



**HCR 1010**  
**Core Health Benefit**  
**Task Force**  
**Report and**  
**Recommendations**

December 31, 2007

HCR 1010 established the Core Health Benefit Task Force charged with exploring the scope of coverage that can and should be offered under a low cost, basic health insurance policy. The Oklahoma Insurance Department was charged with providing the Task Force with information necessary for the formulation of its recommendations. And, to assist in enhancing the Task Force's deliberations, the Department engaged Oklahoma citizens in the discussion. Beginning in August, the Oklahoma Insurance Department embarked on a 12 week process of public education and opinion gathering through a computer simulation called Choosing Healthplans All Together (CHAT). A comprehensive description of the CHAT initiative and participant responses is attached as Appendix A.

The Task Force held its first meeting on October 4, 2007, then on repeated occasions through December 2007. The Task Force heard from a number of organizations and each other on topics relative to the scope and cost effectiveness of health care services necessary to ensure the optimal health of our citizenry. Presentation and discussion subject matter included, but was not limited to:

- Public engagement via CHAT
- Defining an "affordable" basic health plan and targeted populations for coverage
- State and federal statutes relative to health insurance coverage requirements, underwriting, and rating
- Current state health insurance market and product offerings, including Oklahoma's InsureOklahoma! premium assistance program
- Economic benefit of coverage for comprehensive mental health and substance abuse services
- Discussion of the Adverse Childhood Experiences (ACE) study and understanding impact of early intervention on long term health
- Effective use of universally accepted evidence-based medical protocols
- Impact of medical malpractice concerns on cost of health care and opportunities for relief
- Medical provider quality improvement opportunities

It was unanimously agreed that more affordable health insurance options are necessary to reduce Oklahoma's high rates of uninsured and that such reduction is critical to the social and economic prosperity of our state. The Task Force also agreed that it is necessary to approach the development of a low cost plan by employing proven cost savings and care management strategies and eliminating requirements for services or suppliers that do not meet a rigorous definition of medical necessity.

*Government should not own health care; instead, it should organize the health care marketplace and then let competition, based on full information, proceed.*

*-Michael Levitt, Secretary, HHS*

The following are our recommendations. The first set of recommendations is general in scope and identifies the further research and study we believe necessary to develop an

appropriate and effective low cost, basic health plan design. It should be noted, however, that these recommended studies will benefit Oklahoma's health care and health insurance system overall. The second set of recommendations itemizes agreed upon benefit plan standards and concepts necessary to accomplish desired patient care and accountability, and sustained cost control.

Recommendations for further review and study for the benefit of our health care and health insurance system in general:

1. The Task Force supports the Institutes of Medicine principals that health care (in Oklahoma) should be safe, effective, patient-centered, timely, efficient and equitable (see Appendix B)
2. Although the CHAT initiative strove to obtain opinions from a representative sample of the Oklahoma public, we still lack information from certain demographics. The Task Force recommends that the CHAT session be expanded to reach out to certain minority and low income populations to ensure a more representative sample.
3. During the development phase of the Insure Oklahoma premium assistance plan, a comprehensive study of Oklahoma's uninsured population was conducted. We recommend that this study, (State Health Access Data Assistance Center, i.e. SHADAC), be updated to clearly identify our uninsured population in terms of age, gender, employment, income, geographic location, etc. Additionally, this study will aid in quantifying targeted populations most likely to benefit from a lower cost health benefit plan. (See Appendix C)
4. We recommend a study be conducted to determine reasonable out of pocket limits (deductibles, copayments and premiums) that cause a plan to be affordable at various income levels.
5. We recommend that all elements of Oklahoma's health care reform efforts, including the development of a low cost benefit plan, leverage all available federal resources.
6. We recommend the state determine the practicality and leverage, if any, that may be gained through pooled purchasing of certain high volume medications, supplies and/or serums (i.e. immunizations, insulin, etc.) to reduce costs.
7. Given all hospitals in Oklahoma are required to offer discount programs to patients who have incomes less than 300% of federal poverty level and are not eligible or enrolled in public or private insurance plans, we recommend an analysis be conducted to determine if/how this requirement might be utilized more effectively as a back drop or reinsurance for high cost claimants of a basic health benefit plan.
8. We support the concept of a primary care "medical home" as necessary to optimal patient care and cost management. We recommend the state explore how medical home parameters and concepts can be facilitated and address known current circumstances and practices that create barriers to primary care access (i.e. primary care provider reimbursement rates, scope of practice limitations, pursuit of funding for additional Federally Qualified Health Centers (FQHCs,) medical workforce limitations, etc.)

9. We recommend the state study the cause and effect of defensive medical practices on the cost of health care and health insurance.
10. We recommend the state continue providing leadership and necessary support in the pursuit of an interoperable health information network and promote the use of health information technology to improve patient care and reduce avoidable hospital readmissions.

Specifically, with respect to a low cost, basic health benefit plan, we recommend the State utilize the information gleaned from studies 1 – 4 above and coordinate with the insurance industry and other public and/or private providers of health coverage to design a plan that incorporates the following precepts:

1. The program shall be offered and delivered by the private insurance market.
2. The program shall be available to individuals and employer groups on an equal basis in terms of underwriting, rating and benefits, subject to thorough research and study of both the individual and group market segments.
3. The program shall be comprehensive and germane to the broad and diverse physical and mental health needs of our population, and shall enable continuous coverage.
4. The program shall develop a transparency methodology that effectively promotes responsible consumption, competition, and quality.
5. The program shall promote personal responsibility and good health through effective financial and/or benefit incentives.
6. The program shall create incentives for the use of available evidence based medical protocols for chronic care management.
7. The program shall reward physician quality and performance with appropriate and effective incentives.

While outside the specific charge of the Core Health Benefits Task Force, we feel compelled to offer one final recommendation. Oklahoma spends billions of dollars annually on health care through state and federal appropriations, third party payments and personal out-of-pocket expenditures. Yet wide gaps in access to coverage and care continue to exist. Given competing demands on state resources, it is realistic to assume that additional health care appropriations will be limited. We believe it is essential then, and thus recommend, that a thorough assessment be conducted of current state healthcare related appropriations. We further recommend that the receipt and maintenance of all state appropriations for direct and indirect health care services be contingent upon regular and meaningful performance measurement to assure ongoing accountability, adequacy and relevance.

In conclusion, the Core Health Benefits Task Force wishes to express its appreciation to HCR1010 authors Senator Susan Paddock and Representative Ron Peterson for their foresight and leadership in commending this effort. We hereby present this report and its recommendations to Governor Brad Henry, President Pro Tempore Mike Morgan, Co-President Pro Tempore Glenn Coffee, and Speaker of the House of Representatives Lance Cargill with our respectful urging for their thoughtful consideration.

HCR 1010 Task Force Members

Senator Susan Paddack, Chair  
Mr. Matt Robison, State Chamber, Vice Chair  
Commissioner Mike Crutcher, M.D., ODOH  
Commissioner Terri White, ODMHSAS  
Ms. Anne Roberts, OICA  
Ms. Marjorie Lyons, AARP  
Mr. Greg Burn, BCBS

Representative Ron Peterson  
Commissioner Kim Holland, OID  
Mr. Mike Fogarty, OHCA  
Dr. William Geffen  
Mr. David Blatt, CAP  
Ms. Patti Davis, OHA

# Oklahoma CHAT

## The Concept

Choosing Healthplans All Together (CHAT) is a computer simulation developed by physician ethicists at the National Institutes of Health and the University of Michigan. Through the simulation, participants are faced with making decisions about health plan benefit packages when there are more choices than resources.

Once carried out statewide, this simulation process provides a unique insight into the health care priorities of Oklahoma residents. With this information, policy makers will have empirical data to assist in identifying ways to cover the nearly 700,000 uninsured in Oklahoma.

## The Process

For the purposes of demographic representation, we divided the state into six regions: Northeast, Southeast, Northwest, Southwest, Metropolitan Tulsa and Oklahoma City. Within each of the four quadrants, we identified five to six separate communities (depending on population) in which to hold sessions. In the Tulsa and Oklahoma City municipal areas, multiple sessions were organized. (See Appendix A-1)

Once the communities were determined, Oklahoma Insurance Department (OID) staff identified partners/leaders within each community to assist in populating the sessions. The focus was placed heavily on leaders in the business community (chambers of commerce, civic organizations), not-for-profit community (United Ways), the health sector (Turning Point volunteers and hospital administrators), and the government sector (Oklahoma Municipal League). With assistance from the Oklahoma Department of Commerce, the community leaders were provided demographic profiles (race, gender, age, socio-economic) of their counties. Although a concerted effort was made to ensure demographically representative groups were selected to participate, not all of the demographics targeted are represented in the results. Additional sessions should be arranged to capture the underrepresented groups (primarily minority and low income).

Each session lasted approximately 2½ hours, with 7-12 attendees participating in four separate rounds of plan formulation and design. Each round involved a CHAT benefit “pie” (see Appendix A-2,) representing a typical health plan. The pie is divided into 15 slices, each representing a service or type of coverage offered under a typical benefit plan and the amount of resources devoted to that type of service.

For instance, the slice devoted to hospital care was significantly larger than the slice devoted to preventative care, representing the greater resources typically expended by a plan for hospital services. Each category or slice offered participants the opportunity to “purchase” up to 3 tier levels of coverage (see Appendix A-3 for description of each category and tier of coverage.) Improved levels of coverage did not necessarily mean

more benefits, but usually greater choice in terms of provider selection or wait times. In the case of prescription drug coverage for instance, Tier 1 (lowest level of benefit) offered generic drugs whereas Tier 2 offered generic and name brand drugs. Tier 1 coverage was less costly than Tier 2). Thirteen of the health benefit categories were optional; two (Premiums and Co-Payments) were required. Each slice was populated with dots that represented the cost to purchase each tier within each slice. There are a total of 80 dots on the CHAT benefit pie. The challenge for participants was to agree on a plan that included what they felt was necessary coverage using only 50 markers (roughly 2/3 the \$350/month cost of an individual health benefit plan in Oklahoma). Attendees were challenged to develop “the minimum health benefit package that should be provided to all people in Oklahoma, excluding publicly-funded programs.” They were reminded this plan should be “the floor, not the ceiling.”

