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RECOMMENDATIONS IN BRIEF:

- ⇒ Build upon the foundations of programs and policies adopted in recent years;
- ⇒ Expand Medicaid eligibility for parents up to the federal poverty level;
- ⇒ Monitor the impact of cost-sharing requirements and benefit limits on participants in the Insure Oklahoma program;
- ⇒ Balance the goals of expanding coverage and covering a full range of medically necessary services;
- ⇒ Strengthen the high-risk insurance pool;
- ⇒ Study options for strengthening consumer protections in the individual and small group insurance markets.

EXPANDING ACCESS TO AFFORDABLE HEALTH INSURANCE: RECOMMENDATIONS TO THE OKLAHOMA HEALTH CARE TASK FORCE

The availability and cost of health insurance rank among the most worrisome issues facing Oklahoma families and among the most pressing challenges confronting Oklahoma policymakers. The most recent U.S. Census Bureau survey revealed that over one out of every five non-elderly Oklahomans (21.0 percent) is without health insurance (Figure 1).¹ Over recent years, there has been a steady erosion of employer-based health insurance coverage in Oklahoma, a decline which has not been fully offset by an expansion of public health insurance for children and some adults.² Meanwhile, those with health insurance are facing steeply rising costs. A new study from Families USA finds that between

2000 and 2007, the average family premium paid by an employee with employer-based coverage rose \$4,301, or 62 percent, in Oklahoma. During this same period, the median earnings of Oklahoma's workers grew by just \$3,919, or 18.8 percent.³

The Oklahoma Health Care Reform Task Force, appointed by House Speaker Chris Benge and co-chaired by Representatives Kris Steele and Doug Cox, provides a promising opportunity to develop policy ideas that can help provide more Oklahomans access to affordable health insurance coverage. Oklahoma Policy Institute, which has participated as a member of the

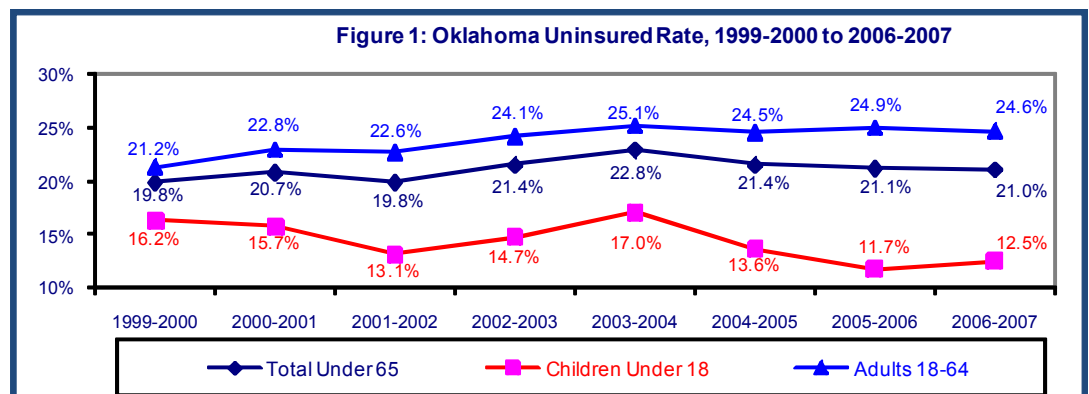
Task Force's advisory committee, believes that the following recommendations should serve as a basis for the Task Force's report and subsequent legislative initiatives.

Recommendation #1

In pursuing options for expanding access to quality, affordable health insurance coverage, Oklahoma should build upon the foundations of our current health care system and upon programs and policies adopted in recent years.

DISCUSSION

In recent years, the Oklahoma Legislature has enacted a series of balanced and incremental



policies aimed at expanding health insurance coverage. These efforts should be continued and strengthened.

One cornerstone of the state’s efforts has been the Insure Oklahoma program, which provides a public subsidy for low-income employees and their spouses to purchase employer-sponsored insurance when that is offered, or to buy-in directly to a public product when employer-sponsored coverage is not available.

The Insure Oklahoma program is based on several principles that make it a solid foundation for ongoing efforts to expand health insurance coverage in Oklahoma:

- It builds upon and strengthens the existing system of employer-based group coverage, which continues to serve as the primary source of health insurance for Oklahomans. As such, the program represents a strong private-public partnership approach to addressing the problem of the uninsured;
- It targets a population most likely to be without health insurance, namely low-income working adults who are employed by small and medium-sized businesses or who are self-employed or unemployed;
- It provides substantial subsidies to assist with the purchase of insurance, while requiring program participants to share in the cost of care through premiums and co-payments.

