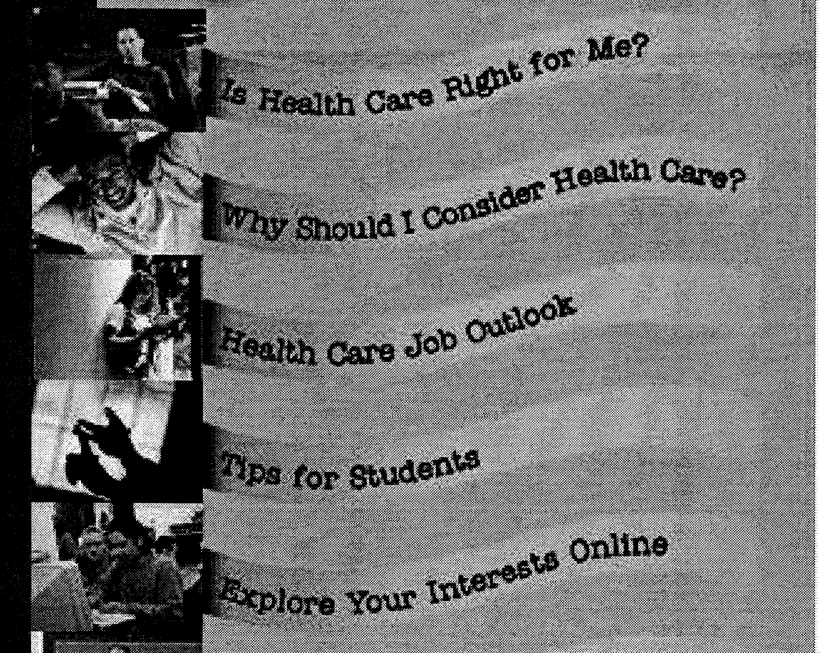
Recruitment

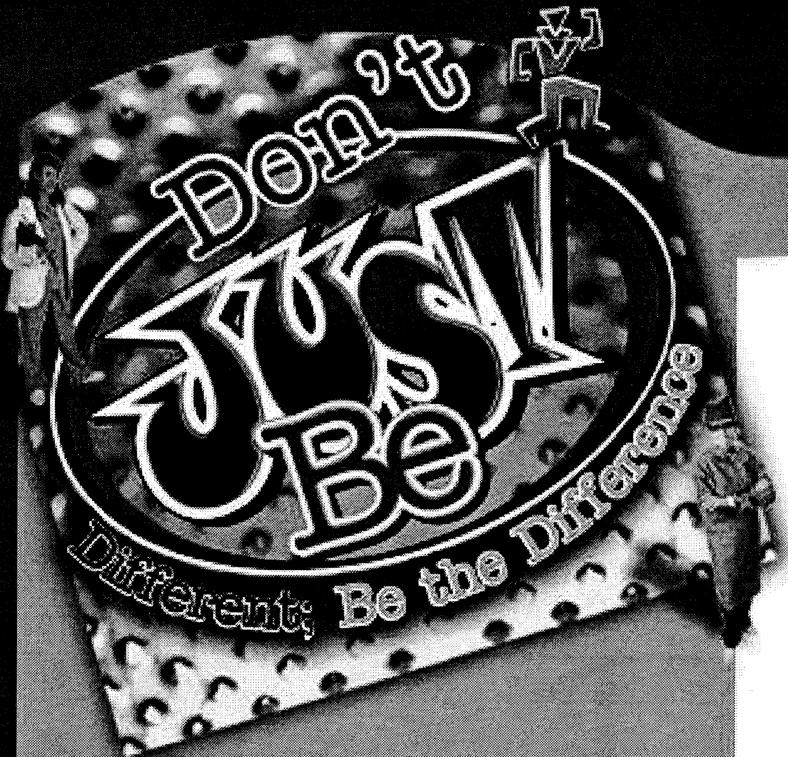
2008 Meetings:

- Counselor's Only – March
- Simulation Conference – May
- Alternative Education Conference – June
- Superintendent's Leadership Conference – July
- Encyclo-media – September
- Hospital Association Statewide Conference – November
- Safe & Healthy Schools Conference – November

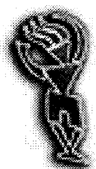
Center's Action Plan







Be THE Difference… Choose Health Care!



Do you know what you want to do with your life following high school? If not, don't worry. It's as important to know what you DON'T want to do before you head off in a new direction. As you think about your career and life choices, and what differences you are going to make in the world, think about choosing a career in health care. Opportunities are unlimited!

Whether or not you:

- Are a young man or woman;
- Are seeking a two-year degree, a four-year degree or are interested in a quicker certification process;
- Enjoy traveling or staying close to home;
- Prefer working as a team or individually; or
- Like working in direct patient care, or prefer a business office setting…

…there is a job in health care especially for YOU!

New Program Pilot

Middle School Students

- After School Program
- Launch Spring 2009 – Six OKC Area Hospitals & Middle Schools
- Interactive, fun science education + health career exploration
- Hands-on science demos
- Health care professionals
  - What they do, where they work & equipment they use
- Engages Students

HealthExplore™ Topics

- Mission Nutrition
- Body Basics
- Build Your Bones
- Tobacco Cessation
- DNA
- UV Exposure

OKHEALTHJOBS.COM

Oklahoma's Health Care Job Source

Health Care Job Seekers

513 openings are now available!

Your Auto Search Agents!
Find over 400 current Oklahoma hospital, nursing, and allied health care jobs listed on this non-profit site operated by the Oklahoma Hospital Association ... and it's free to job seekers!

Employers

Open employer account

This site is currently reserved for Oklahoma Hospital Association member employers only. If you are an active member of OHA, you can click here to create an employer account and review the price structure.

Once you receive your login information, you will be able to post unlimited listings of health care job openings and search the resume database. You will find many tools to help you manage your jobs and your employee

Information Booth

OKLAHOMA CITY ... In the early 1990s, the leaders of Oklahoma City were faced with a decision: to compete or retreat. To compete, the city would launch a visionary project -- one that would change the face of Oklahoma City forever. That plan is Metropolitan Area Projects (MAPS), an ambitious program that's one of the most aggressive and successful public-private partnerships ever undertaken in the U.S. The current amount being spent in this public/private partnership exceeds $1 billion. Oklahoma City offers everything you look for in a modern metropolitan community - an abundance of the arts, quality health care, excellence in education and more. And it does so without high costs, energy shortages, smog or traffic congestion.

TULSA ... You will be taken with Tulsa-

Data Collection & Analysis

GCWED Health Care Industry Analysis - 2006

Data Projects Currently Underway:

- Oklahoma Health Care Educator Survey (June 2008)
- Health Care Vacancy/Turnover
- Educational Pipeline Capacity
- Quantifying Hospitals' Contribution to Oklahoma's Health Care Educational System

Funding

- Expand Educational Capacity
- Fund the launch & demonstration of an online student affiliation management system
  - Online clinical placement scheduling
  - Mandatory courses (HIPAA, OSHA, etc.)
  - Hospital orientation/policies
- Career Awareness Materials
- okhealthcareers.com

Building Public Awareness

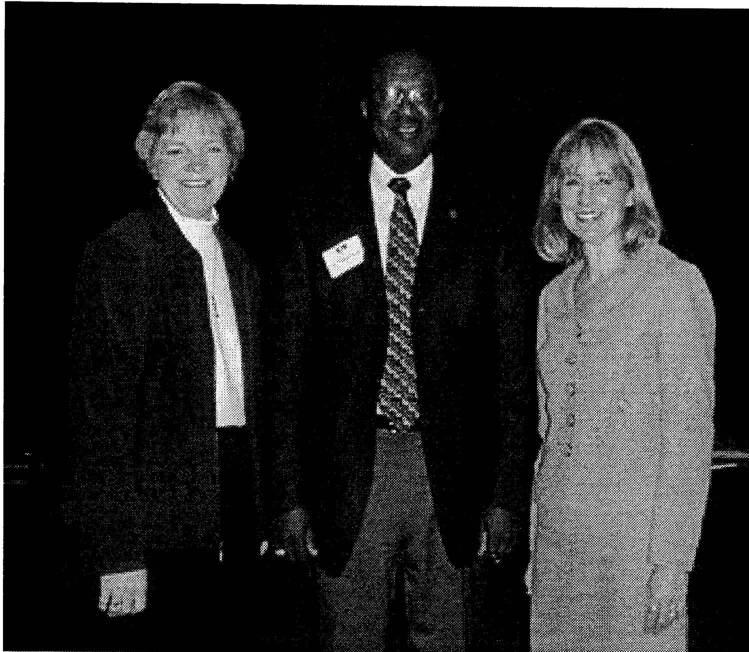
Press Releases

Media Interviews

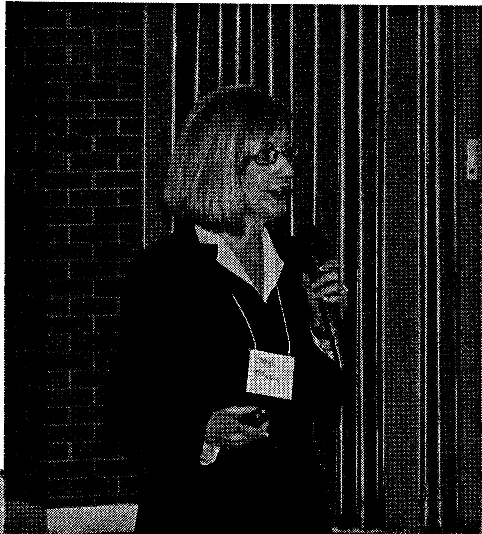
Formal Presentations in 2007 (20)

Additional Reports/Updates (21)

Regional Strategic Planning – Eastern & Southern WIBs



Regional Strategic Planning – NE Region: 4-State Summit



"Never doubt that a small group of committed people can CHANGE THE WORLD. Indeed, it is the only thing that every has."

-Margaret Mead

Questions/Comments

Contact Information:

Sheryl Ray McLain, MS
Executive Director
Oklahoma Health Care Workforce Center
655 Research Parkway, Suite 440
Oklahoma City, OK
405.319.8690
sheryl@ohcwc.com
www.ohcwc.com

www.okhealthcareers.com
www.okhealthjobs.com

Appendix P

Health Reform in Oklahoma

"Building on a Solid Foundation"

Oklahoma Health Care Task Force
September 22, 2008

Kathleen Stoll
Deputy Executive Director
Families USA
kstoll@familiesusa.org * (202) 628-3030

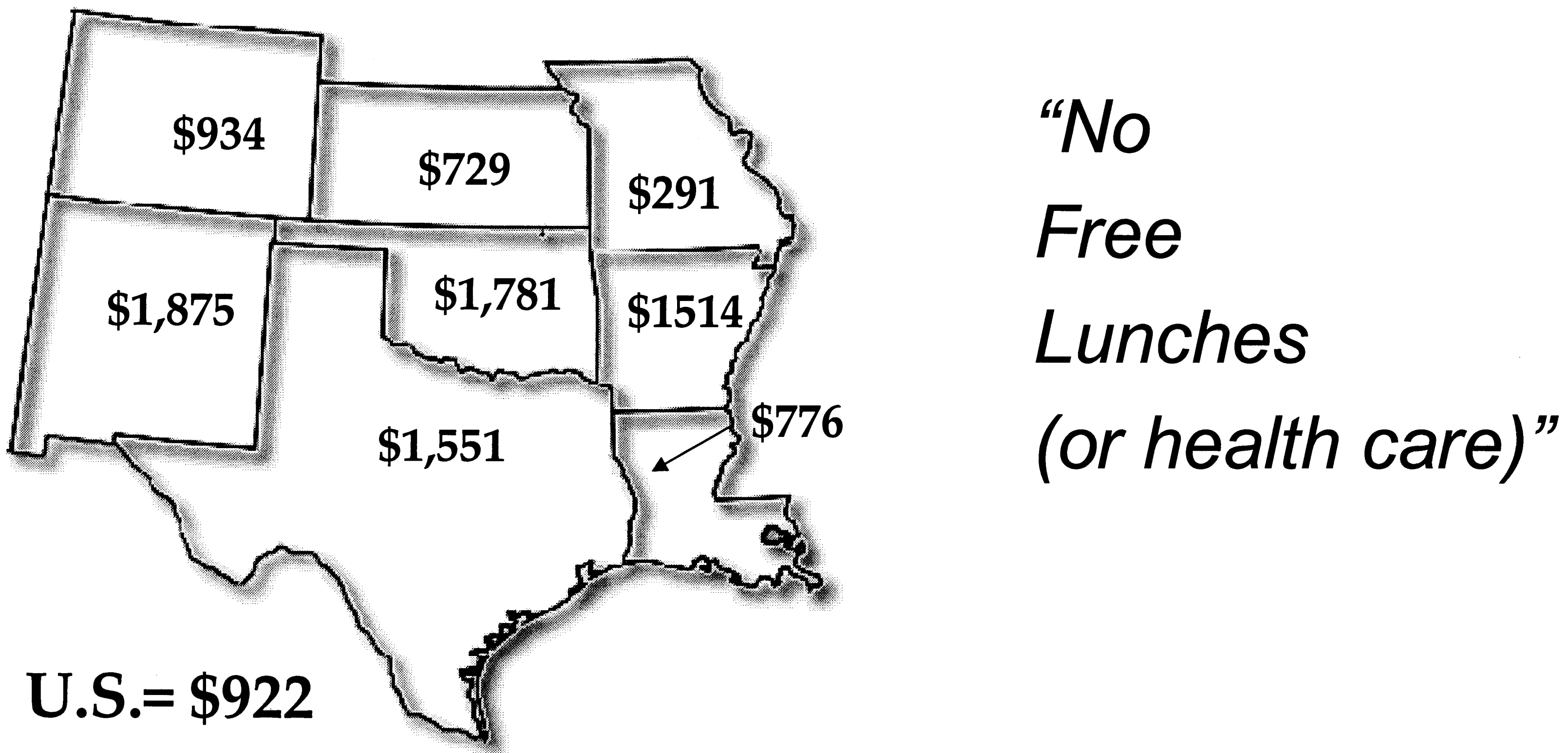
Oklahoma

- 661,000 Oklahomans are uninsured – We all Pay!

- Medicaid expansions – Federal Match! Build on These!

- Few consumer protections in the private insurance market – Strengthen!

Increase in Premiums Due to Health Care for the Uninsured 2005



"No Free Lunches (or health care)"

Recommendations Roadmap

1. Build on good programs you have put in place
2. Continue to maximize Medicaid/CHIP federal matching dollars
3. Expand SoonerCare to 100% FPL for parents and 200% for kids
4. Improve Insure Oklahoma – esp. IP
5. Improve outreach and enrollment
6. Expand Insure Oklahoma income eligibility as high as you can with dedicated dollars
7. Strengthen oversight of private market

Public Programs

Medicaid
Enrollment

- **Total Medicaid enrollment** (SoonerCare/Insure OK)
  - FY 2007 = 763,565 (21% of the population)
  - FY 2008 = 797,556 for fiscal year 2008
  - Month of July 2008 = 613,821

- **FY 2007 Enrollment Breakdown**
  - 71% were children and parents
  - 18% were aged, blind or disabled
  - Less than 1 % (.44%) were in Insure OK

- **Insure Oklahoma Enrollment for July 2008**
  - 2,969 Small Businesses enrolled in ESI
  - 9,349 employees enrolled in ESI premium assistance
  - 3,299 enrolled in the Individual Plan

Medicaid
Spending

- **Total Medicaid spending for FY 2007 was approximately $3.4 billion**
  - $2.2 billion federal
  - $1.2 billion state

- **Expenditures by population**
  - 37% on children and parents
  - 58% aged, blind and disabled
  - 0.11% on Insure Oklahoma

SoonerCare
Programs

- **SoonerCare Traditional** - FFS program
  - institutionalized
  - dual eligible
  - in state or tribal custody
  - covered under a private HMO
  - enrolled in a HCBS waiver

- **SoonerPlan**
  - family planning services for women/men age 19 +

- **Oklahoma Cares**
  - uninsured women under 65 in need of treatment for breast/cervical cancer

SoonerCare
1115 Demonstration Waiver

Two Main Programs under the Waiver

- **<u>SoonerCare Choice</u>**

  Primary Care Case Management (PCCM) system

  (A GREAT Program!)

- **<u>Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)</u>**

  Premium Assistance Program (Insure Oklahoma)

  (A Solid Foundation!)

SoonerCare Choice

- **Members are assigned to a primary care provider**

- **Groups covered**
  - low-income parents and children
  - non-Medicare aged, blind and disabled,
  - TEFRA (The Tax Equity and Fiscal Responsibility Act) Children who have physical or mental disabilities, but whose family income and resources make them ineligible for SSI.

- **Benefits**

  Members receive traditional Medicaid benefits

- **Cost-Sharing**

  follows traditional Medicaid rules

Insure Oklahoma
(O-EPIC)

- **Premium assistance program for adults with incomes up to 200% FPL ($35,200 for a family of three in 2008)**

- **Two components**
  - Employer-Sponsored Insurance Program
  - O-EPIC Individual Plan

- **Funding**
  - Medicaid funds
  - tobacco tax – dedicated funds
  - employer and employee contributions.

Insure Oklahoma

Employer-Sponsored Plan

- State pays part of the health premiums for eligible employees
- Eligible businesses have 50 or fewer FTEs
- Employer participation in O-EPIC is voluntary – must contribute 25% of premiums

Insure Oklahoma
Employer-Sponsored Plan

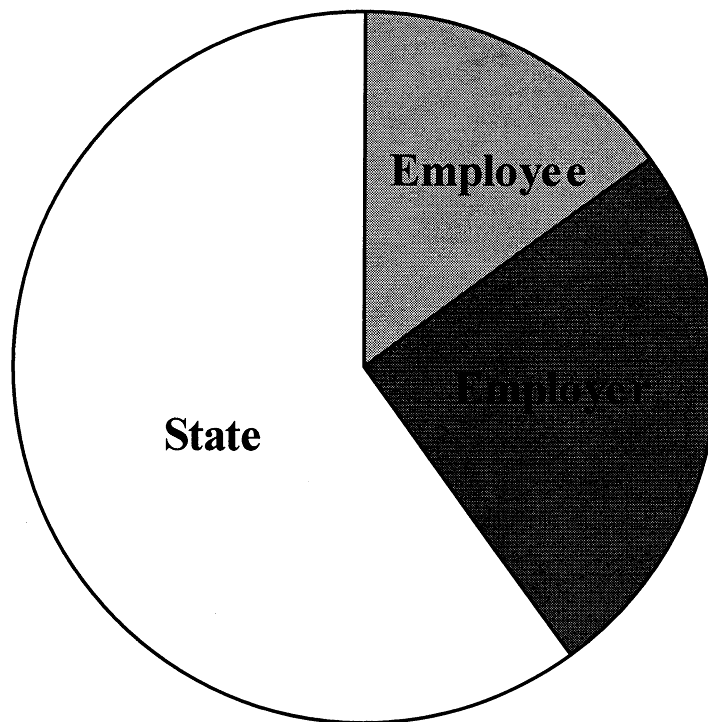
<u>Cost Sharing</u>

Individual:

- Employer - 25%*
- Employee - 15%
- State – 60%

Spouse:

- Employee - 15%
- State – 85%



Insure Oklahoma

Employer-Sponsored Plan

Cost Sharing

- Enrollees pay co-pays set forth by the plan with some caps set by the state

- Max amount of all cost sharing cannot exceed 5% of a family's total gross income

- State reimburses for out-of-pocket costs above 5% cap *but only up to $900 per eligibility period*

Insure Oklahoma
Employer-Sponsored Plan

Benefits

- Employers must offer an approved Qualified Health Plan set by the state

- A qualifying plan must offer, at a minimum:
  - hospital services
  - physician services
  - clinical laboratory and radiology
  - pharmacy
  - office visits

Insure Oklahoma
Individual Plan

Cost Sharing

- monthly premiums are based on income
- cost of premiums cannot exceed 4% of monthly gross household income
- Co-pays are higher than allowed under traditional Medicaid

Insure Oklahoma

Individual Plan

Income Related to Federal Poverty Level	Worker Only Coverage	Worker and Spouse Coverage
0 – 25 percent	No Premium	No Premium
26 – 50 percent	$8.50 per month	$11.50 per month
51 – 100 percent	$16.50 per month	$22.50 per month
101 – 150 percent	$33.00 per month	$44.50 per month
151 percent & higher	$49.00 per month	$66.50 per month

Insure Oklahoma
Individual Plan

Benefits

- **6 prescriptions per month**
- **4 office visits per month** (includes primary and specialty care visits)
- **Overall lifetime benefit of $1 million**
- **Some services not covered**
  - testing and treatment for allergies
  - dental care
  - vision and hearing
  - emergency or non-emergency transportation
  - nursing home care and hospice
  - physical, speech or occupational therapy
  - transplants

Public Programs

- **There have been recent attempts to expand coverage**

- **August 2007, waiver amendment request to CMS**

  - Kids in families with incomes up to 300% FPL eligible for the Insure OK ESI Program (use federal CHIP funds)

  - Kids in families with incomes up 185% FPL eligible for SoonerCare Choice **or** Insure OK ESI Program

  - College students age 19 through 22 with incomes up to 300% FPL eligible for the O-EPIC programs

  - Working adults with incomes up to 250 % FPL eligible for Insure OK ESI or IP programs (currently 200%)

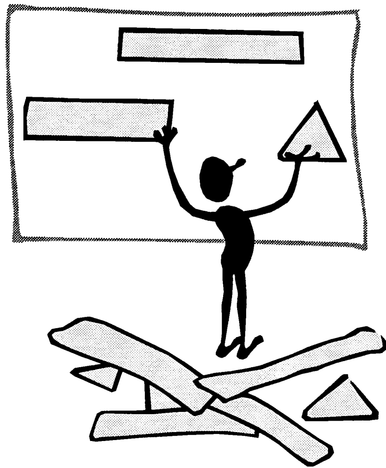
  - Expand employer size eligibility from 50 to 250 employees

Public Programs

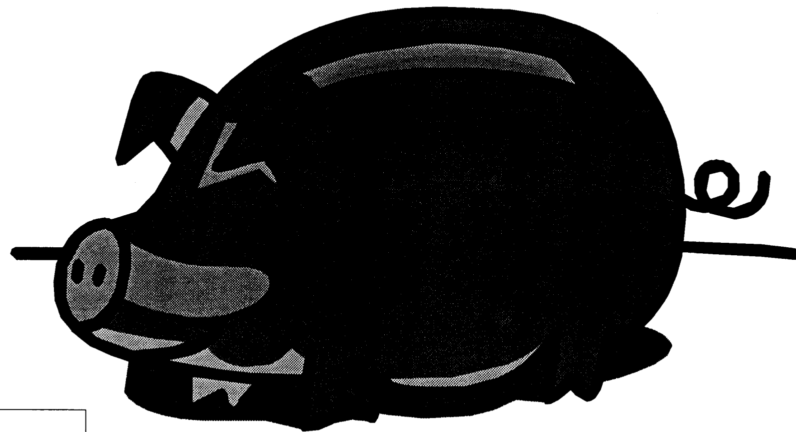
Waiver Request

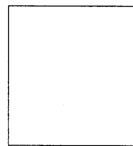
- CMS has kept the waiver request on hold for fourteen months
- They will not consider a proposal to expand coverage to adults above 200% or children above 250%
- Oklahoma modified their initial request to meet these income levels, but with income disregards, which CMS is not happy with
- The state is still in negotiations over the amendment

Ideas for Reform

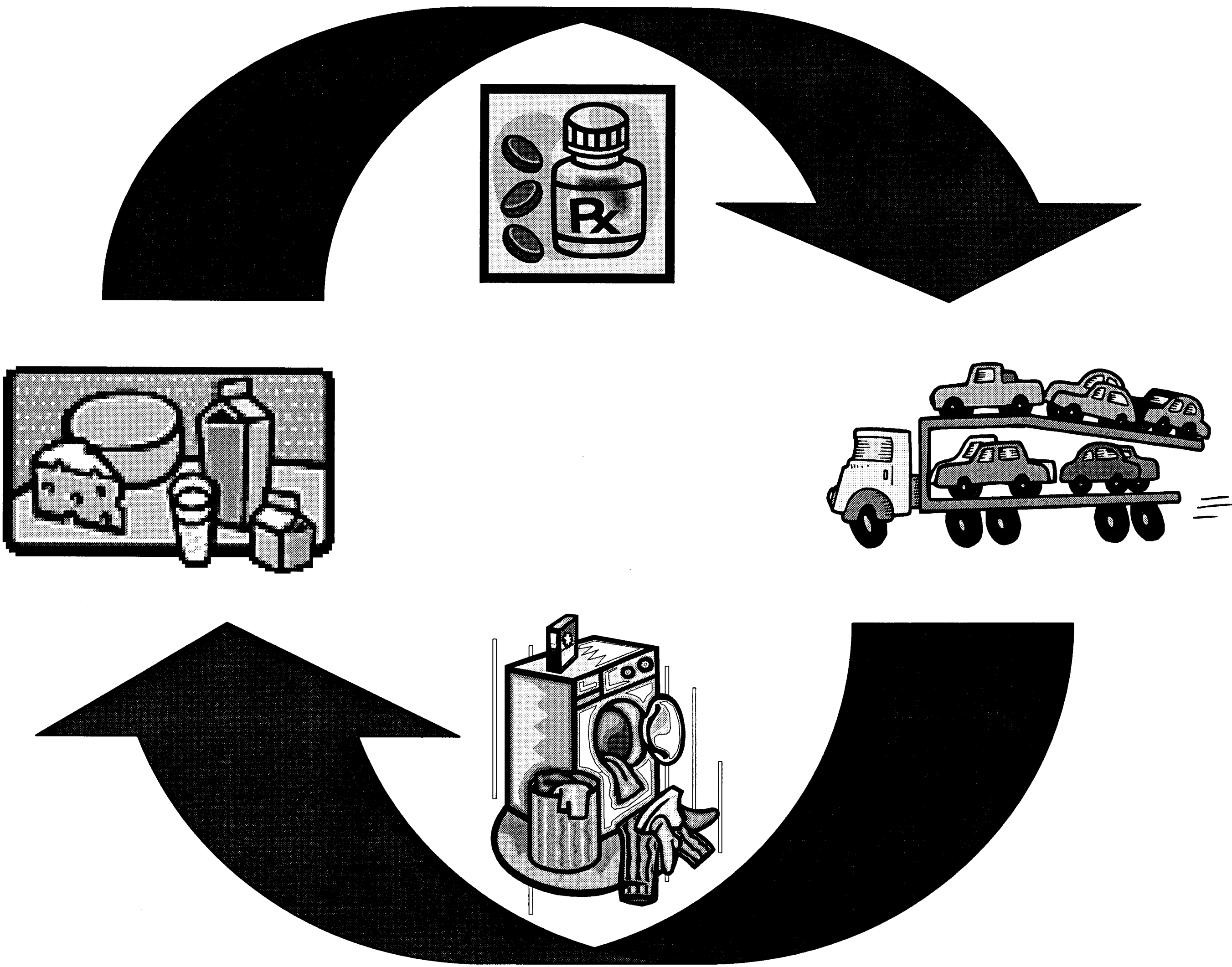


Expand Medicaid: Good Medicine for Oklahoma's Economy





The Multiplier Effect



More Bang for the Buck

$1.00 = $3.04

Every dollar of state spending lets you buy $3.04 in health care services

Potential Gains for Oklahoma

New Jobs – 1,573

Wages from New Jobs –

$50 million

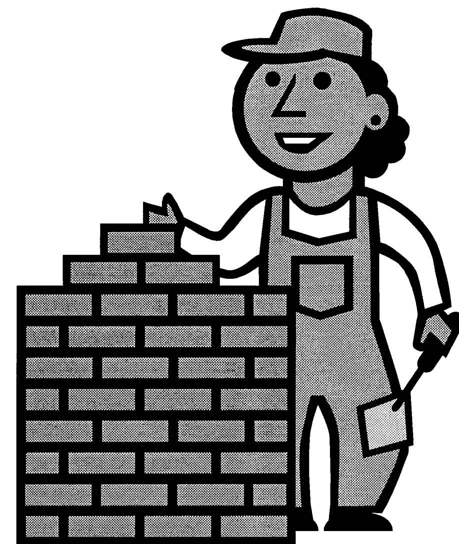
Business Activity –

$138 million

Public Programs
Ideas for Reform

- **Insure Oklahoma is a good foundation**
  - High income levels for kids and parents
  - Covers childless adults

- **But can be expanded and improved**



Public Programs
Ideas for Reform

- **Can do more to provide more comprehensive and affordable coverage to kids and adults**
  - Cover children up to 200% and parents up to 100% FPL under traditional Medicaid (SoonerCare or SoonerCare Choice)
  - Improve the benefits and reduce costs under Insure OK Individual Plan
  - Reduce cost-sharing maximums under Insure OK ESI Program

Ideas for Reform

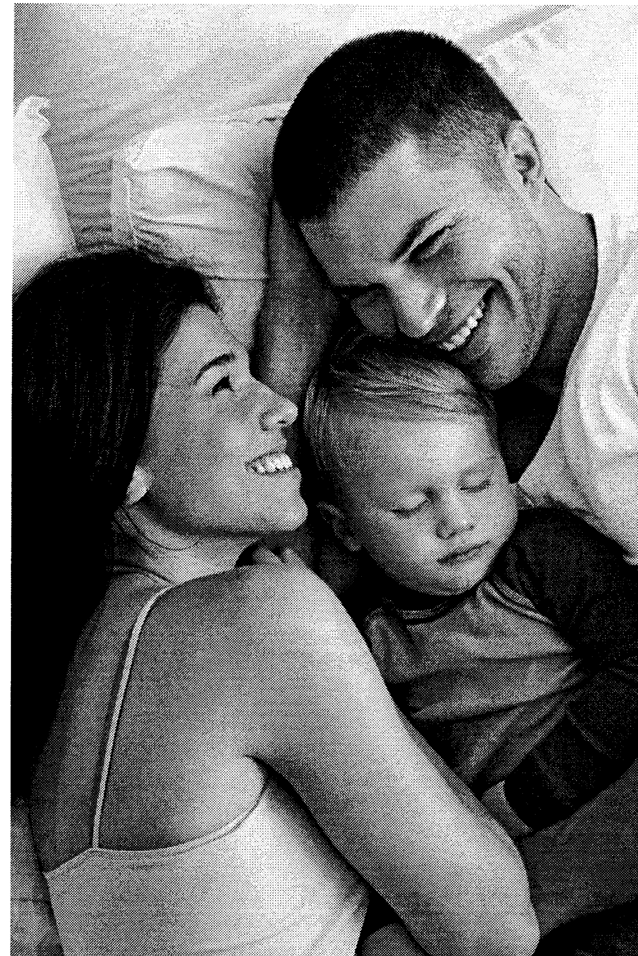
Expand eligibility under traditional Medicaid and Insure OK

Category	Current Eligibility		Proposed Expansion	
	% of FPL	Amount*	% of FPL	Amount*
Kids (Traditional Medicaid)	185%	$32,560	200%	$35,200
Parents (Traditional Medicaid)	32% 50%	$5,652 $8,800	100%	$17,600
Insure Oklahoma Parents/Childless Adults	200%	$35,200	250/300%	$44,000/ $52,800
Insure Oklahoma Kids	N/A	N/A	300%	$52,800

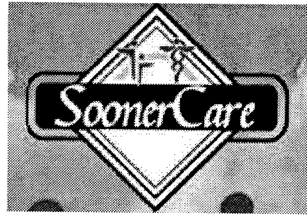
Figures are for a family of three in 2008

Ideas for Reform

16 States and the District of Columbia have expanded traditional Medicaid to parents with incomes at 100% FPL or above



State	Non-Working Parents	Working Parents
Arizona	200%	200%
California	100%	106%
Connecticut	185%	191%
Delaware	100%	106%
District of Columbia	200%	207%
Hawaii	100%	100%
Illinois	185%	191%
Maine	200%	206%
Maryland	116%	116%
Massachusetts	133%	133%
Minnesota	275%	275%
New Jersey	133%	133%
New York	150%	150%
Oregon	100%	100%
Rhode Island	185%	191%
Vermont	185%	191%
Wisconsin	200%	200%



Ideas for Reform

Improve SoonerCare Outreach and Enrollment

- Online applications
- Streamline applications
- **<u>Presumptive Eligibility</u>**
- 12 month continuous eligibility?
- Media campaign
- Adequate funding for outreach and enrollment workers

Private Market

Premiums vs Paychecks
2000 - 2007

Change in Average Family Premium	Change in Median Worker Earnings	Premium Increase as a Multiple of Earnings Growth
62%	18.8%	**3.3**

State Private Market Regulation

- **Goal**: affordable, available, accessible, adequate plans for individuals and small business

- **Limitations**:
  - ERISA: states can't regulate employer benefits plans, but they can regulate insurance.
  - No jurisdiction over self-funded plans, including most large employers.
  - States and feds share regulation of individual market. HIPAA for individuals leaving group coverage.