Each session took participants through four rounds of plan building. The introductory round was performed by each, individually. The second round was conducted in pairs who were required to reach agreement as to coverage selection. The third round brought all participants together to reach agreement. The fourth and final round provided each individual the opportunity to complete the process alone. After each round, computer generated questions challenged participant decisions, forcing each to transition from the perspective of “a minimum health benefit package for all” to “this plan is acceptable to me for myself, my family and loved-ones”.

## **The Results**

In collaboration with the OU College of Public Health (OUCPH), the CHAT data gathered during our 40+ sessions was analyzed and tabulated by CPH’s Department of Biostatistics and Epidemiology (DBE). (See Appendix A-4)

While there were over 450 participants who attended sessions, approximately 100 of those participants attended “special sessions.” designed to capture responses from specific populations in order to offer comparative data to that of the general public. These special sessions were attended by small business owners, health plan administrators, physicians, and MPH (Masters of Public Health) students (See Appendix A-5). There were also scheduled sessions with the three major minority groups in the state (African American, Native American, and Hispanic), but due to scheduling conflicts, attendance was too low to consider the responses representative of the groups.

For the purposes of the general public response, analysis was performed on roughly 340 valid responses. While there are a number of ways the data can be viewed, the OI staff and OU’s DBE chose to look at the data in two frameworks: the change in coverage choices between Rounds 1 and 4 and the Round 3 results, which more realistically mirror the legislative process (large group consensus). In addition, the data was stratified by rural vs. urban, insured vs. uninsured, and by three income classification ranges.

A pre-CHAT survey contained questions about the respondents' demographic make-up (gender, income, age, race, educational attainment, and insurance coverage). The findings reveal that there was a higher percentage of females than males participating (63% vs. 37%), almost 75% with incomes of \$60,000 or higher, a median age of almost 50, 84% Caucasian/white, over two-thirds with a four-year college degree or higher, and 82% with insurance coverage.

When compared to the most current statistics on Oklahoma, the attendees were significantly wealthier and better educated. While there was a lack of participation from the African American, Hispanic, and Asian population, the data collected matched almost identically the percentage of Oklahomans that are uninsured (18%).

### **Round 1 vs. Round 4: Summary Findings**

In general, CHAT participants selected coverage in slightly MORE categories in Round 4 as compared to Round 1, but at lower benefit tiers. This would suggest that they were willing to forego richer coverage (higher tiers) among certain categories for a broader coverage plan (more categories). They were also consistent from Round 1 to Round 4 in terms of having coverage in the following optional categories: Hospital Care, Pharmacy, Primary Care, Scans and X-Rays, Specialty Care, Tests, and Dental/Vision. Categories that saw at least an 8% point *increase* from Round 1 to Round 4 were Mental Behavioral (from 68.5% to 87.9%), Prevention (75.4% to 87.9%), Rehab Services (76.9% to 88.9%), and Last Chance (44.2% to 52.3%). Those categories that showed *decreases* from Round 1 to Round 4 were Quality of Life (14.5% to 5.6%) and Complementary (24.6% to 17.6%). Finally, 82% of CHAT participants made at least one change in coverage choices from Round 1 to Round 4.

### **Round 3: Summary Findings**

In general, 100% of the groups chose coverage in seven of the thirteen optional categories: Hospital Care, Pharmacy, Prevention, Primary Care, Scans and X-Rays, Specialty Care, and Tests. Over 90% of the Round 3 groups chose coverage in: Mental Behavioral and Rehab Services. Like the preceding analysis, Complementary (9%) and Quality of Life (0%) were rarely selected to be a part of a core benefit plan. Finally, Tier 1 coverage was the choice for all selected categories except two: Hospital Care and Pharmacy, which in the majority of cases garnered Tier 2 coverage.

### **Urban vs. Rural: Summary Findings**

Regardless of geographic status, nearly 100% of all participants selected Hospital Care, Pharmacy, Primary Care, and Scans and X-Rays to be a part of a basic benefit plan. By Round 4, Specialty Care and Tests reached the 98% level. The Mental Behavioral category saw the largest percentage *increases* from Round 1 to Round 4 in BOTH the rural and urban categories, from 63.5% to 83.1% and 75.7% to 94%, respectively. But there was a difference between rural and urban in the percentage who felt it should be a part of a core benefit plan, 83% vs. 94%. Finally, among rural participants, the most

common change between Round 1 and Round 4 was from NO coverage to SOME coverage for Mental Behavioral and Dental/Vision. Among the urban participants, the most common change between Round 1 and Round 4 was an increase in the benefit tier (from 1 to 2 or higher) for Mental Behavioral and from Tier 1 coverage to NO coverage for Dental/Vision.

### **Insured vs. Uninsured: Summary Findings**

Regardless of insurance coverage status, nearly 100% of participants selected coverage in Hospital Care, Pharmacy, Primary Care, and Scans and X-Rays. Among five other categories, the percentage increases between Round 1 and Round 4, for BOTH the insured and uninsured were significant. For the insured, the increase range was from 7% (99.2% to 99.9%) for Tests to 18% (70.6% to 89.3%) for Mental Behavioral. For the uninsured, the increase range was from 6% (88.5% to 94.8%) for Tests to 24% (59.0% to 82.8%) for Mental Behavioral. Specialty Care, Rehab Services and Prevention fell somewhere in between. Among the required categories, the uninsured were more likely to expand tier coverage (33%-Co-Pays and 47%-Premium) from Tier 1 to Tier 2/3 than the insured (28%-Co-Pays and 39%-Premium). Finally, the insured went from NO coverage for Dental/Vision in Round 1 to Tier 1 coverage for Dental/Vision in Round 4. For the uninsured, the exact opposite occurred; they dropped coverage completely in Round 4 from having coverage in Round 1.

### **Income Ranges: Summary Findings**

While there were five income ranges offered in the pre-CHAT survey, the data was aggregated into three categories: less than \$35,000, \$35,000-\$90,000, and over \$90,000. Regardless of income range, over 90% of participants selected coverage in the following five categories: Hospital Care, Pharmacy, Primary Care, Specialty Care, and Scans and X-Rays. There were four other optional categories that saw increases from Round 1 to Round 4: Tests, Rehab Services, Prevention, and Mental Behavioral. Among those four categories, the range of increases, by income level, were as follows: Under \$35, 000, a low of 2% (76.3% to 78.1%) for Prevention to a high of 17% (60.5% to 78.1%) for Mental Behavioral; \$35,000-\$90,000, a low of 10% (87.0% to 97.1%) for Tests to a high of 19% (67.8% to 86.9%) for Mental Behavioral; and \$90,000 and above, a low of 3% (96.4% to 100%) for Tests to a high of 21% (71.4% to 92.0%) for Mental Behavioral. Like previous analyses, selection coverage levels for Complementary and Quality of Life were relatively low AND showed declines for *each* income level from Round 1 to Round 4.

One of the post-CHAT questions asked: “If you were to lose your health insurance, would you consider the basic plan you created as a group to be an acceptable plan for yourself?” Over 90% of the respondents considered “their” group-developed plan to be acceptable; only 3.1% answered “disagree” or “strongly disagree.” The favorable responses validate the process itself. Anecdotally, the responses the facilitators received from participants during or after the sessions were equally positive.

## **Concluding Comments**

The CHAT process proved to be a very effective educational tool for both the participants and recipients of their data. Few people, participants included, actually know the specifics of their health plan benefits. This process helped educate consumers about the key components of a health plan as well as the magnitude of the problems associated with the large number of uninsured in this state. More importantly, it forced the participants to make “tough choices” from an important list of benefit options, given the scarcity of resources available.