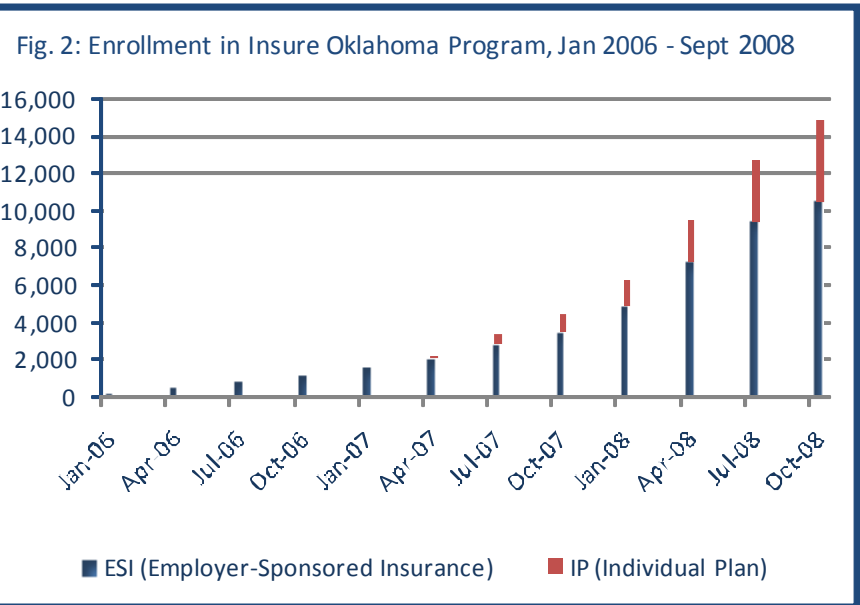
To date, some 15,000 individuals are enrolled in Insure Oklahoma – 10,401 through employer-sponsored insurance and 4,467 through the Indi-

vidual Plan (Figure 2).⁴ Enrollment has increased steadily over the past year but still remains well below the target of 40,000 participants for whom earmarked funding is available. The Legislature took positive action in 2007 to strengthen Insure Oklahoma by expanding eligibility in the program for businesses with up to 250 employees, compared to the current 50, and to employees with income up to 250 percent of poverty, compared to 200 percent currently. The Legislature also approved eligibility for children between 185 percent and 300 percent of poverty in Insure Oklahoma. Unfortunately, the state plan amendment needed to implement these changes continues to await federal approval.

A second cornerstone of the state’s health care system is the Medicaid program. A total of 606,078 Oklahomans, including 393,742 children, 39,497 working-age adults, and 136,878 aged, blind and disabled, are covered by Medicaid.⁵ Research has consistently found the Medicaid program to be a

cost-effective form of health insurance and a program that provides substantial economic benefit to the state, due in large part to the availability of federal matching funds.⁶ The last major expansion of Medicaid in Oklahoma occurred in 1997, when eligibility for children and pregnant women was raised to 185 percent of the poverty level. Since then, there have been narrow expansions to cover individuals in need of targeted services, such as family planning and breast and cervical cancer.

We believe that policy changes that would involve a fundamental redesign of the state’s health care system would be ill-advised, especially given current uncertainty about the direction of health care reform at the federal level that could greatly impact the policy environment facing the states. While there are definitely ways to strengthen the



current system, building off the existing foundations of Insure Oklahoma and Medicaid seems the most promising and sensible way to move forward.

Recommendation #2

The Legislature should expand Medicaid eligibility for categorically -eligible adults (parents of dependent children) up to 100 percent of the federal poverty level. Childless adults and parents between 100 percent and 250 percent of poverty would be eligible for coverage through Insure Oklahoma.

