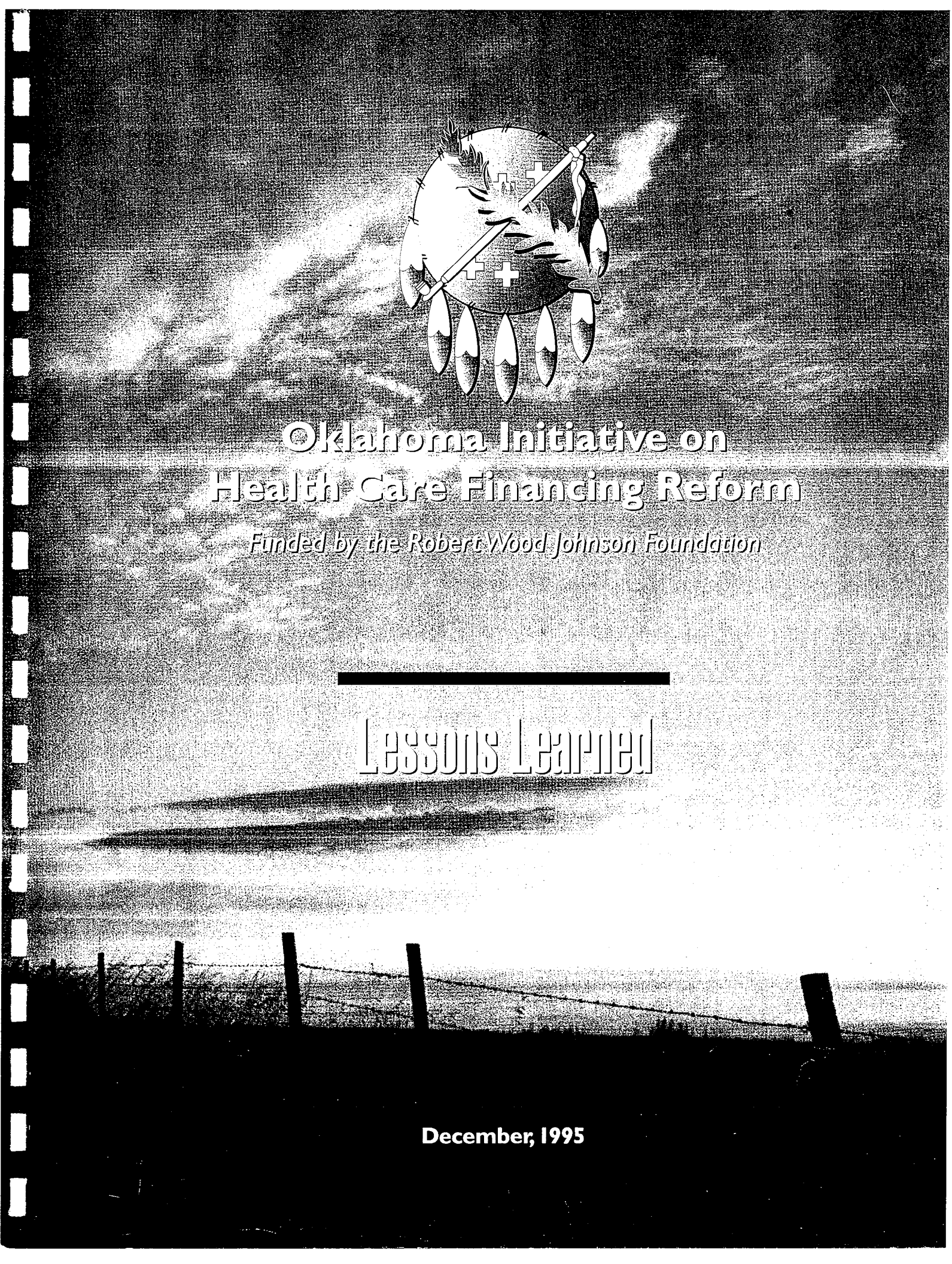
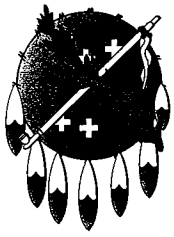


