IT'S HEALTH CARE, NOT WELFARE

FINAL REPORT

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Article IV, Section 4.7. DFPM shall produce a final report detailing the services rendered and findings of the studies conducted.

Health Care Not Welfare Project

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EXECUTIVE SUMMARY

Five studies were undertaken by faculty and staff in the Department of Family & Preventive Medicine (DFPM) at the University of Oklahoma Health Sciences Center (OUHSC) to determine the attitudes and opinions of various stakeholders toward potential reform of the Medicaid health care system. These studies were performed under a contract with the Oklahoma Health Care Authority (OHCA), which is requesting a five-year Medicaid Research and Demonstration Waiver to redesign the current Medicaid program in Oklahoma. This fifth and final report in the series will describe the services rendered and report the findings of the previous studies[1-4] in terms of the six key objectives of the "**It's Health Care, Not Welfare"** Medicaid reform program:

1. Patient Responsibility
2. Effective Purchasing
3. Acceptable Provider Reimbursement
4. Flexible Benefits
5. Expanded Eligibility
6. Budget Predictability

Contract Elements: DFPM faculty and staff were contracted to investigate the following questions (listed below by contract item) relevant to Medicaid reform:

4.0 *What is the estimated percentage of allowed co-payments currently being collected by Medicaid providers?*[2]

4.1 *What are the attitudes of potential beneficiaries toward paying enrollment fees, co-payments and premiums to obtain health insurance coverage?*[3]

4.2 *What is the appropriate reimbursement rate structure for providing Medicaid services?*[2]

4.3 *What is the level of interest of small business employers in participating in an expanded Medicaid health insurance program either through voucher or buy-in?*[4]

4.4 *What are the key programmatic elements necessary to ensure provider participation in an expanded Medicaid program?*[1]

FINDINGS FROM STUDIES

Findings from the five studies are reported here by key objective. (The relevant contract element for each objective is shown in parentheses following the definition of the objective.)

NOTE: the results reported herein have been updated if additional data was received following completion of four interim reports.

1. **Patient Responsibility**: appropriate utilization of health care (including preventive care) at the right time, in the right setting, and acceptance of a reasonable portion of the costs (cost-sharing) by each individual patient. (4.0, 4.1)

Our studies found that all stakeholders – potential beneficiaries, physicians and other health care providers, and employers – felt that patients should pay a portion of their health care costs in order to "overcome the perception that

coverage is free."* Table 1 shows the cost-sharing amounts indicated by our research.[3] More than half (59%) of the 138 potential beneficiaries surveyed indicated that they could afford between 1% and 2% of their net family income each year for health care.

Table 1. Fair Cost Sharing as Indicated by Potential Program Beneficiaries (n=138)

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

If cost-sharing is to be effective, health care providers must be able to collect the payments from beneficiaries. To determine how effective current collection efforts among Oklahoma providers are, we asked physicians and other providers who are eligible to collect co-payments from beneficiaries to estimate the percentage of co-payments they currently collect. On average, providers collect only 29% of allowed co-payments from Medicaid patients due mostly to the patients' failure to pay and providers' inability to require payment. For cost-sharing to be successful, steps to help providers collect co-payments could be considered.[2]

Health care policymakers, providers, employers, and even beneficiaries assert that cost-sharing promotes patient responsibility.

"All patients must have some co-pay. They must have some responsibility in their own health care."

An Oklahoma physician
August 2003

Nonetheless, it should be noted that an extensive review of the health policy and medical literature could not confirm this assertion. Several national studies did report that cost-sharing reduces utilization of health care services. Unfortunately, it is utilization of cost-effective services, such as preventive health care (pre-natal, well child, immunizations, and PAP smears, etc.), that declines.[5] Individuals with already limited financial resources will cut back on so-called "discretionary" care (e.g., preventive care), which can ultimately lead to increased health care costs if these individuals become ill and require expensive emergency room or hospital care.[6] Caution is advised when implementing cost sharing measures in low and moderate income populations. A solution might be to eliminate co-payments for preventive health services, and perhaps require specific preventive services (pap smears, mammograms, prostate exams) to maintain coverage.[6]

2. **Effective Purchasing**: the collaboration between payers (state and federal government), employers, providers, and program beneficiaries to make appropriate health care services available at reasonable cost and provide partial financing through cost-sharing and employer-based subsidies. (4.0, 4.1, 4.2, 4.3, 4.4)

Adequate availability of health coverage and care along with appropriate utilization of health care services and cost-sharing are the key components of effective purchasing. To determine what services the potential beneficiary group desired, 138 low-income individuals rated 16 key health care services by order of importance (Table 2).

* Source: Medicaid – It's Health Care, Not Welfare Contact paper, OHCA, November 2002.

Table 2. Most Important Health Care Services Rated by Potential Beneficiaries

Rating	Item	Mean	Std. Dev.
1	Prescriptions	4.62	0.67
2	Emergency	4.50	0.76
3	Vision	4.39	0.84
4	PCP Visits	4.38	0.91
5	Dental	4.38	0.94
6	Inpatient Hospital	4.29	0.95
7	Lab	4.29	0.86
8	Outpatient Hospital	4.19	0.98
9	Specialist Visit	4.18	1.10
10	Transport	3.84	1.20
11	Well Child	3.75	1.54
12	Medical Supplies	3.58	1.30
13	Behavioral	3.45	1.33
14	Physical Therapy	3.24	1.39
15	Maternity	3.14	1.70
16	Home Health	3.02	1.42

Prescriptions were rated first, followed by access to emergency services. Disappointingly, well child and maternity and pre-natal care rated 11th and 15th, respectively, which might be explained by the fact that most of the potential beneficiaries surveyed were men. Nonetheless, an education program aimed at informing potential beneficiaries about the appropriate utilization of health care services, particularly preventive and public health services, might be considered.[3] In addition, more than half of the potential beneficiaries interviewed had a chronic illness (diabetes, asthma). A benefit package that includes chronic disease management might also be considered.

Most of the insured in the U.S. obtain coverage through their employer. However, employer-sponsored insurance (ESI) is declining due to rapidly increasing premium costs (15.9% last year).[7] Most of the 59 small business employers surveyed were likely to participate in either a buy-in (59%) or voucher (66%) program. Employers not currently offering ESI, particularly new businesses, expressed concern that they might have to reduce or eliminate coverage if premium costs increased or if their profit margin narrowed. Before small business employers in Oklahoma will buy in to a health insurance program for their employees, a stop-gap program that protects them from increases in health costs could be investigated. [1,2,4]

Effective purchasing relies upon the availability of service providers. Low reimbursement and excessive administrative hassles are the main reasons physicians and other health care providers are dissatisfied with Medicaid. On average, 100% of Medicare was suggested as a fair rate for fee-based Medicaid services. Next to reimbursement, providers surveyed felt that new funds available for health care in Oklahoma should be used to cover the uninsured.[1]

3. **Acceptable Provider Reimbursement**: instituting a fee structure for services that allows providers to maintain financial viability with a minimum of administrative hassle so that providing services to low-income, uninsured or underinsured individuals and families is cost-effective and readily accessible. (4.0, 4.2, 4.4)

To ensure provider participation in an expanded Medicaid program, an acceptable level of provider reimbursement is critical. When asked what would be a fair fee structure, as a percent of Medicare, for their colleagues to provide Medicaid services, providers responded that about 100% of Medicare would be reasonable as shown on Table 3a (page iv).

Table 3a. Fair Reimbursement as a Percent of Medicare for Colleagues Who Participate in Medicaid by Provider Group

Provider Groups	Mean	Median	95% CI	
			Lower	Upper
Physicians	101.8%	100.0%	98.1%	105.5%
Non-physicians*	85.7%	90.0%	81.6%	91.9%
Combined†	99.7%	100.0%	93.7%	99.0%

When asked what percent of Medicare they personally would need to be a Medicaid provider, the average response was roughly 96% (Table 3b).[2]

Table 3b. Reimbursement as a Percent of Medicare Necessary to Participate in Medicaid by Provider Group

Provider Groups	Mean	Median	95% CI	
			Lower	Upper
Physicians	98.2%	100.0%	93.3%	103.1%
Non-physicians*	84.2%	80.0%	77.1%	91.2%
Combined†	95.8%	100.0%	91.5%	100.0%

As one physician said, "Paying at least Medicare rates would be a start. If we got Medicare rates, it would be like winning the lottery!"

In addition, a concomitant reduction in paperwork and other administrative functions associated with Medicaid would make the provision of services more cost-effective and more attractive for providers. Some suggestions include:

- ✓ Electronic or web-based eligibility verification and pre-authorization system.
- ✓ Accessible formulary. The Pharmacy Hotline has been well-received. Providers would like more access to information about benefits, services, etc., and easier ways to contact OHCA.
- ✓ Faster, easier claims filing and payment. The longer providers are out-of-pocket for services, the less likely they are to continue accepting Medicaid patients or to support an expanded program.[1]

Collection of co-payments is a subset of reimbursement. Currently, providers report collecting on average 29% of allowed co-payments from Medicaid recipients.[2] For reimbursement to be fair, adequate measures to ensure that providers are able to collect co-payments might be instituted (Table 4).

Table 4. Allowed Co-payments Collected by Eligible Provider Group

Provider Groups	Mean	Median	95% CI	
			Lower	Upper
Physicians	25.2%	5.0%	21.7%	28.7%
Pharmacists	64.1%	87.5%	54.6%	73.7%
Other	20.3%	5.0%	13.3%	27.3%
Total (All Eligible Providers)	29.0%	5.0%	26.7%	31.3%

One possibility is a co-payment "debit card". Depending on income, beneficiaries could "purchase" a co-payment card, which would work like a debit card, which they could present during physician visits. When the card balance drops to a designated level, the beneficiary could buy more co-payment credits either through a Medicaid subsidy, family health account program, personal funds, or a combination. This system places more responsibility on the patient to pay and less administrative burden on the provider to collect.

4. **Flexible Benefits**: the necessary and cost-effective services for a diverse patient population and offering choices that are medically appropriate and meet patient needs. (4.1)

As shown in Table 2 (previous page) potential beneficiaries indicated that prescription drugs were their number 1 priority.[3] However, studies show that the inappropriate use of emergency room services and failure to

* Non-physicians include nurse practitioners, physician assistants, and health care administrators.

† Combined includes all physicians and non-physicians (excluding dentists and pharmacists who have a separate fee structure).

obtain routine preventive services contribute significantly to the rising costs of health care.[5,6,12,13] Any benefit program might therefore include education and incentives to promote appropriate utilization of health care. Policymakers may want to consider exempting preventive or public health services from cost-sharing for lower income populations.

5. **Expanded Eligibility**: extending health insurance to low-income individuals and families with a net family income up to 200% of the federal poverty level (FPL) without regard to Welfare categories. Current Medicaid eligibility excludes most single, low-income working adults as well as families with incomes between 185% and 200% of the FPL. (4.1, 4.3, 4.4)

Our study indicated that 112 of the 138 potential program beneficiaries surveyed (81%) were likely to participate in a Medicaid health insurance program. Small business employers also expressed interest: 39 of 59 (66%) said they were likely to participate in a voucher system with moderate state support, and 35 of 59 (59%) said they were likely to participate in a buy-in program with moderate state support. Employers were concerned, though, about the potential impacts (financial and administrative) for their businesses.[4] Physicians were skeptical about the success of such a program but were willing to discuss it and indicated that, next to reimbursement, new funds available for health care should be used for the uninsured. [1]

6. **Budget Predictability:** the anticipated outcome of Medicaid reform; achievement of the five objectives detailed above, including beneficiary cost-sharing, flexible and appropriate benefits programs, employer buy-in, and adequate provider participation resulting in accessible and cost-effective health care. (4.0, 4.1, 4.2, 4.3, 4.4)

By accomplishing the goals of the "It's Health Care, Not Welfare" program, the OHCA hopes to implement a quality, affordable health insurance program for low-income Oklahomans using the existing infrastructure of the current Medicaid system. For this to be successful, funding for the program must be stable and predictable. To determine the acceptability of a cash reserve system for Medicaid, providers were asked if they supported a cash reserve system to level out the gaps in Medicaid funding that occur with the fluctuations in state and federal funding. By an overwhelming margin (78%), and regardless of their opinion of the current Medicaid system, providers supported establishing a cash reserve system to provide a stable funding base for Medicaid.[1] (Table 5).

Table 5. Would You Support Cash Reserves for OHCA to Stabilize Medicaid Funding?