DISCUSSION

Adults living in poverty are one of the largest segments of Oklahoma’s uninsured population. The Oklahoma Health Care Authority estimates that there were 166,764 uninsured adults below the poverty level in 2006 (\$20,000 for a family of four).⁶ This group represents almost one-third (31 percent) of all uninsured adults and one-quarter (25.8 percent) of the entire uninsured population in Oklahoma.⁷ According to the Kaiser Family Foundation, 55 percent of poor adults were without health insurance in Oklahoma in 2006-2007, the fifth highest rate in the nation.⁸

Until recently, most adult Oklahomans living in poverty were ineligible for any public health insurance programs unless they were pregnant, elderly or had a disability. Medicaid in Oklahoma covers only parents of dependent children up to 50 percent of the federal poverty level (\$711 per month in 2008 for a family of three).⁹ Par-

ents of children with income above 50% percent of poverty, as well as childless adults, were ineligible for coverage. Since poverty and poor health are intertwined and mutually reinforcing, it is precisely those low-income working adults, who may have their employment and earnings limited by poor health, who often have the greatest need for health insurance.

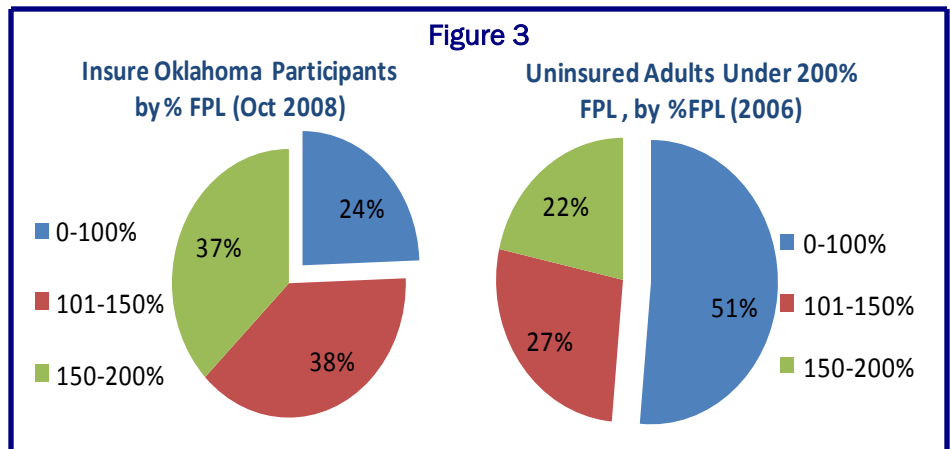
With implementation of Insure Oklahoma, adults below the poverty level became eligible for subsidized coverage either by buying into their employer-sponsored insurance or buying into the state’s Individual Plan. However, participation in Insure Oklahoma requires the enrollee to contribute 15 percent of the plan’s premium, up to 3 percent of family income (4 percent for Individual Plan) and to assume other cost-sharing obligations up to a maximum of 5 percent of family income.

A substantial literature has shown that for very low-income individuals, even a modest level of cost-sharing can serve as an insurmountable barrier to enrollment in coverage.¹⁰ A family of four earn-

ing, say, 75 percent of poverty, is trying to make ends meet off of \$1,325 per month. Their monthly premium would be \$40 per month for employer-sponsored coverage or \$53 per month in the Individual Plan. This amount may simply be unaffordable for a family struggling with the cost of rent, utilities, gas, clothing, car payments, etc. and likely trying to cope with mounting unpaid debts.

The evidence appears to confirm that Insure Oklahoma is failing to serve adults below the poverty level. OHCA data shows that just under one-quarter (24 percent) of participants in Insure Oklahoma have incomes that fall below the poverty level, despite the fact that there are more uninsured adults below 100 percent of the Federal Poverty Level (FPL) than there are between 100 percent and 200 percent FPL (Figure 3). The average income for participants in the program is just over 130 percent of FPL, considerably higher than the average income of the eligible population.¹¹

Affordability is likely a major explanation for the low participa-



tion rate of below-poverty adults in Insure Oklahoma. Affordability may also be contributing to apparently high rates of turn-over, or churning, in the program. According to OHCA data, nearly one-quarter of those who had enrolled in the Individual Program since March 2007 were no longer enrolled as of October 2008.¹² This may be a result of low-income employees being unable to keep up with monthly premiums.

There are several ways Oklahoma could do a better job of extending coverage to the lowest-income adults. For example:

- Expand Medicaid eligibility for parents of dependent children to the federal poverty level. Existing Medicaid law allows states to exercise this option with only a state plan amendment. This approach has been endorsed by OHCA;
- Waive cost-sharing entirely for families below the poverty level in Insure Oklahoma; or
- Implement a sliding-scale cost-sharing schedule for Insure Oklahoma in which contributions from individuals below the poverty level could be limited to, say, 2 percent of family income rather than 5 percent.

