

Oklahoma

State Planning Grant

Interim Report

September 2004



State of Oklahoma
Health Care Authority
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Executive Summary

The State of Oklahoma received a State Planning Grant from the Health Resources and Services Administration in September of 2003. The Oklahoma Health Care Authority (OHCA), the lead agency for this project, has used grant resources to conduct multiple research projects to study the issue of the uninsured. Oklahoma joins 32 past applicants and is one of 10 current 2003 applicants. HRSA's purpose of this grant is to develop a plan to assure access to health insurance for the people of Oklahoma. The purpose of this report is to summarize our progress to date.

Our twelve-month grant period has allowed the Health Care Authority to take a closer look into the uninsured of Oklahoma. Nationally, Oklahoma has the ninth highest rate of medically uninsured. Census figures show nearly twenty percent or around 675,000 Oklahomans share this common problem. Most people in Oklahoma without health insurance are low-income working adults: 71 percent work full-time or have a member of a household who works full-time, and another 13 percent work part-time. According to the 2004 Community Action Project, there are at least three reasons why these workers are not being insured at their place of employment:

- the employer may not offer an insurance plan;
- the employee may not be eligible for a plan even if one is offered;
- moreover, the employee may not participate in a plan even if he or she is eligible.

The allocation of funds received by the State Planning Grant (SPG) revolved around collection and analysis of data which are used in the planning process. When all data are fully available to us, Oklahoma will be given an opportunity to look comprehensively at the availability of health insurance across the state. Our progress in this first year has given us information on; Oklahoma businesses, individual attitudes, opinions on the accessibility and affordability of health insurance, and health care. Key decision-makers have begun to map out a premium assistance program that will reflect the needs of this state.

Data collected:

Oklahoma Household Survey. The University of Minnesota's Survey Center, SHADAC, is putting finishing touches on providing Oklahoma with a random digit dial telephone survey conducted to provide an accurate estimate of the number of uninsured by location, income, and characteristics of the population that vary with insurance status. This survey has gathered information on demographic characteristics, employment status, access to health insurance, percentages of uninsured, and many other values within these categories. Oklahoma will have this information fully available in the final report.

Focus Groups. The University of Oklahoma, Department of Family & Preventive Medicine conducted beneficiary focus group studies to assess the general beneficiary attitudes toward paying enrollment fees, co-payments or coinsurance, and premiums in order to maintain or obtain health insurance coverage. These focus groups were designed and conducted to answer the following questions; what are the demographics of the low-income uninsured, what health care services has this population utilized in the past year, what services do they feel are most

important, and what portion of their health costs are these potential beneficiaries willing to pay or able to afford.

Small Business Survey. The University of Oklahoma, Department of Family & Preventive Medicine also surveyed small business to determine the interest level of employers participating in the proposed program. A study was designed and conducted to answer three major questions; what types of small businesses offer insurance and is there any significant demographic difference when compared with businesses that do not offer insurance, how many small business employees participate in employer-sponsored insurance, and what is the likelihood that small businesses will participate in some type of government sponsored employee benefit program.

Policy Opportunities. The Health Care Authority is developing options toward a potential premium assistance program. These options are forming the blueprint of our plan to roll out an innovative program designed to fit the needs of the people of Oklahoma. Workgroups have formed from leadership across our state. The members were selected based on experience and influence on healthcare related issues. These workgroups have been tasked to develop viable, realistic and effective strategies for Oklahoma to consider in order to offer health insurance coverage to the uninsured residents of our state. A listing of key contributors can be found in Appendix VII.

The data collection and analysis process also included the evaluation of information from additional sources including information from the Medical Expenditure Panel Insurance Component (MEPS-IC), the Behavioral Risk Factor Surveillance Survey (BRFSS), and Kaiser Foundation information based on the Current Population Survey (CPS). Other reviews included policy and opinion papers from a range of sources.

Oklahoma will have complete information fully available in the final report with regards to recommendations for Federal action to support State efforts to provide health insurance for the uninsured.

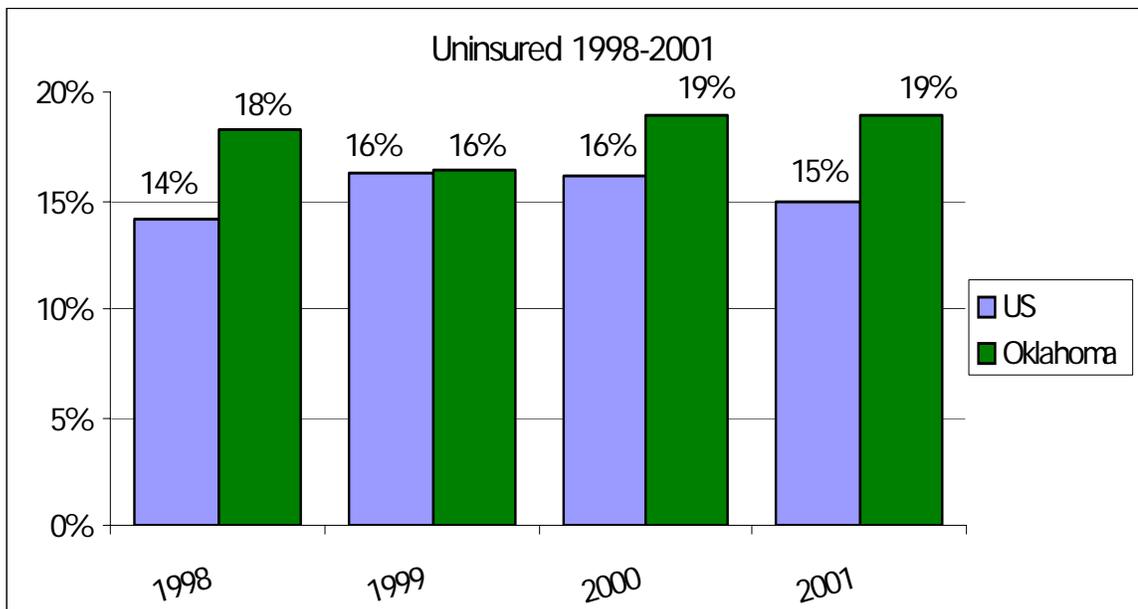
Section 1: Uninsured Individuals and Families

The purpose of this section is to describe (1) who the uninsured are in your State; (2) what strategy was used to obtain this information; and (3) how these findings are reflected in the coverage options that your State has selected or is currently considering. In discussing your survey findings, please be sure to link the results directly to your State's coverage expansion strategy.

This Section provides a preliminary overview of who the uninsured are in Oklahoma. This information was completed through the efforts of the Oklahoma Health Care Authority and research gathered by the Department of Family & Preventive Medicine (DFPM). All information compiled was shared and discussed through large and small State Planning Grant workgroup meetings as well as a Governor's Task Force Committee. More detailed information can be obtained by contacting Oklahoma Health Care Authority (OHCA).

Characteristics of Oklahoma's Uninsured (Section 1.1 and 1.2)

While our most recent data indicates Oklahoma's uninsured population to be averaged around 650,000, we anticipate the information obtained by the Coordinated State Coverage Survey (CSCS) recently completed by University of Minnesota SHADAC will provide a more detailed picture of the uninsured. SHADAC used a simple random sample telephone survey to provide pertinent information about the health and health care utilization of Oklahoma residents. A few preliminary results of the SHADAC's study design and content are included in Appendix I.



Source: Kaiser Commission on Medicaid and the Uninsured, Uninsured estimates are from the Current Populational Survey.

Oklahoma SPG Secondary Sources of Information on the Uninsured

| Source of Information | Description of Data | | | | | | | | | | | | | | | | | | |
|-------------------------|---|-----|------|-----|----------|-----------|-----|------------|---------|----|----------|---------|-----|----------|---------|-----|-----------|---------|-----|
| University of Minnesota | Will provide Oklahoma with information from a telephone survey about health status and uninsured information | | | | | | | | | | | | | | | | | | |
| Kaiser Studies | <p>2002 Uninsured facts show 610,200 Oklahomans are without health insurance</p> <table border="1"> <thead> <tr> <th></th> <th>OK #</th> <th>OK%</th> </tr> </thead> <tbody> <tr> <td>Employer</td> <td>1,825,130</td> <td>54%</td> </tr> <tr> <td>Individual</td> <td>153,580</td> <td>5%</td> </tr> <tr> <td>Medicaid</td> <td>386,340</td> <td>11%</td> </tr> <tr> <td>Medicare</td> <td>428,860</td> <td>13%</td> </tr> <tr> <td>Uninsured</td> <td>610,200</td> <td>18%</td> </tr> </tbody> </table> | | OK # | OK% | Employer | 1,825,130 | 54% | Individual | 153,580 | 5% | Medicaid | 386,340 | 11% | Medicare | 428,860 | 13% | Uninsured | 610,200 | 18% |
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| Employer | 1,825,130 | 54% | | | | | | | | | | | | | | | | | |
| Individual | 153,580 | 5% | | | | | | | | | | | | | | | | | |
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| Medicare | 428,860 | 13% | | | | | | | | | | | | | | | | | |
| Uninsured | 610,200 | 18% | | | | | | | | | | | | | | | | | |
| US Census Bureau | A 3 year average (2001-2003) shows 19.7% of Oklahomans are uninsured | | | | | | | | | | | | | | | | | | |
| BRFSS | 2002 information show of those 18 to 64 years of age 501,139 or 23.5% are without health insurance | | | | | | | | | | | | | | | | | | |
| MEPS | Provides Oklahoma with employer and employee insured information as well as provides average premium payments paid. Detailed graphs and tables can be seen in appendix IV | | | | | | | | | | | | | | | | | | |

Population Groups in Particular Need of Premium Assistance (Section 1.3)

In Oklahoma’s health care marketplace, there are several key factors contributing to the lack of health care coverage. Oklahoma’s small and large workgroups have determined that we will assist the neediest populations that lack the adequate income to purchase employer sponsored insurance. We will assist smaller firms who are less likely to offer insurance and provide a way for these employers to purchase an insurance plan. We will focus on lower-income workers, especially those who work part-time and cannot afford health insurance premiums.