	Responses	Percent
Yes	188	78%
No	25	10%
No Response	28	12%
Total	241	100%

CONCLUSIONS & RECOMMENDATIONS

General Study Conclusions

- Potential beneficiaries (low-income working adults and their families) are willing to pay a portion of their health care costs.[3]
- Providers on average have a low (less than 30%) rate of collecting allowed co-payments from current Medicaid patients.[2]
- Physicians and other providers of fee-based services feel that a fee structure that approaches 100% of Medicare combined with a concomitant reduction in hassle and paperwork, would make providing Medicaid services financially viable.[1,2]
- Although they are interested, small business employers will need incentives and administrative assistance if they are to participate in a voucher or buy-in Medicaid program. Major concerns are adverse financial and

administrative (e.g., paperwork) impacts, and fear of having to reduce or eliminate coverage if it becomes too costly or the state/federal subsidy is eliminated.[4]

Recommendations by Contract Item

4.0 Additional discussions could be held with current Medicaid beneficiaries and contracted health care providers to develop and implement an effective means for levying and collecting co-payments. A co-payment "debit" card, which beneficiaries would present at physician visits, might also be considered.[2]

4.1 Potential beneficiaries indicated a willingness to pay a portion of their health care. Cost-sharing measures that encourage the use of cost-saving preventive and public health services (physical exams, pre-natal care, immunizations, etc.) might be considered. One approach could be to exempt preventive services from cost-sharing and possibly to require routine health care services to maintain coverage.[3]

4.2 Fee-based reimbursement at approximately 100% of the Medicare fee schedule is suggested. However, a reduction in the administrative burden of providing Medicaid services (e.g., streamlined pre-authorization, eligibility verification, faster claims processing) could partially offset reimbursement.[2]

4.3 Small business employers are moderately interested in offering health insurance but worry that the financial and administrative costs may be too high. They also fear having to withdraw coverage if the financial viability of their businesses should become compromised or if state dollars are reduced or eliminated. Any program that involves small business employers should address these issues up front to gain small employer buy-in. New or start-up companies are less likely to offer ESI and are more at risk to suffer adverse consequences. A program that offers incentives and reassurances for new businesses could have a positive impact on the number of working uninsured in Oklahoma. Positive benefits of ESI for small businesses should be identified and communicated.[4]

4.4 Fair reimbursement and reduced administrative hassle including streamlined pre-authorization procedures were the key programmatic elements required to ensure provider participation in Medicaid. Suggestions include more services like the Pharmacy Hotline and additional uses of the internet and other electronic services to make pre-authorizations, claims processing and eligibility verification faster and easier.[1]

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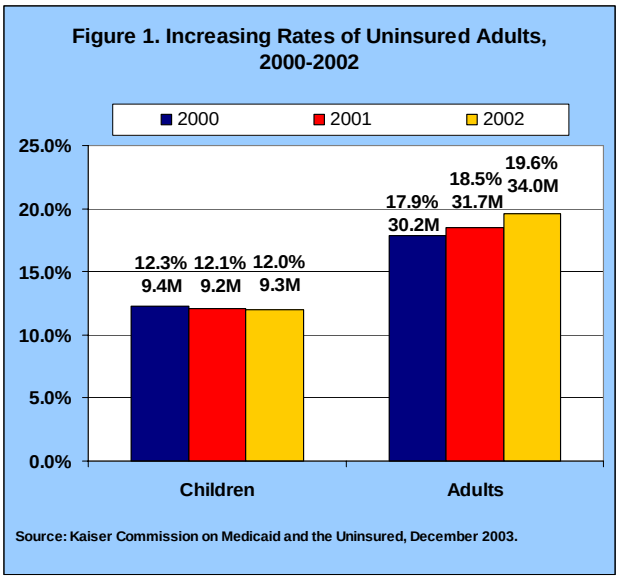
Background and Statement of the Problem

The number of Americans without health insurance coverage reached more than 43.6 million in 2003. This figure is up approximately 2.4 million from 2002, according to a newly released study by the Commonwealth Fund. More troubling is the fact that, between 1996 and 1999, more than 85 million people (38% of the population under age 65) were without coverage at some point in time.[8]

Annually, the United States loses from $65 billion to $130 billion when people who are uninsured get sick and/or die early, according to an Institute of Medicine (IOM) report released in 2003. The IOM report found that it would cost less to "simply insure" all Americans who now lack health insurance.[7] Overall health care costs are estimated to be rising at 7% annually and premiums are increasing at an alarming rate of 14% annually. Health care is now consuming nearly 13% of our gross national product (GNP).[9] The Physicians' Working Group on Single-Payer National Health Insurance say it is time to re-open discussions about universal health care.[10] A group studying Medi-Cal (California's Medicaid system) has also proposed that the time is ripe to consider scrapping Medicaid and replacing it with "a mainstream health insurance plan that covers Americans at all income levels."[11]

When people lose health insurance coverage for whatever reason (job loss, eligibility, illness, availability, cost), Medicaid programs and SCHIP (State Children's Health Insurance Program) step into the breach to provide coverage for children but "public coverage for adults has not increased to offset the loss of job-based coverage" according to a Kaiser Family Foundation report.[12] According to the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, the number of uninsured rose steadily from 2000 to 2003 (Figure 1).[12]



Newspapers, television, and the health care policy, medicine, and law literature are filled with articles on health care reform and covering

the uninsured and underinsured. Books and reports from organizations such as The Urban Institute,[13] the Kaiser Family Foundation,[12] and the Robert Wood Johnson Foundation[14] define the problems from multiple perspectives and offer solutions. Web sites designed to collect and disseminate information about the plight of the uninsured in America proliferate. CoverTheUninsuredWeek.org (sponsored by the Robert Wood Johnson Foundation) and www.HSChange.org (the web site for the Center for Studying Health System Change) offer subscribers weekly alerts.

The ballooning mass of information about the crisis in health care in the United States is one small indication of the magnitude of the problem. A series of recent newspaper articles describe the problems and how some of states are attempting to cope with the financial and social problems of covering the uninsured.[15] In Georgia, $100 million in health care cuts are being considered that would result in 12,500 pregnant women and 14,700 children being dropped from Medicaid. In addition, Georgia is considering raising the premium rates on the SCHIP program from $20 per month to $90 per month. In Pennsylvania, 13% of residents are uninsured and two-thirds of those have incomes below 200% of the poverty level.[16]

Hawaii has had a law requiring employers to offer health care coverage to full-time employees since 1974. The state is now considering a measure that would force the state's businesses to provide coverage for part-time workers to stem the tide of the state's rising numbers of uninsured workers.

Massachusetts Governor Matt Romney admits that cuts he has proposed to the Medicaid program would increase premiums in the private sector but the state may have no choice if rising costs cannot be contained some other way.

In Oregon, the first state to institute health care rationing to provide broad coverage for its uninsured citizens, voters rejected a measure that would increase income taxes for 3 years to fund an $800 million health care package. The purpose of the bill was to balance the state budget while at the time, covering the state's growing number of uninsured.

A Tennessee pediatrician had difficulty holding back tears when he announced at a legislative dinner that he was forced to close his long-time practice in a rural Tennessee community, and join a group practice in a larger community some distance away. "I was in such debt by this point that even though I was cutting my income more and more, I couldn't keep my head above water." The majority of the patients in his rural practice were TennCare patients, Tennessee's Medicaid program.[17]

In Texas (which has 23% uninsured, the highest percentage in the country), an insurance company plans to offer a "stripped down" health insurance plan for the state's uninsured. Some legislators are touting the plan, which offers a range of services with a corresponding range of cost-sharing options; advocates for the state's low-income, uninsured say the plan offers products of "questionable value, high deductibles and limited benefits in the name of choice." This plan, for example, would not cover pregnancies.[15] In addition, the University of Texas Medical Branch at Galveston, the state's oldest public hospital and medical school, announced recently that it will begin rationing services to those who cannot pay. Although no patient will be turned away, selective services (such as expensive drugs and surgeries) will no longer be available to patients without adequate health insurance. According to an NBC news report, rationing like this could be "the future of American medicine for those who cannot pay."[18]

Minnesota initiated a state-subsidized health insurance program for the working poor. A recently published study about the MinnesotaCare program found that, after controlling for hospital characteristics and market variation, enrollment of low-income, previously uninsured workers in the MinnesotaCare program resulted in a "cumulative savings of $58.6 million in uncompensated hospital care costs" alone.

Here in Oklahoma, approximately 643,000 individuals are uninsured. Most are low-income individuals (with annual earnings at or below 200% of the federal poverty level) In 2003, only 38% of small Oklahoma businesses (50 employees or less) offered health insurance coverage to full-time employees. In 1996, Oklahoma spent 20% of its state budget on health care for the uninsured and underinsured, the highest percentage of any state.[19] Like the states listed above, Oklahoma is struggling to come to terms with the growing crisis presented by the lack of affordable health care coverage for its low-income citizens.

Most individuals and families with health insurance are covered under an employee benefit package through their place of business. However, as employer-sponsored insurance (ESI) premiums continue their double digit increases (13.9%-15%), employers must either decline to offer ESI or increase the amounts their employees must contribute through premiums, deductibles and co-payments. These increases in cost-sharing cause many patients to forego necessary or preventive health care or to decline insurance coverage altogether.[20]

The uninsured are four times more likely to require costly emergency room or hospital care. A recent Associated Press article noted that emergency room use is on the rise for insured individuals as well.[21] Reasons for this were not clear but could include lack of timely access to primary care providers or failure to utilize health intervention early during onset of illness due to increased co-payments, deductibles or co-insurance. Many of the low-income, uninsured and underinsured are unable to pay the costs of the health care services they receive which results in uncompensated care forcing providers to shift the costs of their services to their paying patients in the form of higher charges. This cost-shifting, in turn, drives up insurance premiums (Figure 2. Insurance Death Spiral).

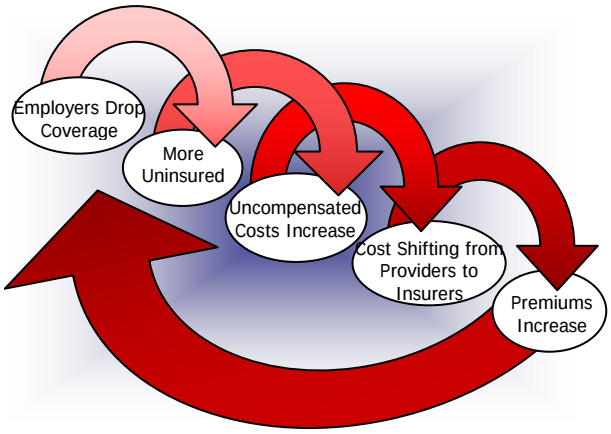


Figure 2. Insurance Death Spiral

The Oklahoma Health Care Authority (OHCA), on behalf of the State of Oklahoma, under the authority of Sec. 1115 of the Social Security Act, is requesting a five-year Medicaid Research and Demonstration Waiver to redesign the current Medicaid program and develop mechanisms for making health insurance coverage accessible for low-income, working Oklahomans and their families (those with incomes below 200% of the U.S. federal poverty level, Table 6).

Table 6. FY 2003 Federal Poverty Levels Based on Family Size and Income*

Family Size	Annual (and Monthly) Income by Federal Poverty Level Percentage			
	100%	133%	185%	200%
1	$8,980	$11,943	$16,613	$17,960
	($748)	($995)	($1,384)	($1,497)
2	$12,120	$16,120	$22,422	$24,240
	($1,010)	($91,343)	($1,869)	($2,020)
3	$15,260	$20,296	$28,231	$30,520
	($1,272)	($1,691)	($2,353)	($2,543)
4	$18,400	$24,472	$34,040	$36,800
	($1,533)	($2,039)	($2,837)	($3,067)
5	$21,540	$28,648	$39,849	$43,080
	($1,795)	($2,387)	($3,321)	($3,590)
6	$24,680	$32,824	$45,658	$49,360
	($2,057	($2,735)	($3,805)	($4,113)

*Source: Oklahoma Health Care Authority, 2003

These low-income workers, whose taxes help support the Medicaid program, often earn too much to be eligible for public assistance and too little to afford employer-sponsored coverage. OHCA is considering expanding the current Medicaid program to provide health insurance coverage to the state's working poor.

The reform options would be implemented to accomplish six key objectives:

1. Patient Responsibility
2. Effective Purchasing
3. Acceptable Provider Reimbursement
4. Flexible Benefits
5. Expanded Eligibility
6. Budget Predictability

In this fifth and final report in a series of studies for the Oklahoma Health Care Authority (OHCA) by the University of Oklahoma Health Sciences Center (OUHSC), we report on the findings from all five previous studies and relate the results to the six key objectives of the "It's Health Care Not Welfare" Medicaid program.

1. PATIENT RESPONSIBILITY

Patient responsibility is the appropriate utilization of health care (including preventive care) at the right time, in the right setting, and the acceptance of a reasonable portion of the costs (cost-sharing) for health care services by each individual patient. In order to develop reasonable, effective, and enforceable cost-sharing programs, policy and decision makers must understand the population involved, and determine the acceptability and potential impact of the cost-sharing measures on those who will pay as well as on those who will collect co-payments.

"All patients must have some co-pay. They must have some responsibility in their own health care."

An Oklahoma physician
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To determine the level of cost-sharing that would be acceptable and affordable for the potential beneficiaries of Medicaid reform, 138 low-income adults between the ages of 18 and 66 were surveyed.[3] In addition, we conducted an in-depth literature analysis into the problems associated with cost-sharing in low to moderate income populations.

To determine the effectiveness of current cost-sharing efforts, 846 physicians and other health care providers statewide were asked to estimate the percentage of co-payments they were currently collecting from Medicaid patients.[2]

In addition, we discussed Medicaid and health insurance programs with members of all stakeholder groups and collected comments and opinions from each (89 from potential beneficiaries, 49 from small business employers, 438 from providers). Some of the comments that relate to cost-sharing and patient responsibility will be included in this section.

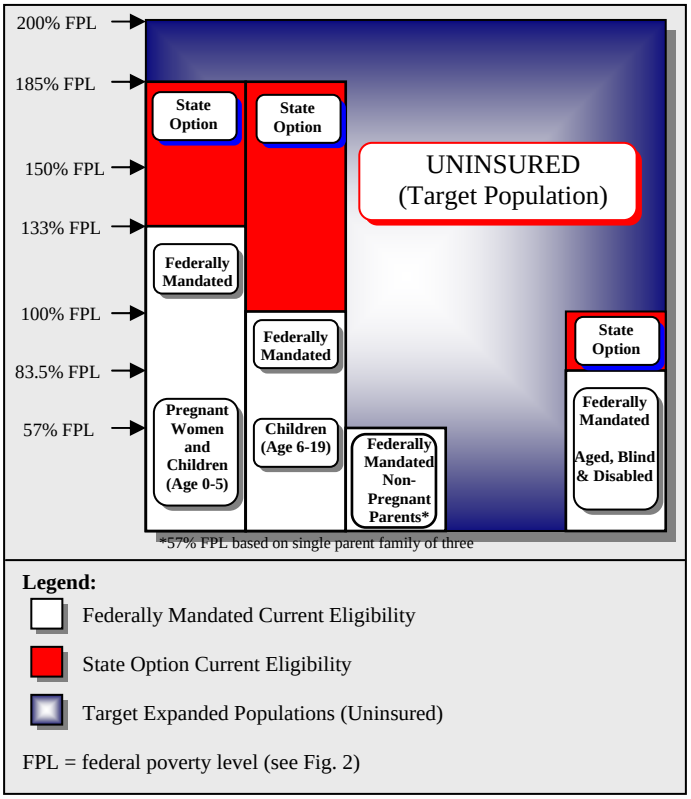


Figure 3. Current and Expansion Medicaid Eligibility

Beneficiary Demographics, Socioeconomics, and Health Insurance Status

To assure that the sample population was representative of the target population, we collected data about the demographic and socioeconomic status of the potential beneficiaries who participated in this study. The target population includes working adults and families with income levels up to 200% of the federal poverty level (FPL) who may not currently be eligible for health coverage under Medicaid. Approximately half those surveyed had insurance at the time of the survey, while half did not. (Some of those surveyed may have had Medicaid as insurance.) Figure 3 shows the current and expanded eligibility categories for Medicaid.

