Health Reform in Oklahoma

“Building on a Solid Foundation”

Oklahoma Health Care Task Force
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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!

Families USA is a non-profit, non-partisan organization based in Washington, D.C. that brings the voice of consumers to federal and state health care debates. We are not driven by any particular ideological perspective. Rather, we look for good policies that can be passed and implemented to further expand health care consumers’ opportunities to have quality, affordable health insurance coverage.
Premiums for family health insurance are $1,781 more per year because of the shift of cost of caring for the uninsured. By the way, only two state have a higher cost shift – your neighbors in New Mexico and my home state of West Virginia.

What is this cost shift? When uninsured Oklahomans get sick, research shows they often put off getting care for health problems or forgo care altogether. When the symptoms can no longer be ignored, the uninsured do see doctors and go to hospitals. Without insurance to pay the tab, the uninsured struggle to pay as much as they can: more than 75% of the total cost of health care services provided to people without health insurance is paid out-of-pocket by the uninsured themselves.

The remainder of the this bill is primarily paid by two sources: roughly one-third is reimbursed by a number of government programs, and two-thirds is paid through higher premiums for people with health insurance.
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

One “trap” that I think it is important that Oklahoma avoid: a numbers game that is entirely focused on simply being able to say that you reduced the number of uninsured people.

By this, I mean that it may make more sense for Oklahoma to use part of your available dollars to improve the benefits and reduce the cost-sharing for the lowest income and most vulnerable individuals and families. This will improve your take-up rates among these populations, and it will save you money in the long run if people are getting all the care they need when they need it.

Trying to stretch available dollars as far as you can to as many people as possible can be counter-productive. It is smart to try to balance reasonable improvements to the coverage available to the lowest income population while also reaching to expand the income eligibility. I believe you can do this within the framework of the existing good array of programs that you have in Oklahoma.
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

-- Total enrollment includes SoonerCare and Insure Oklahoma

-- Congratulations!

After launching a statewide media campaign in October, 2007, the program saw a significant increase in enrollment over the following five months. Enrollment grew from 4,439 to 8,041, an increase of 81%. (Oklahoma Health Care Authority, *Insure Oklahoma Enrollment Climbs 81 Percent*, Press Release, March 17, 2008)

The state's goal for overall enrollment is O-EPIC is 50,000 individuals, 25,000 in the ESI program and 25,000 in the Individual Plan. (Academy Health, State Coverage Initiatives, *Profiles in Coverage: Oklahoma O-EPIC Program*)

(Enrollment numbers reflect unduplicated members for the entire fiscal year. Fiscal year 2007 ran from July 1, 2006 to June 30, 2007 and fiscal year 2008 ran from July 1, 2007 to June 30, 2008.)

Sources:
- Oklahoma Health Care Authority, SoonerCare Fast Facts, June 2008.
- Kaiser State Health Facts
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

I always like to point out that the largest portion of any state’s Medicaid budget goes to seniors and persons with disabilities. Children (and most working-age, non-disabled adults) are relatively inexpensive to cover.

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

There are various programs under the SoonerCare umbrella covering different populations.

Oklahoma Cares provides full Medicaid benefits, not just those related to cancer prevention and treatment. BRAVO!
The SoonerCare 1115 waiver was originally implemented in April 1996 and most recently renewed in June 2006 with an expiration date of December 31, 2009. Originally under the waiver, SoonerCare had two separate managed care programs – SoonerCare Plus and SoonerCare Choice. SoonerCare Plus was a traditional managed care program that was operated in a few areas of the state, and was discontinued starting in January 2004, when SoonerCare Choice went statewide. In 2005, the waiver was amended to add TEFRA children and the O-EPIC programs.

(Slides 10 -13 – here to show you that I did my homework and studied hard to understand the foundation of programs already in place in Oklahoma – you know your programs!)
SoonerCare Choice is a Primary Care Case Management (PCCM) system. The state contracts directly with primary care providers and case managers who provide and/or authorize all primary care and specialty services, except for those services that do not require authorization. THIS IS A GREAT PROGRAM!

Benefits:
Except for O-EPIC, all SoonerCare enrollees, including those in SoonerCare Choice, get the standard Medicaid benefit package. In addition, the SoonerCare Disease Management Program (SDMP) is offered to all adult SoonerCare beneficiaries, again except those in O-EPIC, with diabetes, hypertension, and heart failure. The Program offers educational materials about managing chronic disease, calls from health professionals to monitor adherence to treatment, and in severe cases intensive case management.