Questions 1.4 through 1.13 focus on qualitative research work conducted by the Department of Family & Preventive Medicine. This research has been presented and then discussed among Workgroups. We have provided information where available at this interim point.

Affordable Coverage and Willingness to Pay for Coverage (Section 1.4)

In focus groups executed by the Department of Family and Preventive Medicine (DFPM) participants overwhelmingly indicated willingness, and even an eagerness to pay a portion of their health care provided it would not be a financial hardship for them or their families. The table below illustrates what 122 respondents would be willing to cost share in monetary value.

| Cost Share Category | Mean | Median | 95% CI | |
|---------------------|---------|---------|---------|---------|
| | | | Lower | Upper |
| Enrollment Fee | \$40.55 | \$25.00 | \$37.14 | \$43.95 |
| Premium | \$63.64 | \$50.00 | \$58.57 | \$68.70 |
| Deductible | \$75.40 | \$50.00 | \$61.09 | \$89.72 |
| Co-Payment | \$ 8.35 | \$10.00 | \$ 7.38 | \$ 9.32 |
| Co-Insurance (pt %) | 8% | 5% | 7% | 9% |

Source: OU DFPM, *It's Health Care Not Welfare Study*

Individuals Influenced by Available Subsidies (Section 1.9):

DFPM surveyed beneficiary focus groups to assess the general attitudes toward paying enrollment fees, co-payments or coinsurance, and premiums in order to maintain or obtain health insurance coverage. DFPM found that because Oklahomans are sensitive to the price of coverage it would suggest even a very small subsidy such as \$50 per month could entice a large portion to take up coverage when offered.

Non-Monetary Barriers to Purchasing Health Insurance (Section 1.10)

Affordability is the major factor in Oklahoma but other factors preventing purchase according to our workgroup may include: the variety of the benefit package, lack of coverage for pre-existing conditions, the hassle of paperwork, lack of access to health care providers, confusion surrounding insurance plans, and some people feel they just won't get sick.

How Oklahomans Get Their Medical Needs Met (Section 1.11)

Many Oklahomans are neglecting their medical needs by foregoing the care until the condition is significantly worse. Many end up going to the emergency room for assistance.

Some Oklahomans see safety net providers such as non-profit clinics and charitable clinics that attempt to provide help to the uninsured. Others have the small chance of getting free care from non-profit and county-funded hospitals.

Features of an Adequate, Barebones Benefit Package (Section 1.12)

Oklahoma has mandates set for what small business insurance must provide in their benefits package. The workgroup has agreed at this point that those mandated health benefits will be a good place to start. These health benefits are: Coverage of newly born children, Enrollment of child under parent's health plan, Adopted children, Mammography screening, Bone density testing, Treatment of diabetes, Maternity benefits, Child immunization, Oklahoma Breast Cancer Patient Protection Act, Dental procedures (minor or severely disabled), Audiological services, Prostate cancer screening, Colorectal cancer coverage, and Coverage for wigs.

Section 2. Employer-Based Coverage

The purpose of this section is to document your State's research activities related to employer-based coverage: (1) what is the state of employer-based coverage? (2) how was the information obtained (surveys, focus group, etc.): and (3) how are the findings reflected in the coverage options that have been selected (or are being considered by the State)?

This section focuses on employer-based coverage in Oklahoma and includes characteristics of Oklahoma's business environment. Much of the information was completed through the efforts of the Oklahoma Health Care Authority and research gathered by the Department of Family & Preventive Medicine (DFPM). Detailed data was taken from US Census Bureau and Medical Expenditure Panel Survey (MEPS). All information compiled was shared and discussed through large and small State Planning Grant workgroup meetings as well as a Governor's Task Force Committee. More detailed information can be obtained by contacting Oklahoma Health Care Authority (OHCA).

Characteristics of Firms That Do and Do Not Offer Coverage (Section 2.1)

A sample of 150 small business firms was surveyed statewide in 2003 by DFPM. Forty-nine valid surveys were used. The 21-item survey was designed to solicit demographic data about small businesses and employers' attitudes and opinions concerning a statewide health insurance benefits package for low-income workers and their families. DFPM looked at whether or not a business offering health care coverage to its employees was statistically significant related to several factors including; size of business, type of business, average annual salary of employees, perceived importance of health insurance to employees, and urban/rural county designation.

One-half of the small businesses surveyed (25 out of 49) offered health care benefits for their employees. One significant finding was that the number of years in business impacted whether or not employer-sponsored insurance (ESI) was available. Nationally validated variables predicting ESI, such as corporate status, type of business, or urban vs. rural location, had no impact on whether ESI was offered, although in the study, rural businesses were slightly more likely to provide health care benefits than urban businesses.

The types of businesses represented in the sample were roughly similar to the mix of business types in Oklahoma and in the U.S., according to data from the U.S. Department of Commerce. The only difference was that there were a disproportionate number of health care employers represented. However, no single demographic characteristic had a significant impact upon the answers to the major questions of the study.

| Number of Businesses in Our Sample by Type of Business* | |
|---|-----------------|
| Industry | # in the Sample |
| Agri, forestry, fishing, hunting | |
| Mining | |
| Utilities | 1 |
| Construction | |
| Manufacturing | 2 |
| Wholesale trade | 2 |
| Retail trade | 7 |
| Transportation, warehousing | |
| Information | |
| Finance, insurance | 6 |
| Real estate | |
| Professional, scientific, technical | 2 |
| Mgmt of companies, enterprises | 1 |
| Admin., support, waste mgmt, remedial services | |
| Educational services | 1 |
| Health care, social assistance | 12 |
| Arts, entertainment and recreation | |
| Accommodation and food services | 6 |
| Other services | 7 |
| Unknown | 2 |
| Total | 49 |

*Business types are from the U.S. Department of Commerce

Income level of employees was another predictor of employee-sponsored health insurance. As the income of employees in a business increases, the likelihood that the employer will offer a more robust employee benefits package for workers tends to increase as well. Forty-three employers (87.8%) responded to the question concerning income level of employees in their business. A weighted income level index was generated using the number of employees for each education level. Businesses with a higher income level (mean=\$26,000) among their employees were somewhat more likely to offer ESI but the results were not statistically significant.

Decisions on Providing Coverage (Section 2.2)

In the study those who did not offer ESI ranked employee retention as the most important reason for providing employee health benefits. A state or federal subsidy was the second most important factor suggesting that small businesses not currently offering an employee health package would be receptive to either a voucher or a buy-in option.

The rankings were as follows.

| Reason | Average Ranking* |
|--------------------------|------------------|
| 1. Employee retention | 3.9 |
| 2. State/federal subsidy | 3.4 |
| 3. Employee recruitment | 3.4 |

| | | |
|----|------------------------|-----|
| 4. | Employee request | 3.2 |
| 5. | Increased productivity | 3.0 |
| 6. | Reduced absenteeism | 2.7 |

* Ranked on a scale of 1-5, with 1 being not at all important.

In order for small businesses in Oklahoma, that do not currently offer coverage, to participate in a state health benefits program they require the following; assurance the state could effectively manage such a program, input into the development of the coverage package, financial and other incentives, relief for any administrative burdens, and flexibility.

Employers who offered ESI indicated employee retention was the most important factor followed by employee request. However, this group ranked state/federal subsidy as the least important reason suggesting this portion of small businesses would be less likely to participate in a voucher or buy-in option.

The rankings were as follows.

| Reason | Average Ranking* |
|---------------------------|------------------|
| 1. Employee retention | 4.0 |
| 2. Employee request | 3.8 |
| 3. Employee recruitment | 3.7 |
| 4. Reduced absenteeism | 3.1 |
| 5. Increased productivity | 2.8 |
| 6. State/federal subsidy | 1.9 |

* Ranked on a scale of 1-5, with 1 being not at all important.

Concerns and major issues from employers already offering insurance are; profit margins, cash reserves, administrative burden, potential impact of having to rescind benefits or increase employee contribution in the future, and a mistrust of government and government-sponsored programs.

Employers Response to an Economic Downturn (Section 2.4)

Determined by the small workgroup, the likely response to providing health insurance during an economic downturn might be to:

- Reduce benefits
- Increase employees cost share
- Raise deductibles
- Rescind coverage altogether
- Large companies might go to self-insurance

Motivating Employers Not Providing Health Insurance Coverage (Section 2.6-2.7)

Among employers who do not currently offer ESI, a state or federal subsidy was an important motivating factor for offering ESI, which suggests that small businesses not currently offering an employee health benefits package would be receptive to either a voucher or a buy-in option.

Businesses not currently offering any kind of ESI were likely to participate in a voucher/buy-in program with the desire to maintain some control of the program.

Section 3. Health Care Marketplace

The purpose of this section is to document your State's research activities related to the State's health care marketplace. The State should discuss (1) findings relating to the marketplace; (2) how the information was obtained; and (3) how the findings affected policy deliberations in the State.