Table 7. Demographics of Potential Beneficiaries (n=138)

Age Range	n	%
18-20	9	7.1%
21-30	32	25.2%
31-40	33	26.0%
41-50	30	23.6%
51-60	18	14.2%
Over 60	5	3.0%
No answer	11	
Marital Status		
Single	55	40.1%
Married	49	35.8%
Separated/Divorced	30	21.9%
Widowed	3	2.2%
No answer	1	
# of Dependents		
0	62	47.3%
1	25	19.1%
2	20	15.3%
3	13	9.9%
4	5	3.8%
5	5	3.8%
6	1	0.8%
No answer	11	

As reported in the study by Crawford et al.,[3] 138 potential beneficiaries who met the inclusion criteria (total family income at or below 200% of FPL, Figure 3) participated in this study and shared their attitudes and opinions toward participating in an expansion of the current Medicaid program. Table 7 shows the demographics; Table 8 shows the income, education and employment status of the potential beneficiaries who participated in this study.

Table 8. Income, Education and Employment Status of Potential Beneficiaries

Income Level (% FPL) *	#	%
100% FPL	38	43.7%
133% FPL	21	24.1%
185% FPL	5	5.7%
200% FPL	23	26.4%
No answer	49	
Education Level		
No high school	4	2.9%
Some high school	17	12.3%
High school graduate/GED	43	31.2%
Some college/technical school	59	42.8%
College Graduate	14	10.1%
Post-College Training	1	0.7%
No answer	0	
Employment Status		
Full-time	88	65.7%
Part-time	21	15.7%
Full- and part-time	10	7.5%
Unemployed	15	11.2%
No answer	4	

All potential beneficiaries who answered the question regarding income (n=89) reported net family incomes below 200% of the federal poverty level (49 did not answer the question). Most were employed either full or part-time (88.9%, n=119). About one-third had completed high school (31.2 %), and nearly half (42.8 %) had some post-high school or technical school

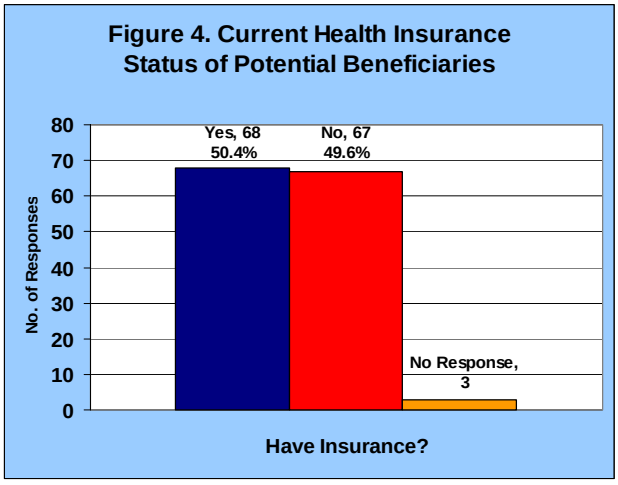
* See Table 6, page 3, for a chart of current federal poverty level breakdowns by family size and income.

training; 15 (11%) had completed college or had some post-college training.*

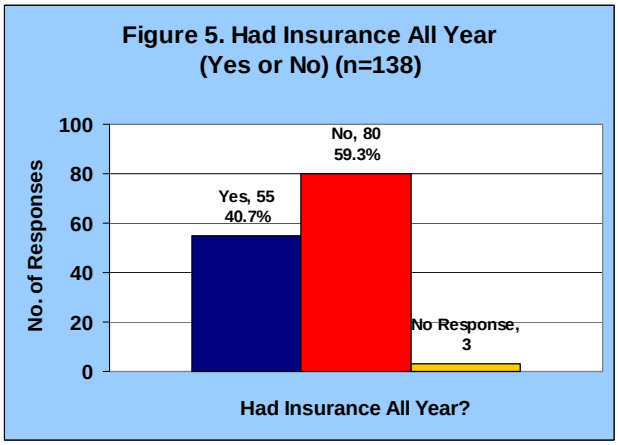
"It would make a tremendous difference in our lives to have medical treatment financially available. We make too much to receive Medicaid yet we cannot afford to purchase private insurance…we sacrifice our own health needs to afford [health care for] our child. We don't visit a dentist on a regular basis. I have endometriosis and let it go untreated because of finances."

A low-income uninsured mother
August 2003

Slightly more than half (50.4%, 68) of the potential beneficiaries surveyed had health insurance for themselves at the time of the survey while half (49.6%, 67) were uninsured (Figure 4); 3 did not answer the question. Approximately half reported having coverage for family members.

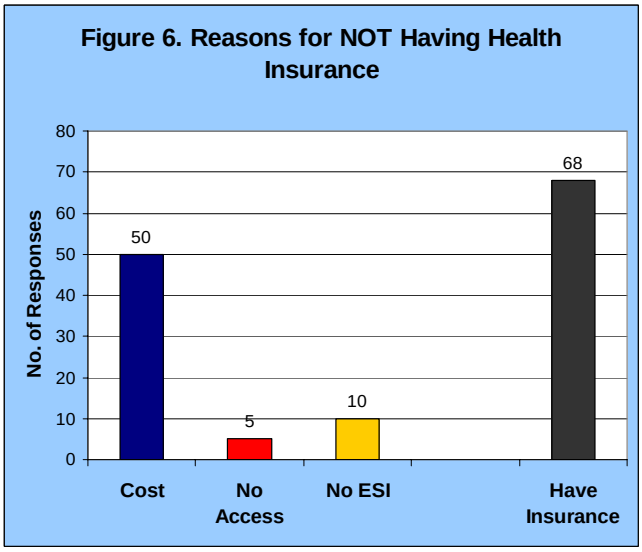


Of greater importance from a policy perspective, however, is that only 40.7% (55 of the 135 who answered the question) reported having health insurance for the entire past year whereas 59.3% (80 of the 135 who answered the question) were uninsured for at least part of the previous year (Figure 5).



These findings correspond with national studies, which report that the population of uninsured is constantly fluctuating. Although approximately 43.3-43.6 million Americans are without health care coverage currently, nearly double that number (85 million or 38% of the population) reported being uninsured at some point between 1996 and 1999.[8,12]

Of the 67 individuals who reported <u>not</u> having health insurance coverage at the time of the study, most said that cost was the reason they were uninsured (76.9%, n=50); no access to health insurance either privately or through their employer accounted for about 23% (n=15) of the uninsured (Figure 6). Two did not answer the question.



* For detailed data and results generated by these studies, please refer to the reports themselves.

When income level, education level, employment and health insurance status are viewed together, the picture that emerges of this population is that they are hard-working individuals who are struggling financially. The study sample, therefore, is reasonably representative of the target population for the proposed Medicaid reform program.

Attitudes, Opinions and Acceptability of Health Care Cost-Sharing

Despite the indication that cost was the primary reason that nearly half of the potential beneficiaries surveyed did not have health insurance, our studies found that all parties – potential beneficiaries, providers and employers – felt that beneficiaries should pay a portion of their health care costs.[3] Most potential beneficiaries surveyed felt they should share the cost of their health care if a cost structure could be established that would not adversely impact their families financially. Even modest cost-sharing amounts can cause low-income people to delay seeking necessary care.[22]

Table 9. Fair Cost Sharing Amounts Selected by Potential Beneficiaries (n=138)

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

Most (71, 55%) would pay an **enrollment fee** of at least $25 per year. Much fewer were able to afford either $50 or $75 per year (Figure 7 and Table 10).

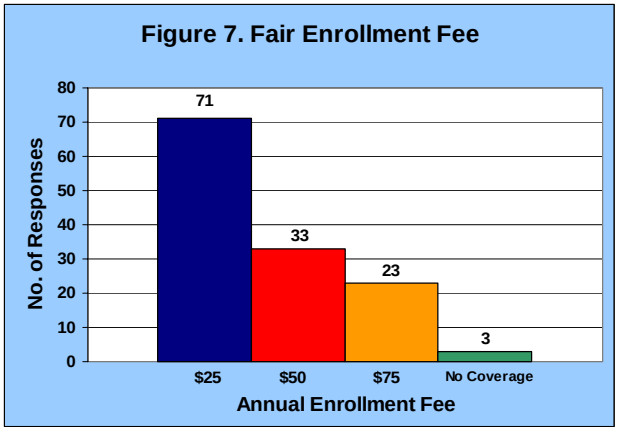


Table 10. Fair Enrollment Fee

Fair Enrollment Fee	Frequency	%	Cumulative %*
$25/year	71	55%	98%
$50/year	33	25%	43%
$75/year	23	18%	18%

*The cumulative percent of respondents who said the specified payment level was fair or better than fair.

When asked about monthly **premium costs**, most (95) felt they could afford to pay $50 per month. $100 to $150 per month was out of reach for most potential beneficiaries in this study (Figure 8, Table 11).

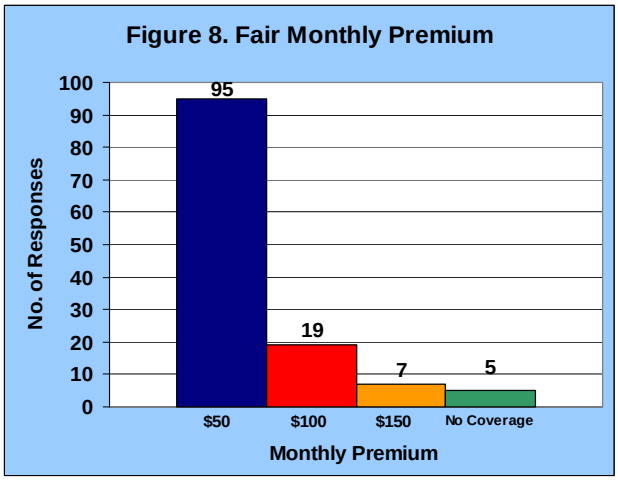


Table 11. Fair Monthly Premium

Fair Premium	Frequency	%	Cumulative % *
$50/month	95	75%	96%
$100/month	19	15%	21%
$150/month	7	6%	6%

*The cumulative percent of respondents who said the specified payment level was fair or better than fair.

Similarly, most (93, 72%) felt that they could only afford $50 per year **deductible**. Only 20% felt they could afford $100 per year deductible (Figure 9, Table 12).

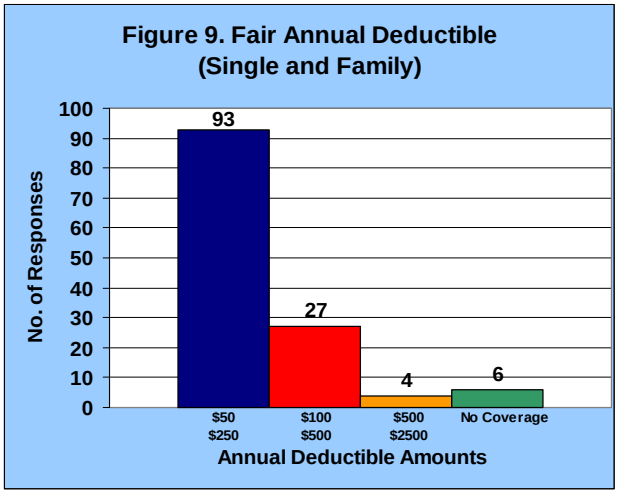


Table 12. Fair Annual Deductible

Fair Deductible	Frequency	%	Cumulative %*
$50/single $250/family	93	72%	95%
$100/single $500/family	27	21%	24%
$500/single $2500/family	4	3%	3%

*The cumulative percent of respondents who said the specified payment level was fair or better than fair.

Surprisingly, a large number of study respondents (34%, 45) felt they could afford a $10 **co-payment** per doctor visit; 20% (26) felt that they could afford $5.00 per visit. Seventeen percent (22) could only afford $1.00. Most of potential beneficiaries felt they should pay a health care co-payment (Figure 10, Table 13).

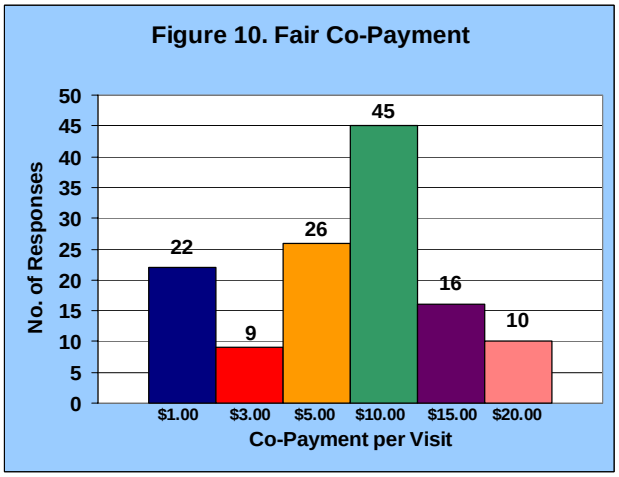


Table 13. Fair Co-Payment

Fair Co-Payment	Frequency	%	Cumulative %*
$1.00/visit	22	17%	97%
$3.00/visit	9	7%	80%
$5.00/visit	26	20%	73%
$10.00/visit	45	34%	54%
$15.00/visit	16	12%	20%
$20.00/visit	10	8%	8%

*The cumulative percent of respondents who said the specified payment level was fair or better than fair.

Thirty-six percent (46) felt they could afford a 5% **co-insurance** while 25% (32) felt they could afford a 10% co-insurance (Figure 11, Table 14).