Cost Sharing:
Cost-sharing follows traditional Medicaid rules, and is only allowed for non-pregnant adults. These adults have nominal copayments of $1 to $3, depending on the cost of the service. No co-payments are allowed for emergency room and family planning services.
**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.

**O-EPIC = Oklahoma Employer/Employee Partnership for Insurance Coverage Program**

The O-EPIC program is a result of an amendment to the HIFA waiver, approved by CMS in September 2005, to provide Medicaid premium assistance to adults with incomes up to 200% of poverty. Adult working disabled and non-disabled low income workers and spouses who work for small employers, are self-employed, or are unemployed and seeking work are eligible for O-EPIC.

In FY08 the Medicaid and CHIP FMAPs were 67.1% and 76.97%. In FY09, the Medicaid and CHIP FMAPS are 65.9% and 76.13%, respectively.
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**

**Cost Sharing**

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

**Spouse:**
- Employee - 15%
- State – 85%

*Employee’s share of the premiums for both themselves and their spouse is capped at 3% of family income, so an employee may end up paying less than 15%. The state picks up the difference.*
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

Enrollees are subject to the co-pays set forth by the plan; however, office visit co-pays cannot exceed $50 per visit and annual pharmacy deductibles cannot exceed $500 per individual.

Reimbursement for out-of-pocket costs subject to available funds. I find your $900 out-of-pocket reimbursement cap very worrisome. I would recommend that you monitor this carefully to see if people are hitting the cap. If so, why?

Looking through the waiver docs for info on reimbursement for costs over the 5% cap under the ESI program, it states:

The State will provide reimbursement for out-of-pocket costs in excess of the five percent annual gross household income cap, in a manner defined by the State and subject to the availability of funds, for individuals (or their eligible O-EPIC spouse) enrolled in the Premium Assistance Program. **A medical expense must be for an allowed and covered service by the health plan, to be eligible for reimbursement.** The State has established a current household maximum out of pocket reimbursement of $900 per eligibility period.

This means that any uncovered health care service must be paid for by the individual – above and beyond the 5% cap and no reimbursement is available for these services. This makes the issue of what services are covered and are not covered under a “Qualified Health Plan” offered by an employer extremely important. Low-income people with chronic conditions or older people who need more health care may not be getting critical services because of holes in your benefits packages. In the long run, this may end up costing you more.
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

Again, it is extremely important to have a reasonable standard for a “Qualified Health Plan” – and apply it when looking at employer insurance offers – because you do not reimburse for out-of-pocket costs for uncovered services. Even if you did, the $900 cap for reimbursement could easily be used up.
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

Co-pays exceed those specified in the State Plan and range from $5-50 depending on the service.
According to OHCA, the average Individual Plan member premium is $36.75 and the average IP member is at 131% of poverty (although there are some inconsistencies in the data). Thus, it appears that the program is not serving those under 100 FPL.

It is critically important to understand the direct correlation between premium size and take-up rates when working with lower income populations. Extensive research on cost-sharing has established the high degree of price sensitivity for your target income eligible population. You can find summaries of this research on the Families USA website (www.familiesusa.org) and we would be delighted to send our literature review to this task force.

I understand that Oklahoma is considering tying premiums in the Insure Oklahoma Individual Plan to a straight 4% of income with a cap at 20% of the cost of the product. The effect of this change will be to substantially raise premiums for most people. This will hurt your efforts to increase the take-up of the plan among the target population. I would carefully consider how else you might address equity issues in the premium structure without creating significant increases in premiums.

I understand the $900 reimbursement cap also applies to the Individual plan. Again, this is very worrisome.
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

The Individual Plan has some benefit limits. Services that would be available if these individuals were covered under regular Medicaid are not covered.

For Oklahoma parents under 100% of the federal poverty level ($17,600 for a family of three), these benefit limits are very worrisome. For families living on this tight of a family budget, it will be very hard to pay for any uncovered services.
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

In August 2007, Oklahoma submitted a request to CMS to amend the SoonerCare Waiver to expand coverage under the O-EPIC premium assistance program. Under the amendment:

  • Non-disabled working adult parents with incomes up to 185% FPL would be allowed to choose whether to enroll their dependent children into SoonerCare Choice or cover them through the O-EPIC ESI program.