This section provides a description of the health care marketplace in Oklahoma as well as an overview of the findings from numerous policy issue papers. This information was compiled from literature reviews and discussions with state staff and consultants responsible for health coverage programs. All information was shared and discussed through large and small State Planning Grant meetings as well as a Governor's Task Force Committee.

Health insurance trends in Oklahoma are similar to other states; the acceleration of premium costs, a reduction in the number of participating insurers, and a reduction in employers offering insurance as a benefit. Premium increases are a factor in the recent surge in the underlying health care costs and utilization of covered services. Cost shifting from the provider to the recipient is another trend that has led to increased uninsured. The Balanced Budget Act of 1997 significantly reduced reimbursements to hospitals under the Medicare program. This in turn put pressure on hospitals to make up for reductions in Medicare reimbursement by cost shifting to private insurers.

The Oklahoma State Medical Association malpractice rates rose 25 to 30 percent for 2003. In the years 1991-2000 Physicians Liability which provides insurance to about 90 percent of Oklahoma doctors paid an average of 18 million in claims and nearly doubled that at 33 million in claims in 2002.

In the current Oklahoma climate, HMOs have had a premium increase of 26 percent compared with an 18 percent increase nationally. Blue Cross/Blue Shield had increases of 14 to 16 percent in premiums and HealthChoice averaged 8.58 percent in premium increases. On average Oklahoma hospitals receive 62 cents for every 1 dollar of care. During 2003, 152 million dollars were considered uncompensated care by Oklahoma hospitals. (www.okoha.com)

Oklahoma would like to deal with these issues by solving the problems the Community Action Project has addressed as barriers to obtaining insurance. Examples listed are; employers may not offer an insurance plan, employees may not be eligible for a plan – even if one is offered, and employees may not participate in a plan even if he or she is eligible.

Legislation passed during the 2004 session directs the Oklahoma Health Care Authority to develop a premium assistance program that will enable small employers, and/or employed, uninsured adults with or without children to purchase employer-sponsored, state-approved private, or state-sponsored health care coverage through a state premium assistance payment plan, and develop flexible health care benefit packages based upon patient need and cost. Also, the Authority is authorized to develop and implement a pilot premium assistance plan to assist small businesses and/or their eligible employees to purchase employer-sponsored insurance or “buy-in” to a state-sponsored benefit plan. Copies of these legislative laws and their content are included in Appendix III.

Variation in Benefits Among Groups (Section 3.2)

In a review of President Bush's Tax Credits for Nongroup Insurance, authors compare out-of-pocket spending for health care by lower-income uninsured people with their net spending on insurance and health care. Nongroup insurance covers only about 5 percent of the non-elderly population in Oklahoma and is generally regarded as the residual source of health insurance coverage for those without access to employer-sponsored or public coverage. If tax credits are given to subsidize the purchase of nongroup health insurance, Oklahomans would benefit from the credit but the current proposal may not interest the uninsured in Oklahoma.

The Governor, in a press conference covering uninsured issues, discussed the variation of benefits between two small group employers and larger firms in Oklahoma. Approximately 31% of employers with 10 or less employees offer insurance. The small group employers indicated a desire to cover their employees' health insurance needs but did not have the financial means to provide such a benefit. For many small groups, the only options that are financially viable are plans that have catastrophic coverage only or are major medical plans with high deductibles. These plans do not cover regular check-ups and may not provide pharmacy or dental benefits which are primary forms of prevention.

Among large employers with fifty or more employees, ninety-seven percent offer insurance and more often than not offer more than one plan. Large employers, who offer more than one insurance plan, offer the choice of Health Maintenance Organization (HMO) or a catastrophic coverage product with high cost sharing, along with traditional indemnity and Preferred Provider Organization (PPO) plans.

Prevalence of Self-Insured Firms and Impact on the Marketplace (Section 3.3)

Self-insurance is common among large employers but is less prevalent and a far riskier undertaking for smaller firms, who have fewer employees over which to spread the risk of costly claims. According to the National Employer Health Insurance Survey conducted by the CDC the data show 24.1 percent of establishments in Oklahoma are self-insured. Because these establishments tend to be the largest employers within the state, the number of people covered by these plans is substantial. National data show the more years in business the more likely the business is to be self-insured.

Looking at Experiences of Other States in the Health Insurance Marketplace (Section 3.9)

Oklahoma would like to promote public/private partnerships by creating a premium assistance program which would provide a subsidy to eligible individuals and families to purchase employer-sponsored health insurance. Oklahoma has researched other states that have obtained a HIFA waiver in order to learn about the experiences they have gained. The OHCA project team looked at; Arizona, California, Colorado, Illinois, Maine, Minnesota, New Jersey, New Mexico and Oregon. Each of these states offered ideas on how to conduct eligibility, fiscal flow of dollars into and out of the program, cost effectiveness and subsidy amounts.

Section 4. Options for expanding coverage

The purpose of this section to provide specific details about the policy options selected by the State. A number of States have not reached a consensus on a coverage expansion strategy and are not yet in a position to answer the questions included in this section. These States should answer questions 4.1 through 4.15 as applicable, but should focus primarily on questions 4.16, 4.18, and 4.19.

In the course of the State Planning Grant funding period, there were a number of public program expansions which were both implemented and legislatively adopted by the State. This section was largely answered through small and large workgroups convened to model a program that works for Oklahoma. Information has been shared with businesses and State agencies while gathering opinions on the program.

Coverage Expansion Options Selected by the State (Section 4.1)

Oklahoma passed Senate Bill 1546 relating to poor persons, recognizing that many Oklahomans do not have health care benefits or health care coverage, and that many small businesses cannot afford to provide health care benefits to their employees. OHCA is directed to promote personal responsibility for health care services and appropriate utilization of health care benefits through the use of public-private cost sharing. This bill authorizes the OHCA to develop and implement a pilot premium assistance plan.

Oklahoma selected policy options that will target any person at or below 200 percent of the federal poverty level (FPL).

- Coverage of adults under 200 percent FPL in small businesses
- Expand eligible SCHIP participants up to 200 percent FPL

Covering adults through a public-private partnership: According to BRFSS 23.5 percent of the population aged 18-64 are uninsured. Oklahoma recommends covering this population with the approach of a public-private partnership. Oklahoma's plan will share the health premium between the individual, the employer, and the state and federal government. This program will extend to small businesses first because they employ many of our State's low wage workers. Small businesses of 50 or less employees make up 77.4 percent of our businesses in Oklahoma and of this group 54.3 percent are able to offer insurance to their employees. This number drops off significantly to 31 percent in establishments of 10 or less employees. Almost 20 percent of employees do not participate in the coverage offered by their employer. This is primarily due to the fact that their share of health insurance costs has increased by more than 50 percent over the last 3 years.

Target Eligibility Group (Section 4.2)

Covering Adults to 200% of FPL – Public-Private Partnership: The target population for this option would be adults ages 19 through 64 who are not currently eligible for Medicaid and who have household incomes up to 200% FPL.

Administration of the Program (Section 4.3)

At this time, final decisions have not been made concerning the actual administration of the program. OHCA will be working with our large and small workgroups to design and implement administration options.

Administration of application: The administration of the application for the individual will likely be done by the State's Department of Human Services (DHS). The application will be a standard Medicaid application with attached specific information for the premium assistance program. The administration of the application for employers to join the premium assistance program may be handled by an outside agent.

Fiscal Agent: A fiscal agent may be chosen to direct the flow of money from all the cost sharing partners to the health insurance agency of choice.

Management: OHCA will determine the process of evaluation, what the indicators will be, and how they are to be collected. OHCA will design audit trails, fraud detection and program integrity processes. OHCA will also make any changes to current Medicaid rates, reimbursements, payment processes, and grievance processes as the program moves along.

Conduction of Outreach and Enrollment (Section 4.4)

Oklahoma hopes to create an extensive marketing and outreach program. Our strategies will range from grassroots networking to possible mass-market advertising campaigns. It will be Oklahoma's goal to reach businesses, families, and adults by using different messages. Oklahoma would like to support the program by using outreach methods currently in use by South Carolina. Outreach and enrollment techniques include:

Education: OHCA will educate the public by using objectives Oklahomans will respond to. To be successful we may partner with local and state Chambers, business associations, and other organizations to promote objectives of the SPG. Effective education programs will vary in the content depending on the audience. Handouts will be created that summarize remarks. In addition, OHCA will use sign-in sheets to be used for later feedback.

Public Service Announcements: The goal of these announcements is to entice the public to obtain more information about Oklahoma's initiatives on covering the uninsured. The announcements will inform the public of health fairs, where to pick up information booklets, and who to contact for additional information.

Partner Organizations: Oklahoma will partner with organizations such as insurance companies, disease management specialists, and/or fitness/wellness vendors.

Premium Sharing and Benefit Structure Requirements (Section 4.5 – 4.6)

In the model Oklahoma is currently considering the state would provide 20 percent of the total cost of health insurance, with the federal government contributing 49 percent of the total cost. The remaining 31 percent of the health insurance cost would be split between employers and employees, 20 percent and 11 percent respectively.

The benefit structure would meet the minimum HIFA requirements mandated by the waiver. Each business would be allowed to choose a commercial insurance product that meets these minimum requirements, but may offer any package or standard package on top of the waiver mandates.

Projected Cost of Expansion and How the Program is Financed (Section 4.7 -4.8)

Every State dollar that is federally matched will leverage between \$2.42 and \$4.00 (depending on the enrollee's age and poverty level) in federal money. That is a 70%-80% rate of return. With voluntary employer participation, a \$100 million state investment could draw down \$420 million in federal and employer and employee contributions, while generating additional economic activity in the private sector.