Private Market Protections

Individual Coverage

- Guaranteed affordable coverage option? NO
- Affordable premiums for people with pre-existing conditions? NO
- Premium oversight and efficiency? NO
- Exclusions of coverage for pre-existing conditions limited? NO
- Unfair coverage revocations prohibited? NO

Private Market Protections

Group Coverage

- Affordable premiums for small businesses whose employees have pre-existing conditions? NO
- Premium oversight and efficiency for small business? NO
- Availability of small group coverage to sole-proprietors? NO
- Ability to keep young adults on employer coverage? NO

High-Risk Pool Coverage

- Covers Oklahomans with pre-existing conditions denied by insurance companies
- About 2,400 people
- Funding: insurer assessments & premiums
- Premiums up to 50% higher
- Premiums vary by age and gender
- No income-based subsidies
- Low lifetime benefit maximum: $500,000
- One-year wait period for pre-existing conditions

Private Market Protections

Individuals

Guarantee affordable coverage:

1. Guaranteed issue
   - Pros: ease and choice for consumers
   - Cons: adverse selection may drive up premiums for comprehensive coverage
2. High-risk pool improvements
   - Pros: spreads risk without market disruption, can administer good subsidies
   - Cons: expensive, hard to enroll, constant battle for adequate funding

Private Market Protections
Individuals

Make premiums affordable & fair:

- Prohibit setting premiums based on health
  - Pros: nondiscriminatory
  - Cons: may drive up premiums for younger, healthier
- Limit premium variation based on health, age and gender
  - Pros: places some limits, gradual change from your wild wild west market
  - Cons: still unfair, may allow for huge variations

Private Market Protections

Individuals

Hold insurers accountable:

- Prior approval of premium increases
  - Pros: Gives regulator authority to disapprove outrageous premiums;
  - Cons: Requires vigilant regulator; still may see disappointing rate increases

- Minimum medical loss ratio requirement
  - Pros: Easy to administer, controls profits
  - Cons: Still doesn't get at underlying cost

Private Market Protections
Individuals

- **Protect individuals with pre-existing conditions:**
  - Limit how long insurers can exclude coverage
  - Limit look-back period
  - Define "pre-existing condition"

- **Prohibit unfair coverage revocations:**
  - Eliminate post-claims underwriting

Private Market Protections

Group Coverage

- **Make premiums fair for small businesses:**
  - Prohibit insurers from setting premiums based on employees' health status
  - Require insurers to spend reasonable portion of premiums on medical care

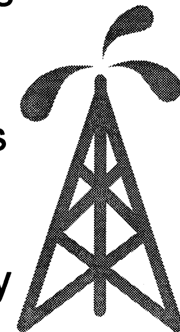
Private Market Protections
Group Coverage

- **Reduce uninsured via group coverage:**
  - Allow sole-proprietors into small group market
  - Extend dependent coverage to young adults

- **Other mechanisms to consider *later*:**
  - Merge individual and small group markets
  - Create a "connector" – a health insurance exchange to administer subsidies and standardize insurance products
  - Reinsurance – spreads risk of highest-cost individuals among insurers and products

Revenue Ideas

- Private market regulatory reforms are revenue neutral
- Unlike many other states, OK was able to fill their budget gap for Fiscal Year 2009
- OK not feeling as big budget crunch of other states because of oil. State has a surplus.
- Tobacco tax still relatively low at $1.03/per pack – raise again in a few years (resolve problems with tribal retailers)?
- Dedicated tobacco tax dollars for Insure OK: $40 mil/year and spending only $8-10 mil/year – don't let those dollars slip into the black hole!
- Extend your assesment on insurers (premium tax 2.25%) to TPAs (Third Party Administrators)
- Rate review (to capture savings from covering the uninsured and reduce premiums)
- Dedicate a provider tax to covering the uninsured



THANK YOU

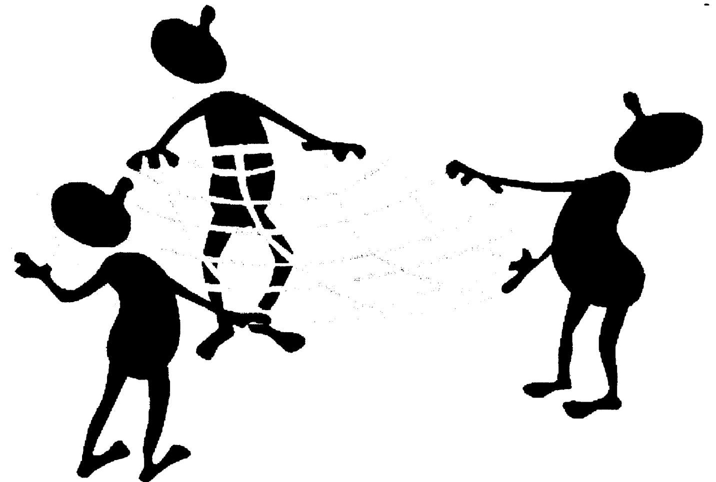
Appendix Q

O-CHIP

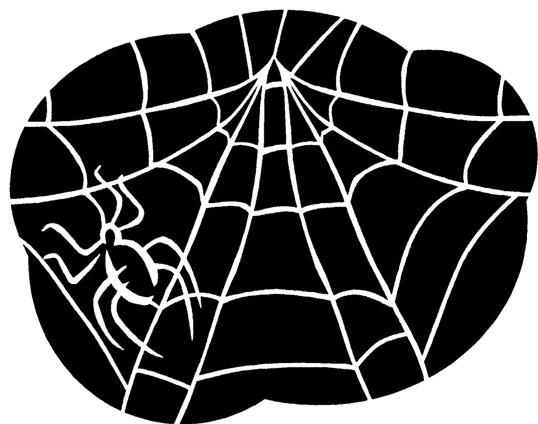
Oklahoma Comprehensive
Health Independence Plan

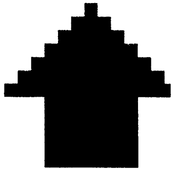
By Tom Daxon

OCPA



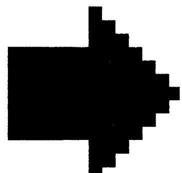
Do we have a safety net or a trap?

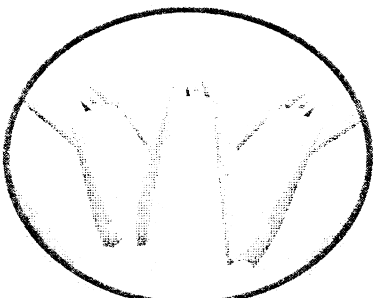


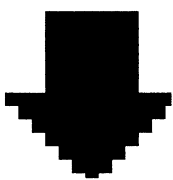


Internal Revenue Service
United States Department of the Treasury

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT







Taken Together, Our Safety Net

- Discourages Personal Initiative
- Undermines Family Stability

Why are so many without Health Insurance?

- They can't afford it

  OR

- They don't want it

The Uninsured

- **Lower income**

  BUT ALSO

- **Younger, healthier**

Pool Risk vs. Pool Cost

- Risk that something bad may happen to you
- Risk that something bad may happen to someone who smokes, overeats, etc.
- Near certainty that those with chronic illness will incur costs that your policy will help pay

Decision Of Youthful Adults to Forego Health Insurance

- Irresponsible action

  OR

- Rational decision?

Profit-making companies will naturally provide better service to their most profitable clients.

Tax Insured Only

vs.

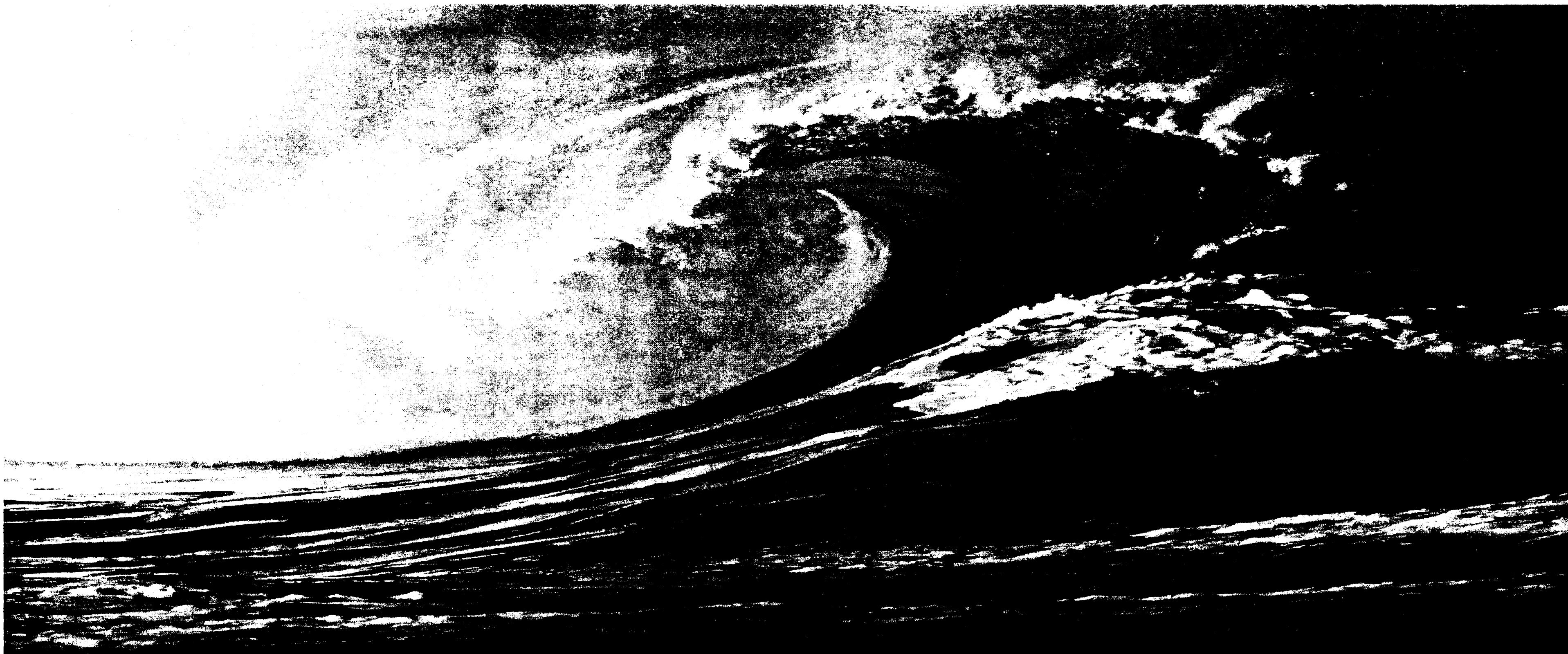
Tax Everyone

How valuable is a health insurance benefit?

Fire Mike Fogarty

Rural Areas Face Special Issues

- More people uninsured
- Greater reliance on Medicaid
- Hospital vital for growth



The Coming Health Insurance Tsunami

Three Factors Forcing Change

- Employers self insure
- 85/15
- Health care inflation

Non-Discrimination Worries

- Age
- Health status
- Health risk

Example- Status Quo

• 3 workers	$85,000
• 17 workers	15,000
• 20 workers	$100,000
• Average	$5,000

New Entrant with Modern Plan

- 4 workers $ 8,000
- Average $ 2,000
- Advantage $ 3,000

Healthy

- Raise
- Coverage
- Goes to new entrant

Chronic Illness

- Must cover deductible
- More than wipes out raise
- Stays with existing employer

New Entrant's Advantages:

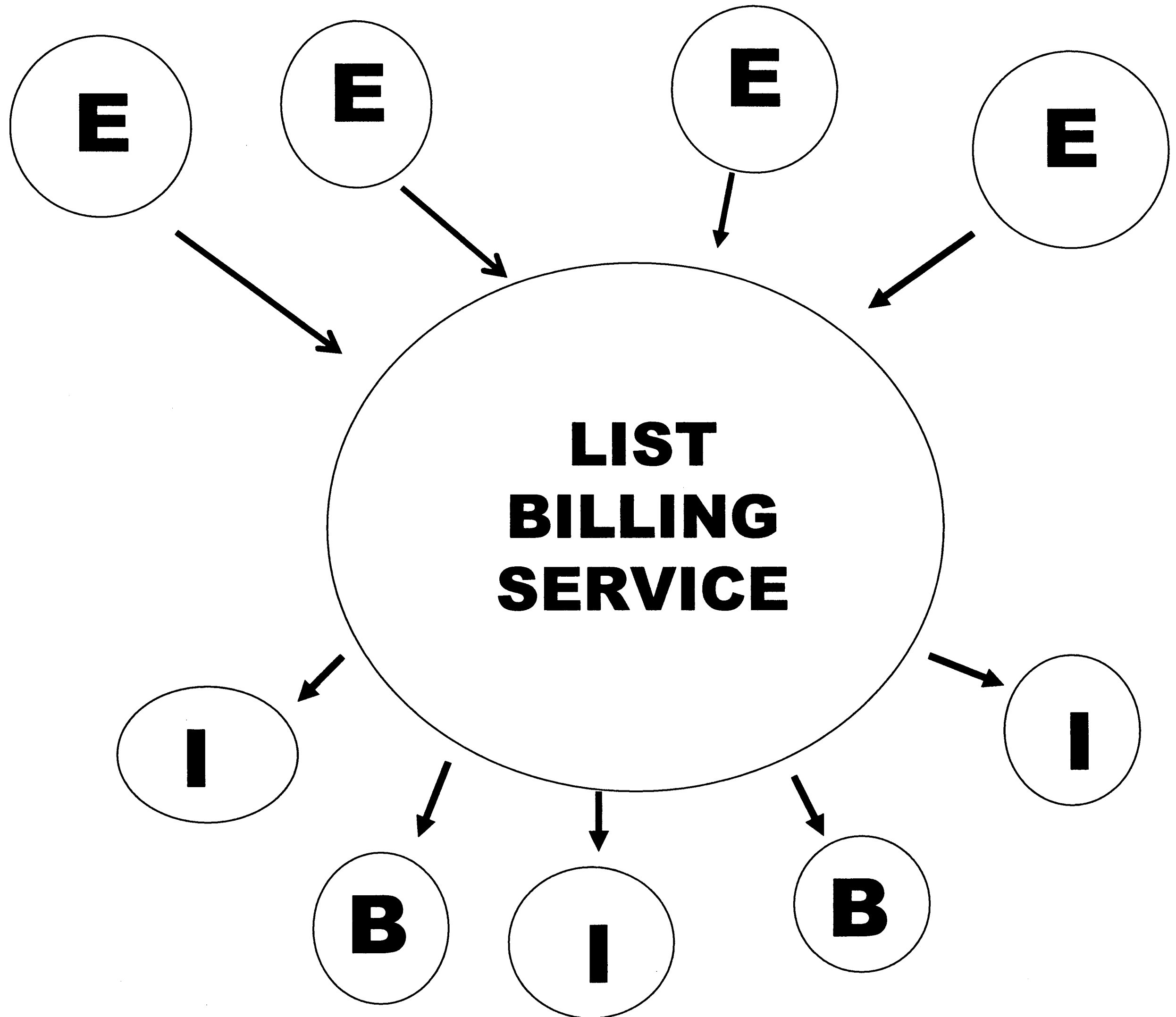
- More attractive to workers
- Lower cost
- Avoids discrimination

NOTE: High cost workers discriminate against the new entrant.

Some Innocent People Get Hurt

Possible Solution

- List billing service
- Special high cost pool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High Cost Pool

- One-time window
- Keep existing coverage
- No premium increase

Individual Coverage

- Portable
- Long-term outlook
  i.e., wellness and prevention
- Guaranteed renewal

Benefits

- Chronically ill- portable coverage
- Young & healthy- lower premiums
- Providers- less uncompensated care
- Employers- lower costs
  - Competitive advantage
    - More jobs
    - Better jobs
    - Acquirers in mergers

QUESTIONS

and

COMMENTS

Appendix R

Covering the Uninsured: A Public – Private Partnership

Insure Oklahoma/O-EPIC

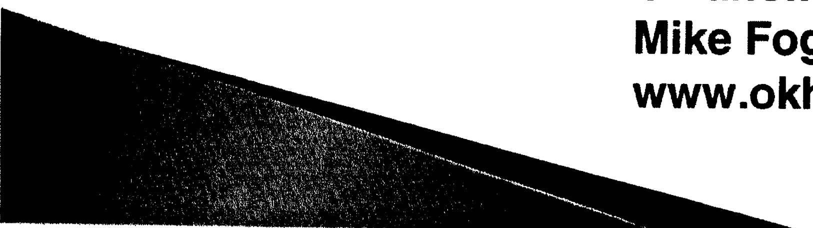
www.insureoklahoma.org

Next Generation Managed Care

SoonerCare Choice:
Patient Centered Medical Home

www.okhca.org/medical-home

Health Care Reform Task Force
October 14, 2008
Oklahoma Health Care Authority
Mike Fogarty, CEO
www.okhca.org



Insure Oklahoma!

Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)

The OHCA received approval to increase Oklahomans' access to health care coverage under the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. Since implementation, the OHCA has enrolled more than 14,000 employees, spouses and individuals under Insure Oklahoma.

Insure Oklahoma Employer-Sponsored Insurance (ESI) is open to small businesses with 50 or fewer employees. Premium assistance is available for workers and their spouses with household incomes at or below 200 percent of the federal poverty level (FPL). Participating employers pay at least 25 percent of the employees' premium and the employee pays no more than 15 percent. The Insure Oklahoma Program pays the remaining 60 percent. Dependent spouses may also be covered with the premium split 15 percent by employee and 85 percent by the Program. Employees and dependents are also responsible for limited deductibles and co-payments.

Insure Oklahoma Individual Plan (IP) is available to qualified uninsured Oklahomans who are self-employed and those who are unemployed - actively seeking employment. Individuals are responsible for sliding-scale premiums and applicable deductibles and co-payments.

Broader coverage was enacted by the Oklahoma Legislature during SFY2007 and is pending federal approval. Extended coverage will offer premium assistance to more Oklahomans and to businesses with up to 250 employees. One legislative enactment, the All Kids Act, offers premium assistance coverage to uninsured children, including full time college students through age 22, whose family income is up to 300 percent of the FPL. The income qualification for the employee (and spouse) and those seeking coverage by the Individual Plan will be raised to 250 percent of FPL.

9/2008

Insure Oklahoma/O-EPIC

(All statistics are as of October 1, 2008 unless otherwise noted)

1. *Number of Approved Healthcare Carriers:* ***17***
2. *Number of Approved Healthcare Plan Options:* ***187***
3. *ESI Members Enrolled:* ***10,401 (up 117% from Jan 08 – 4,784)***
4. *IP Members Enrolled:* ***4,467 (up 207% from Jan 08 – 1,453***
5. *ESI Businesses Enrolled:* ***3,435 (up 106% from Jan 08 – 1,667)***
6. *ESI Average Subsidy Payment (per Member per Month as of Sept 30):* ***$237.13***
7. *IP Average Claims Paid (per Member per Month as of Sept 30):* ***$296 (Approximately)***
8. *IP Member Average Premium (as of Sept 30):* ***$37.30***
9. *Insure Oklahoma/O-EPIC Participating PCP's:* ***722***
10. *Participating Counties (ESI & IP):* ***77 of 77***
11. *InsureOklahoma.Org Website Hits since program inception:* ***1,525,145 (1.5 million)***
12. *Insure Oklahoma Call Center Statistics (Aug only):* ***8,304 Calls Taken***
13. *Participating Qualified Agents:* ***137***

ESI = Employer Sponsored Insurance
IP = Individual Plan

Oklahoma Managed Care: Next Generation

Patient-Centered Medical Home

Background

The Oklahoma Health Care Authority (OHCA) formerly operated two managed care delivery systems in different areas of the state. The fully capitated managed care organization (MCO) system called SoonerCare Plus was offered in three urban service areas comprised of 16 counties. The remaining 61 rural counties of the state were served in an enhanced primary care delivery system that was partially capitated. The SoonerCare Plus program was discontinued December 31, 2003. OHCA to disenrolled approximately 187,000 SoonerCare Plus members from contracted managed care plans at 12 midnight on December 31, 2003. Concurrent with their disenrollment from managed care these individuals were automatically enrolled in the Oklahoma Medicaid fee-for-service program effective at 12:01 a.m. on January 1, 2004. A subsequent transition from the traditional Medicaid fee-for-service program to SoonerCare Choice doubled the size of the Choice program. Since the transition January 1, 2004, the SoonerCare Choice managed care delivery system has remained operational statewide.

PCP

All SoonerCare Choice members select or are aligned with a Primary Care Provider (PCP). Effective January 1, 2009, these providers will be responsible for serving as the "medical home" for enrolled managed care members. Building on the successes of the existing network, OHCA believes this transition to an enhanced service delivery model will help ensure that members get the right care at the right time from the right provider.

OHCA intends to make this transition seamless to the members. Members who remain qualified will continue to be enrolled with the same PCP in the new year. New members or those regaining requalifying will be able to select a new PCP if desired or will be permitted to re-enroll with the former PCP.

Reimbursement

The new program addresses reimbursement in three components:

1. A monthly care coordination fee that is determined by the provider's self-selection of services available at the medical home
2. Visit-based services are paid fee-for-service at the Medicare allowable
3. A performance based payment will be developed to recognize provider excellence and measurable improvement

Contracted PCPs are responsible for providing or otherwise assuring the provision of medically necessary primary care and case management services and for making specialty care referrals. PCPs are also responsible for providing telephone coverage for their members; this coverage is augmented by an OHCA-contracted Patient Advice Line staffed by registered nurses who utilize nationally established protocols in assisting callers. The Patient Advice Line is available to all SoonerCare members.

Medical Home Tiers and Care Coordination PMPM

In the current prepaid partially capitated program, the case management portion of the monthly payment is a set amount, either $2 or $3, depending on the age/gender cell of the member and if the member has a disability classification. The Medical Advisory Task Force has recommended that OHCA adopt a tiered approach to its 2009 Patient Centered Medical Home model, much like the tiers proposed in the Medicare Medical Home pilot. Three tiers have been established – the Entry Level, Advanced and Optimal Medical Homes. A contracted PCP will have to meet certain requirements to qualify for payments in each tier. The payment will also be stratified according to the PCP panel composition – children only, children and adults or adults only. In the 2009 program, care coordination payments will range from $3.03 to $8.69. Care coordination payments will be capitated – paid monthly to the contractor on a per member per month (PMPM) basis according to the enrollment on the day these payments are generated.

Conclusion

In summary, Oklahoma is proposing to convert from its current prepaid ambulatory health plan system of managed care to no-risk primary care case management. Financial analyses of the proposed change indicate Oklahoma will operate within current budget neutrality forecasts already submitted by the state and additional funding will not be required.

Oklahoma Health Care Authority: 10 years better

For more than 10 years, Oklahoma has substantially overhauled its programs through a series of reform initiatives; extending coverage to more Oklahoman's who have no health insurance including the state's most vulnerable populations: children, elders and individuals with disabilities.

Connecting qualified people to quality health care

- Children enrolled in SoonerCare – 161,732 in November 1997 to 416,796 in November 2007, a 158 percent increase. The number of uninsured children dropped from 18.9 percent to 12.5 percent in that same period.
- Pregnant women enrolled in SoonerCare – 14,311 in June 1997 to 22,036 in June 2007, a 54 percent increase.
- In 1997, SoonerCare paid for 19,000 births and that number increased to 32,000 in SFY 2007.

Promoting preventive care

- In 2007, 96.8 percent of enrolled children, 15 months of age and under, received one or more regular child health check-ups, an increase from 87.6 percent in 2001.
- In SFY 2008, more than 93 percent of the pregnant women enrolled in SoonerCare received prenatal care.
- The number of children going to the dentist at least once a year has also increased more than 15 percent in the six-year span of 2001 to 2007 (41.6 percent up to 52.7 percent).
- These SoonerCare Choice members are served through a network of about 1,250 primary care providers, including 50 Indian Health or tribally-owned facilities. Almost 10,000 physicians, 500 hospitals and 1,200 pharmacies participate in the SoonerCare network.

Staying efficient

- In state fiscal year 2007, the ER utilization project resulted in 19,260 fewer visits and saved an estimated $5.8 million.
- Using our technical infrastructure, babies can be enrolled in SoonerCare and establish a medical home before they leave the hospital.
- Next year, anyone with Internet access will be able to apply for any SoonerCare program with real-time determination of qualification and enrollment. This will not be available to individuals seeking long-term care services in this initial phase.

10/08

Appendix S

QUALIFICATIONS

To qualify, a business should:

1. Have 50 or fewer full-time employees.
2. Be located in Oklahoma.
3. Offer a qualified health plan.
4. Complete an application packet.
5. Contribute at least 25 percent of premiums for qualified employees.

Oklahoma Employee and Spouse Qualifications

To qualify, an employee should:

1. Be between the ages of 19 and 64.
2. Be an Oklahoma resident and meet citizenship guidelines.
3. Have a gross annual household income at or below the annual household guidelines.
4. Complete an application to enroll in an employer-sponsored qualified health plan.
5. Contribute up to 15 percent of monthly premium cost for self, and up to 15 percent of premium cost for eligible spouse (not to exceed 3 percent of gross annual household income).

This publication was printed and issued by the Oklahoma Health Care Authority as authorized by 65 O.S. 1991, sec. 3-110, and was funded by tobacco tax revenues deposited into the Health Employee and Economy Improvement Act Revolving fund at a cost of $616.50 for 7,500 copies. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

oklahoma health care authority
4545 N. Lincoln Boulevard, Suite 124
Oklahoma City, Oklahoma 73105

Insure Oklahoma At-A-Glance

What is INSURE OKLAHOMA?
INSURE OKLAHOMA is a health coverage subsidy to help small business owners (with 50 or fewer full-time employees) provide health insurance to their lower to moderate income employees and employees' spouses.

How much of the monthly premium does the program pay?
INSURE OKLAHOMA pays 60 percent or MORE of the employee's premium cost and 85 percent or MORE of the premium cost for the employee's spouse.

Where does the money come from?
The program is funded by Oklahoma's tobacco tax along with matching federal money.

Are children covered under the program?
For purposes of calculating gross household income, children are counted toward family size. However, children are not eligible under INSURE OKLAHOMA. They may be covered by SoonerCare. Information is available from the Oklahoma Health Care Authority (OHCA), at okhca.org or 1-800-987-7767.

I am a small business owner AND I am the only employee, can I qualify?
Yes, if your company can get group insurance and you meet the qualification guidelines. Contact INSURE OKLAHOMA for specific questions at 1-888-365-3742.

What if my employees are family members?
All employees may qualify, regardless of relationship to the business owner.

How long do I have to wait for coverage?
Coverage begins the first day of the month following the date of approval.

What if my small business already has a health coverage plan?
Contact your insurance agent who can help you determine if your health coverage plan is qualified by INSURE OKLAHOMA. You can also check by going to insureoklahoma.org. If your insurance coverage plan is not already qualified, ask your agent to contact INSURE OKLAHOMA to see if it CAN be qualified.

SUBSIDIZING HEALTH COVERAGE

insure oklahoma!

SAVE 60% or MORE on health coverage premiums!