Expanding Medicaid eligibility to adults below the poverty level would also ensure that these individuals, who frequently have chronic and complicated health issues, would be eligible for the comprehensive scope of benefits covered by Medicaid.

Recommendation #3

The Oklahoma Health Care Authority should study and monitor the impact of cost-sharing requirements and benefit restrictions on participants in the Insure Oklahoma program. In particular, OHCA should study total out-of-pocket health care expenses among participants (including uncovered benefits), and monitor the number and situation of participants reaching the cap in reimbursable expenses to help determine if modifications should be made to coverage and cost-sharing provisions in the program.

DISCUSSION

Participants in Insure Oklahoma are required to contribute a portion of their health care costs in the form of monthly premiums and co-payments, subject to a cap of 5 percent of a family's gross household income. Under the state's current waiver, out-of-pocket expenses exceeding 5 percent of gross household income are reimbursed by the State up to a maximum of \$900 per year. Medical services that are not covered by a participant's employer-sponsored insurance or the Individual Plan, or that exceed benefit caps, do not count towards the 5 percent cap but are rather the patient's full financial responsibility.

The \$900 annual cap on reimbursable out-of-pocket medical expenses should be carefully monitored by OHCA. Individuals who have chronic health conditions or who experience a serious illness or

injury may easily hit or exceed the \$900 reimbursement limit in a given year. This may be especially true for participants in employer-sponsored insurance plans, which may include annual deductibles up to \$1,000 and co-insurance obligations, along with co-payments. The reimbursement cap on out-of-pocket expenses could place great financial strains on low-income families that have already contributed 5 percent of their household income towards cost-sharing, leading them either to avoid necessary care or to withdraw from the program. The collection and review of data on the extent to which reimbursement limits are being hit or exceeded would allow for a reasoned debate on whether the limit should be maintained, modified or abolished.

OHCA should also undertake an analysis of participants in the Individual Plan to assess the impact of benefit caps and uncovered services. IP does not cover some important health care services, including physical, speech and occupational therapy, allergy testing and treatment, dental services and emergency transportation. These services can become very expensive for individuals with chronic health issues or emergency needs. Benefit limits in the IP include four physician service visits per month and six prescription drugs per month. Services beyond those limits, even when medically necessary, are not covered and the cost for such ser-

vices do not count towards the 5 percent cost-sharing cap, which means they are the patient's full financial responsibility. These exclusions may serve to deter participants from seeking timely and appropriate care, and may ultimately drive up costs when treatment is delayed. A process whereby service utilization above certain levels triggers a review and possible further action may be more equitable and cost-effective than blanket benefit limits.

Recommendation #4

Oklahoma should balance the goal of expanding coverage with the goal of promoting insurance that covers a full range of medically necessary services.

Discussion

Efforts to expand health insurance coverage involve at least some trade-off between the number of persons provided coverage and the comprehensiveness of the coverage that is made available. Some have argued that the best way to expand health insurance coverage is to relax coverage standards and offer more choices for minimal or bare-bones coverage options. This is seen as especially attractive to the young and healthy, who currently may only be offered more benefits than they want at a cost they cannot afford or choose not to pay. Rather than provide some people a Cadillac while others are left taking the bus, the argument goes, allow folks the choice of a Kia or Dodge.

There are two problems, however, with this approach. The first is that in the health insurance market, the choice of some for a low-cost product will invariably raise the price for those obliged to seek more comprehensive coverage. By pulling healthier consumers into a low-cost, low-benefit market, the cost of insurance for those with a certainty or likelihood of greater health care needs – which includes most older people, people with disabilities, and women of childbearing age – quickly will become prohibitively expensive. This could price more of the high-cost population out of coverage. We could end up in a situation where, while we have no fewer uninsured, the uninsured we do have are more in need of care. Alternately, we could end up with less comprehensive coverage for everyone, leaving those with chronic medical conditions underinsured.

The second problem is that individuals opting for the low-cost, low-benefit alternative may be left unprepared for their actual health care needs in the case of illness or injury. Not only might this population be left without coverage for the medical bills they have unexpectedly incurred, they are also unlikely to be able to purchase the coverage they need going forward. Unlike car owners, who are free to trade in their Kias for Cadillacs as their circumstances change, pre-existing condition exclusions strongly limit consumers' ability to get the insurance they need when they need it.