\$100 million in State funds:

- Up to \$420 million in matching dollars leveraged
- Up to 200,000 more Oklahomans with health insurance
- Up to \$528 million in new income will be generated for Oklahomans
- Up to \$1.5 billion in new business activity for Oklahoma
- Up to 18,000 new jobs supported through the additional business activity

Oklahoma will have on the ballot in November a tobacco tax increase from which a portion of the funds will be taken and federally matched to support the premium assistance program. While this tax will provide funding for approximately 100,000 Oklahomans, it does not provide funding options for the other uninsured in the State. Additionally, this tax may decline over time and as such, Oklahoma wishes to use grant money to pursue research of other long term funding sources.

To determine the availability of long term funding sources, staff at OHCA will conduct the following activities:

- Provide a literature review with a comparative analysis of other states
- Research explanations of Oklahoma's historical practices to obtain long term funding (legislative, public)
- Access current information to determine public and private sources of funding both inside and outside the state
- Review current Medicaid benefits to follow suit with other states in potentially sizing down option plans
- Prepare a comprehensive report that describes the process of gaining long term funding sources
- **Remain available** for consultation regarding Oklahoma's discussions surrounding premium assistance

Strategies to Contain Cost (Section 4.9)

The model Oklahoma has designed will include an element of cost-sharing and therefore a requirement for personal responsibility on the part of the individual. This element relies on a three-way sharing of the premium cost, spreading cost between employees, employers, and a combined state and federal subsidy.

Because employers will be making the decision of the insurance provider, Oklahoma will have a capped contribution amount for an individual. For those individuals who work for businesses not purchasing an insurance product, or for those self-employed individuals, Oklahoma will provide a state sponsored plan as an alternative to commercial insurance.

Preliminary cost control mechanisms thought to be included in the Oklahoma model include 1) phase in of the program beginning with the smallest employers (possibly 2-11 employers) and expanding up to firms with 50 employees or less as soon as budget projections allow; and 2) adjusting the size of the premium assistance voucher amounts as need arises. Due to political commitment to the individual eligibility level of less than 200 percent FPL, this has not been considered an area of flexibility when it comes to cost control. As planning efforts progress other options for cost control and / or coverage sizes will be developed.

How Services Will be Delivered (Section 4.10)

Health care services will be provided through the commercial insurance network of providers, and the state's Medicaid providers as necessary.

Methods for Ensuring Quality (Section 4.11)

OHCA will establish internal due process mechanisms, ensuring the members have an effective avenue of recourse should they be dissatisfied with the services they receive under the program.

OHCA will use the same quality mechanisms they are responsible for when overseeing the Medicaid program in Oklahoma. This responsibility may include the auditing of providers, fraud detection, and program integrity design.

Crowd-Out Avoidance (Section 4.13)

OHCA has discussed crowd-out in our workgroup meetings. Because the program will be phased in and by design will be open to all eligible employees and their families, as well as utilize the existing private insurance market, this issue does not appear to be a concern at this time.

Data Collected and Audited (Section 4.14)

Relevant data will be derived from several public-private agencies:

- Employee data – Oklahoma DHS agency and county agencies will conduct eligibility and enrollment procedures with clients who qualify for premium assistance
- Employer data – collects data on Oklahoma businesses such as type of firms, their characteristics, wages and benefits provided, and profitability
- Insurance industry data – will certify benefits offered meet HIFA waiver standards

Employee data: Oklahoma will collect data from each member using a standard application all enrolling agencies will carry. The application will ask standard Medicaid questions with an attached section asking questions in connection with the premium assistance program.

Employer data: Oklahoma will collect data from each participating businesses member with the application enrolling them as a member into the program. The application will ask questions such as the number of employees – full/part time, salary ratio, insurance status, and other characteristics that make up the firm.

Insurance industry data: Companies will submit their own coverage package plan that will be used for the waiver population. Oklahoma will assess whether this package meets state standards or not.

How and How Often the Program Will Be Evaluated (Section 4.15)

To assess whether the program wavier implementations have produced changes in the programs and effectiveness of the delivery system, the program evaluation plan will compare data from the current processes to past studies. Other incremental evaluations will focus on maintaining and improving access, improving quality of care, monitoring consumer satisfaction and containing costs of providing premium assistance.

OHCA will produce a comprehensive annual report; the report will look into cost savings, program evaluation, and core functions. Throughout the year there will be on-going evaluation of the premium assistance program.

Progress in Implementing the Selected Policy Options (Section 4.17)

The 2004 Oklahoma Legislature passed Senate bill 1546, calling for increased access to health care for Oklahomans. SB1546 allowed OHCA to apply for the wavier with provisions to reform the Oklahoma Medicaid program to promote personal responsibility for health care services and appropriate utilization of health care benefits through the use of public-private cost sharing. SB1546 also authorized OHCA to develop and implement a pilot premium assistance plan to assist small businesses and/or their eligible employees to purchase employer-sponsored insurance or “buy-in” to a state-sponsored benefit plan.

OHCA has held several large workgroup meetings throughout the planning period year. Policy options were discussed and given thought on the way the system will work. Modeling for the program was decided upon in small workgroup meetings after evaluation of policy suggestions within both the small and large workgroups. OHCA still faces several challenges as it heads toward obtaining a HIFA waiver, they include: a delivery system that balances both the public and private markets; a fiscal agent; and finding employers that are interested in the program.

Policy Options Not Selected (Section 4.18)

During the modeling process a version of Health Savings Accounts was brought up, this plan contained a way for individuals to monitor their own account but left out actively involving small business in the model. This method worked against OKHRA's common goal of providing insurance to the uninsured with the least amount of confusion. Utilization of this model would leave a heavy administrative burden on the beneficiary. Selected and non-selected models can be seen in Appendix V.

Section 5. Consensus Building Strategy

Governance Structure Within Planning Process (Section 5.1)

The Oklahoma Health Care Authority (OHCA) is the lead agency in implementing the premium assistance program. OHCA established small and large workgroups.

The leadership of the Small Workgroup is responsible for ongoing project management. The team supervises the work of the project teams, focus of policy issues, ensures ongoing coordination and communications, and defines the scope of each team project. The Small Workgroup meets periodically. This group specifically makes decisions regarding “next steps” on the project, reviews current progress, and provides direction to the project director. The Small Workgroup is composed of the Secretary of Health and staff within OHCA.

The Small Workgroup provides needed direction to the Project Director who coordinates with contractors and monitors the progress of the overall project. The Project Director guides staff on research and also schedules meetings and prepares reports.

The Large Workgroup contains state capitol staff, legislative sub-group members, chamber sub-group members, and interested parties from the Department of Mental Health, Department of Health, Department of Human Services, Oklahoma State and Education Employees’ Group Insurance Board and Oklahoma Insurance Department. This large group also has various providers (MD, DO, and PHARM), university representatives, hospital administrative staff, private insurance representatives, and Native American interest groups. Finally the large group has OHCA board members and staff. This group has met quarterly and is responsible for providing comments and feedback to the structure of the on-going State Planning Grant.

Methods Used to Obtain Input from Public and Key Constituencies (Section 5.2 & 5.4)

Oklahoma has taken multiple methods to obtain input. They include:

- Governor’s presentation to stakeholders throughout the past year
- Meetings with health policy experts
- Meetings with key constituents of the private market such as Blue Cross Blue Shield
- Notice of events surrounding State Planning Grant by email and posted mail
- Participation in multiple conferences and community events by Project Director

Activities among OHCA and constituents have created interest amongst Oklahoma businesses, private insurers, legislators, and other State agencies. The acknowledgement that the uninsured are a problem within Oklahoma has set an agenda for impacting this societal problem. Outside of the HRSA Grant team, a Task Force and interest groups have been formed to assist in developing an action plan to reduce the number of uninsured.

Section 6. Lessons Learned and Recommendations to States

Efficiency of Data Collection

Attaining data specific to Oklahoma from contributors like SHADAC and DFPM is very important in defining the scope of our decision-making process. Because uninsured data for Oklahoma are largely obtained through national sources, policy makers find it beneficial to have state-specific data from surveys we helped design.

Additional data collection activities have been requested by those contributing to Oklahoma's State Planning Grant. This group would like to see more in-depth estimates compiled through our contract with SHADAC. Estimates for populations, specifically for geographic area examples are:

- Obtain and format county-level data
- Link administrative data to the 2004 Oklahoma Health Insurance Survey data
- Construct database of linked data
- Run statistical models

All data collection activities proposed thus far are completed (employer, beneficiary, cost, and programmatic elements surveys), underway (focus groups and state demographic and uninsured data), or will be carried out within the extension request period. Most results are expected shortly after completion of this report.

Key Recommendation to Other States (Section 6.8)

Key recommendations from Oklahoma would be to conduct an in depth study of other states and their processes in State Planning Grant development. We found the models and the issues other states handled to be beneficial in our hopes of developing something that could work for Oklahoma's uninsured.

The collection of data is very important in understanding the needs of each individual state. Enlisting the right agency to do your research is imperative in obtaining useable information you can trust.

Flexibility in your design will bring about the best results for your state.

Changes to the Political and Economic Environment (Section 6.9)

Oklahoma is challenged like most states, with a budget crisis. With a program such as the State Planning Grant, Oklahoma must respond with state support. A tobacco tax has been proposed and if passed by the people a portion of the tax will support SPG efforts. The course of this grant will be delayed if Oklahoma needs to find an alternative funding source.

Section 7. Recommendations to the Federal Government

This section will be covered in the project's Final Report.