Small business owners! You can provide quality health insurance coverage for your qualifying employees with the support of **INSURE OKLAHOMA.**

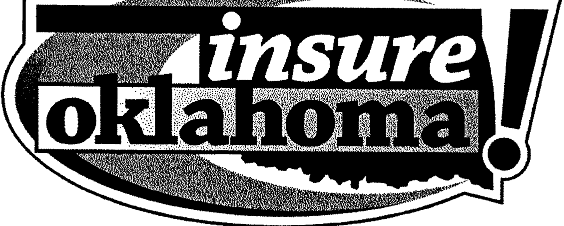
Take advantage of this subsidy, designed to give you and your employees peace of mind.

To find out more, contact your local insurance agent. If you need more information or you don't have an agent, call **1-888-365-3742** or visit **insureoklahoma.org**

INSURE OKLAHOMA is enhancing the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) subsidy.

APRIL 2008

SUBSIDIZING HEALTH COVERAGE



APRIL 2008
Expanded Annual Income Guidelines

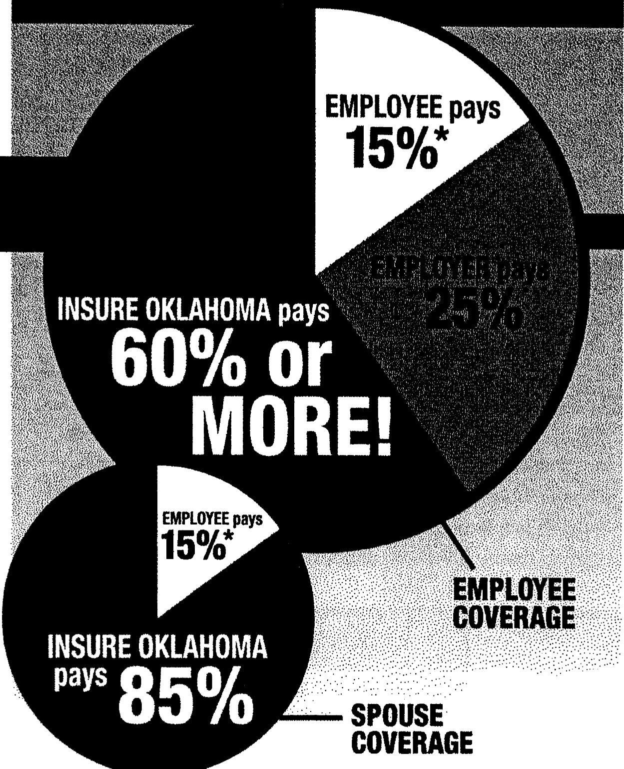
Family Size*	Single Income (gross)	Dual Income (gross)
1	$23,680	- -
2	$30,880	$33,760
3	$38,080	$40,960
4	$45,280	$48,160
5	$52,480	$55,360
6	$59,680	$62,560
7	$66,880	$69,760
8	$74,080	$76,960
9	$81,280	$84,160

* For purposes of calculating gross household income, children are counted toward family size. However, children are not eligible under INSURE OKLAHOMA. They may be covered by SoonerCare.

To qualify, the applicant must have gross household income at or below the Annual Income Guidelines noted above. Gross income is defined as income before taxes or any other deductions.

Self-employed individuals have different guidelines. If you are self-employed, please contact 1-888-365-3742.

How much health coverage cost does INSURE OKLAHOMA subsidize?



EXAMPLE BENEFIT

INSURE OKLAHOMA will calculate the following:

	Individual	Spouse	Total
Total Premium (monthly)	$275	$280	$555
PAYER:			
Employee*	$41.25 (15%)	$42.00 (15%)	$83.25 (15%)
Employer	$68.75 (25%)	0 (0%)	$68.75 (12%)
Insure Oklahoma	$165 (60%)	$238 (85%)	$403 (73%)

* Actual payment based on income, and could be less than 15 percent. The employee share cannot exceed 3 percent of the employee's family income; the INSURE OKLAHOMA subsidy pays the remaining balance of the total premium cost.

How INSURE OKLAHOMA works:

- Check eligibility requirements for employer and employees.
- Contact your insurance agent or find a qualified agent at insureoklahoma.org.
- Complete a program business application.
- Upon approval, employer will receive application information for employees.
- Employees fill out a simple application which must be approved.
- Employer sends full payment to the insurance company.
- Employer sends a monthly health plan invoice to INSURE OKLAHOMA.
- INSURE OKLAHOMA pays the premium subsidy to the employer monthly.

CONTACT INFORMATION

For all applications and a listing of qualified health plans, please contact your local health insurance agent. For more information or if you don't have a health insurance agent, please call

1-888-365-3742 or visit
insureoklahoma.org

SERVICES NOT COVERED

While most health care services are covered, there are some services that will not be paid for by the plan. Those that are excluded:

- Allergy testing and treatment
- Dental services
- Emergency and non-emergency transportation
- Nursing home care
- Physical, speech or occupational therapy
- Transplants
- Hospice
- Hearing or vision testing and treatment

Some benefits covered by Insure Oklahoma/ O-EPIC Individual Plan may have limits. There is an annual maximum benefit of $15,000 for durable medical equipment and an overall lifetime benefit of $1 million for total plan services. Office visits and prescriptions also have monthly limits (see member handbook).

NOTE: This is not a complete listing. Please refer to the member handbook or call 1-888-365-3742 with questions.

DEPENDENTS

Coverage is available for spouses of working and temporarily unemployed adults. Spouses of members with disabilities must apply for membership separately due to income guidelines.

Children do not qualify for enrollment in the Insure Oklahoma Individual Plan, but may be covered under SoonerCare. Please visit okhca.org/client/client.asp or contact your local county OKDHS office to find out.

HOW TO ENROLL

Call
1-888-365-3742
to have the forms mailed to you

Applications are also available online at
insureoklahoma.org

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SUBSIDIZING HEALTH CARE

(OKLAHOMA EMPLOYER/EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE, O-EPIC)

Individual Plan

Gain access to affordable health coverage with the support of

INSURE OKLAHOMA.

Take advantage of this subsidy, partially funded by the Oklahoma tobacco tax.

oklahoma health care authority
4545 N. Lincoln Boulevard, Suite 124
Oklahoma City, Oklahoma 73105

APRIL 2008

SUBSIDIZING HEALTH COVERAGE

INDIVIDUAL PLAN

The Insure Oklahoma (Oklahoma Employer/Employee Partnership for Insurance Coverage, O-EPIC) Individual Plan is available to those persons who meet the definition in one of the following groups:

QUALIFYING GROUP ONE

Working adults who do not qualify for an Insure Oklahoma/O-EPIC employer-sponsored Qualified Health Plan, and work for an Oklahoma business with 50 or fewer full-time employees (self employed).

QUALIFYING GROUP TWO

Temporarily unemployed adults who qualify to receive unemployment benefits through the Oklahoma Employment Security Commission (OESC).

QUALIFYING GROUP THREE

Working adults with a disability who work for any size employer and have a ticket to work.

QUALIFICATIONS

An Oklahoman wishing to apply for the Insure Oklahoma/O-EPIC Individual Plan must:

- Be in one of the three qualifying groups (see details at left)
- Be an Oklahoma resident
- Be between the ages of 19 and 64
- Not be currently enrolled in Medicaid or Medicare
- Provide proof of U.S. Citizenship (or qualified alien)
- Provide Social Security numbers for all household members
- Have an annual GROSS household income within the qualifying guidelines listed below

APRIL 2008
Expanded Annual Income Guidelines

Family Size*	Single Income (gross)	Dual Income (gross)
1	$23,680	- -
2	$30,880	$33,760
3	$38,080	$40,960
4	$45,280	$48,160
5	$52,480	$55,360
6	$59,680	$62,560
7	$66,880	$69,760
8	$74,080	$76,960
9	$81,280	$84,160

Fill out an application online or call to see if you qualify!

PREMIUMS

The monthly premium will not exceed four percent of the monthly gross household income.

COVERED SERVICES AND CO-PAYMENTS

Below are some of the covered services with co-payment amounts:

	CO-PAY
Office Visit:	$10
Pharmacy Generic:	$5
Pharmacy Brand:	$10
Emergency Visit: (waived if admitted)	$30
Hospital Inpatient Stay:	$50
Hospital Outpatient Services:	$25

All services must be medically necessary and referred by their Primary Care Provider (PCP). Some services require an additional prior authorization.

It is the individual's responsibility to make the co-payment at the time of service.

Please see the member handbook for complete information.

CONTACT INFORMATION

For more information, please call
1-888-365-3742
TDD: 1-405-416-6848
or visit insureoklahoma.org

Appendix T

Presentation to the Oklahoma House of Representatives Health Care Reform Task Force on State Premium Assistance Programs

Anne Winter, Burns & Associates, Inc.

October 14, 2008

BURNS & ASSOCIATES, INC.
Health Policy Consultants

State Premium Assistance Programs—

- Overview of types of state premium assistance programs
- Rationale for choosing states for today's discussion
- Funding mechanisms and enrollment
- Program Design Features
- Take Aways

State Premium Assistance Programs—General Types

- Health Insurance Premium Payment (HIPP)
  - Title XIX
- SCHIP/1115 (HIFA) Waiver Programs—HIPP like
  - Title XXI
- Targeted Premium Assistance Programs
  - Title XIX
  - Title XXI
  - State Funding Only

State Premium Assistance Programs--HIPP

- Authorized by OBRA 1990
- Implemented in early 1990's
- States may pay for premiums, deductibles and copayments of Medicaid eligible parents and children if found to be more cost effective than providing through the Medicaid program
- Few states implemented due to administrative challenges

State Premium Assistance Programs—HIFA Waivers

- Authorized by Health Insurance Flexibility and Accountability Act of 2000 (HIFA)
- States may pay for premiums, deductibles and copayments of Medicaid eligible parents and children if found to be more cost effective that providing the same services through the SCHIP program
- Uses unspent SCHIP dollars
- More flexibility on benefit design especially since the Deficit Reduction Act 2005 was passed

State Premium Assistance Programs—HIFA Waivers

- CMS flexibility has allowed states to target certain populations for premium assistance while maintaining certain restrictions
- Low income employees in small businesses are often targeted because of traditional low rates of insurance for this population as compared to similar employees in larger businesses
- States can use TXIX DSH funds and room under their budget neutrality cap
- TXIX funds no longer available

State Premium Assistance Programs—Rationale for state programs to be discussed today

- Relevancy to Insure Oklahoma
- Did not include HIPP programs and HIPP-like programs
- Chose programs that targeted small businesses, leveraged the private sector or focused on individuals (such as IP Insure Oklahoma program)
- State has role in financing a part of the insurance premium either directly or indirectly
- Included both state-only funded programs and federal/state funded programs (no county/local three share programs)

State Premium Assistance Programs Reviewed

- Arkansas — ARHealthNet
- Idaho — Access to Health Insurance (AHI)
- Indiana — Healthy Indiana Plan (HIP)
- Maine — DirigoChoice
- Montana — Insure Montana
- New Mexico — State Coverage Insurance (SCI)
- New York — Healthy NY
- Oklahoma — Insure Oklahoma
- Oregon — Family Health Insurance Assistance Program (FHIAP)
- Pennsylvania — adultBasic
- Utah — Utah's Premium Partnership (UPP)
- Vermont — Catamount Health Plan and ESI

State Premium Assistance Programs—Funding

State	State Funding Source	Federal Funds Available
Arkansas	Tobacco Settlement Funds	√
Idaho	Premium Tax on Insurers	√
Indiana	Tobacco Tax	√
Maine	Tobacco, Alcohol, Soft Drink Tax	
Montana	Tobacco Tax	
New Mexico	General Fund	√
New York	Tobacco Tax	
Oklahoma	Tobacco Tax	√
Oregon	General Fund and Insurer Assessment	√
Pennsylvania	Tobacco Settlement Funds	
Utah	Tobacco Tax	√
Vermont	General fund	√

State Premium Assistance Programs—Current Enrollment

State	Implementation	Current Enrollment (Est.)	Capped ?
Arkansas	July 2007	5,000	
Idaho	July 2005	389	
Indiana	Jan 2008	23,800	
Maine	Jan 2005	12,500	√
Montana	Jan 2006	3,900 purchasing pool 4,500 tax credit	√
New Mexico	July 2005	23,161	
New York	Jan 2001	150,000	
Oklahoma	Jan 2005	10,401 ESI 4,467 Individual	
Oregon	Jan 2002	5,017 Group 10,783 Individual	√
Pennsylvania	2002	48,679	√
Utah	July 2007	527	
Vermont	Oct 2007	409 ESI 5,276 Individual	

BURNS & ASSOCIATES, INC.
Health Policy Consultants

State Premium Assistance Programs—Program Design

- Individual Eligibility
- Employer Eligibility
- Premium Assistance
- Benefit Design and Cost Sharing
- Delivery System and Crowd Out provisions

State Premium Assistance Programs—Individual Eligibility

State	Income/Federal Poverty Level	Spouse Covered	Children Covered
Arkansas	< 200%	Yes	No
Idaho	<185%	Yes	Yes
Indiana	<200%	Yes	No
Maine	<300%	Yes	Yes
Montana	< $75,000 annual income	Yes	Yes
New Mexico	<200%	No	No
New York	<250%	Yes	Yes
Oklahoma	<200%	Yes	No
Oregon	<185%	Yes	Yes
Pennsylvania	<200%	Yes	Yes
Utah	<150%	Yes	Yes
Vermont	<300%	Yes	No

State Premium Assistance Programs—Employer Eligibility

State	Number of Employees	Employer Premium Contribution
Arkansas	2-500	9.5%-13.5%
Idaho	2-50	50%
Indiana	N/A	N/A
Maine	<50	60%
Montana	2-9	25%
New Mexico	50 or fewer	$75/month
New York	<50	50%
Oklahoma	50 or fewer	25%
Oregon	Unlimited	Commercial Requirement
Pennsylvania	N/A	N/A
Utah	>2	50%
Vermont	Unlimited	Commercial Requirement

State Premium Assistance Programs—Premium Assistance

State	Sliding Scale Premium	Flat Voucher
Arkansas	√	
Idaho		√
Indiana	√	
Maine	√	
Montana	√	
New Mexico		√
New York	N/A	N/A
Oklahoma	√	
Oregon	√	
Pennsylvania	√ (fixed)	
Utah		√
Vermont	√	√

State Premium Assistance Programs—Benefit Design

State	Slimmed Down Benefit	High Deductible Plans (>$1,000)	Deductibles	Copayments
Arkansas	√		√	√
Idaho		√	√	√
Indiana	√			√ (ER only)
Maine		√	√	√
Montana		√	√	√
New Mexico	√			√
New York	√		√	√
Oklahoma		√	√	√
Oregon	√		√	√
Pennsylvania	√			√
Utah	√		√	√
Vermont			√	√

State Premium Assistance Programs—Delivery System

State	Delivery System	Number of Plans
Arkansas	State issued RFP	1
Idaho	Qualified Commercial Plans	All
Indiana	State issued RFP	3
Maine	State issued RFP	1
Montana	State issued RFP	1
New Mexico	Medicaid MCOs	3
New York	Requirement of HMOs in state	17
Oklahoma	Qualified Commercial Plans (ESI) Medicaid Network (IP)	21
Oregon	Qualified Commercial Plans	9
Pennsylvania	State issued RFP	5
Utah	Qualified Commercial Plans	All
Vermont	Qualified Commercial Plans (ESI) RFP (Catamount)	All 2

State Premium Assistance Programs—Crowd Out Provisions

State	Employer Bare	Employee Bare	Notes
Arkansas	12 Months	None	
Idaho	No time limit	None	No access to individual insurance
Indiana	N/A	6 months	Cannot be eligible for ESI
Maine	12 months	None	
Montana	24 months	None	No bare period for tax credit
New Mexico	12 months	6 months	
New York	12 months	None	Requirement waived for individuals with qualifying circumstances
Oklahoma	None	None	
Oregon	None	6 months	
Pennsylvania	N/A	90 days	
Utah	None	90 days	
Vermont	None	Uninsured	Must be uninsured no limits

State Premium Assistance Programs—Take Aways

- Financing mechanism can influence target population (e.g. federal limits on FPL levels for adults)
- Target population can influence delivery system (e.g. employer-sponsored vs. individual coverage)
- Great flexibility in state designs, particularly related to level of personal responsibility
- Most programs are so new that there is no preferred model yet
- Each program studied has pluses and minuses

Appendix U

Health Care Reform Advisory Panel Recommendations
Marianne Ingels Bacharach, MD

1. As we work to make comprehensive health insurance available to everyone who chooses to purchase it, we should also give consideration to mandating that all our citizens do their fair share by instituting an individual mandate for catastrophic care coverage with provisions for guaranteed issue and renewal, modified community rating, and tiered premiums based on income.

   By limiting the mandate to catastrophic care coverage, the cost of premiums would be lower than for comprehensive insurance. It would address the "free rider" problem in the current system. Even young and healthy people should have this basic coverage as a matter of personal and social responsibility.

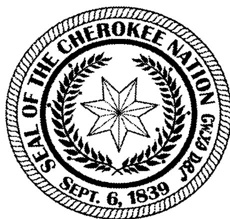
2. The state should find creative ways to support primary care providers. Consideration should be given to using economies of scale, for instance, by having the state serve as vaccine purchaser for pooled providers. Primary care physicians currently struggle with having to purchase their own vaccine supplies while at the same time many insurance companies no longer cover the cost of immunizations.

3. We must address the underlying health and wellness of our citizens. Among other ideas to consider would be increasing the physical education requirement in schools and using our prison industries to make fitness equipment (climbing walls, etc.) for schools and communities.

4. We should institute private market insurance protections in both the group market and in individual plans, as put forward by Kathleen Stoll of Families USA.

5. We should address the incentives built into our current system that favor specialty care over primary care, and should include an examination of the role of specialty "boutique" hospitals. Provider taxes could be used to help level the playing field.

6. Malpractice laws should be reformed in order to decrease the expense of defensive medicine and address the comparative disincentives for physician practice in Oklahoma relative to other states. Reforms should include adequate patient protections as well as incentives for openly addressing medical errors and working to improve patient care.



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CHEROKEE NATION©

P.O. Box 948 • Tahlequah, OK 74465-0948 • (918) 453-5000

[illegible]
Chad "Corntassel" Smith
Principal Chief

[illegible]
Joe Grayson, Jr.
Deputy Principal Chief

Cherokee Nation

Recommendations for

Oklahoma House of Representatives
Health Care Reform Task Force

September 29, 2008

The Cherokee Nation is extremely appreciative to have the opportunity to participate on the Oklahoma House of Representatives Health Care Reform Task Force. The Cherokee Nation is dedicated to addressing the health and well-being of its citizens and employees and looks forward to continued collaboration and dialogue with the State to address the high number of Oklahomans without health insurance. As the Oklahoma House of Representatives considers legislative proposals to reform health care, the Cherokee Nation would like to offer the following:

Recognizing the positive financial impact of the Indian health system in Oklahoma – As of October 1, 2008, Cherokee Nation Health Services will employ over 1,500 employees and maintain an annual budget in excess of $190 million. The budget consists of funding for direct healthcare services, utilization of non-Tribal health providers through contract health services, staffing, facility construction/maintenance, emergency medical services, etc.

For the entire state of Oklahoma, initial estimates indicate an annual financial contribution in excess of $450 million annually for Indian health. In addition to funding related to health care, the majority of full-time Tribal employees are provided health insurance coverage as part of their benefits package. Therefore, when considering reform efforts, it is vital that the State of Oklahoma recognize the financial contributions of Tribes in terms of direct funding for health care and as employers providing health insurance coverage to thousands of Oklahomans residing in rural areas.

Tribal health coverage premium assistance, financial contributions, etc. – Over the past several months, much discussion has taken place on the possibility of Tribes financially assisting Tribal citizens by providing premium assistance, supporting participation in the "Insure Oklahoma" program, etc. While some Tribes may be able to participate, many others may not due to several factors including: the geographic location of Tribal citizens (a significant number of citizens of Oklahoma Tribes reside outside of their respective Tribal jurisdictions, including out of state); the lack of availability of

recurring funds for such activities; the number of Tribal citizens may make such an activity cost prohibitive, etc.

For instance, the Cherokee Nation has the second largest Tribal population in the United States and therefore purchasing health coverage for Cherokee citizens is cost prohibitive. However, the Cherokee Nation is exploring ways to increase health coverage for its citizens and is currently working with health insurance providers to determine if providing access to coverage for certain defined major medical services is economically feasible.

The Cherokee Nation recommends that any legislative proposals include opportunities to explore collaboration between Tribes, health insurance companies, employers, the Oklahoma Insurance Department, Oklahoma Health Care Authority, Oklahoma State Department of Health, or any other applicable state entity, to increase coverage in the American Indian/Alaska Native (AI/AN) population. Such opportunities should be pursued with the understanding that each Tribe is unique and any collaborations must be approached in a manner that recognizes the Tribe's particular circumstances.

Mandating Participation – While health coverage reform efforts in other states have included mandatory participation, based on the numerous meetings convened in Oklahoma concerning increasing health coverage, mandating participation in Oklahoma would have little support. However, should a proposal move forward with a mandatory participation provision, the Cherokee Nation asks that the American Indian/Alaska Native (AI/AN) population not be allowed to "opt-out" of the health insurance program solely based on an individual's status as a Tribal citizen. The rationale for the Cherokee Nation's position is that while the Indian health system should meet all of the health needs of American Indians/Alaska Natives, the reality is that it does not. The lack of adequate funding, sparsely located facilities, and limited services have created a situation where American Indians/Alaska Natives view the Indian health system as a substandard alternative to other health care providers. For this reason, the U.S. Census Bureau's Current Population Survey (CPS) has determined that individuals who report Indian Health Services (IHS) and no other coverage are classified as uninsured.

Protecting 100% Federal Matching Assistance Percentage (FMAP) – During Medicaid reform efforts, the Oklahoma legislature ensured the provisions of the Oklahoma Medicaid Reform Act of 2006 did not have a negative impact on the ability of AI/AN Medicaid beneficiaries to access health services within the Indian health system. Language was also included to preserve the reimbursement structure currently in practice between the OHCA and Indian health facilities. Finally, language was included to provide the ability for tribally operated health facilities to provide care to non AI/AN Medicaid beneficiaries and seek reimbursement for such services.

The primary reasons for the language was to preserve two very important aspects of Medicaid reimbursements to the Indian health system: 1) 100% FMAP reimbursement for health services provided to American Indian Medicaid enrollees in Indian health facilities; and 2) The "All-inclusive" rate for such services.

Tobacco taxes as a funding mechanism – In order to fund efforts to address the high number of uninsured Oklahomans, an increase to the State tobacco tax has been discussed as an alternative. Unfortunately, Tribes often receive unfair criticism due to the negotiated terms of tobacco compacts between the State of Oklahoma and Tribes. Any discussions regarding healthcare reform, state taxation, and the interplay of Tribal jurisdictions should be prefaced with the overall positive impact of the Indian health system in Oklahoma, as well as the programs/services funded by Tribes through Tribal taxes.

For example, a partnership between the Cherokee Nation and the University of Oklahoma has been established that is funded through Cherokee Nation tax revenue. The Cherokee Nation provides significant funding to the University of Oklahoma, Tulsa (OU-Tulsa) to address the prevention, treatment, and research of diabetes and cancer in both the Tribal and non-Tribal population.

Supporting collaboration – In order to achieve a healthier population, the Cherokee Nation has placed an emphasis on collaboration with Oklahoma state agencies, local governments, and the private sector. However, governmental rules/regulations often impede collaboration. Building partnerships and removing unnecessary impediments should be addressed as part of this and other health reform efforts.

Additionally, an emphasis should be placed on bringing together Tribes and non-Tribal entities to plot a course for the future of healthcare delivery in Oklahoma. The Cherokee Nation is currently undertaking an effort to work with health care industry leaders in northeastern Oklahoma in a strategic planning effort to develop a comprehensive, long-term industry growth plan to meet the current and future needs within the Cherokee Nation's fourteen county area. The first stage of this process includes: a Healthcare Services Assessment; an Employer Base Assessment; the development of a Regional Healthcare Service Collaboration and Development Plan; and other activities. The Cherokee Nation has conducted several research projects, interviews, and meetings towards this effort and will complete the first stage of the process by September 30, 2008. Similar efforts should take place across Oklahoma.

Collective Advocacy for Equitable Funding for Oklahoma – Tribal governments, the State of Oklahoma, local governments, and the private sector should seek ways to collectively advocate, through the Oklahoma Congressional delegation and federal agencies, to ensure that Oklahoma receives equitable funding in the distribution of federal funds among the states. Examples include Indian Health Service funding, transportation funding, etc.

Additional pertinent Information:

- The per capita personal health care expenditures for the Indian Health Service (IHS) user population are significantly less than the general population. In 2003, the federal government expended only $1,914 per capita for the IHS user population, compared to general population expenditures in the amount of $5,085.

- According to the Indian Health Service, per capita spending for the IHS user population is approximately one-half of the per capita spending for Medicaid beneficiaries ($3,879); one-third the per capita spending for Veterans Administration (VA) beneficiaries ($5,214); and approximately one-half of the per capita spending for a federal prisoner's health care ($3,803).

- In the federal appropriations process, IHS funding is discretionary, and funding is not required to be adjusted to address population increases and inflation. While the IHS user population increases by approximately 30,000 annually and medical inflation rates over the past ten years have averaged 11%, IHS funding is increased by only 3-4% annually.

- In Oklahoma, the per capita personal health care expenditure for the IHS population is only $976, compared to $1,914 nationwide. The amount received in Oklahoma represents only 44% of the actual need according to the Federal Disparity Index and is the lowest funded area within the Indian Health Service.

- According to the 2000 U.S. Census, 391,949 residents of Oklahoma were identified as American Indian/Alaska Native, which equals 11.4% of the total Oklahoma population and is second only to California in total American Indian/Alaska Native population. California is home to 627,562 American Indians/Alaska Natives, which represents 1.9% of the total California population.

- According to a 2004 Oklahoma Indian Affairs Commission Tribal Survey, combined enrollment for the 37 federally-recognized Tribes within Oklahoma equaled 643,588, of which 302,007 resided in Oklahoma.

- The U.S. Census Bureau's Current Population Survey (CPS) is the most commonly used data source for estimating the rates of health insurance coverage nationally and across states. According to the CPS, individuals who report Indian Health Services (IHS) and no other coverage are classified as uninsured.

- According to the 2004 Oklahoma Health Care Insurance and Access Survey, 27% of Oklahoma's AI/AN population are uninsured. Nationally, over 35% of the AI/AN population are uninsured (Source: Henry J. Kaiser Family Foundation Issue Brief, February 2004).

Oklahoma Hospital Association
Recommendations
to the
Oklahoma Health Care Reform Task Force
September 30, 2008

Improving Insurance and Health Care Access in Oklahoma

After careful review of initiatives from other states to address reducing the number of uninsured, it appears that Oklahoma may be in the forefront of enacting programs and advancing initiatives such as: InsureOklahoma, the state's public-private premium assistance partnership; the State Coverage Initiative, a collaborative effort attempting to design an affordable basic health benefit program; and continuous efforts to address a health improvement plan for Oklahoma, such as SJR 41 requiring the State Board of Health to submit a health improvement plan to the state Legislature.

The Oklahoma Hospital Association (OHA) believes initial positive building blocks are in place for the reform necessary to reduce the number of uninsured while working to improve access to quality health care. As described below, in order for successful initiatives and reform to occur, OHA recommends the following:

InsureOklahoma

Maximum efforts should be made by elected and appointed officials, provider groups, patient advocacy groups and business leaders to urge Oklahoma's congressional delegation to assist in efforts to seek CMS approval of the waivers necessary to implement state legislative authorizations for coverage initiatives, such as:

- Expanded participation by employers with employees up to 250 at 250% of the federal poverty level (HB 1225 – 2007); and
- All Kids Act (SB 424 – 2007).

Funding

Should CMS approval be obtained, Oklahoma must identify and implement a sustainable funding source for the state's share in order to receive the federal Medicaid match. Oklahoma should carefully examine additional options for public/private partnerships to successfully fund InsureOklahoma or similar coverage programs.

- According to the Oklahoma Health Care Authority, an additional $423 million is the estimated state's share should all current waivers be approved for InsureOklahoma, and participation in the program attains capacity.

- Provider fee – When OHA initiated a provider fee proposal in 2005, it was designed to raise approximately $90 million in state funds by assessing hospitals less than 1% of gross patient revenue to fund the gap in the Medicaid program for covering the costs of care provided by hospitals and physicians. The provider fees generated in the 2005 proposal would not be sufficient to cover the projected needs from the approved expansion of InsureOklahoma. It would be necessary to initiate discussions with other provider groups to seek support for a provider fee sufficient to expand the required revenue pool.

- Additionally, Oklahoma should explore other funding sources to address the state's growing health care needs, including maximizing available federal funds where possible.

Health Care Workforce

Right now there are inadequate numbers of required nursing and allied personnel employed by Oklahoma's health care providers. Oklahoma hospitals give significant financial support to enhance current educational efforts to address the critical shortage in the health care workforce. Currently, only 57% of qualified applicants in Oklahoma are admitted into nursing and other high demand allied health programs because these programs lack the capacity to meet Oklahoma's needs. As the private sector does its part, we also need financial assistance from the state to help address this critical shortage area. The following initiatives should be addressed by the state:

- Creating additional nursing or allied health faculty by providing scholarships to cover individuals' costs of gaining the advanced degrees necessary to serve as faculty members in such programs;

- Expanding and modernizing learning environments by providing matching grants to nursing and allied health education institutions to increase the number of clinical opportunities, and to better utilize online and distance learning, simulations, and other innovative methods to provide education and training; and

- Attracting more students in nursing and allied health careers by providing scholarships to cover individuals' costs of gaining degrees or certifications necessary to prepare them for nursing and allied health occupations.

The request is estimated to cost $18 million appropriated over three years. The projected FY 2010 cost is $7.8 million, with an addition of approximately $5.1 million in both FY 2011 and FY 2012.

Achieving Participation

Should CMS approval be granted and funding is secured, the state and the private sector should develop a strategy to remove barriers for obtaining insurance coverage by employers and employees.