There is certainly room for a healthy discussion about the appropriate scope of coverage that must be included as part of health insurance products offered in Oklahoma, and value in looking for ways to enhance choice and flexibility as part of an expansion of coverage. However, we must be extremely careful to avoid apparent solutions that will ultimately shift more of the cost and more of the risk onto those Oklahomans with the greatest health care needs.

Recommendation #5

The Legislature should strengthen and improve the high-risk pool as a source of affordable, quality coverage for Oklahomans who cannot buy an affordable policy that meets their health care needs in the current non-group (individual) private market.

DISCUSSION

Oklahoma is among 31 states that have created a high-risk pool to serve as a "safety valve" to guarantee that anyone can purchase health insurance, regardless of their health status. However, Oklahoma's high-risk pool, which covers a mere 2,400 people, does not seem to be fulfilling the aim of effectively serving individuals whose pre-existing health conditions price them out of the regular commercial market. The limitations of Oklahoma's program include:

- Premiums can be up to 50

percent more than those charged to other people in the private market. The 2006 monthly premium for a 50-year old woman for a plan with a \$500 deductible was \$1,123, or \$457 per month for a plan with a \$7,500 deductible;

- No subsidy for low- or moderate-income individuals;
- A one-year waiting period for coverage of pre-existing conditions;
- A \$500,000 lifetime benefit maximum. Only two other states—Mississippi and Louisiana—have lifetime benefit maximums that are as low. No state is lower, many states' limits are at least \$1 million, and several states have no lifetime maximum.¹³

Families USA has proposed a number of recommendations aimed at expanding access to the high-risk pool. These include lowering premium caps to no more than 125 percent of average premiums for comparable policies in the individual market; shortening the waiting period for pre-existing conditions; providing premium subsidies to low-income applicants, and increasing the lifetime benefit limit.¹⁴ Tom Daxon's O-CHIP proposal for the Oklahoma Council of Public Affairs, which favors steering high-cost individuals to a high-cost pool, would put strict limits on the premiums that individuals could be charged and prohibit the cancellation of policies so long as premiums are paid.¹⁵

A major challenge to strengthening the high risk pool is to find funding mechanisms that will allow for adequate coverage at reasonable

rates. O-CHIP proposes that the state issue bonds to subsidize the costs of individuals in the high-cost pool.¹⁶ Other funding mechanisms, involving contributions of insurers, health care providers and government, should also be considered.

Recommendation #6

The Insurance Commissioner should undertake a study of reasonable consumer protections in the individual and small group market to identify options for making private coverage more accessible and more affordable for Oklahoma consumers. This study should explore issues including the possibility of community rating in the individual market; rate review mechanisms; medical loss ratio standards; limits to how pre-existing conditions are defined and what kinds of elimination riders, exclusions, and denials are allowed; and limits on revocation of policies.

DISCUSSION

Strengthening consumer protections in the individual health insurance market can expand coverage by making affordable health insurance accessible to individuals who may currently be priced out of the market. A recent report by Families USA entitled **Failing Grades: State Consumer Protections in the Individual Health Insurance Market** found Oklahoma to be among the states with the weakest set of regulatory standards to assist individuals purchase and maintain affordable individual coverage.¹⁷ Among the obstacles to coverage under existing law in Oklahoma, and the approaches that other states have adopted are the following:

- Oklahoma has no limits on how much insurance companies can vary

premiums based on an individual's health status. A *modified community rating* system would not allow premium variation based on health, but would allow some variation for other factors, such as age and geography. Alternatively, imposing rate bands to limit variations in premiums based on health to 25 percent or less would be a less aggressive way to spread risks and expand access to individuals with pre-existing health conditions;

- Oklahoma does not require that regulators be allowed to review rate and premium increases prior to the rates going into effect. Providing *advance review* would prevent insurers from adopting unreasonable and arbitrary premium increases, thereby holding down premium costs for consumers;

- Oklahoma does not require insurers to spend a minimum share of premiums towards medical services in the individual health market. A *minimum medical loss ratio* of 75 percent would limit the share of premiums that can be allocated for administration, marketing and profit, and hold down premium costs for consumers;

- Oklahoma sets no limit on the length of time insurance companies can exclude coverage for the treatment of pre-existing conditions. It also does not limit how far into your medical history insurers can look back (called the *look-back period*) to determine which

pre-existing conditions they will exclude, or provide an objective standard which insurers must use to determine what qualifies as a pre-existing condition. Limiting pre-existing condition exclusion periods to six or twelve months, limiting the look-back period to six or twelve months, and using the objective standard to define pre-existing conditions could all expand coverage to vulnerable consumers.