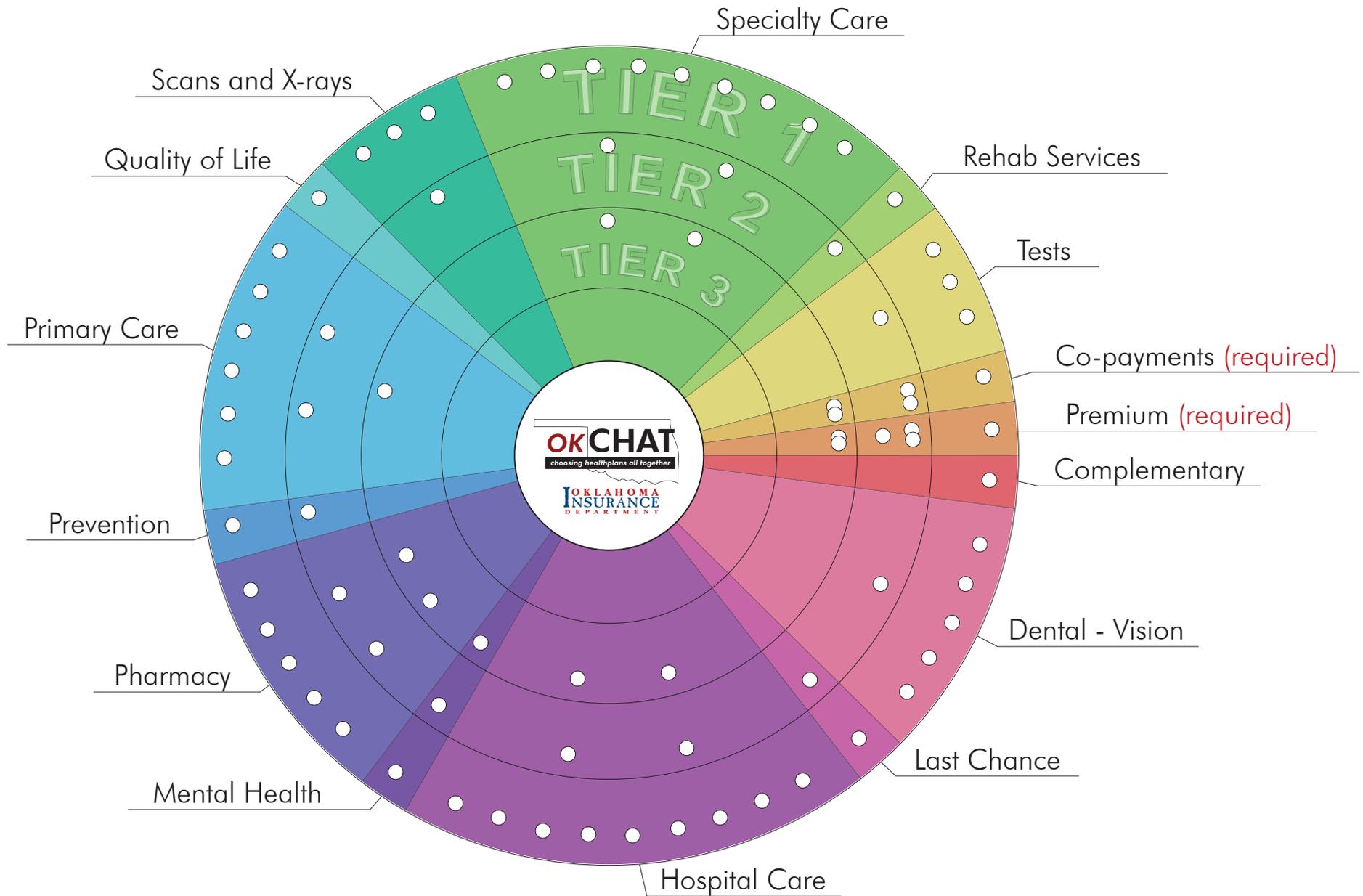
While the total number and the demographic make-up of the participants did not match the “planned ideals” set at the outset of the process, the quality of the data collected is encouraging, and the gaps can be filled with more targeted audiences in the near future. Through the State Coverage Initiative, there is a plan to expand the number of CHAT sessions to supplement our existing set of data. Those sessions will be conducted in the spring and summer months of 2008.

Finally, Oklahoma is the first state in the Union to implement such a comprehensive application of the CHAT process. The principals associated with the CHAT program have applauded our efforts and remain involved in separate research associated with our process. This process also yielded a core team of experienced facilitators, who can either facilitate future sessions and/or train others to do so. Oklahoma legislators now have access to new insights into the health benefit priorities of their constituents. This should assist them in their future deliberations of how to address the high rates of uninsured in this state.

### CHAT Dates and Locations

Date	Day of Week	Time	Location	Facility	Attendance
<b>Southwest</b>					
21-Aug	Tues	1:00	Chickasha	Canadian Valley Technology Center	21
22-Aug	Wed	9:00	Elk City (Sayre)	Western Technology Center	2
22-Aug	Wed	1:00	Altus	Southwest Technology Center	18
23-Aug	Thur	9:00	Lawton	Great Plains Technology Center	5
23-Aug	Thur	1:00	Duncan	Red River Technology Center	16
<b>Northwest</b>					
28-Aug	Tues	1:00	Weatherford	Western Technology Center	13
29-Aug	Wed	9:00	Woodward	High Plains Technology Center	16
29-Aug	Wed	1:00	Ponca City	Pioneer Technology Center	11
30-Aug	Thur	9:00	Enid	Autry Technology Center	21
30-Aug	Thur	4:00	Guymon	Guymon Junior High School	9
<b>Northeast</b>					
11-Sep	Tues	4:00	Miami	Miami High School	6
5-Sep	Wed	9:00	Tahlequah	NSU	7
13-Sep	Wed	1:00	Muskogee	Indian Capital Technology Center	12
6-Sep	Thur	9:00	Bartlesville	Tri County Technology Center	8
6-Sep	Thur	1:00	Pryor	Northeast Technology Center	9
10-Sep	Mon	4:00	Grove	Grove High School	3
<b>Southeast</b>					
11-Sep	Tues	1:00	Broken Bow (Idabel)	Kiamichi Technology Center	6
12-Sep	Wed	9:00	McAlester	Kiamichi Technology Center	5
12-Sep	Wed	2:00	Poteau	Carl Albert College	9
15-Nov	Thur	9:00	Durant	REI	12
13-Sep	Thur	1:00	Ada	Pontotoc Technology Center	14
<b>OKC Metro</b>					
11-Sep	Tues	9:00	Norman	Moore Norman Technology Center	9
11-Sep	Tues	1:00	Edmond	Francis Tuttle Technology Center	4
12-Sep	Wed	9:00	Yukon	Canadian Valley Technology Center	6
12-Sep	Wed	1:00	OKC	Springlake Technology Center	10
13-Sep	Thur	9:00	OKC	Mid-Del Technology Center	8
13-Sep	Thur	1:00	OKC	Francis Tuttle Technology Center	16
18-Sep	Tues	9:00	Shawnee	Gordon Cooper Technology Center	10
<b>Tulsa Metro</b>					
18-Sep	Tues	1:00	Tulsa	Tulsa Technology Center	11
19-Sep	Wed	9:00	Tulsa	Tulsa Technology Center	11
19-Sep	Wed	1:00	Tulsa	Tulsa Technology Center	6
20-Sep	Thur	9:00	Owasso	Owasso Student Services Center (Barnes Elementary)	8
20-Sep	Thur	1:00	Sapulpa	Central Technology Center	4
25-Sep	Tues	9:00	Broken Arrow	TCC SE campus	11
25-Sep	Tues	1:00	Stillwater	Meridian Technology Center	14
<b>Special Sessions</b>					
17-Sep	Mon	9:00	Morton	Morton Health Center (Tulsa)	11
27-Sep	Thur	9:00	Native American	Cherokee Nation (Tahlequah)	9
28-Sep	Fri	9:00	Small Business	TTC (Tulsa)	14
28-Sep	Fri	1:00	Hispanic	OU-Tulsa	5
29-Sep	Sat		MPH Students	OU Schustermann - Tulsa	11
11-Oct	Thur	5:00	Physicians	Springlake Metro Tech	16
24-Oct	Wed	9:00	Health Plans	Springlake Metro Tech	9
TBD	TBD	TBD	Uninsured	Springlake Metro Tech	
<b>Town Halls</b>					
28-Aug	Tues	5:00	Lawton Town Hall	Great Plains Technology Center	
4-Sep	Tues	5:00	Enid Town Hall	Autry Technology Center	
13-Sep	Thur	5:00	Muskogee Town Hall	Indian Capital Technology Center	
18-Sep	Tues	5:00	Ada Town Hall	Pontotoc Technology Center	
3-Oct	Thur	5:00	OKC Town Hall	Francis Tuttle Technology Center	
23-Oct	Tues	5:00	Tulsa Town Hall	Tulsa Technology Center	

**Total Attendance      426**



## CHAT SERVICES AND TIERS

**Complementary** – These are various types of “alternative” treatments that some people use.

**Tier 1** – 1 Marker

Covers up to 10 visits per year of chiropractor for back or neck problems and acupuncture and acupressure for pain.

**Tier 2** – This level of coverage is not available.

**Tier 3** – This level of coverage is not available.

**Dental – Vision** – For preventing and treating dental problems; testing and correcting for problems with eyesight.

**Tier 1** – 5 Markers

Dental care only. Cleanings, x-rays yearly without co-payment. Basic dental services are 80% covered, such as emergencies, cavities, oral surgery. Max. coverage is \$1,000 yr.

**Tier 2** – 5 + 1 Markers

In addition to Dental Care in Tier 1, also covers Vision Care which is vision testing once a year, if needed. Covers \$75 towards glasses every 2 years but not contact lenses.

**Tier 3** – This level of coverage is not available.

**Last Chance** – When there is a very serious or life-threatening situation, this is for extraordinary, uncommon treatments if customary care no longer is helping the patient.

**Tier 1** – 1 Marker

Covers treatments like heart transplants (and other major medical care to very serious conditions) but ONLY if the procedure has a good chance of helping the patient.

**Tier 2** – 1 + 1 Markers

Covers all uncommon treatments, even those that have a very small chance of helping – but are the only hope left. Example: a \$50,000 cancer treatment that might extend a patient’s life by several months.

**Tier 3** – This level of coverage is not available.

**Hospital Care** – For coverage of in-patient services when the doctor determines that it is needed. Does not include mental health care.

**Tier 1** – 9 Markers

There is no choice of hospital to go to. For non-emergency care, patients may be required to go to a hospital outside their community.

**Tier 2** – 9 + 2 Markers

There is a larger selection of hospitals but there are still some restrictions on choice.

**Tier 3** – 9 + 2 + 2 Markers

The patient can go to any hospital he or she prefers.

**Mental – Behavioral** – For detecting and treating mental illness. Also covers treatment for unhealthy habits like over-eating, smoking and substance addiction.

**Tier 1** – 1 Marker

Covers treatment of severe mental illness. Examples: bipolar disease, severe depression and schizophrenia. Includes hospital stay, therapy and medicine. Does NOT provide treatment for over-eating, smoking, alcohol or other addiction problems.

**Tier 2** – 1 + 1 Markers

In addition to Tier 1, covers short-term therapy and medicine for less severe mental health problems like mild depression or anxiety. Also covers counseling and medicine for obesity, smoking, alcohol and drug addiction problems.

**Tier 3 – 1 + 1 + 1 Markers**

Coverage is better than in Tier 2. Includes long-term therapy for all types of mental health problems. Also covers bariatric surgery for obesity and in-hospital treatment for alcohol and drug addiction, if no other treatment has helped.