- Increasing enrollment:
    1. Hospitals and other health care providers should explore the enrollment procedures of "The Healthy Indiana Plan" which enrolls uninsured patients at the point of service.
    2. The state should consider initiatives with health plans to fast track approval for coverage.

- Increasing participation by employers and individuals:
    1. Aggressive marketing and perhaps incentives for participation should be implemented, as well as maximum cooperation by all state and local entities to assist in identification, education and enrollment efforts before considering mandatory compliance.
    2. The OHA is sensitive to the issue of compelling participation. However, it is an important public policy that warrants discussion.

Additional Issues for Consideration in 2009

- **State Coverage Initiative** – OHA supports the State Coverage Initiative's efforts to develop a basic health benefit plan as well as all efforts to address the growing problem created by a lack of access to health coverage. We urge the continued cooperation of elected and appointed officials as well as provider and patient advocacy groups to work collaboratively. Elected officials should consider recommendations from the State Coverage Initiative to set minimum standards for "health insurance" in statute.

- **The State of State's Health and SJR 41, Oklahoma Health Improvement Plan** – OHA supports the development of a specific plan to improve the health of Oklahomans and pledges its support to achieve this goal.

- **Tulsa market** – The state must address the access-to-care concerns in Tulsa likely to be created by the future geographic shift of the OSU Medical School's residency program that has historically helped to support care of the uninsured in north Tulsa.

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Rep. Kris Steele
Co-Chair, Oklahoma Health Care Reform Task Force
Oklahoma State Capitol
by e-mail to youngli@okhouse.gov

September 29, 2008

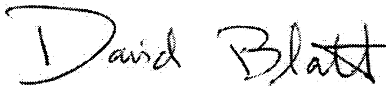
Dear Rep. Steele:

Along with this letter, please find a set of six recommendations for consideration by the Oklahoma Health Care Reform Task Force. Oklahoma Policy Institute believes that these recommendations will help the Task Force achieve its goal of developing proposals to expand quality, affordable and accessible health care coverage in Oklahoma.

I look forward to the opportunity to present these recommendations in person at the October 28th meeting of the Task Force. In the meantime, if you have any questions or wish to discuss these matters, do not hesitate to contact me.

Once again, thank you for your leadership on these issues and for extending the opportunity to serve as a member of the advisory committee and provide input into the Task Force's ultimate proposals.

Yours Sincerely,



David Blatt
Director of Policy
dblatt@okpolicy.org
(918) 382-3228 (w); (918) 859-8747

Better Information, Better Policy

Recommendations to the Oklahoma Health Care Task Force
Submitted by David Blatt, Advisory committee member
Director of Policy, Oklahoma Policy Institute
Submitted September 29, 2008

Recommendation #1

- In pursuing options for expanding access to quality, affordable health insurance coverage, Oklahoma should build upon the foundations of our current health care system and upon programs and policies adopted in recent years.

Recommendation #2

- The Legislature should expand Medicaid eligibility for categorically-eligible adults (parents of dependent children) up to 100% of the federal poverty level. Adults above the poverty level to 250% of poverty would be eligible for coverage through Insure Oklahoma.

Recommendation #3

- The Oklahoma Health Care Authority should monitor and study the impact of cost-sharing requirements on participants in the Insure Oklahoma program. In particular, OHCA should study total out-of-pocket health care expenses among participants (including uncovered benefits), and monitor the number and situation of participants reaching the $900 cap in reimbursable expenses above 5% of family income to help determine if modifications should be made to coverage and cost-sharing provisions in the program.

Recommendation #4

- Oklahoma should balance the goal of expanding coverage with the goal of promoting insurance that covers a full range of medically necessary services.

Recommendation #5

- The Legislature should act to strengthen and improve the high-risk pool as a source of affordable, quality coverage for Oklahomans who cannot buy an affordable policy that meets their health care needs in the current non-group (individual) private market.

Recommendation #6

- The Insurance Commissioner should undertake a study of reasonable consumer protections in the individual and small group market to identify options for making private coverage more accessible and more affordable for Oklahoma consumers. This study should explore issues including the possibility of guaranteed issue in the individual market, rate review mechanisms, medical loss ratio standards, limits to how pre-existing conditions are defined and what kinds of elimination riders, exclusions, and denials are allowed, and limits on revocation of policies.

FACTSHEET

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Oklahoma Policy Institute

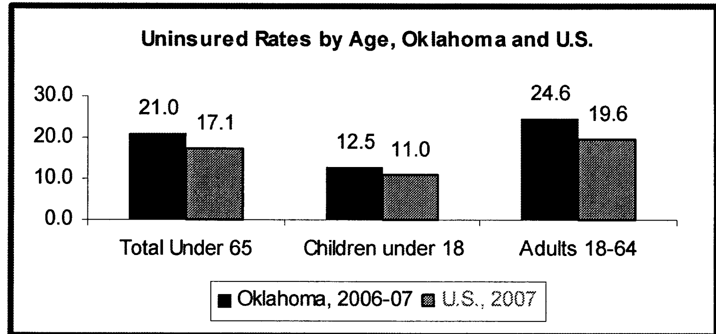
SEPTEMBER 2008

Oklahoma's Uninsured, 1999-2000 to 2006-2007:

Erosion of Private Health Insurance Not Fully Offset by Growth in Public Coverage

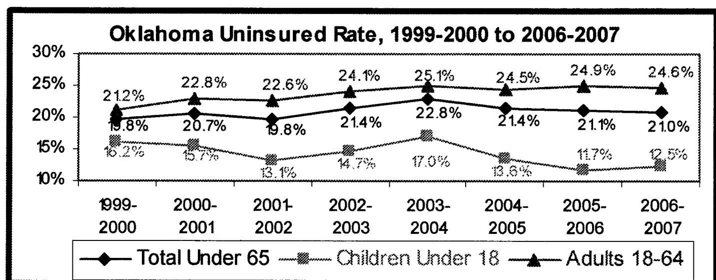
More than One-in-Five Non-Elderly Oklahomans Is Without Health Insurance

- 641,000 Oklahomans under the age of 65 were without health insurance coverage in 2006-07, which is more than one out every five non-elderly Oklahomans (21.0 percent).
- More than four out of five uninsured Oklahomans (81.4 percent) were working-age adults ranging from 18 to 64.
- The uninsured rate for working-age adults (24.6 percent) is almost double the rate for children under 18 (12.5 percent).
- Oklahoma's uninsured rate for those under age 65 is four percentage points higher than the national rate of 17.1 percent.
- Oklahoma's rate of non-insured non-elderly was eighth highest among the 50 states and District of Columbia in 2005-06, behind Texas, New Mexico, Florida, Louisiana, Arkansas, Mississippi and California. (Kaiser Family Foundation, Statehealthfacts.org)



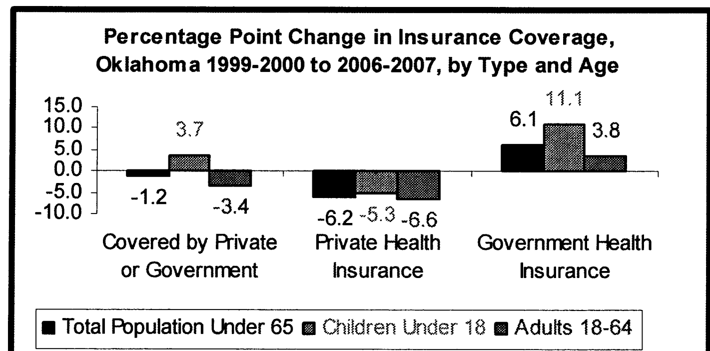
Oklahoma's Uninsured Rate Has Inched Upwards in Recent Years

- Oklahoma's non-elderly uninsured rate has inched upwards in recent years, increasing from 19.8 percent in 1999-2000 to the current 21.0 percent.
- The number of uninsured under age 65 has increased by an additional 74,000, from 567,000 to 641,000.
- While the percentage of Oklahomans without health insurance of any type has fallen for children (-3.7 percentage points), it has risen for working-age adults (+3.4 percentage points).



Private Coverage Down, Public Coverage Up

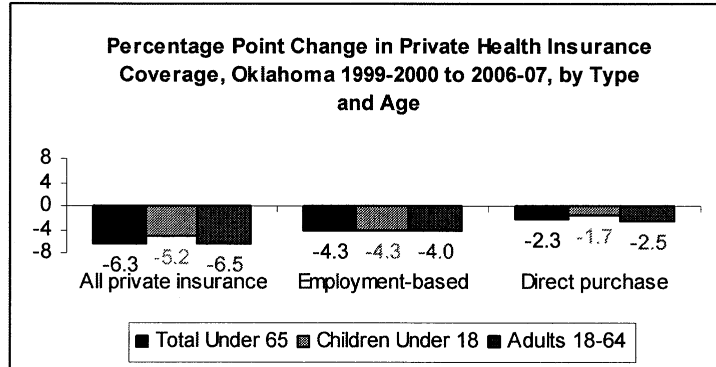
- Since 1999-2000, there has been a steep drop in the percentage of non-elderly Oklahomans covered by private health insurance (-6.2 percentage points).
- This has been largely, but not entirely, offset by an increase in coverage by public health insurance programs (+6.1 percentage points).
- Nationally, the percentage of Americans with all types of private health insurance declined by 5.0 percentage points from 1999 to 2007, while there has been a 2.8 percentage point increase in the share of the population with government health insurance.



NOTES AND SOURCES: Unless otherwise noted, all data is from the U.S. Census Bureau Current Population Survey (CPS) historical health insurance tables at http://www.census.gov/hhes/www/hlthins/historic/index.html . In using state-level data, the Census Bureau recommends using a two-year average to ensure statistical significance. Individuals are considered "uninsured" if they were not covered by any type of health insurance at any time in the calendar year prior to the survey. The Census Bureau counts as uninsured individuals with no coverage other than access to Indian Health Service.

The Erosion of Private Health Insurance Coverage

- Between 1999-2000 and 2006-07, the share of Oklahomans covered by private health insurance fell by 6.3 percentage points, from 68.1 percent in 1999-2000 to 61.8 percent in 2006-2007.
- The erosion of private coverage has affected both employment-based insurance, which declined by 4.3 percentage points, and direct purchase insurance, which declined by 2.3 percentage points.
- Nationally, the percentage of Americans with all types of private health insurance declined by 5.0 percentage points from 1999 to 2007; for employment-based coverage, the decline has been 4.6 percentage points.
- Private coverage has declined every year since 1999-2000, with the exception of a minor uptick between 2003-04 and 2004-05.
- In total, 117,000 fewer Oklahomans had private coverage in 2006-07 than in 1999-2000, even as the state's population increased by some 175,000 people.
- The erosion of private health coverage in Oklahoma has affected working-age adults even more than children.
  - ⇒In 2006-07, 70.9 percent of adults aged 18-64 had private coverage, a 6.5 percentage point drop compared to 1999-2000.
  - ⇒The drop in private coverage among children under 18 was 5.2 percentage points, from 61.1 percent in 1999-2000 to 55.9 percent in 2006-07.
- Currently, a bare majority of Oklahomans (53.3 percent) have health care coverage through their employment.
- Oklahoma's rate of employer-sponsored coverage was tied for seventh lowest in the nation (2005-06, Statehealthfacts.org).



Explaining the Decline in Employer Coverage

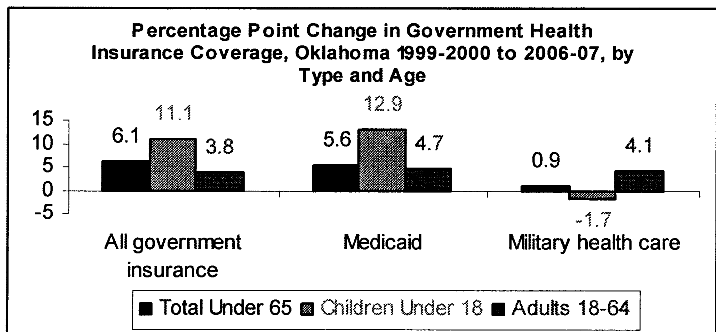
A number of factors have been advanced to account for the decline in employer-sponsored coverage this decade. A 2006 analysis for the Kaiser Commission on Medicaid and the Uninsured pointed to the following national trends:

- The rapid growth in health care costs has led to declines in employers offering health benefits and in employees taking-up coverage;
- A shift towards employment in small firms and to self-employment;
- A decline in employment in industries that have historically provided high rates of coverage (e.g., manufacturing, finance and government) and a substantial increase in industries that have not (e.g., services, construction and agriculture).

Source: John Holahan and Allison Cook, *Why Did the Number of Uninsured Continue to Increase in 2005*?, Kaiser Commission on Medicaid and the Uninsured, October 2006

The Expansion of Public Health Insurance

- In 2006-07, just under one in four (23.0 percent) of all non-elderly Oklahomans were covered by one or more public health programs, an increase of 6.1 percentage points from 1999-2000.
  - ⇒The largest growth was in Medicaid coverage (+5.6 percentage points). Military health care coverage also expanded (+0.9 percentage points).
  - ⇒Just under three percent of the non-elderly population was covered by the Medicare program.
- Nationally, between 1999 and 2007, the United States saw a 2.8 percentage point increase rate in the share of the population with government health insurance.



- The percentage of Oklahomans with government health insurance is 4.9 percentage points higher than the national average, due primarily to much higher rates of military health care coverage.
- Oklahoma ranks 14th among the states for share of non-elderly population covered by all public insurance and 19th in the share covered by Medicaid (2005-06, Statehealthfacts.org).
- The growth in public health insurance coverage in Oklahoma has been much greater among children (+11.1 percentage points) than among adults (+3.8 percentage points).
- The percentage of children covered by Medicaid in Oklahoma grew by 12.9 percentage points, from 20.4 percent in 1999-2000 to 33.3 percent in 2000-07, reflecting the full implementation of Oklahoma's Medicaid eligibility expansion for children of the late 1990's and eroding private coverage.
- Among adults, the Census reports Medicaid coverage in Oklahoma growing by 4.7 percentage points from 1999-2000 to 2006-07.
  - ⇒Although this was considerably smaller growth than for children, it still seems surprisingly high given that Oklahoma did not enact significant Medicaid eligibility changes for adults during this period.

VOLUME 1, ISSUE4
OCTOBER 2008

ISSUE BRIEF

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RECOMMENDATIONS IN BRIEF:

- ⇒Build upon the foundations of programs and policies adopted in recent years;
- ⇒Expand Medicaid eligibility for parents up to the federal poverty level;
- ⇒Monitor the impact of cost-sharing requirements and benefit limits on participants in the Insure Oklahoma program;
- ⇒Balance the goals of expanding coverage and covering a full range of medically necessary services;
- ⇒Strengthen the high-risk insurance pool;
- ⇒Study options for strengthening consumer protections in the individual and small group insurance markets.

EXPANDING ACCESS TO AFFORDABLE HEALTH INSURANCE:
RECOMMENDATIONS TO THE OKLAHOMA HEALTH CARE TASK FORCE

The availability and cost of health insurance rank among the most worrisome issues facing Oklahoma families and among the most pressing challenges confronting Oklahoma policymakers. The most recent U.S. Census Bureau survey revealed that over one out of every five non-elderly Oklahomans (21.0 percent) is without health insurance (Figure 1).[1] Over recent years, there has been a steady erosion of employer-based health insurance coverage in Oklahoma, a decline which has not been fully offset by an expansion of public health insurance for children and some adults.[2] Meanwhile, those with health insurance are facing steeply rising costs. A new study from Families USA finds that between 2000 and 2007, the average family premium paid by an employee with employer-based coverage rose $4,301, or 62 percent, in Oklahoma. During this same period, the median earnings of Oklahoma's workers grew by just $3,919, or 18.8 percent.[3]

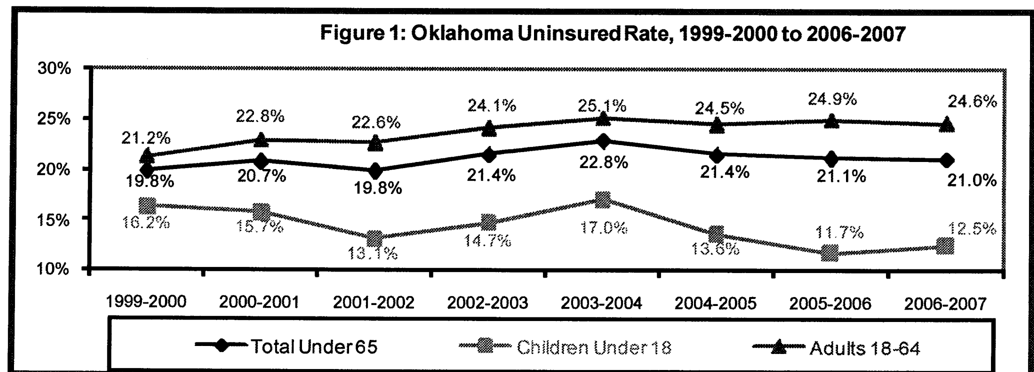
The Oklahoma Health Care Reform Task Force, appointed by House Speaker Chris Benge and co-chaired by Representatives Kris Steele and Doug Cox, provides a promising opportunity to develop policy ideas that can help provide more Oklahomans access to affordable health insurance coverage. Oklahoma Policy Institute, which has participated as a member of the Task Force's advisory committee, believes that the following recommendations should serve as a basis for the Task Force's report and subsequent legislative initiatives.

Recommendation #1

In pursuing options for expanding access to quality, affordable health insurance coverage, Oklahoma should build upon the foundations of our current health care system and upon programs and policies adopted in recent years.

DISCUSSION

In recent years, the Oklahoma Legislature has enacted a series of balanced and incremental



policies aimed at expanding health insurance coverage. These efforts should be continued and strengthened.

One cornerstone of the state's efforts has been the Insure Oklahoma program, which provides a public subsidy for low-income employees and their spouses to purchase employer-sponsored insurance when that is offered, or to buy-in directly to a public product when employer-sponsored coverage is not available.

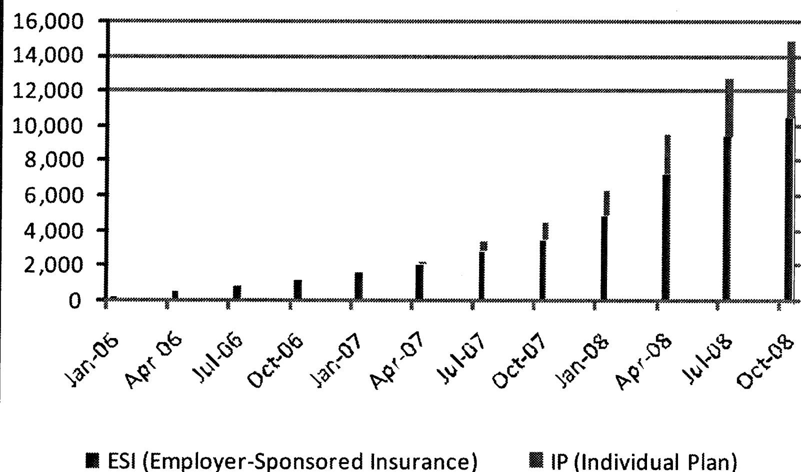
The Insure Oklahoma program is based on several principles that make it a solid foundation for ongoing efforts to expand health insurance coverage in Oklahoma:

- It builds upon and strengthens the existing system of employer-based group coverage, which continues to serve as the primary source of health insurance for Oklahomans. As such, the program represents a strong private-public partnership approach to addressing the problem of the uninsured;
- It targets a population most likely to be without health insurance, namely low-income working adults who are employed by small and medium-sized businesses or who are self-employed or unemployed;
- It provides substantial subsidies to assist with the purchase of insurance, while requiring program participants to share in the cost of care through premiums and co-payments.

To date, some 15,000 individuals are enrolled in Insure Oklahoma – 10,401 through employer-sponsored insurance and 4,467 through the Individual Plan (Figure 2).[4] Enrollment has increased steadily over the past year but still remains well below the target of 40,000 participants for whom earmarked funding is available. The Legislature took positive action in 2007 to strengthen Insure Oklahoma by expanding eligibility in the program for businesses with up to 250 employees, compared to the current 50, and to employees with income up to 250 percent of poverty, compared to 200 percent currently. The Legislature also approved eligibility for children between 185 percent and 300 percent of poverty in Insure Oklahoma. Unfortunately, the state plan amendment needed to implement these changes continues to await federal approval.

A second cornerstone of the state's health care system is the Medicaid program. A total of 606,078 Oklahomans, including 393,742 children, 39,497 working-age adults, and 136,878 aged, blind and disabled, are covered by Medicaid.[5] Research has consistently found the Medicaid program to be a cost-effective form of health insurance and a program that provides substantial economic benefit to the state, due in large part to the availability of federal matching funds.[6] The last major expansion of Medicaid in Oklahoma occurred in 1997, when eligibility for children and pregnant women was raised to 185 percent of the poverty level. Since then, there have been narrow expansions to cover individuals in need of targeted services, such as family planning and breast and cervical cancer.

We believe that policy changes that would involve a fundamental redesign of the state's health care system would be ill-advised, especially given current uncertainty about the direction of health care reform at the federal level that could greatly impact the policy environment facing the states. While there are definitely ways to strengthen the



current system, building off the existing foundations of Insure Oklahoma and Medicaid seems the most promising and sensible way to move forward.

> **Recommendation #2**
>
> The Legislature should expand Medicaid eligibility for categorically-eligible adults (parents of dependent children) up to 100 percent of the federal poverty level. Childless adults and parents between 100 percent and 250 percent of poverty would be eligible for coverage through Insure Oklahoma.

Discussion

Adults living in poverty are one of the largest segments of Oklahoma's uninsured population. The Oklahoma Health Care Authority estimates that there were 166,764 uninsured adults below the poverty level in 2006 ($20,000 for a family of four).[6] This group represents almost one-third (31 percent) of all uninsured adults and one-quarter (25.8 percent) of the entire uninsured population in Oklahoma.[7] According to the Kaiser Family Foundation, 55 percent of poor adults were without health insurance in Oklahoma in 2006-2007, the fifth highest rate in the nation.[8]

Until recently, most adult Oklahomans living in poverty were ineligible for any public health insurance programs unless they were pregnant, elderly or had a disability. Medicaid in Oklahoma covers only parents of dependent children up to 50 percent of the federal poverty level ($711 per month in 2008 for a family of three).[9] Parents of children with income above 50% percent of poverty, as well as childless adults, were ineligible for coverage. Since poverty and poor health are intertwined and mutually reinforcing, it is precisely those low-income working adults, who may have their employment and earnings limited by poor health, who often have the greatest need for health insurance.

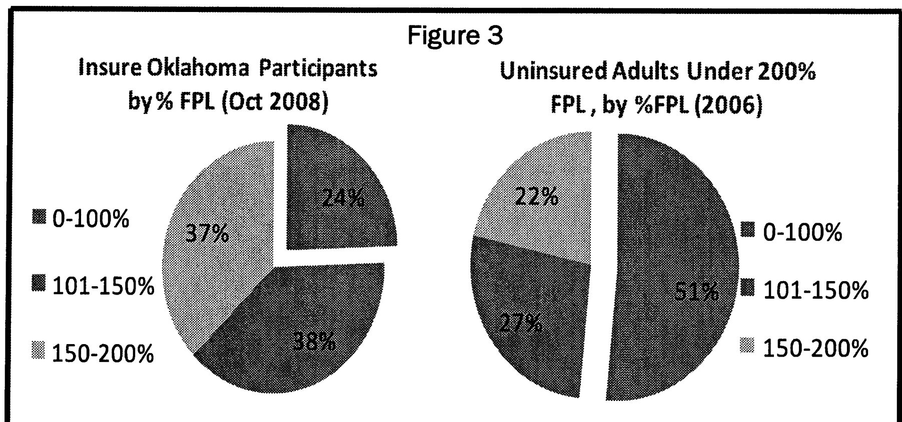
With implementation of Insure Oklahoma, adults below the poverty level became eligible for subsidized coverage either by buying into their employer-sponsored insurance or buying into the state's Individual Plan. However, participation in Insure Oklahoma requires the enrollee to contribute 15 percent of the plan's premium, up to 3 percent of family income (4 percent for Individual Plan) and to assume other cost-sharing obligations up to a maximum of 5 percent of family income.

A substantial literature has shown that for very low-income individuals, even a modest level of cost-sharing can serve as an insurmountable barrier to enrollment in coverage.[10] A family of four earning, say, 75 percent of poverty, is trying to make ends meet off of $1,325 per month. Their monthly premium would be $40 per month for employer-sponsored coverage or $53 per month in the Individual Plan. This amount may simply be unaffordable for a family struggling with the cost of rent, utilities, gas, clothing, car payments, etc. and likely trying to cope with mounting unpaid debts.

The evidence appears to confirm that Insure Oklahoma is failing to serve adults below the poverty level. OHCA data shows that just under one-quarter (24 percent) of participants in Insure Oklahoma have incomes that fall below the poverty level, despite the fact that there are more uninsured adults below 100 percent of the Federal Poverty Level (FPL) than there are between 100 percent and 200 percent FPL (Figure 3). The average income for participants in the program is just over 130 percent of FPL, considerably higher than the average income of the eligible-population.[11]

Affordability is likely a major explanation for the low participa-

Figure 3



tion rate of below-poverty adults in Insure Oklahoma. Affordability may also be contributing to apparently high rates of turn-over, or churning, in the program. According to OHCA data, nearly one-quarter of those who had enrolled in the Individual Program since March 2007 were no longer enrolled as of October 2008.[12] This may be a result of low-income employees being unable to keep up with monthly premiums.

There are several ways Oklahoma could do a better job of extending coverage to the lowest-income adults. For example:

- Expand Medicaid eligibility for parents of dependent children to the federal poverty level. Existing Medicaid law allows states to exercise this option with only a state plan amendment. This approach has been endorsed by OHCA;
- Waive cost-sharing entirely for families below the poverty level in Insure Oklahoma; or
- Implement a sliding-scale cost-sharing schedule for Insure Oklahoma in which contributions from individuals below the poverty level could be limited to, say, 2 percent of family income rather than 5 percent.

Expanding Medicaid eligibility to adults below the poverty level would also ensure that these individuals, who frequently have chronic and complicated health issues, would be eligible for the comprehensive scope of benefits covered by Medicaid.

Recommendation #3

The Oklahoma Health Care Authority should study and monitor the impact of cost-sharing requirements and benefit restrictions on participants in the Insure Oklahoma program. In particular, OHCA should study total out-of-pocket health care expenses among participants (including uncovered benefits), and monitor the number and situation of participants reaching the cap in reimbursable expenses to help determine if modifications should be made to coverage and cost-sharing provisions in the program.

Discussion

Participants in Insure Oklahoma are required to contribute a portion of their health care costs in the form of monthly premiums and co-payments, subject to a cap of 5 percent of a family's gross household income. Under the state's current waiver, out-of-pocket expenses exceeding 5 percent of gross household income are reimbursed by the State up to a maximum of $900 per year. Medical services that are not covered by a participant's employer-sponsored insurance or the Individual Plan, or that exceed benefit caps, do not count towards the 5 percent cap but are rather the patient's full financial responsibility.

The $900 annual cap on reimbursable out-of-pocket medical expenses should be carefully monitored by OHCA. Individuals who have chronic health conditions or who experience a serious illness or injury may easily hit or exceed the $900 reimbursement limit in a given year. This may be especially true for participants in employer-sponsored insurance plans, which may include annual deductibles up to $1,000 and co-insurance obligations, along with co-payments. The reimbursement cap on out-of-pocket expenses could place great financial strains on low-income families that have already contributed 5 percent of their household income towards cost-sharing, leading them either to avoid necessary care or to withdraw from the program. The collection and review of data on the extent to which reimbursement limits are being hit or exceeded would allow for a reasoned debate on whether the limit should be maintained, modified or abolished.

OHCA should also undertake an analysis of participants in the Individual Plan to assess the impact of benefit caps and uncovered services. IP does not cover some important health care services, including physical, speech and occupational therapy, allergy testing and treatment, dental services and emergency transportation. These services can become very expensive for individuals with chronic health issues or emergency needs. Benefit limits in the IP include four physician service visits per month and six prescription drugs per month. Services beyond those limits, even when medically necessary, are not covered and the cost for such ser-

vices do not count towards the 5 percent cost-sharing cap, which means they are the patient's full financial responsibility. These exclusions may serve to deter participants from seeking timely and appropriate care, and may ultimately drive up costs when treatment is delayed. A process whereby service utilization above certain levels triggers a review and possible further action may be more equitable and cost-effective than blanket benefit limits.

Recommendation #4

Oklahoma should balance the goal of expanding coverage with the goal of promoting insurance that covers a full range of medically necessary services.

Discussion

Efforts to expand health insurance coverage involve at least some trade-off between the number of persons provided coverage and the comprehensiveness of the coverage that is made available. Some have argued that the best way to expand health insurance coverage is to relax coverage standards and offer more choices for minimal or bare-bones coverage options. This is seen as especially attractive to the young and healthy, who currently may only be offered more benefits than they want at a cost they cannot afford or choose not to pay. Rather than provide some people a Cadillac while others are left taking the bus, the argument goes, allow folks the choice of a Kia or Dodge.

There are two problems, however, with this approach. The first is that in the health insurance market, the choice of some for a low-cost product will invariably raise the price for those obliged to seek more comprehensive coverage. By pulling healthier consumers into a low-cost, low-benefit market, the cost of insurance for those with a certainty or likelihood of greater health care needs – which includes most older people, people with disabilities, and women of childbearing age - quickly will become prohibitively expensive. This could price more of the high-cost population out of coverage. We could end up in a situation where, while we have no fewer uninsured, the uninsured we do have are more in need of care. Alternately, we could end up with less comprehensive coverage for everyone, leaving those with chronic medical conditions underinsured.

The second problem is that individuals opting for the low-cost, low-benefit alternative may be left unprepared for their actual health care needs in the case of illness or injury. Not only might this population be left without coverage for the medical bills they have unexpectedly incurred, they are also unlikely to be able to purchase the coverage they need going forward. Unlike car owners, who are free to trade in their Kias for Cadillacs as their circumstances change, pre-existing condition exclusions strongly limit consumers' ability to get the insurance they need when they need it.