Oklahoma Initiative on Health Care Financing Reform

Funded by the Robert Wood Johnson Foundation

Lessons Learned

December, 1995



Oklahoma Initiative on Health Care Financing Reform

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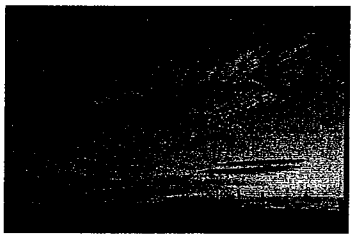


INTRODUCTION

The Oklahoma Initiative on Health Care Financing Reform

Oklahoma has a proud historical and cultural tradition, punctuated by a strong sense of self reliance among its citizens. Hence, it became essential for the State to develop a solution for problems related to health care access and cost control that would work in Oklahoma, for Oklahomans. Ultimately, analysis of the State's health system led former Governor David Walters to adopt a market-based approach to health reform. The Oklahoma Family Choice Health Plan, the basis for the State's application for funding under the Robert Wood Johnson Foundation's State Initiatives project, evolved from this process.

Oklahoma made application to the Robert Wood Johnson Foundation for support of the Family Choice Health Plan concept in February, 1992. It was one of twelve states awarded grants in August, 1992, under the State Initiatives program.

When Oklahoma was awarded its Grant, Governor Walters directed Garth Splinter, M.D., M.B.A., the project's Principal Investigator, to establish the Initiative as a free-standing entity that could both develop mechanisms for enhancing costs and promoting cost containment and act as an information resource for all of the State's health care interests. The Oklahoma Health Sciences Center and the Oklahoma Department of Health assisted in support of the project's staff (see Appendix 4) and expenses.

In 1994, Governor Walters designated the Oklahoma Health Care Authority as the lead agency for the Oklahoma Initiative. After Governor Frank Keating took office in 1995, Dr. Splinter worked with the new administration to assist them in gaining knowledge of the structure and mission of the Oklahoma Initiative. Without hesitation, Governor Keating encouraged Dr. Splinter to continue the work of the Initiative in the spirit of improving Oklahoma's health care environment. However, he emphasized movement away from concepts of universal coverage and towards reliance on reforms which would bolster self-purchased coverage or increase the effectiveness of state-purchased coverage. The market-based approach was to continue.

The Commission on Oklahoma Health Care

On February 5, 1992, Governor Walters established the Commission on Oklahoma Health Care to consider fundamental structural changes in the health care system. The Commission assisted the State Initiative in its efforts.

The formation of the Commission coincided with the nation's growing interest in health care reform. The objective was straightforward, but potentially difficult to achieve: to increase health

care coverage in an environment that has diminishing resources, but in which it is necessary to consistently evolve towards greater efficiency. The scarcity of new revenue sources combined with the strain on existing revenues suggested that a creative solution to Oklahoma's health care problems was required.

In establishing the Commission, Governor Walters created a forum for addressing many of the issues which affect the health of Oklahoma's citizens. He understood that there were many factors which were not subject to exclusive state control but were instead influenced by federal law and regulations. However, in light of the inability of the U.S. government to deal quickly with health care reform on a national level, he urged Oklahoma to seize its own destiny in improving health care for the State. The Commission worked to initiate the process of reforming the health care system. While recognizing that health care must be available for individuals who are unable to secure access due to poverty or poor health, it acknowledged the responsibility of every Oklahoman to change their behavior to the greatest extent possible to achieve good health. If this could be accomplished, dollars currently spent on health care would be markedly reduced.

Under the terms of House Bill 1578 (1992), the Legislature statutorily authorized the ongoing work of the Commission. In its enabling legislation, the Commission was directed to build upon previous health care reform planning in the State. The Commission was required to study three models for health care reform: a Universal Health Care Plan described in H.B. 1578; the Small Employers Health Insurance Availability Model Act of the National Association of Insurance Commissioners; and, proposals providing for Individual/Family Health Accounts. In their final report to the Legislature and the Governor (December, 1993), the Commission recommended that Family Health Accounts be established through the Oklahoma Health Care Authority.