**Pharmacy** – These are the medicines that doctors prescribe for patients.

**Tier 1 – 5 Markers**

Covers the least costly medications that are proven to be effective for most people. More costly ones, like many brand-name drugs, must be paid entirely by the patient.

**Tier 2 – 5 + 2 Markers**

Besides Tier 1, this also covers more expensive drugs if less expensive ones are not working for the patient. Doctor must follow expert guidelines for when to use those costly drugs.

**Tier 3 – 5 + 2 + 2 Markers**

The doctor can prescribe any medicine that he or she thinks might help the patient.

**Prevention** – Education and screening tests that identify problems early or help people stay as healthy as possible. Includes a Health Review form and Care Management for people having trouble managing their medical problem.

**Tier 1 – 1 Marker**

Covers routine prevention such as flu shots, PAP tests and colon exam at age 50. Patients complete a Health Review form and must participate in a Care Management program if the doctor says to.

**Tier 2 – 1 + 1 Markers**

Same as Tier 1, but the patient does NOT have to complete a Health Review form or attend a Care Management program if he or she doesn't want to.

**Tier 3** – This level of coverage is not available.

**Primary Care** – These are the healthcare providers for patients' regular medical care, including short-term conditions like strep throat, pregnancy and minor injuries, as well as for chronic conditions like asthma or diabetes.

**Tier 1 – 6 Markers**

Medical care is provided by a specific group of primary care doctors in the community; choice of doctor is limited.

**Tier 2 – 6 + 2 Markers**

Medical care is provided by a larger group than Tier 1. While there is greater choice of doctors, there are still restrictions on which doctors can be used.

**Tier 3 – 6 + 2 + 1 Markers**

Medical care is provided by any primary care doctor that the patient chooses.

**Quality of Life** – For problems in function, appearance or comfort that are not seriously disabling but may impact quality of life. Examples: treatment for infertility, impotence, hair loss and for problems that impair athletic ability.

**Tier 1 – 1 Marker**

Covers all drugs, medical and surgical treatment to try and correct problems like these.

**Tier 2** – This level of coverage is not available.

**Tier 3** – This level of coverage is not available.

**Scans and X-rays** – These are x-rays and high-tech scans (such as CAT scans and MRIs) that help identify certain medical problems.

**Tier 1 – 3 Markers**

Doctor must follow expert guidelines when ordering expensive scans. This can mean that other treatments must be tried first before a scan is ordered. Example: a trial period of rest or therapy for back pain before an MRI is ordered.

**Tier 2 – 3 + 1 Markers**

Doctor does not have to follow expert guidelines for ordering expensive scans.

**Tier 3** – This level of coverage is not available.

**Specialty Care** – Visits with a specialist, including treatments for severe or complex conditions, such as cancer, heart disease and major surgery. These are problems that the primary care doctor does not handle.

**Tier 1 – 9 Markers**

Referrals to specialists are given sparingly by the primary care doctor. Choice of specialist is limited. When the treatment is not life-saving – like hip or knee replacements – there may be a long waiting period.

**Tier 2 – 9 + 2 Markers**

Referrals to specialists are easier to get than Tier 1, but there still are restrictions on choice. Waiting periods for procedures like joint replacements are shorter than in Tier 1.

**Tier 3 – 9 + 2 + 2 Markers**

Referrals to specialists are easily available, there is more choice and waiting times are very short.

**Rehab Services** – For repairing the ability to do basic daily activities (walking, talking, dressing, bathing, working). This is often needed after broken bones, surgery on joints, strokes or amputations.

**Tier 1 – 1 Marker**

Covers all necessary rehab therapies (such as out-patient physical therapy) to improve important functions. Covers artificial limbs but not other patient equipment.

**Tier 2 – 1 + 1 Markers**

In addition to Tier 1, covers basic equipment like crutches and regular wheelchairs. Also covers half the cost of more expensive equipment like electric wheelchairs.

**Tier 3** – This level of coverage is not available.

**Tests** – Laboratory and other testing (such as treadmill tests for the heart) to help diagnose when a medical problem is suspected. This does not include x-rays or scans.

**Tier 1 – 3 Markers**

Urgent problems are tested quickly. If not urgent, the patient may have to wait several weeks or longer for getting tests done.

**Tier 2 – 3 + 1 Markers**

Whether it is urgent or not, patient has very little waiting time to get tests done.

**Tier 3** – This level of coverage is not available.

**Co-Payments – R – (Required)** These are the amounts that people pay when they use health care services. Co-payments are not required for the services in the Prevention category.

**Tier 1 – 1 Marker**

There are co-payments for most services, such as \$30 for doctor or therapist visit. Medication co-payments range from \$15 to \$30; an ER visit is \$150; and a hospital admission co-payment is \$500.

**Tier 2 – 1 + 2 Markers**

Co-payments are lower than in Tier 1. Doctor visits are \$15. Medication co-payments range from \$10 to \$25; an ER visit is \$75; and a hospital admission co-payment is \$250.

**Tier 3 – 1 +2 + 2 Markers**

Co-payments are lower than in Tier 2. Doctor visits are \$5. Medication co-payments range from \$5 to \$10; an ER visit is \$25; and a hospital admission co-payment is \$100.

**Premium – R – (Required)** Most of the monthly \$250 health insurance premium is paid by government and business. This category sets the amount that each individual or family must pay for their portion of the total.

**Tier 1 – 1 Marker**

Each person pays \$80 per month (up to \$300 per family) towards the cost of the health insurance premium.

**Tier 2 – 1 + 3 Markers**

Each person pays \$50 per month (up to \$200 per family) towards the cost of the health insurance premium.

**Tier 3 – 1 + 3 + 2 Markers**

Each person pays \$30 per month (up to \$100 per family) towards the cost of the health insurance premium.

## Comments about CHAT Round 1 and Round 4 Among Rural and Urban Locations

- The percentage of participants who selected coverage in the following categories was similar for rural and urban locations as well as for Round 1 and Round 4. Nearly 100% of participants selected coverage in:
  - Hospital Care
  - Pharmacy
  - Primary Care
  - Scans and X-rays
  
- From Round 1 to Round 4, the percentage of people who selected coverage increased slightly in the following categories; additionally, the percentage of participants who selected coverage was similar for rural and urban locations.
  - Specialty Care
    - approximately 93% in Round 1
    - approximately 98% in Round 4
  - Tests
    - approximately 91% in Round 1
    - approximately 98% in Round 4
  
- In Round 4, the following categories had an increase in the percentage of participants in both rural and urban locations who selected coverage; however, the percentage of participants who chose each category may or may not be the same in rural and urban locations:
  - Prevention
    - In both rounds, the percentage of participants in rural and urban locations who chose coverage was approximately the same
      - The percentage of rural participants who selected coverage increased from 74% in Round 1 to 87% in Round 4
      - The percentage of urban participants who selected coverage increased from 78% in Round 1 to 89% in Round 4
  - Rehab and Services
    - In both rounds, a larger percent of participants in urban locations selected coverage than in rural locations
      - The percentage of rural participants who selected coverage increased from 73% in Round 1 to 87% in Round 4
      - The percentage of urban participants who selected coverage increased from 83% in Round 1 to 92% in Round 4
  - Mental Behavior
    - In both rounds, a larger percent of participants in urban locations selected coverage than in rural locations
      - The percentage of rural participants who selected coverage increased from 64% in Round 1 to 83% in Round 4
      - The percentage of urban participants who selected coverage increased from 76% in Round 1 to 94% in Round 4

- In Round 4, the following categories had a decrease in the percentage of participants in both rural and urban locations who selected coverage:
  - Complementary
    - In both rounds, the percentage of participants in rural and urban locations who chose coverage was approximately the same
      - The percentage of rural participants who selected coverage decreased from 24% in Round 1 to 18% in Round 4
      - The percentage of urban participants who selected coverage decreased from 26% in Round 1 to 17% in Round 4
  - Quality of Life
    - In both rounds, a larger percent of participants in rural locations selected coverage than in urban locations
      - The percentage of rural participants who selected coverage decreased from 19% in Round 1 to 7% in Round 4
      - The percentage of urban participants who selected coverage decreased from 9% in Round 1 to 4% in Round 4
  
- The pattern of change from Round 1 to Round 4 was different for participants in rural and urban locations in the following categories:
  - Dental/Vision
    - The percentage of participants in rural locations who chose coverage increased slightly from Round 1 to Round 4 (67% to 73%)
    - The percentage of participants in urban locations who chose coverage decreased slightly from Round 1 to Round 4 (65% to 63%)
  - Last Chance
    - The percentage of participants in rural locations who chose coverage remained similar in Round 1 and Round 4 (45% and 48%)
    - The percentage of participants in urban locations who chose coverage increased from Round 1 to Round 4 (44% to 58%)
  
- Differences between rural and urban locations in the most common changes participants made to their plans from Round 1 to Round 4
  - Among Rural participants, the most common change was no coverage in Round 1 to coverage in Round 4 for:
    - Mental Behavior
    - Dental/Vision
  - Among Urban participants:
    - Mental Behavior – the most common change was an increase in benefit tier
    - Dental/Vision – the most common change was coverage in Round 1 to no coverage in Round 4
      - Although, no coverage in Round 1 to coverage in Round 4 was the second most common change