There is certainly room for a healthy discussion about the appropriate scope of coverage that must be included as part of health insurance products offered in Oklahoma, and value in looking for ways to enhance choice and flexibility as part of an expansion of coverage. However, we must be extremely careful to avoid apparent solutions that will ultimately shift more of the cost and more of the risk onto those Oklahomans with the greatest health care needs.

Recommendation #5

The Legislature should strengthen and improve the high-risk pool as a source of affordable, quality coverage for Oklahomans who cannot buy an affordable policy that meets their health care needs in the current non-group (individual) private market.

DISCUSSION

Oklahoma is among 31 states that have created a high-risk pool to serve as a "safety valve" to guarantee that anyone can purchase health insurance, regardless of their health status. However, Oklahoma's high-risk pool, which covers a mere 2,400 people, does not seem to be fulfilling the aim of effectively serving individuals whose pre-existing health conditions price them out of the regular commercial market. The limitations of Oklahoma's program include:

- Premiums can be up to 50

percent more than those charged to other people in the private market. The 2006 monthly premium for a 50 -year old woman for a plan with a $500 deductible was $1,123, or $457 per month for a plan with a $7,500 deductible;

- No subsidy for low- or moderate-income individuals;

- A one-year waiting period for coverage of pre-existing conditions;

- A $500,000 lifetime benefit maximum. Only two other states—Mississippi and Louisiana—have lifetime benefit maximums that are as low. No state is lower, many states' limits are at least $1 million, and several states have no lifetime maximum.[13]

Families USA has proposed a number of recommendations aimed at expanding access to the high-risk pool. These include lowering premium caps to no more than 125 per cent of average premiums for comparable policies in the individual market; shortening the waiting period for pre-existing conditions; providing premium subsidies to low-income applicants, and increasing the lifetime benefit limit.[14] Tom Daxon's O-CHIP proposal for the Oklahoma Council of Public Affairs, which favors steering high-cost individuals to a high-cost pool, would put strict limits on the premiums that individuals could be charged and prohibit the cancellation of policies so long as premiums are paid.[15]

A major challenge to strengthening the high risk pool is to find funding mechanisms that will allow for adequate coverage at reasonable rates. O-CHIP proposes that the state issue bonds to subsidize the costs of individuals in the high-cost pool.[16] Other funding mechanisms, involving contributions of insurers, health care providers and government, should also be considered.

Recommendation #6

The Insurance Commissioner should undertake a study of reasonable consumer protections in the individual and small group market to identify options for making private coverage more accessible and more affordable for Oklahoma consumers. This study should explore issues including the possibility of community rating in the individual market; rate review mechanisms; medical loss ratio standards; limits to how pre-existing conditions are defined and what kinds of elimination riders, exclusions, and denials are allowed; and limits on revocation of policies.

DISCUSSION

Strengthening consumer protections in the individual health insurance market can expand coverage by making affordable health insurance accessible to individuals who may currently be priced out of the market. A recent report by Families USA entitled **Failing Grades: State Consumer Protections in the Individual Health Insurance Market** found Oklahoma to be among the states with the weakest set of regulatory standards to assist individuals purchase and maintain affordable individual coverage.[17] Among the obstacles to coverage under existing law in Oklahoma, and the approaches that other states have adopted are the following:

- Oklahoma has no limits on how much insurance companies can vary premiums based on an individual's health status. A *modified community rating* system would not allow premium variation based on health, but would allow some variation for other factors, such as age and geography. Alternatively, imposing rate bands to limit variations in premiums based on health to 25 percent or less would be a less aggressive way to spread risks and expand access to individuals with pre-existing health conditions;

- Oklahoma does not require that regulators be allowed to review rate and premium increases prior to the rates going into effect. Providing *advance review* would prevent insurers from adopting unreasonable and arbitrary premium increases, thereby holding down premium costs for consumers;

- Oklahoma does not require insurers to spend a minimum share of premiums towards medical services in the individual health market. A *minimum medical loss ratio* of 75 percent would limit the share of premiums that can be allocated for administration, marketing and profit, and hold down premium costs for consumers;

- Oklahoma sets no limit on the length of time insurance companies can exclude coverage for the treatment of pre-existing conditions. It also does not limit how far into your medical history insurers can look back (called the *look-back* period) to determine which

pre-existing conditions they will exclude, or provide an objective standard which insurers must use to determine what qualifies as a pre-existing condition. Limiting pre-existing condition exclusion periods to six or twelve months, limiting the look-back period to six or twelve months, and using the objective standard to define pre-existing conditions could all expand coverage to vulnerable consumers.

Similar to the individual market, regulatory changes in the small group market related to community rating, medical loss ratios, underwriting practices and other issues, could also serve to expand access to affordable health insurance for small businesses.[18]

Many of the issues related to the individual and small group insurance markets are closely inter-related. We believe that it would be worthwhile for the Insurance Commissioner to conduct a comprehensive review of options that Oklahoma could pursue to expand consumer access to affordable private coverage. As long as insurance companies are competing on a level, well-regulated playing field, the goals of expanding coverage and keeping the cost of coverage affordable should be reconcilable.

ENDNOTES

[1] U.S. Census Bureau, *Income, Poverty and Health Insurance in the United States: 2007,* August 2008; online at: http://www.census.gov/prod/2008pubs/p60-235.pdf

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[10] Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations,* Kaiser Commission on Medicaid and the Uninsured, April 2003.

[11] Calculated from Oklahoma Health Care Authority, *Insure Oklahoma: Fast Facts*, October 2008; online at: http://www.insureoklahoma.org/index.aspx

[12] Ibid. There were 4,467 members enrolled in IP in October 2008, and 5,862 total members since the program's inception in March 2007. Similar number for ESI are unavailable.

[13] Information from Oklahoma High Risk Pool website; online at: http://okhrp.org/benefit_info.asp

[14] Families USA, *High Risk Health Insurance Pools*, May 2006; online at: http://www.familiesusa.org/assets/pdfs/High-Risk-Pools-May-2006.pdf

[15] Tom Daxon, *O-CHIP: Oklahoma Comprehensive Health Independence Plan*, Oklahoma Council of Public Affairs, June 2008, p. 31.

[16] Ibid.

[17] Families USA, *Failing Grades: State Consumer Protections in the Individual Health Insurance Market, June 2008*; online at: http://www.familiesusa.org/assets/failing-grades.pdf

[18] See the presentation by Kathleen Stoll of Families USA to the Oklahoma Health Care Task Force, September 22, 2008; online at: http://okpolicy.org/familiesUSA-presentation

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Oklahoma Policy Institute (OK Policy) is committed to advancing policies aimed at alleviating poverty, expanding economic opportunity and promoting fiscal responsibility. To that end, OK Policy conducts objective analysis of state policy issues in order to better position Oklahoma to become a more prosperous, better educated, healthier and increasingly equitable state.

CONTACT US

OKLAHOMA POLICY INSTITUTE
228 ROBERT S. KERR, SUITE 750
OKLAHOMA CITY, OK 73102
405-601-7692
INFO@OKPOLICY.ORG
WWW.OKPOLICY.ORG

EXECUTIVE DIRECTOR: MATT GUILLORY — MGUILLORY@OKPOLICY.ORG
DIRECTOR OF POLICY: DAVID BLATT — DBLATT@OKPOLICY.ORG
DIRECTOR OF COMMUNICATIONS: LINDSAY LANCASTER — LLANCASTER@OKPOLICY.ORG

Considerations for the

Oklahoma Health Care Reform Task Force

2008

Oklahoma Primary Care Association

Advisory Committee Member

Summary

Community-based safety net providers like community health centers have a role to play in any direction of health policy change. While health insurance significantly impacts access to care and efforts must be made to address the number of uninsured, there are barriers to care that no amount of insurance alone can overcome. Health centers help patients overcome these barriers by identifying the issues at the local level and addressing them with practical solutions. Whether that is affordably providing services or medications not covered in a given policy, obtaining transportation, offering extended hours, connecting patients with charitable or government services to fill a need, or providing care in a culturally-sensitive manner, these providers help bridge the gap.

OPCA upholds that health care should be effective, efficient, timely, of high quality, patient-centered and guided, and provided in such a manner as to eliminate disparities.

- While we as a state strive to broaden insurance coverage, appropriate to adequately ensure comprehensive, preventive, and primary care is available for all persons especially for highest need populations. In so doing, methods of encouraging personal responsibility should be incorporated as in the sliding fee scale of community health centers. An investment in early, quality care for underserved populations can yield savings for the whole

- Develop policies and consider short-term, targeted financial assistance for the planning and development of safety-net providers in areas that currently do not have adequate access that incorporates appropriate accountability measures

- Utilize health centers and community-based safety net providers to facilitate enrollment of individuals who are eligible for programs and distribute related information

- Encourage safety-net providers as options in insurance plans to foster timely and preventive care for enrollees who live in underserved communities

- Assist safety-net providers to stretch limited resources by ensuring that they have appropriate tax relief – e.g. for purchases

- Consider options for assisting with the adoption of health information technologies by safety-net providers – contracts to assist with training, targeted subsidies, and building upon current efforts toward infrastructure and policy development to more easily exchange and report health information while protecting patient privacy

- Assist underserved areas to recruit and retain providers by developing clinicians from those communities, training them in-state, and offering financial incentives, in some cases, to serve underserved areas

- Ensure that policies encourage and do not inadvertently inhibit care coordination and innovative partnerships between provider types

Undoubtedly, insurance coverage significantly improves access to care. Health care access has a significant positive impact on health outcomes. Better information through technology and care coordination through a central point of care further improves quality and reduces costs. Further, access fosters timely and preventive care which has the potential to alleviate strain from the 80/20 rule of chronic disease treatment costs. As 80% of health care spending is associated with chronic conditions, we simply must address the prevention and mitigation of these conditions.

As we consider the many possibilities for expanding coverage to include more of the uninsured, increase portability, and look at ways to address insurance costs, we also must not lose sight of the fact that insurance coverage does not, in and of itself, equal access, and there are many barriers to care that remain once a person is insured. A person with insurance coverage must still weigh the opportunity cost of transportation, insurance cost sharing, and time off work to see the doctor with other options in the family budget. This decision can be difficult for some – especially low-income individuals. Care might still be delayed if these concerns are not addressed. Sadly, the situation can be so dire that well-intended, responsible, working individuals chose to forgo the care they should not do without – and they may do so with a sacrificial mind, thinking they are sacrificing self to provide dollars for others in the family.

Barriers are most readily identified locally – by the patients, the community. Enter the possibility of community-based safety net providers such as community health centers to address these concerns.

Overview of Community Health Centers

Community health centers are largely private, non-profit organizations that offer a central point of care access – more than a medical home, but a health care home – for comprehensive, primary care services including primary medical care, oral health, mental health, enabling services (e.g. transportation), and patient education. If these services are not incorporated within a health center facility they are contracted or available by referral so as to provide a continuum of care without unnecessarily duplicating resources but filling the voids in the community. Health centers:

- Must serve communities of high need and underservice;
- Are governed by a voluntary community board of directors of which the majority is composed of patients of the facility they govern;
- Serve all people regardless of ability to pay via a sliding fee scale;
- Provide a comprehensive array of primary health care services;
- Must adhere to performance and accountability requirements for administration, finance and clinical quality.

Health centers are supported, in part, by a Federal grant from the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services. All health centers are eligible for an enhanced reimbursement from Medicare and a cost-based reimbursement mechanism from Medicaid when deemed as a Federally Qualified Health Center (FQHC) by the Centers for Medicare and Medicaid Services.

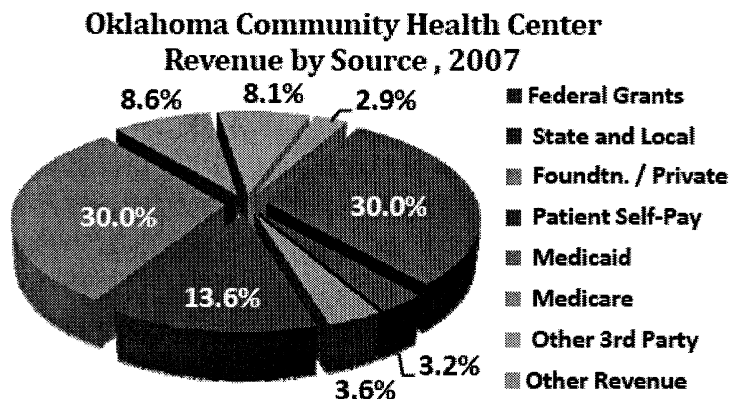
Geographic Areas of Highest Need

The community health center model is designed to address barriers to care at the local level. They do so in areas that lack the capacity to meet the current primary care demand, that have, in many cases, extreme socio-economic related needs of the population, and in which the community has come together to work toward a common goal of better health care access. More specifically, health centers must be physically located in or serve a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP).

Community needs must be demonstrated in grant applications and those of the highest need have the greatest likelihood of being successful in obtaining an initial award. For emphasis, health center new access point awards went to those scoring a 96 or higher on a 100 point scale in the last grant cycle. Only 42 of 262 (16%) applications for new community health centers access points received awards.

Leveraging Resources / Public – Private Partnership

Health centers begin with the collaboration of volunteer community members who collect resources, prepare for the beginning of a new business and practice, and collectively work toward a Federal grant application. Grant awards for new organizations are up to $650,000 per year. However, only $150,000 of the award from the first year may be used for capital expenditures – and that does not include acquiring or constructing a building for the practice in its entirety. Therefore, the community must find means to build infrastructure outside of the Federal grant to the point of being prepared to serve patients within 120 days of an initial grant award. Clearly, much is developed outside of the grant resources. Ultimately, on average, the **Federal grant accounts for 20-30% of health center revenues.** These dollars are primarily used to pay for statutorily required discounts offered to lower income, uninsured patients (household income less than 200% of Federal poverty) via a sliding fee scale



that is established by a voluntary community board and updated annually.

State and local grant or contract revenues represented a little more than 3% of Oklahoma health center revenues. In dollars, Oklahoma provides about $1.3M to assist health centers with low income, uninsured patient care. The State has also provided appropriation to help new communities that are interested in starting a health center.

Patient Directed Care

As mentioned earlier, the majority of volunteer health center board members must be patients of the health center they govern. This means that patients and members of the local community determine the types of services that are offered, hours of operation, the levels of the sliding fee scale, and have authority over the chief administrator. The people that best understand local barriers to care can choose to provide assistance as the community needs it within the resources of the organization.

Efficient and Quality Care

Total Average Cost per Patient in Oklahoma CHCs in 2007: $464

Despite serving a disproportionate share of low income, uninsured patients and patients who often have greater health care needs, total costs per patient for medical services in health centers last year was $270. For the comprehensive array of services, the total cost was $464 per patient in 2007 (actual average utilization of 3.4 visits per patient).

Cost is only part of the equation; to obtain value, one must also consider outcomes and quality. Several studies have reported about health center quality and their ability to improve health outcomes. As an example related to quality, one 2008 article abstract cited that in a study of health centers, "not only can these safety net providers readily integrate standardized measures, the quality of care being provided compare favorably to national benchmarks."[1]

What is the outlook for community health centers?

A large number of Oklahoma's 77 counties (56 as of January 2008)[2] have a Medically Underserved Area (MUA) designation for at least a portion of the county -- the first criterion for establishing a community health center. Beyond that illustrated by MUA designation criteria, many of these communities have other significant health care, socio-economic, and related needs, and, therefore, could potentially create a competitive grant application. While some communities with MUAs might choose alternatives, those who desire to have a community health center should be afforded the opportunity. The model offers significant benefits for

those communities who so choose to dedicate themselves to the community engagement, data collection, infrastructure development, grant writing processes, and on-going support.

That opportunity might come their way. In late September, Congress reauthorized the health center program in the Health Care Safety Net Act of 2008 which passed both houses of Congress unanimously among a myriad of other significant legislative topics. Within that bill, Congress provided authorization to significantly expand the number and breadth of health centers over five years.

Oklahoma has fewer health centers than many states in total and proportionate to various elements such as the poor or uninsured. However, more communities are interested in pursuing this option.

Considerations

If a market-based health insurance environment with limited restrictions successfully reduces premiums by limiting benefits or benefit amounts and broadening the risk pool through greater enrollment, there yet would most likely remain those who fall through the cracks even if plans are made affordable. We all still pay for that. If insurance became a requirement, much like car insurance, there, again, would likely be those who remain without coverage despite the requirement. With carrots or sticks, there remains a role of community-based safety net providers.

Further, for those with insurance in underserved areas, especially if they are of households with lower income, obtaining timely care may still be difficult if it were not for an accessible local provider who understood their situation and needs. Add to that the fact that many times dental insurance is separate from medical insurance and, once again, there is a role for an accessible, comprehensive provider location. Oral health can have a very real impact on overall health. If in poor condition, it can impact esteem which hinders initiative and, truthfully, career advancement opportunities. We need a vibrant, motivated workforce.

Some programmatic proposals require that participants have no other insurance for a given period of time – say, six months. There is a reason for that. However, when a person becomes unemployed, no longer has coverage, and has health conditions in need of treatment during those months, safety net providers can bridge the gap.

Comparing the role and need of these providers, their efficiency, and quality with the large cost shifting that occurs from the uninsured and underinsured, episodic care, and the delay of preventive care and early treatment, it stands to reason that taxpayers receive a reasonable return on their investment for supporting the provider groups serving populations in need.

Taxpayers assisted the uninsured in Oklahoma health centers with about $274 each in 2007 for the entire array of services offered by health centers when both Federal Section 330 CHC grant

dollars and State appropriations for uninsured care contracts are combined. For perspective, Federal Section 330 grant dollars and State uninsured care appropriations combined was about $14.7 million. Of that, the State appropriation for uninsured care was about $1.34 million. Self-pay patients served by health centers in Oklahoma contributed $6.14 million toward their care on the sliding fee scale (discounts only apply to those with income below 200% of poverty). Obviously, the uninsured are contributing dollars to their health and wellness via a mechanism in place in health centers. They are contributing what they can afford.

Appropriations

While efforts are made to reduce the number of uninsured, health centers experience roughly a $2.5 million uncompensated care amount for the uninsured beyond the existing State appropriation. The State could help mitigate the poor health outcomes and extreme costs of delayed care for many of those in the state's underserved areas and reduce the amount of cost shift that goes to premiums by supporting community health centers. Consider what it would cost to allow a diabetic to move to the point of crisis requiring stabilization and expensive on-going treatments versus preventing a person from becoming diabetic in the first place or keeping diabetes in check. A similar comparison can, obviously, be made for other diseases such as cardiovascular disease.

To ensure a level of accountability, cost reporting is required to receive an allocation of health center uninsured appropriations. Health centers currently receive allocations based on their proportion of uncompensated uninsured care.

If health reform proposals are successful in reducing the number of lower income, uninsured, theoretically, these organizations would not have the uncompensated care costs in the proportions that they experience today.

Health Centers as Enrollment Facilitators

Due to the socio-economic status of patients served by safety net providers, these providers can be ideal locations for the facilitation of enrollment. For insurance plans or programs, reaching patients when they are thinking about their health care could prove an opportune time to enroll them in programs for which they are eligible or refer them to information about related plans. Appropriate placement of enrollment workers and enrollment facilitation devices in these provider offices might be a useful strategy in reducing the number of uninsured.

Safety Net Provider Participation in Qualified Plans

In consideration of the fact that safety net providers help patients overcome barriers that are faced by even those insured, policy makers should encourage that health centers and other community-based safety net providers are included as optional providers for enrollees of various insurance programs or products.

Health Information Technology

Primary care safety net providers such as health centers are actively pursuing health information technologies. However, especially for new or smaller health centers with already limited resources, developing a fully functional health information system that is capable of interoperability can be an overwhelmingly costly challenge – not just in terms of purchases, but in modifications and lost productivity during implementation. However, there are cost advantages that might be shared by these safety net providers, taxpayers, and policy holders alike when such systems are in place.

The State might find that it is a prudent investment to further assist providers who serve a disproportionate share of lower income, uninsured, or Medicaid recipients in the implementation of appropriate health information technologies beyond the existing or developing support mechanisms in this area.

Workforce

Community-based safety net providers face similar struggles as do many other provider groups when it comes to recruitment in today's health care workforce shortage. While health centers have the benefit of Federal Tort Claims Act (FTCA) protection for potential malpractice claim, competition for providers can be tough – especially for rural areas. FTCA helps alleviate some of the concerns that many may not be willing to admit – concerns that lower income patients may be more litigious than other groups of patients. It also helps alleviate strains that might otherwise be placed on higher risk providers such as OB/Gyn physicians. Even with that benefit, however, health centers often find recruitment a challenge – those that serve are very mission-minded providers and, for rural health centers, those that truly enjoy rural Oklahoma living.

With this in mind, "growing our own" providers and keeping them here should be a priority. Targeted capacity in Oklahoma educational institutions should be developed.

Further, as a recruiting tool for some locations, financial incentives such as loan repayment may be a reasonable option to bolster in State policy. Loan repayers have determined their subject area of practice and are willing to serve underserved areas. However, sufficient penalties and enforcement provisions need to be in place to safe guard taxpayer dollars for breach of

contract. While penalties do not immediately fill the remaining hole in the community, at a minimum, the taxpayer dollars are not swirling behind the bumper of the exiting provider and can be used to place another provider.

Innovative Partnerships

Policy-makers should ensure that policies developed for good do not inadvertently hinder the ability of various provider organizations to form innovative partnerships. Whether it is the shared use of connectors such as community health workers, co-location of provider organizations with different payment policies, the use of new technologies in telehealth, or otherwise, providers should retain flexibility in their ability to be creative in health care design.

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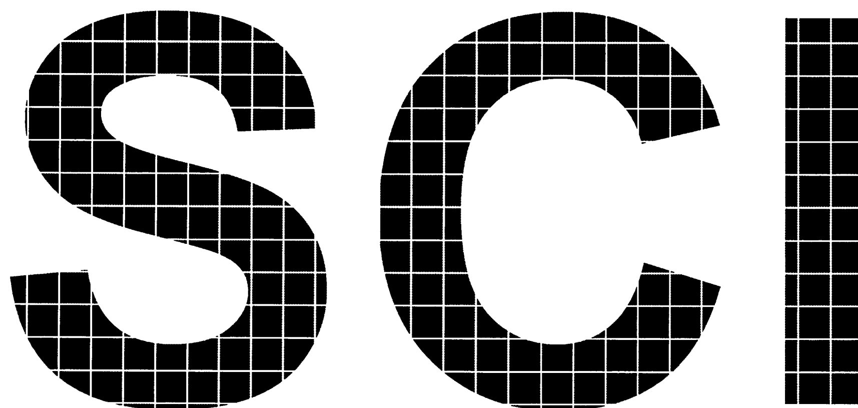
[1] Shin P, Markus A, Rosenbaum S, Sharac J. "Adoption of Health Center Performance Measures and National Benchmarks." January-March 2008 *Journal of Ambulatory Care Management* 31(1): 69-75

[2] Health Resources and Services Administration, U.S. Department of Health and Human Services. Medically Underserved Area database search performed January 17, 2008 for all Oklahoma counties. Database available online: http://muafind.hrsa.gov.



A BLUEPRINT FOR OKLAHOMA

Presented to the Oklahoma Health Care Reform Task Force by the Oklahoma State Coverage Initiative Team

September 30, 2008

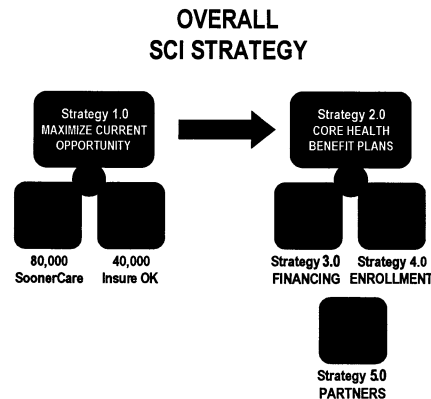
THE SCI PROCESS

The State Coverage Initiative team is comprised of 12 Oklahoma leaders from government, private sector and tribal organizations. It has established an 18-month process to craft certain public policy recommendations to ensure all Oklahomans have access to high quality health care and affordable health insurance. The objectives of these reform recommendations are as follows:

- Lower the cost of private health insurance
- Reduce the number of uninsured/uncovered
- Increase access to health care services
- Reduce the insurance premium burden caused by the uninsured

AN EVOLVING STRATEGY

The SCI Team's strategy for reform is still evolving. This paper represents a draft of our broad principles and direction, with an emphasis on affordable health insurance. The Team's recommendations will be finalized by mid-November. As an interim step we offer this draft to the Speaker's Health Care Reform Task Force for your consideration and comment as the SCI Team concludes its deliberations.



The overall approach has at least five interlocking and interdependent strategies for addressing key health insurance related issues in Oklahoma. These strategies will be deployed over multiple years. They are listed here as Strategies 1.0 through 5.0. Each succeeding step of the overall plan will be triggered by the attainment of an enrollment and/or cost related benchmark or milestone. They will include:

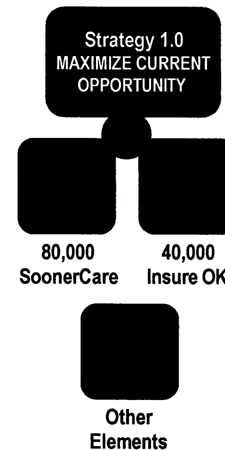
1.0: Maximize Current Opportunity
2.0: Creation of the Core Health Benefits Plan
3.0: Financing Mechanisms
4.0: Enrollment Policies

Additionally, the SCI Team will recommend that the following supportive strategies (5.0) be developed or supported:

- Engage Federal Government
- Support the Oklahoma Health Improvement Plan
- Support "No Wrong Door" OHCA Program
- Support Health Workforce Enhancement

Strategy 1.0
MAXIMIZING CURRENT OPPORTUNITY

It is agreed that the initial (first year) action steps of the strategy should be to maximize current opportunities that are already in place and funded – but not yet fully subscribed. A successful implementation would reduce the uninsured by almost 120,000 Oklahomans as follows:



1. Exhaust current Insure Oklahoma capacity of 40,000 newly insured Oklahomans. This will require an accelerated and more intense marketing effort to brokers and private employers.

2. The Oklahoma Health Care Authority will deploy an electronic presumptive eligibility and enrollment process for SoonerCare in the fall 2009 (No Wrong Door). This process will result in instantaneous enrollment and same-day payment authorizations. We support an aggressive effort to promote this as a means of enrolling all eligible uninsured children through the Internet. This process will immediately and operationally reduce the number of uninsured children by an estimated 80,000.

Additionally there are other initial actions that are recommended in order to prepare the marketplace for the expansions anticipated in the near future. These actions are:

1. Extend required dependent insurance eligibility to a floor of age 25. This would include state and public education employee dependents.

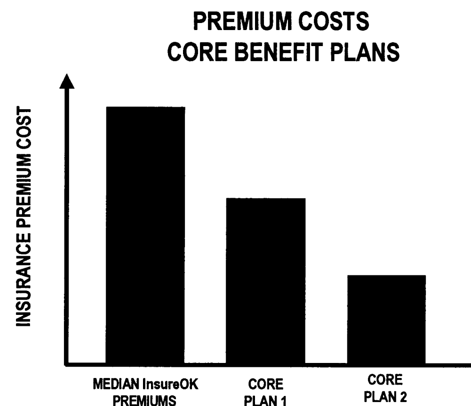
2. Propose that Insure Oklahoma generated insurer premium tax revenues be earmarked, subject to budget cap, for Insure Oklahoma program marketing.

3. Prepare the legislative foundation for a dual track provider fee system (see elsewhere for more detail). It is recognized that any effort in this area will likely be subject to SQ 640 provisions.

Strategy 2.0
THE CORE HEALTH BENEFITS PLAN

It is agreed that a lower cost health insurance option is important to providing Oklahomans access to care and coverage. The SCI recommendations will be a synthesis of work performed by the HCR1010 Core Health Benefit Task Force, the SCI Insurance Marketplace and Core Health Benefits workgroups, the findings of the two-year CHAT (Choosing Healthplans All Together) workshops, and input provided by SCI monthly meeting presenters.

The consensus of the CHAT and SCI Workgroups has been that the current Insure Oklahoma benefit plans should serve as the basis for the creation of a modified core health benefit plan.



Work will begin that adjusts the most popular plans and reduces their costs to two-thirds and one-third of the current cost. This will be done by not covering those services determined by the CHAT and SCI workgroups to be expendable, standardizing provider reimbursement rates, and adjusting co-payments and annual limits to achieve the affordability.

Evolve High Risk Pool

The High Risk Pool (HRP) provides an important safety net for those that have serious medical conditions and have no other option for coverage. If a lower cost benefit becomes available, individuals with moderate health conditions will be able to access coverage, and those with more serious conditions will be able to afford coverage for the majority of their expenses. Our recommendation is that the High Risk Pool continues its current mission but also becomes a reinsurance mechanism for the Core Health Benefits Plan. We recommend the following measures be taken:

- Perform actuarial analysis to determine risk of insuring an individual's medical expense in excess of $50,000/12 month period.
- Perform actuarial analysis, in conjunction with the Core Health Benefits Plan analysis, to determine the most cost effective reinsurance level to be assumed by the Pool.
- Transform current HRP funding assessment to a per-insured model to capture self-insured plans whose employees are eligible to purchase from the Pool.

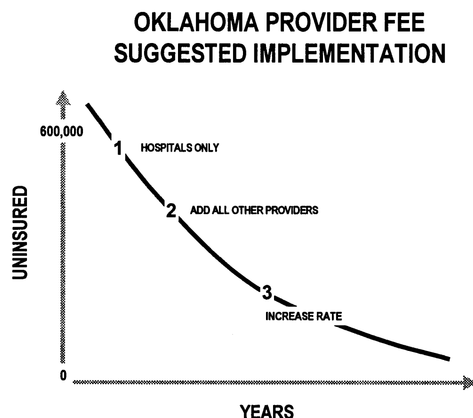
Additional Elements
These additional elements will allow the Core Benefit Plans to be available for purchase by small business consumers no later than 7/01/09.