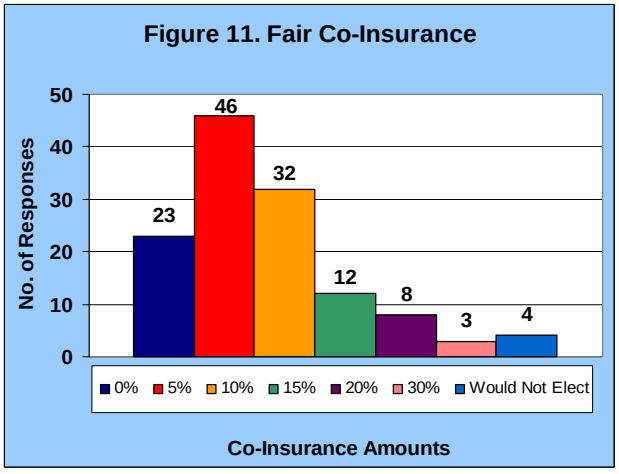


Table 14. Fair Co-Insurance

Fair Co-Insurance	Frequency	%	Cumulative %*
0%	23	18%	97%
5%	46	36%	79%
10%	32	25%	43%
15%	12	9%	18%
20%	8	6%	9%
30%	3	2%	2%

*The cumulative percent of respondents who said the specified payment level was fair or better than fair.

More than half of the potential beneficiaries who participated in this study felt they could pay between 1% and 2% of their net annual income for health care (Figure 12).

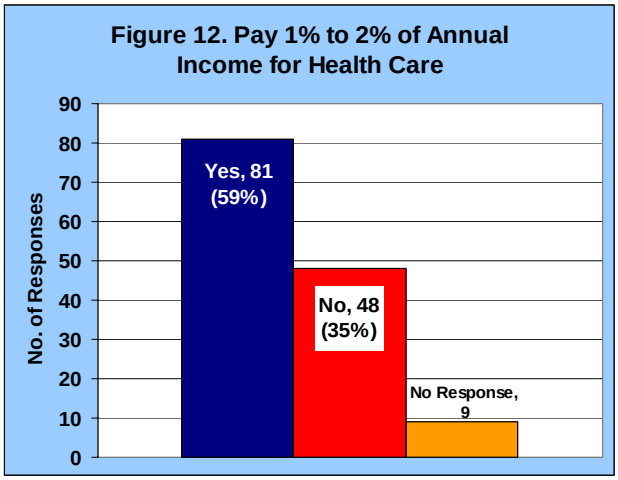
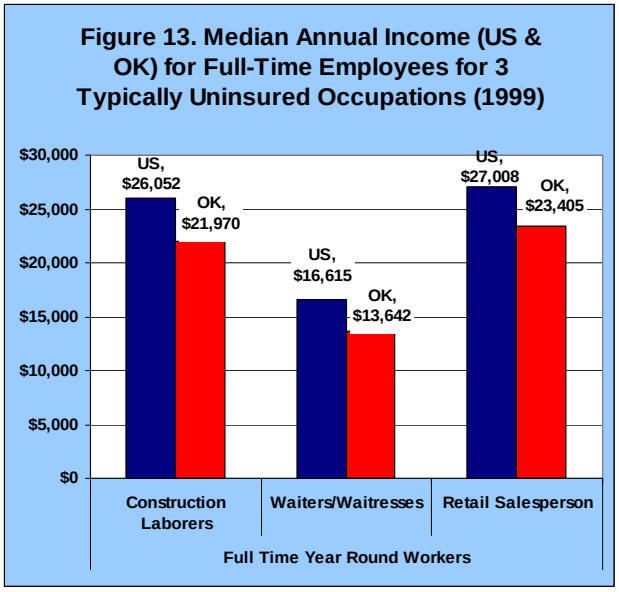


Figure 13 compares incomes for three occupations that traditionally do not offer health insurance coverage for workers – construction laborers, waiters and waitresses, and retail sales personnel. In Oklahoma, a construction laborer, employed year round, for 35 hours or more per week earns approximately $21,970 per year (compared with $26,052 for the US as a whole). If this worker were to expend 1% of his or her income on health care, that would be roughly $220.



Source: www.census.gov, 2000 Census.

Although the potential beneficiaries who participated in this study were willing to share a fair percentage of their health care costs, caution is advised when determining the level of cost sharing and the services to be included in or exempted from cost sharing. A number of well-designed national studies indicate that appropriate utilization of so-called "discretionary health care" (e.g., preventive care, immunizations, well-child visits, pre-natal care) declined when cost-sharing was implemented in low- and moderately low income populations.[5,20,23,24]

Providers' Collection of Co-Payments

In order for cost-sharing to be effective, physicians and other health care providers must be able to collect co-payments and co-insurance. Likewise, insurers (in this case, Medicaid) and employers, who manage and sponsor health insurance, must be able to collect premiums, deductibles, enrollment fees, etc., from beneficiaries with a minimum of administrative hassle.

A study of physicians and other health care providers in Oklahoma indicated that collecting co-payments from low-income patients is problematic. Providers report collecting only about 29% of allowable co-payments from

Medicaid patients currently. In fact, many of the providers with whom we spoke chose to simply write-off co-payments from low-income and Medicaid patients. This decision results in a loss of income to providers (overall resulting in a reduced fee schedule) and may increase any negative opinions about government sponsored health care and Medicaid patients.

"The co-pay is useless. Remove the co-pay or make it enough that it makes a difference in the choices the client makes."

The following remarks were typical when providers were asked to comment on the topic of co-payments.

1. "The co-pays should be higher just like regular insurance."
2. "Co-pays are random, especially for surgeries. We don't know what the co-pay is until after the procedure is done. Then we can't collect from the patient."
3. "The entire system should have some co-pay to make them accountable."
4. "Implement a sliding scale co-pay. That might make it more attractive to providers."

When patients do not (or cannot) pay allowable co-payments, and/or providers fail (for whatever reason) to collect co-payments, then the premise that cost-sharing promotes patient responsibility breaks down and the "mind set" that Medicaid is "government and doesn't cost anything" is reinforced.* If cost-sharing is to be mandated in an expanded Medicaid program, effective mechanisms to ensure the timely and adequate collection of co-payments could be enacted as well.[2] This will probably require educating the patient population about appropriate health care utilization, and providing administrative assistance for providers.

A word of caution: an extensive search of the health policy literature did not retrieve any studies supporting the use of cost-sharing to increase patient responsibility.[5,20,23,24] Most studies report that health care utilization by low and moderate income workers declines in direct proportion to the increases in co-payments, deductibles, and co-insurance. This decline in utilization occurs for cost-effective preventive services (physical exams, pap smears, well child check-ups, pre-natal care) and not for expensive acute care services. Our findings corroborate these studies. Emergency Room access is high (2nd) on the list of desired services while well-child and maternity care are near the bottom of the list (11th and 15th, respectively) (Table 15).

Table 15. Rating of Desired Health Care Services by Potential Beneficiaries (n=138)

Rating	Item	Mean	Std. Dev.
1	Prescriptions	4.62	0.67
2	Emergency	4.50	0.76
3	Vision	4.39	0.84
4	PCP Visits	4.38	0.91
5	Dental	4.38	0.94
6	Inpatient Hospital	4.29	0.95
7	Lab	4.29	0.86
8	Outpatient Hospital	4.19	0.98
9	Specialist Visit	4.18	1.10
10	Transport	3.84	1.20
11	Well Child	3.75	1.54
12	Medical Supplies	3.58	1.30
13	Behavioral	3.45	1.33
14	Physical Therapy	3.24	1.39
15	Maternity	3.14	1.70
16	Home Health	3.02	1.42

This quote from a recent Urban Institute report is typical of the financial concerns of low-income workers.[25]

* Quote from OHCA Medicaid, It's Health Care Not Welfare concept paper, November 2002, pg. 14.

"Sometimes, I have to hold off paying a bill to keep the gas and electricity on. My most important priorities are getting the girls fed and paying for the car so I can get to work, so health care falls low on the list."

A low-income, uninsured mother

From Long SK. Hardship among the uninsured: choosing among food, housing, and health insurance. Washington, DC: Urban Institute; May 2003.

Here in the United States, we have a "shadow" national health care system. It's called the **Emergency Room**. Funds to provide emergency room visits for those who cannot pay are absorbed into the system and providers are forced to shift those costs to other payers.

In the end, people who get sick will get treatment. The question is, then, where will the treatment be supplied and by whom? Will the patient respond appropriately, seek care with a primary care provider, and share in a reasonable portion of the cost? Or, will the patient, fearing the cost of regular health care, remain uninsured and seek care in the emergency room? The potential beneficiaries of a reformed and expanded Medicaid program interviewed for this study seemed ready to become more responsible health care consumers.[3]

2. EFFECTIVE PURCHASING

Effective purchasing is the collaboration between payers (including the state and federal government), employers, and program beneficiaries to make appropriate health care services available at a reasonable cost. According to the OHCA "It's Health Care Not Welfare" concept paper, a "no-premium policy" would be the most effective solution if cost were not an issue.* But obviously, such a program would be extremely expensive. Therefore, policymakers are looking for innovative methods to share the costs of purchasing and providing health care among the stakeholders. Some options under consideration for enhancing effective purchasing of health care include:

- Implementing and enforcing beneficiary cost-sharing.
- Offering subsidies, in the form of vouchers, so small businesses (50 employees or fewer), new or start-up businesses, and low profit margin businesses (e.g., food service) can make health insurance accessible to employees (employer-sponsored insurance, ESI).
- Offering buy-in opportunities so that low-income workers, either alone or through their employer, can subscribe to an extended Medicaid program.
- Establishing a rational fee structure for health care services so that providers can afford to offer the number and quality of services required by the patient population. A more generous provider reimbursement could result in increasing numbers of physicians and other health care providers offering Medicaid services needed by employers and individuals.
- Utilizing any new funds that become available for health care in Oklahoma to subsidize health insurance for low-income workers either independently or through their employers.

Figure 14 demonstrates the potential impact of an effective health care purchasing (and utilization) program. In theory, effective purchasing (and delivery) of health care services might result in a reduction in the use of inappropriate health care services (particularly high cost emergency services and in-patient hospital care) by uninsured or underinsured individuals by placing an appropriate range of health care services within their financial grasp.

Additionally, since it is widely accepted that access to health care improves health and well-being, another benefit of effective purchasing should be a healthier patient population. Healthier populations tend to require fewer expensive health care services (emergency visits, in-patient hospital care), which, in turn, could result in a decline in the amount of uncompensated care (care provided by hospitals, physicians and other health care practitioners for which they receive no reimbursement), and an overall reduction in health care costs (see Figure 14).[26]

* Quote from: OHCA Medicaid-It's Health Care, Not Welfare Concept Paper, November 2002.

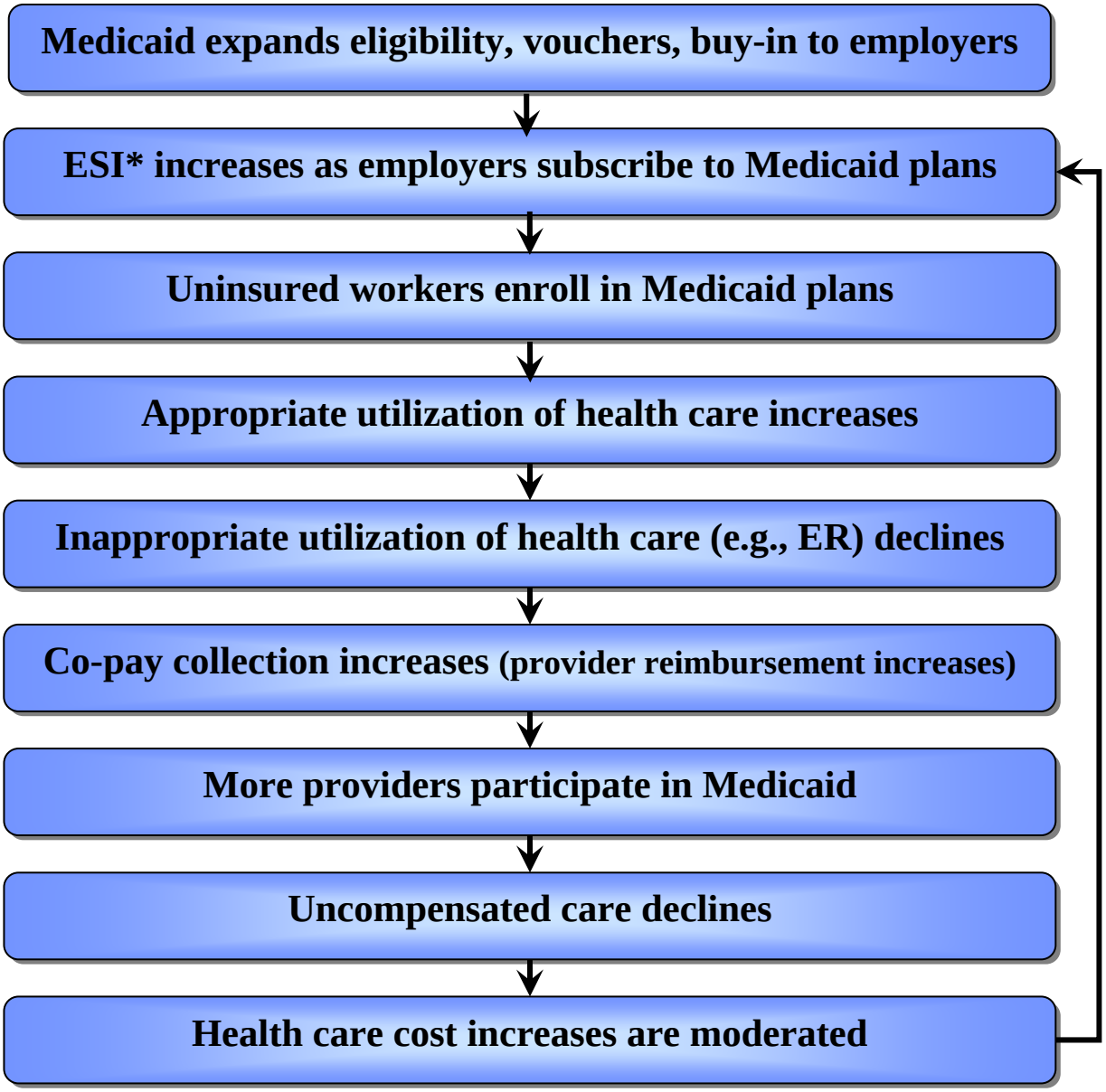


Figure 14. Potential Outcome of Effective Purchasing

Figure 14 demonstrates how a successful effective purchasing plan has the potential to reduce health care costs, increase coverage and access for low-income families, and improve provider satisfaction and reimbursement resulting in more provider participation in Medicaid.