The Oklahoma Health Care Authority

During the 1993 Legislative session, the Oklahoma Legislature passed two important bills, House Bill 1573 and Senate Bill 76, that had a positive impact on health reform and laid the foundation for the Family Choice Health Plan. H.B. 1573 established the Oklahoma Health Care Authority, with the mandate to coordinate all State purchased/State subsidized health care. S.B. 76 transferred the Medicaid program to the newly formed Authority and mandated statewide conversion of the Title XIX program to a managed care system. In addition to its responsibilities under the Medicaid program, H.B. 1573 gave the Health Care Authority the responsibility for approving and directing the purchase of health care products for State employees through the Oklahoma Employees Benefits Council.

On October 12, 1995, Oklahoma became the twelfth state to gain Department of Health and Human Services approval of an 1115(a) waiver. SoonerCare, the State's Medicaid demonstration project, will enroll Medicaid beneficiaries into managed care, and test different models of health delivery systems in urban and rural areas. During the first year of the demonstration, most of the 342,000 who are eligible annually for Title XIX services through Aid to Families with Dependent Children (AFDC) recipients and AFDC-related Title XIX beneficiaries will be enrolled in managed care programs. Most of the 84,000 non-institutionalized aged, blind, and disabled beneficiaries in Oklahoma who are not dually-eligible will be enrolled in managed care during the second year of the demonstration.

Employees Benefits Council

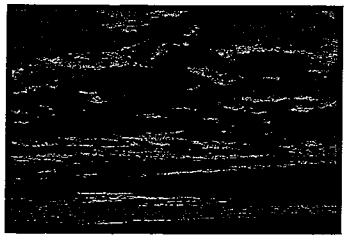
The Oklahoma Employees Benefits Council (EBC), whose purchasing actions are ultimately under the direction of the Oklahoma Health Care Authority, stands as one of the major purchasers of managed care in Oklahoma. The EBC administers the Flexible Benefits Plan for approximately 40,000 active State employees and their dependents. Under the name "SoonerChoice," EBC offers medical and dental insurance, group life insurance and disability coverage. Participants are required to select either the State's Employees Group Insurance Plan (an indemnity product) or one of several HMOs approved by the EBC and the Authority. The EBC also oversees a Section 125 Plan which allows enrollees to have pre-tax reimbursement accounts for medical expenses and dependent (child) care. Through the Section 125 Plan, State employees are offered a premium conversion feature which allows medical insurance premiums to be paid with pre-tax dollars. The Authority has been instrumental in promoting enhanced education of State employees and teachers about Section 125 accounts and other deferred compensation options.

Division of Health Care Information

In addition to provisions in H.B. 1573 involving the State's Title XIX program, the legislation transferred the Division of Health Care Information (DHCI) from the Oklahoma Health Department to the Health Care Authority. In order to promote health care planning and cost containment within the State, the DHCI was directed in its enabling legislation to establish and maintain a comprehensive health care information database for Oklahoma. This information base was designed to facilitate the ongoing analysis and evaluation of patterns and trends in the utilization and costs of health care services and to enhance the capabilities of various components of the health care industry to provide needed services. Leigh Brown, J.D., M.P.H., Project Director for the Oklahoma Initiative, is the senior administrator for the DHCI. Currently, the DHCI is developing consumer satisfaction instruments to be administered to Medicaid recipients, State employees, and teachers. Health plan report cards are being prepared to allow informed consumer choice by State employees. These will then be extended to the Medicaid population.

Oklahoma's Initiative for Health Care Financing Reform

Three years after submission of its proposal, as the Oklahoma Initiative comes to a close, it is appropriate to look back on the broad range of lessons for future policy discussions in Oklahoma, as well as across the nation.



CHARACTERISTICS OF THE STATE

Introduction

Oklahoma has characteristics which create difficulties in access to health services for many of its citizens. Oklahoma is a relatively poor state. In 1993, per capita income in the State was $17,020, making Oklahoma forty-second in the nation in per capita income. For persons relying on income from self-employment farming operations, the average farm self-employment income for the State, at $7,340, was less than one half the average non-farm self-employment income.