## Comments about CHAT Round 1 and Round 4 Among Insured and Uninsured Individuals

- The percentage of participants who selected coverage in the following categories was similar for insured and uninsured participants as well as for Round 1 and Round 4. Nearly 100% of participants selected coverage in:
  - Hospital Care
  - Pharmacy
  - Primary Care
  - Scans and X-rays
- From Round 1 to Round 4, the percentage of people who selected coverage increased slightly in the Specialty Care category; additionally, the percentage of participants who selected coverage was similar for insured and uninsured individuals.
  - Specialty Care
    - approximately 92% in Round 1
    - approximately 98% in Round 4
- In Round 4, the following categories had an increase in the percentage of insured and uninsured participants who selected coverage; additionally, the percentage of participants who chose each category was not the same among insured and uninsured individuals:
  - Tests
    - In both rounds, a larger percent of insured participants selected coverage than uninsured participants
      - The percentage of insured participants who selected coverage increased from 92% in Round 1 to 99% in Round 4
      - The percentage of uninsured participants who selected coverage increased from 89% in Round 1 to 95% in Round 4
  - Rehab and Services
    - In both rounds, a larger percent of insured participants selected coverage than uninsured participants
      - The percentage of insured participants who selected coverage increased from 78% in Round 1 to 91% in Round 4
      - The percentage of uninsured participants who selected coverage increased from 74% in Round 1 to 83% in Round 4
  - Prevention
    - In both rounds, a larger percent of insured participants selected coverage than uninsured participants
      - The percentage of insured participants who selected coverage increased from 77% in Round 1 to 89% in Round 4
      - The percentage of uninsured participants who selected coverage increased from 66% in Round 1 to 83% in Round 4
  - Mental Behavior
    - In both rounds, a larger percent of insured participants selected coverage than uninsured participants
      - The percentage of insured participants who selected coverage increased from 71% in Round 1 to 89% in Round 4
      - The percentage of uninsured participants who selected coverage increased from 59% in Round 1 to 83% in Round 4

- In Round 4, the following categories had a decrease in the percentage of both insured participants and uninsured participants who selected coverage:
  - Complementary
    - In both rounds, the percentage of insured and uninsured participants who chose coverage was approximately the same
      - The percentage of insured participants who selected coverage decreased from 24% in Round 1 to 18% in Round 4
      - The percentage of uninsured participants who selected coverage decreased from 25% in Round 1 to 17% in Round 4
  - Quality of Life
    - In both rounds, the percentage of insured and uninsured participants who chose coverage was approximately the same
      - The percentage of insured participants who selected coverage decreased from 15% in Round 1 to 6% in Round 4
      - The percentage of uninsured participants who selected coverage decreased from 15% in Round 1 to 5% in Round 4
- The pattern of change from Round 1 to Round 4 was different for insured and uninsured participants in the following categories:
  - Dental/Vision
    - The percentage of insured participants who chose coverage increased slightly from Round 1 to Round 4 (64% to 68%)
    - The percentage of uninsured participants who chose coverage decreased from Round 1 to Round 4 (77% to 66%)
  - Last Chance
    - The percentage of insured participants who chose coverage increased slightly in Round 1 and Round 4 (47% and 52%)
    - The percentage of uninsured participants who chose coverage increased dramatically from Round 1 to Round 4 (33% to 52%)
- Differences among insured and uninsured individuals in the most common changes participants made to their plans from Round 1 to Round 4
  - Among insured participants, the most common change was no coverage in Round 1 to coverage in Round 4 for:
    - Dental/Vision
  - Among uninsured participants:
    - Dental/Vision – the most common change was coverage in Round 1 to no coverage in Round 4

## Comments about CHAT Round 1 and Round 4 Among Yearly Household Income Levels

- The percentage of participants who selected coverage in the following categories was at least 90% for all income levels as well as for Round 1 and Round 4:
  - Hospital Care
  - Pharmacy
  - Primary Care
  - Specialty Care
  - Scans and X-rays

### **There was an increase in the percentage of participants in all income levels that selected coverage in the following categories:**

- Tests
  - In Round 1, a greater percentage of participants with the highest yearly household income selected coverage:
    - Less than \$35,000: 90% of participants selected coverage
    - \$35,000 to \$90,000: 87% of participants selected coverage
    - \$90,000 or more: 96% of participants selected coverage
  - However, in Round 4, the percentage of participants who selected coverage was similar in all income levels:
    - Less than \$35,000: 97% of participants selected coverage
    - \$35,000 to \$90,000: 97% of participants selected coverage
    - \$90,000 or more: 100% of participants selected coverage
- Rehab and Services
  - In Round 1, a greater percentage of participants with the highest yearly household income selected coverage:
    - Less than \$35,000: 74% of participants selected coverage
    - \$35,000 to \$90,000: 74% of participants selected coverage
    - \$90,000 or more: 81% of participants selected coverage
  - In Round 4, the percentage of participants who selected coverage increased in all income levels; however, the highest income level still had the greatest percentage of participants that selected coverage:
    - Less than \$35,000: 84% of participants selected coverage
    - \$35,000 to \$90,000: 86% of participants selected coverage
    - \$90,000 or more: 94% of participants selected coverage
- Prevention
  - In Round 1, the smallest percentage of participants that selected coverage was in the middle household income level:
    - Less than \$35,000: 76% of participants selected coverage
    - \$35,000 to \$90,000: 71% of participants selected coverage
    - \$90,000 or more: 80% of participants selected coverage
  - In Round 4, the percentage of participants who selected coverage increased in all income levels; however, the lowest income level had the smallest percentage of participants that selected coverage:
    - Less than \$35,000: 78% of participants selected coverage
    - \$35,000 to \$90,000: 88% of participants selected coverage
    - \$90,000 or more: 91% of participants selected coverage

- Mental Behavior
  - In Round 1, the smallest percentage of participants that selected coverage was in the lowest household income level, while the greatest percentage of participants that selected coverage was in the highest income level:
    - Less than \$35,000: 61% of participants selected coverage
    - \$35,000 to \$90,000: 68% of participants selected coverage
    - \$90,000 or more: 71% of participants selected coverage
  - In Round 4, the percentage of participants that selected coverage increased in all income levels, but remained the smallest in the lowest household income level and the greatest in the highest income level:
    - Less than \$35,000: 78% of participants selected coverage
    - \$35,000 to \$90,000: 87% of participants selected coverage
    - \$90,000 or more: 92% of participants selected coverage

**There was a decrease in the percentage of participants in all income levels that selected coverage in the following categories:**

- Complementary
  - In Round 1, the greatest percentage of participants that selected coverage was in the lowest household income level, while the smallest percentage of participants that selected coverage was in the highest household income level :
    - Less than \$35,000: 37% of participants selected coverage
    - \$35,000 to \$90,000: 23% of participants selected coverage
    - \$90,000 or more: 21% of participants selected coverage
  - In Round 4, the percentage of participants that selected coverage decreased in all income levels, but remained greatest in the lowest income level:
    - Less than \$35,000: 25% of participants selected coverage
    - \$35,000 to \$90,000: 17% of participants selected coverage
    - \$90,000 or more: 17% of participants selected coverage
- Quality of Life
  - In Round 1, the greatest percentage of participants that selected coverage was in the lowest household income level, while the smallest percentage of participants that selected coverage was in the highest household income level :
    - Less than \$35,000: 24% of participants selected coverage
    - \$35,000 to \$90,000: 15% of participants selected coverage
    - \$90,000 or more: 11% of participants selected coverage
  - In Round 4, the percentage of participants that selected coverage decreased in all income levels, but remained greatest in the lowest income level:
    - Less than \$35,000: 9% of participants selected coverage
    - \$35,000 to \$90,000: 7% of participants selected coverage
    - \$90,000 or more: 4% of participants selected coverage

**The change in the percentage of participants that selected coverage was different among the three income levels in the following categories:**

- Dental/Vision
  - In Round 1, the greatest percentage of participants that selected coverage was in the lowest household income level, while the two higher income levels had a smaller percentage of participants that selected coverage:
    - Less than \$35,000: 90% of participants selected coverage
    - \$35,000 to \$90,000: 63% of participants selected coverage

- \$90,000 or more: 64% of participants selected coverage
  - In Round 4, the percentage of participants that selected coverage decreased in the lowest income level, increased in the middle income level, and remained about the same in the highest income level:
    - Less than \$35,000: 75% of participants selected coverage
    - \$35,000 to \$90,000: 70% of participants selected coverage
    - \$90,000 or more: 65% of participants selected coverage
- Last Chance
  - In Round 1, the smallest percentage of participants that selected coverage was in the highest household income level, while the two lower income levels had a greater percentage of participants that selected coverage and were similar to one another:
    - Less than \$35,000: 47% of participants selected coverage
    - \$35,000 to \$90,000: 47% of participants selected coverage
    - \$90,000 or more: 41% of participants selected coverage
  - In Round 4, the percentage of participants that selected coverage increased in the highest income level to become the greatest percentage of participants that selected coverage, while it remained about the same as in Round 1 in the two lower income levels:
    - Less than \$35,000: 50% of participants selected coverage
    - \$35,000 to \$90,000: 47% of participants selected coverage
    - \$90,000 or more: 56% of participants selected coverage

#### **Most commonly chosen benefit tiers:**

- Differences in chosen benefit tier in Round 4 among income levels
  - Among participants in the two highest income levels:
    - Benefit Tier 2 was the most commonly chosen tier for Hospital Care and Pharmacy
    - Benefit Tier 1 was the most commonly chosen tier for all other categories
  - Among participants in the lowest income level:
    - Benefit Tier 2 was the most commonly chosen tier for Mental Behavior
    - Benefit Tier 1 was the most commonly chosen tier for all other categories

#### **Most common changes from Round 1 to Round 4:**

- Differences in the most common changes participants made to their plans from Round 1 to Round 4 among income levels
  - Co-payments:
    - Participants in the highest income level were equally as likely to decrease benefit tiers as they were to increase benefit tiers
    - Participants in the lower two income levels were most likely to decrease benefit tiers
  - Pharmacy:
    - Participants in the lowest income level were most likely to increase benefit tiers
    - Participants in the higher two income levels were most likely to decrease benefit tiers
  - Scans and X-rays:
    - Participants in the lowest income level were equally as likely to decrease benefit tiers as they were to increase benefit tiers