  • Non-disabled working adult parents with incomes up to 300% FPL would be allowed to enroll their children in the O-EPIC ESI or Individual Plan program, effectively increasing children’s coverage income eligibility from 185% to 300% of poverty. The state would use federal CHIP funds for this expansion.

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

  • Expanded employer size eligibility to include businesses with up to 250 employees and expand coverage under the O-EPIC programs to working adults from 200% FPL to 250% FPL.
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

In a letter to Oklahoma in May 2008, CMS indicated that the state’s request to expand coverage to adults above 200% was not under active consideration, and that expanding coverage to children with gross income above 250% was not in compliance with the August 17th CHIP directive. Oklahoma modified their initial request for adults to go to 200% instead of 250% FPL, for children to go to 250% instead of 300% FPL, and college students to be covered up to 200% instead of 300%. These new income limits include income disregards. The state is still in negotiations over the amendment, but CMS has reiterated its position that income disregards would allow kids and parents above these levels to be eligible, which they are not considering at this time. The waiver has been on hold for fourteen months.
Ideas for Reform
Let me take a minute for a commercial break for Medicaid. You understand that expanding Medicaid state spending allows you to pull down federal matching dollars to pay for health care coverage for uninsured Oklahomans. But those new federal dollars flowing into the state can also play a unique role stimulating state business activity and state economies. Medicaid provides a uniquely positive, counter-cyclical economic stimulus and Medicaid spending decisions affect the health of the overall state economy.
Here’s why.

Every dollar as state spends on Medicaid pulls new federal dollars into the state because of the federal match. Dollars that would not otherwise flow into the state. These new dollars pass from one person to another in successive rounds of spending. For example, health care employees spend part of their salaries on new cars, which adds to the income of employees of the auto dealership, enabling them to spend part of their salaries on washing machines, which enables appliance store employees to spend additional money on groceries, and so on. Economists call these successive rounds of spending the “multiplier effect.”

Because of the multiplier effect, the aggregate impact of Medicaid spending on a state’s economy is much greater than the value of services purchased directly by the Medicaid program.

The Medicaid multiplier effect can be quantified. Families USA used the RIMS II input-output economic model created by the U.S. Department of Commerce, Bureau of Economic Analysis. The RIMS II Model allows us to capture the specific economic conditions in each state and then calculate the new economic activity that will be generated by Medicaid spending in three areas:

1. Business activity (the increased output of goods and services)
2. Employment (the number of new jobs created)
3. Employee Earnings (wages and salary income associated with these new jobs)
More **Bang** for the Buck

$1.00 = $3.04

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

I’d like to walk you through this:

First, Oklahoma has a high Medicaid matching rate -- 67.1% in 2008. This means that for every dollar of state money you spend on Medicaid, you get $3.04 in health care services. Second, when Oklahoma residents buy health care, they rarely go out of state for that care so the economic multiplier effect is significant.
Potential Gains for Oklahoma

New Jobs – 1,573

Wages from New Jobs –

$50 million

Business Activity –

$138 million

What if you spent an additional $30 million in dedicated state spending on Medicaid?

This would generate approximately $138 million in new business activity, $50 million in new wages, and 1,573 new jobs.

Not only does your Medicaid spending provide essential health care services to your most vulnerable populations, Medicaid spending is a tremendous economic stimulus policy.

As you weigh and balance state budget options, the equation should include recognition of the economic benefit of using state spending on Medicaid. Medicaid spending is good medicine—both for the health of state residents and for an ailing economy.
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

Insure OK is a good foundation in terms of expanding coverage to higher income kids and parent, and covers childless adults.
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

100% FPL - $17,600 for family of three
200% FPL - $35,200 for a family of three

Traditional Medicaid will provide access to much needed health care services with minimal cost-sharing. Extensive research shows that even minimal cost sharing can hinder low-income families’ ability to access care, so even the seemingly modest premiums under Insure Oklahoma are likely too high for very low-income families. The state has indicated in its waiver expansion request that the Insure OK take up rate is much slower than expected.

The Insure OK Individual Plan provides limited benefits. Severely limiting primary and specialty care is especially troublesome because individuals will only seek care when they are sick, leading to costlier treatment, ER use, and hospitalizations, driving up costs for everyone.

The Insure OK ESI program does not provide enough protection against high copayments, allowing up to $50 for an office visit and a $500 deductible for pharmacy. In addition the state has established a current household maximum out of pocket reimbursement of $900 per eligibility period. This cap is easily reached if anyone one in the house has a chronic condition.