*ESI: employer-sponsored insurance

Research performed as part of the "It's Health Care Not Welfare" project that provides insight into creating an effective health care purchasing program in Oklahoma are:

1. A sliding scale cost-sharing system that would be acceptable and affordable for potential beneficiaries.
2. Health care services desired by potential beneficiaries.
3. Health care utilization patterns of potential beneficiaries.
4. Oklahoma small business employers interest in providing employer-sponsored insurance.
5. Medicaid program changes necessary to ensure adequate provider participation considering an expanded Medicaid population.
6. Providers' opinions about how any new funds for health care should be spent.

Cost-Sharing, Desired Health Care Services and Health Care Utilization

Cost-Sharing. Study results on the attitudes, opinions and acceptability of cost-sharing among low-income workers (potential program beneficiaries) were described in detail in Section 1. Patient Responsibility, and in the complete study report.[3] However, the ability of this target population to "effectively purchase" and manage health care is critical to designing a successful health insurance program. Therefore, some relevant data will be repeated in this section and framed to reflect the potential impact the results may indicate for effective purchasing of health care services.

Study participants (138 adults earning less than 200% FPL) indicated that they would be willing to pay a portion of the costs for health care provided their ability to provide for their basic needs – housing, food and transportation – were not adversely impacted. Table 16 (duplicated from Table 9 for convenience) shows the cost-share amounts selected by study participants.

Table 16. Fair Cost Sharing Amounts Selected by Potential Beneficiaries

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

A major goal of the "It's Health Care Not Welfare" program is to empower low-income working adults to be responsible for their health care. "Charging premiums (and other cost-sharing amounts) is one way of overcoming the perception that coverage is 'free'."[*] To ensure, however, that coverage remains within the economic grasp of the target population, a sliding scale cost-share program could be investigated.

"It would be nice to have insurance for cheaper, specially being a single parent to my kids. It would be great for those who earn low income to still have insurance. "

Uninsured survey respondent
September 2003

Effective purchasing also implies that the services offered reflect the needs of the consumer. To determine the health care service needs of the target population, potential beneficiaries were asked to rate 16 health care services that could be available as part of the expanded Medicaid program. Table 17 (duplicated from Table 15 for convenience) shows the 16 services and the mean rating and standard deviation of each as determined by our research analysis. Study participants were asked to rate each item on a scale of 1-5, with 1 signifying Not At All Important and 5 signifying Very Important.

[*] Source: Medicaid – It's Health Care, Not Welfare concept paper, OHCA, November 2002.

Table 17. Mean Rating of Desired Health Care Services by Potential Beneficiaries

Rating	Item	Mean	Std. Dev.
1	Prescriptions	4.62	0.67
2	Emergency	4.50	0.76
3	Vision	4.39	0.84
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8	Outpatient Hospital	4.19	0.98
9	Specialist Visit	4.18	1.10
10	Transport	3.84	1.20
11	Well Child	3.75	1.54
12	Medical Supplies	3.58	1.30
13	Behavioral	3.45	1.33
14	Physical Therapy	3.24	1.39
15	Maternity	3.14	1.70
16	Home Health	3.02	1.42

I think there should be a sliding scale for eligibility and patient co-pays according to income levels. I would like to collect something from the patients to make them appreciate the services and increase our reimbursement. There should be premiums keyed to income levels as well.

An Oklahoma Health Care Provider
August 2003

Next to prescription drugs, emergency room access was rated highest. This finding is troubling because research has indicated that inappropriate utilization of emergency room services for non-emergent health care problems may have a significant adverse impact on health care and costs. Additionally, many health care financing and policy experts believe that inappropriate use of emergency rooms by uninsured and low-income individuals contributes to health care cost-shifting – the phenomena that occurs when health care providers and facilities provide uncompensated or under compensated care.[26]

Use of New Funds to Provide Benefits for Uninsured

As Medicaid and other health care reform initiatives move forward, policymakers must consider how to allocate any new funds that might enter the health care system, either through additional premiums and enrollment fees from beneficiaries, premiums contributed by employers, or federal or state funds. Physicians and other providers were asked how they would like to see any new funds that enter the health care marketplace allocated.

On a scale of 1-5 (with 1 being Not At all Important, and 5 being Very Important) providers rated reimbursement first, followed by extending health care benefits to the uninsured (Figure 15, Table 18). Most (196 out of 228, 78%) said it was Important to Very Important to use new funds for health care benefits for the currently uninsured.

Figure 15. Use of New Funds as Designated by Health Care Providers

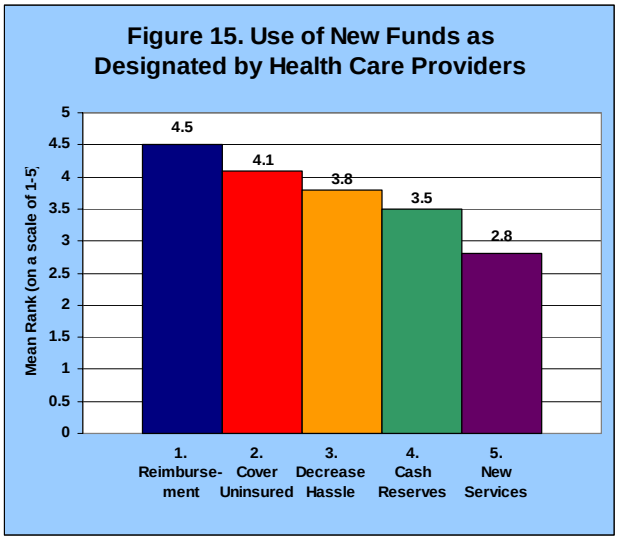


Table 18. Use of New Funds to Provide Health Care for the Uninsured

	Frequency	%
Not at All Important	2	1%
Slightly Important	16	7%
Somewhat Important	34	15%
Important	88	39%
Very Important	88	39%
Total	228	

3. ACCEPTABLE PROVIDER REIMBURSEMENT

"Paying AT LEAST Medicare rates would be a start. If we got Medicare rates, it would be like winning the lottery!"

An Oklahoma Physician
August 2003

Acceptable Provider Reimbursement is the fee structure for services rendered that allows providers to maintain financial viability with a minimum of administrative hassle so that providing services to low-income, uninsured or underinsured individuals and families is cost-effective and thus readily available.

Providing health care services to individuals who are unemployed or low-income workers, uninsured or underinsured, is an active topic of debate nationally.[7,10,12,15,16,25,27-31] Much of the discussion revolves around universal coverage, Medicaid reform, financing, access to care, decline in provider participation in Medicaid, and state efforts to stretch already thin health care dollars. With the rise in the cost of health care, states have been forced to reduce provider reimbursement for Medicaid services to balance their budgets. When the balance between financial viability and providing care for low or no reimbursement collide, physicians and other health care professionals make the painful decision to opt out of Medicaid.

A recent article describes efforts of the TennCare program (Tennessee's Medicaid) to attract physicians using a "carrot and stick" approach.[32] The contention in this article was that physicians, given their druthers, would not extend services to low-income uninsured populations because they wouldn't make enough money. Therefore, TennCare was investigating a plan to deny access to paying patients for physicians who reduced the number of TennCare patients they would see or refused to see them altogether.

In Oklahoma, we queried 846 physicians (MDs and DOs) and other health care providers – pharmacists, nurse practitioners (ARNPs), physician assistants (PAs), hospital administrators, and dentists, asking them to help us establish an acceptable level of reimbursement (as a percent of Medicare) to ensure provider participation in Medicaid.

Because ability to collect co-payments is a subset of reimbursement, practitioners were also asked to estimate the percentage of co-payments currently being received from program beneficiaries. In addition to completing a survey instrument, practitioners were invited to talk with DFPM faculty and staff about Medicaid.

Providers were surveyed from urban and rural areas. Many respondents were current Medicaid providers; some had never participated in Medicaid and still others had been Medicaid providers but had opted out. In general, our study sample represented a cross-section of health care providers in Oklahoma.[1,2]

Adequate Fee Structure to Participate in Medicaid

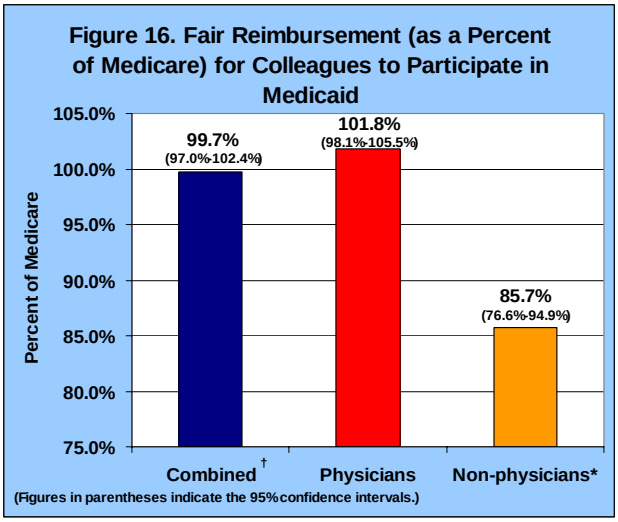
"We still only get $29 per (ER) patient if they are a Medicaid HMO, $25 if they are a FFS. You know, I pay my vet twice that just for a routine visit for my dog."

We asked providers the following two questions:

1. ***What percent of Medicare would be a fair reimbursement for your colleagues providing Medicaid services?***
2. ***At what level of Medicaid reimbursement would you most likely participate?***

The results are interesting.

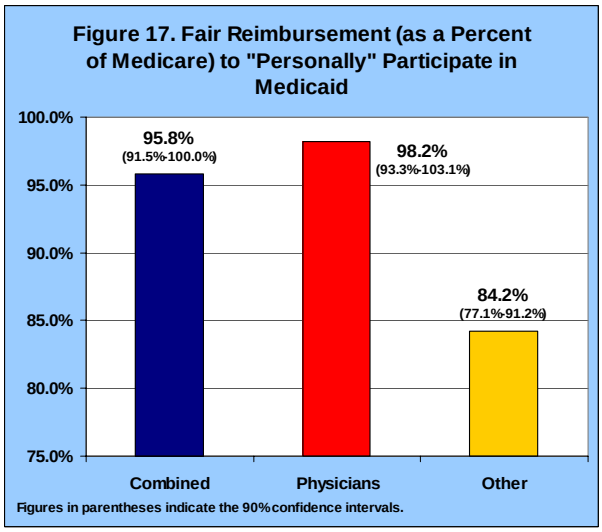
In response to question 1, providers indicated that, on average, 100% of Medicare would be a fair reimbursement for their colleagues who provide fee-based Medicaid services (Figure 16).[2]



*Non-physicians includes registered nurse practitioners, physician assistants and health care administrators.

†Combined includes physicians and non-physicians, and excludes dentists and pharmacists who have a separate reimbursement structure.

In response to question 2, providers indicated that they personally would take somewhat less, stating that on average 95.8% of the Medicare fee structure would be adequate to ensure their individual participation in Medicaid (Figure 17).



"All the providers in the rural community want to provide a better, caring service and be reimbursed at a rate that is comparable with their abilities and profession."

It would appear that the physicians and other health care providers surveyed wanted the system to be fair and generous for their colleagues. They personally, however, were willing accept somewhat less for Medicaid services rendered.

Most of the providers we spoke with were sympathetic to the plight of the uninsured. Most wanted to do the right thing and provide health care services. However, most were frustrated with the excessive administrative burden associated with Medicaid and the current Medicaid beneficiaries' lack of responsibility.

"Providers would like Medicaid to JUST COVER THEIR COSTS! Medicaid reimbursement has to be at a competitive rate before anyone will be interested in participating."

Physicians and other providers interviewed for this study were altruistic and anxious to do the right thing.[2] This is contrary to the contention held by some that providers are

greedy and should be forced to see Medicaid patients. In a report recent article, Sloan and colleague,[32] declared that physicians in Tennessee should forced to take Medicaid patients in order to have access to paying patients. Many of the providers who participated in this study were seeing patients at free local or community clinics. Most were still providing Medicaid services despite low reimbursement, inability to collect allowed co-payments, slow claims processing, and an overwhelming administrative burden. As one physician told us,

"I could provide 4 freebies a month instead of providing Medicaid services and I'd be way ahead. Charity care is certainly more rewarding."

The following comments regarding Medicaid reimbursement rates and participation in Medicaid were transcribed from small group and individual discussions with physicians and other health care providers.[2]

1. "If Medicaid would increase reimbursement, they would have no trouble keeping the numbers of providers to give the system quality. More specialists would be interested in participating."
2. "With overall reimbursement changes, this year my nurses take home more money each month than I do."
3. "Currently, I am now taking home 25% of what I made in 1989."
4. (Hospital Administrator) "Reimbursement for physicians is key. If we don't have physicians who will take care of these people. What will we do?"
5. "Even if the increase in reimbursement was gradual – 5% this year, 5% next year and 5% the following year…just as an example."
6. "If you want me to participate in Medicaid – you've got to pay me and I need to make at least a small profit."
7. "Physicians are mandated to see patients - yet we are unfunded." <ANGRY>
8. "Reasonable reimbursement for a Level III visit is $65 – $70 – Medicaid doesn't even reimburse one-half of that."
9. "If you increase reimbursement to at least the Medicare fee schedule – I think you'll get enough access to specialists."
10. "If reimbursement is not increased there won't be enough physicians to see an expanded (Medicaid) population."
11. "I cannot take Medicaid patients because the reimbursement rate is so low."
12. "When we file for the Medicaid reimbursement from Medicare/Medicaid patients, we NEVER get the Medicaid portion. Its not worth it to rebill when it costs us $5 every time we have to rebill. We've had claims that were denied, sent the same claim back in and it was approved. It seems like it is a guessing game".
13. "Reimbursement for OB deliveries is outrageous. For our commercial patients, we are paid by commercial insurance $2000 for prenatal care and deliver. For SoonerCare it is $650."
14. "Reimbursement for deliveries STINKS. I'm seeing these kids for free because I took the mother into my practice for OB. I would call, write letters, sign papers to have the kids added to my practice, (even though the practice was closed to additional kids), and still the baby won't end up on my list."
15. "I completely did away with the adult Medicaid population in my practice because of the reimbursement. Occasionally I will add a mother to my practice when she is pregnant and her other children are already in my practice."
16. "I work in the ER. We have 20,000 patients per year that are Medicaid. It doesn't matter if the patient is a level 1 or level 5 we still only get $29 per patient if they are a Medicaid HMO, $25 if they are a FFS. You know, I pay my vet twice that just for a routine visit for my dog."
17. "For the same visit, I would bill Medicare $400, they would pay $157. If Medicaid

would at least pay the Medicare rate that would help—although I don't think that will ever happen."