- Participants in the higher two income levels were most likely to decrease benefit tiers
- Rehab and Services:
  - Participants in the lowest income level were most likely to increase benefit tiers
  - For participants in the higher two income levels, the most common change was no coverage in Round 1 to coverage in Round 4
- Prevention:
  - For participants in the lowest income level, the most common change was coverage in Round 1 to no coverage in Round 4
  - For participants in the higher two income levels, the most common change was no coverage in Round 1 to coverage in Round 4
- Dental/Vision:
  - Participants in the lowest income level were equally as likely to decrease benefit tiers as they were to increase benefit tiers
  - For participants in the higher two income levels, the most common change was no coverage in Round 1 to coverage in Round 4



# CHAT Group Comparisons

**Commissioner Kim Holland**  
*Oklahoma Insurance Department*

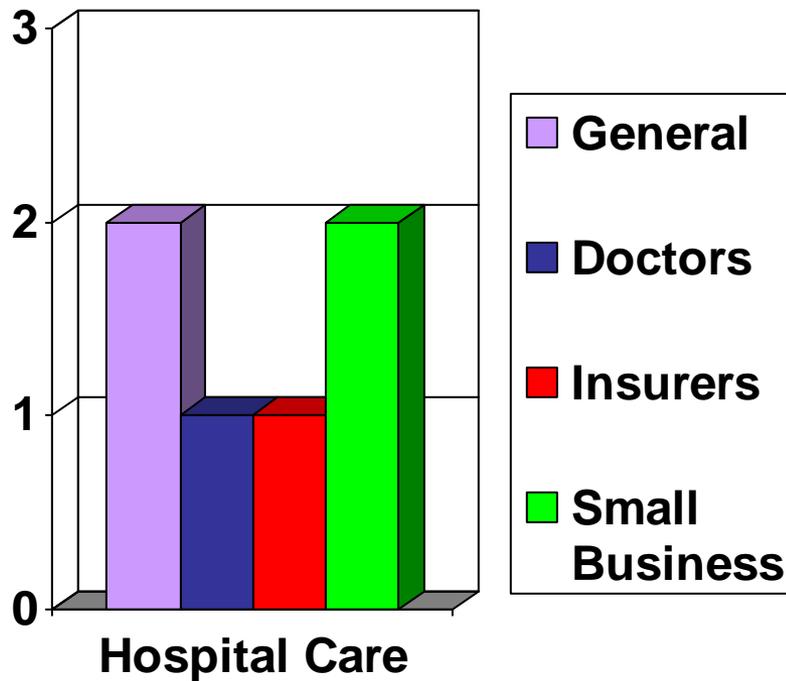


## Utilizing Round 3 Consensus Data

- **General** – 400+ members of 31 statewide communities
- **Doctors** – 16 practicing physicians
- **Insurers** – 9 members of Oklahoma Association of Health Plans
- **Small Business** – 14 State Chamber members



# Group Comparisons

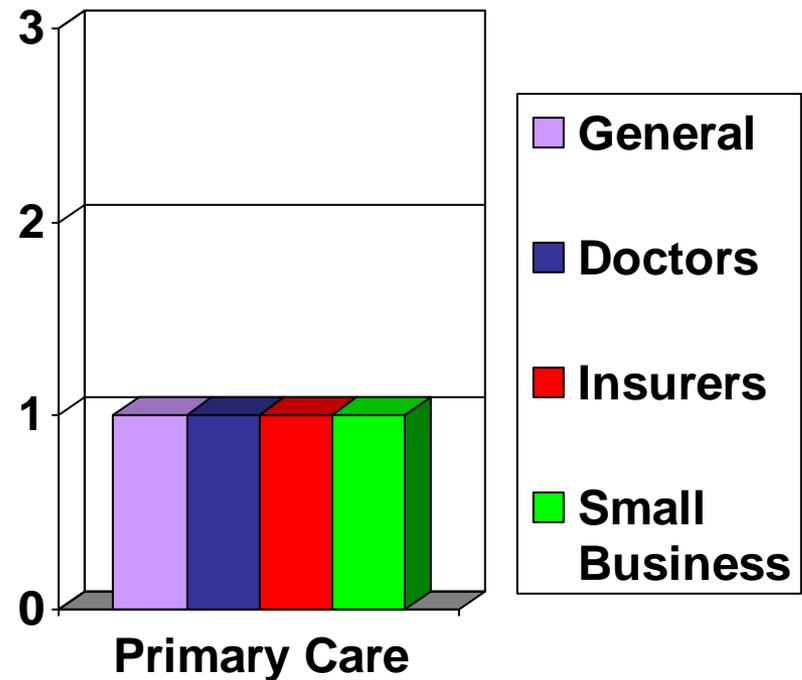


- Increase in Tier indicated desire to have more “choice” of access to hospitals



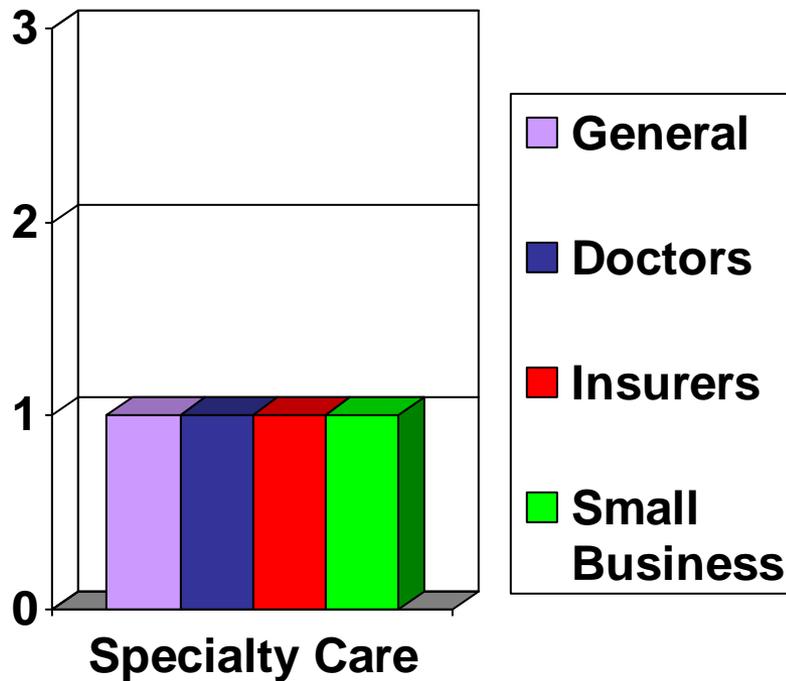
# Group Comparisons

- Increase in Tier would indicate a greater “choice” in selecting a primary care physician





# Group Comparisons

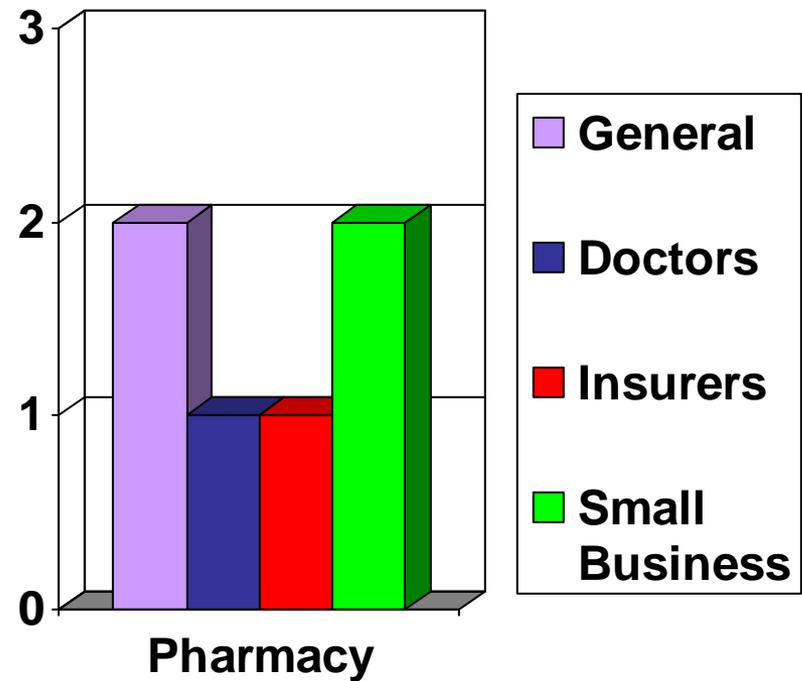


- Increase in Tier would give insured lower wait times and increased access via referral



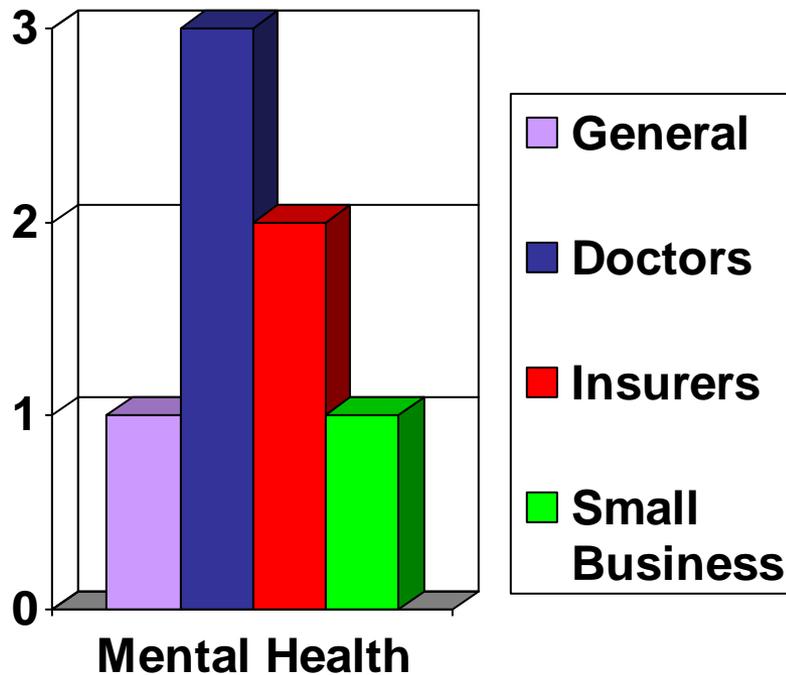
# Group Comparisons

- Increase in Tier indicated desire for greater access to “name brand” prescription drugs