Again, a medical expense must be for an allowed and covered service by the health plan, to be eligible for reimbursement. So if a service is not covered, a low-income person must pay the cost out-of-pocket without any reimbursement. Thus, it is extremely important to understand that holes in covered services must be carefully evaluated.

If the state is serious about reducing the number of uninsured Oklahomans and is planning to expand coverage using the Insure OK program, these recommendations should be considered to insure that very low-income families are provided with comprehensive and affordable care.
Ideas for Reform

Expand eligibility under traditional Medicaid and Insure OK

<table>
<thead>
<tr>
<th>Category</th>
<th>Current Eligibility</th>
<th>Proposed Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of FPL</td>
<td>Amount*</td>
</tr>
<tr>
<td><strong>Kids (Traditional Medicaid)</strong></td>
<td>185%</td>
<td>$32,560</td>
</tr>
<tr>
<td><strong>Parents (Traditional Medicaid)</strong></td>
<td>32%</td>
<td>$5,652</td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td>$8,800</td>
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<tr>
<td><strong>Insure Oklahoma Parents/Childless Adults</strong></td>
<td>200%</td>
<td>$35,200</td>
</tr>
<tr>
<td><strong>Insure Oklahoma Kids</strong></td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Figures are for a family of three in 2008

There are two categories of parents eligible for Medicaid – working and non-working. The non-working are eligible up to roughly 32% FPL ($471 per month) and based on income disregards available, working parents are eligible up to roughly 50% ($700 per month)

Note that about 43% of adult parents under 100% FPL are uninsured – more than 300,000 uninsured.
Ideas for Reform

16 States and the District of Columbia have expanded traditional Medicaid to parents with incomes at 100% FPL or above
<table>
<thead>
<tr>
<th>State</th>
<th>Non-Working Parents</th>
<th>Working Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>200%</td>
<td>200%</td>
</tr>
<tr>
<td>California</td>
<td>100%</td>
<td>106%</td>
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<tr>
<td>Connecticut</td>
<td>185%</td>
<td>191%</td>
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<tr>
<td>Delaware</td>
<td>100%</td>
<td>106%</td>
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<tr>
<td>District of Columbia</td>
<td>200%</td>
<td>207%</td>
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<tr>
<td>Hawaii</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Illinois</td>
<td>185%</td>
<td>191%</td>
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<tr>
<td>Maine</td>
<td>200%</td>
<td>206%</td>
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<tr>
<td>Maryland</td>
<td>116%</td>
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<tr>
<td>Massachusetts</td>
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<tr>
<td>Minnesota</td>
<td>275%</td>
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<tr>
<td>New Jersey</td>
<td>133%</td>
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<tr>
<td>New York</td>
<td>150%</td>
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<tr>
<td>Oregon</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Rhode Island</td>
<td>185%</td>
<td>191%</td>
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<tr>
<td>Vermont</td>
<td>185%</td>
<td>191%</td>
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<tr>
<td>Wisconsin</td>
<td>200%</td>
<td>200%</td>
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Ideas for Reform

Improve SoonerCare Outreach and Enrollment

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

— Currently, applications are available online to download and mail in, but they cannot be submitted online. I understand you may be in the process of providing for online submissions through an initiative called “No Wrong Doors”?

— Suggestion: create streamlined application/renewal forms that will allow individuals to apply/renew for Medicaid and Insure OK to ensure that individuals are screened for all available programs. Some states even streamline eligibility for all public programs, such as food stamps, TANF, Medicaid, etc to ensure a single point of entry for all available programs. In addition, allow one application/renewal form for the entire family.

— Suggestion: implement presumptive eligibility to allow kids and parents who appear to be eligible, based, for example, on their eligibility for other public programs, to enroll while they are completing the application process. This allows them access to urgently needed care.

— Guarantee children 12 months of coverage regardless of changes in their income status.

— Oklahoma saw a jump in Insure OK enrollment after launching a statewide media campaign and you can do the same for Traditional Medicaid.

— Ensure adequate funding for outreach/enrollment workers to be staffed at clinics and hospitals

Currently:
Face to face application is not required
Administrative verification - they consult state data bases or available case records to verify income rather than applicants having to bring in documents
Renewal is once a year
Private Market
## Premiums vs Paychecks
### 2000 - 2007

<table>
<thead>
<tr>
<th>Change in Average Family Premium</th>
<th>Change in Median Worker Earnings</th>
<th>Premium Increase as a Multiple of Earnings Growth</th>
</tr>
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<tbody>
<tr>
<td>62%</td>
<td>18.8%</td>
<td>3.3</td>
</tr>
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</table>
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.