Appendix I: Baseline Information

Population:

- The total population in Oklahoma is 3,511,500
- From 1990 to 2003 the state has experienced a net increase of 365,924 people or 10.4%
- Oklahoma is expected to gain about 680,900 people and have a population of 4,192,400 by 2030

Number and Percent of Uninsured:

- Community Action Data 2001-2002: Oklahoma has the fifth highest uninsurance rate in the nation. 610,200 Oklahomans lacked health insurance; 608,570 of these were nonelderly.
- BRFSS Data 2002: The uninsurance rate for adults, ages 18-64 is 501,139 or 23.5 percent
- Current Population Survey 2001-2002: The uninsurance rate for adults ages 19-64 is 478,600 or 23 percent
- For at least the past six years, the percentage of Oklahomans without health insurance has remained above the national average

Average age of population:

- Oklahoma's age distribution is very similar to surrounding states and the United States as a whole. The largest population percent lies between ages 18-64 at 60 percent while the smallest segment is ages 75+ at 6 percent.

Ethnic Distribution:

- The largest ethnic group in Oklahoma are Whites at 78 percent of the population, followed by Blacks at 7 percent and Hispanics at 5 percent

Percent of Population Living in Poverty:

- Approximately 18 percent of the Oklahoma population lives in poverty
- Of those 15 percent are living in metropolitan areas and 23 percent live in non-metropolitan areas
- Blacks and Hispanics have the highest poverty stricken rates at 34 and 33 percent

Primary Industries:

- Of Oklahoma's total population 2,666,724 are in the labor force
- Our three largest employer industries are educational, health, and social services at 20.5 percent, manufacturing at 12.5 percent, and retail at 12 percent
- Of Oklahoma businesses 77.4 percent have fewer than 50 employees

Number and Percent of Employers Offering Coverage: (MEPS data 2001)

- 50.9 percent or 71,497 private sector business establishments in Oklahoma offer employer coverage
- 37.6 percent of businesses with less than 50 employees offer employee coverage; of those individuals offered coverage at the establishments only 65.2 percent are enrolled
- 96.8 percent of businesses with more than 50 employees offer employee coverage; of those individuals offered coverage at the establishments only 64.7 percent are enrolled

Number and Percent of Self-Insured Firms: (MEPS data 2001)

- Of the 71,430 private sector businesses that offer insurance in Oklahoma, approximately 52.5 percent or 37,500 are self-insured
- In establishments with less than 50 employees, 7.5% or 83,617 individuals are enrolled in a self-insured plan. In establishments with 50 or more employees, 77.2% or 860,707 individuals are enrolled in a self-insured plan.

Payer Mix: (Census CPS data 2002)

- The Census estimated 82.7% of Oklahomans had health care coverage in 2002
- 65.5% are covered by employer sponsored plans
- 10.4% are covered by individual direct purchases of private insurance
- 11.8% are covered by state and federal Medicaid assistance
- 14.7% are covered by federal Medicare assistance
- 5.9% are covered by other federal assistance, such as military programs

Provider Competition: *This section will be covered in the project's Final Report.*

Insurance Market Reforms: *This section will be covered in the project's Final Report.*

Eligibility For Existing Coverage Programs (Medicaid/ SCHIP/other):

- Children (ages 0-5) and pregnant women and are currently eligible for Medicaid up to 185% FPL
- Children (ages 6-19) are currently eligible for Medicaid up to 185% FPL
- Non-Pregnant parents are currently eligible for Medicaid up to 57% FPL

Use of Federal Waivers: *This section will be covered in the project's Final Report.*

Appendix II: Links To Research Findings and Methodologies

The Oklahoma Health Care Authority has the lead role in the HRSA State Planning Grant, and has developed a link on their home page to access current information on the State Planning Grant. The OHCA home page can be accessed from the website <http://www.ohca.state.ok.us>

Appendix III. Legislative Bills Relating to Health Care

Below are two bills passed in the latest legislative secession (2004), they are in reference to the State Planning Grant. These bills show the willingness of Oklahoma Legislatures to do their part in solving the problem of health care.

*ENGROSSED HOUSE
BILL NO. 2660*

By: Adair and Pope of the House

and

Hobson of the Senate

(revenue and taxation – legislative referendum – codification – effective
date – ballot title – filing)

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

SECTION 1. Pursuant to Section 3 of Article V of the Oklahoma Constitution, there is hereby ordered the following legislative referendum which shall be filed with the Secretary of State and addressed to the Governor of the state, who shall submit the same to the people for their approval or rejection at the next General Election.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 302-5 of Title 68, unless there is created a duplication in numbering, reads as follows:

There is hereby created in the State Treasury a revolving fund to be designated the "Comprehensive Cancer Center Bond Fund". The fund shall be a continuing fund, not subject to

fiscal year limitations, and shall consist of all monies deposited to the credit of the fund by law. All monies accruing to the credit of the fund are hereby appropriated and may be budgeted and expended for the sole purpose of servicing any debt obligations incurred by the state in the construction of a comprehensive cancer center.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 302-6 of Title 68, unless there is created a duplication in numbering, reads as follows:

There is hereby created in the State Treasury a revolving fund for the State Department of Health to be designated the "Special Health Care Revolving Fund". The fund shall be a continuing fund, not subject to fiscal year limitations, and shall consist of all monies deposited to the credit of the fund by law. All monies accruing to the credit of the fund are hereby appropriated and may be budgeted and expended by the State Department of Health for the purpose of funding future health care costs. Expenditures from the fund shall be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of State Finance for approval and payment.

SECTION 4. This act shall become effective January 1, 2005.

SECTION 5. The Ballot Title for the proposed act shall be in the following form:

BALLOT TITLE

Legislative Referendum No. _____

State Question No. _____

THE GIST OF THE PROPOSITION IS AS FOLLOWS:

The measure creates the Comprehensive Cancer Center Bond Fund. The monies in the fund are to be used to service debt obligations for construction of a comprehensive cancer center. The measure creates the Special Health Care Revolving Fund. The monies in the

fund are to be used to fund future health care costs. The act will become effective on January 1, 2005.

SHALL THE PROPOSAL BE APPROVED?

FOR THE PROPOSAL — YES _____

AGAINST THE PROPOSAL — NO _____

SECTION 6. The Chief Clerk of the House of Representatives, immediately after the passage of this act, shall prepare and file one copy thereof, including the Ballot Title set forth in SECTION 5 hereof, with the Secretary of State and one copy with the Attorney General.

Passed the House of Representatives the 10th day of March, 2004.

Presiding Officer of the House of
Representatives

Passed the Senate the ____ day of _____, 2004.

Presiding Officer of the Senate

*ENROLLED SENATE
BILL NO. 1546*

By: Robinson of the Senate

and

Leist of the House

An Act relating to poor persons; amending 56 O.S. 2001, Section 1010.1, as amended by Section 1, Chapter 464, O.S.L. 2003, (56 O.S. Supp. 2003, Section 1010.1), which relates to the Oklahoma Medicaid Program Reform Act of 2003; modifying negotiation provisions for a waiver or waivers; authorizing development and implementation of specified pilot premium assistance plan for certain purpose; creating the Health Employee and Economy Improvement Act (HEEIA) Revolving Fund; providing for fund contents; providing an effective date; and declaring an emergency.

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

SECTION 7. AMENDATORY 56 O.S. 2001, Section 1010.1, as amended by Section 1, Chapter 464, O.S.L. 2003 (56 O.S. Supp. 2003, Section 1010.1), is amended to read as follows:

Section 1010.1 A. Sections 1010.1 through 1010.7 of this title shall be known and may be cited as the "Oklahoma Medicaid Program Reform Act of 2003".

B. Recognizing that many Oklahomans do not have health care benefits or health care coverage, that many small businesses cannot afford to provide health care benefits to their employees, and that, under federal law, barriers exist to providing Medicaid benefits to the uninsured, the Oklahoma Legislature hereby establishes provisions to lower the number of uninsured, assist businesses in their ability to afford health care benefits and coverage for their employees, and eliminate barriers to providing health coverage to eligible enrollees under federal law.

C. The Oklahoma Health Care Authority shall provide coverage under the state Medicaid program to children under the age of eighteen (18) years whose family incomes do not exceed one hundred eighty-five percent (185%) of the federal poverty level.

D. 1. The Authority is hereby directed to apply for a waiver or waivers to the Centers for Medicaid and Medicare Services (CMS) that will accomplish the purposes outlined in subsection B of this section. The Authority is further directed to negotiate with CMS to include in such waiver authority provisions to ~~accomplish the following goals:~~

- a. ~~increased~~ increase access to health care for Oklahomans,
- b. reform ~~of~~ the Oklahoma Medicaid Program to promote personal responsibility ~~with regard to~~ for health care services and appropriate utilization of health care benefits through the use of public-private cost sharing,
- c. ~~the enable~~ enable small employers, and/or employed, uninsured adults with or without children to purchase ~~of~~ employer-sponsored, state-approved private, or state-sponsored health care coverage using “buy-in” arrangements for small employers and/or voucher arrangements for employer-sponsored insurance purchasing through a state premium assistance payment plan, and
- d. ~~development of~~ develop flexible health care benefit packages based upon patient need and cost.

2. The Authority may phase in any waiver or waivers it receives based upon available funding.

3. The Authority is hereby authorized to develop and implement a pilot premium assistance plan to assist small businesses and/or their eligible employees to purchase employer-sponsored insurance or “buy-in” to a state-sponsored benefit plan.

E. 1. There is hereby created in the State Treasury a revolving fund to be designated the “Health Employee and Economy Improvement Act (HEEIA) Revolving Fund”.