- The target market will be for employers and employees in smaller (<50 employees) businesses.
- Provider reimbursement rates will equal Medicare or Medicaid rates, whichever are greater. Rates will be publicly disclosed for transparency.
- The plan will permit 0% reimbursement for out of network services with accommodations for services that are not available within a defined service area.
- Services determined by CHAT participants to be expendable will not be covered under the plan.
- When available, generic drugs are dispensed on a mandatory basis.
- Plan will provide no or low cost emphasis on stipulated preventive services, including smoking cessation.
- The plan will incorporate features that promote responsible consumption of healthcare services.
- A modified pre-existing condition limitation will be required for those previously uninsured. Guaranteed issuance will be required.
- Dependent children will be covered to a floor of age 25.
- The plan will otherwise meet all qualifications to be eligible for inclusion in the Insure Oklahoma portfolio of products, but will be available for purchase by any willing small group purchaser. All plans should include benefits for physicians, hospital inpatient and outpatient, pharmacy, and ancillary services to continue being eligible for applicable federal matching premium assistance.

Additional Necessary Analysis
(1) Determine to what degree quantifying an upper limit, either in terms of total benefits paid or in number of visits/services, will impact pricing; (2) determine cost savings generated by limiting carrier participation through bid process vs. open to all domestic carriers; (3) determine if there are specific populations that should be targeted as priority prospects for enrollment. This might be based on income level (lowest to highest), hospital market area based on patient mix, county by percentage uninsured, or other demographic or health services characteristics; and (4) explore the State of Indiana Power Account (Healthy Indiana Plan) concept of purchasing preventive services.

Strategy 3.0
FINANCING MECHANISMS

It is agreed that the most efficient means of revenue generation is an earmarked provider fee. When fully deployed, this process would be equitably applicable to all medical providers including hospitals (for-profit and not-for-profit), outpatient surgical facilities, clinics, physicians, laboratories, diagnostic centers, pharmacies, or other healthcare providers.



The funds would be earmarked for InsureOklahoma, including the SCI/HCR1010 recommended core health benefits plans.

It is further agreed and recommended that any such measure would be deployed in three phases:

Phase I:
Hospitals only and at a relatively low percentage (1%):
This Phase will be implemented when the Insure Oklahoma program has enrolled 75% of capacity (30,000). Current capacity is an estimated 40,000; current enrollment is 14,000.

Phase II:
All other providers included at the same rate:
Phase II will be implemented when Phase I has reached its 75% enrollment target.

Phase III:
Hospitals and all other providers at a greater rate:
Similarly, once 75% of the benchmark for Phase II has been met (increased number of insured), Phase III will be implemented. These revenues would provide the necessary funds to cover the last cohorts of the uninsured.

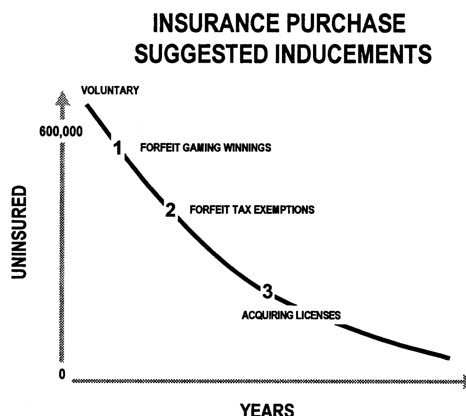
Strategy 4.0
ENROLLMENT POLICIES

Although we would like to believe that individuals and businesses would voluntarily offer and take up affordable insurance coverage, studies and our own experiences suggest otherwise. There is a public policy continuum between voluntary and mandatory enrollment.

The SCI believes that mandatory enrollment is not yet necessary. Nevertheless, it is expected that the positive effects of voluntary enrollment will be limited. Therefore the recommendations include a toolkit of presumptive and induced measures. These measures will be carefully vetted and deployed only when pre-determined benchmarks are achieved.

We believe phased-in inducements to encourage take-up must be implemented. To encourage personal responsibility, we support the following inducements, implemented as appropriate based on take-up rates:

- Initially, require individuals to demonstrate proof that health insurance has been in force for the six month period prior to a windfall event caused by reportable lottery and/or gaming winnings, or be required to forgo such winnings. Forfeited winnings would be diverted to the InsureOklahoma program account.



- Additional measures as required to further encourage those most reluctant to purchase insurance. These may include actions such a: the elimination of personal tax exemption, a predicate for obtaining drivers license, and a predicate for obtaining auto/recreational vehicle registration tag.

- We also support tougher recourse and consequences for those able but unwilling to pay their medical debts.

- Commensurate with encouraging personal responsibility is the need to create inducements for small business employers to offer coverage. The InsureOklahoma subsidy is an important incentive; however, further inducement is likely to be necessary to gain full enrollment.

Strategy 5.0
PARTNERSHIPS AND SUPPORT

The SCI Team recommends that the following supportive strategies be developed or advanced:

Federal Government

There are three important federal actions in process that could directly and significantly assist in reducing the numbers of Oklahomans without health insurance. It is recommended that Oklahoma health policy leaders organize and deploy a significant effort to create the energy and support of our federal delegation to pursue the adoption of these strategies.

Medicaid Waiver – the Oklahoma 1115 Medicaid Waiver has languished at CMMS for well over a year. The approval of this waiver is essential to the full deployment of SCI Team recommendations.

Indian Health – the Oklahoma City Area of the Indian Health Service Region is the most inadequately funded region in the United States. A significant number of Oklahoma's uninsured are Indians. An equity and parity in the funding of IHS and the tribal services will significantly help Oklahoma.

Medicaid Disproportionate Share Hospital (DSH) Funds – there are two separate legislative efforts to provide Oklahoma a fairer share of these funds. One is the extension of a five-year window to reapportion funds to low-DSH states (like Oklahoma), and another is to aggressively redirect unused DSH funds to low DSH states for hospital and ambulatory network use. Both efforts have been supported by the OHCA and Congressman John Sullivan. Both efforts have been thwarted to-date.

Oklahoma Health Improvement Plan

The State Board of Health has initiated the development of a formal Health Improvement Plan per Oklahoma SJR 41. The majority of the states have such a plan. Oklahoma does not. The SCI Team endorses all responsible efforts to create and implement a plan that would directly improve the health status of Oklahomans.

Support "No Wrong Door"

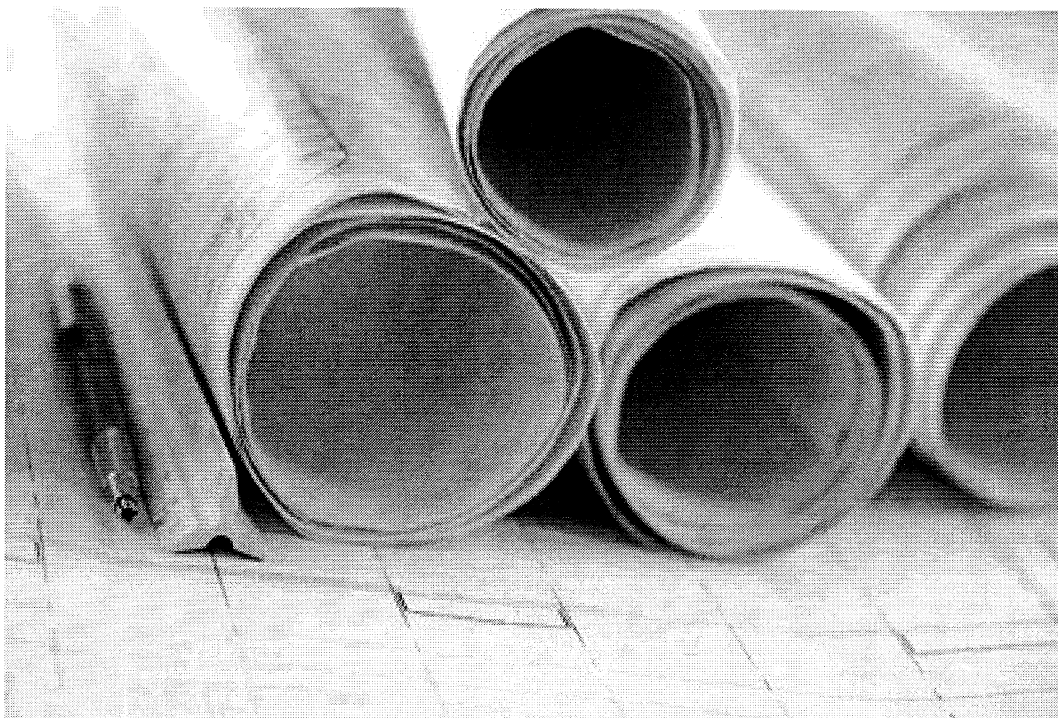
The Oklahoma Health Care Authority will deploy an electronic presumptive eligibility and enrollment process for SoonerCare in the fall 2009. We support an aggressive effort to promote this as a means of enrolling eligible uninsured children. This process will immediately and operationally reduce the number of uninsured children by an estimated 80,000.

Workforce Enhancement

Support all appropriate expansions of the quantity and quality of health care professionals and workers, and support all practices, such as the Patient Centered Medical Home, that allow this workforce to operate at "the top of their licenses" in order to maximize productivity.

SCI

A BLUEPRINT FOR OKLAHOMA



THE OKLAHOMA STATE COVERAGE INITIATIVE

ONE OF 12 STATES SUPPORTED BY A GRANT FROM THE ROBERT WOOD JOHNSON FOUNDATION

WHAT IS SCI?

SCI IS A TEAM
Legislators, Agency Directors & Commissioners, Representatives of Private Insurers, Tribal Health and Medical Communities

SCI IS A PROCESS
Monthly information meetings - directed research consensus building - plan formulation

SCI builds upon principles of HCR 1010

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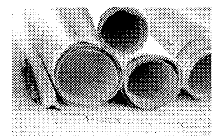

TIMETABLE

Approaching the end of our 18-month opinion seeking, information gathering and planning process.

We are refining our recommended strategies and are in the process of developing final detail and consensus.

Will present completed plan in late November or early December.

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PARTICIPATION

Our proposal will represent the participation of thousands of individual Oklahomans and scores of Oklahoma organizations, agencies and institutions.

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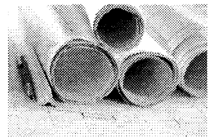
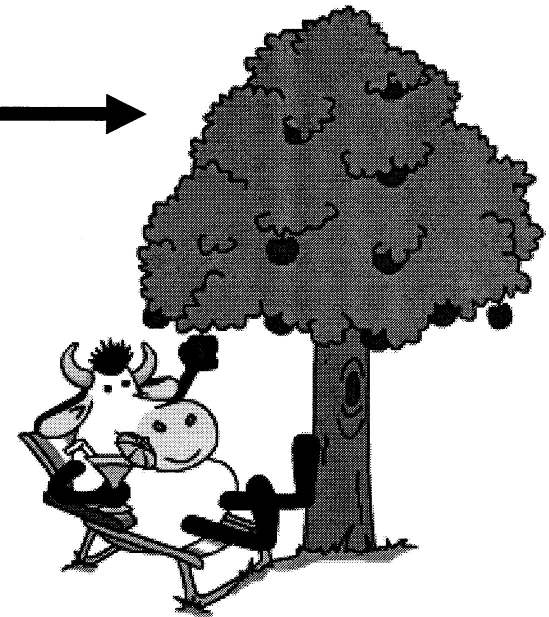


STRATEGY 1.0

MAXIMIZE EXISTING OPPORTUNITY

"LOW HANGING FRUIT" →



Does not require new money

Does not require new authorization

Can reduce uninsured by 120,000

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STRATEGY 2.0

AFFORDABLE BENEFIT PLAN

PRINCIPLES

Uses principles of HCR 1010

Uses findings of 700+ CHAT responses statewide

Considers findings of SCI Workgroups

DETAIL

Intend to qualify for federal premium assistance

Aiming at significantly reduced premium cost

Work underway to confirm benefits and costs

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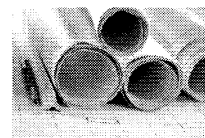

STRATEGY 3.0
FINANCING MECHANISMS

Recommends a version of a Medical Provider Fee

Only potential revenue source commonly supported by most groups

Methods and applications of a Medical Provider Fee will be refined, discussed and reconciled during November-December

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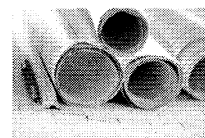
FOR OKLAHOMA



STRATEGY 4.0
ENROLLMENT CONSIDERATIONS

Something more than voluntary and less than mandated - will be “induced” and/or “presumptive”

Will depend upon selected financing mechanism

Will involve targeted communications and outreach strategy

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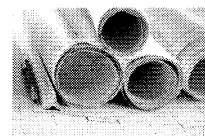

STRATEGY 5.0

PARTNERSHIPS

The SCI Team and Process respects that others have valid perspectives. Every effort has been made to blend and synthesize them.

The SCI Team and Process respects that others have important contributions in areas collateral to health insurance - and supports those that will improve health status and health system functions.

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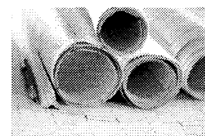
FOR OKLAHOMA



OUR NEXT STEPS

Draft final recommendations will be discussed at the November 17 SCI Team meeting.

A subsequent special executive session to reconcile issues will be held in early December.

Final recommendations will be presented for consideration in the 2009 Legislature.

Upon introduction of a Bill, SCI will convert from a planning effort to one of implementation.

QUESTIONS?

A BLUEPRINT FOR OKLAHOMA

THE OKLAHOMA STATE COVERAGE INITIATIVE

SUPPORTED BY A GRANT FROM THE ROBERT WOOD JOHNSON FOUNDATION

HCR 1010 PRINCIPLES

The program shall be offered and delivered by the private insurance market.

The program shall be available to individuals and employer groups on an equal basis in terms of underwriting, rating and benefits, subject to thorough research and study of both the individual and group market segments.

The program shall be comprehensive and germane to the broad and diverse physical and mental health needs of our population, and shall enable continuous coverage.

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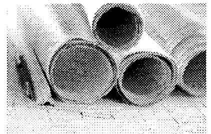
FOR OKLAHOMA



HCR 1010 PRINCIPLES

The program shall develop a transparency methodology that effectively promotes responsible consumption, competition, and quality.

The program shall promote personal responsibility and good health through effective financial and/or benefit incentives.

The program shall create incentives for the use of available evidence based medical protocols for chronic care management.

The program shall reward physician quality and performance with appropriate and effective incentives.

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FOR OKLAHOMA

HCR 1010 RECOMMENDATIONS

1. The Task Force supports the Institutes of Medicine principals that health care (in Oklahoma) should be safe, effective, patient-centered, timely, efficient and equitable (see Appendix B) STATUS: Acknowledged throughout

2. Although the CHAT initiative strove to obtain opinions from a representative sample of the Oklahoma public, we still lack information from certain demographics. The Task Force recommends that the CHAT session be expanded to reach out to certain minority and low income populations to ensure a more representative sample. STATUS: Completed

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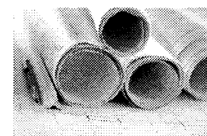
FOR OKLAHOMA



HCR 1010 RECOMMENDATIONS

3. During the development phase of the Insure Oklahoma premium assistance plan, a comprehensive study of Oklahoma's uninsured population was conducted. We recommend that this study, (State Health Access Data Assistance Center, i.e. SHADAC), be updated to clearly identify our uninsured population in terms of age, gender, employment, income, geographic location, etc. Additionally, this study will aid in quantifying targeted populations most likely to benefit from a lower cost health benefit plan. (See Appendix C) STATUS: In Progress

4. We recommend a study be conducted to determine reasonable out of pocket limits (deductibles, copayments and premiums) that cause a plan to be affordable at various income levels.
STATUS: Pending

HCR 1010 RECOMMENDATIONS

5. We recommend that all elements of Oklahoma's health care reform efforts, including the development of a low cost benefit plan, leverage all available federal resources.
STATUS: Acknowledged throughout

6. We recommend the state determine the practicality and leverage, if any, that may be gained through pooled purchasing of certain high volume medications, supplies and/or serums (i.e. immunizations, insulin, etc.) to reduce costs. STATUS: Pending

7. Given all hospitals in Oklahoma are required to offer discount programs to patients who have incomes less than 300% of federal poverty level and are not eligible or enrolled in public or private insurance plans, we recommend an analysis be conducted to determine if/how this requirement might be utilized more effectively as a back drop or reinsurance for high cost claimants of a basic health benefit plan.
STATUS: In Progress

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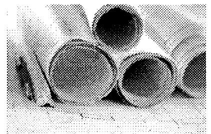
FOR OKLAHOMA



HCR 1010 RECOMMENDATIONS

8. We support the concept of a primary care “medical home” as necessary to optimal patient care and cost management. We recommend the state explore how medical home parameters and concepts can be facilitated and address known current circumstances and practices that create barriers to primary care access (i.e. primary care provider reimbursement rates, scope of practice limitations, pursuit of funding for additional Federally Qualified Health Centers (FQHCs,) medical workforce limitations, etc.) STATUS: In Progress

9. We recommend the state study the cause and effect of defensive medical practices on the cost of health care and health insurance. STATUS: Pending

10. We recommend the state continue providing leadership and necessary support in the pursuit of an interoperable health information network and promote the use of health information technology to improve patient care and reduce avoidable hospital readmissions. STATUS: In Progress

THE OBSERVATIONS AND RECOMMENDATIONS OF TASK FORCE ADVISORY COMMITTEE MEMBER BARRY L. SMITH

- The opinions and recommendations expressed herein are primarily informed by my professional history and experience. I am a Health Care Lawyer with clients ranging from individual physicians to large health systems and to medical schools; in addition, I have also served as an employee and member of the senior executive team for a large health system. I also serve on the Oklahoma State Board of Health and am in my second year as President of the Board.
- I think there should be an acknowledgement that the issue we confront is incredibly complex and multi-faceted. Simplistic political jargon will not work; likewise, reliance on anecdote and urban legend will also lead to failure.
  - There seems to be a persistent belief by some people that Medicaid beneficiaries are somehow cheating the system and/or are not trying hard enough to "improve their lot in life". The notion of beneficiary abuse was furthered by at least one of the presenters to this Task Force relaying the anecdote about the Medicaid beneficiary seeing as many as four different specialists to get medications. Besides the fact that it would be an incredibly unusual Medicaid system and an incredibly unusual number of specialists that would so cavalierly schedule, diagnose, and treat Medicaid patients, that anecdote (even if true) does not fairly represent the flow of most Medicaid dollars. (This is not to excuse fraud and abuse in the Medicaid system. In my experience, however, the emphasis on fraud and abuse protection is far more demanding by the federal government than by

the private sector.) The largest percentage of Medicaid dollars flows to categorical beneficiaries, primarily the aged, blind and disabled. With respect to the notion that these beneficiaries are not working hard enough to improve their lot in life, it seems more than a little misinformed to believe the disabled would not gladly trade their disability; that the blind would not gladly opt for vision; and, that the aged would not readily welcome youth.

- My recommendations include three broad elements: educational, programmatic and funding options. With respect to all parts, we should recognize that there is no single silver bullet which will provide all the answers.
- I strongly believe there must be a better understanding of Oklahoma's poor health status. At times we seem almost blissfully unaware of the fact that Oklahomans are among the unhealthiest people in the country. This is especially significant when one considers that the United States ranked 37th in health outcomes in the world, despite spending more dollars per capita than any other country on health care.

  It think it also important to note the outcome data about to be referenced is not subjective information put forth by some political organization but instead is objective measurements relied upon by health care professionals throughout the country.

  - In 1990 Oklahoma's health outcomes (all health outcomes combined) were ranked 25th in the nation by the United Health Foundation; by 2007 they had fallen to 48th.

- Other 2007 United Health Foundation Report data reveals Oklahoma's poor rankings:
  - Smoking: 47th
  - Obesity: 44th (some say we are actually worse than that)
  - Poor mental health days: 47th
  - Poor physical health days: 48th
  - Infant mortality: 40th
  - Cancer deaths: 43rd
  - Premature deaths: 43rd
  - Cardiovascular deaths: 50th
- When risk factors for health are measured, Oklahoma also ranks low (BRFSS-Behavioral Risk Factor Surveillance System):
  - Income: 47th
  - Health insurance: 44th
  - Tobacco use: 47th
  - Nutrition: 50th
  - Exercise: 47th
  - Mental Health: 50th
  - Obesity: 44th
  - Problems with diabetes: 46th
  - Problems with high blood pressure: 45th
- Oklahoma's poor health status impacts more than just the individual or family struggling with disease. The already strapped health care industry in Oklahoma must deal with patients that are sicker than in many other

states. Also, despite one's desire to brag about the high quality of the Oklahoma work force, the simple fact is that most employers in Oklahoma must deal with a work force that is unhealthier than in other states – its manifest in increased cost for insurance and lost work productivity.

- We should also acknowledge the effect of the uninsured on the health care system. From a financial standpoint the existence of a cost shift is indisputable. That equates to a hidden tax that falls disproportionately on the shoulders of insured Oklahomans.
    - The Legislature must be educated about the existence of the "hidden tax." Much of the recent political debate in Oklahoma about alternate funding solutions for health care degenerates into jargon: "No New Taxes" or "sick tax". Hopefully, education about the impact of the indigent will raise the level of the analysis.
- From a programmatic standpoint we should stay with the premium assistance model and the contemplated plan expansions. The expansions include O-EPIC-IP, continued pursuit of the waiver, etc.
    - Most of the speakers have agreed, at least in general terms, with the approach started by Oklahoma. It seems to incorporate elements from other programs and allows flexibility and creativity going forward.
    - We should use all available carrots and sticks to increase uptake of the programs.
    - All the speakers presented what I thought was wise advice: don't be in a rush just to change the statistics of the uninsured; focus on a viable product that creates needed access and allows appropriate reimbursement.

We have also been told that a relatively small percentage of uninsured individuals create a disproportionately high percentage of unreimbursed cost and expense. It seems prudent to focus efforts on those individuals and, whether through an employee-sponsored program or an individual plan, attempt better case management and utilization.

- We should not ignore the public health component of addressing Oklahoma's health status. Last year the Legislature instructed the State Board of Health to develop a State Health Improvement Plan. As part of that process, and perhaps combined with O-EPIC expansion, we should work to combat preventable disease.
- Adequate funding is crucial. Besides funding to make the programs work, the prospect of available funding will be necessary to inspire the support of the health care community.
    - Through my association with health care organizations, I have observed the importance to health care executives of consistent, predictable, and stable planning. If stability, consistency, and predictability are measured in terms of a period of time greater than two years, one could not say the legislative approach to health care has been consistent, predictable or stable.
- One source of stable funding is a provider fee. A provider fee, fashioned consistent with CMS regulations, can also serve as the basis for matching federal dollars. Although the match rate changes (unfortunately it seems to get worse) in rough numbers one dollar of state money can be turned into almost three dollars for appropriate health care use.

- The provision of medical services are not directly tied to a state's economic good times or bad times; thus, a provider fee will allow stability even during economic down times.
- It has been frequently observed that health care costs grow faster than the economy as a whole. A provider fee, however, would grow at approximately the same pace as the growth of health care delivery.
- Opponents may argue that a provider fee violates a No New Tax pledge or is a "sick tax". It is commonly accepted however, that a hidden tax is already being paid by the insured population in the form of a cost shift to cover the uninsured. The burden of the uninsured creates more than just a cost shift or hidden tax – there is also a burden placed on available resources that can impact all people, whether insured or not.

  As an example of that last point, backed up emergency rooms impact acute access for all people; it is illegal (besides unethical) to provide quicker or preferential emergency treatment based on insurance status or income. The resulting delays can be dangerous to all patients.
- It has been estimated that a provider fee of one percent of gross revenue will generate approximately $155 million state dollars. With a federal match this can be turned into over $450 million dollars to help combat the problems.

- Providers must be reimbursed at rates that allow their long-term involvement. For hospitals that means the UPL; for physicians it is at least the Medicare allowable.

- It is only in the last five years that Oklahoma hospitals and doctors have been paid something that even comes close to their cost of services. The inability to maintain those rates, or even the fear the rates will not continue, decreases confidence, participation and possible expansion. Thus, a stable sense of state funding for UPL, rate stability, and program stability is necessary if we truly hope to achieve effective reform.

From: Bert Marshall, President of Blue Cross Blue Shield of Oklahoma and Beverly Binkowski, Director, Public Affairs for Blue Cross Blue Shield of Oklahoma

To: Rep. Kris Steele

Re: Recommendation to the Task Force

Please accept the following recommendation to the Task Force on behalf of Blue Cross Blue Shield of Oklahoma:

A recent survey of 400+ *Insure Oklahoma* employers shows that *Insure Oklahoma* is:

- Decreasing the uninsured in small group market
- Increasing the availability of employer coverage
- Leveraging employer subsidies for greatest impact
- Generating support among participating small employers

The survey found that 56 percent of all *Insure Oklahoma* enrollees were previously uninsured. *Insure Oklahoma* helped some firms offer coverage for the first time – 37 percent of the program's employers were uninsured previously and 85 percent of these employers said the primary reason they couldn't offer coverage before was their employees couldn't afford it.

The program also helped employees that previously had access to employer coverage but could not afford it. In firms that offered coverage prior to the program, 36 percent of their enrollees had been uninsured before *Insure Oklahoma*. The program, which has broad support from insurers, small employers, hospitals and doctors, has enabled 55 percent of small employers with less than five employees to offer coverage for the first time.

The *Insure Oklahoma* program is an employer-sponsored insurance program that provides premium assistance to small employers with low-wage workers. It has

been highly successful in decreasing the uninsured in the small group market and currently provides coverage to almost 10,000 employees. The survey also found that all workers – not just those with state subsidies – benefit when small firms offer coverage for the first time. Of employers that did not previously offer coverage, for every five *Insure Oklahoma* – subsidized employees there are seven employees that don't receive a state subsidy but are now offered employer coverage for the first time.

BCBS of Oklahoma believes *Insure Oklahoma* is an example of a successful public private partnership and should be an integral part of any plan to address our uninsured population.

Recommendation to the Healthcare Reform Task Force

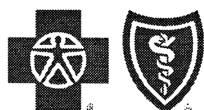
Insure Oklahoma

Greg Burn presenting on behalf of

Bert Marshall, President

Blue Cross and Blue Shield of Oklahoma

October 28, 2008



BlueCross BlueShield
of Oklahoma

Background: *Insure Oklahoma*

2003

State recognized many of its uninsured were small businesses

- Governor reports only 37% of small businesses offer coverage

Coalition formed to address health issues, including helping low wage workers get health coverage

- Insurers, small employers, hospitals, and doctors
- Advocated tobacco tax as funding source

2004

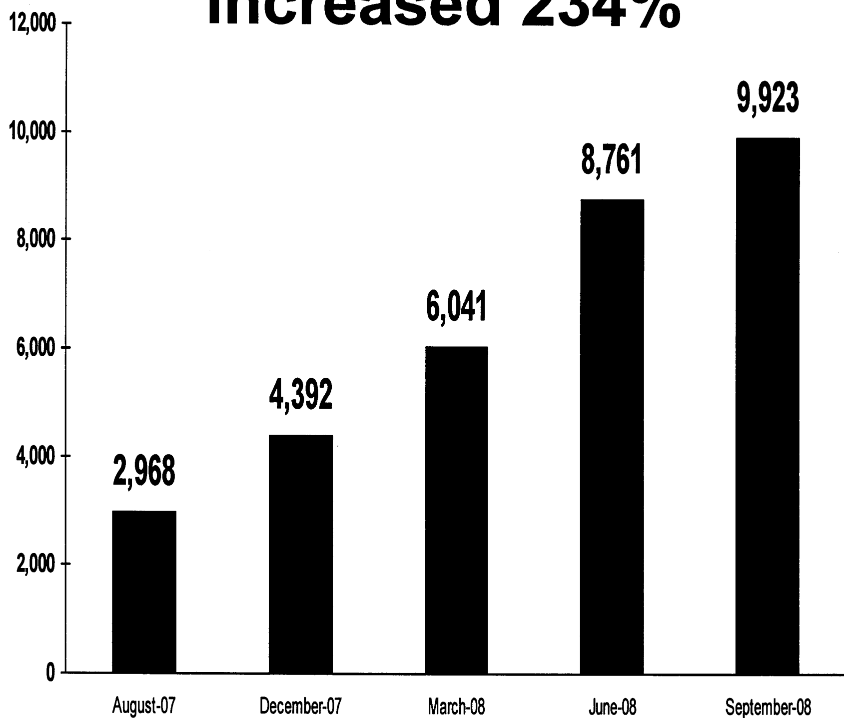
"*Insure Oklahoma*" subsidy program enacted

2005

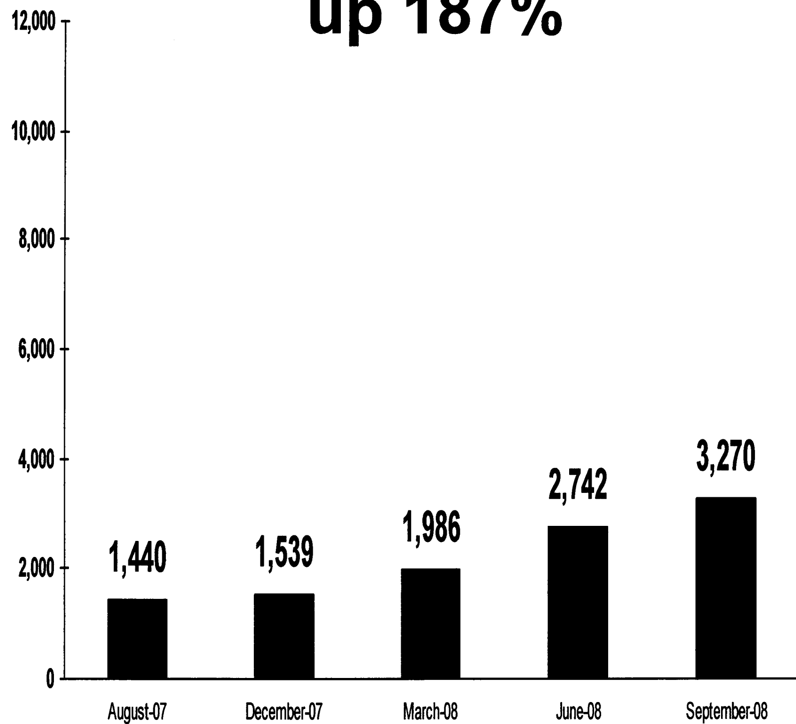
CMS Medicaid Health Insurance Flexibility and Accountability (HIFA) waiver approved for federal funding

Background: *Insure Oklahoma* Grew Exponentially in Past Year

Employee enrollment increased 234%



Employer enrollment up 187%



Background: How Does *Insure Oklahoma* Work?