One of the arguments that I hear over and over again is that regulations will drive up cost to the point where coverage is unaffordable. This simply isn’t supported by the evidence.

Further, it is very hard to talk about regulations as a broad concept. There are different kinds of ways states can regulate the individual/non-group and the small group markets. In the slides that follow, I have tried to add in some concrete evidence about how different regulations impact the premiums. I have also tried to honestly present the pros and cons for you.

-- Modified community rating, to be honest, can raise premiums for the youngest and healthiest, but it lowers premiums for older people and people not in perfect health.

-- Medical loss ratios (a requirement about how much of premium dollars collected must be spent on paying claims for health services) lowers premiums for everyone

-- Rate review mechanisms that give the state the right to look carefully at premium increases certainly lowers premiums

This is the fair caveat: No insurance regulation address the underlying reason why health insurance is expensive and why premiums growth faster than wages. The single most important driver of insurance costs is underlying health care costs.
Based on the criteria with which we evaluated state’s individual market regulations in our *Failing Grades* report, Oklahoma does not have any of the essential consumer protections we would hope to find in a state.
# 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**

According to the data we collected regarding the small group market, protections for small businesses are inadequate in Oklahoma as well.
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

There is a lot of variation in premiums. According to premium charts pulled from the OHRP website effective May 2006: a woman aged 50-54 would pay $1,123/month for a plan with a $500 deductible. Yikes!
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

Oklahoma should make health coverage more accessible to individuals regardless of their health status or occupation. It could accomplish this is two ways.

**Alternative One:** Oklahoma could require all insurance companies to take all applicants—a requirement known as guaranteed issue.

**Alternative Two:** Oklahoma could introduce greater regulation in the individual market’s underwriting practices and make improvements to its high-risk pool that would make it significantly more accessible, including:

- **Standardize the application forms and medical underwriting criteria among individual market insurers** to prevent insurers from rejecting applicants who are not, in fact, high-risk, as in Washington and Oregon. The new underwriting criteria may include a list of health conditions that are grounds for denial.

- **Cap the high-risk pool premiums at 125 percent of standard market rates.** In California, Minnesota and Oregon, state regulations limit high-risk pool premiums to 125 percent of standard rates. Connecticut, Idaho, Indiana, Maryland, Missouri, Montana, New Hampshire, and Washington reported having at least one product priced within this range, even in the absence of law or regulation


- **Shorten the waiting period for coverage of previously uninsured enrollees’ preexisting conditions.** The pre-existing condition exclusion period for previously-uninsured is currently one year.

- **Increase the lifetime benefit maximum,** which is only $500,000 right now. 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.
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

In Oklahoma, there are no limits on how much an insurance company can vary premiums based on an individual’s health status. Oklahoma should prohibit insurance companies from setting premiums based on individuals’ health status and limit the amount insurers vary premiums for other factors (such as occupation and age), a system called modified community rating. A tempered approach to addressing this problem is to introduce rate bands that limit how much insurers can vary premiums based on health to 25 percent or less. This step would begin to move away from the vast variation in premiums that may exist in Oklahoma’s unregulated market and promote greater risk-sharing.

Oklahoma should require insurers to submit requests to increase premiums with the Division of Insurance. Requests should be permitted no more than once per year, and insurers should be required to prove that the rate increase is necessary and that it is not based on individuals’ health status. The state should also enforce a medical loss ratio of at least 75 percent. Meeting the medical loss ratio should be one of the criteria for the department of insurance to evaluate insurance companies’ rate increase requests.
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

Oklahoma should require insurers to submit requests to increase premiums with the Division of Insurance. Requests should be permitted no more than once per year, and insurers should be required to prove that the rate increase is necessary and that it is not based on individuals’ health status. The state should also enforce a medical loss ratio (MLR) of at least 75 percent. Meeting the medical loss ratio should be one of the criteria for the department of insurance to evaluate insurance companies’ rate increase requests.

If you are not ready to enforce a MLR requirement, you could first standardize the accounting procedures used to report how premium dollars are spent, and require that this information be publicly available in an understandable and uniform format (transparency for consumers).