2. The fund shall be a continuing fund, not subject to fiscal year limitations, and shall consist of:

- a. all monies received by the Authority pursuant to this section and otherwise specified or authorized by law,
- b. monies received by the Authority due to federal financial participation pursuant to Title XIX of the Social Security Act, and
- c. interest attributable to investment of money in the fund.

3. All monies accruing to the credit of the fund are hereby appropriated and shall be budgeted and expended by the Authority to implement a premium assistance plan.

SECTION 8. This act shall become effective July 1, 2004.

SECTION 9. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the Senate the 9th day of March, 2004.

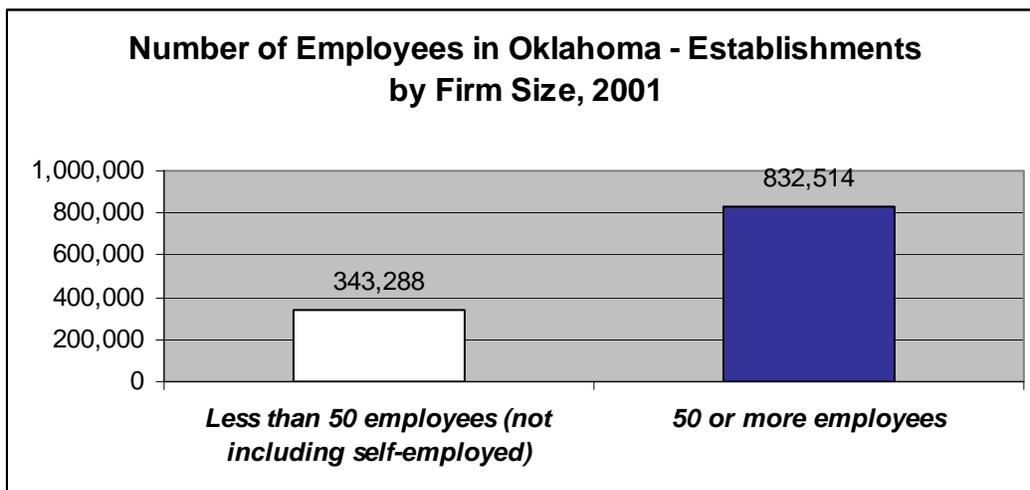
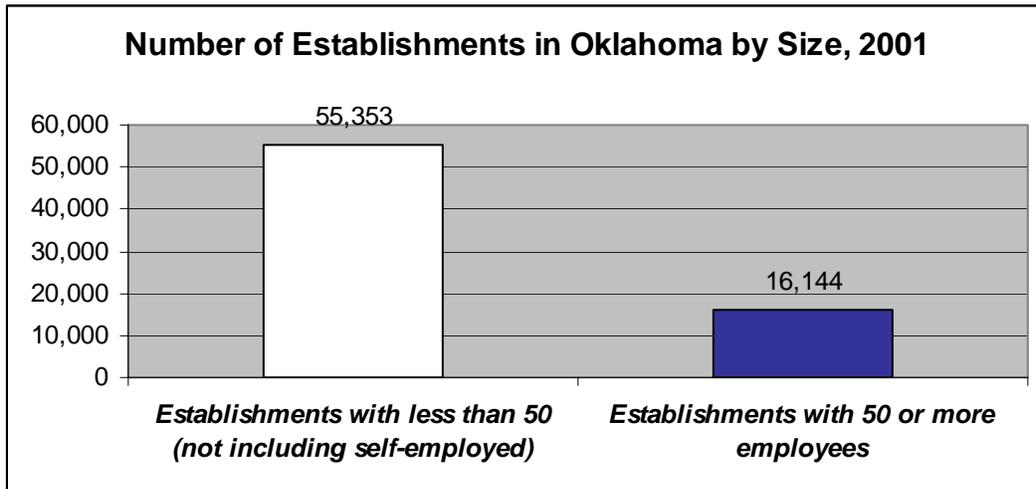
Presiding Officer of the Senate

Passed the House of Representatives the 13th day of April, 2004.

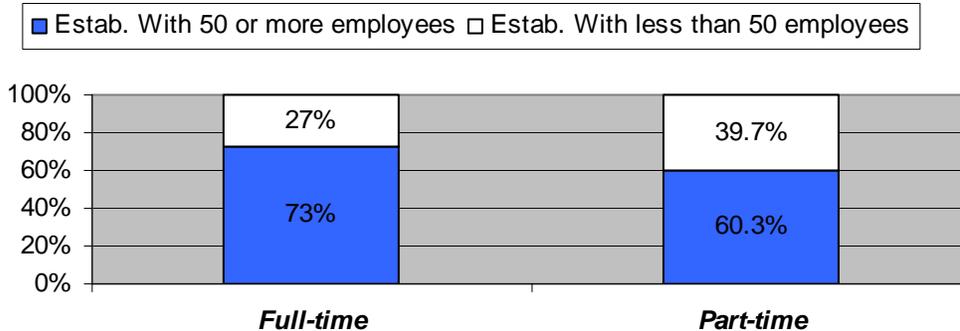
Presiding Officer of the House
of Representatives

Appendix IV. Oklahoma Employer Data

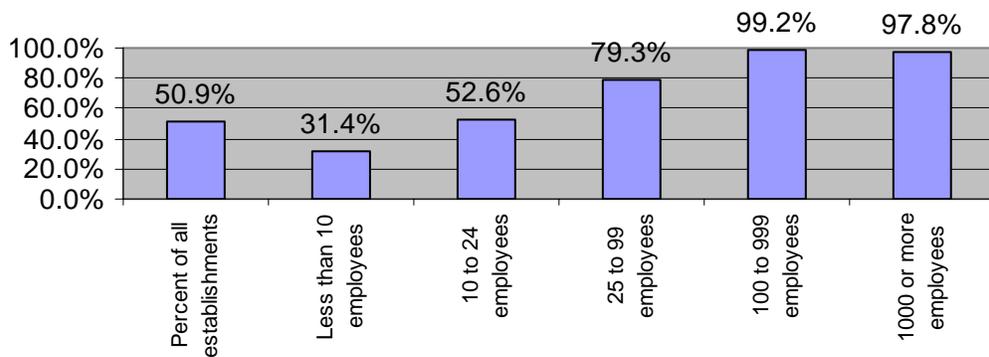
Source of the following information in Appendix IV: Agency for Healthcare Research and Quality: 1999-2001 Medical Expenditure Panel Survey – Insurance Component



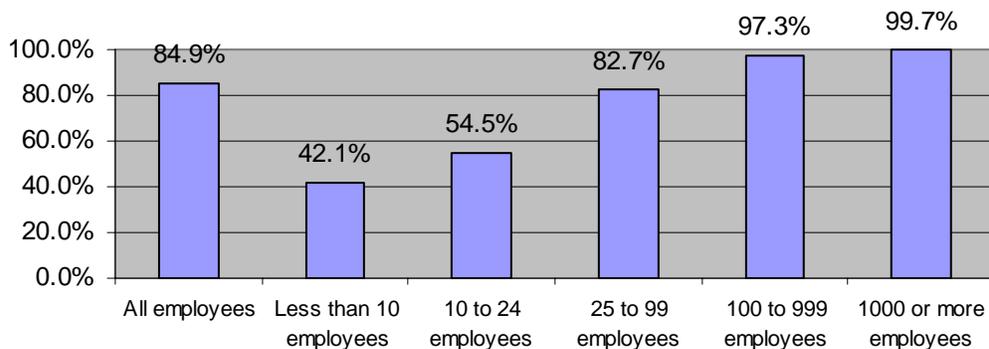
Distribution of Full-time and Part-time Employees by Firm Size, 2001



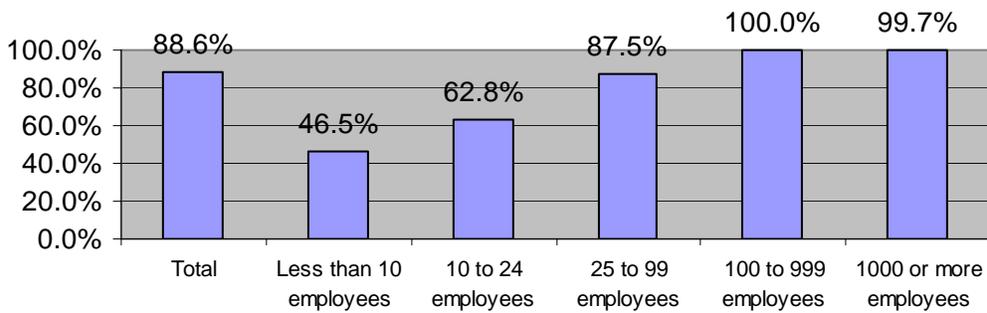
Percent of Oklahoma Establishments That Offer Health Insurance, by Firm Size, 2001



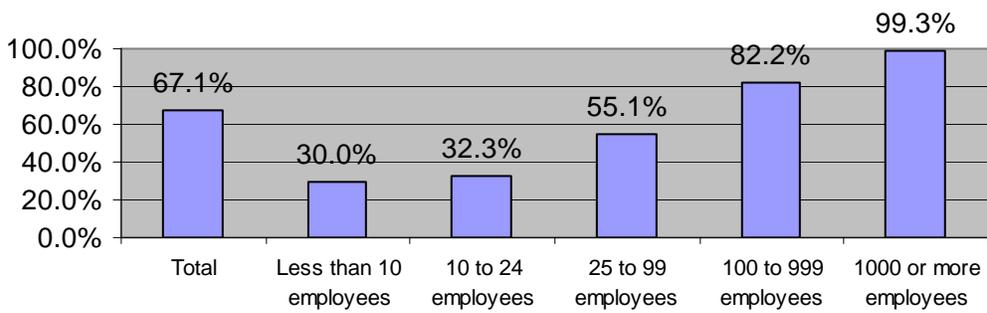
Percent of Oklahoma Employees who are Offered Health Insurance, by Firm Size, 2001