Subsidizes Small Employers with Low Income Employees

- Eligible Employers:
  - 2-50 employees
-
-
  - eligible employee premium
  - Eligible employee pays 15% of premium (not to exceed 3% of employee family income)
  - State pays remainder

Maximizes Choice

- Employer chooses "off the shelf" products for all employees
-
  - $500 deductible pharmacy max
- 20 Insurers offer qualified plans

Avoids Unnecessary Bureaucracy

- Employer applies to existing state agency-Oklahoma
-
-
- Employers may use brokers/agents to assist in enrollment process

No new entity needed

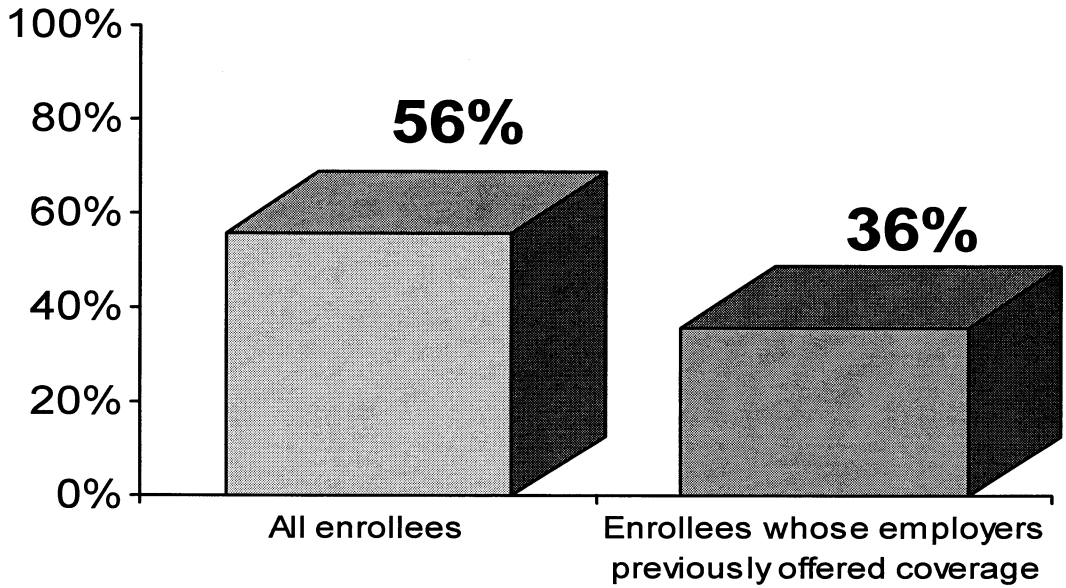
Insure Oklahoma: Employer Survey Results

Recent survey of 400+ *Insure Oklahoma* employers shows that *Insure Oklahoma* is:

- Decreasing the uninsured in small group market
- Increasing the availability of employer coverage
- Leveraging employer subsidies for greatest impact
- Generating support among participating small employers

Insure Oklahoma: Decreasing the Uninsured

56% of Insure Oklahoma enrollees were previously uninsured



% of Enrollees Previously Uninsured

Insure Oklahoma: Increasing the Availability of Employer Coverage

Insure Oklahoma helps firms:

Offer for the first time:

- 37% of *Insure Oklahoma* employers offering coverage for first time
  - 55% of very small (<5) employers offering for the first time
- 90% of employers credit *Insure Oklahoma* as “one of the most or the most” important factors in decision to offer coverage

Retain Coverage:

- 25% of all participating employers considered dropping coverage before *Insure Oklahoma*
  - 43% of very small employers (<5) considered dropping coverage before Insure Oklahoma

Insure Oklahoma: Leveraging Employer Subsidies for Greatest Impact

- All workers – not just those with state subsidies – benefit when small firms offer coverage for first time
- For every *Insure Oklahoma* subsidized employee there are 1.4 who are newly offered employer coverage

Example: 12 Person Gas Station Offers Coverage for First Time

State subsidizes employer coverage for 5

Another 7 offered employer coverage (with employer subsidy but no state subsidy) for first time

***Insure Oklahoma:* Generating Support Among Participating Employers**

- 95% will continue participation
- 86% have a favorable view
- 95% would recommend Insure Oklahoma to business associate/friend
- 97% of employers with less than five employees would recommend Insure Oklahoma to business associate/friend

Wrap-Up

Insure Oklahoma is working for Oklahomans and could be replicated in other states

- Broad support of insurers, small employers, hospitals, and doctors
- Great results

oklahoma
health care
authority

A Recommendation to the Oklahoma Health Care Reform Task Force by the Oklahoma Health Care Authority

October 14, 2008

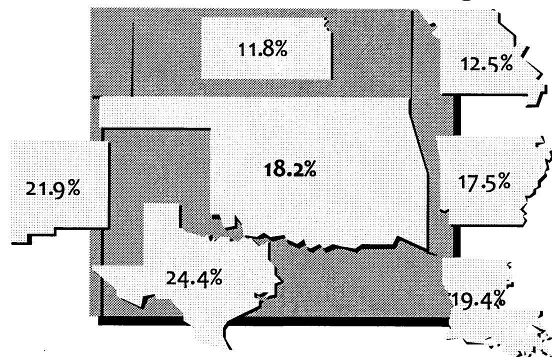
A Recommendation to the Oklahoma Health Care Reform Task Force by the Oklahoma Health Care Authority

October 14, 2008

Identifying the Issues

In 2007, more than 45 million people or 15.4 percent of the population in the United States lacked health insurance. In Oklahoma, 18.2 percent of the population, or roughly 640,000, individuals are uninsured. Reversing the trend of the high number of uninsured has become the focus of many task forces and policy efforts.

Uninsured Rate Comparison with Surrounding States, 2007



Source: U.S. Census Bureau Income, Poverty and Health Insurance Coverage in the United States, 2007, August 2008.

Most of the uninsured are in working families and do not have access to employer-sponsored insurance. Eight in ten of the uninsured live in families with at least one worker. Uninsured workers typically do not have employer-sponsored insurance offered through their jobs and cannot access it through a family member.[1]

More than eight in ten of the uninsured are low or moderate income families. About two-thirds of the uninsured have incomes below 200 percent of the federal poverty level (FPL) (about $42,000 for a family of four). Only about one in ten are above 400 percent of the FPL. The average annual cost of employer-sponsored family coverage for 2008 rose to $12,680 – with employees paying $3,354 on average out of their paychecks.[2] This year many workers are also facing higher deductibles in their plans, including a growing number with general plan deductibles of at least $1,000.

Premiums have more than doubled since 1999 when total family premiums stood at $5,791 (of which workers paid $1,543). During that same time period, workers' wages increased 34 percent and general inflation rose 29 percent.

One preconceived notion is that by virtue of being low income, all of these individuals are eligible to enroll in Medicaid. Not true. Most low and moderate income uninsured adults are not eligible for Medicaid. Medicaid coverage is primarily available to low-income children, very low-income parents, pregnant women, people with disabilities, and the elderly. Most non-disabled adults under age 65 who do not have dependent children are not eligible for Medicaid regardless of their income.

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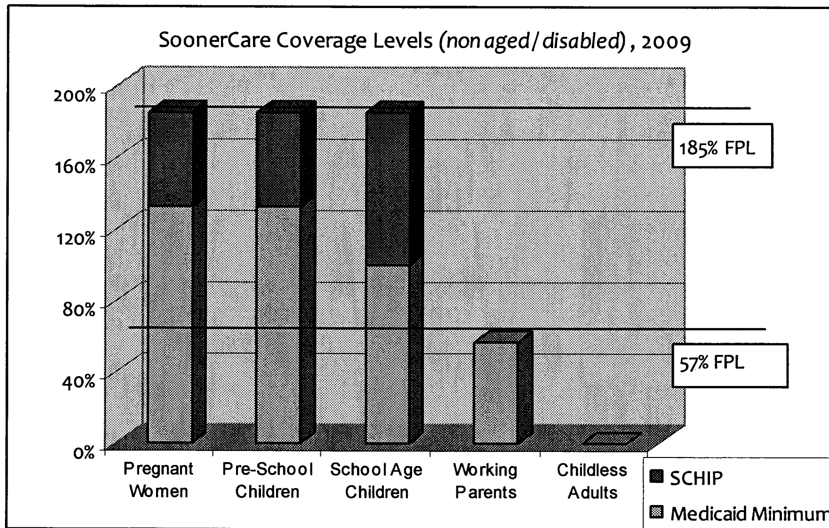
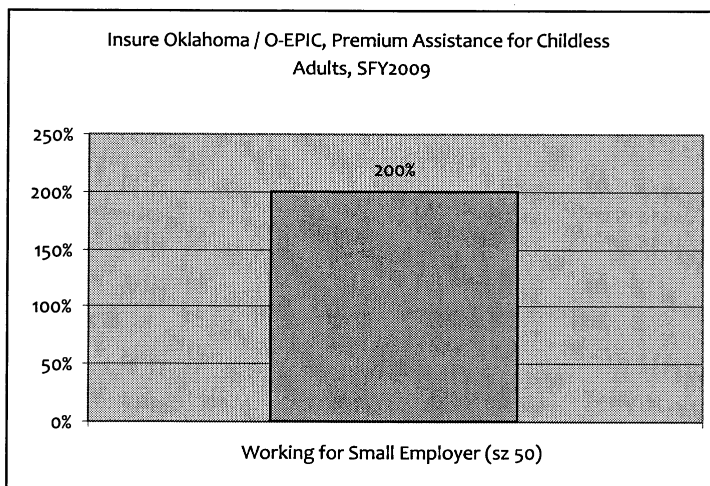
[1] L. Clemans-Cope, B. Garrett, and C Hoffman, 2006, "Changes in Employees Health Insurance Coverage 2001-2005," Kaiser Commission on Medicaid and the Uninsured (#7570 October), http://www.kff.org/uninsured/7570.cfm

[2] Kaiser Family Foundation and Health Research and Educational Trust, 2008, "Employer Health Benefits 2007 Annual Survey."

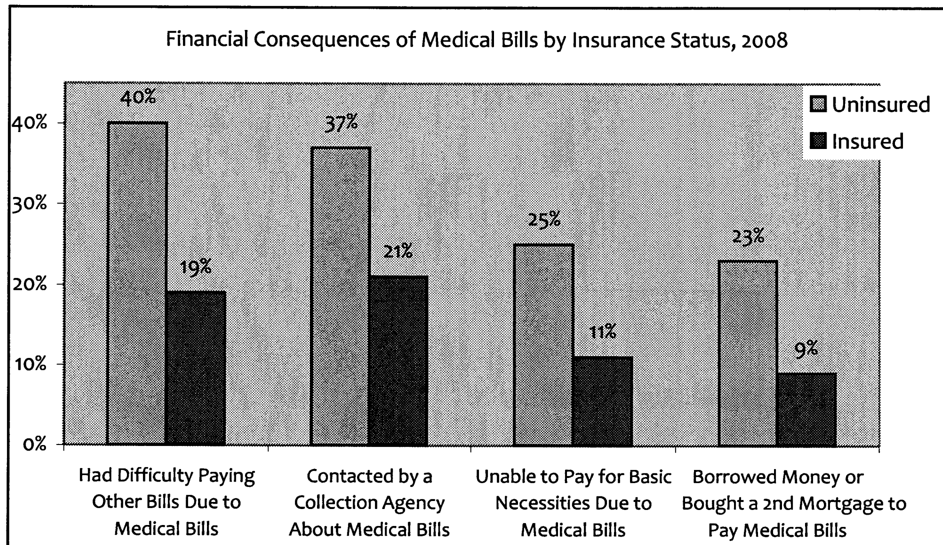




The uninsured suffer from negative health consequences due to their lack of access to necessary medical care. About one-quarter of uninsured adults go without needed care due to cost each year. The uninsured are less likely than those with insurance to receive preventive care and services for major health conditions. Lack of access to timely care causes more than 20,000 uninsured adults to die prematurely each year.[3]

Medical bills are a burden for the uninsured and frequently leave them with debt. The uninsured often face unaffordable medical bills when they do seek care. The uninsured pay for more than one-third of their care out of pocket and are often charged higher amounts for their care than the insured pay. These bills can quickly translate into unaffordable levels of medical debt since most of the uninsured have low or moderate incomes and have little, if any, savings.

[3] S. Dorn, 2008 "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality," Urban Institute, http://www.urban.org/publications/411588.html



Source: Kaiser Family Foundation, 2008 "Economic Problems Facing Families," (#7773 April)

The bottom line:
Oklahoma has a high percentage of uninsured – most of whom belong to working families, make below 300 percent of the federal poverty level (FPL), can't access affordable health care insurance, and don't qualify for SoonerCare because of federal policy barriers.

Identifying the Solution

Build on firm foundation of the Insure Oklahoma, Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) Program

In September 2005, the Centers for Medicare and Medicaid Services (CMS) approved Oklahoma's HIFA (Health Insurance Flexibility and Accountability) waiver, authorizing the implementation of the Insure Oklahoma, Oklahoma's Employer/Employee Partnership for Insurance Coverage (O-EPIC) program. The program currently provides a means to affordable health coverage for more than 14,000 working Oklahomans. This waiver is funded by tobacco tax collections and therefore is limited in funding. Since the Insure Oklahoma program is not an entitlement program like SoonerCare, enrollment may be limited based on available funding. At current levels and projections, tobacco tax collections would provide funding for 37,000 to 40,000 adults.

Phase one of the program, otherwise known as Employer-Sponsored Insurance (ESI), was implemented in November 2005 and initially benefited qualified Oklahoma small businesses with 25 or fewer employees. The Medicaid Reform Act of 2006 (56 O.S. 1011.1 through 1011.11) authorized the program to be offered to small businesses with 50 or fewer employees. This was implemented in October 2006. The program pays for part of the private health plan premiums for qualified employees working for small businesses. Insure Oklahoma ESI has shown increased enrollment over the last fiscal year. In order to continue the upward trend, Insure Oklahoma announced a co-op advertising opportunity for insurance agents. Co-op advertising is a cost-sharing arrangement between the program and the private business to purchase newspaper, radio and television ads. The agency has also

partnered with the Oklahoma Insurance Department (OID) to hire three insurance agent liaisons. In 2007, the OHCA awarded a marketing contract to Griffin Communications. Advertising for Insure Oklahoma began in mid-October of 2007 and to date has more than doubled the existing membership of the program.

Phase two of the Insure Oklahoma program, the Individual Plan (IP), is a health care coverage product for people who cannot access private health coverage through their employer. The Insure Oklahoma IP program kicked off in January 2007. This plan extends coverage to uninsured self-employed individuals, workers whose qualified employers do not offer health coverage, workers who are not eligible to participate in their employer's health plan, sole proprietors not eligible for small group health coverage, and the unemployed who are currently seeking work. The Individual Plan allows qualified persons to purchase state-sponsored health coverage for a monthly premium based on household income. Individuals are responsible for co-pays on certain benefits, and may access services from a network of IP-contracted providers. The plan offers a limited benefit package and a lifetime benefit maximum. Total out-of-pocket costs (including premiums) for the family can not exceed 5 percent of household income.

~Adults

With both the Insure Oklahoma ESI and IP programs running successfully, the OHCA is ready to take on the new opportunities provided by recent legislation. In 2007, the legislature revised the Medicaid Reform Act of 2006 (56 O.S. 1011.1 through 1011.11), by expanding the participation for Insure Oklahoma to businesses with 250 or fewer employees and workers with total household incomes of up to 250 percent of the Federal Poverty Level (FPL). This will greatly expand the number of businesses and employees qualified for coverage in the program.

The first phase of the adult expansion was implemented in November 2007. OHCA's existing waiver currently allows income guidelines to be 200 percent of the FPL and business size guidelines to remain at 50 or fewer employees. The second phase of the adult expansion will occur upon federal waiver approval, increasing business size guidelines with the use of a phased-in approach allowing the smallest businesses with 50 or fewer employees the first opportunity to enroll, medium-size businesses with fewer than 100 employees the second opportunity to enroll, and larger businesses with up to 250 employees the third opportunity to enroll. While the state legislation allows for adults to be covered with incomes up to 250 percent of the FPL, federal guidance from the August 17, 2007, State Health Care Official letter, as well as new policy interpretations by CMS, allow adults to be covered only to 200 percent FPL. The OHCA continues to negotiate with its federal partner to alleviate this barrier to coverage. The Insure Oklahoma adult expansion is anticipated to become operational upon federal waiver approval.

~College Students

The Medicaid Reform Act of 2006 (56 O.S. 1011.1 through 1011.11), directs the OHCA to provide health care benefits to qualified students up to the age of 23, if the person is enrolled as a full-time student at an accredited college or university in the state of Oklahoma. Under current federal law, this group is not qualified for SoonerCare coverage. National statistics show that 30.6 percent of individuals aged 19-23 are uninsured.[4] Due to the historically high rate of uninsured, this age group has been nicknamed the "young immortals" by the insurance industry. As a result, this age group has become the target of many efforts to decrease the overall numbers of uninsured.

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[4] (US Census Bureau; Income, Poverty, and Health Insurance Coverage in the United States: 2005; People With or Without Health Insurance Coverage by Selected Characteristics: 2004 and 2005).

The college student expansion is anticipated to begin upon federal waiver approval with the first phase including students with income up to 200 percent of the FPL. While the state legislation allows for college students to be covered with incomes to 300 percent of the FPL, federal guidance from the August 17, 2007, State Health Care Official letter, as well as new policy interpretations by CMS, considers this group as adults and allow adults to be covered only to 200 percent FPL. The OHCA continues to negotiate with its federal partner to alleviate this barrier to coverage.

~Children

Children will also be qualified to participate in the Insure Oklahoma program as a result of the "All Kids Act," Senate Bill 424, passed in May 2008. As part of the "All Kids Act" (56 O.S. 1009.1 and 1009.2), children between 186 percent and 300 percent of the FPL, whose parents work for a small business, may be qualified to participate in either Insure Oklahoma ESI or IP. Through the program these families will receive premium assistance in a manner similar to current Insure Oklahoma members. This will give families the opportunity to maintain a single source of health care coverage, within the private market. Children in households with income less than 185 percent of the FPL may continue to enroll in SoonerCare coverage.

The "All Kids" expansion is anticipated to begin upon federal waiver approval with the first phase increasing income guidelines to 250 percent of the FPL, for families with parents working at businesses with fewer than 250 employees. The OHCA chose to phase in the "All Kids" program due to ongoing federal debate over SCHIP reauthorization and guidance received in an August 17, 2007 State Health Care Official letter which added additional administrative monitoring and reporting of states expanding programs above 250 percent FPL. Children in families with parents working at any size business and with incomes between 251 percent and 300 percent of the FPL will be phased-in contingent upon federal approval and available funding.

A Recommendation to the Oklahoma Health Care Reform Task Force by the Oklahoma Health Care Authority

October 14, 2008

Recommended Action Plans

We recommend a plan that would reduce Oklahoma's uninsured rate to 7.7 percent using only a minimal hospital provider fee. This would mean a drop of more than 10 percentage points, catapulting our state from 45th in the country to the number 1 ranking in fewest uninsured people. In fiscal year 2009, there were provider fees in place in 45 states. Of those 45 states, 22 currently have a hospital provider fee including neighboring states, Kansas and Missouri. Those two states also have the lowest uninsured rates in our geographical region.

This plan would provide greater access to the commercial health insurance and strengthen the marketplace for insurers, hospitals, physicians and other health care providers. This plan would also provide a financial lifeline to hospitals that serve more indigent patients who cannot pay their bill while shifting more uninsured Oklahomans to the private market. This effort should also strengthen private insurance market for insured individuals by reducing cost shifts and moderating premium costs.

Pending federal approval, the state has passed legislation to reach more than 340,000 Oklahomans. This plan will provide the funding necessary to keep this statutory commitment. We recommend changing the SoonerCare qualification limits to 100 percent of the federal poverty level for adults (from 57 percent) and 200 percent for children (from 185 percent). This will create a more realistic transition from SoonerCare coverage to commercial coverage available in the Insure Oklahoma program by preventing a "donut hole" of people who could not afford the cost sharing requirements. This would also effectively eliminate the "cliff effect" and encourage SoonerCare members to improve their incomes without fear of losing their health insurance. This plan would focus on outreach to encourage adults and children who are qualified for either SoonerCare or Insure Oklahoma to enroll without a mandate.

We recognize that participation will take time and people will not immediately take up the newly accessible insurance. Therefore, we recommend using the entire unmatched state share to create a transition catastrophic plan covering uncompensated emergency room and inpatient hospital and related physician care of indigent patients. The state-only funds would shift from the catastrophic plan to Insure Oklahoma coverage as more people become insured. This would meet the immediate crisis of hospitals and physicians that serve a disproportionate share of patients who cannot pay for their care. To incentivize insurance enrollment an individual will only have one opportunity to receive the limited benefits of the catastrophic plan. Any individual participating in the catastrophic plan will be required to enroll in health care insurance options and will not receive additional catastrophic plan benefits. To assist, a health insurance connector would be established to proactively connect individuals without health insurance to coverage options. This would help educate and encourage consumers to take control of their health care needs. It would also reduce medical-related bankruptcies and cost shifting from uncompensated care. According to Kenneth Thorpe, PhD, *Paying a Premium: The Added Cost of Care for the Uninsured* (Families USA, 2005), Oklahomans pay $954 million annually in cost shifted to pay for the care of the state's uninsured population. This amounts to the 3rd highest "hidden tax" burden in the nation.

Our hospital fee proposal will not raise costs for consumers. Consumers will likely save money in the long-term with the elimination of the "hidden tax." In fact, hospitals can expect to receive an 18 percent return on the investment, anchoring economic development opportunities in rural Oklahoma and strengthening the safety net for urban providers. This plan also includes a rate increase made available using the federally recognized Medicare cost limitations.

Here is how it will work:

Hospital Provider Fee - Estimated Return on Investment

	Proposed Assessment	Amount
1)	Estimated FY 2010 Gross Revenues	16,971,522,325
2)	Proposed Fee	2.225%
	Estimated Collections	377,616,372

	Proposed Expenditures	Amount
1)	Hospital Rate Increases	106,462,707
	State Share	37,477,535
	Federal Share	68,985,173
2)	Additional Funding for Insure OK Coverage	
	346,226 Members [1]	966,234,890
	State Share [2]	340,138,837
	Federal Share	626,096,053

	Summary	Amount
3)	Percentage of Medical Expended for Hospital Care [3]	35.16%
	Subtotal to Hospitals from Insure Oklahoma	339,728,011
	Hospital Rate Increase	106,462,707
	Estimated Return	446,190,719
	% of Return on Fee	118.16%

Notes:

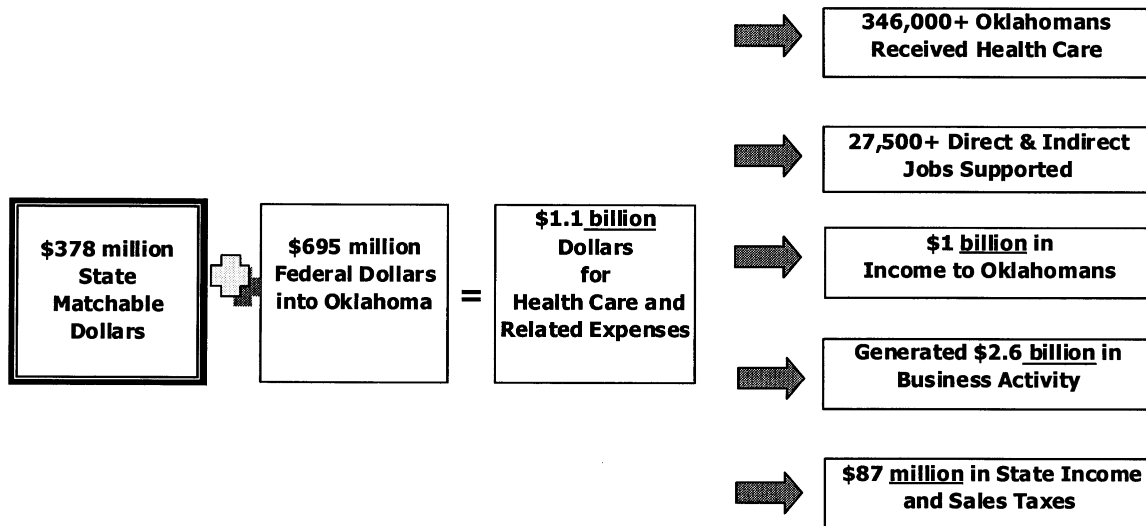
1)	Data reflect the number of kids and adults OHCA expects to cover	SoonerCare	Insure Oklahoma	Totals	Total Cost Estimate
	Kids @ $1325 per	69,303	34,107	103,410	$ 137,018,250
	Adults @ $3415 per	67,142	175,674	242,816	$ 829,216,640
	Totals	136,445	209,781	346,226	$ 966,234,890

2) Hospital Based Uncompensated Care Reimbursement Program

The state share amount of $340 .1 million will be set aside in a separate fund to expand health care coverage to the uninsured through Insure Oklahoma. As Insure Oklahoma expands there will be a transition period. During the transition the unmatched state share will be placed into a separate fund created for a catastrophic plan covering uncompensated emergency room and inpatient hospital and related physician care of indigent patients. These state-only funds will shift from the catastrophic plan to Insure Oklahoma coverage as more people become insured. The intent of the program will be to meet the immediate crisis of hospitals and physicians that serve a disproportionate share of patients who cannot pay for their care. To incentivize insurance enrollment an individual will only have one opportunity to receive the limited benefits of the catastrophic plan. Individuals participating in the catastrophic plan will be required to enroll in health care insurance options and will not receive additional catastrophic plan benefits after the initial encounter. To assist, a health insurance connector will be established to proactively connect individuals without health insurance to coverage options. This would help educate and encourage consumers to take control of their health care needs.

3)	CMS Report: National Health Expenditures by Type of Service: Five Year Average	Total (in millions)
	Net Total Expenditures w/o CMS Programs	857,541
	Hospital Total Expenditures w/o CMS	301,511
	Hospital Percent of Total Expenditures	35.16%

Economic Impact
Based on Hospital Provider Fee Proposal



Source: Economic Impact of the Medicaid Program on Oklahoma's Economy, June 2007, prepared by the National Center for Rural Health Works.

OKLAHOMA DEPARTMENT OF MENTAL HEALTH
AND SUBSTANCE ABUSE SERVICES

October 13, 2008

Dear Chairmen and Members of the Task Force,

On behalf of the Oklahoma Department of Mental Health and Substance Abuse Services, and the 3.6 million Oklahomans that we are charged to serve, I am pleased to share with you our recommendations for health care reform in Oklahoma.

First, let me extend our appreciation for being invited to the table for this discussion. Just a few short years ago, mental illness and addiction would not have been considered relevant to a discussion on healthcare. Today, many in this chamber, and certainly the members of this task force, understand the medical nature of these conditions. For the 26% of our state's population affected by mental illness, addiction, or both, inclusion in the discussion is critical.

Many intriguing ideas have been discussed thus far in the process and there will likely be great debate on the merits of various approaches in the upcoming months. Rather than weighing in on specific proposals, ODMHSAS's recommendation for reform is centered on fair and equitable treatment for mental illnesses and addictions regardless what approach is prioritized by this body. We believe, and recent national developments confirm, that mental health and chemical dependency services (both inpatient and outpatient)should be covered in a benefit plan as medically necessary. Benefit design in terms of co-pays and deductibles for these services should be the same as those assigned to other health conditions. Additionally, those requiring pharmaceutical interventions for their mental illness or chemical dependency should have access to a pharmacy formulary that is as broad or as narrow as the pharmacy formulary for other health conditions. Also, any health coverage model should provide access to a broad spectrum of treatment providers, including specialists in behavioral healthcare.

I should emphasize that coverage of these conditions has been a consistent theme in presentations by guests of the task force. For example, O-CHIP, presented by Tom Daxon, offers coverage on behavioral health care. Also the Indiana and Massachusetts plans included coverage in their benefit design for behavioral health. Adding weight to this emphasis is the historic agreement reached by Congress and the executive branch on a federal behavioral health parity benefit. By the time you read this, it is probable parity will be law.

Other Oklahoma initiatives have also reached the same conclusion about including mental health and addiction benefits in any healthcare expansion. In CHAT, a process initiated by Insurance Commissioner Holland that allowed Oklahomans to prioritize what they desired in a core health plan, services for mental health and addiction was broadly desired. In follow up activities related to the State Coverage Initiative and the Core Health Benefits Task Force, both initiatives reached the same conclusion: inclusion of a

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mental health and substance abuse benefit is important for the state of Oklahoma, and in fact, lowers cost.

In closing, I want to underscore two specific reasons coverage for these conditions are a good investment. First, failure to provide services for those experiencing mental illness or addiction is costing our state millions. Without services, people end up in jails and prisons or present to our hospital emergency departments without the benefit of a third party payer source. Providing treatment saves our state money.

Secondly, these illnesses are diseases of the young. Most illnesses occur as individual's age. Mental illness and addiction, on the other hand, develop in the late teens and early twenties, precisely the age band represented by the "invulnerables", those most likely to be uninsured.

As this task force completes its work, I ask you to remember those living with addiction and mental illness in your recommendations and clearly articulate that coverage of these conditions is a fundamental element of any health reform advanced for consideration. Thank you again for the opportunity to provide input.

Sincerely,

Terri White, MSW
Commissioner

Oklahoma State Department of Health
Creating a State of Health

October 17, 2008

The Honorable Kris Steele
Co-Chair, Oklahoma Health Care Reform Task Force
Oklahoma House of Representatives
State Capitol Building, Room 438
2300 N. Lincoln Blvd.
Oklahoma City, OK 73105

Dear Chairman Steele:

Thank you for the work that you and Representative Cox are doing to address the critical issue of health system reform in Oklahoma, and for the opportunity for me to provide input into this effort.