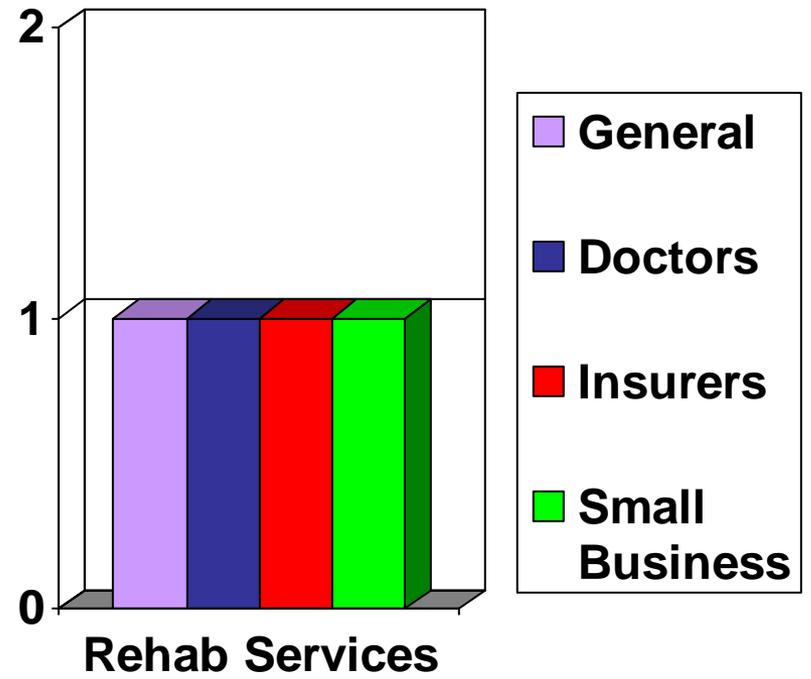
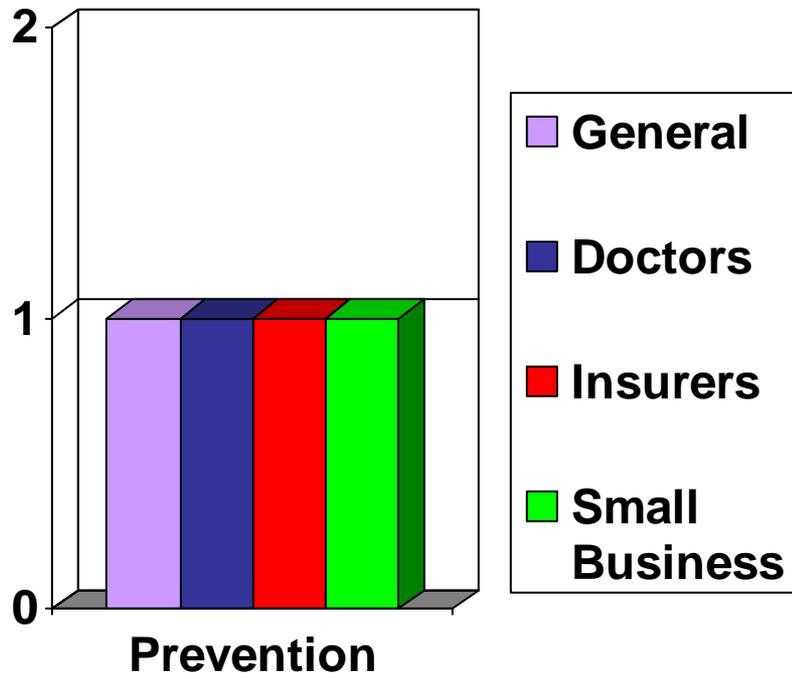
# Group Comparisons



- Increase in Tier indicated expansion of services to include (Tier 2) behavioral addictions and (Tier 3) long-term therapy

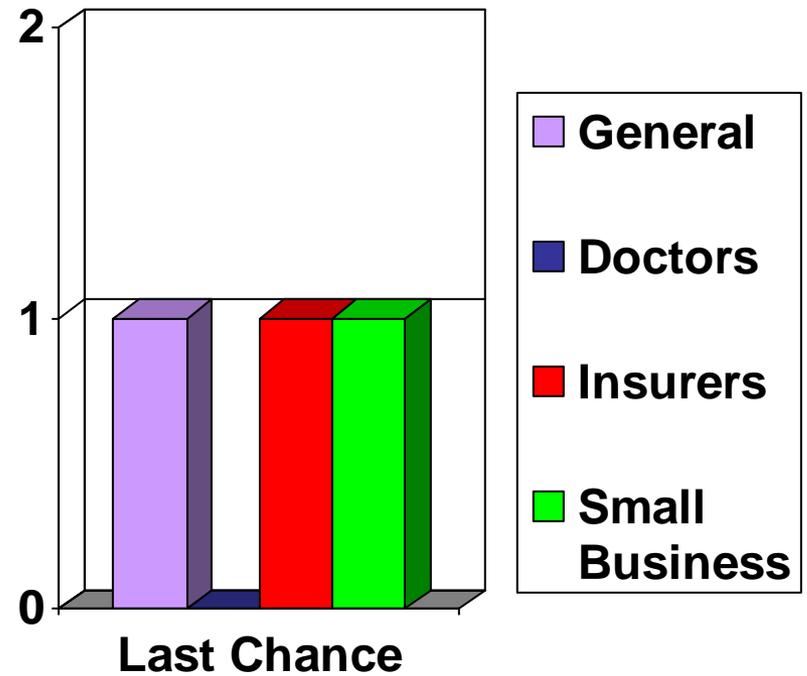
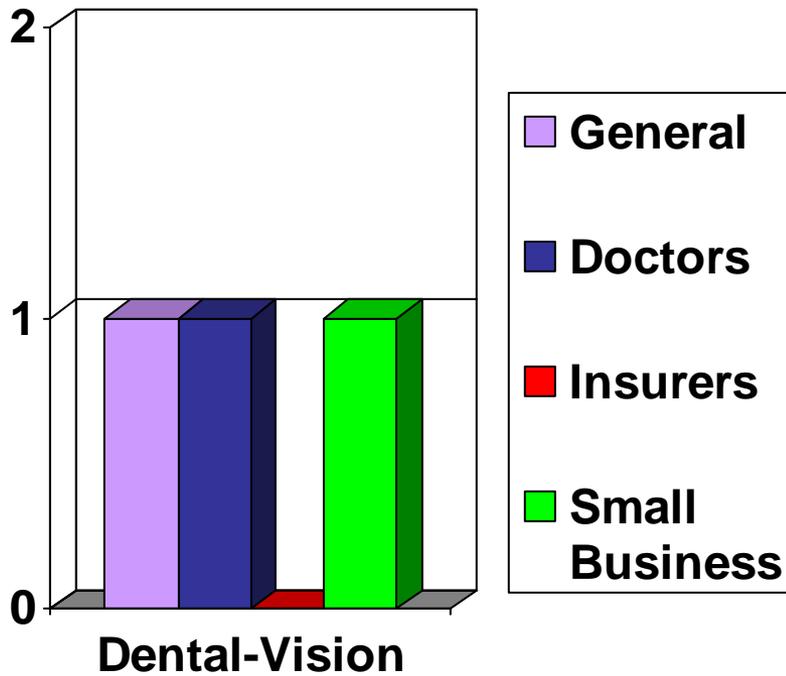


# Group Comparisons



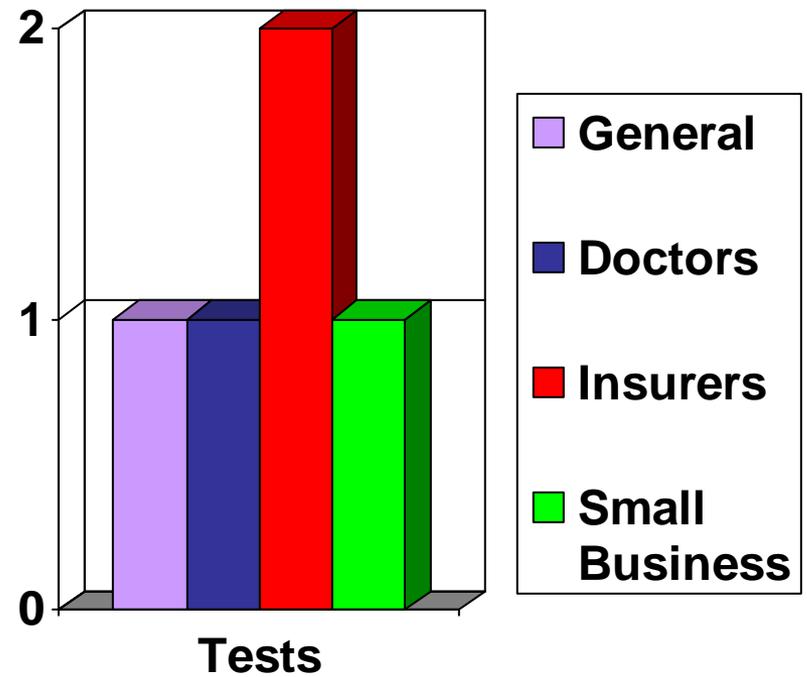
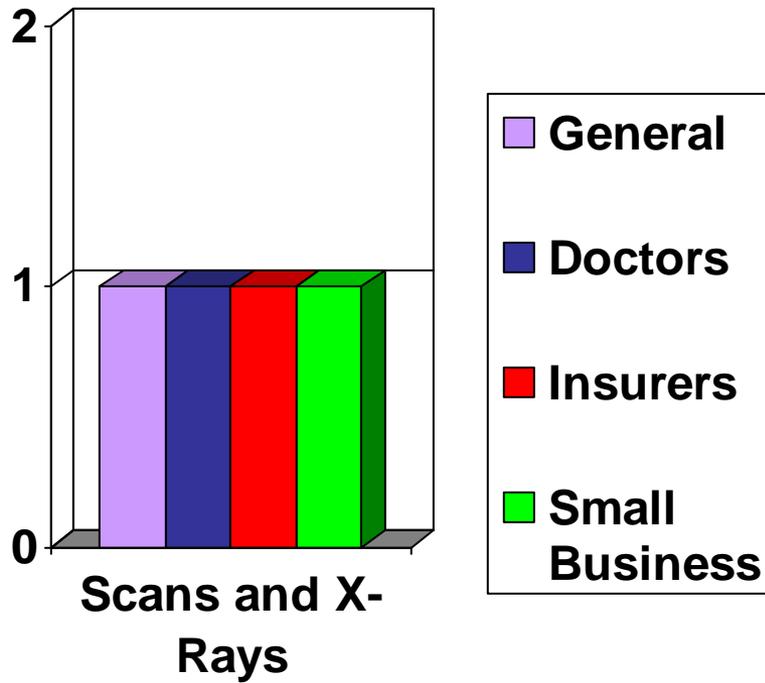