According to census data, approximately 17% of the State's population, and 13% of its households, live below the poverty level. The proportion of Oklahoma households living in poverty is 34% higher than the U.S. average. Of the households in Oklahoma which are below the poverty level, over 14% have a woman as the sole head of the household. In these families, approximately 38% live below the poverty level. This is a significantly larger proportion than for families in general. The proportion of family with female heads of household which live below the poverty level rises to over 60% in families containing children under age 5.

Like many states, Oklahoma has been deeply affected by economic problems which have troubled the entire nation over the last decade. In particular, the "Oil Bust" of the early- to mid-1980s created significant difficulties for many Oklahomans, resulting in long-lasting trends in unemployment and poverty, affecting both persons employed within the oil industry and persons employed in communities which had become dependent on the tax base and commerce associated with thriving oil production. However, recent data suggests that Oklahoma's employment picture is significantly improving, with the unemployment rate dropping from 6.2% to 4.9%, compared to a drop in the national average from 5.9% to 5.2%.

Oklahoma's Health Care System.

Many problems associated with access to health services are exacerbated by the characteristics of the State's population distribution. Oklahoma is a largely rural state. It is ranked 20th among the 50 states in area (70,000 square miles), but 28th in total population (3.2 million). This translates into a population density of about 46 persons per square mile. By contrast, there are 71 persons per square mile in the country as a whole and approximately 1,000 persons per square mile in the nation's most densely-populated states, New Jersey and Rhode Island. Even these statistics do not fully reflect Oklahoma's rural make-up, as over 50 percent of the state's population is concentrated in just two metropolitan areas — Oklahoma City and Tulsa. Excluding these two urban centers, the state's population density averages less than 25 persons per square mile. Because Oklahoma is a largely rural state with a significant number of small businesses, many working in the State's agricultural industry, it is difficult for employers to provide their employees health insurance at an affordable price.

Regardless of the source of data related to the percentage of uninsured in the State, Oklahoma has a larger percentage of its population than the national average who are without health insurance. According to the Employee Benefit Research Institute (EBRI), Oklahoma leads the nation in the percentage of non-elderly uninsured, with 27.4% of its population without health insurance, compared to a national average of 18.1%. Even more conservative data developed by the RAND Corporation, which took into account factors not ordinarily considered, such as services delivered through the Indian Health Service, places the percentage of uninsured at 22.9%. EBRI estimates that, of the uninsured, approximately 75% are workers or dependents of workers. In addition to persons without insurance, approximately 14% of the State's population are eligible for services through the State's Medicaid program.

According to a survey conducted by the RAND Corporation during the planning phase of the project, relatively few small businesses in Oklahoma provide health coverage to employees: only 34.6% of establishments with 1-4 employees and 55.5% of establishments with 5 - 9 employees offer coverage, compared to 95.3% of employers with over 50 employees. Regardless of establishment size, employers with higher mean annual payrolls are more likely to offer insurance than those with lower payrolls. Comparing establishments of all sizes, employers who offer coverage have mean annual payrolls of $22,580 or greater, while employers who do not provide insurance have mean annual payrolls of $16,789 or less.

For the most part, employee ability to choose among employer-provided health plans is relatively limited. Establishment size influences the number of health plan choices available to employees, but plan options are limited even among large employers, with over 90% of establishments with 1-4 employees offering only one option, compared to a still relatively high percentage, 66.1%, of employers with greater than 50 employees offering only one option.

Just as availability of health insurance in employment settings is affected by the rural nature of the State, access to health services is more difficult by the state's rural nature. Oklahoma's rural areas lack adequate numbers of providers in comparison to urban communities. There is currently an alarming shortage of primary care resources in rural Oklahoma. Thirty-eight counties of the State's seventy-seven counties are designated as wholly medically-underserved, and an additional twenty-two counties are designated as partially underserved. The state has fewer physicians per 100,000 population than the country overall, and the physicians it does have are not evenly distributed. Despite the fact that greater than one-third of the State's population lives in rural areas, over 75% of the State's 4,700 physicians are located in the State's five urban areas. In fact, over 70 percent of the state's doctors — and more than 50 percent of its primary care physicians — are concentrated in the Oklahoma City and Tulsa metropolitan areas, alone. Outside of these cities, health care delivery options for Oklahoma residents are limited. "Seeking care" often means traveling relatively long distances to the nearest physician, hospital or nursing home, assuming transportation can be arranged. Not surprisingly, many individuals elect to forego health care services if a problem is not emergent, particularly if the care required is primary or preventive in nature.