Similar to the individual market, regulatory changes in the small group market related to community rating, medical loss ratios, underwriting practices and other issues, could also serve to expand access to affordable health insurance for small businesses.¹⁸

Many of the issues related to the individual and small group insurance markets are closely inter-related. We believe that it would be worthwhile for the Insurance Commissioner to conduct a comprehensive review of options that Oklahoma could pursue to expand consumer access to affordable private coverage. As long as insurance companies are competing on a level, well-regulated playing field, the goals of expanding coverage and keeping the cost of coverage affordable should be reconcilable.

ENDNOTES

¹ U.S. Census Bureau, *Income, Poverty and Health Insurance in the United States: 2007*, August 2008; online at: <http://www.census.gov/prod/2008pubs/p60-235.pdf>

² Oklahoma Policy Institute, *Oklahoma's Uninsured: Erosion of Private Health Insurance Not Fully Offset by Growth in Public Coverage*, September 2008; online at <http://okpolicy.org/oklahomas-uninsured-september-2008>

³ Families USA, *Premiums vs. Paychecks: A Growing Burden for Oklahoma Workers*, October 2008; online at <http://www.familiesusa.org/assets/pdfs/premiums-vs-paychecks-2008/oklahoma.pdf>

⁴ Oklahoma Health Care Authority, *Insure Oklahoma: Fast Facts*, October 2008; online at: <http://www.insureoklahoma.org/index.aspx>

⁵ Oklahoma Health Care Authority, *SoonerCare Fast Facts*, October 2008; online at: <http://www.ohca.state.ok.us/research.aspx?id=87>

⁶ See, for example, Leighton Ku and Matthew Broaddus, *Public and Private Insurance: Stacking Up the Costs*, *Health Affairs* (web exclusive), June 24, 2008; online at: <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.4.w318> and Cheryl F. St Clair, *The Economic Impact of the Medicaid Program on Oklahoma's Economy*, May 2007; online at http://www.ruralhealthworks.org/downloads/Economic/Oklahoma_Medicaid_Report_May_2007.pdf

⁷ Oklahoma Health Care Authority, *Uninsured*, prepared for the OHCA Board Retreat, August 2008.

⁸ Kaiser Family Foundation, *statehealthfacts.org*; online at: <http://www.statehealthfacts.kff.org/comparebar.jsp?ind=131&cat=3>

⁹ Kaiser Commission on Medicaid and the Uninsured, *Health Coverage for*

Families and Children in Medicaid and SCHIP: State Efforts Face New Hurdles, January 2008, Table 3; online at: <http://www.kff.org/medicaid/upload/7740.pdf>

¹⁰ Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, April 2003.

¹¹ Calculated from Oklahoma Health Care Authority, *Insure Oklahoma: Fast Facts*, October 2008; online at: <http://www.insureoklahoma.org/index.aspx>

¹² *Ibid.* There were 4,467 members enrolled in IP in October 2008, and 5,862 total members since the program's inception in March 2007. Similar number for ESI are unavailable.

¹³ Information from Oklahoma High Risk Pool website; online at: http://okhrp.org/benefit_info.asp

¹⁴ Families USA, *High Risk Health Insurance Pools*, May 2006; online at: <http://www.familiesusa.org/assets/pdfs/High-Risk-Pools-May-2006.pdf>

¹⁵ Tom Daxon, *O-CHIP: Oklahoma Comprehensive Health Independence Plan*, Oklahoma Council of Public Affairs, June 2008, p. 31.

¹⁶ *Ibid.*

¹⁷ Families USA, *Failing Grades: State Consumer Protections in the Individual Health Insurance Market*, June 2008; online at: <http://www.familiesusa.org/assets/failing-grades.pdf>

¹⁸ See the presentation by Kathleen Stoll of Families USA to the Oklahoma Health Care Task Force, September 22, 2008; online at: <http://okpolicy.org/familiesUSA-presentation>

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OUR MISSION

Oklahoma Policy Institute (OK Policy) is committed to advancing policies aimed at alleviating poverty, expanding economic opportunity and promoting fiscal responsibility. To that end, OK Policy conducts objective analysis of state policy issues in order to better position Oklahoma to become a more prosperous, better educated, healthier and increasingly equitable state.

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