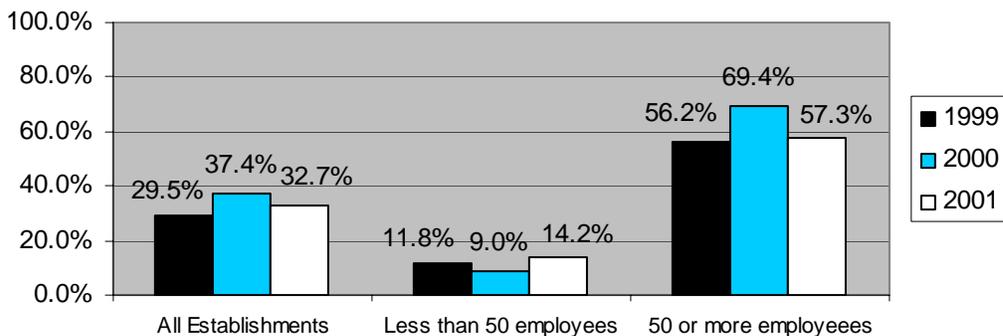
Percent of Full-Time Oklahoma Employees at Establishments that Offer Health Insurance, by Firm Size, 2001



Percent of Part-time Oklahoma Employees at Establishments that Offer Health Insurance, by Firm Size, 2001



Percent of Oklahoma Establishments that Offer Health Insurance and Self-fund at Least One Plan, by Firm Size, 2001



| All Employees | | | | |
|---------------|------------------------------|---------------------------------------|--|---|
| Year | At establishments that offer | Eligible at Establishments That offer | Eligible and Enrolled at Establishments That offer | Enrolled (or the total number of employees at the establishment-whether eligible or not eligible) |
| 1999 | 84.6% | 76.8% | 82.4% | 63.2% |
| 2000 | 83% | 81.6% | 77.6% | 63.3% |
| 2001 | 84.9% | 78.1% | 82.9% | 64.8% |

| Full-Time Employees | | | | |
|---------------------|------------------------------|---------------------------------------|--|---|
| Year | At establishments that offer | Eligible at Establishments That offer | Eligible and Enrolled at Establishments That offer | Enrolled (or the total number of employees at the establishment-whether eligible or not eligible) |
| 1999 | 87.2% | 84.4% | 84.5% | 71.3% |
| 2000 | 87.2% | 89.9% | 79% | 71% |
| 2001 | 88.6% | 85.8% | 84.1% | 72.1% |

| Part-Time Employees | | | | |
|---------------------|------------------------------|---------------------------------------|--|---|
| Year | At establishments that offer | Eligible at Establishments That offer | Eligible and Enrolled at Establishments That offer | Enrolled (or the total number of employees at the establishment-whether eligible or not eligible) |
| 1999 | 71.7% | 30.1% | 46.5% | 14% |
| 2000 | 62.3% | 24.6% | 42.4% | 10.4% |
| 2001 | 67.1% | 30.1% | 61.5% | 18.5% |

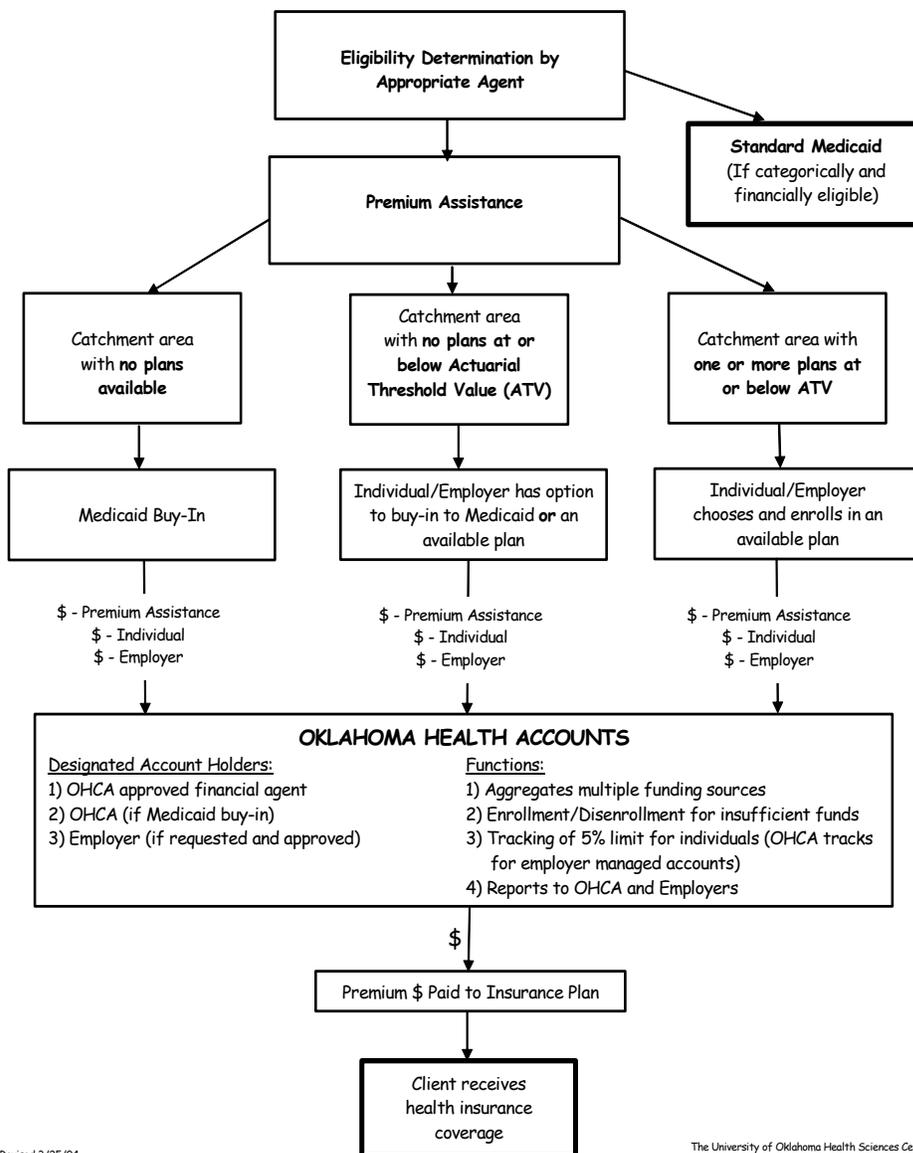
Appendix V. Oklahoma Premium and Voucher Models and Actuarial Analysis

In the discussions to decide the plans for how an Oklahoma model would work, OHCA had Garth Splinter from Primary Care Health Policy Division and Andy Cohen from Pacific Health Policy Group present models. The decision was made to go with the voucher system model which is the second model in this appendix. The model however is still in a tentative stage and has room to adapt to a model most fitting for Oklahoma.

Models One and Two are presented below:

Draft

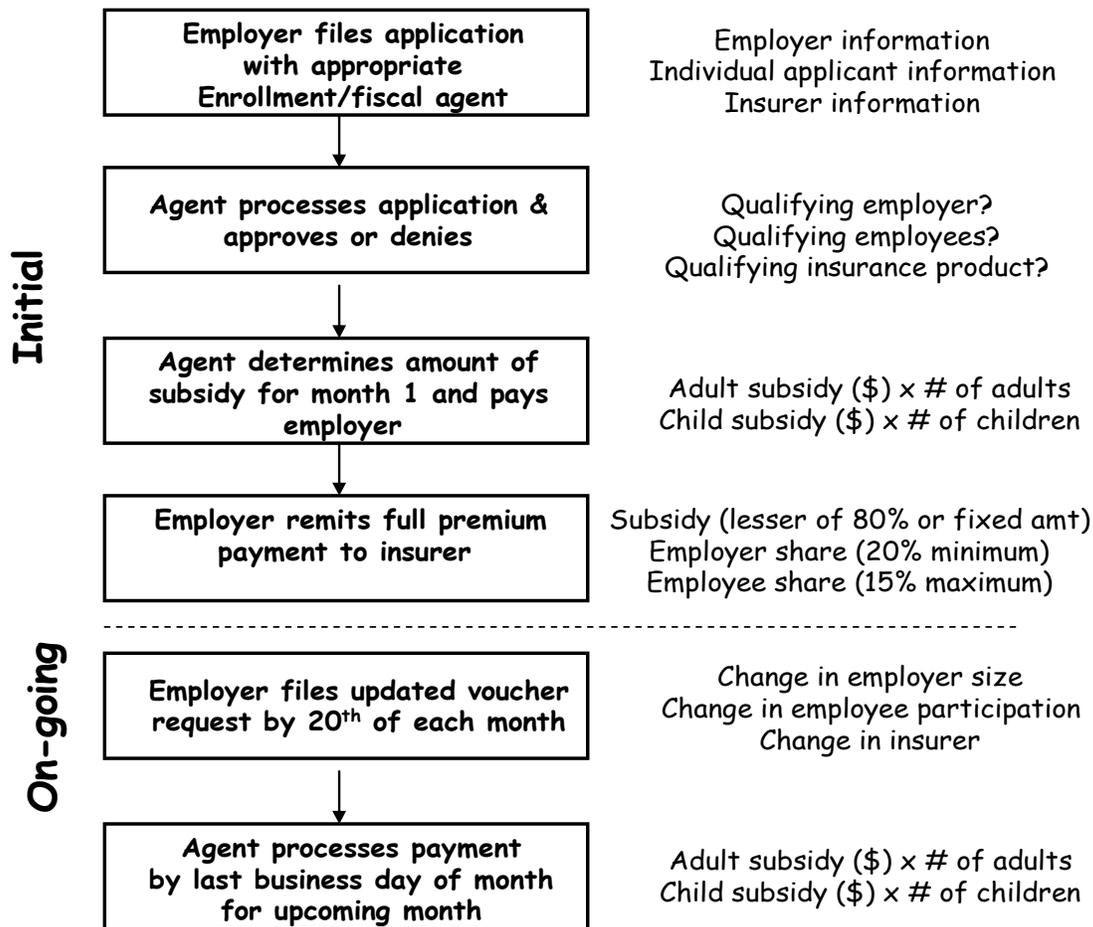
Oklahoma Health Care Recovery Act Oklahoma Premium Model