18. "Medicaid reimbursement has squeezed the pharmacists down from $9 per RX to $2. It is hard as a pharmacist not to take care of these patients when they are not only patients but friends."
19. "I have reservations about adding 450,000 to the current Medicaid population unless reimbursement is raised substantially."
20. "The fair reimbursement rate is AT LEAST at the Medicare rate."
21. "Many physicians are dropping Medicare because the reimbursement rate is so low, I can't imagine that they would eagerly accept less than Medicare reimbursement [to see Medicaid patients]"
22. "PLICO increased more than 82% for us [obstetricians]. We can't afford to take care of Medicaid patients. Every time I see a patient, I am losing money."

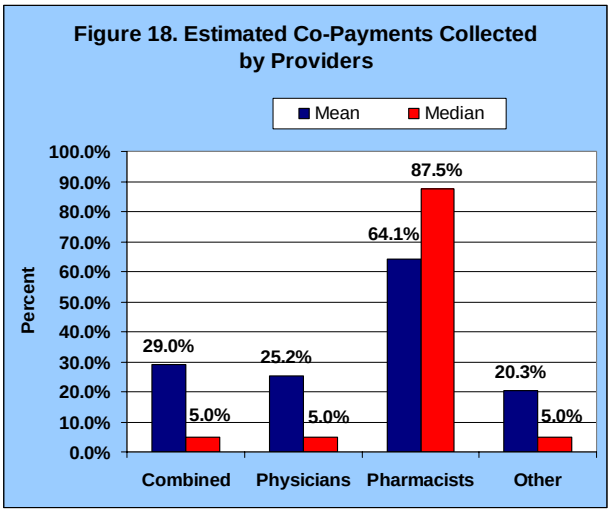
"It costs me more administratively to 'chase' the reimbursement dollars than the amount itself."

It should also be noted that providers expressed feeling overburdened by excessive paperwork and other administrative hassles associated with Medicaid. Streamlined pre-authorization and eligibility verification procedures, faster and more efficient claims processing, and immediate access to OHCA either by telephone or internet could also tip the cost-benefit scale in favor of Medicaid.

"Being able to file on the web has been very helpful. This has made a significant improvement. It also helps with determining eligibility. It would also help if the computer could give us additional information regarding their spend-down (if any) and the standard co-pay for particular services."

Collection of Co-Payments from Current Medicaid Beneficiaries

Collecting co-payments is a subset of reimbursement. Providers who participated in these studies reported difficulty collecting co-payments from current Medicaid beneficiaries and were skeptical about expanding the Medicaid eligibility and increasing cost-sharing. Figure 17 shows the estimated percentage of co-payments currently collected, by provider type.[2] Pharmacists are more successful collecting co-payments (64.1%) than are physicians (25.2%).



For a Medicaid expansion to be successful, policies and procedures for the payment and collection of patient cost-sharing amounts will need to be developed, drafted and communicated. This, of course, is tied in with initiating cost-sharing to promote patient buy-in and responsibility to eliminate the perception that with Medicaid, health care is "free."

"I sometimes think the families don't have any idea how much we get reimbursed for their visits. They feel entitled. They want someone else to pay for their care."

As described previously, a co-pay "debit" card which the patient purchases, either with Medicaid funds, personal funds, with family health account funds or a combination holds promise and could be investigated.

Making Medicaid More Attractive

For an expansion of Medicaid to be successful, sufficient numbers of health care providers must be available to see an increased number of patients. To itemize the changes that would make Medicaid more attractive, providers rated 11 key program elements. Reimbursement was first overall, followed by reduced administrative hassle, easier pre-authorization for treatment, and access to specialists (Table 19).

Table 19. Program Changes that Would Make Medicaid More Attractive for Providers

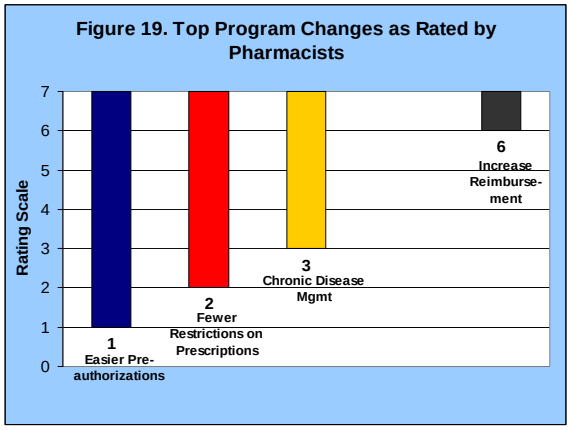
Item	Rating	Mean	Std. Dev.
Increase Reimbursement	1	4.62	0.74
Reduced "Hassle"	2	4.07	1.03
Easier Pre-authorizations	3	4.02	1.04
Greater Access to Specialist	4	3.96	1.29
Chronic Disease Management	5	3.74	1.14
Fewer Restrictions on Visits	6	3.58	1.20
12 Mo. Eligibility Period	7	3.62	1.26
Fewer Restrictions – Rx's	8	3.32	1.20
Fewer Restrictions - Inpt Days	9	3.20	1.29
Case Management Services	10	3.05	1.15
Financial Incentives for Volume	11	2.59	1.32

Table 20 compares the responses between physicians and pharmacists.

Table 20. Comparison of Program Changes Among Physicians and Pharmacists

Item	Physicians	Pharmacists
Increase Reimbursement	1	6
Reduced "Hassle"	2	5
Easier Pre-authorizations	3	1
Greater Access to Specialist	4	8
Chronic Disease Management	5	3
Fewer Restrictions on Visits	6	9
12 Mo. Eligibility Period	7	6
Fewer Restrictions - Rx	8	2
Fewer Restrictions - Inpatient	9	10
Case Management Services	10	7
Financial Incentives for Volume	11	11

Pharmacists rated Easier Pre-Authorizations 1st, compared with physicians who rated it 3rd. Physicians rated reimbursement 1st and pharmacists rated it 6th.



Not surprisingly, pharmacists rated Fewer Restrictions on Prescriptions 2nd, compared with physicians who rated it 8th. It is also interesting to note that none of the providers surveyed were interested in a program that provided financial incentives for volume. Overall, financial incentives was rated last among the 11 choices by all providers surveyed.

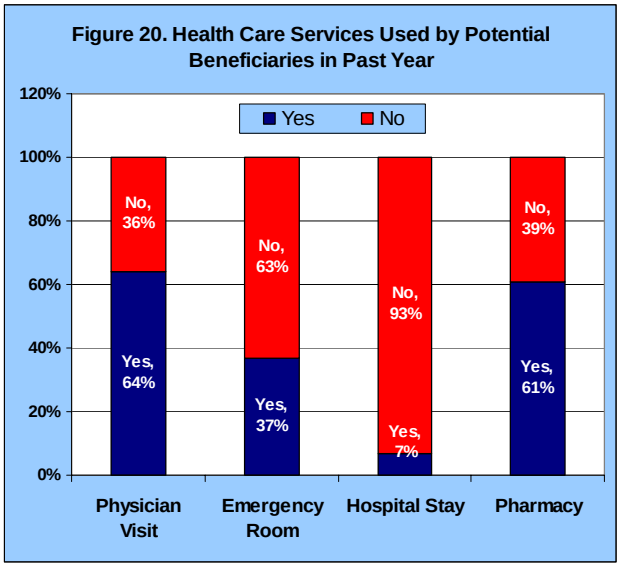
In summary, providers surveyed agreed that a fair fee structure combined with a reduction in the administrative hassles, particularly those associated with pre-authorization and eligibility would make being a Medicaid provider more attractive. Chronic disease management services, which would be beneficial in the target population where half of the patients have a chronic medical condition, were an important element as well. If these program changes were facilitated, it is possible that a greater number of specialists and sub-specialists would enroll in the program, thus alleviating the problems associated with referrals.

4. FLEXIBLE BENEFITS

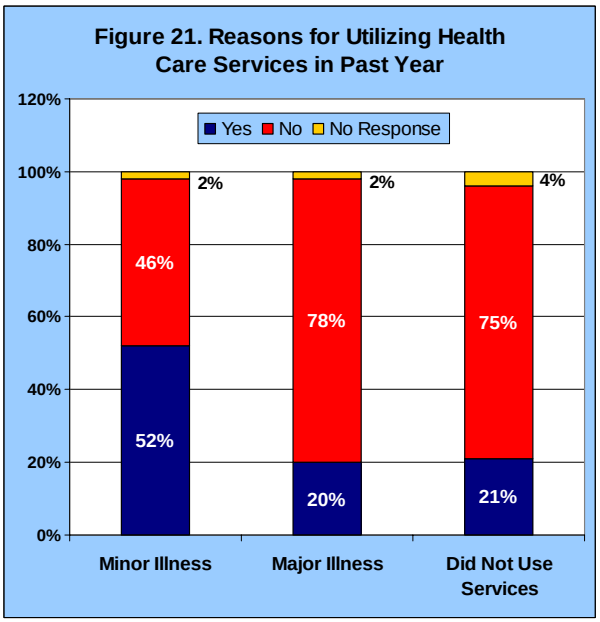
Flexible Benefits is determining the necessary and cost-effective services for the beneficiaries and offering choices that are medically appropriate and meet patient needs. As a first step in developing an appropriate benefits package for the proposed expansion population, we attempted to determine the health status of the potential beneficiary group. In addition, we asked which health care services they used during the past year.

Health Status of Potential Beneficiaries

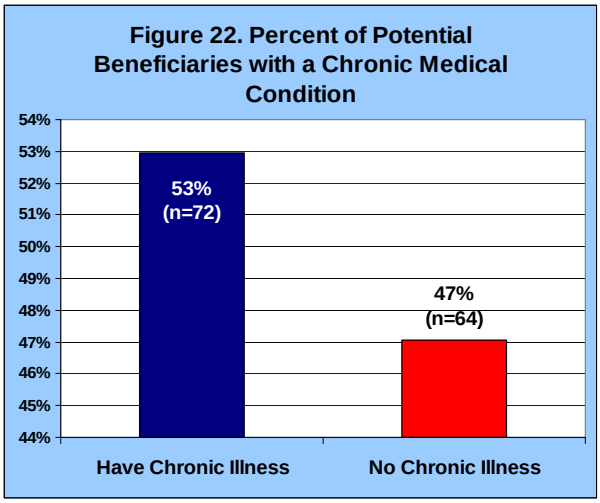
Sixty-four percent (78) reported visiting a physician; 61% (75) reported utilizing pharmacy services and 38% (46) reported going to the emergency room. Only 10 respondents (8%) reported a hospital stay during the past year. Twenty-two percent (27) reported not utilizing health care services in the past year (Figure 20).



Potential beneficiaries were asked why they needed medical care. Most who reported needing medical care said it was for a minor illness (61, 50%); 27 (22%) said it was for a major illness, 16 (13%) declined to share the reason for needing health care services (Figure 21).



More than half of the potential beneficiaries indicated they or someone in their family had a chronic medical condition (asthma, diabetes, etc.) (Figure 22). A benefits package that includes chronic disease management services could be very cost-effective and might be considered. It is interesting to note that chronic disease management services was rated as being moderately important by physicians and other health care providers (see Tables 19 and 20).



Most Important Health Care Services to the Sample Population

To determine the benefits most desired by the expansion population, we asked potential beneficiaries to rate 16 health care services by order of importance on a scale of 1 to 5, with 1 being not at all important and 5, very important.

Table 21. Rating of Important Health Services

Rating	Item	Mean	Std. Dev.
1	Prescriptions	4.62	0.67
2	Emergency	4.50	0.76
3	Vision	4.39	0.84
4	Primary Care Phys.	4.38	0.91
5	Dental	4.38	0.94
6	Inpatient Hospital	4.29	0.95
7	Lab	4.29	0.86
8	Outpatient Hospital	4.19	0.98
9	Specialist Visit	4.18	1.10
10	Transport	3.84	1.20
11	Well Child	3.75	1.54
12	Medical Supplies	3.58	1.30
13	Behavioral	3.45	1.33
14	Physical Therapy	3.24	1.39
15	Maternity	3.14	1.70
16	Home Health	3.02	1.42

Prescriptions were the most important health care service followed by access to emergency services. Vision care rated 3rd in the final data analysis (5th in the initial report) and access to a primary care physician fell to 4th (from 3rd).[3]

Unfortunately, cost effective preventive services such as well-child visits and pre-natal and maternity care were rated low (11th and 15th, respectively).[3] This might indicate a lack of understanding by potential beneficiaries about the importance of routine health care.

Part of encouraging greater patient responsibility among potential beneficiaries is developing benefits programs that promote appropriate utilization of health care services. Many low-income uninsured and underinsured individuals fail to get cost-effective, routine and preventive health care.[3,12,13,23,24] The uninsured are four times more likely to require expensive emergency room and in-hospital care than those who are insured. This use of emergency services becomes ingrained. As our study showed, next to prescription drugs, emergency services were the most desired health care services in the potential beneficiary population.

"I have type I Diabetes. No one but the Oklahoma High Risk pool will cover me. My parents are still paying for my premium of $280 per month because there is no way I can afford it and there is no way I can go without it. I need help."

A young working Oklahoman
September 2003

For a flexible benefits package with choices of services and reasonable patient cost-sharing to be successful, an education program that encourages the appropriate use of health care, particularly preventive care, and discourages the inappropriate use of emergency room services might be considered. Chronic disease management services might also be beneficial for the target beneficiary population as nearly half of those surveyed indicated that they or a close family member, suffered from a chronic illness.

"It would be nice to have affordable insurance that would cover the medical needs of my family and myself. My spouse has diabetes and two children have asthma. I have disk space narrowing in my back. It is very difficult to find coverage for our family and when we do, it is very expensive. I hope the state can do something to help out families like mine. Thank you."