For more information on Medical Loss Ratios see [http://familiesusa.org/assets/pdfs/medical-loss-ratio.pdf](http://familiesusa.org/assets/pdfs/medical-loss-ratio.pdf).

**MLRs can save consumers money!**

For example, as a result of Maine’s medical loss ratio requirement (75% in small group market if companies are subject to rate hearings, 78% in small group market if company doesn’t want a hearing), in 2008, one Maine insurance company will refund policyholders $6.6 million and another will refund policyholders $1 million.

Between 1993 (when the state implemented the 75 percent medical loss ratio in the individual market) and 2006, insurers that failed to meet the requirement refunded a total of $11.6 million dollars to consumers.

In late May 2008, New York’s Governor and Department of Insurance announced that Oxford Health Insurance will refund $50 million to 37,000 small businesses in the state because, in 2006, they did not achieve the 75 percent minimum medical loss ratio.
For more information about Prior Approval see [http://familiesusa.org/assets/pdfs/prior-approval.pdf](http://familiesusa.org/assets/pdfs/prior-approval.pdf)

In contrast to what health insurers say, insurance regulators in states with prior approval report that it helps to keep premium rates and premium increases reasonable:

-- Indiana regulators estimate that they negotiate lower premium increases about 50 percent of the time.
-- In *Iowa*, regulators have negotiated down about 30 percent of requested premium increases since January 2007. The rates that were approved after insurers reduced their proposed increases were, on average, 40 percent lower.
-- A *Maryland* insurer kept its premiums artificially low for two consecutive years and then requested a 46 percent increase, according to state regulators. The state denied that high increase and won in court when the insurance company challenged its decision. Regulators there report that they reduce about half of all proposed premium increases that come in.
-- *New Hampshire* regulators negotiated with an insurer to bring a proposed 100 percent increase down to 12.5 percent.
-- *North Dakota* regulators worked with insurers to bring down about 37 percent of the proposed premium increases (also known as rate filings) that have come in since the beginning of 2007.
-- *Ohio* regulators report that they often negotiate with health insurers for lower premium rates, or they require a reduction in proposed rates, as part of the prior approval process.
-- *Tennessee* regulators report that they often negotiate reductions in premiums or deny premium rate increases. Before Tennessee began its rigorous rate review process, insurers were charging higher rates for their products in Tennessee than they were in many other states. By using prior approval, Tennessee has curtailed that practice. For example, the state has denied insurer requests to increase premiums by 25 percent and 32 percent when insurers’ rates in Tennessee were already 33 percent higher than the rates they charged in other states.
-- *Vermont* insurance regulators estimate that they deny proposed premium rate increases or negotiate with insurers for lower rate increases about 75 percent of the time.

**The Tale of Washington State:**

Washington had a prior approval process in place from the early 1990s until 2000. It was repealed in 2000 as part of a deal with insurers. Not surprisingly, premiums rose steeply after that, and consumers complained to the Washington Office of the Insurance Commissioner. But without prior approval regulations, the Insurance Commissioner’s office was unable to determine if the premium increases were always justified. Because of these concerns, the legislature considered reinstating prior approval in 2007. The insurance industry assured lawmakers that the measure was excessive and unnecessary. However, as soon as the prior approval bill died, the state’s largest insurer in the individual health insurance market hit policyholders with 20 and 40 percent rate increases even though the company was already making lots of money in the individual market (20 percent of the premium dollars that the insurer collected the previous year went to profits). During the 2008 legislative session, Washington legislators enacted a bill to reinstate prior approval in the individual health insurance market. Regulators report that since the law was enacted, they’ve already received two significant rate filings that will have to be negotiated down.
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

PRE-EX:
• In Oklahoma, there is no limit on the length of time insurance companies can exclude coverage for the treatment of pre-existing conditions. Oklahoma also allows insurers to sell policies that contain elimination riders—contractual clauses that say that the insurer will never cover an individual’s treatment for a specific pre-existing condition.
• Oklahoma law does not limit how far into an individual’s medical history insurance companies may look to determine what pre-existing conditions they will exclude from the policy.
• In order to protect consumers, eighteen states use the objective standard that defines a pre-existing condition as a health condition for which a health care professional provided or recommended treatment, as opposed to a condition that an individual unknowingly had and that had not been diagnosed by a health care provider. Oklahoma has no standard in place to guide insurance companies about what qualifies as a pre-existing condition, leaving consumers vulnerable.