Revised 3/25/04

The University of Oklahoma Health Sciences Center
Department of Family and Preventive Medicine
Primary Care Health Policy Division

Oklahoma Health Care Recovery Act Oklahoma Voucher Model



Pros

- Easy to administer
- Budget flexibility for state
- No private market crowd-out
- Greater employer freedom-of-choice
- No SoonerCare Plus "Issues"
- Reduced opportunities for fraud

Cons

- Less consistency of benefits
- Less control over affordability

9April04 SPG Meeting

**Oklahoma Health Care Recovery Act
Oklahoma Voucher Model**

Examples

EXAMPLE A

| | | |
|---|------------------|------------|
| Health Insurance Premium (Adult) | \$ 250.00 | |
| Distribution by Payor | | |
| State/Federal (lesser of 80% or \$140) | \$ 140.00 | 56% |
| Employer (20% min) | \$ 72.50 | 29% |
| Employee (15% max) | <u>\$ 37.50</u> | <u>15%</u> |
| Total | \$ 250.00 | 100% |

EXAMPLE B

| | | |
|---|------------------|------------|
| Health Insurance Premium (Adult) | \$ 200.00 | |
| Distribution by Payor | | |
| State/Federal (lesser of 80% or \$140) | \$ 140.00 | 70% |
| Employer (20% min) | \$ 40.00 | 20% |
| Employee (15% max) | <u>\$ 20.00</u> | <u>10%</u> |
| Total | \$ 200.00 | 100% |

EXAMPLE C

| | | |
|---|------------------|-----------|
| Health Insurance Premium (Adult) | \$ 150.00 | |
| Distribution by Payor | | |
| State/Federal (lesser of 80% or \$140) | \$ 120.00 | 80% |
| Employer (20% min) | \$ 30.00 | 20% |
| Employee (15% max) | <u>\$ -</u> | <u>0%</u> |
| Total | \$ 150.00 | 100% |

Appendix VI: SPG Key Discussion Points and Meeting Dates and Discussions

| <i>Date of Meeting</i> | <i>Type of Meeting</i> | <i>Location</i> | <i>Time</i> |
|------------------------|--|--|-------------------|
| October 08, 2003 | Small Workgroup | OHCA Board Room 4545 N Lincoln, Suite 124 | 1 p.m. to 3 p.m. |
| October 21, 2003 | Small Workgroup | OHCA Board Room 4545 N Lincoln, Suite 124 | 1 p.m. to 3 p.m. |
| November 20, 2003 | Large Workgroup | OHCA Board Room 4545 N Lincoln, Suite 124 | 9 a.m. to 11 a.m. |
| Presentations: | <u>Health Care Status</u> , Cindy Roberts Oklahoma Health Care Authority | | |
| | | | |
| <i>Date of Meeting</i> | <i>Type of Meeting</i> | <i>Location</i> | <i>Time</i> |
| February 10, 2004 | Small Workgroup | OHCA 4545 N Lincoln, Suite 124 | 1 p.m. to 3 p.m. |
| Presentations: | <u>It's Health Care Not Welfare</u> , Garth Splinter Primary Care Health Policy Division <u>HIFA – Other States Premium Assistance Plans</u> , Cindy Roberts, Matt Lucas, Buffy Heater Oklahoma Health Care Authority <u>Options for Expanding Coverage</u> , Andy Cohen, Pacific Health Policy Group Discussion of: Premium Assistance Model, Pilot Project, and Funding | | |
| | | | |
| <i>Date of Meeting</i> | <i>Type of Meeting</i> | <i>Location</i> | <i>Time</i> |
| March 10, 2004 | Large Workgroup | OHCA Board Room 4545 N Lincoln, Suite 124 | 1 p.m. to 3 p.m. |
| Presentations: | <u>It's Health Care Not Welfare</u> , “Study Summaries” Garth Splinter, Primary Care Health Policy Division <u>Premium Assistance Implementation Designs</u> , “Other States” Buffy Heater, Oklahoma Health Care Authority <u>Oklahoma Premium Model</u> , “Fiscal Impact Analysis” Andy Cohen, Pacific Health Policy Group Discussion of: Next steps and Feedback from attendees | | |
| | | | |
| <i>Date of Meeting</i> | <i>Type of Meeting</i> | <i>Location</i> | <i>Time</i> |
| April 09, 2004 | Small Workgroup | OHCA 4545 N Lincoln, Suite 124 | 1 p.m. to 3 p.m. |
| Presentations: | <u>Options for Expanding Coverage</u> , “Model 1 Presentation” Garth Splinter, Primary Care Health Policy Division <u>Options for Expanding Coverage</u> , “Model 2 Presentation” Andy Cohen, Pacific Health Policy Group Discussion of models presented with workgroups choice to go with premium assistance Model 2 <u>Governor’s Proposal to Expand Health Insurance Coverage</u> , Tom Adelson, Secretary of Health | | |
| | | | |
| <i>Date of Meeting</i> | <i>Type of Meeting</i> | <i>Location</i> | <i>Time</i> |
| April 30, 2004 | Small Workgroup Blue Cross Blue Shield | OHCA Board Room 4545 N Lincoln, Suite 124 | 1 p.m. to 2 p.m. |
| Presentations: | Explanation to BCBS about the choice to go the route of premium assistance, Tom Adelson, Secretary of Health Care Authority <u>Oklahoma Voucher Model</u> , Cindy Roberts, Oklahoma Health Care Authority <u>Rate Review of BCBS Number</u> , Bert Marshall, Mike Rhoads, Blue Cross Blue Shield Consensus that BCBS would support a Voucher Model that promoted private businesses in health insurance | | |

| <i>Date of Meeting</i> | <i>Type of Meeting</i> | <i>Location</i> | <i>Time</i> |
|------------------------|--|-----------------------------------|------------------|
| August 11, 2004 | Small Workgroup | OHCA 4545 N Lincoln, Suite 124 | 1 p.m. to 3 p.m. |
| Presentations: | Grant update, Matt Lucas, Oklahoma Health Care Authority <u>Fall back Coverage</u> , Cindy Roberts, Oklahoma Health Care Authority <u>Model Review</u> , Matt Lucas, Oklahoma Health Care Authority <u>Timing Issues</u> , Matt Lucas, Oklahoma Health Care Authority | | |

Appendix VII. Contributors of the State Planning Grant

| State Planning Grant Small Workgroup | | |
|---|--------------------------------|--------------------------------------|
| <i>Name</i> | <i>Business</i> | <i>Title</i> |
| Matthew Lucas | Oklahoma Health Care Authority | Projects Manager |
| Cindy Roberts | Oklahoma Health Care Authority | Director Management & Audit Services |
| Tom Adelson | State of Oklahoma | Secretary of Health |
| Kim Holland | Team Insurance Group | Director |
| Patti Davis | Oklahoma Hospital Association | Lobbyist |
| Mike Fogarty | Oklahoma Health Care Authority | CEO |
| Lynn Mitchell | Oklahoma Health Care Authority | Director Medicaid & Medical Services |
| Ed McFall | Oklahoma Health Care Authority | Board Member |
| Anne Garcia | Oklahoma Health Care Authority | Director of Financial Services |
| Buffy Heater | Oklahoma Health Care Authority | Research Analyst |
| Derek Lieser | Oklahoma Health Care Authority | Research Analyst |

| State Planning Grant Large Workgroup | | |
|---|---|--|
| Leeland Alexander | Al Allee | Patricia Andersen Oklahoma Hospital Assoc. |
| Calvin Anthony | David Blatt Com. Action Project | Peter Budetti OU College of Public Health |
| Russell Burkhart Indian HealthCare Resource Center | Tanya Case Prime Advantage | Gerard Clancy OU College of Medicine |
| Tom Coble | Glen Coffee | Steven Crawford |
| Jim Garrett | Jauna Head Office of State Finance | Howard Hendrick Dept. Human Services |
| Mickey Hepner | John Hudgens Dept. of Mental Health | Tammie Kilpatrick Southwestern Bell |
| Gene Kozekoski OU Medical Center | Michael Lapolla OU College of Public Health | Mary Katherine Long Center of Disability Education |
| Don Lorack Hillcrest Hospital | Joe McCoy OSEEGIB | Michael Metzger Univ. Of Central Oklahoma |
| Mark Newman Legislature | Willie Osborn Osborn Drugs | Anne Roberts Institute for Child Advocacy |
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