All of us involved in this process are well aware of the dismal health outcomes of the Oklahoma population and large number of people without health insurance. Recent reports have also revealed that Oklahoma ranks low on several other issues related to the delivery of health services, such as health care quality, cost of health services, disparities in access and outcomes between different subpopulations, lack of an adequate supply of heath care workers (especially primary care physicians), and poor access to mental health and addiction services. Another important report that is worth noting here is the 2001 Institute of Medicine report "Crossing the Quality Chasm," which addressed the problems with our current health care system and what we should do to create a better system. The report stated that the guiding philosophy in this effort should be that health constituencies work to assure that all Americans receive care that is Safe, Effective, Patient Centered, Timely, Efficient, and Equitable.

In addressing this complex array of issues, I summarize our challenges as an attempt to "Improve health outcomes and assure access to high quality, affordable health care for all Oklahomans, for both physical and mental health." To accomplish this, I broadly categorize the needed efforts into five major areas of work:

(1) Access: Increase the availability and accessibility of health services;
(2) Workforce development: Assure an adequate supply of well-trained health professionals;
(3) Quality and cost control: Improve the quality and safety of our healthcare system and control costs;
(4) Equity: Assure equitable distribution of health services and outcomes; and
(5) Prevention: Improve the health of our population through disease prevention and health promotion, decreasing the demand for expensive health services.

Secretary of Health and Commissioner of Health
James M Crutcher, MD, MPH
An Equal Opportunity Employer

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Cris Hart-Wolfe

1000 NE 10TH Street
Oklahoma City, OK 73117-1299
www.health.ok.gov

Although the primary concern for the work of this task force is access to care, I would assert that all of these areas are important to consider if we want to have a health system that is widely and easily accessible to all Oklahomans, safe and of high quality, affordable and sustainable, and that strives to improve the health of the population by promoting health and wellness instead of just treating disease. All of these issues apply to both physical and mental health; we must start giving greater importance to mental/behavioral health and the role it plays in the health of individuals and our overall state's health.

In addressing access to care, the primary effort underway at present is the State Coverage Initiative (SCI), led by Commissioner Holland. I am a member of this effort and fully support the work of the multidisciplinary team. The main thrust of the effort at present is to accurately define our uninsured population, determine a basic insurance package, and then work to make it as widely available as possible, primarily by maximizing the utilization of existing public (SoonerCare) or public-private (Insure Oklahoma) programs. Expanding coverage will obviously require identifying additional funds, which I know is a focus area of this task force. Other important components in the delivery of health services in the state include the services provided by the tribes and the Indian Health Service, Federally Qualified Health Centers, and volunteer services. We should also consider the role that telemedicine can play in meeting service needs.

Workforce development is obviously critical in the discussion of access to quality health care. Nursing shortages have been recognized for many years, but a recent report also revealed that Oklahoma has one of the lowest per capita concentrations of physicians in the U.S., especially primary care physicians. The recently established Health Care Workforce Resource Center is assessing the issue of shortages of nurses and other allied health personnel, and developing plans to address those shortages. However, at present there is no coordinated effort to address physician shortages in the state. A similar process as that established for nurses needs to be developed for physicians.

The area of quality of health care systems has received a lot of discussion over the last several years, but is still an area that is poorly understood by most health professionals. In general, it is an attempt to assure that providers and systems are utilizing evidence-based practices to improve the likelihood of achieving established outcomes. After the Commonwealth Fund report came out in 2007, in which Oklahoma ranked 43rd in the area of quality, the State Health Department created the Oklahoma Health Care Quality Improvement Advisory Committee. The committee is comprised of many of the major health care partners and its mission is to improve the quality of care in the four service areas identified by the Commonwealth report—hospitals, home health, long-term care and outpatient care.

Improving equity focuses on efforts to decrease the gaps that exist between different segments of the populations, in terms of both health outcomes and access to care. The underlying reasons for these inequities are primarily related to poverty, education, and other social determinants of health; however, they generally are recognized as disparities between racial/ethnic groups. For example, for most of the routine health indicators, African Americans have the worst health outcomes of any racial group, and Native Americans and Hispanics have poorer outcomes for many of the health indicators. It is imperative that we focus significant attention on improving the health of these most adversely impacted groups in our efforts to improve the overall health of the state. Current efforts to address this issue at the state level include the Governor's Task Force on the Elimination of Health Disparities and the State Health Department's Office of Health Equity and Resource Opportunities.

A critical component of any plan to improve the health of our state must be to give increased attention to prevention and health promotion activities in order to decrease the impact of behavior-related chronic diseases on the Oklahoma population. Oklahoma significantly exceeds the national average in the top four causes of death—heart disease, cancer, stroke and chronic lung disease—and it is this fact that causes us to rank so low in most reports. To decrease the impact of these diseases we must decrease the prevalence of the risk factor associated with these diseases—tobacco use, lack of physical activity, poor nutrition, and obesity. Focusing more resources on keeping people healthy instead of just treating disease will not only improve health outcomes, but also has the potential to decrease costs by avoiding the need for expensive health care for diseases like heart disease and cancer. We must aggressively continue our efforts to decrease tobacco use while we take on the new challenges of improving the fitness and nutrition habits of Oklahomans. Some of the current efforts in this area include the Strong and Healthy Oklahoma Initiative, The Fit Kids Coalition, and numerous school related activities around the state. Also, the recently established work group to develop the Oklahoma Health Improvement Plan will initially focus on efforts to address tobacco use, obesity, and children's health.

Thank you again for the work that you are doing to address this difficult issue. I look forward to continuing to work with you and others to improve the health of our state and to assure that all Oklahomans have access to high quality, affordable health care.

Sincerely,

James M. Crutcher, M.D., M.P.H.
Secretary of Health and Commissioner of Health

Improving Health Outcomes and Assuring Access to High Quality, Affordable Health Care for All Oklahomans

(for both physical and behavioral health)

Mike Crutcher, MD, MPH

Commissioner of Health

Oklahoma State Department of Health

Recent Reports Assessing Health Outcomes and Health Systems in the U.S.

- United Health Foundation Report, 2007
- Commonwealth Fund Report, 2007
- Robert Wood Johnson Foundation "A Checkup on Health Care Markets," 2007
- Institute of Medicine Report "Crossing the Quality Chasm," 2001

United Health Foundation Report, Oklahoma

	2007		2006	
Overall Rank	47		44	
Health Outcomes	Data	Rank	Data	Rank
Poor Mental Health Days	4.3	47	3.6	41
Poor Physical Health Days	4.5	48	4.1	44
Infant Mortality (/1,000)	8.0	40	8.2	43
Cancer Deaths (/100,000)	215.2	43	216.5	44
Premature Death (yrs/100,000)	9,307	43	9,290	43
CVD Deaths (/100,000)	412.1	50	416.4	50

Risk Factors for Health
(OK Rank)

- Income (<$25,000) (47)
- Education (<HS, < Col) (41, 47)
- Health Insurance (44)
- Tobacco use (47)
- Nutrition (50)
- Exercise (47)
- Obesity (44)
- Mental illness (50)
- Prevalence of diabetes (46)
- Prevalence of HBP (45)

*2005 BRFSS

Commonwealth Fund Report, 2007
OK Ranking

- Overall rank: Tied with MS — 50

- Health outcomes — 47
- Access to care — 49
- Quality — 43
- Avoidable hospital use and costs — 50
- Equity — 50

7 Attributes of a Highly-Functioning Health Care Market

RWJF "A Checkup of Health Care Markets": Apr 2007

1. Community leadership
2. Quality improvement
3. Performance management
4. Public reporting
5. Provider financial incentives
6. HIT incentives and infrastructure
7. Consumer engagement

The health care system should work to ensure that all Americans receive care that is:

1. Safe
2. Effective
3. Patient centered
4. Timely
5. Efficient
6. Equitable

Ref: “Crossing the Quality Chasm”, IOM, 2001

Improving Health Outcomes and Assuring Access to High Quality, Affordable Health Care for All Oklahomans (includes physical and behavioral health)

- Prevention and health promotion
- Access
- Quality / Cost control
- Equity
- Workforce development

THE STATE CHAMBER OF OKLAHOMA
LEGISLATIVE ADVOCATES FOR BUSINESS

Oklahoma House of Representatives
Health Care Reform Task Force Recommendations

Submitted by The State Chamber of Oklahoma

The State Chamber of Oklahoma would like to thank the Oklahoma House of Representatives for conducting a thorough task force interim study regarding the condition of Oklahoma's health care delivery system. The focus has been an attempt to develop methods for improving the affordability and accessibility of health care to Oklahoma citizens.

One can initiate discussion on this topic by admitting the fact that Oklahomans are simply unhealthy due to our own bad habits. We have dismal health statistics and simply must change behaviors. This in and of itself translates into high health care costs and a high number of uninsured whose pre-conditions preclude the ability to obtain health insurance. Initiating education programs designed to curb this trend will, in the long term, be extremely beneficial in developing a more accessible and affordable health care system for our state's citizens.

That being said, at approximately twenty percent, Oklahoma has one of the highest per capita uninsured health insurance coverage levels in the nation. This places tremendous upward pressure on the premiums those with insurance pay as well as a strain on state appropriations in paying for those who access indigent care.

The State Chamber supports building on the employer-based system to improve quality, rein in costs and expand coverage. Reforms should be targeted in an effort to help cover the nearly 20 percent of Oklahomans who do not have health insurance rather than create massive reforms which affect those who are satisfied with their current coverage and the health care delivery system. Incentives to the private sector which enhance the level of participation in the free market system are the best method for offsetting this strain on the system.

In addition to the House of Representatives Health Care Reform Task Force, another ongoing effort to address this serious issue is the State Coverage Initiative (SCI) program conducted within the Oklahoma Insurance Department through a Robert Woods Johnson grant. Combined, these efforts should present several alternative plans which will assure that Oklahoma can appropriately incorporate methods to significantly reduce the number of uninsured as well as enhance the affordability of quality health insurance.

One of the significant focuses of the SCI effort is the creation of a "core" health benefit insurance plan which does not have to conform to state health coverage mandates. Although all mandates are well intended, the required added cost to health insurance premiums continues to drive up costs and make insurance less affordable. Anything that will add to the cost further burdens the already stressed small business owner and employees - potentially impacting those offering coverage to no longer do so or those contemplating offering to postpone until "times are better" financially. Adding mandates just exacerbates the increased cost and hampers affordability.

The development of a core plan would immediately initiate a marketplace for new and more affordable policies which would most likely be more enticing to the small business community, which is where most of the employed but uninsured are found.

In conjunction with the effort to make health insurance more appealing to the small business market is the *InsureOklahoma!* premium assistance program. This program, when fully utilized, represents expanded coverage for 40,000 Oklahomans and stands to be a tremendous tool to help small employers provide affordable health insurance for their employees. If approved by the Center for Medicare and Medicaid Services (CMS), a waiver currently under consideration would increase the eligibility of qualifying wages from 200% of the federal poverty level (FPL) to 250% FPL. This will prove to be a tremendous enhancement when attempting to achieve the maximum utilization of this program currently available for businesses of 50 or fewer employees. In addition to securing an identifiable and sustainable funding source for the *InsureOklahoma!* program and potential program enhancements, such funds should also be dedicated solely for the program's utilization and should NOT be utilized for any other budgetary purpose.

In addition, in order to further make health insurance more affordable and accessible, the legislature should develop statutory incentives to be utilized by the private sector health insurance marketplace. This can be done by creating tax credits or other inducements for plans that incorporate cost saving initiatives such as the utilization of evidence based medicine, information technology, pay for performance enticements, liability limitations on employers and providers, incentives for preventative care and tax deductibility for all health related out-of-pocket expenses.

Thank you for allowing The State Chamber of Oklahoma the opportunity to participate in this important effort addressing the problems and issues associated with the state's health care delivery system.

October 1, 2008

Dear Health Care Reform Task Force:

On behalf of the Chickasaw Nation, we appreciate the opportunity to discuss one of the most important issues facing the State of Oklahoma which is to improve access of quality healthcare for our entire community and state. Although healthcare is a broad complex issue, the following recommendations we are making are potentially straightforward solutions that have been discussed by many leaders across our state.

Recommendations are:

1. If there are financial and benefit advantages to the current SoonerCare benefit plan then we should consider offering the Soonercare healthcare product to be purchased by the citizens of the State of Oklahoma who currently do not qualify for the program. The advantages of the current SoonerCare program include infrastructure, expertise, economies of scale, standard fee scales with hospitals/providers and a track record of quality performance.

2. Establish a chronic disease management initiative with a SoonerCare type product which would provide a financial incentive for individuals who effectively manage their chronic disease or for those that maintain a measureable level of wellness. An example would be a citizen who has known heart disease and has high cholesterol. A financial incentive could be provided to that citizen for modifying their diet and taking medication to get their cholesterol within normal limits. The voluntarily group that participate in a successful voluntary chronic disease management and wellness program could inspire employer based insurance providers to model the program if both financial and health benefits are established.

3. We would also recommend an established priority for subsidized expansion of health coverage towards the following general categories in this recommended order:
    1. Uninsured children
    2. Employed/working uninsured
    3. All other uninsured

4. Promote and support faculty development/retention for all levels of academic professions who instruct healthcare related programs. Increasing our healthcare capacity via addressing our workforce shortage will be a critical part of our strategy to improving access to care.

5. Any proposed health benefit plan should include a holistic approach to health including behavioral health, mental health, and substance abuse services.

We applaud the efforts of the Health Care Reform Task Force and look forward in participating in the final recommendations.

Sincerely,

Dr. Judy Goforth-Parker

Oklahoma House of Representatives
Health Care Reform Task Force Recommendations

Submitted by The Greater Oklahoman City Chamber

Beginning in June 2008 the Oklahoma House of Representatives began a task force interim study regarding Oklahoma's health care delivery system. The focus has been to address options for affordability and accessibility of health care for Oklahomans.

The Taskforce has been instrumental in opening discussions which promote market-based reforms, reduce barriers to purchasing health insurance coverage, and encourage personal responsibility through education and wellness programs.

Nevertheless, with approximately 660,000 or 20% of Oklahomans being uninsured, we have one of the highest per capita uninsured levels in the nation. This places the strain of higher premiums on those with insurance as well as financial pressure on state appropriations that pay for those accessing free/indigent care.

The Chamber supports initiatives and solutions that incorporate market-based approaches, increased market competition, personal responsibility, portability, transparency and increased use of technology. Therefore, instigating change in the form of transformation; individual empowerment; behavioral change and not cost shifting; affordability in the forms of rewards and incentives; increased choices; and financial security. All these things would help to create a culture of health in Oklahoma and encourage a holistic approach to health and healthcare without affecting those who are satisfied with their current coverage and health care delivery system.

The Chamber also supports ongoing efforts by the State Coverage Initiative (SCI) that look at developing a "core" health benefit insurance plan that does not have to conform to state health care mandates. The Chamber vigorously opposes unnecessary coverage mandates that drive up the cost of premiums, thus making insurance less affordable for the small business owner and employees. The impact of which would be felt by those small businesses being unable to offer health insurance.

A core plan would initiate a more competitive marketplace for new and more affordable policies. These policies are more enticing to the small business community, which is where most of the employed but uninsured are found.

The Chamber also supports the *InsureOklahoma!* premium assistance program and finding a dedicated funding source that would be used solely for this program. The program has the potential to provide coverage to 40,000 Oklahomans and offers a remarkable opportunity for small employers to provide affordable health insurance for their employees.

Finally, we believe wide spread coverage can be achieved through innovative market-based solutions, private and corporate efforts, tax incentives, information technology, liability limitations on employers and providers, preventative care incentives and strong community support.

November 10, 2008

The Honorable Kris Steele
Co-Chair, Oklahoma Health Care Reform Task Force
Oklahoma House of Representatives
State Capitol Building, Room 438
2300 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105

Dear Chairman Steele:

It has been my privilege to serve as a health care professional for over 30 years. During that time I have been responsible for small rural hospitals to very large tertiary and quaternary single hospitals, as well as small to large regional health systems consisting of physician groups, hospitals and insurance plans. A copy of my practice experience is attached to my statement. Most of my experience has been with faith-based health systems in the following states: Texas, California, Tennessee and now Oklahoma.

I currently serve a 501(c)(3) Catholic health system. The Saint Francis Health System feels a moral, not just a legal, duty to serve the underserved and vulnerable. I personally share that mission and vision. Below is an example of what we deal with at Saint Francis:

- Saint Francis sees 46,000 inpatient admissions each year;
- Saint Francis has over 336,000 outpatient visits;
- The 275 employed physicians within Warren Clinic see over five percent of the state's population;
- Saint Francis emergency rooms see 91,000 patients each year;
- Saint Francis provides over 36,000 Medicaid days of each year;

- The community benefit the health system provided since 2002 exceeds $260 million (at cost); and
- Saint Francis opened the new Children's Hospital at Saint Francis this year in response to the needs of the most vulnerable in our society.

Through the course of my career I have had many opportunities to observe the relationship between politics and health care delivery. I do not mean this as a political message, but I strongly believe the health care industry is too complex to fit nicely into any particular political ideology. Said another way, I believe the willingness to set aside pre-formed political prejudices and examine the reality of the issues as they are confronted by providers, by insurers, and by patients will be necessary for any meaningful reform outcome. I appreciate the seeming willingness of the Committee Members to engage in such a process.

Oklahoma has historically done a very poor job in terms of accessing federal dollars to combine with state dollars. This historical failure, whether it is our low-DSH status or our only recent efforts to achieve UPL, has no doubt contributed cumulatively to many of Oklahoma's health woes.

Oklahoma's health statistics are among the worst in the U.S.; that fact must be acknowledged and understood if we are to change them. In my profession this means patients who present to our system are often sicker and suffering from more complications and co-morbidities; this stretches the available resources and increases costs.

Oklahoma, as we have been told, also suffers from a high percentage of uninsured. The absence of health insurance harms not only the individual without coverage, but also the health care system and, in some ways, the economy as a whole. It is certainly true that the "cost shift" associated with the uninsured is a hidden tax paid by the rest of Oklahoma citizens.

The efforts to reach UPL and maximize DSH are greatly appreciated – they have allowed my organization to do things in terms of care that otherwise could not have been done. Examples include the scope of the Children's Hospital and the ability to recruit much-needed specialists to Oklahoma.

We cannot lose sight of the fact that health care is a business. The business of health care, fortunately or unfortunately, can be greatly influenced by State action or inaction.

Good stewards plan for the hard times – in this instance that means we must take advantage of the State's relative financial good times to prepare for the inevitable cyclical decline. To waste this opportunity and find ourselves, whether it be two, five or ten years down the road, without taking advantage of our current blessings would be lamentable.

We must maximize the value of our dollars. It should go without saying (but it apparently must be said) that using the match process to turn one dollar into three dollars is a good deal. Good businessmen and good stewards do not fail to take advantage of such opportunities.

For future planning and expansion of care the Saint Francis Health System organization needs some sense of stability, consistency and predictability in the flow of state dollars. I understand the legislative appropriation process is a yearly one but the Legislature should understand that planning year to year in the health care industry is the mark of a very poor business, one that is likely to fail. The purchase of expensive medical equipment, the building of a new hospital or clinic sites, and the recruitment of medical specialist are all long-term propositions. When you do not know from year to year whether Medicaid reimbursement will be at 60 percent of cost or 95 percent of cost it is difficult, if not impossible, to effectively plan and grow. At a minimum the willingness to take risk diminishes.

We must increase access to care in this State. I honestly do not know if O-EPIC is the best way to do that but I am unaware of any other way that is better. With O-EPIC there is a process that seems to be working on a small scale and that also seems to encompass the best elements from other plans around the country.

We should continue with the O-EPIC model, becoming even more aggressive to expand it.

We need to identify a dedicated and consistent source of funding for State programs such as Medicaid and UPL. Consistent with that we must make every effort to assure providers that, at least, cost based reimbursement will be available.

A source of dedicated funding for the state share of a federal match is a provider fee. This issue has been debated for the past several years but has always seemed to die as a result of a political process and not as the result of

sound financial planning and a prudent approach to government health care spending.

The restrictions on provider fees at the federal level have increased in the last few years and it is reasonable to believe they may increase more in the future. We should not waste one more year in our effort to take advantage of these funding possibilities.

Simply providing insurance is not enough. The scope and nature of the insurance product must also be examined and must be appropriate for the needs of the patient.

As an example, the proliferation of high deductible insurance policies currently fashionable does equate to increased insurance coverage for statistical purposes. However, such plans have also been responsible for the rather dramatic increase in bad debt at many facilities and such plans do nothing to provide a medical home or preventive care.

Likewise, while HSA's and the like may be attractive to a certain tier of Oklahomans, they do not seem to have great utility for the most poor and vulnerable in our society. Utilizing a hot current political buzzword may make good press, but it does not address the issues we are struggling with in Oklahoma.

I am most grateful to the task force for the opportunity to submit these written comments.

Best regards,

Jake Henry Jr.

Appendix V

House of Representatives

STATE OF OKLAHOMA

DATE: November 12, 2008
TO: Oklahoma Healthcare Reform Task Force
FROM: Rep. Ben Sherrer, Task Force Member
RE: Recommendations

To increase access to healthcare to over 600,000 uninsured Oklahomans, the State should take the following steps:

Recommendation #1
The state should capitalize on and expand its Insure Oklahoma program, as recommended by most presenters. As specifically recommended by Task Force Advisory Committee members and presenters including Barry L. Smith, Dr. Marianne Bacharach, The Oklahoma Hospital Association, The Oklahoma Healthcare Authority, and the Oklahoma State Coverage Initiative, Oklahoma should implement a 1% provider fee which will be used to leverage Federal funding for the Insure Oklahoma program. The provider fee should be a dedicated funding source

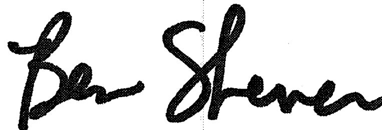
Recommendation #2
Implementation of the Provider Fee should be as recommended by the Oklahoma State Coverage Initiative, based upon enrollment/utilization in the program. *See* SCI Strategy 3.0.

Recommendation #3
As recommended by the State Chamber (as presented by Matt Robison) Oklahoma should provide incentives to the private sector to enroll participants in the program. This can be accomplished by providing compensation to the entity enrolling the participant, with an emphasis on point-of-service enrollment.

Recommendation #4
As recommended by the Greater Oklahoma City Chamber (as presented by Advisory Committee Member Dean Schirf) and Advisory Committee Member Dr. Judy Goforth-Parker with the Chickasaw Nation (as presented by Bill Lance), Oklahoma should provide preventative care incentives. These incentives should be directed at individual responsibility for healthy behaviors/lifestyles. Oklahoma should implement an incentive program similar to the POWER Account in the Healthy Indiana Plan that will provide a State match to individual funds placed into an account for individual wellness. Funds placed into such an account should reduce Oklahoma taxable income.

Recommendation #5
As recommended by Advisory Committee Member David Blatt the Legislature should expand Medicaid eligibility for categorically eligible adults (parents of dependent children) up to 100% FPL.

Recommendation #6
Consistent with reports from Advisory Committee members Brent Wilborn with the Oklahoma Primary Care Association, Advisory Committee Member Dr. Judy Goforth-Parker with the Chickasaw Nation (as presented by Bill Lance) and Melissa Gower with the Cherokee Nation (as presented by J.T. Petherick) Oklahoma should work together with Federally Qualified Health Centers and Tribal Health Providers to insure maximum utilization of those services to eligible Oklahomans.



Pam Peterson
State Representative
District 67

303 State Capitol Building
2300 N. Lincoln Blvd.
Oklahoma City, OK 73105
Phone: (405) 557-7341
Fax: (405) 962-7672
E-mail: pampeterson@okhouse.gov

COMMITTEES:
Education, Higher Ed &
Career Tech Subcommittee

Judiciary & Public Safety,
Criminal Justice Subcommittee

Human Services Committee

CHAIRMAN:
Children & Families Subcommittee

November 13, 2008

Thank you co-chairmen, Rep. Kris Steele and Rep. Doug Cox for an oustanding job in assembling a wide variety of presenters to our task force.
We were exposed to a wide array of differing plans and ideas for helping us develop ways of improving our health care system in Oklahoma.
As we move forward with a specific plan, I would recommend focusing on the following areas:

1- Continue to build upon our InsureOklahoma plan, which is currently being underutilized.

2- We need to implement a chronic disease management plan. "The Asheville Project" model is an example of a multidisciplinary approach to diabetes management.

3- The Community Health Centers model needs to be expanded and utilized to provide basic mediacal care to the underserved and uninsured.
a) consider partnerships between federal, state and locally funded centers and Indian Health Centers.

b) allowing debt forgiveness for educational loans to health care professional serving in these centers.

4- Since nearly 4 out of 10 workers change jobs every year, we need to increase portability of health plans.

5- Tort reform- True tort reform will increase physicians in Oklahoma. Tort reform has had a positive impact in both TX and MS. Access to health care in Mississippi was in serious jeopardy before these reforms were implemented.

As part of any plan, we must try to educate and motivate the vast majority of Oklahomans to take responsibility for their health and well being. Education and prevention should be at the forefront of any initiative.

Rep. Pam Peterson

Rep. Doug Cox M.D.
Healthcare Task Force on the Uninsured
November 13, 2008

I. Keeping insurance affordable by holding down medical costs
   A. Medical education
   B. Insurance/Physician cooperation
   C. Electronic Medical Record
   D. Pricing transparency

II. Topic high points
   A. IHS/Tribes
      1. excellent facilities
      2. high disease rates
      3. insufficient hours of access
      4. need better cooperation with private
      5. tobacco issue

   B. Federally Qualified Health Care Clinics
      1. Arduous process-overwhelming to communities
      2. Primary Care Assoc. must be much more proactive
   C. Insurance
      1. CHAT
         1. model for private insurance companies
      2. Mandates
         A. pro/con
            1. Unexpected denial of covered services
            2. Upfront knowledge of covered services
            3. Mental illness
               a. increasing incidence
               b. parity of coverage
            4. Point of service sign-up
            5. "Bare-bones" coverage

D. Current Oklahoma Programs
   1. Model for other states
   2. Need Feds to approve waivers
   3. Increasing marketing means funding woes
      a. Cigarette tax increase unlikely due to tribal smoke shop policy
      b. Provider donor plan to garner more fed. funds
   4. Medical Savings Accounts
   5. Cafeteria Plan

Health Care Reform Task Force Recommendations
Rep. Kris Steele

1. **Reform/improve Insure Oklahoma**
   Insure Oklahoma is an effective public-private model for providing subsidized health care coverage for those who meet certain eligibility requirements. The program, however, can and should be improved. For example, the program, including both the employer sponsored insurance and the individual insurance plans should offer more low cost choices such as high deductible plans compatible with health savings accounts. Incentives for the use of preventative care and improved wellness, as have been employed in states such as Indiana, should be incorporated into Insure Oklahoma. In addition, Insure Oklahoma should also be reformed to be more customer-friendly especially at the point of eligibility determination and enrollment. The Legislature should revisit pending eligibility requirements within Insure Oklahoma to protect the original intent of being a small business initiative. Finally, the Legislature should carefully consider whether reforming the individual plan component of Insure Oklahoma by relying upon private plans will increase access to insurance by increasing choice and lowering costs through increased savings and efficiencies.

2. **Reform the Individual Market**
   The Legislature should allow insurance providers to offer basic preventative plans with catastrophic coverage free from mandates so more low cost choices can be offered to uninsured Oklahomans.

3. **Encourage the use of Section 125 Plans**
   The Legislature should offer incentives for businesses to offer Section 125 Plans so that employees can utilize pre-tax dollars to purchase health care coverage.

4. **Establish the equivalent of an Oklahoma Connector/Exchange**
   The state should build upon its current infrastructure to offer a service that would "connect" individuals with an insurance plan purchased, in most instances, with pre-tax dollars, from the private sector that would meet their needs. Anyone choosing to use this service who does not qualify for a subsidy would pay a minimal administration fee.

5. **Reform the High Risk Pool**
   A high percentage of health care costs in general, and care for which providers are not compensated in particular, are incurred by a relatively small percentage of people with chronic health problems. These people very often cannot obtain insurance in the private market. The state's current high risk pool, intended to offer insurance to those who cannot purchase it privately, does not adequately address these problems. The program should be reformed both by lowering the cost of insurance to those who cannot purchase private insurance and by providing subsidies for those with lower incomes. The insurance plans offered should include the provision of a primary case physician who will supervise the

patient's care and effective disease management programs for the chronically ill.

6. **Focus on Workforce Development and Physician Manpower**
   As efforts continue to increase the number of Oklahomans with access to quality health care, the state must address the problem of both the present and future shortage of qualified health care personnel in Oklahoma, particularly nurses and primary care physicians. The state should consider increasing support for programs that develop the health care workforce, including scholarships for students seeking advanced nursing degrees that would qualify graduates to fill the critical need for nursing school faculty and matching grants to nursing and allied health education institutions to increase the number of clinical opportunities and better utilize online and distance learning, simulations, and other innovative teaching methods.

7. **Establish Uncompensated Care Pool/Enrollment at Point of Access**
   In order to provide greater access to private health insurance and to strengthen the marketplace for insurers, hospitals, physicians and other health care providers, cost shifting must be reduced to moderate premiums. The state should develop a plan to address uncompensated emergency room and inpatient hospital and related physician care of indigent patients. The funds would shift from covering the costs of uncompensated care to Insure Oklahoma coverage as more people become insured. This concept would address the problem of hospitals and physicians that serve a disproportionate share of patients who cannot pay for their care. To incentivize insurance enrollment an individual will be offered one opportunity to not be held responsible for uncompensated care. Any individual who accepts the state's offer will be required to enroll in an insurance plan and will be held financially responsible for future care. A health insurance connector should be established to proactively connect individuals without health insurance to coverage options.

8. **Fund Reforms**
   Any plan to increase access to health insurance should address how these reforms will be funded.