# Group Comparisons



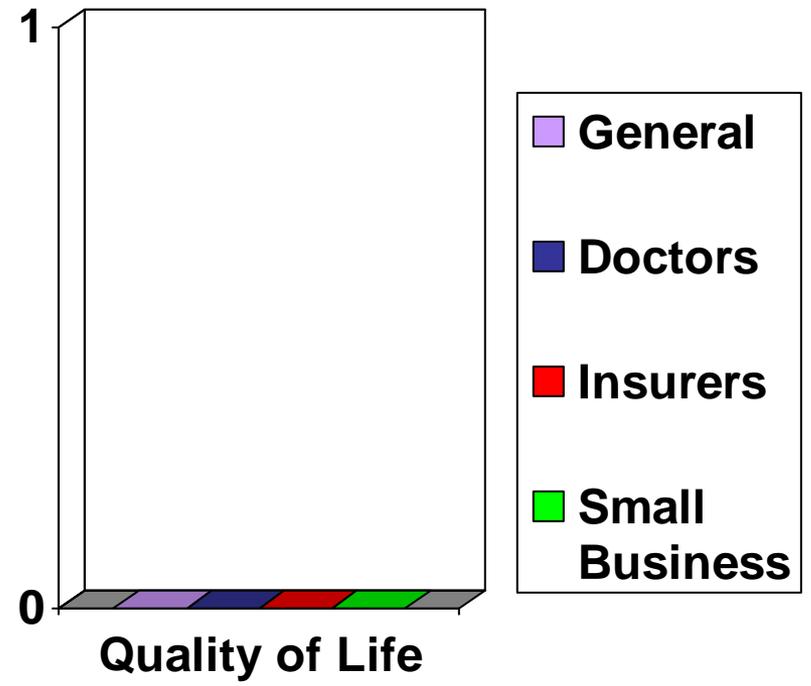
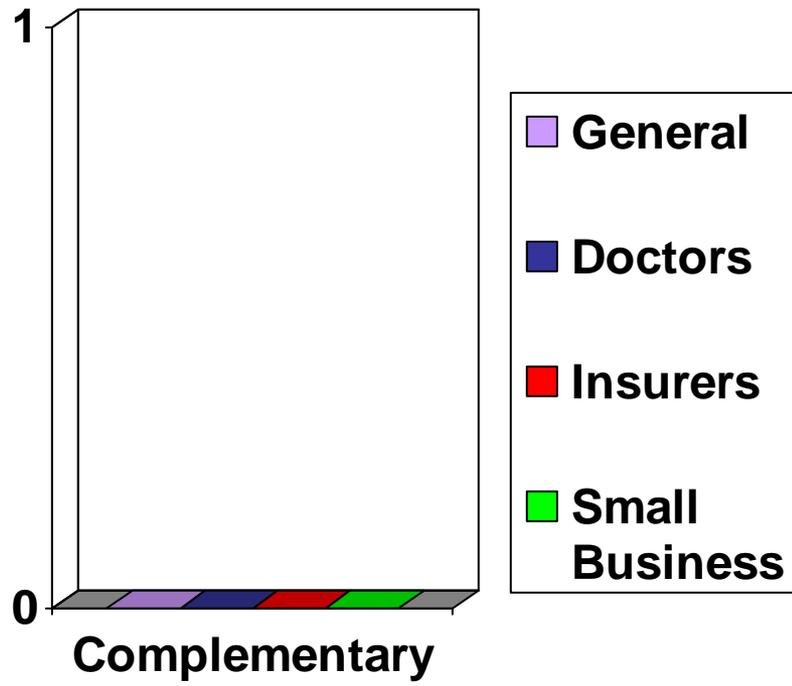


# Group Comparisons



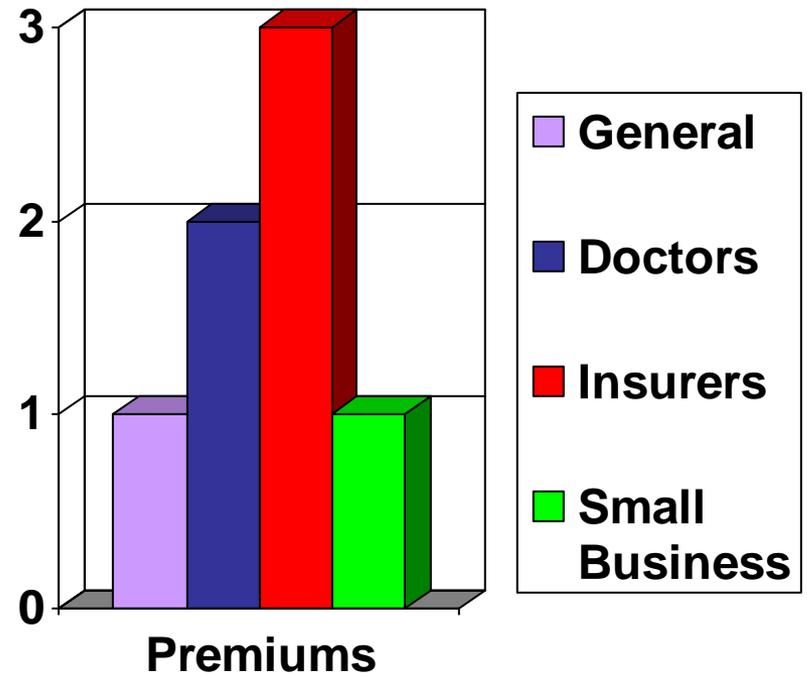
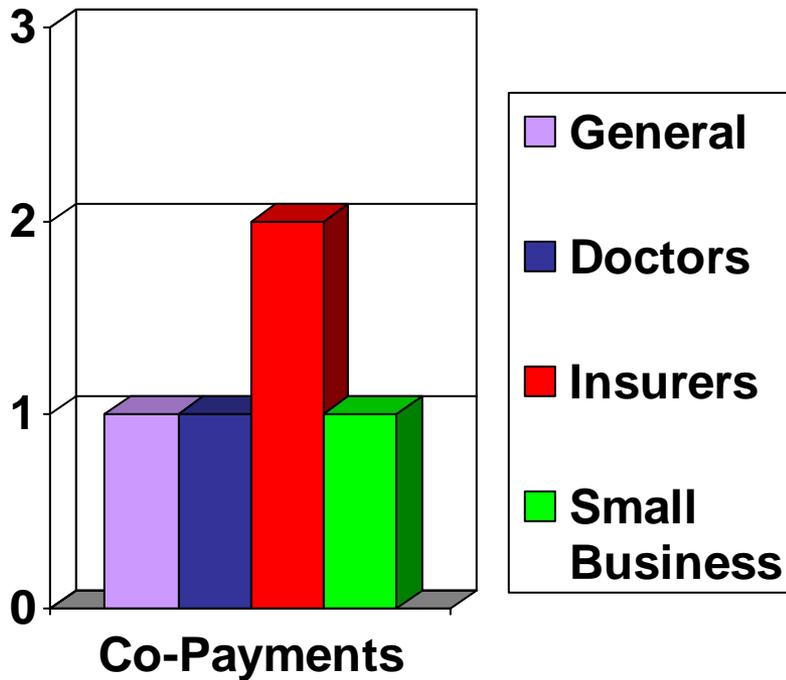


# Group Comparisons





# Group Comparisons



Institute of Medicine Principals on Health Care  
Adopted by The Core Health Benefits Task Force

We agree that health care in Oklahoma should be:

- Safe – avoiding injuries to patients from the care that is intended to help them
- Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit
- Patient-centered – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions
- Timely – reducing waits and sometimes harmful delays for both those who receive and those who give care
- Efficient – avoiding waste, including waste of equipment, supplies, ideas, and energy
- Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status

# The Nation's Uninsured

## "How does Oklahoma compare?"

Kaiser State Health Facts, Oklahoma Health Insurance Coverage, Based on analysis of the U.S. Census Bureau March 2005 and 2006 Current Population Survey, Annual Social and Economic Supplement, representing 2-year averages.

United States				
	All Ages	Children 0-18 years	Adults 19-64 years	Elderly 65+ years
Total Number Uninsured	46,994,627	9,442,071	37,011,340	541,216
Percent Uninsured	16%	12%	20%	1%

Oklahoma				
	All Ages	Children 0-18 years	Adults 19-64 years	Elderly 65+ years
Total Number Uninsured	644,292	113,735	524,480	6,077
Percent Uninsured	19%	12%	25%	1%

Source: <http://www.statehealthfacts.org/profilecat.jsp?rqn=38&cat=3>