Physician recruitment and retention are major problems in rural areas, leading to a critical shortage of primary care physicians. There are significant barriers for primary care physicians in the non-metropolitan counties, including limited availability of hospital services and resources, limited numbers of other physicians with whom to share coverage and a lack of proximity to specialty services. Rural areas have become more dependent on non-physician primary care providers because of the

lack of availability of physicians. However, of the 200 physician assistants and 226 nurse practitioners in the State, approximately two-thirds are located in urban areas.

In addition, the managed-care industry in Oklahoma is still in its infancy, although it continues to expand rapidly. Federally-qualified health maintenance organizations have achieved a market penetration rate of only 7.2%, which places Oklahoma 30th in the nation in level of penetration. However, recent expansion by three health maintenance organizations into rural northeast and southwest Oklahoma offer new opportunities for the State to extend managed care delivery to its rural Medicaid recipients. In addition, two hospital networks, the Baptist Health Organization from Oklahoma City and the Catholic Hospital Network of Tulsa, have recently been approved as health maintenance organizations (HMOs) by the Oklahoma State Department of Health, the State agency responsible for HMO licensure. Both networks have initiated expansion of capitated network services into rural areas of the State. The recent transition of the Oklahoma Medicaid program from a fee-for-service system to a system of managed care has both significantly influenced the creation of new managed care products in the State and enhanced the rate at which managed care organizations are penetrating into less densely-populated areas of the State.

THE FAMILY CHOICE HEALTH PLAN

Introduction

The Family Choice Health Plan is a market-based model designed to encourage consumers to select the lowest-cost health coverage appropriate for their needs. This is accomplished using a system of Family Health Accounts, similar to, but broader than, the structure of medical savings accounts, to consolidate all potential revenue sources for the purchase of health coverage and other health care services. The aggregation of funds achieved through accounts, combined with increased consumer cost-consciousness and family choice of coverage, should drive the health care delivery system towards greater efficiency through normal market forces.

Success of the Family Choice Health Plan is dependent on informed consumers making health care purchasing decisions in a price-sensitive environment. Therefore, an education system must be developed and implemented to let purchasers know they are at full financial risk at the margin based on their health care choices. For example, it is essential that consumers understand that the differential in premium cost between the lowest cost plan available, and the plan that they choose would be at their expense. This will encourage consumers to select the plan that could best meet their needs for the lowest overall cost. By ensuring a broad range of coverage options, the Family Choice Health Plan makes it possible for individuals/families to decide whether to enroll in a managed care plan, a traditional indemnity plan, or a catastrophic plan. By regularly informing consumers, the system continuously strives to improve itself and adapt to the demands of the marketplace.

The proposal for the Family Choice Health Plan had as one of its cornerstones universal coverage. Although politically controversial, universal coverage would allow the State to achieve important objectives. First, health services could potentially be available to individuals who lack the necessary financial resources to afford care. Second, if every Oklahoman had some form of health insurance coverage, inefficiencies within the health care marketplace could be dramatically reduced. Cost-shifting from the uninsured and underinsured would be likely to decline or be eliminated. For a market-driven approach to work, it is necessary for the product prices to reflect the true underlying economics of the plan; to achieve the best results, this also requires the elimination of cost-shifting. Finally, to eliminate the possibility of "gaming" the system, all persons who are financially able should be required to pay into the system.

While, universal coverage accomplished through regulation is not seen as a feasible mechanism for enhancing access or resolving inefficiencies, nonetheless, a great deal may be accomplished through establishment of market-based alternatives. For example, mechanisms should be developed that enhance the availability of affordable health insurance products and create incentives for appropriate health care purchasing decisions and health system utilization. If incremental changes in consumer behavior and market dynamics can be accomplished through the creation of effective incentives, the rate of increase of both the number of uninsured and overall health care costs could decline significantly.