A working Oklahoman
August 2003

5. EXPANDED ELIGIBILITY

"It would make a tremendous difference in our lives to have medical treatment financially available. We make too much to receive Medicaid yet we cannot afford to purchase private insurance. Because of this, we sacrifice our own health needs to afford the needs of our child. We don't visit a dentist on a regular basis (cleaning, x-rays, etc.). I have endometriosis and let it go untreated because of finances. Thank you for considering a program that would change all of this."

A hard-working Oklahoma mother
August 2003

Expanded Eligibility involves extending health insurance to low-income individuals and families with a total family income of up to 200% of the federal poverty (FPL) without regard to Welfare categories; current Medicaid eligibility excludes many single, low-income working adults as well as families with incomes between 185% and 200% of the FPL.

Of the 43.6 million Americans who are currently uninsured, 60% are low income adults, under 200% of the federal poverty level, and most are working full-time. Most insured Americans are covered through employer-sponsored insurance benefits packages. However, as health care costs and thus insurance costs rise precipitously, employers are having to cut back on their contributions, increasing employee portions of premiums, raising deductibles, co-payments, and co-insurance percentages. These increases, which are the same for employees at all levels and incomes, move health care coverage out of reach for low-income workers. Employers, especially those with small businesses, can't pay more without jeopardizing the stability of their businesses. U.S. manufacturers already pay 10 times as much as Canadians pay for health coverage.[33]

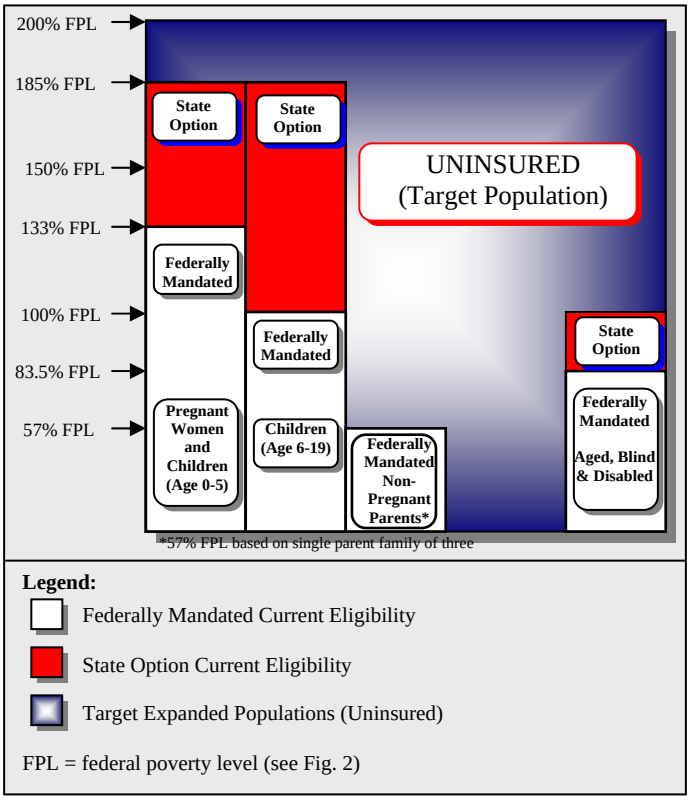


Figure 23. Current and Expansion Medicaid Eligibility

In Oklahoma, more than 650,000 (18%) were uninsured during 1999-2000, 75% of whom are adults between the ages of 19 and 64,* and are categorically ineligible for health coverage under Medicaid (Figure 23). These statistics do not include the underinsured – those individuals and families who have either insufficient coverage or coverage that is so expensive they cannot afford to use it.

To provide access to affordable health insurance for uninsured and underinsured Oklahomans, OHCA is considering applying for a demonstration waiver that would allow the state to extend coverage under Medicaid to low-income working families. To determine how acceptable this program would be to stakeholders, we surveyed potential beneficiaries about their attitudes and opinions toward participating in such a program. We also asked small business employers if they, too, would be willing to participate through either a subsidy or direct buy-in (to Medicaid) program.

Potential Beneficiaries

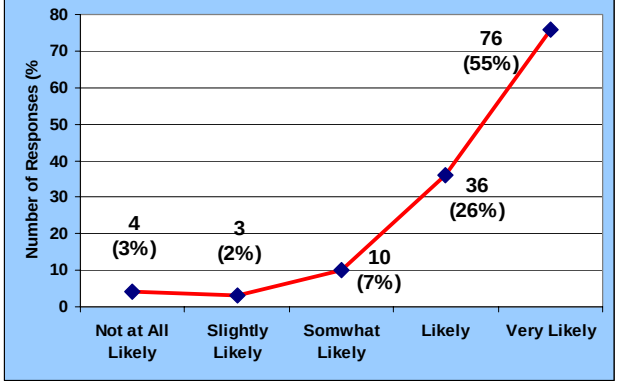
"I am very ill. My husband has problems, also. I've tried to get Medicaid -- too young. We're going through disability fights in court. 50 % of my income is spent on prescriptions and doctors."

A young working woman
August 2003

One hundred thirty eight low-income adults participated in this study. The reform options were described and potential beneficiaries were asked how likely they would be to participate in the program. As shown in Figure 24, 81% of those surveyed indicated they were Likely to Very Likely to participate in the program.

To be successful, the potential expanded Medicaid health insurance program for low-income families would have to be simple to use. Although, as previously indicated, the potential beneficiary group is willing to share in the costs of health care, cost-sharing amounts should be keyed to income so that the currently uninsured do not become one of the underinsured. If this program attracts even 50% of the eligible potential beneficiary population, 325,000 Oklahomans who are without health care coverage today could be insured.

Figure 24. Likelihood that Potential Beneficiaries Will Participate in a Medicaid Health Insurance Program



"My own personal experience -- I don't have health insurance, so I don't go to doctor when I need to go. We need good reasonable health insurance. Let's do this!"

A working Oklahoman
September 2003

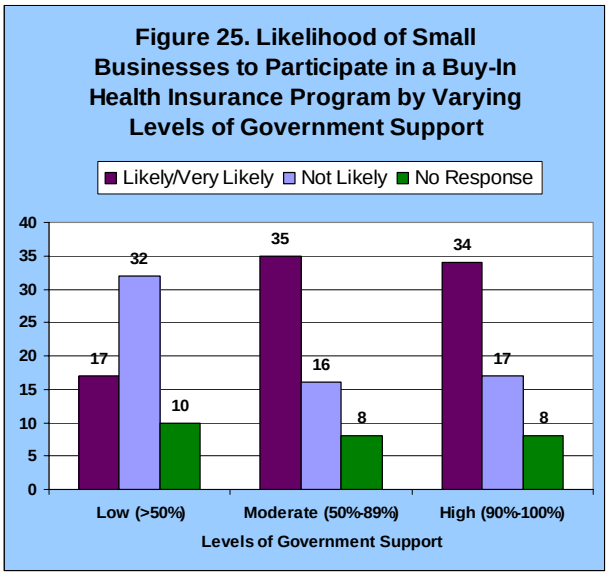
Small Business Employers

Because the expansion population is most likely to be low-income working adults and their families, and because in the U.S., most people have health insurance through their place of business, it is important to know whether small business employers (50 employees or less) in Oklahoma would participate in a Medicaid health insurance program and what their role in the process might be. The program could include a direct buy-in to the current Medicaid program or a voucher-style subsidy system. It is also important to understand what opinion, if

* The percentage of uninsured in the general U.S. population for the same time period was 14%. Source: Kaiser Family Foundation.

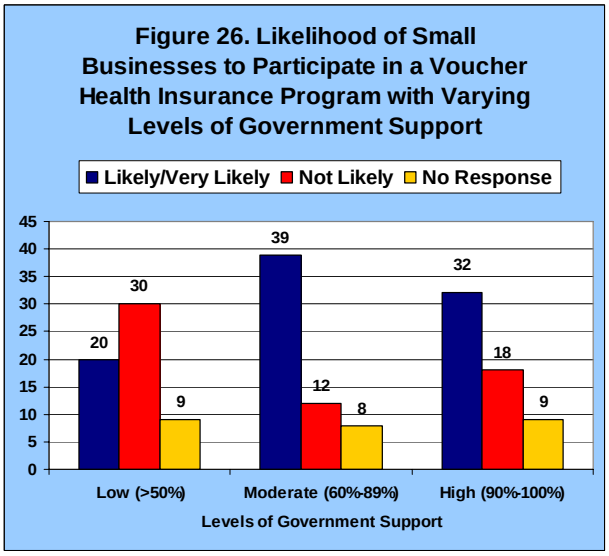
any, employers have of the current Medicaid program. Figures 25-26 show the likelihood that small business employers in Oklahoma will participate in either a voucher or buy-in program. Figure 27 shows the current opinion of Medicaid held by small business employers who completed our survey.

We asked a group of 59 employers how much financial assistance they would need to participate in a Medicaid sponsored health insurance buy-in program: high government support (90% to 100%), moderate government support (50% to 89%) or low government support (40% or less). The results, shown in Figure 25, indicates that small businesses would require a moderate to high amount of financial support to sponsor a Medicaid insurance program through their businesses. In addition, they would need assurances that support would be stable. They may also require some administrative assistance as many of the business employers interviewed did not have the personnel to handle additional paperwork. Smaller and younger businesses may need more financial and administrative support than larger, more established companies. All employers expressed the need for stable funding.



It is interesting to note that when asked about supporting a voucher-style system 17 employers said they were Unlikely to participate with a High level of government support. This finding could indicate that some employers wish to retain financial control over any company sponsored health insurance program.

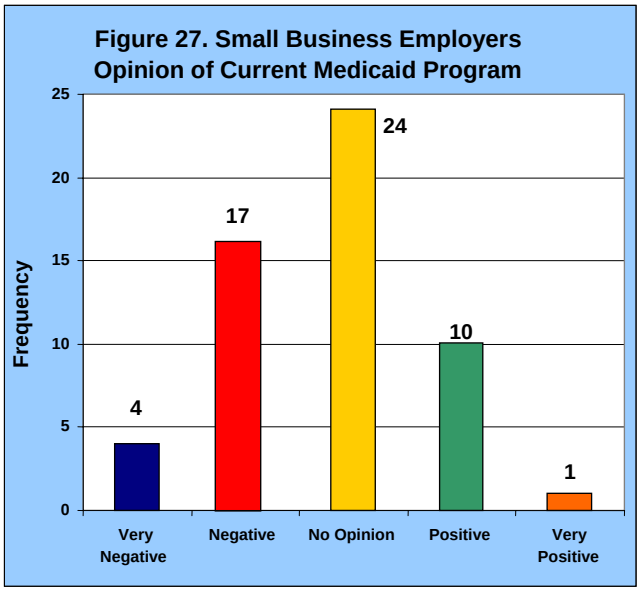
We asked the same employers how much financial support they would need to participate in a health insurance voucher system. The results, as shown in Figure 26, are similar to those for buy-in. Most indicated that high to moderate government support would be necessary for their participation in a Medicaid health insurance voucher system.



Like the buy-in program, however, 18 employers said they were Unlikely to participate with a high (90% to 100%) level of government. Again, we interpret this to mean that some employers would prefer to some retain control over the financial aspects of a government sponsored health insurance program.

We asked employers their opinion of the current Medicaid program to test whether they would have a bias (either positively or negatively) about participating in a health insurance program with the state. Most (24 out of 56) had no opinion of Medicaid. Of those

who did, most were negative to very negative Three did not respond to the question. (Figure 27).



Despite an ambivalent opinion of the current Medicaid system, small business employers in Oklahoma expressed interest in participating in an expansion of the current Medicaid program to provide health insurance benefits for their employees, either through a voucher, buy-in or both (Figures 25-26 above).

As stated previously, small business employers, who would take on additional administrative and financial burden if Medicaid were expanded to include low-income working Oklahomans, will require reassurance that the state will help them support this program. They fear jeopardizing the financial viability of their companies and risking adverse impacts to their employees if the costs of the program (administrative and financial) become too great and they are forced to rescind benefits.

"For me to insure all my employees, I would have to increase my business production by 30% to pay for it."

Small business employer
July 2003

Since it is unlikely that supporting the Medicaid reform program will have any immediate (or even long-term) benefits for their company, incentives, such as administrative assistance, etc., and assurances, particularly regarding a stable funding source for the program, should be put in place and communicated to small business employers to gain their support. Benefits to their businesses, such as better recruitment and retention of key employees, will be need to delineated and communicated as well. It will be important to continue engaging the business community in discussions as the "It's Health Care Not Welfare" reform program moves forward.

6. BUDGET PREDICTABILITY

Budget Predictability is the anticipated outcome of achieving the five objectives detailed above, including beneficiary cost-sharing, adequate provider participation, and a stable funding source. By accomplishing the goals of the "It's Health Care, Not Welfare" program, the OHCA hopes to create an effective and efficient health care program for low-income Oklahomans.

Cost-Sharing

Potential beneficiaries would be willing (and were even eager) to participate in cost-sharing (Table 22).

Table 22. Fair Cost Sharing Amounts Selected by Potential Beneficiaries

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

However, national studies have shown that cost-sharing in low-income populations can actually increase health care costs by providing financially insurmountable barriers to routine and preventive services.[5,20,23] In addition, collecting patient co-payments has been problematic for providers.[2] To be cost-effective, the program should include education about appropriate utilization, particularly of ER services, means to require co-payments by beneficiaries (i.e., the co-pay "debit card") and support for providers in their efforts to collect co-payments and other cost-share amounts.

Physician Participation

To ensure that there will be a sufficient number of physicians and other health care providers to serve an expanded Medicaid population, provider respondents indicated adequate reimbursement for fee-based services at approximately 100% of the Medicare fee structure. This is true for primary care providers and is particularly true for specialists and sub specialists.

"[There is] such poor reimbursement for specialists that no specialist in town will see [Medicaid patients]."

An Oklahoma physician
August 2003

"Getting paid is even worse. We deal with sick, non-compliant patients and it's becoming extremely difficult to find specialists to care for them."