POST-CLAIMS / REVOCATIONS:
Oklahoma does not have specific statutory language that protects against post-claims underwriting. While there is a law on the books that may be helpful in fighting post-claims underwriting, we recommend that they enact stronger, more explicit statues.
• Require insurers to present clear questions on insurance applications and to communicate the importance of answering completely.
• Require insurers to complete all medical underwriting at the time of application and contact applicants or review additional health information to clarify any confusing or incomplete answers before issuing a policy.
• Insist that insurers revoke policies only under exceptional circumstances, when the insurer can demonstrate willful misrepresentation and intent to deceive.
• Prohibit insurers who revoke policies from refusing to pay providers for treatment that the insurers have already authorized after policies are cancelled.
• Require that insurers submit requests to revoke policyholders’ coverage to the state insurance commissioner for review.
• Give consumers the opportunity to participate in any investigations about whether they willfully misrepresented their health on applications, and allow consumers to appeal decisions both through their health plan and through an outside government agency.
• Have state insurance regulators oversee insurance companies to ensure that those companies are complying with the state’s consumer protections.
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 a reasonable portion of premiums on medical care

Oklahoma oversees insurance companies' premium increases in the small group market by requiring insurers to submit proposed rates and proposed rate increases for prior approval. This is an important regulatory measure to ensure premiums are reasonable.

However, the state does not require insurers to efficiently use premium dollars on medical services. The minimum medical loss ratio in the small group market is only 60 percent, allowing insurance companies to retain 40 percent of small business premiums for administration, marketing, and profit. Insurance companies can do better than spending just 60 percent of small business health insurance premiums on medical services. Oklahoma should hold them to a higher standard of at least 75 percent. Some states are moving toward 85 percent (California legislators recently sent the governor a bill requiring an 85 percent loss ratio, and a similar bill is pending in Pennsylvania), but 75 percent is a good starting place to ensure greater efficiency and transparency.

Many states require higher medical loss ratios in the small group market returning significant savings for small businesses:

-- **Maine's** minimum medical loss ratio is 78 percent for insurers who opt out of the Department of Insurance premium review process, or 75 percent for insurers who agree to participate in the process. In 2008, one Maine insurance company will refund policyholders $6.6 million and another will refund policyholders $1 million.

-- **New York** set its medical loss ratio at 75 percent for small business carriers, and 80 percent for individual market carriers. In late May 2008, New York’s Governor and Department of Insurance announced that Oxford Health Insurance will refund $50 million to 37,000 small businesses in the state.

-- **New Jersey** has required a 75 percent minimum medical loss ratio in the individual and small group market since 1993. Between 1993 and 2006, individual market insurers that failed to meet the requirement refunded a total of $11.6 million dollars to consumers.
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

Many states are coming up with ways to include sole-proprietors and young adults in group coverage, rather than leaving them to seek coverage in the individual market. Though regulations should be enacted to make the individual health insurance market a friendlier place for consumers, there are incremental steps to help individuals gain or maintain group coverage in the interim.

According to data we collected for but did not report in *Failing Grades*, fourteen states reported that they allow sole-proprietors or “groups of one” to buy health insurance coverage through the small group market (although, because we did not report the data, we did not authenticate all these responses with state statutes, and some states may have answered yes without understanding what the question really asked). With this kind of group of one law, insurance companies are not permitted to deny sole-proprietors coverage based on pre-existing conditions, and in many states the premium limitations are greater in the small group market than in the individual market.

In an effort to stem the growth of uninsured rates among young adults, nineteen states have enacted laws that allow young adults to retain dependent coverage past age and education typical limits. These laws allow young adults who have graduated from high school or college but have not secured a job that offers health benefits to stay on their family’s health plan. Young adults in their twenties tend to be healthier than older individuals, and keeping them in the risk pool can be beneficial as well.

Both types of legislation are straightforward ways to reduce the number of uninsured in Oklahoma.
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 assessment 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

Oklahoma’s fiscal year 2008 ended strongly with a rainy day fund filled it to capacity, and $82.8 million in surplus.

I understand that you have a statutory provision that if, by 2012, you are not spending 75% of dedicated tobacco dollars on Insure OK then you are authorized to expand eligibility to parents of children eligible for Medicaid.

Assuming your waiver is approved, you could be in the beautiful situation of having both parents and children eligible for Insure OK coverage up to 300% of FPL.

That thought is a great one to end on!
THANK YOU