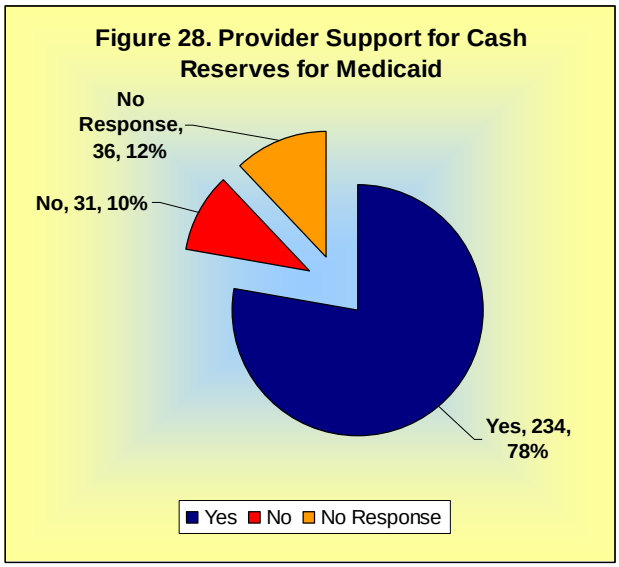
An Oklahoma physician
August 2003

In addition, a reduction in the administrative hassles associated with Medicaid – pre-authorization, eligibility verification, claims processing, etc. – would create a more positive environment for practitioners.

Stable Funding Source

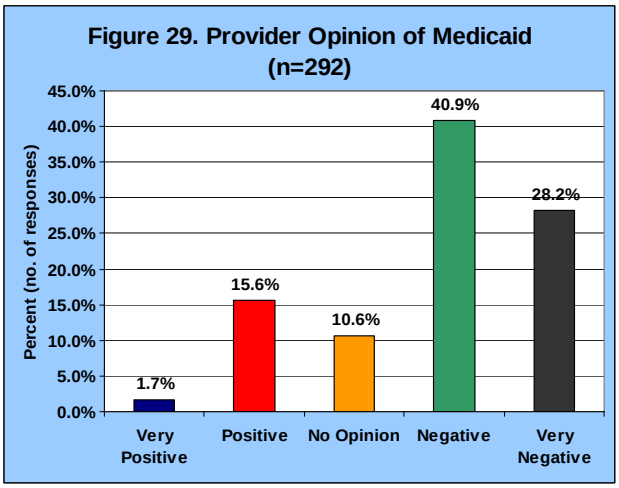
To establish a stable financial base, measures that mitigate the ebb and flow of funds into Medicaid due to fluctuations in state revenue or federal subsidies. Funding stability is an important issue for both providers and small business employers, who are concerned for the financial viability of their business enterprises.

We surveyed physicians and other health care providers about their attitudes and opinion of establishing a case reserve system for Medicaid that would help level out the funding base. By a large margin (78%), providers who participated in these studies supported the establishment of a cash reserve system for Medicaid (Figure 28).[1] This support transcended the negative opinion that most providers expressed of the current Medicaid program (Figure 29).



"My business requires cash reserves. Any well-run business/operation has cash reserve."

An Oklahoma physician
August 2003



As discussed previously, small business employers would most likely be receptive to a cash reserve system as well. Such a program would reassure employers about the financial stability of a Medicaid-sponsored insurance program for their employees. One of the most common fears voiced by employers about implementing a benefits program is the possibility that they may have to increase cost-sharing, reduce benefits or eliminate coverage all together if premium costs become a financial burden. A stable funding source, which can provide stop-gap financial assistance for small businesses, would increase the likelihood that businesses would participate in the reform program.

7. SUMMARY AND DISCUSSION

There is a crisis in health care in America. The number of uninsured rose to 43.6 million during 2002.[12] A recent article by the Commonwealth Fund reported that as many as 85 million Americans were uninsured at some point between 1996-1999.[8] The uninsured in the U.S. cost the economy from $65 to $130 billion annually,[7] and many of the uninsured themselves have to choose between food, shelter and health care.[25]

The State of Oklahoma wishes to improve access to health care for low-income working adults and their families who are categorically ineligible for Medicaid but who earn too little to afford adequate health care coverage for themselves and their families. The "It's Health Care Not Welfare Medicaid" reform program focuses on six key issues to improve access to health care for the uninsured in Oklahoma: patient responsibility, effective purchasing, acceptable provider reimbursement, flexible benefits, expanded eligibility, and budget predictability.

Study Summaries by Key Objective

1. Patient Responsibility

- Most (59%) of the potential beneficiaries surveyed said they could pay a portion of their health care costs (from 1% to 2% of net annual income) including deductibles, enrollment fees, premiums, co-payments and co-insurance.
- National studies indicate that cost-sharing in low-income "at risk" individuals and families can impact utilization of cost-effective services such as preventive care, routine health care and public health services.[5,6,20,23,24]
- For cost-sharing to be effective, policy-makers might consider exempting preventive services from co-payments to encourage the appropriate utilization of health care services.
- Collection of co-payments by providers from current Medicaid beneficiaries is low (~29%).
- Physicians and other providers might be given support (perhaps in the form of a health care "debit" card) to reduce problems associated with collecting co-payments from Medicaid beneficiaries.

"All patients must have some co-pay. They must have some responsibility in their own health care."

An Oklahoma physician
August 2003

2. Effective Purchasing

- Potential beneficiaries rated prescription drugs, access to emergency services, vision care, and (a relationship with) a primary care provider as the most important health services.
- Cost-sharing from 1% to 2% of the net annual income would be acceptable to 59% of potential beneficiaries surveyed to purchase health care.
- An education program on appropriate utilization would be cost effective.

- Small business employers in Oklahoma were receptive to participating in a health insurance program in collaboration with Medicaid. They would require financial and administrative assistance to keep the program viable.
- Effective purchasing relies on the availability of providers. Therefore, acceptable reimbursement combined with a reduction in the administrative aspects of Medicaid could be negotiated to assure a sufficient supply of health care providers for an expanded Medicaid population.
- If new funds become available for health care in Oklahoma, next to reimbursement, providers felt that extending benefits to the currently uninsured would be the best use of funds.

3. Acceptable Provider Reimbursement

- Physicians and other providers suggest that fee-based reimbursement at 100% of Medicare would ensure adequate provider participation.
- If new funds for health care become available, providers surveyed felt that the number one priority for the use of those funds, to make Medicaid more attractive, was to increase reimbursement.
- Effective procedures for collecting co-payments from Medicaid beneficiaries would also help assure provider participation. On average, providers report collecting only 29% of co-payments from Medicaid patients.

4. Flexible Benefits

- Potential beneficiaries were asked which services they felt were most important to them as health care consumers. Prescriptions, access to emergency services, vision care, and a relationship with a primary care provider were listed as the four most important services.
- Like effective purchasing, benefits packages that meet the needs of the target population AND that encourage the medically appropriate utilization of health care services, particularly preventive and ER services, could be designed.
- All providers felt that a chronic disease management program was moderately important. Given that more than half of the potential beneficiaries surveyed reported that they or a close family member had a chronic medical condition, chronic disease management would most likely be cost-effective in this population.

5. Expanded Eligibility

- Potential beneficiaries who participated in our study clearly met the criteria for the target population:
  - Low-income (less than 200% of the federal poverty level)
  - Uninsured/underinsured[*]
  - Working or looking for work
- Most indicated they would be willing to participate in a Medicaid sponsored health insurance program.
- Similarly, most small business employers, upon whom some of the responsibility for identifying eligible workers and for administering the voucher or buy-in will fall, indicated they would be interested in a Medicaid sponsored health insurance program for workers provided:
  - The costs were not prohibitive.
  - Assistance is available to mitigate some of the administrative burden.

[*] By underinsured we mean individuals who are offered insurance through their employers but cannot afford to pay their portion of the costs. These individuals on average are not able to cover their families because the premiums are too high, and they do not get preventive care services that require co-payments, deductibles, or co-insurance amounts.

- A safety net (such as a cash reserve system) is in place to protect the insurance program during economic downturns so that employers are not faced with reducing or eliminating benefits if premiums increase or if federal subsidies are reduced or eliminated.

6. **Budget Predictability**
   - ♦ Physicians and other providers who participated in this study indicated, by an overwhelming margin (78%) that a cash reserve system for Medicaid would result in a more stable program.

Recommendations

1. **Develop a sliding scale** cost-sharing health care program for low-income working adults and families. Health Savings Accounts, voucher systems and employer buy-in, provided the administrative burden was low, could all work to provide a viable health care system for this population.
2. **Require patients to pay a fair portion for their own health care;** potential beneficiaries surveyed felt they could afford to spend from 1% to2% of their net annual income for health care. More might also be considered.
3. Investigate the use of a "**debit card**" that could be used for office visits and other health care services. The beneficiary could "purchase" credits on their co-payment card either through voucher, personal payment or through funds from a health savings account.
4. A benefit package that encourages the use of cost-effective **preventive services** could be considered. Exempting preventive care from cost-sharing and even requiring certain services to maintain coverage could promote healthier Oklahomans and more appropriate utilization.
5. The benefit package might include access to **chronic disease management** specialists, such as diabetes and asthma educators. Many of the uninsured potential beneficiaries interviewed indicated that a chronic illness among themselves or family members contributed to their inability to obtain health care coverage.
6. The benefits package might also include education on the **appropriate utilization of health care services,** particularly emergency room services. Stable and on-going access to a primary care physician could also help reduce inappropriate ER use and promote continuity of care.
7. A fee structure, for physicians and other health care providers, that approaches **100% of Medicare** would be reasonable and might help assure a sufficient supply of physicians for Medicaid patients considering an expanded population.
8. **Small business employers** will require incentives and support – financial and administrative – to participate in either a voucher or a buy-in health insurance program in order to maintain the financial viability of their businesses.
9. A program that targets **new or start-up businesses** in Oklahoma could have a positive impact on the number of uninsured workers. Younger companies and smaller companies are less likely to have a health insurance benefits program in place than larger, established companies.
10. OHCA might investigate a **cash reserve system** that would allow sufficient financial resources to stabilize the Medicaid system's funding and eliminate the need for drastic program cuts in response to budget fluctuations. This will be important to providers, beneficiaries and employers.
11. **Input from all potential stakeholders** in the design and implementation of any reform program could help ensure that the

program developed would be acceptable and successful.

12. **A public relations and educational effort** aimed at enlightening all stakeholders about the goals, objectives and capabilities of the Medicaid program would be critical to achieving buy-in to an expanded program. Disclosure of the costs and benefits of an expansion of the program as well as an honest appraisal of the downsides (short- and long-term) of the reform options would be helpful in establishing trust between stakeholder groups and the Oklahoma Health Care authority.

8. LIMITATIONS OF THESE STUDIES

There are two major limitations of these studies: lack of random sampling and small sample size. A third, less important limitation was the decision not to use electronic data recording devices.

(1) **Random sampling was not possible** in this study, nor was there any intention to create a random group. Project staff contacted a number of provider professional associations and organizations, small business employers, chambers of commerce, and community advocacy groups in at attempt to assemble the largest possible sample population for each study. No interested individual was excluded from the study provided they met inclusion criteria for the studies:

- Providers: Physicians and other health care providers who either are now or could potential become Medicaid providers.
- Potential Beneficiaries: Uninsured or underinsured individuals with net annual family incomes at or below 200% of the federal poverty level.
- Small Business Employers: Companies employing 50 people or fewer.

Individuals who responded were most likely to be interested in the topic and have issues and concerns. The lack of randomization, therefore, limits the generalizability of these results to all stakeholder groups in Oklahoma. Nonetheless, the comments and opinions stated by those who participated in these studies corroborate similarly focused national studies. Thus these results can be useful for policymakers who are developing health care options for low-income uninsured and underinsured Oklahomans.

(2) **Small sample size** is a second limitation. Project staff contacted a variety of resources in an attempt to recruit larger numbers of participants into the studies. As mentioned previously, no interested individuals were excluded from the study if they met inclusion criteria. We were successful in contacting a large number of providers to participate in a short post card (846). Only about a quarter (301) of that group completed the longer survey used in two of the studies and took part in the group discussions or individual interviews.

We were less successful with the potential beneficiary group. This is a challenging group to isolate as there are very few organizations and associations that are actively tracking low-income, uninsured or underinsured workers in Oklahoma. Likewise, engaging small business owners in the studies was difficult. As one employer told us 'off the record,' "It's not easy to admit you don't offer health insurance."

However, the themes and concerns voiced by the participants in these studies as well as the data from analysis of survey responses offer insights into this population that policymakers may find useful.

(3) A third, less important limitation of this study is that electronic devices were not used to record comments nor were standard procedures for measuring verbal and nonverbal responses used for analyzing results of the group and individual sessions. Nonverbal data and comments and opinions from the focus-type group discussions, presentations and individual interviews were hand-recorded using paper and pen by the facilitator and/or assistant facilitator. During pilot studies with DFPM faculty,

participants expressed a degree of discomfort, with electronic recording (audio or video) of the sessions.

Participants stated during pilot testing they would be much more forthcoming and honest if no electronic recordings of the discussion were made, and thus their anonymity could be assured. Because honesty in the attitudes, opinions, and suggestions of participants was paramount for the success of this project, a less invasive system of note taking was employed.

Full reports for the studies cited in this report are available through the Oklahoma Health Care Authority and from the "It's Health Care Not Welfare" policy group in the Department of Family & Preventive Medicine at the University of Oklahoma Health Sciences Center, Oklahoma City.

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9. APPENDICES

A. Statistics Summary and Comparison
B. Biographical Sketches of Program Staff
C. **Executive Summary**: Attitudes and Opinions of Small Business Employers in Oklahoma Toward Reforms to the Medicaid Health Care System
D. **Executive Summary**: Key Programmatic Elements Needed to Ensure Provider Participation in the Medicaid Health Care Program
E. **Executive Summary**: Appropriate Rate Structure for Services Rendered and Estimated Percent of Co-Pays Collected Under the Medicaid Program
F. **Executive Summary**: Beneficiary Attitudes Towards Paying Enrollment Fees, Co-payments and Premiums to Obtain Health Insurance Coverage Under an Expanded Medicaid Program
G. Stakeholder Surveys
H. Disclosure Statement

Copies of the full reports listed above may be available through the Oklahoma Health Care Authority or the "It's Health Care Not Welfare" policy group at the Department of Family & Preventive Medicine, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma.