COMMISSION ON OKLAHOMA HEALTH CARE

REPORT TO THE LEGISLATURE AND GOVERNOR

DECEMBER, 1993

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EXECUTIVE SUMMARY

Problems within the health care system have become the focus of considerable public discussion and debate during recent years. Health care costs have continued to rise, consuming 14% of the Gross Domestic Product in 1992. Without intervention, they are projected to rise to almost 20% of the Gross Domestic Product by the year 2000. Yet meaningful access to health services have been denied to many Americans, including almost 600,000 Oklahomans, because they are uninsured. The Commission has developed recommendations which we believe address many of the problems which currently adversely affect the health care system in Oklahoma.

If national health care reform does not mandate a guaranteed package of health benefits for all Americans, the Commission recognizes that Oklahoma may need to consider whether such a package should be developed for its citizens and, if so, what health services would be included. The Commission recommends that a legislatively-appointed body be created by January 1, 1995 to develop a uniform package of benefits which could be available to all Oklahomans.

The Commission believes that all Oklahomans are entitled to a basic level of health services which emphasizes primary care and preventive services. Legislation should be enacted which restructures graduate medical education to produce more primary care physicians and encourages the use of mid-level providers, such as physicians' assistants, nurse practitioners and nurse midwives in underserved areas. Telemedicine projects should be enhanced to increase access to medical diagnostic and consultative services in rural areas. In addition, the Legislature is encouraged to ensure that adequate funding is available for the Division of Health Care Information to establish formal guidelines and coordinate data collection and exchange of information among public and private health care providers.

Restructuring of the health care delivery system to emphasize more cost-effective methods of service delivery is essential. Managed care systems development should be increased and structured to allow for competing integrated health service delivery networks. To encourage cost-effective care, capitation should be encouraged as the primary strategy to align incentives within the context of integrated delivery networks.

The Commission recognizes that effective cost containment may be achieved only if the health care system is restructured to enhance consumer awareness of costs and responsibility for health care purchases. In addition, cost shifting will be controlled only to the extent that universal coverage for health services which adequately reimburses providers for services rendered is achieved.

The Governor and the Legislature are encouraged to continue the work of the Oklahoma Family Choice Health Plan, which has been funded by the Robert Wood Johnson Foundation to identify and recommend health care financing strategies. The Commission recommends that Family Health Accounts be established through the Oklahoma Health Care Authority.

The Commission recognizes that insurance reform is an important component of any comprehensive reform of the health care system. As state legislation related to insurance reform

is developed, it should be coordinated to the greatest extent possible with expected federal reform. Incentives should be created to encourage individuals and employers to purchase cost-effective plans. A reformed system should rely heavily on market-based incentives and should emphasize patient freedom of choice of providers.

The Commission believes that health care purchasing can be conducted most effectively through health alliances which organize the purchasing power of consumers and allow them to choose their own health care coverage based on cost, quality and personal need. At least one health alliance should be established within the state. The function of the health alliance should be a 'passive price-taker', not a purchaser.

The Commission recommends that an oversight organization be created to set standards for health plans, analyze and distribute information, establish and provide technical support for state health alliances and monitor the implementation of small group health insurance reform. Health alliances should be chartered, non-profit organizations offering health plans which meet established standards.

Reform of the state's medical malpractice system is vital. The Commission recommends that state-approved practice standards be developed which render health practitioners immune from liability if their practice falls within the established standards. The Commission recommends that limited liability be provided by law to fully-licensed professionals, including health care professionals, operating within their scope of practice, who provide services to the needy or indigent without charge. In addition, Oklahoma should abolish rules providing for joint and several liability and replace them with a standard of relative negligence in tort litigation. Oklahoma should also abolish rules and practices which prevent courts from considering collateral sources of payment.

PREFACE

Oklahomans are justifiably proud of their unique history and culture, but they are not unique in the types of problems they face. Like Americans living in other states, they are subject to economic, environmental and national defense developments. They are also affected by the growing health care crisis in this country. While the quality of life in Oklahoma stacks up well against that in many states, on a number of fronts Oklahoma does not fare well when one considers the number of citizens uninsured and the health of its children. Even individuals who have "adequate" health insurance coverage are at the mercy of a system (or non-system) which gives them relatively little control over their own good health and even less over health care costs. In addition, Oklahoma has a large number of geographical areas that are medically underserved.

In initially establishing the Commission on Oklahoma Health Care, the Governor created a forum for addressing many of the issues which bear on the health of Oklahoma's citizens. The Governor understood that there were many factors which were not subject to exclusive state control but were instead influenced by federal law and regulations. Subsequently, the Legislature established the Commission by statute. This was also done with the recognition that state and federal issues both had a bearing on the problems involved. The Commission has worked to initiate the process of reforming the health care system in this state and, consequently, to improve the health of Oklahoma citizens with the provision of cost-effective health care. We must all begin to change our understanding and expectations of what the health care system can and should provide, how much this would cost and who should pay for it. We must also change our behavior to take responsibility for our own good health and for the amount of money which we as a state spend on health care.

The Commission realizes there is no single answer or easy solution. Many problems are now on the table at the federal level. It is not clear what, if any, "legislative solutions" will be enacted there and when such solutions will be offered. There is, however, some reason for encouragement. Oklahoma has begun, like many other states, to address the issues and offer its own solutions. And there is a growing recognition that regardless of which specific approach to reform is adopted many of the basic elements will be the same. These elements will also influence the delivery of health care even if we maintain some ostensible commitment to the status quo. The recommendations submitted in this Report begin to suggest some of the ways in which the system can be reformed to achieve the desired changes in expectations and behavior. They must be considered within the above context. It is only with an understanding of the problems and consensus about acceptable solutions that the goals of good health and better value for health care will be attained.

REPORT TO THE LEGISLATURE AND GOVERNOR

INTRODUCTION

Problems within the health care system have become the focus of considerable public discussion and debate during recent years. However, both state and national attention became focused on health care reform during 1992. Health care costs had continued to rise, consuming 14% of the Gross Domestic Product in that year. Without intervention, they were projected to rise to almost 20% of the Gross Domestic Product by the year 2000. Yet meaningful access to health services had been denied to many Americans, including almost 600,000 Oklahomans, because they were uninsured.

Even prior to the national presidential elections in 1992, many health policy experts, as well as states and the federal government, had developed significant proposals for reform. With the election of President Bill Clinton, health care reform has become one of the highest policy priorities for the nation and the individual states.

Oklahoma responded early to pressures created by rising health care costs and inadequate access to health services within the State. The Commission on Oklahoma Health Care was created by Governor David Walters in February, 1992 to make recommendations for improvement of the health care system in Oklahoma. The Commission was charged by the Governor to consider comprehensive, systemic reform of the health care system rather than just marginal reform. The Commission prepared its Report to the Governor in November, 1992, detailing problems within the system and recommendations for reform. Many complex issues were addressed. The recommendations provided clear direction for future efforts. However, because analysis of the current system and future options for comprehensive reform encompassed a broad range of issues, it became clear very early in the process that development of complete, detailed recommendations could not be completed during 1992.

The Oklahoma State Legislature recognized that continuing the review and analysis of the State's health care system was essential. House Bill 1578 (included in Appendix 4) was passed during the 1992 session, establishing a health care study commission through the Governor's office to continue the work of the previous Commission. The new Commission was directed to prepare a report to the Legislature by January 1, 1994 with a mandate to study a number of specific models for reform, including small insurance models, the Universal Health Care Act which had been introduced during the 1991 legislative session, and a model focusing on the use of individual or family health accounts as a financing mechanism. In addition, the Commission was to review any other appropriate models.

This Report to the Legislature and the Governor contains recommendations for reform which have been developed during the 1993 meetings of the Commission, including two all-day retreats and six public hearings. The recommendations build upon those developed by the Commission in 1992. The Commission has also carefully considered current reform proposed within the state,

in other states and nationally. Because this Commission was designed to represent all aspects of Oklahoma society, and one limited group such as this may not do so, the Commission decided to submit this Report to, and solicit responses from various other interested groups. These responses are included in Appendix 7. We believe the recommendations contained in this Report provide a significant framework for future reform of Oklahoma's health care system.

Much of the work of the Commission was done through subcommittees and this division of labor is reflected in the organization of this Report. Appendix 6 contains reports from four of these subcommittees to allow review of work which was not adopted by the full Commission.

The Commission wishes to strongly emphasize the fact that these recommendations encompass interdependent, system-wide reforms of the health care system, and not single or piecemeal solutions to the problem. If some of these recommendations are extracted and implemented individually, they could potentially exacerbate the current problems in the system. For example, health care providers could be put at risk by the use of a purely capitated approach without concurrent limits on professional liability for actions taken within established practice parameters.

REVIEW OF THE 1992 ACTIVITY OF THE COMMISSION

As mentioned above, at its first meeting the Commission adopted the recommendations of the 1992 Governor's Commission. The following are the Mission Statement, Goals, and Executive Summary from the 1992 Report to the Governor and is included as a policy statement of the 1993 Commission.

1992 MISSION STATEMENT

To develop a systemic approach to the delivery of a continuum of health care such that all citizens of Oklahoma have access to high quality, cost effective health care.

1992 GOALS

1. There must be adequate control of health care costs.
2. Health insurance should be affordable regardless of previous or current medical conditions and not dependent upon present job status.
3. All Oklahomans should have access to health care which emphasizes primary care and prevention.
4. The health of children should be emphasized in any health care system reform.
5. Proposed reforms should be generally acceptable and politically feasible.
6. The reform process should be dynamic and include periodic review and modification.

1992 EXECUTIVE SUMMARY

The Commission has identified skyrocketing health care costs and inadequate access to health services as the two major health care problems facing the citizens of our State. The Commission believes that all Oklahomans have a right to basic health services. All groups - individuals, employers and the government - have a shared responsibility for ensuring that these services are available. However, improved access without meaningful control of health care costs will not lead to successful resolution of current problems. Costs may be influenced significantly by mechanisms which are used to finance health services. The Commission feels that a system of health care financing should be developed based on a market approach, with negotiation and regulation used to assure access and control costs. Reform within the health insurance industry will be essential. Standardized insurance products, claims processing, data collection and records will be important components in any insurance reform. Community rating should be used by insurance companies to set rates, although the Commission has yet to define the parameters of a community rating mechanism. Guaranteed issue coupled with risk sharing mechanisms will improve access for persons with pre-existing conditions or those who are otherwise limited in their ability to obtain insurance coverage.

The Commission believes that the right to health care can best be assured through development of a basic benefit package. Primary care and prevention should be emphasized. Child-oriented services should be available in basic packages, including pre and perinatal services, early developmental screening and immunizations. Consumer education should be stressed in any basic benefits package.

With the increased emphasis on primary care prevention and maintenance measures, the current supply and distribution of health personnel and facilities should be reviewed in order to determine if the current supply and distribution are sufficient to meet the needs of our citizens. Future reform will need to rely on primary care providers. It is essential that institutions of higher education focus on effective training of primary care professionals. Adequate continuing support for health professionals must be provided by these institutions, particularly in rural sites.

Health-related tort reform will be an important mechanism for reducing excessive health care costs. Large malpractice awards and the increasing necessity for physicians to practice defensive medicine have contributed to this problem. The use by health care professionals of practice guidelines based on outcomes research will permit practitioners to provide high quality care without the constant fear of liability.

A public authority model should be the formal organizational structure used to implement reform. This authority should have components for regional and local planning and must have the authority to influence health care costs and services through planning and regulation.

ADDITIONAL 1993 RECOMMENDATIONS

UNIFORM BENEFITS

It is possible that a guaranteed package of health benefits may be mandated through national reform. However, if that does not occur, or if state modifications are allowed, the Commission recognizes that Oklahoma may need to consider whether, or to what extent, a package of benefits should be required for the citizens of the state by insurance carriers or health care delivery systems doing business within the state.

The Commission recommends (subject to nationally-enacted reform provisions) that a legislatively-appointed body be created by January 1, 1995, to develop a uniform benefits package which could be available to all Oklahomans. This body should include a broad representation of health providers and consumers. Development of this package should consider quality, access to services and cost. A range of services should be studied, with an emphasis on preventive, including prenatal care, immunizations and developmental screening for children, along with routine services, catastrophic care and long-term care. In developing a uniform benefits package, professional practice guidelines may provide the standards which are necessary to ensure that realistic and reasonable services are included. Cost-effectiveness of benefits, in the most flexible provider environment, and the availability of financial resources are important factors in determining which benefits should be included. The Commission believes that cost-sharing by patients is an important mechanism for appropriate utilization of health services.

To reduce the risk of decreasing access to health care services not included in the uniform benefits package, the Commission recommends that tax deductibility of insurance premiums for both employers and employees be continued.

ACCESS, HEALTH PERSONNEL AND FACILITIES

As reflected in the Goals which have been adopted by the Commission, we believe that all Oklahomans are entitled to a basic level of health services which emphasizes primary care and preventive services. Primary health care is defined by the Commission as characterized by comprehensive, continuous, first-contact care. The Commission recommends that the leadership of the Graduate Medical Education system recognize the need for more primary care physicians, and support and reinforce all efforts to increase their numbers. Also, using public/private partnerships, telemedicine projects should be significantly expanded to increase access to medical diagnostic and consultative services for rural communities.

Educational opportunities should be expanded by legislation which encourages allied health professionals to serve in underserved urban and rural areas. The Legislature is encouraged to address the problems of availability and accessibility of mid-level providers, such as physicians' assistants, nurse practitioners and nurse midwives, who provide primary care services to many

underserved citizens of the State. Areas to be addressed should include limited prescriptive authority, reimbursement for services and increased funding for training and education.

The State Legislature should provide adequate funding for the Division of Health Care Information to insure that the Division can adequately carry out its mandate to establish formal guidelines and coordinate data collection and exchange of information with entities across the State. In addition, the Legislature should create an advisory board to continue to evaluate the present health care delivery system in Oklahoma, including health personnel, health facilities and reimbursement issues to improve access to services for all Oklahomans.

COST CONTAINMENT AND FINANCE

Development of most of the current health care system reform proposals has been driven by the recognition that skyrocketing health care costs must be contained (see subcommittee report in Appendix 6). Restructuring of the health care delivery system to emphasize more cost-effective methods of service delivery is essential. The Commission recommends the increased development of managed care systems for the delivery of health care with structuring of the system to allow for competing integrated delivery networks. The health care system should align incentives in order to encourage cost-effective care, with capitation as the primary strategy to align incentives within the context of integrated delivery networks.

The Commission recognizes that effective cost containment may only be achieved if the system is restructured to enhance consumer awareness of costs and responsibility for health care purchases. Incentives must be developed which influence individual responsibility for prudent purchasing and appropriate utilization of covered services. Purchasing strategies (i.e., purchase of plans rather than direct services) should be the economic force which influences ongoing cost containment. Also, as discussed in the section on tort reform, strategies should be developed to reduce the practice of defensive medicine.

A disproportionate amount of the current dollars expended for health care pays for care which is delivered in the last days of life. The Commission suggests that any strategies for effectively controlling health care costs will be successful only to the extent that patients, families and providers accept life as finite, ensure that curing is balanced with caring so that death comes with dignity. Mechanisms to ensure that scarce resources are not inefficiently expended must be developed.

Reimbursement for much of the care delivered to patients who are uninsured or on public assistance programs is inadequate. This results in the shifting of costs from patients or programs which under-reimburse to those which reimburse more fully, usually private insurance companies. In fact, it is estimated that private payors in Oklahoma reimburse forty cents to cover the hospital care of patients who have not paid for every dollar they pay for their own insureds. Cost shifting will be controlled only with mandated universal benefit coverage which adequately reimburses providers for services rendered.

It is important to recognize that the mandate on hospitals to provide emergency room care, regardless of ability to pay, results in a type of universal coverage paid for by cost-shifting. However, this approach to universal coverage is irrational in many ways. It results in delayed treatment and failure to appropriately use preventive care, is extremely expensive relative to the cost of obtaining earlier, appropriate treatment and does not include adequate follow-up care.

Oklahoma has developed a specific financing reform initiative, the Family Choice Health Plan, the study of which has been funded by the Robert Wood Johnson Foundation. The Governor and the Legislature are encouraged to continue the work of the initiative to identify and recommend financing strategies. The Commission recommends that Family Health Accounts be established through the Oklahoma Health Care Authority. See Appendix 4 for details of the Family Choice Health Plan as developed to date.

While the Commission believes funding sources should be maintained approximately as they are currently, the sources of additional funding required to provide universal coverage is a major issue in Oklahoma as well as nationally. The Commission was unable to determine specific recommendations for additional funding sources but did conclude that the State should look to individuals as having the greatest financial responsibility, then to businesses, and finally to tax revenues.

INSURANCE REFORM

All current national reform proposals contain provisions which would significantly modify insurance practices. In addition, many states have successfully adopted insurance reform legislation. The Commission recognizes that insurance reform is an important component of the comprehensive process of reform in Oklahoma.

The Commission recommends that State legislation be coordinated with expected federal reform. Oklahoma legislation should move forward with initiatives that will complement federal reforms. The Legislature should enact legislation which would define Accountable Health Plans (integrated service delivery networks) and encourage individual employers and employees to purchase their health care coverage from these plans. Incentives should be created to encourage individuals and employers to purchase cost-effective plans and to use the health benefits wisely.

The Commission believes any changes in industry practice should emphasize patient freedom of choice of providers. In addition, a reformed system should rely heavily on market-based incentives. Administrative processes should be developed which standardize and simplify forms and reduce paperwork. Standardized consumer evaluations of health insurance companies or health plans should be available.

GOVERNANCE AND ADMINISTRATION

Regardless of whether the purchase of health care coverage in a reformed system is voluntary or mandated, an administrative infrastructure must be developed which effectively organizes the system's components. In addition to the organizational structure necessary for efficient operations, mechanisms for oversight of system functions and enforcement of any regulatory activity must be established. The Commission believes that health care purchasing can be conducted most effectively through health alliances which organize the purchasing power of consumers and allow them to choose their own health care coverage based on cost, quality and personal need. The Commission recognizes the need for at least one health alliance within the State. The function of the health alliance should be that of a 'passive price-taker', not a purchaser.

In discussion of these issues, there was considerable debate over whether health alliances should be voluntary or mandated. The Commission decided that recommendations should not refer specifically to either voluntary or mandated systems.

1. The Commission recommends that an oversight organization be created to:

A. Set standards for accountable health plans. Such standards will include, but not be limited to:
   1. Quality and service
   2. Financial solvency
   3. Grievance procedure
   4. Other consumer protection standards

B. Analyze and disseminate information

C. Establish health alliances for the state.

D. Provide technical support to health alliances.

E. Prior to universal coverage, monitor implementation of small group health insurance reforms.

2. The Commission recognizes the need for health alliances in Oklahoma as a means of cooperative purchasing for employees and individuals. These health alliances should be separately chartered non-profit organizations and will offer all accountable health plans which meet established standards. Each health alliance should have a governing board composed of payors (usually employers) and consumers. The Board will:

A. Review products to ensure standards are met.

B. Disseminate information to alliance members.

C. Identify projected average cost for purchase of uniform basic benefits.

D. Collect premiums and pay plans, as needed.

E. Provide member services.

3. The Commission recommends that existing efficient processes should be used whenever possible.

TORT REFORM

Malpractice reform is essential to reduce costs within the health care system related to malpractice awards, the practice of defensive medicine, skyrocketing malpractice insurance premiums, and the costs of litigation.

The Commission recommends that malpractice reform provide that medical practice consistent with state-approved standards of practice render practitioners for whom standards of care have been developed immune from liability for non-feasance. The Commission also recommends that limited liability be provided by law to fully-licensed health care professionals, operating within their scope of practice, who provide services to the needy or indigent, as determined by the Legislature, without charge.

The Commission believes that Oklahoma should abolish rules providing for joint and several liability and replace them with a standard of relative negligence in tort litigation. Oklahoma should also abolish rules and practices which prevent courts from considering collateral sources of payment, such as disability, workers compensation or insurance payments, when making awards for compensatory damages in tort cases. Such information should be available after trial to facilitate the accounting process, rather than during the trial where it may become a prejudicial trial tactic. Legislation should also be passed which provides that in successful tort actions for damages, periodic payments be allowed for awards over a specified amount with suitable guarantees for the plaintiff.

The Commission recommends that continuing study of tort reform be undertaken. That study should address all issues relevant to malpractice actions including, but not limited to, punitive damages, limits on non-economic damages, alternative dispute resolutions, pre-filing notice procedure, and pre-trial medical screening panels. Discussion was held on the issue of setting limits, or caps, on punitive damages, similar to current protection of state-employed physicians, but no recommendation was made.

OTHER ISSUES

In addition to the areas of health care reform addressed by this Report, three other issues need to be mentioned. These are 24 hour coverage, long-term care and consolidating medical coverage paid through automobile insurance with health insurance policies.

The Commission has performed preliminary work on long-term care. Due to the complexity of this topic additional research must be conducted before specific recommendations for reform can be made. The diverse issues involved in long-term care, including those related to access and the multiplicity of approaches to care and financing, places this topic beyond the scope of a one-year study group. However, the Commission recognizes that long-term care needs to be studied and addressed in the context of development of basic benefits, perhaps by the Legislature.

Twenty-four (24) hour coverage is another issue that must be studied. Under most current definitions, twenty-four hour coverage occurs when the health insurance portion of workers' compensation is integrated with an employee's regular health insurance plan. Implementation of this type of coverage would help reform the Worker's Compensation system to reduce fraud, lower costs and decrease fragmentation of health service delivery. In a system of twenty-four hour coverage, employees should not be held responsible for any cost sharing with on-the-job injuries. In addition, it is important that employer premiums be risk adjusted for the work-related injury portions of premiums to insure that companies which maintain safe workplaces continue to have financial incentives to do so.

Another important health care reform issue concerns the potential integration of the medical insurance portion of automobile insurance policies with available health benefits plans. Greater cost savings may be realized when this coverage is delivered through comprehensive health policies as opposed to purchasing medical care via automobile liability insurance.

CONCLUSION

Since the initial creation of the Commission on Oklahoma Health Care by Governor David Walters in early 1992, health care reform has become one of the most compelling policy issues in the United States. The increasing availability of information about and analysis of health reform proposals and strategies has provided the Commission with a wealth of materials from which to craft its recommendations. In addition, the ongoing work of the Commission into late 1993 has provided its members with the opportunity to explore issues and ideas fully and to achieve consensus in many areas which were unresolved when the November, 1992 Report was presented to the Governor. The integration of new Commission members with long-term members in early 1993 proceeded smoothly, with new members bringing a diversity of backgrounds and experiences into the process.

We continue to believe that comprehensive health care reform must be an extremely high priority for the Legislature and the Governor. We believe that a market-based system which

utilizes health alliances to enhance and organize health care purchasing for consumers will provide the most politically-feasible and efficient arrangement. Although calling for universal coverage, the Commission was unable to agree on an acceptable funding scheme. However, cost shifting will be reduced and access enhanced if uniform benefits which are adequately reimbursed are universally available through health plans offered by the health alliances. In addition, for a market-based system to function most effectively, premiums should be reflective of the underlying efficiency of the health care delivery system. This will be achieved only in an environment of universal coverage in which cost-shifting has been eliminated.

Incentives which enhance consumer awareness of health care costs and promote individual responsibility in purchasing decisions are essential. Health care costs may also be significantly reduced through restructuring of service delivery to promote primary care and prevention. Medical malpractice reform may lead to reduced costs if physicians are able to significantly limit defensive medical practices and mechanisms are developed to reduce the expenses of litigation. The development of practice standards based on outcomes research is an important component of malpractice reform. In addition to their usefulness in the malpractice area, effective development of practice standards may lead to higher quality service delivery with reduced costs to the system as unnecessary procedures and treatments are identified and eliminated.

We encourage the Legislature to carefully and thoughtfully develop legislative proposals which achieve comprehensive and meaningful reform. We trust that the recommendations presented here will provide an important foundation for this future reform.

APPENDIX 1

COMMISSION ON OKLAHOMA HEALTH CARE MEETING DATES

Listed below are meetings conducted since the inception of the Commission on Oklahoma Health Care (February 5, 1992).

1992

February 27, 1992
Leon Harris Building
Oklahoma City, Oklahoma

April 2, 1992
Leon Harris Building
Oklahoma City, Oklahoma

April 23, 1992
Red Rock Comprehensive Mental Health Center
Oklahoma City, Oklahoma

May 7, 1992
Red Rock Comprehensive Mental Health Center
Oklahoma City, Oklahoma

June 25, 1992
Hillcrest Medical Center
Tulsa, Oklahoma

July 16, 1992
Hillcrest Medical Center
Tulsa, Oklahoma

August 20, 1992
Red Rock Comprehensive Mental Health Center
Oklahoma City, Oklahoma

September 17, 1992
Red Rock Comprehensive Mental Health Center
Oklahoma City, Oklahoma

October 8, 1992
Stroud Best Western Conference Room
Stroud, Oklahoma

November 5, 1992
State Capitol Building - Room 432-A
Oklahoma City, Oklahoma

Retreats

August 1, 1992
County Line Restaurant
Oklahoma City, Oklahoma

September 26, 1992
Hillcrest Medical CenterCenter
Tulsa, Oklahoma

1993

January 28, 1993
State Capitol Building - Gov. Large Conf. Room
Oklahoma City, Oklahoma

February 25, 1993
Oklahoma Osteopathic Association
Oklahoma City, Oklahoma

March 25, 1993
Oklahoma Osteopathic Association
Oklahoma City, Oklahoma

April 22, 1993
Red Rock Comprehensive Mental Health Center
Oklahoma City, Oklahoma

May 27, 1993
Oklahoma Osteopathic Association
Oklahoma City, Oklahoma

June 24, 1993
Hillcrest Medical Center
Tulsa, Oklahoma

July 22, 1993
Oklahoma Hospital Association
Oklahoma City, Oklahoma

October 28, 1993
OU College of Nursing
Oklahoma City, Oklahoma

December 2, 1993
State & Education Employees Group Insurance
Oklahoma City, Oklahoma

Retreats

August 28, 1993
Hillcrest Medical Center
Tulsa, Oklahoma

September 18, 1993
County Line Restaurant
Oklahoma City, Oklahoma

APPENDIX 2

COMMISSION ON OKLAHOMA HEALTH CARE GROUND RULES

The following shall prevail at all meetings for the Commission of any subcommittee of the Commission.

1. **Attendance**
   The Chairman of the Commission as well as the Chairman of each subcommittee shall keep a record of attendance of the members at each meeting.

2. **Lack of Quorum**
   At any time while the Commission is in session and considering any action, a motion to adjourn for lack of a quorum by any member will prevail if the roll call reflects less than a majority of the Commission present. A quorum is not necessary for the purpose of hearing testimony.

3. **Agenda**
   Any item which has not been set for consideration shall not be considered at any meeting except by unanimous consent of the Members, a quorum being present.

4. **Record of Meetings**
   A permanent record of motions and amendments shall be kept. If a recorded vote is requested by any member of the Commission, votes taken thereon shall be recorded.

5. **Public Meetings**
   All meetings and hearings of the Task Force shall be open to the public, and notice shall be posted in the manner provided for in the Opening Meetings Act.

6. **Time Limitation on Debate**
   Testimony and debate may be limited by the Chair except by a vote of the majority of the members of the Commission or of a subcommittee.

7. **Recording Testimony**
   Meetings and hearings held by the Commission shall be recorded; any portion of such recording shall be available to the members of the Commission prior to final action on any issues by the Commission.

8. **Testimony of Witnesses**
   As nearly as is feasible, all testimony by witnesses before the Commission shall be submitted in writing at the time of the hearing, or in advance thereof.

9. **Subcommittee Reports**
   Subcommittees appointed by the Chair shall, within a reasonable time, report back to the Commission with its recommendations. By a majority vote of the members of the Commission, any report of the subcommittee may be accepted or rejected or re-referred to such subcommittee or any other subcommittee appointed by the Chairman for further study.

10. **Voting**
    Only members of the Commission shall be eligible to vote.

APPENDIX 3

1993 TOWN MEETINGS AND SURVEY RESULTS

PREPARED BY

Anita Rowe, BSN
Trevlyn Terry
Raymond L. Goldsteen, Dr. P.H.
Karen Goldsteen, Ph.D

THE UNIVERSITY OF OKLAHOMA
CENTER FOR HEALTH POLICY RESEARCH AND DEVELOPMENT

Report to
THE COMMISSION ON OKLAHOMA HEALTH CARE

Introduction

The Commission on Oklahoma Health Care was established by Governor David Walters in 1992. This Commission was comprised of individuals representing health care personnel, the insurance industry, consumers, the government, and business. This diverse group had the task of studying complex health issues facing the State of Oklahoma. The purpose of the Commission was:

- to recommend methods for cost containment
- to recommend ways to improve quality of health care
- to recommend ways to ensure access to health care for all Oklahomans

The Commission conducted a series of 14 public meetings between May 18, and June 30, 1992. The purpose of these meetings was to learn about the health care problems facing citizens of the State, and to provide an open forum for suggestions for change. All of the meetings were moderated by Dr. Garth Splinter, Commission Chairman, and attended by at least one other Commissioner. During each meeting, notes were taken about comments by those who attended. Their statements were also taped. At the conclusion of each meeting, every adult who attended was asked to complete a survey that solicited his or her opinions concerning health care reform. These responses were analyzed and included in the *Report to the Governor* published in the Fall of 1992.

The 1992 legislative session passed House Bill 1578 which legislatively established and expanded the role of the Commission and allowed it to pursue its work. The Commission continued its grass roots effort with six more public meetings which were co-sponsored by the Oklahoma Initiative on Health Care Financing Reform, a project which was funded by the Robert Wood Johnson Foundation and awarded to the Governor's office. These public meetings were held in Ardmore, McAlester, Tulsa, Enid, Elk City, and Oklahoma City from June 17th, to July 21st, 1993 and were attended by at least three Commission members and representatives of the grant staff.

Local residents were made aware of the meetings in several ways. Individualized press releases were sent to local newspapers and radio stations. Commission staff members also contacted local health care organizations, civic organizations, labor and business representatives, and the local Chambers of Commerce. These groups helped by placing flyers throughout the communities and including them in their mass mailings. In addition, a media briefing was conducted in Tulsa prior to the public meeting there to provide the media with relevant health reform terminology and to cite pressing health care issues facing Oklahoma consumers.

Ardmore, the first meeting of the series, was held on June 17th. There was considerable interaction with the community and many insights were given in the area of health care reform. The local cable access facility videotaped the meeting and aired it later so that individuals who were unable to attend could view the proceedings.

The McAlester public meeting was held in conjunction with the Oklahoma Rural Health Association's southeast regional meeting on June 19th. Rural health representatives from throughout the southeast Oklahoma region expressed their views on health care reform and how it pertains to the complex issues they face today. A video crew taped the proceedings and aired it locally on TCI Cablevision of Oklahoma on July 15.

The Tulsa public meeting took place June 22nd at the Dunlap Auditorium on the campus of the Oklahoma State University College of Osteopathic Medicine. Over 150 people attended and expressed numerous thoughts, concerns, and solutions to the problems plaguing the health care system. Like Ardmore and McAlester, the Tulsa meeting was videotaped and aired on TCI Cablevision of Oklahoma.

In order to reach remote areas of the panhandle, satellite technology was employed at the Enid public meeting on June 16th. This meeting was uplinked to sites in Woodward and Guymon as an outreach program designed to involve more citizens of the northwest region. Telephone lines enabled citizens at these locations to interact with the panel members and have their voices heard. Approximately one hundred people participated in the telecommunications exchange. This meeting was also held in conjunction with an Oklahoma Rural Health Association regional meeting. In addition to the live, regional broadcast, a tape of the meeting was aired later on Pegasys, Enid's community television facility.

Forty-one citizens attended the Elk City public meeting on July 8th. There were concerns voiced from the audience about the negative impact that reform could have on Oklahomans. On the other hand, many attending expressed their support for reform in hopes of containing the skyrocketing costs of health care while increasing access to basic health services.

The final public meeting of the summer was aired live, statewide from the studios of the Oklahoma Educational Television Authority (OETA) on July 21st. This televised public meeting was designed as a wrap-up of the 5 regional meetings held previously in June and July. A toll-free telephone number was available during the course of the broadcast to ensure that any Oklahoman viewing the meeting had the opportunity to participate. The 24 operators on hand took over 400 telephone calls from Oklahoma citizens who wished to share their thoughts and concerns about health care. In addition, the studio was filled to capacity with an audience of almost 70 citizens.

Representatives from the University of Oklahoma Center for Health Policy Research and Development were present at each of the meetings and provided a survey to every adult who attended. In addition to the six public meetings, representatives administered the surveys at two other Oklahoma Rural Health Association regional meetings in Lawton on June 12th, and in Claremore on June 22nd. This report summarizes the findings from the survey of the 1993 public meetings.

The Survey

A total of 405 adults completed the survey. The number of participants in each town meeting ranged from five in Guymon to 93 in Tulsa. (See **Table 1**) It is estimated that surveys were completed by more than 90 percent of those who attended the meetings and were eligible to complete a survey.

TABLE 1
Number of People Who Completed A Survey in Each Town or City

Town /City	Number
Ardmore	71
McAlester	23
Tulsa	93
Enid	67
Elk City	33
Oklahoma City	42
Guymon	5
Woodward	15
Lawton	14
Claremore	42
Total	*405*

Characteristics of Respondents

Demographic Attributes: Respondents were more likely to be women (58.5 percent), and were more likely to be residents of a rural area. About 33 percent of all respondents lived in one of Oklahoma's major urban areas, either Oklahoma City or Tulsa.

Respondents ranged in age from 19 to 85 years, with an average age of 49 years. Sixty percent of the respondents had no children under the age of 18 living at home while 16 percent had at least one child under 18 years of age living in the household.

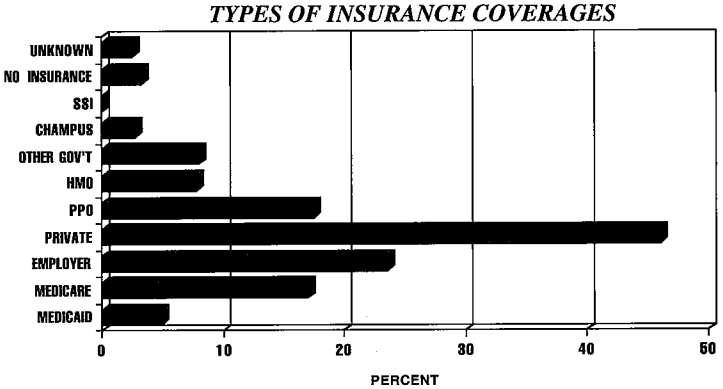
Respondents were more educated than the general population. Only 4 percent had not graduated from high school; 6.9 percent had a high school diploma; 15.3 percent had taken some college courses; 21.7 percent held a college degree; and 51.4 percent had some post-graduate training. The high level of education may be attributed, in part, to the occupations of the respondents (See **Table 2**). Forty nine percent of the respondents were health professionals including health care administrators (10.6 percent), physicians (5.9 percent), nurses (13.6 percent), optometrists (2 percent), pharmacists (.5 percent), chiropractors (.2 percent), and other health professionals (15.8 percent). Approximately 10 percent had a spouse who was a health professional making nearly 59 percent of the sample either health professionals or closely related to a health professional.

TABLE 2
Occupations of Respondents

Occupations	Frequency	Percent
Non health care professional/owners	49	12.1
Technical worker	26	6.4
Skilled worker	49	12.1
Unskilled worker	3	.7
Farmers/Rancher	10	2.5
Physician	24	5.9
Nurse	55	13.6
Optometrist	8	2.0
Chiropractor	1	.2
Pharmacist	2	.5
Health care administrator	43	10.6
Other health care personnel	64	15.8
Unemployed	4	1.0
Retired	47	11.6
Student	6	1.5
Houseperson	4	1.0
Disabled	4	1.0
Unknown	6	1.5
Total	*405*	*100.0*

Type of Health Insurance: According to the Oklahoma State Department of Health Behavioral Risk Factors Survey (1992) the proportion of Oklahomans without health insurance was approximately 18.5 percent in urban areas and 20.7 percent in rural areas. However, the results of the 1993 public meeting survey show that the number of respondents with health insurance is high relative to the general population. Only 3.2 percent of respondents to the survey had no health insurance, 67.9 percent had one health insurance plan, and 27.4 percent had two or more types of health insurance coverage. Nearly 17 percent of those with insurance were covered by Medicare, 4.9 percent by Medicaid, 2.7 percent by CHAMPUS and 7.9 percent by some other form of government insurance. Approximately 46 percent of the insured had private health insurance, 7.7 percent belonged to a health maintenance organization (HMO), 17.5 percent utilized a preferred provider organization (PPO), and 23.5 percent were covered by an employer's health insurance plan. (See **Figure 1**)

FIGURE 1
PERCENT OF RESPONDENTS WITH DIFFERENT TYPES OF INSURANCE COVERAGES



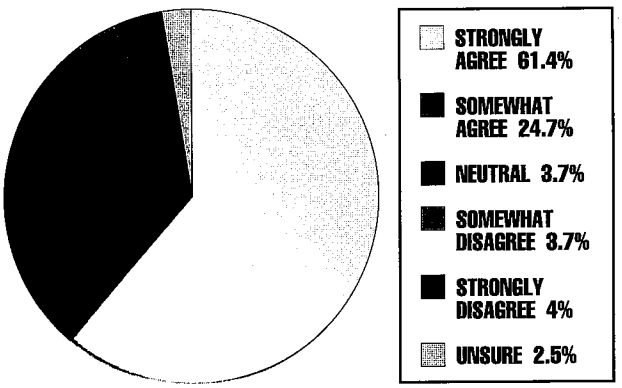
Of all respondents to the public meeting surveys, 23.7 percent stated that they were very satisfied with their financial ability to obtain access to health care and 42.2 percent were somewhat satisfied. Of the remaining 32.4 percent, 11.9 percent were not satisfied with their financial ability to access health care, 8.9 percent were somewhat dissatisfied, 11.6 percent were very dissatisfied and 1.7 percent were unsure or did not respond to the question.

Perceived Status: In 1992, two of the key political issues were the economy and health care. This was reflected in both the 1992 and 1993 public meeting survey results. The 1993 survey results showed that 63 percent of respondents viewed their health and that of individuals in their household as about the same as four years ago while 15.5 percent considered it better and 20.8 percent considered it worse than four years ago. Approximately 29 percent of the 1993 respondents perceived their financial situation as about the same as four years ago while 44.2 percent considered their situation improved and 26.4 percent viewed it as worse than four years ago.

Attitudes Toward Controlling Health Care Costs

FIGURE 2

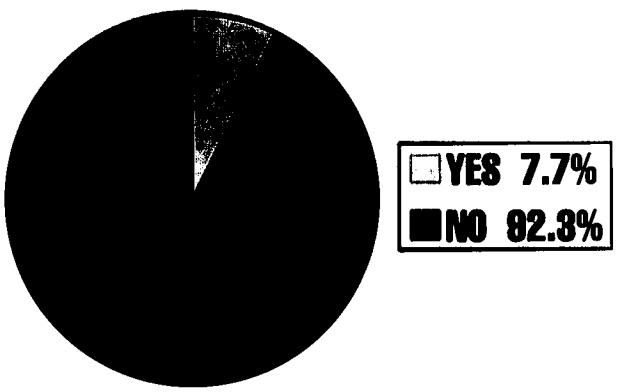
SHOULD WE MAKE MAJOR CHANGES IN THE WAY WE FINANCE HEALTH CARE?



In both the 1992 and 1993 public meetings there was widespread support for major change in the health care financing system. When asked to respond to the question "Do you feel we should make major changes in the way we finance health care?" 86.2 percent of the 1993 respondents either strongly agreed or somewhat agreed. (See **Figure 2**) This figure is slightly less than the 1992 figure, which indicated that 90 percent of the respondents either strongly agreed or somewhat agreed that we should make some major change in the way we finance our health care.

FIGURE 3

SHOULD WE KEEP THE SYSTEM WE HAVE NOW?



In 1993, 7.7 percent of the respondents agreed that "We should keep the system we have now" as a method for controlling health care costs. (See **Figure 3**) In 1992, only 3 percent of the respondents agreed. The number of respondents who wanted to keep the present system more than doubled between 1992 and 1993.

Although most respondents agreed that change in the way we finance our health care is necessary, the public meeting respondents were unable to agree on *how* these changes should be accomplished. In 1992, and 1993, the cost control method which received the least support was to decrease services. Only 6.7 percent of the 1993 respondents thought this was a viable method for controlling costs. (See **Figure 4**)

Two methods for controlling health care cost which received moderate support from the 1993 respondents were requiring employers to contribute to a fund for purchasing employee health insurance and requiring government to provide for people at greatest financial risk even if a tax increase was necessary. Both of these methods received approximately equal support with 24.2 percent agreeing that employers should pay for their employee health insurance coverage, (See **Figure 5**), and 23.2 percent agreeing for government to assume responsibility for the individuals at greatest financial risk. (See **Figure 6**) This was an increase from the 1992 results of 18 percent and 18 percent, respectively.

Although many of the respondents expressed concern about government involvement in health care, there was a substantial minority who supported government rate setting. A slightly higher percentage of the 1993 respondents (35.3 percent up from 32 percent in 1992) supported government rate setting for health services as a means to control cost. (See **Figure 7**)

FIGURE 4

SHOULD WE HOLD DOWN COST BY DECREASING SERVICES?

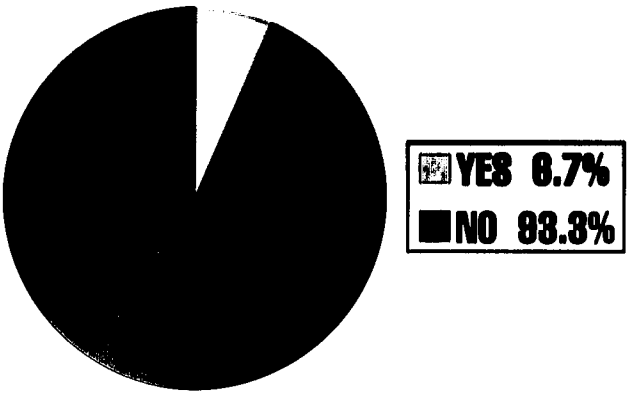


FIGURE 5

SHOULD EMPLOYERS BE REQUIRED TO CONTRIBUTE TO A FUND FOR THE PURCHASE OF EMPLOYEE'S HEALTH INSURANCE?

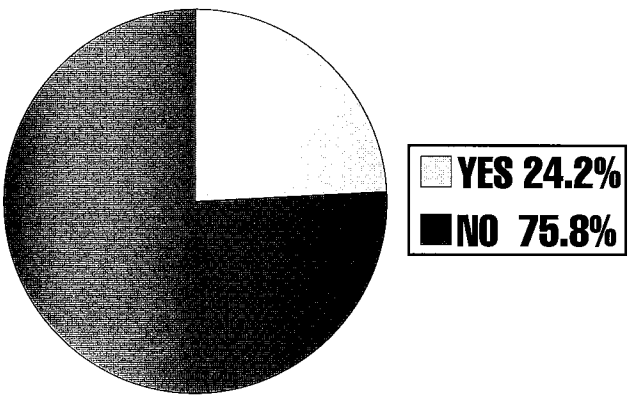


FIGURE 6

SHOULD THE GOVERNMENT PROVIDE FOR PEOPLE AT GREATEST FINANCIAL RISK, EVEN IF TAXES GO UP?

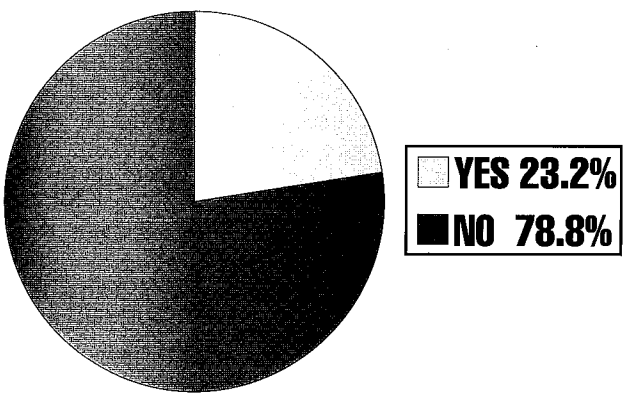


FIGURE 7

SHOULD THE GOVERNMENT BE INVOLVED IN SETTING RATES FOR HEALTH SERVICES TO KEEP HEALTH CARE COSTS FROM INCREASING?

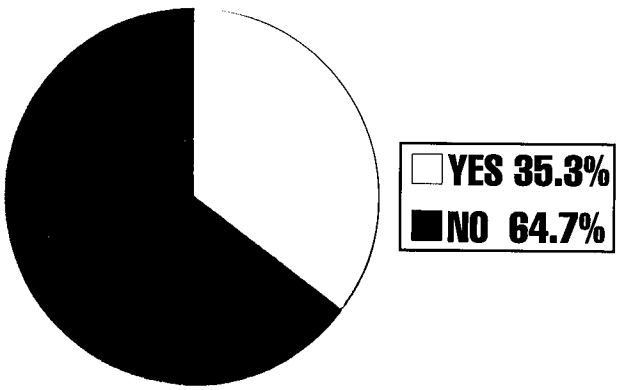


FIGURE 8

SHOULD INDIVIDUALS/FAMILIES CHOOSE THEIR OWN HEALTH CARE COVERAGE?

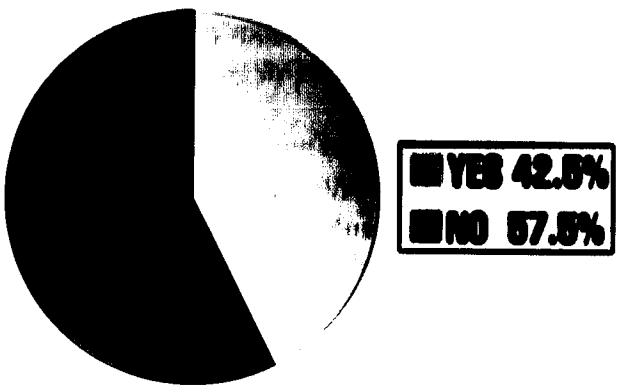
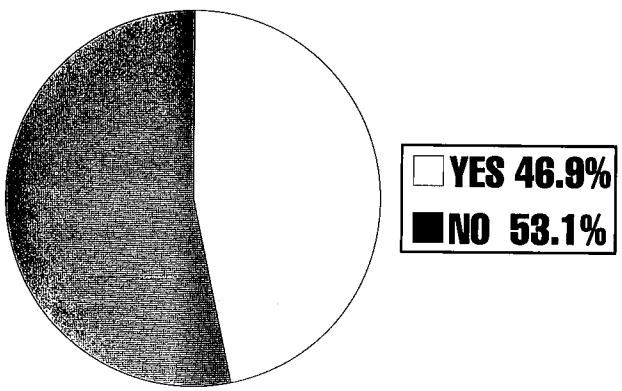


FIGURE 9

SHOULD EVERYONE HAVE EQUAL ACCESS TO HEALTH CARE, EVEN IF TAXES INCREASE?



The two areas which received greatest support from the 1993 respondents dealt with individuals' freedom of choice and equal access to care. The question of allowing individuals and families to choose their own insurance coverage rather than allowing employers or the government to make this choice received 42.5 percent agreement from the 1993 respondents. This was a full 10 percent increase over the 1992 survey results of 32 percent. (See **Figure 8**) The most widely agreed upon statement was "everyone should have equal access to health care even if taxes go up." Of the 1993 respondents, 46.9 percent agreed upon this statement. (See **Figure 9**)

In summary, the majority of respondents favored making major changes in the health care financing system. However, there was considerably less support for decreasing services to control costs, requiring employers to contribute to the purchase of employees' health insurance coverage, or requiring the government to provide for health care benefits for those at greatest financial risk than for government rate setting, equal access to health care, and allowing families to choose their own health insurance.

Explaining Differences in Attitudes

This section will discuss the differences in attitudes which may be partially attributed to sex, educational level, location, age, and perceived financial and health status. When asked, "Do you feel we should make major changes in the way we finance health care?", men and women differed in their views. Men were more likely than women to remain neutral or disagree with this statement. Men were also more likely to favor keeping the current system intact.

The level of education appeared to have no impact on how respondents felt about the question of equal access. Nor did it have an impact on how respondents felt about freedom to choose their own health care plan. However, the higher the educational level of the respondent the more likely he or she was to oppose government rate setting and to feel that the current system should be changed.

The responses from rural and urban residents were remarkably similar. Both groups strongly favored changing the present system. However, one significant difference was that rural respondents seemed more favorable towards choosing their own health insurance than their urban counterparts. This may be explained by the prevalence of HMO's and PPO's in urban areas and their acceptance by urban health care users.

Respondents from all occupations supported change in the way health care is financed. However, the responses from physicians indicated a somewhat lesser degree of support for change than was indicated by respondents from other occupations.

When comparing Medicare to Medicaid respondents both, were similar in their attitudes towards keeping the present system intact. However, Medicaid beneficiaries were more likely to believe that services should not be decreased and all citizens should have access to health care. It was also of interest that those respondents currently covered by Medicaid largely disagreed (80 percent) that government should provide for those people at greatest financial risk. Those respondents with no insurance strongly supported change in how health care is financed (84.6 percent) and equal access to health care (76.9 percent).

Comments From Respondents

This section contains comments made by participants of the 1993 public meetings. Some comments were written while others were taken from telephone conversations or remarks noted during the course of the meetings. These comments cover a wide range of topics. Some are lengthy while others may be just a few words. However, each comment expresses the opinion of an individual who is interested in shaping the future of health care in Oklahoma.

Telephone Comments— Because of the statewide telephone access, the Oklahoma City meeting produced an abundance of respondent comments. During the televised session, there were a total of 396 recorded comments. However, 21 of the comments dealt with the members of the panel, and five calls were simply requests for additional information about the Commission which were forwarded directly to the Commission for response.

Calls from the Oklahoma City meeting were analyzed and divided into categories. These categories are state and federal government, non-primary health care, financing for our health care delivery system, facilities, general health care reform, malpractice, education, managed care or the Family Choice Health Plan, and health insurance. The category which generated the most interest was health insurance and included cost of insurance, pre-existing conditions, employer participation and the lack of insurance.

General Comments—The following comments came from telephone conversations, remarks during the meeting, and remarks placed on the written surveys. The comments were categorized according to their prevalence.

Insurance Reform/Government—Many respondents expressed uncertainty about a national health care policy. They felt that the government should provide for those who cannot pay for their own insurance yet they felt that "state government should regulate insurance industry, not get involved in delivery or rate setting." Many respondents noted that insurance companies should "provide coverage for all without regard to pre-existing (conditions)" and develop pools for high risk individuals. One respondent suggested that we "do not tax the middle class until they are unable to provide for their own health care needs" while another wanted to "exclude the middle man as much as possible." Two respondents noted that we needed a system of "socialized medicine" while another felt that our system was simply the "most unfair health care system in the world." One respondent felt that we should "avoid incrementalism and piece meal reform."

Universal Access—Some of the most frequent comments pertained to universal access or basic health care for everyone. One respondent stated that "universal access is the most important thing to health care reform." Other respondents felt that "health care is a right and must be protected at all costs," and we should "pool the funding of fragmented groups to provide coverage for all." One person wrote that in order to provide universal access we must "review barriers to accessing high-tech care," including transportation and "dollars." Another stated that "we must decrease the cost of health care to allow for basic benefits for all individuals." Still another felt that "our state values must reflect universal access."

Basic Benefits—Services to help people achieve and maintain better health were major concerns of Oklahoma citizens. Many comments addressed the need for health education and promotion services and the hope that these services would be included in a basic benefits package. "We need to provide care other than 'sick' care" and "prevention and education are greatly needed" were comments frequently heard at the town meetings. One respondent wrote, "We don't teach our kids about health. We need to educate them in school so they know how to take care of themselves."

"Mental health services should be part of any basic benefits," wrote an Ardmore respondent. "Don't forget mental health services, especially in rural areas," was also expressed. Respondents from various meetings considered mental health a "necessity" in any basic benefit package.

Lifestyle and Behavior—An opinion frequently stated was that "people must take responsibility for themselves" and "I don't desire to pay for someone else to have health care." One

woman wrote that "we need education so that I don't have to pay for Welfare mothers." Many people felt that they didn't want to "pay for AIDS " because life style issues were at the root of the problem. Drug abuse was another area where "we shouldn't have to pay because someone uses drugs," according to one respondent.

Tort Reform—At all the town meetings, some comments were made regarding tort reform or the need to "cap" malpractice judgments. One person said that "we must do away with practicing defensive medicine if we want to control costs." Another suggested that "we need some kind of panel to review malpractice cases and settle them out of court." Many people felt that health care reform could not be effective unless this issue is addressed and we put "money into health care, not lawyer's pockets."

Mid-Level Practitioners—The lack of health care providers in Oklahoma and concern about how to get providers into rural areas lead to much discussion about mid-level practitioners. "Let's provide incentives and training for mid-level personnel," wrote one Tulsa respondent. "Get the legislature to mandate mid-level reimbursement," was also noted at the Tulsa meeting. "More training for nurse practitioners is needed, and train them in rural areas!" was heard from an Oklahoma City participant, as well as "expand the nurse practitioners' role." Some comments were unfavorable toward mid-level practitioners including, "Do you think that Mr. Clinton would go to a nurse practitioner when he was sick? I think not," and "if nurses want to be doctors they should go to medical school." One respondent simply stated "just don't take the caring out of our health care."

Conclusion

It is important for the members of the Commission on Oklahoma Health Care and others who read this report to recognize the limitations of the findings of the 1993 public meetings. The results of this report were based on 405 surveys obtained from citizens of Oklahoma who took the time and made an effort to attend the public meetings. However, these people were largely health care professionals or had a special interest in health care issues. As such, they were not representative of the general population of Oklahoma. It is impossible to know if their views accurately represent the views of Oklahoma citizens although it is not unreasonable to assume that some of the findings from the public meetings could be replicated in a survey of the general population.

The benefit of public meetings is that they allow the most interested and motivated individuals an opportunity to voice their concerns. They empower these citizens to direct their future and the future of their health care system whether this means changing the present system or keeping it intact. Public meetings also provide information to policy makers about their most involved and committed constituents.

APPENDIX 4

REFORM MODELS CONSIDERED BY THE COMMISSION ON OKLAHOMA HEALTH CARE 1993

Under the terms of House Bill 1578 (1992), attached, which established the Commission as a Legislative commission and expanded upon the work of the first year, the Commission was required to study various models for health care reform during 1993. Three models were explicitly mandated in House Bill 1578 - the Universal Health Care Plan described in House Bill 1578, the Small Employers Health Insurance Availability Model Act of the National Association of Insurance Commissioners, and proposals providing for individual and family health accounts. These three models were studied by the Commission during the course of their monthly meetings.

I. Universal Health Care Plan

At its March 25, 1993 meeting, the Commission reviewed and discussed the Universal Health Care Plan as it is set out in the Commission's enabling legislation, House Bill 1578, Section 6. This plan calls for a state-run, single-payer system of universal health coverage for Oklahoma. Under the Universal Health Care Plan, all residents of the state would receive health care services necessary to maintain health, or to diagnose, treat or rehabilitate a disease, injury or disability. These services would include hospital care, physicians and other health providers' services, prescription drugs, mental health treatment, and health promotion and prevention services.

The Universal Health Care Plan as outlined in the legislation provides for patient freedom of choice among providers of health care, a system of fee-for-service, salaried or capitated reimbursement for health care providers under the Plan, and reimbursement of providers located outside the state who provide emergency or other urgently-needed health care services to Oklahomans. This Health Care Plan also calls for state-wide budgeting for health care services, yearly hospital budgeting, designation of hospitals that provide trauma and tertiary services, and a uniform contracting process for the provision of prescription drugs, durable medical equipment, eyeglasses, hearing aids, and the like.

II. Small Employer Insurance Model Act - NAIC

The Commission heard a presentation on May 27, 1993, by Karen L. Collier, Legal Analyst, on the National Association of Insurance Commissioners' Small Employer Health Insurance Availability Model Act. The Commission then discussed the Model Act and the current small employer health insurance statutes in Oklahoma.

The NAIC Model Act promotes the availability of health insurance coverage to small employers (25 employees or less), regardless of claims experience or health status. It seeks to improve the overall efficiency and fairness of the small group insurance market by preventing abusive ratings practices, limiting use of pre-existing conditions exclusions and guaranteeing issue and renewal of policies. This Model Act also establishes a risk-sharing mechanism for the insurance carriers in the small group market.

The Model Act mandates that insurance rates can only be set according to case characteristics, such as age, gender, family composition, geographic location and industry, and not according to claims experience or health status. Rates may be subsequently adjusted, within limits, according to claims experience, health status and duration of coverage of the small employers. Pre-existing conditions cannot be permanently excluded from coverage, and insurance carriers are limited in their ability to temporarily exclude such conditions.

III. Family Choice Health Plan

At the Commission's June 24, 1993 meeting, Leigh Brown, Policy and Program Director, made a presentation on the Oklahoma Family Choice Health Plan. This Plan is based on restructuring of the existing health care marketplace, with an emphasis on consumer choice through the use of Family Health Accounts.

The Oklahoma Family Choice Health Plan would establish Family Health Accounts which could be used by individuals and families for tax-free purchases of health insurance and to pay for other authorized health expenses. Each person or family with a health account would be able to choose their own insurance coverage and the insurance company which best meets their needs. Contributions into Family Health Accounts would be from the same sources which currently pay for insurance and health care - individuals, employers and the government. Accounts would be administered through a public trust and held in existing financial institutions. Income or interest that accumulates on the accounts would be used to help fund contributions for small employers and for those who are unemployed but not eligible for public assistance.

Under this Plan, insurance companies would be required to offer standardized insurance policies with basic benefits which would be available to every Oklahoman. No one could be denied coverage because of pre-existing medical conditions. Also, because each person would select their own insurance coverage, people could change jobs without changing insurance companies. With a job change, only the employer who contributes to the account would change. Health account funds could accumulate from year-to-year. If the account balance was high enough, funds could potentially be converted to ordinary income. There are incentives for health insurance companies to control costs of policies because they must offer insurance in a competitive, non-segmented market.

An Act

ENROLLED HOUSE
BILL NO. 1578

BY: MONSON, STOTTLEMYRE, HUTCHCROFT, BOYD, GLOVER, HAMILTON (Jeff), HUDSON, LARASON, LESTER, MASS, MATLOCK, McCORKELL, MONKS, NIEMI, PAULK, PELTIER, ROBERTS (Walt), ROSS, SMITH (Dale), STANLEY, STITES, THOMAS, WILLIAMS and YORK of the HOUSE

and

HORNER, MILES-LaGRANGE, ROBINSON and WILLIAMS (Penny) of the SENATE

AN ACT RELATING TO PUBLIC HEALTH AND SAFETY; CREATING THE UNIVERSAL HEALTH CARE ACT; PROVIDING SHORT TITLE; STATING LEGISLATIVE FINDINGS; STATING PURPOSE; DEFINING TERMS; CREATING THE HEALTH CARE STUDY COMMISSION AND PROVIDING FOR MEMBERSHIP AND OFFICERS; PROVIDING FOR TRAVEL REIMBURSEMENT; PROVIDING FOR STAFF AND ADMINISTRATIVE SUPPORT OR TECHNICAL ASSISTANCE; PROVIDING FOR A COMPREHENSIVE EXAMINATION OF CERTAIN SYSTEMS; PROVIDING FOR CONTENTS OF CERTAIN STUDY; PROVIDING FOR SUBMISSION OF RECOMMENDATIONS; PROVIDING FOR CONSIDERATION OF CERTAIN PLAN; CREATING THE HEALTH CARE STUDY REVOLVING ACCOUNT; PROVIDING FOR CODIFICATION; AND PROVIDING AN EFFECTIVE DATE:

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2521 of Title 63, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Universal Health Care Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2522 of Title 63, unless there is created a duplication in numbering, reads as follows:

It is the finding of the Oklahoma Legislature that health care is a basic social right that should be available to all of the residents of this state. The purpose of the Universal Health Care Act is to provide access to health care and to promote and preserve the good health of the people of this state.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2523 of Title 63, unless there is created a duplication in numbering, reads as follows:

As used in the Universal Health Care Act, unless the context clearly requires otherwise:

1. "Commission" means the Health Care Study Commission created by Section 4 of this act; and

2. "Plan" means the Universal Health Care Plan established by Section 6 of this act.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2524 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. There is hereby created within the Office of the Governor until January 1, 1994, the Health Care Study Commission.

B. The Health Care Study Commission shall be composed of not more than thirty-one (31) appointed members as follows:

1. Three members of the Oklahoma State Senate, appointed by the President Pro Tempore of the Senate;

2. Three members of the Oklahoma House of Representatives, appointed by the Speaker of the House of Representatives; and

3. Twenty-five members appointed by the Governor as follows:

a. ten persons who are or who represent health care providers,

b. three persons who represent private health insurers,

c. eight persons who are consumers or who represent consumer groups,

d. two persons who represent small employers. For purposes of this act, "small employer" means firms with twenty-five or fewer employees, and

e. two persons who represent large employers.

C. The Director of the Department of Human Services, or his designee; the Commissioner of Health, or her designee; the Commissioner of Mental Health and Substance Abuse Services, or his designee; the Dean of the University of Oklahoma College of Public Health, or his designee; and the Director of the State and Education Employees Group Insurance Board, or his designee, shall be ex officio, nonvoting members of the Commission.

D. The Governor shall appoint a chairman and vice-chairman of the Health Care Study Commission. The Commission shall meet at least monthly, and may meet more often as necessary. The members of the Commission shall serve without compensation and shall be reimbursed pursuant to the provisions of the State Travel Reimbursement Act, Section 500.1 et seq. of Title 74 of the Oklahoma Statutes. Members shall be appointed to serve until January 1, 1995, and any vacancies occurring on the Commission shall be filled by the appointing authority from the same class or category as the original appointment.

E. From funds appropriated or otherwise available for that purpose, the Commission may employ staff personnel necessary to ensure the proper performance of the duties and responsibilities of the Commission. The Commission may provide for administrative support or technical assistance through interagency agreements pursuant to the Interlocal Cooperation Act, Section 1001 et seq. of Title 74 of the Oklahoma Statutes, with the other state agencies represented on the Health Care Study Commission, including public institutions for higher education. For purposes of this act, technical assistance may include, but not be limited to, a contract with a public agency for the development of a health care statistical reporting system.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2525 of Title 63, unless there is crated a duplication in numbering, reads as follows:

A. The Health Care Study Commission shall conduct a comprehensive examination of the Oklahoma health care delivery and financing systems and design and recommend changes in the Oklahoma health care system that will result in:

1. Universal health insurance coverage;

2. Health care cost containment;

3. Appropriate allocation of resources; and

4. Increased public knowledge of the health system.

B. As a part of its study the Health Care Study Commission shall:

1. Hold public hearings or community meetings in all regions of the state;

2. Consider the following issues and concerns:

a. universal health care coverage for all citizens,

b. methods of reducing administrative expenses and other expenses not related to the direct provision of medical services,

c. methods of achieving a rational balance between health care cost controls, resource allocation, and incentives for the achievement of high levels of efficiency within the health care delivery and financing systems,

d. methods of providing for the continued funding of medical research, particularly with regard to research related to clinical decision-making and patient outcomes,

e. methods of ensuring the public accountability of the health care delivery and financing systems,

f. methods for providing for training and continuing education programs and recruiting and retraining needed health care professionals and other health service providers, and for ensuring appropriate distribution of health care service providers statewide, and

g. medical malpractice review and litigation;

3. Study and make recommendations regarding:

a. the Universal Health Care Plan described in Section 6 of this act,

b. the Small Employers Health Insurance Availability Model Act of the National Association of Insurance Commissioners,

c. proposals providing for individual and family health care accounts, and

d. other appropriate models and proposals;

4. Make public the projected costs of any and all recommendations and the financial impact of said recommendations upon

health care providers, insurers and their policyholders, and the citizens of Oklahoma.

C. The Commission shall submit recommendations regarding statutory enactments to the Legislature prior to January 1, 1994. Any plan recommended by the Commission shall be approved by the Legislature prior to implementation.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2526 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The Health Care Study Commission shall consider a Universal Health Care Plan for the state. The Plan shall provide, for all residents of this state, for coverage of the following health care services necessary to maintain health, or to diagnose, treat or rehabilitate following a disease, injury or disability:

1. Inpatient or outpatient hospital services;

2. Services of physicians and other licensed health care professionals;

3. Prescription drugs;

4. Mental health treatment;

5. Substance use or abuse treatment; and

6. Services which promote health and the prevention of illness and injury.

B. The Plan shall provide:

1. That no services in connection with cosmetic surgery shall be covered unless such cosmetic surgery is reconstructive;

2. For reimbursement of health care service providers located outside this state who provide emergency services or other urgently needed health care services to persons covered under the Plan;

3. That participants in the Plan shall have freedom to choose the physician, hospital or other provider of health care services under the Plan;

4. That providers of health care services covered under the Plan shall be reimbursed on a fee-for-service, salaried or capitation basis, as established by the Commission, and that no provider accepting reimbursement under the Plan shall charge a person who receives a service covered under the Plan an amount for that service which exceeds the amount of the reimbursement for that service;

5. For the designation of hospitals to provide trauma and tertiary care services under the Plan, based upon the geographic distribution of service providers and the need for those services;

6. For the establishment of a uniform state contracting process for the provision of prescription drugs, durable medical equipment and supplies, eyeglasses, hearing aids, and oxygen and related services;

7. For the development of, before the beginning of every fiscal year, a state health care services budget which is adequate to meet the health care services needs of the residents of this state. The budget shall take into consideration monies expected to be available from federal, state and other sources;

8. For the establishment of, for purposes of determining reimbursement rates, a budget for each hospital which seeks

reimbursement under the Plan. The budget shall be based upon historical data and projected changes and shall allow retrospective adjustments in reimbursement rates bused upon unforeseen circumstances; and

9. That capital development projects and the acquisition of major pieces of medical treatment or testing equipment by health care service providers shall be approved separately from those providers' operating budgets and shall be based on health care service delivery needs in the state.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2527 of Title 63, unless there is created a duplication in numbering, reads as follows:

There is hereby created in the Revolving Fund of the Office of the Governor, an account for the Health Care Study Commission, to be designated the "Health Care Study Revolving Account". The account shall be a continuing account, not subject to fiscal year limitations, and shall consist of all monies received by the Commission, from monies received pursuant to this act. All monies accruing to the credit of said account are hereby appropriated and may be budgeted and expended by the Governor for the purpose of implementing the provisions of this act. Expenditures from said fund shall be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of State Finance for approval and payment.

SECTION 8. This act shall become effective September 1, 1992.

APPENDIX 5

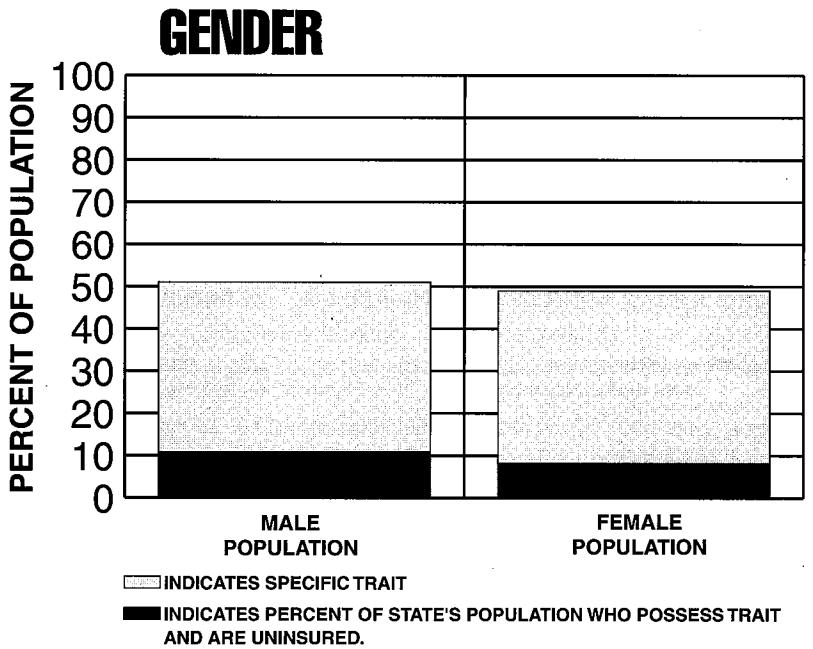
DEMOGRAPHIC AND ECONOMIC CONDITIONS IN OKLAHOMA

Data Sources:
The Urban Institute and the Employee Benefit Research Institute 1992 current population survey

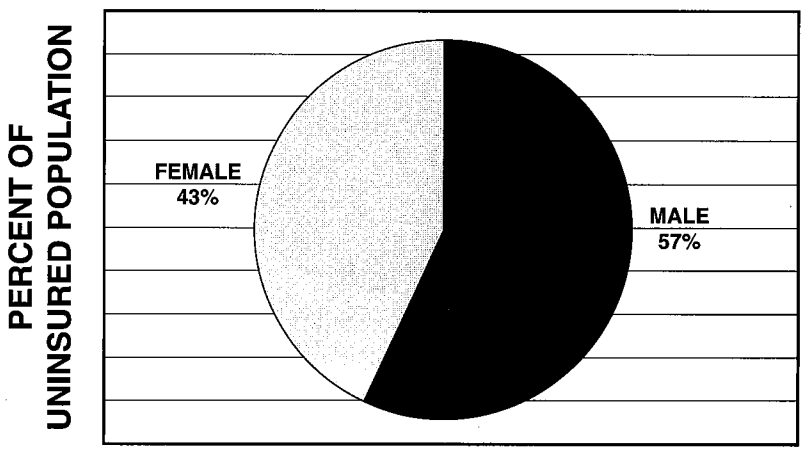
ENVIRONMENTAL ANALYSIS

Demographic and economic conditions

Research of demographic data in the state of Oklahoma is shown below. The data is presented in graphic form followed by a brief description of the findings. Specific characteristics are depicted as well as their relationship with those in the uninsured population. The data sources are from The Urban Institute and the Employee Benefit Research Institute 1992 current population survey.

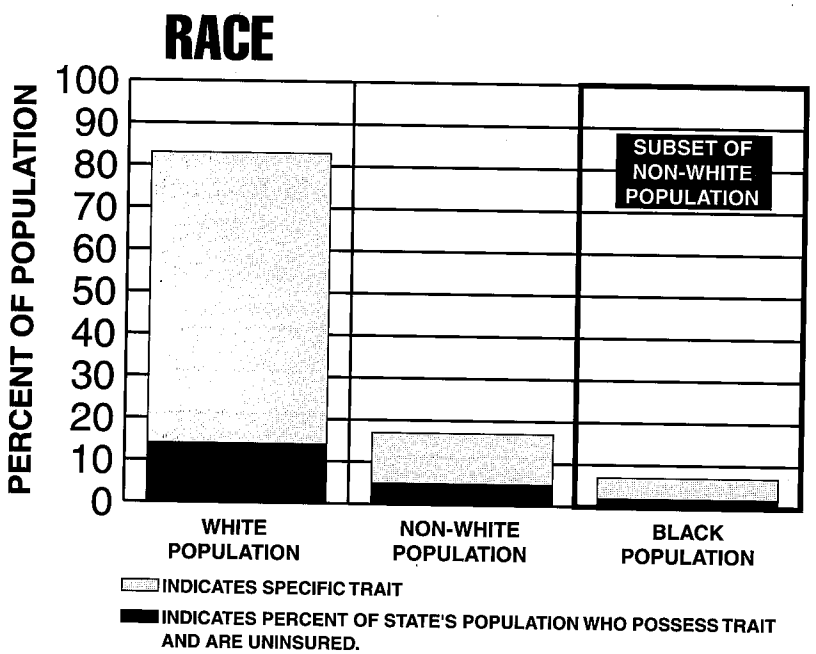


51% of the state's population is comprised of males with 49% being female. Approximately 10.8 % are male and uninsured with 8.2 % being female and uninsured.

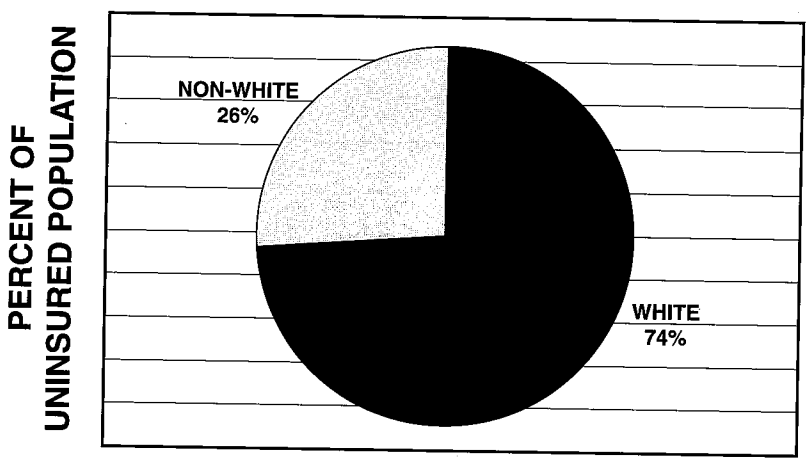


Of the uninsured population, 57% are male and 43% are female.

Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey

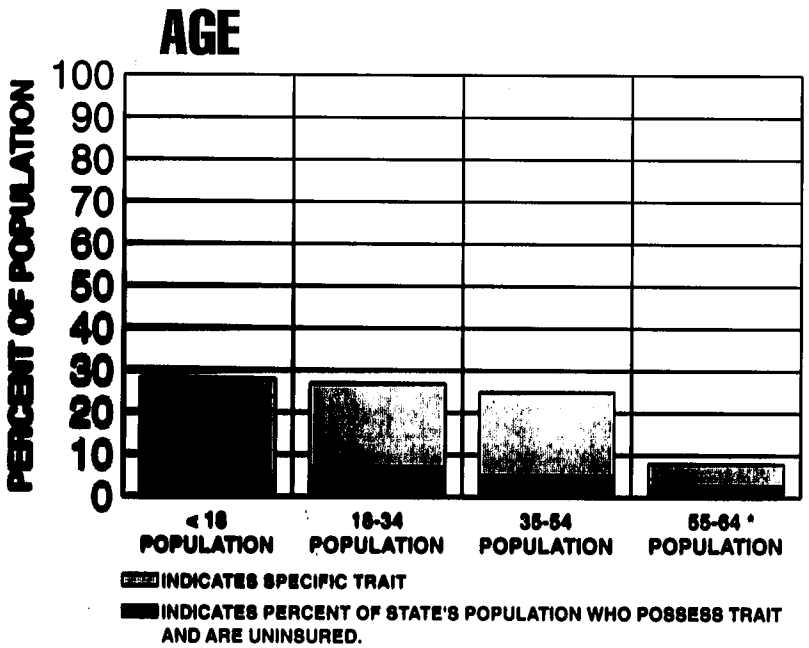


The white population comprises 83 % of the state's population with 17% being non-white and 7% being black. Approximately 14% are white uninsured, 5% are non-white uninsured, and 2% are black uninsured.



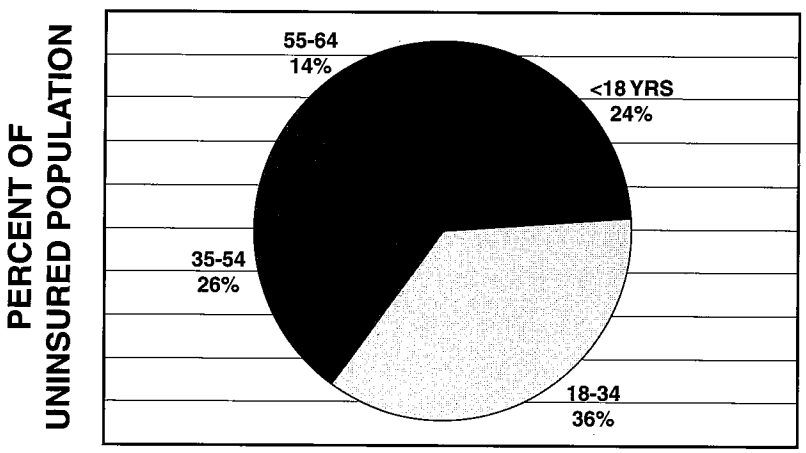
Of the uninsured population, 74% are white and 26% are non-white.

Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey



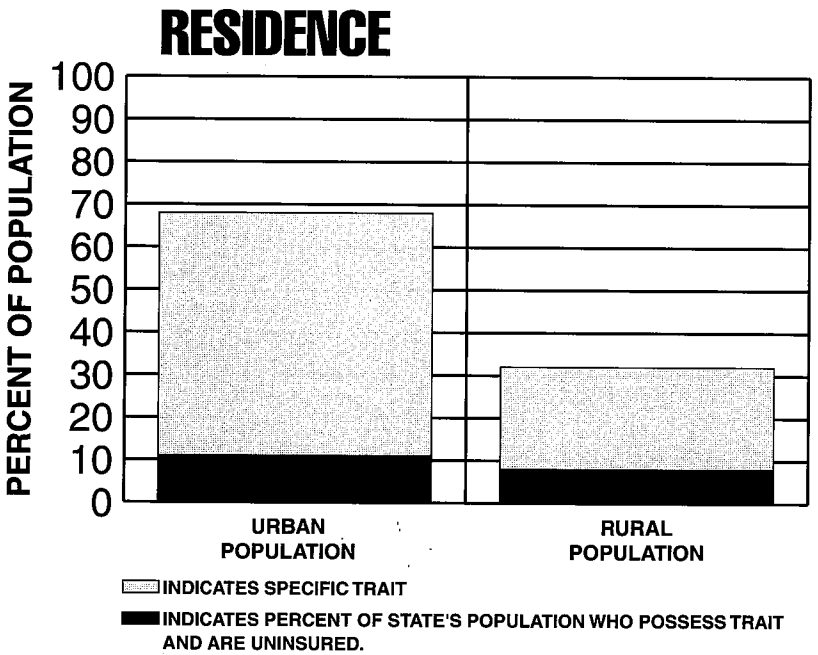
The under 18 population comprises 28% of the State's total population with 27% being from the 19-34 group. The 35-54 group makes up 25% and the 55-64 group closes out the age trait with 8%. Approximately 4.6% of the state's population are under 18 and uninsured, 6.8% are 19-34 and uninsured, 4.9% are 35-54 and uninsured, and 2.7% are 55-64 and uninsured.

The medicare population (i.e. individuals 65 and over) were excluded in the analysis of the uninsured population.

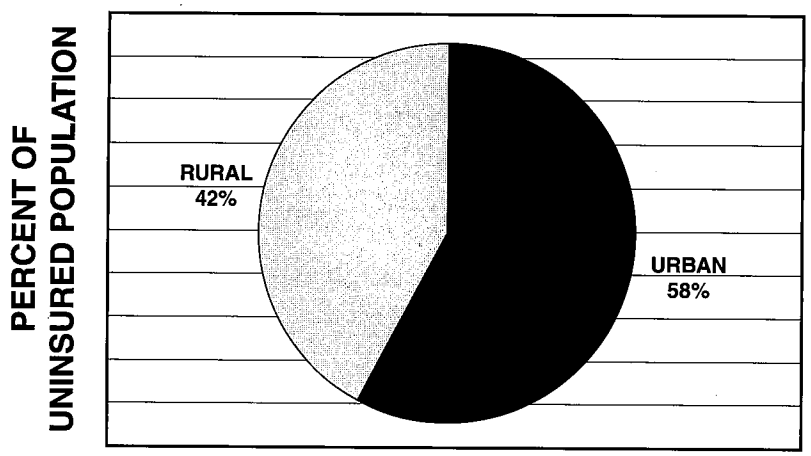


Of the uninsured population, 24% are under 18 years of age, 36% are 18-34, 26% are 35-54, and 14% are 55-64.

Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey

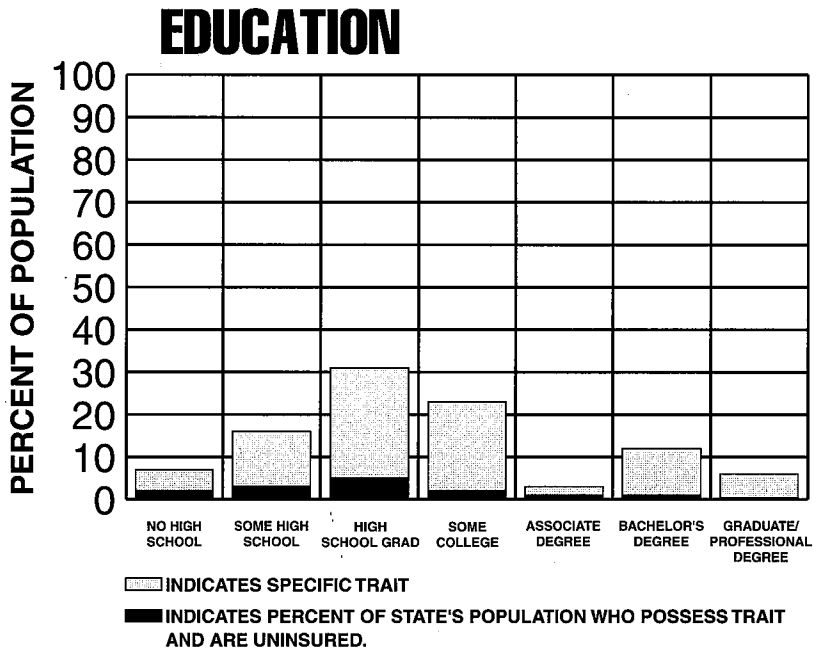


The urban population makes up 68% of the state's population and the rural population comprises 32%. Approximately 11% of the state's population are urban uninsured and 8% are rural uninsured.

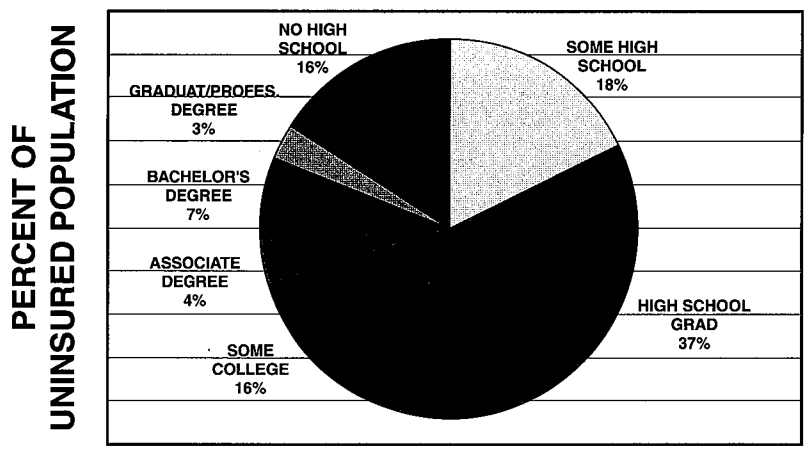


Of the uninsured population, 58% live in urban areas and 42% live in rural areas.

Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey



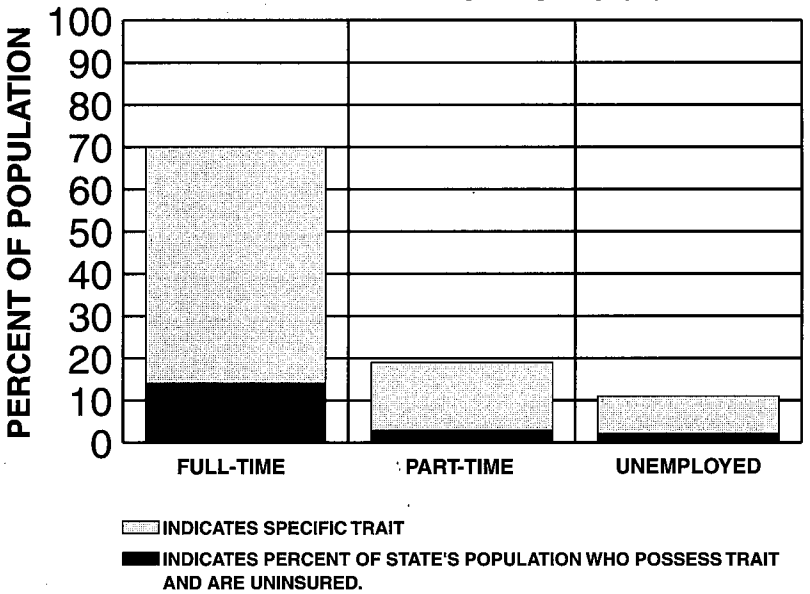
The education breakdown of the state's population is 7% no high school, 16% some high school, 31% high school grad, 23% some college, 3% associate degree, 12% bachelor's degree, and 6% graduate/professional degree. Of the state's population, approximately 2% have had no high school and are uninsured, 3% have had some high school and are uninsured, 5% are high school graduates and are uninsured, 2% have had some college and are uninsured, 1% have an associate degree and are uninsured, 1% have a bachelor's degree and are uninsured, and .4% have a graduate/professional degree and are uninsured.



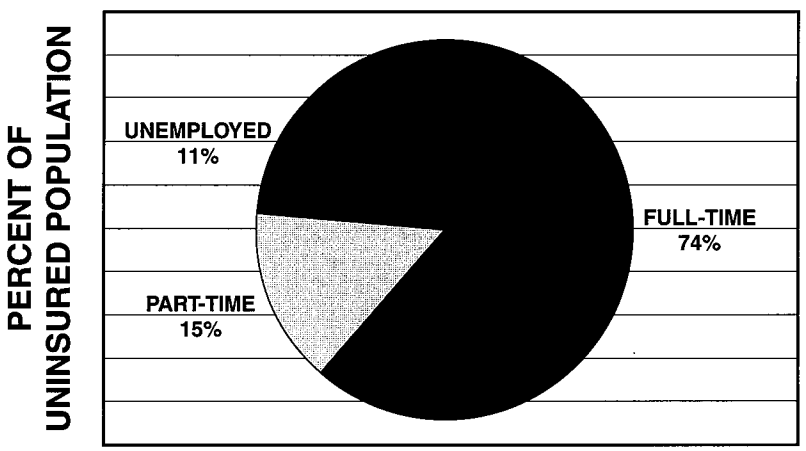
Of the uninsured population, 16% have had no high school education, 18% have had some high school education, 37% are high school graduates, 16% have had some college, 4% have an associate degree, 7% have a bachelor's degree, and 3% have a graduate or professional degree.

Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey

EMPLOYMENT STATUS OF FAMILY HEAD OR SPOUSE

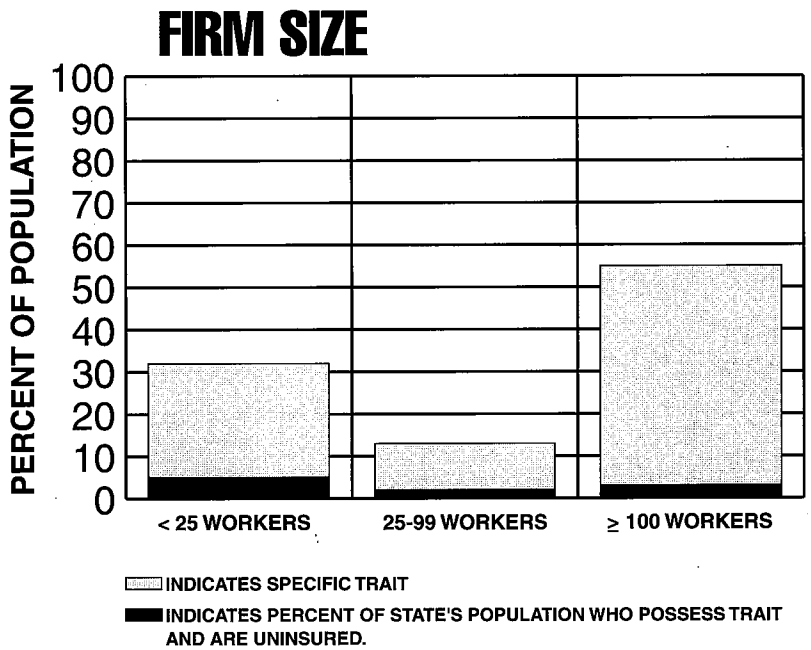


The employment status of the family head or spouse in terms of the state's total population is 70% full-time, 19% part-time, and 11% unemployed. In addition, approximately 14.06% are full-time uninsured, 2.85% are part-time uninsured, and 2.09% are unemployed uninsured.

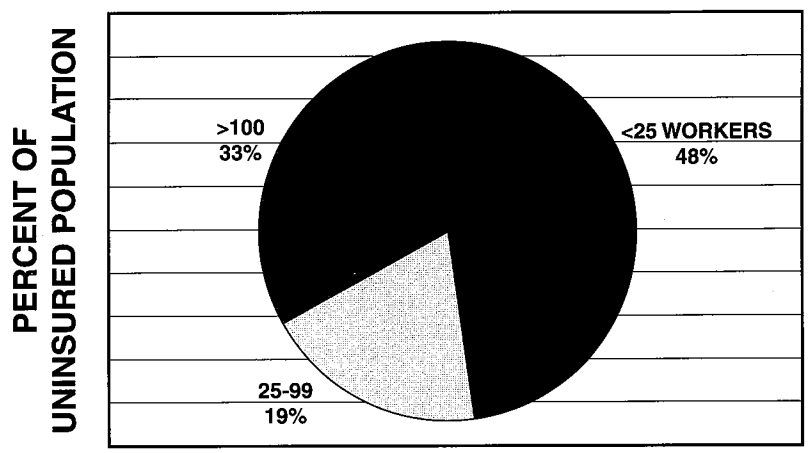


Of the uninsured population, 74% are full-time employees, 15% are part-time employees, and 11% are unemployed.

Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey

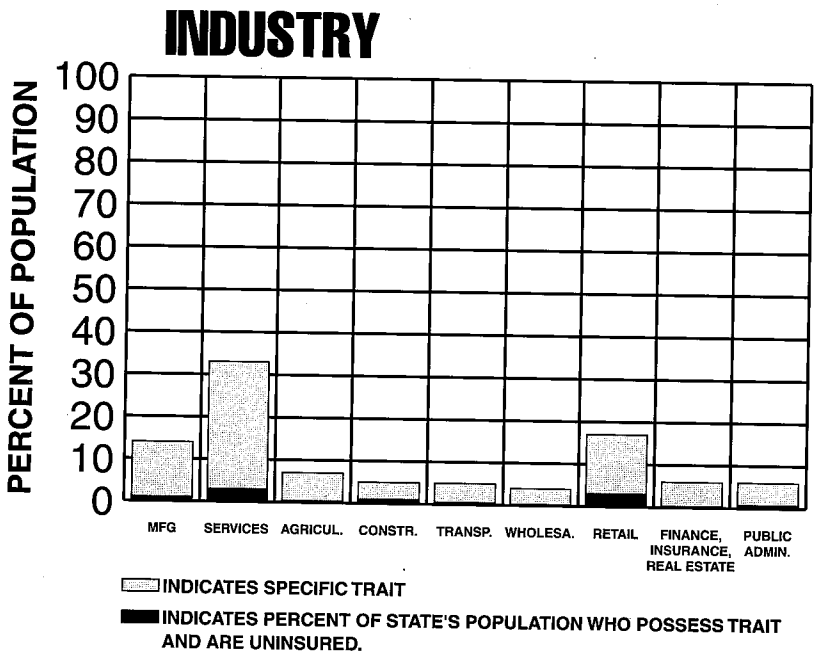


32% of the total working population of the state are employed by firms with less than 25 workers. A firm of 25-99 workers makes up 13% and firms with 100 or more workers comprise 55%. Approximately 5% of the state's workforce are individuals working for firms with less than 25 workers and are uninsured, 2% are individuals employed by firms with 25-99 workers and are uninsured, and 3% are individuals employed by firms with 100 or more workers and are uninsured.

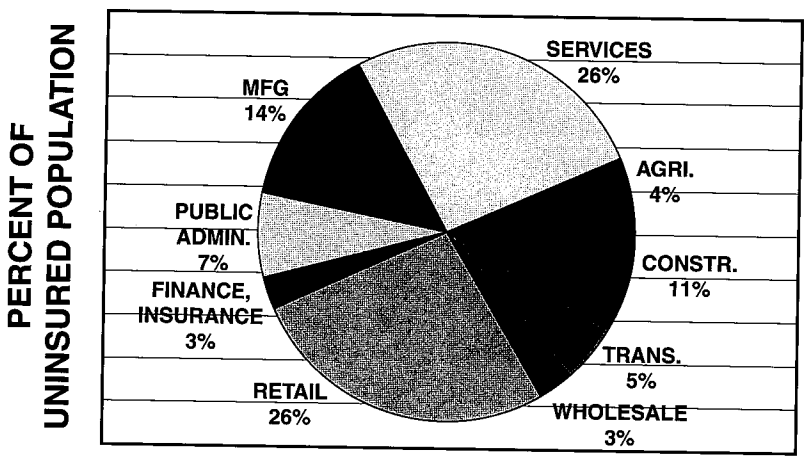


Of the uninsured population, 48% are employed by firms with less than 25 employees, 19% are employed by firms with 25-99 employees, and 33% are employed by firms with more than 100 employees.

Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey

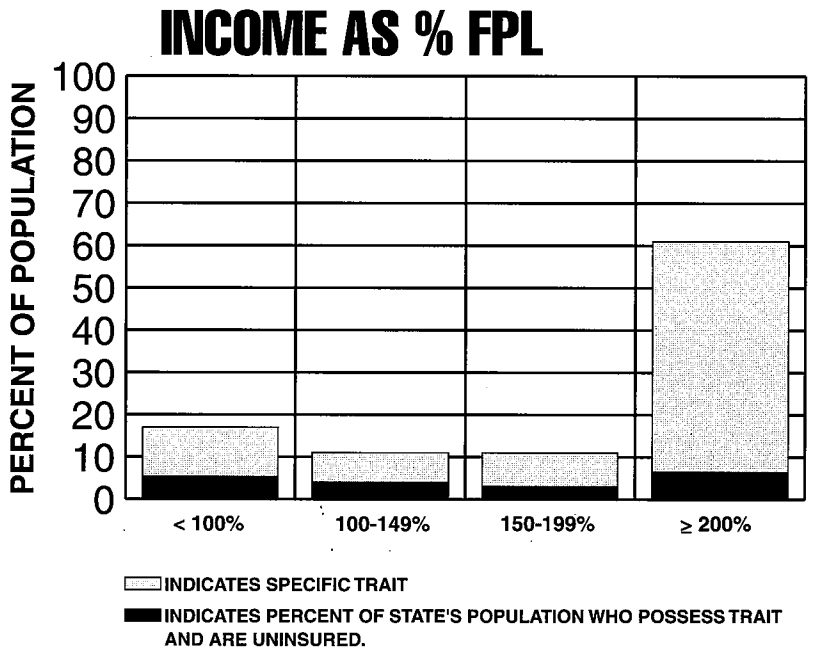


Of the state's total population, industry is broken down in to the following categories: 14% manufacturing, 33% services, 7% agriculture, 5.5% construction, 5% transportation, 4% wholesale, 17% retail, 6% finance, insurance, real estate, and 6% public administration. Approximately 1% of the state's total population work in manufacturing and are uninsured, 3% work in services and are uninsured, .4% work in agriculture and are uninsured, 1% work in construction and are uninsured, .5% work in transportation and are uninsured, .3% work in wholesale and are uninsured, 3% work in retail and are uninsured, .3% work in finance, insurance, and real estate and are uninsured, and .7% work in public administration and are uninsured.

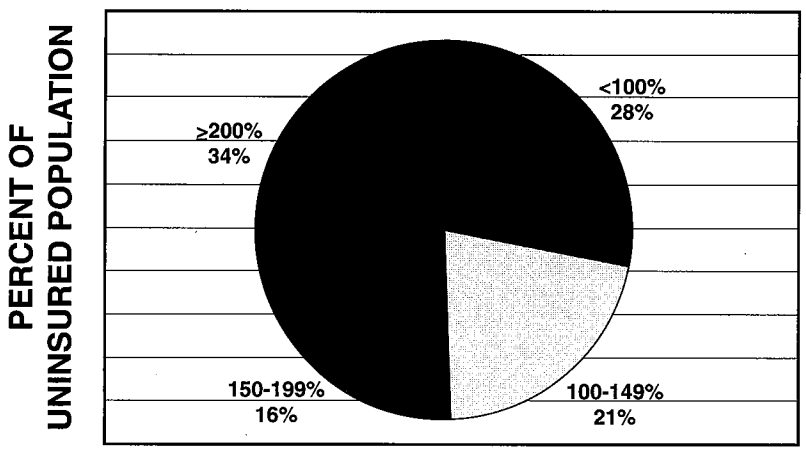


Of the uninsured population, 14% are employed in manufacturing, 26.% are employed in services, 4% are employed in agriculture, 11% are employed in construction, 5% are employed in transportation, 3% are employed in wholesale, 26% are employed in retail industries, 3% are employed in finance and insurance industries, and 7% are employed in public administration.

Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey

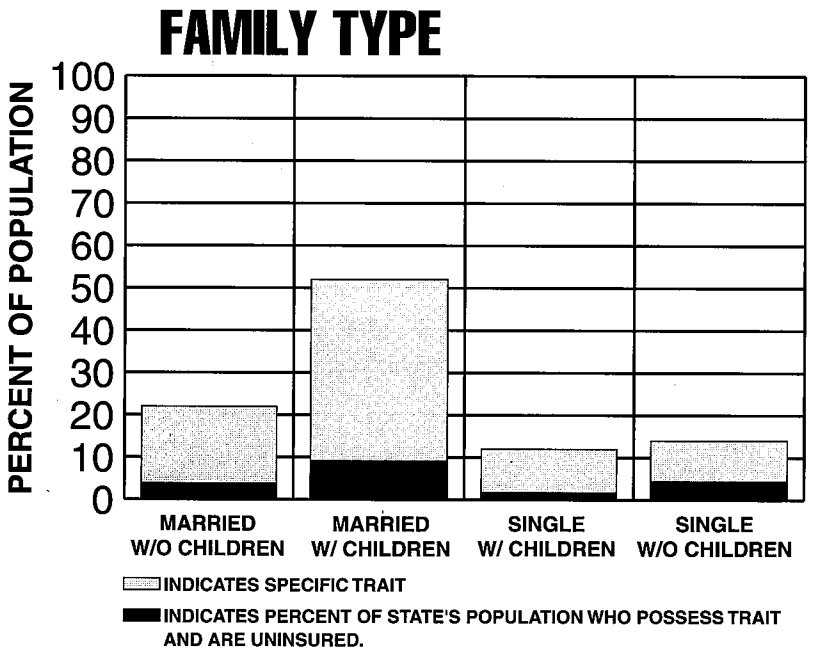


Individuals with incomes at or below 100% of the federal poverty level (FPL) comprise 17% of the state's total population. The individuals with incomes at 100-149% of the FPL make up 11% of the total population and those with incomes at 150-199 % the FPL are also at 11%. The final group of individuals with incomes at or greater than 200% the FPL make up 61% of the state's population. Approximately 5.3% of the state's total population have incomes at or below 100% the FPL and are uninsured, 3.9% have incomes at 100-149% the FPL and are uninsured, 3% have incomes at 150-199% the FPL and are uninsured, and 6.5% have incomes at 200% or greater than the FPL and are uninsured.

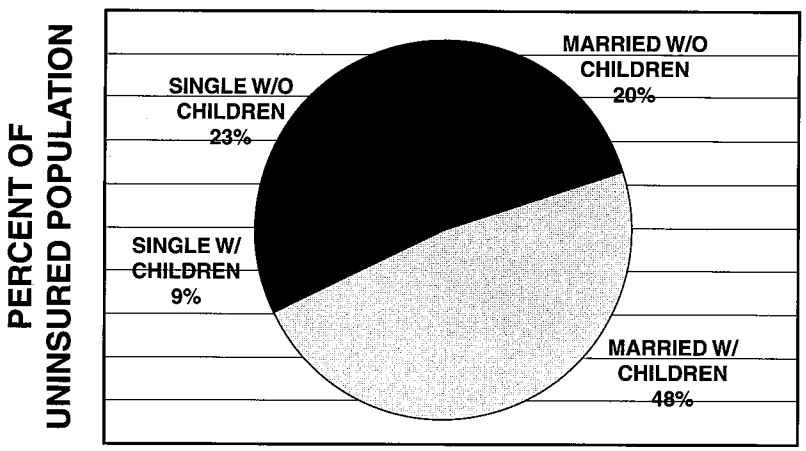


Of the uninsured population, 28% have incomes less than 100% of the federal poverty level, 21% have incomes of 100-149% of the federal poverty level, 16% have incomes of 150-199% of the federal poverty level, and 34% have incomes at 200% or greater than the federal poverty level.

Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey



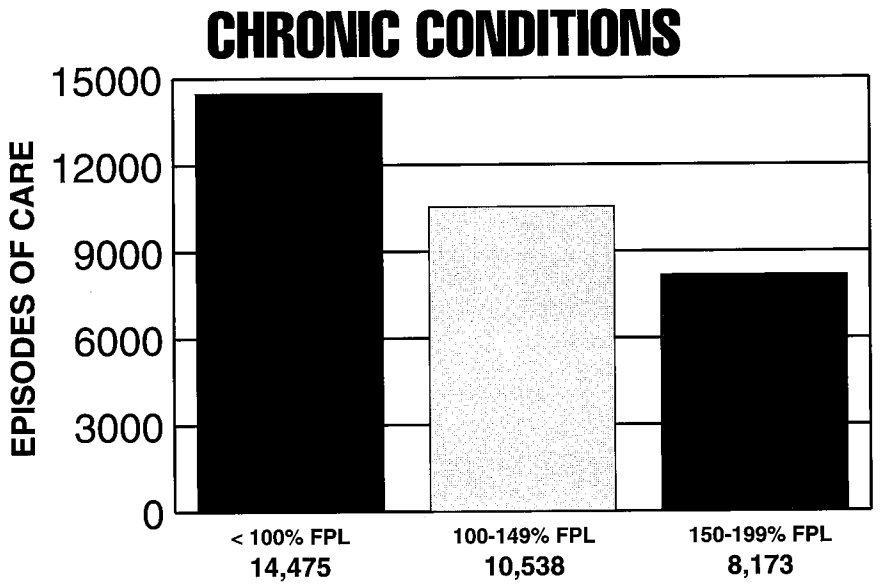
Of the state's total population, 22% are married without children, 52% are married with children, 12% are single with children, and 14% are single without children. Approximately 4% of the state's population are married without children and uninsured, 9% are married with children and uninsured, 2% are single with children and uninsured, and 4% are single without children and uninsured.

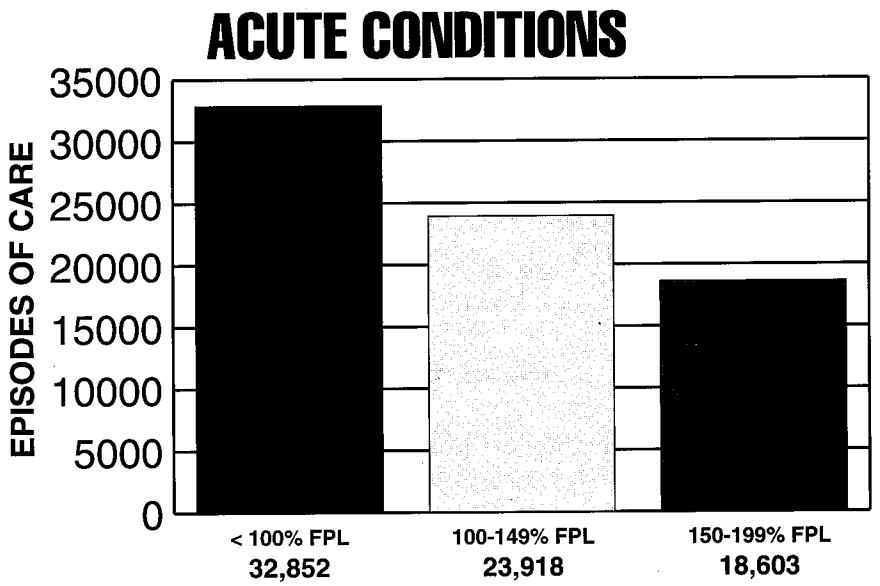


Of the uninsured population, 20% are married without children, 48% are married with children, 9% are single with children, and 23% are single without children.

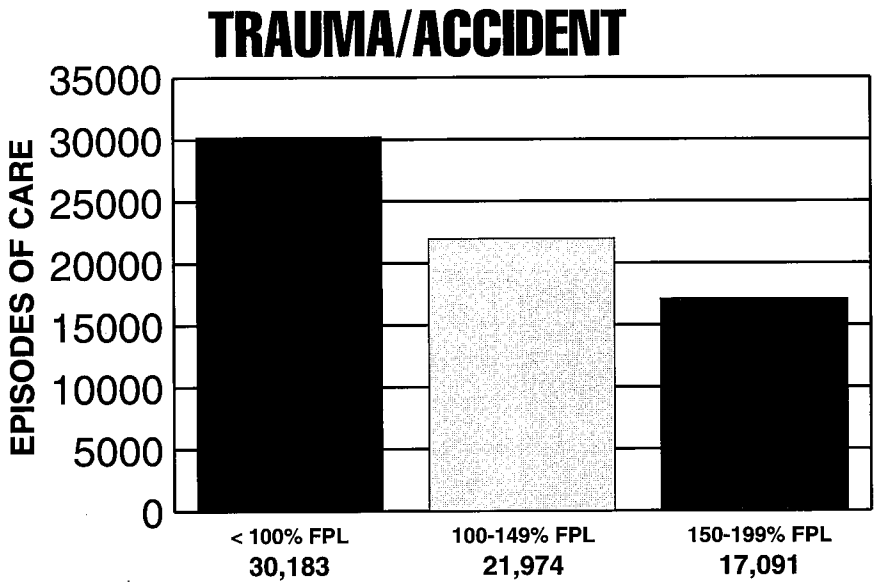
Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey

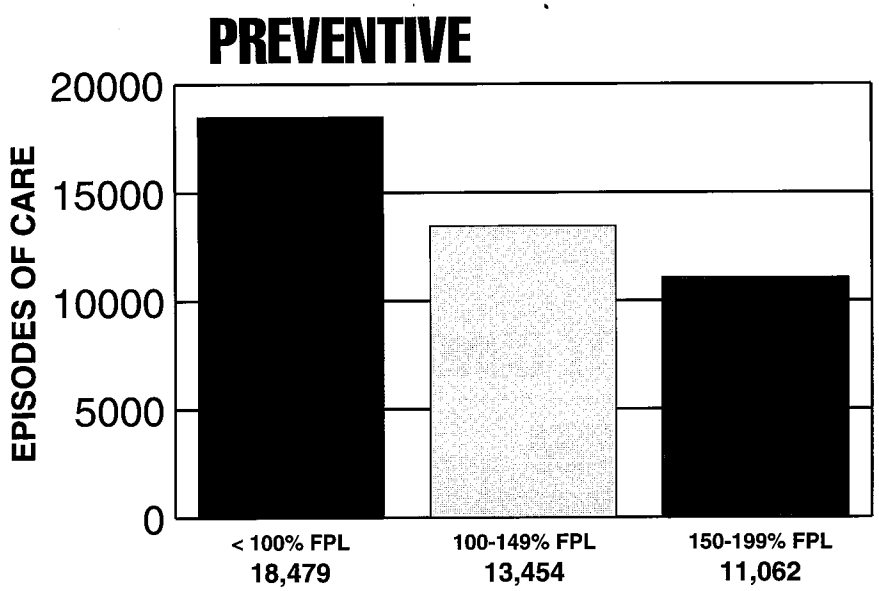
PREDICTED NUMBER OF EPISODES OF CARE IN OKLAHOMA AMONG THE NEWLY INSURED POOR





Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey





The number of episodes, N, of care for a given diagnosis was calculated as

N=AxBxCxDxE

where **A**=probability of episode of care per "poor" adult (1)
B=fraction of all persons at a given income substrata who are uninsured (from in-house demographic analysis)
C=fractional prevalence of a given income strata in the state
D=fractional prevalence of persons age 18-64 years in the state
E=population of the state of Oklahoma

(1) R. Lohr, et al, Effect of cost-sharing on the probability of episodes of care for specific diseases. Medical Care 24(9) supplement (1986).

Data Sources: The Urban Institute and the Employee Benefit Research Institute 1992 current population survey

ESTIMATED[1] DISTRIBUTION OF HEALTH SPENDING IN OKLAHOMA AS A FUNCTION OF FAMILY INCOME

INCOME DECILE	AVERAGE DECILE INCOME	FRACTION OF FAMILIES IN DECILE	EMPLOYER-PAID PREMIUMS[2]	WORKER-PAID PREMIUMS[2]	OUT-OF-POCKET PREMIUMS[2]
1	$3,440	0.05	$3	$1	$20
2	$9,050	0.13	$35	$12	$43
3	$14,300	0.10	$61	$18	$42
4	$19,700	0.10	$98	$27	$49
5	$22,450	0.10	$102	$27	$51
6	$31,680	0.13	$206	$58	$73
7	$38,870	0.11	$209	$60	$69
8	$48,080	0.12	$270	$76	$84
9	$62,240	0.09	$238	$60	$68
10	$109,370	0.06	$164	$43	$105
		TOTALS:	**$1,386**	**$382**	**$566**

[1] Estimates based on The Urban Insitute's Transfer Income Model's estimates of expenditures per family unit for each category of expenses, convolved with the specific distribution of income deciles among Oklahoma's family units (Column 2).

[2] Millions of 1990 dollars

Data Sources: The Urban Institute, the Employee Benefit Research Institute 1992 current population survey and the 1990 Census of Population & Housing (Oklahoma Department of Commerce)

APPENDIX 6

SUBCOMMITTEE REPORTS OF THE COMMISSION ON OKLAHOMA HEALTH CARE

COMMISSION ON OKLAHOMA HEALTH CARE SUBCOMMITTEE ASSIGNMENTS

Uniform Benefits

Will evaluate full array of potential health care insurance benefits to determine list of basic medical services which should be covered in any health insurance plan in Oklahoma, regardless of financial structure of plan or type of insurance product.

Commission Members
Steve Garrett, Chair
C.D. Ashley
Dr. Barney Blue
Dr. Steven Hogg
Sen. Maxine Horner
Dr. Elizabeth Schmelling
Gary Taber
Dr. Charles Tollett, Sr.

Technical Support Staff
Mike Duncan, Co-Chair
Dr. Ron Faulk
Terrie Fritz
Keith Khoo
Dr. Edd Rhoades
Peggy Stoltenberg

Access, Health Personnel and Facilities

Will evaluate mechanisms for enhancing access to health services for all Oklahomans. Analysis will focus on identification of factors which constitute barriers to care and strategies for their removal.

Will review current supply and distribution of health personnel, facilities, transportation links and information links to determine if they are sufficient to meet changing needs of the State's health care system. If the current system is not sufficient, will develop comprehensive and systematic recommendations for changes towards an optimal system. Will evaluate current status of primary care provision in the State and determine changes which are needed to optimize primary care.

Commission Members
Dr. Elizabeth Schmelling, Chair
Lelia Davis, Chair
J. R. Caton
Dr. Billy Dotter
Rep. Jim Glover
Bob Goldman
John Goldthorpe
Rep. Tommy Thomas
Ross Williams

Technical Support Staff
Saundra Gragg, Co-Chair
Marshall Baker
Sam Bowman
Tanya Case
Carolyn Chichester
Dr. Sara DePersio
Kathy Choate
Dan Fox
Dr. Raymond Goldsteen
Matt Hesser for Joe Hagy
Dr. Debbie Booten, Co-Chair
Don Hudman
Cassandra Jackson
Ed McFall
Jim Mertins
Garry Ritzky
Anita Rowe
Dr. George B. Smith
Frank Wahpepah
Dr. Tisha Dowe-Webb

Cost Containment and Finance

Will analyze cost-containment and financing issues and will develop strategies for controlling costs within the health care system. Will address impact of enhanced access on health care costs and identify mechanisms for balancing these two goals.

Commission Members
John Goldthorpe, Chair
J. R. Caton
Barton Williams

Technical Support Staff
David Parsons, Co-Chair
Kathy Austin
John Donner
Ed McFall
Dennis Moore
Jerry Prilliman
Dr. Carol Swink
Claudia Tarrington
Nancy Van Antwerp

Insurance Reform

Will monitor proposed and enacted Oklahoma insurance reform legislation to develop recommendations for ongoing insurance reform in the State. Will analyze issues related to community rating, standardized products, standardized consumer information (for example, cost, consumer satisfaction and financial status of companies), integration of the health insurance portion of worker's compensation with health insurance plans (24-hour coverage), and other insurance reform areas.

Commission Members
Tom Bowser, Chair
Jo Elda Aragon
Orville Eaton
Steve Garrett
Sen. Ben Robinson
Gary Taber

Technical Support Staff
Steve Edmonds, Co-Chair
Phyllis Donley
Lynn Rambo-Jones
John Roberts

Governance/Administration

Will analyze and make recommendations concerning current and proposed legislation to reorganize structure of the State's activities in health care.

Commission Members
Bill Kennedy, Chair
Dr. Barney Blue
Sen. Brooks Douglass
Nancy Kachel
Rep. Angela Monson

Technical Support Staff
Valerie Williams, Co-Chair
Kathy Austin
Ron Cupp
Sandra Downie
Claudia Kamas
Karen Leveridge
Claudia Tarrington
Rhonda Sackett

Tort Reform

Will conduct comprehensive study of tort reform issues, including use of practice guidelines based on outcomes research, defensive medicine and limitations on medical malpractice actions and awards. Will continue development of recommendations for implementation of tort reform in the State. Should develop estimates of the cost of defensive medicine practices.

Commission Members
Dr. Billy Dotter, Chair
George Singer
Don Weinert

Technical Support Staff
David Bickham, Co-Chair
Dr. Jerry Brickner

ACCESS, HEALTH PERSONNEL AND FACILITIES SUBCOMMITTEE OF THE COMMISSION ON OKLAHOMA HEALTH CARE

FINAL REPORT

Mission statement of the Access, Health Personnel and Facilities Subcommittee:

The Access, Health Personnel and Facilities Subcommittee adopted the following mission statement as the basis for its proceedings:

The goal of the State of Oklahoma is to raise the status of health of its citizens to the highest possible level. In order to achieve this goal, the following actions should be taken:

1. Ensure all citizens a basic level of health services with major emphasis on primary, community-oriented preventive and therapeutic services. Emphasis will be placed on teams of providers in local communities. Specialty care will be provided insofar as required to support this community-oriented approach;

2. Attention will be given to supporting programs built upon analysis of the effects of morbidity and mortality such as the Centers for Disease Control Years of Premature Life Lost as an index of the burden of disease and disability in each community.

3. Attention will be given to the education of all citizens pertaining to the elements of healthy lifestyles and to the training of an adequate supply of health care providers;

4. Incentives will be provided for the training of primary care providers, especially those prepared to locate in underserved areas.

Charge to the Access, Health Personnel and Facilities Subcommittee:

The subcommittee is to:

1. evaluate mechanisms for enhancing access to health services for all Oklahomans;

2. focus analysis on the identification of factors which constitute barriers to care and strategies for their removal;

3. review current supply and distribution of health personnel, facilities, transportation and information links;

4. determine if this supply and distribution is/are sufficient to meet the changing needs of the State's health care system;

5. develop comprehensive and systematic recommendations for changes towards an optimal system; and

6. evaluate the current status of primary care provision in the State and determine changes needed to optimize primary care.

Summary of Subcommittee Activity:

The Access, Health Personnel and Facilities Subcommittee has been very active, holding a total of 17 meetings. In view of the sweeping charge of the subcommittee and recognizing limitations of resources and time, the subcommittee established priorities of activity. The provision of primary health care is a major component of all proposed health care delivery systems. Therefore, the subcommittee chose to focus on issues related to the delivery of primary health care. The first topic of discussion was to attempt to formulate an acceptable working definition of "primary health care". Primary health care was conceptualized as referring to: 1) first-contact comprehensive care; 2) continuous coordinated care; and 3) care which usually is not organ specific. Subsequently, the subcommittee received input from committee members representing health care providers, health care administrators, health care educators, and experts in health related information systems. Formal presentations to the subcommittee were received from individuals with expertise in the following areas:

1. health care information systems including Southwestern Bell and OMIN;

2. health care providers in rural and urban settings;

3. representatives of health facilities and specialty services; and

4. engineers specializing in system-wide planning.

The following priorities were identified by the subcommittee:

1. There is a need to create a consumer-oriented delivery system which includes elements of alternative delivery approaches and which will meet short and long-term goals;

2. In order to implement this delivery system, there must be increased numbers and more efficient, cost-effective utilization of primary care providers;

3. While a great quantity of data on the current status of primary health care delivery and primary health care needs is available, it is fragmented with significant omissions and duplication, in multiple formats, often difficult to access, and therefore is not as useful as it otherwise might be.

4. There is a lack of resources to access needed data and to provide the advanced computational techniques to synthesize and present the data in usable form.

The subcommittee has developed specific recommendations to address these issues. These recommendations and the associated rationales are presented below.

Recommendation 1:

The Legislature establish legislation to restructure graduate medical education to produce more primary care physicians.

Recommendation 2:

The Oklahoma Legislature address the problems of availability and accessibility of mid-level providers such as physicians assistants, nurse practitioners and nurse midwives, in the delivery of primary care to underserved groups in Oklahoma by facilitating:

A. Limited prescriptive authority;
B. Reimbursement for services; and
C. Monies for training and education.

Recommendation 3:

The Oklahoma Legislature should expand the educational opportunities for allied health professionals to serve in urban and rural areas.

Recommendation 4:

Expand telemedicine projects to increase access to medical consultation and diagnostic services to rural communities utilizing public-private partnerships.

Rationale: Any change in the health care financing and delivery system which makes access to health care available to more persons will necessarily increase the need for health care providers. The present lack of primary care providers in rural and some urban areas is well documented. Oklahoma is primarily a rural state. Measures must be taken to insure the availability of primary health care practitioners in the rural and under-served urban areas of the state. These practitioners must include primary care physicians and practitioners prepared for mid-level positions. The present shortage of primary care physicians is acute and must be addressed. There is good evidence that "mid-level" practitioners (i.e., Physician's Assistants, Nurse Practitioners, and Nurse Midwives) can provide very efficacious and cost-effective primary health care when working within their scope of practice. The measures addressed in Recommendations 1, 2, 3 and 4 will have the effect of increasing the supply of primary health care providers for Oklahomans.

Recommendation 5:

The State Legislature provide adequate funding for the Division of Health Care Information for the uniform collection of data. The Data Center will establish the format guidelines and coordinate data collection across the state. State entities will be required to participate in the exchange of information and data.

Rationale: At present, there is an overload of available health-related data for Oklahoma. However, these data lack usefulness because they appear in varied formats and are not coordinated. A study of the complex inter-relationships of data elements in the health care delivery system requires the use of advanced computational techniques and high-tech mapping systems (such as the GIS or Geographical Information System) to aid in the analysis and presentation of information. Such an approach will facilitate the gathering and organizing of quality data which will: 1) allow visualization of the current health care delivery system and its interface with consumers; 2) permit changes resulting from alterations in policy to be recorded; 3) facilitate comparisons of the present system with the "ideal" system; and 4) allow modeling of future trends. The recommended data system will significantly facilitate the design of an improved health care delivery system.

Recommendation 6:

The Legislature create an advisory group to evaluate the present health care delivery system in Oklahoma, including health personnel, health facilities and reimbursement issues, to develop recommendations to improve access to health care for all Oklahomans.

Rationale: The Access, Health Personnel and Facilities Subcommittee has spent many hours studying the present and ideal health care delivery system in Oklahoma. Several members of the subcommittee have considerable experience and expertise in this area. An advisory group including some members of this subcommittee should continue the work of the group and establish links with work already completed, thus avoiding needless replication of effort.

COST CONTAINMENT AND FINANCE SUBCOMMITTEE

Mission Statement:

To develop a systematic approach to the delivery of a continuum of health care such that all citizens of Oklahoma have access to high quality, cost effective health care.

Goals:

(1) To analyze cost containment and financing issues.

(2) Develop strategies for controlling costs within the health care system.

Resolutions:

(1) Contain costs by implementing a managed care delivery system.

(2) Allow for competing integrated delivery systems.

(3) Mandate a capitation payment system.

(4) Allow for group purchasing strategies.

(5) Allow for meaningful tort reform.

(6) Mandate universal coverage of basic benefits.

(7) Mandate informed consent by physician.

(8) Enforce individual responsibility.

KEY ELEMENTS OF COST CONTAINMENT

(1) MANAGED CARE:

- Links financing and delivery of services, and emphasizes quality care at a reasonable cost.

  Key Elements are:

- Establishing standards of care and identifying providers who best meet those standards;
- Purchasing care from providers who deliver the greatest value and giving consumers strong incentives to use these superior providers;
- Managing care by guiding patients to appropriate settings and to appropriate providers; and
- Promoting health by emphasizing wellness, primary care, prevention and early detection of chronic illness.

(2) COMPETING INTEGRATED DELIVERY SYSTEMS:

- Facilitate the smooth transfer of patients and information from one care setting to another;
- Establish and nurture a culture of constant improvement;
- Offer a comprehensive range of health care services;
- Improve access to care through geographically dispersed primary care services supported by appropriate transportation and information systems and regionalized tertiary services;
- Correctly align hospital and physician financial incentives;
- Integrate the funding and delivery of health care services;
- Truly manage care by employing proven case management techniques.

(3) CAPITATION PAYMENT SYSTEM:

- Places the delivery system at risk for the total health care services of the covered lives;
- Eliminates the economic incentives to perform unnecessary procedures;
- Provides economic incentives to improve the health status of covered lives;

- All state funded benefits (Medicaid and uninsured) will be provided by a capitated payment system;

- Supports the shift away from expensive inpatient care to appropriate, but less costly settings;

- Tracks under utilization as well as over-utilization of services;

- Provides reinsurance for catastrophic care cases;

- Over time, encourages a better match of primary care physicians and specialists with the needs of enrolled populations.

(4) GROUP PURCHASING STRATEGIES:

- Aggregates the health care coverage purchases of individuals and small groups to achieve large group purchasing power;

- Employs sophisticated purchasing staff and information systems to consistently negotiate prudent purchases of health care coverage;

- Collects data on outcomes, evaluates providers on the basis of those outcomes and regularly informs and educates enrollees, employers and providers on the comparative performance of providers;

- Qualifies participating providers on the basis of established criteria relating to clinical quality, enrollee satisfaction and competitive pricing;

- Includes a mandated Standard Package of Benefits.

(5) MEANINGFUL TORT REFORM:

- Eliminates, or at least significantly decreases, the propensity to practice "defensive medicine" and reduce the cost of malpractice insurance.

- Providers acting within standards of practice eliminates grounds for lawsuits.

(6) MANDATED UNIVERSAL COVERAGE OF BASIC BENEFITS:

- Reduces the growing number of uninsured people;

- Improves access for the uninsured;

- Reduces the need for providers to shift the costs of caring for the uninsured to those who can pay;

- Encourages early detection and treatment of disease.

(7) INFORMED CONSENT BY PHYSICIANS:

- Provides the patient and his family with the pros and cons of recommended treatments and realistic prognoses of the likely outcomes:

- Encourages a better balance between curing and caring. Some health problems cannot be cured and we would do better to focus our efforts on helping the patient achieve as much comfort as possible;

- Creates more accurate perception of what modern medicine can and cannot do, thereby aligning public expectations with clinical and economic realities.

(8) INDIVIDUAL RESPONSIBILITY:

- Places financial responsibility for costly non-standard benefits with the individual;

- Penalizes poor lifestyle choices that unnecessarily add to the overall costs of care.

RECOMMENDATIONS FROM SUBCOMMITTEE ON HEALTH INSURANCE REFORM

COMMISSION ON OKLAHOMA HEALTH CARE

I. ***Coordinate State Legislation with Expected Federal Reforms:*** ***Although comprehensive health care reform at the federal and state level is considered ideal, the Oklahoma Legislature should plan on incremental changes which feature close coordination between federal and state legislation, regulation and enforcement.***

The Subcommittee believes that the health care reform issues are so massive, complex, and costly that it is unlikely that solutions can be achieved with one piece of federal or state legislation. Therefore, the Oklahoma legislature should adopt a model framework for reforms, plan on a lengthy period of implementation, and try to coordinate with federal initiatives whenever possible.

II. ***Move Forward With State Legislative Initiatives Which Will Complement Expected Federal Reforms:*** ***The Oklahoma Legislature should continue to move forward with its own version of reform as opposed to waiting entirely on federal legislation to address these issues.***

House Bills 2154 and 2155 were enacted by the Oklahoma Legislature in 1992 and take large steps toward stabilizing prices and limiting the rates that insurers may charge for small groups. House Bill 1302 was passed by the 1992 Legislature and improved in the 1993 Legislature. This Bill significantly addresses the portability issue since it allows individuals to retain coverage as they move from one job to another.

The Subcommittee believes that the Oklahoma Legislature should move forward with similar legislative initiatives in the future in the following areas:

A. **Worker's Compensation:** Although the Oklahoma Legislature improved the State's Worker's Compensation laws during the 1993 session through House Bill 1447, additional legislation is needed to assure that "Managed Care techniques" are utilized in controlling the medical expense component of Worker's Compensation. These Managed Care techniques are also essential in providing initial medical services in the "24 hour care" period following the work related injury.

B. **Pro-Managed Competition Legislation:** The Oklahoma Legislature should encourage Managed Care concepts. The Legislature should not enact "any willing provider" laws since they undermine the ability of health insurance programs to develop networks which, in turn, control costs.

C. **Guaranteed Issue of Health Insurance:** Some states such as Arizona have enacted laws requiring insurance carriers to sell health benefit plans to all employees, regardless of the health status of such employees. A similar law should be considered in Oklahoma. The Subcommittee studied health insurance reforms in many other states and concluded that it is difficult to provide guaranteed issue without comprehensive reform. Some states have made progress on this front and Oklahoma should continue to monitor methods which enable insurance companies to be more responsive to consumers.

D. **Inclusion of ERISA Plans In State Reforms:** The Subcommittee noted that a significant number of Oklahoma Health Plans are exempt from any state-initiated reform because of ERISA, a problem which must be corrected if reforms are to be effective. The Legislature should look for ways to include health plans which are now exempt from federal ERISA laws in Oklahoma health care reform legislation. Possibilities might include introducing premium taxes on "reinsurance" used by these plans.

III. ***Assure That Patient Freedom Of Choice Of Providers Is Maintained: The Subcommittee believes that any health care reform adopted by the Legislature should provide freedom of choice of providers for consumers.***

The Subcommittee noted that this feature is especially important to Oklahomans and has been verified in various public opinion surveys including one conducted by Blue Cross and Blue Shield of Oklahoma. The Subcommittee noted that the Accountable Health Plan model does preserve freedom of choice since individuals would be allowed to select from a variety of Accountable Health Plans. These Health Plans would, in theory, include different provider networks, thus allowing a consumer to select a desired provider through the selection of a Health Plan. The Subcommittee noted that Oklahomans would soundly reject any health care reform proposal which locks them into a provider network without a choice.

IV. ***Encourage Purchase Of Cost Effective Health Plans: The Oklahoma Legislature should foster and create health insurance plans which provide incentives for groups and individuals to purchase cost effective health insurance plans. These plans should also provide incentives for individual health care consumers to use the benefits in those health plans wisely.***

The Subcommittee has reviewed the Governor's Oklahoma Family Choice Health Plan and endorses its incentive features. The concept of family health accounts is promising because it appears to encourage the purchase of health insurance plans which have proven their ability to hold down costs. The Oklahoma Family Choice Health Plan also appears to provide tangible incentives for individual consumers to use their health benefits wisely since they would be able to retain some of the savings they help generate. Insurance representatives on the Subcommittee are in agreement that there are substantial cost savings possible through individual incentives. It may be possible to tie the Oklahoma Family Choice Health Plan incentive features to some of the concepts described elsewhere for Accountable Health Plans and move forward with a

recommendation for the Oklahoma Legislature. This may become even more practical once the Clinton Administration makes its specific plans known.

V. ***Consider Development Of Accountable Health Plans: The Oklahoma Legislature should consider legislation which would define Accountable Health Plans and encourage individual employers and employees to purchase their health insurance from these Accountable Health Plans.***

Arizona recently passed a law which establishes Accountable Health Plans in that state. The Oklahoma Legislature could establish a legal definition of an Accountable Health Plan which might include standards for insurance companies in areas such as price range, community rating, guaranteed issue, providing a standard benefit package, use of provider networks, and customer satisfaction surveys. Furthermore, the State might require such plans to guarantee that they return a certain portion of premium income to policyholders in the form of benefits through regulations on "loss ratios." For example, an Accountable Health Plan might be required to maintain loss ratios that don't go below 83 to 85%, meaning that no more than 15 to 17% is retained for administration.

Accountable Health Plans could be introduced on a pilot basis for a specific market segment, such as a children's program, small group product, or program for individuals. The Legislature may wish to create incentives for employers and individuals to purchase from Accountable Health Plans. These incentives might include favored tax status within the State's revenue codes, waiver of premium tax, waiver of mandated benefits which are beyond a state-defined standard benefit package, or the imposition of a new tax on health plans which are not deemed Accountable Health Plans.

VI. ***Study Clinton Administration Proposal When Announced And Make Specific Recommendations To Oklahoma Legislature: The commission on Oklahoma Health Care should form a task force to study implications for the State of Oklahoma of President Clinton's health care reform proposal.***

The Health Insurance Sub-Committee recognizes that the President's initial proposal will be vastly changed as it makes it way through Congress. The Commission could assist the Oklahoma Legislature by identifying the actions required of states and by suggesting legislation which might be required to support federal proposals.

VII. ***Standardized Forms, Reduced Paperwork: The subcommittee strongly endorses programs and procedures which will reduce the amount of paperwork involved in insurance transactions for customers, doctors, hospitals, and insurance organizations themselves.***

The Subcommittee noted that adoption of standardized claim forms and the use of electronic claims techniques have demonstrated their ability to simplify administration and encourages their adoption wherever possible.

VIII. ***Standard Benefits Package:*** ***If the State Legislature chooses to move toward a comprehensive legislative reform program, or to support expected federal reforms, it will be necessary to define a minimum benefit package. The federally-defined HMO benefits, Federal Employee standard option, and the State of Oklahoma basic benefit program provide good starting points.***

Should the State Legislature adopt a program which requires employers to offer a health plan, it will be necessary to define a minimum or "standard" benefits package. In terms of benefits plans which might serve as adequate models, the Sub-Committee believes that the most generous or high option might include HMO benefits as defined by the 1973 Federal HMO Act; a mid-range option might include the Blue Cross and Blue Shield Federal Employee standard option program as is being considered by the Clinton Administration; and a low option might be the State of Oklahoma's basis benefit plan definition. The Sub-Committee noted that the cost of such plans varies dramatically and will significantly affect the cost of any mandated programs on employers and supporting tax structures.

IX. ***Consumer Evaluation of Health Insurance Companies:*** ***The Sub-Committee believes that Oklahoma citizens need standardized information on which to make an informed decision about existing and future health plans.***

This information should include the financial health of the insurance organization, the number of customers it serves in Oklahoma, consumer satisfaction survey results, results from Quality Assurance programs which explain any gaps or problems the health plans may have in providing comprehensive health care, price comparisons of health insurance products, benefit comparisons of health insurance products and other items which are needed for informed decision making. The Committee feels this kind of information will become crucial if the state or federal government adopts the Accountable Health Plan model. The Subcommittee believes the Oklahoma Insurance Department is equipped to provide some of the basic information such as the financial health of the insurance organizations, number of customer complaints, and regulatory compliance. However, the Insurance Department, as presently staffed, is not equipped to develop consumer information on the scale that would be required to support Accountable Health Plans.

X. ***Adequate Resources For Enforcement Of Legislative Actions:*** ***The Legislature should provide the Oklahoma Insurance Department with adequate resources to perform the enforcement and regulatory responsibilities which it has been assigned and which it will be asked to take on as further reforms are enacted.***

House Bills 2154, 2155, and 1302 all represent substantial changes in Oklahoma insurance laws. The Insurance Commissioner must be given adequate resources to enforce these and other regulations. The Subcommittee has noted that other states have failed to recognize this need which may result in uneven implementation of desired reforms.

XI. Topics Reviewed Without Consensus or Recommendations

A. **Models For Reform:** The Managed Competition Model appears to be the most acceptable approach to health care reform for Oklahomans, according to some Subcommittee members. Other Subcommittee members felt that the Managed Competition model is too ill-defined and lacks a proven track record for cost control. The Subcommittee looked at a variety of models for health care reform including the Canadian "Single Payer System," the Governor's Family Choice Health Plan, the Clinton Administration's 1993 Health Care Act, the Conservative Democratic Forum, suggestions from various organizations including Prudential, the Health Insurance Association of America, American Hospital Association, American Medical Association, AFL-CIO, and Blue Cross and Blue Shield. Although the cost savings potential of Managed Competition is not yet proven, many Subcommittee members believe the Managed Competition Model offers the most promising approach to a) controlling costs; b) achieving universal access; and c) reforming the health care industry.

B. **Health Insurance Purchasing Cooperatives:** Although Health Insurance Purchasing Cooperatives/Health Alliances show promise in their ability to certify Accountable Health Plans and control costs, the Subcommittee is concerned that some HIPC functions may duplicate those of the Insurance Commissioner's office and of the other resources already available. Therefore, the Subcommittee suggest careful coordination in the development of the Oklahoma Health Authority and the Oklahoma version of Health Alliances, should they become necessary in order to avoid unnecessary costs and bureaucracy.

C. **Community Rating:** The Subcommittee reviewed community rating practices used in other states and by Health Maintenance Organizations in Oklahoma. It was noted that community rating was usually packaged with guaranteed issue and high risk pools when adopted in other states. The Subcommittee noted that community rating is not necessarily a tool for reducing health care costs, since it merely averages premiums which are in place today. It was observed that the cost of implementing community rating, guaranteed issue and high risk pools for small groups had the effect of increasing overall premiums 11 to 20% in some states like Minnesota. It was also noted that community rating has the effect of increasing premiums paid by younger healthier groups and decreasing the premiums for the older and sicker populations. As far as the Subcommittee could determine, the results of community rating in other states are mixed. Some sort of modified community rating such as that used by HMOs might be desirable. Elements needed include adequate flexibility for establishing rating bands, e.g. five year bands and the ability to vary rates by sex. Any steps taken in the direction of HMOs should be preceded by actuarial studies so that the final outcome is as predictable as possible.

D. **High Risk Pools:** The Subcommittee examined the activities of other states and notes that about half of the states have created high risk pools. With few - if any - exceptions, these pools were created before enactment of small group reform/guaranteed issue laws. It should be noted that the states which have enacted high risk pools have reached only a limited number of customers, e.g. 1,500 on average. Although the Subcommittee does not endorse any specific high risk pool, it does believe that the National Association of Insurance Commissions has created several models which have included input from insurers and other affected groups. The Subcommittee also noted that the use of high risk pools are often coupled with state laws which mandate a certain population to provide insurance and mandate that insurance companies offer such insurance on a guaranteed issue basis. The Subcommittee does encourage the State Legislature to look at the use of high risk pools for individual health insurance policies.

E. **Pre-existing Conditions/Waiting Periods:** The Subcommittee noted that it is desirable to abolish the use of pre-existing conditions, waiting periods, and other discriminatory underwriting practices in the issue and renewal of insurance policies. However, it was noted that it is impractical and impossible to eliminate these practices without comprehensive health insurance reform which applies to all carriers, all employers, and all consumers.

F. **ERISA Reform/Section 514 Waivers:** The Subcommittee noted that perhaps as many as two-thirds of Oklahomans with insurance coverage may be exempt from State statutes since their employers offer coverage through ERISA exemptions. The Subcommittee believes that any effective health care reform program must be universally applied to all health plans including those now exempted by ERISA.

G. **System-Wide Portability:** Although Oklahoma has taken positive steps in addressing the portability issue, House Bill 1302 does not reach all groups and all individuals. The Subcommittee encourages continued work on this topic as part of an over-all reform package to ensure that individuals do not lose insurance coverage as they move from job to job.

PRELIMINARY REPORT AND RECOMMENDATIONS OF THE SUBCOMMITTEE ON TORT REFORM

COMMISSION ON OKLAHOMA HEALTH CARE
AUGUST 28, 1993

I. Introduction

The subcommittee believes that any reasonable discussion of changing the tort system insofar as it affects the delivery and the cost of health care requires a basic understanding of and agreement about the purposes of the tort system. In general, the system is intended to compensate individuals who suffer personal injury as a result of the negligent actions of other individuals or entities. By providing compensation to injured parties from those whose actions directly caused the injuries the system attempts to accomplish multiple purposes. First, is an effort to "make whole" the injured parties, restoring them as closely as possible to the positions they were in prior to the injuries; second, the system seeks to place direct responsibility on the shoulders of those causing injuries; and finally, the system seeks to deter individuals and entities from causing actions or allowing them to occur where other individuals are likely to suffer as a consequence.

In theory, the tort system is supposed to place obligations on the part of those who are responsible for negligent (and, in some cases as discussed below, reckless) behavior. The subcommittee believes that all too frequently the system operates on the assumption that where someone is injured someone else must be responsible. Instead of having a rational system which only compensates individuals in cases where others have been negligent, it often tends to grope for a culprit every time there is a victim. While common sense tells us that unfortunate things often happen to individuals without anyone being at fault, our system of civil litigation nevertheless tends to reward creative efforts at identifying wrongdoers or tortfeasors. In effect, our societal standard of responsibility, at least insofar as tort liability is concerned, tends to be a product of ad hoc decisions made by individual juries. The subcommittee would not presume to change the basic thrust of tort law in this country, nor does it desire to do so. It does, however, believe that the American public would be better served if the standards of obligation and responsibility were more clearly defined and were established in reference to some agreed-upon societal norms.

The problems created by failures in practice of our tort system (and again not its theory) have a significant bearing on the cost of health care in the United States. Many patients do not have a good understanding of health care costs and benefits before treatment. Unless there is a better correlation between expectations on both the provider and consumer sides of the equation, litigation will continue to exert an unhealthy drag on the system.

The subcommittee offers the following recommendations and discussion of ways in which improvements can be made in the system.

It should be noted that in some instances the subcommittee has considered items and recommended that changes proposed from a variety of quarters not be adopted. It should also be noted that the subcommittee has attempted to discuss the issues from the viewpoint of public policy and has attempted to strip away as much of the special interest rhetoric as possible.

II. Recommendations

A. Malfeasance vs. non-feasance - Recommendation - The State of Oklahoma should establish an appropriate administrative body which will have the authority to initially establish, maintain and modify practice guidelines in all areas of medical practice.

Although much discussion regarding medical malpractice focuses on the cost to providers of malpractice insurance, the subcommittee does not consider this to be the major factor driving up the cost of health care in this country. Instead, the subcommittee believes that the practice of defensive medicine is a much more significant item. The subcommittee is firmly committed to the maintenance of a system wherein individuals and/or entities responsible for negligent behavior are held accountable for their actions. That includes negligence in medical diagnoses, as well as negligently performed treatments. Of course, plaintiffs are only entitled to recoveries where there has been negligence and where the plaintiffs' injuries have been the direct result of such negligence.

What troubles the subcommittee greatly, however, is the lack of clear standards delineating exactly what is required in each instance without regard to negligence in performance. There is a tremendous body of litigation which has actually been successful in holding medical providers responsible for failure to take certain actions. In fact, in much medical malpractice litigation, the underlying decision for the jury is to determine whether or not various providers have done all that should have been done. Because there is often not universal agreement on what "should have been done", the jury is left in a position of making a decision on a case-by-case basis. The implications of this approach go far beyond the conclusions reached in individual cases being litigated. Of far more consequence is the fact that providers as a whole tend to be conservative for fear of malpractice action and will require more tests and prescribe more treatments than might reasonably make sense in order to avoid being challenged in court. The uncertainty over what "should have been done" leads to a tremendous amount of waste. Estimates range to 30% of the cost of all medical treatment or even higher.

This situation can be improved by the adoption of clearly delineated practice guidelines or standards of care. If such criteria are clearly established, then providers will know exactly what is appropriate and what is expected of them. As indicated above, providers will still have to perform all diagnostic and therapeutic work in an appropriate manner and will be held responsible for any negligence in their performance. The subcommittee believes, however, that where providers act in accordance with standards of care, they should be immune from liability for non-feasance.

The subcommittee does not assume that establishment of such standards will be simple, but in view of all of the work that is going on nationwide to establish various standards, we believe that this is a realistic goal. The subcommittee does not wish to limit this recommendation to physicians and hospitals. The subcommittee believes that all classes of providers of medical care who are subject to licensure and for whom appropriate standards of care have been established and approved should be permitted to rely upon this immunity.

The subcommittee believes that the determination of standards such as described above will result in substantial savings. Many redundant or unnecessary practices will be eliminated. Not only will the cost of medical care be reduced by the elimination of much defensive medicine, the direct cost of malpractice insurance should also be reduced. This is because individual providers will have a better understanding of what is reasonably expected and will be able to more clearly provide services in conformance with societal norms. This approach will also benefit patients. They will receive treatment that is more clearly connected to such norms and they will have a much better expectation as to what will happen to them during the course of treatment. Where a body has both certified the capabilities of practitioners and delineated standards of practice for them, patients should be able to rely upon the "seal of approval" accompanying the medical care they are to receive.

B. Punitive Damages - Recommendation - No statutory changes in current laws on punitive damages are suggested.

Punitive or exemplary damages are, according to theory, assessed when a defendant's behavior has been so reckless as to warrant special treatment. Monetary penalties above and beyond consequential damages serve the purpose of deterring future reckless behavior and making those responsible for it pay an additional burden. The United States Supreme Court has recognized the appropriateness of punitive damages in a number of recent cases. Although the court has refrained from delineating clear standards regarding the relationship between punitive and consequential damages, there has been a recognition that even where the former equal many times the latter no constitutional barrier is crossed. The subcommittee agrees that the assessment of punitive damages is a necessary part of the American tort system.

Having acknowledged that, the subcommittee still has concerns about how punitive damages actually affect the course of medical malpractice litigation. In almost all circumstances, individuals and entities are left on their own to deal with punitive damages. By this we mean that while insurance can be obtained to pay for consequential damages within policy limits, punitive damages are the direct responsibility of the defendants against whom they are assessed and as a matter of public policy cannot be insured. There are already clear standards in Oklahoma for when a court should permit a claim for punitive damages to go forward. The subcommittee, however, has a concern that Oklahoma courts have not exercised full authority in limiting the consideration by juries of punitive damage claims to only those situations where they are appropriate and permitted by law. The subcommittee urges Oklahoma trial and appellate courts to exercise full vigilance in this area. Where there is an agreed-upon societal standard regarding what types of behavior should give rise to punitive damages, only such behavior, when proved,

should form the basis of punitive damage assessments. The failure of the courts to adequately monitor this issue inevitably leads to unwarranted punitive damage claims made in order to give plaintiffs extra leverage in forcing settlements of claims against medical providers. Even where providers do not feel that they have been negligent they often feel pressured to agree to settlement of claims on the basis of fears that punitive damage claims have to be paid out of their own pockets.

Many commentators have questioned whether or not it is appropriate for plaintiffs to receive the benefit of punitive damage when they are assessed. The argument goes that if all consequential damages have been paid, then the plaintiff in a given case has already been made whole. The punitive damages which are intended to penalize the behavior of the defendant should then appropriately go for some general public purpose rather than to the individual plaintiff in a specific case. The subcommittee discussed this matter and concluded that while not perfect, the status quo is preferable to other options in this regard. Most tort litigation is handled by attorneys working on contingent fee agreements. If these attorneys are not to receive their contingent fee share of punitive damages there will be no agent actively pursuing such a claim regardless of the defendant's behavior. In view of the fact that the subcommittee accepts the premise behind punitive damages, we believe that some incentive should exist so that such claims will be pursued.

It has also been suggested that if attorneys get their share of the punitive award, recovery by the plaintiff is not crucial to the proper working of the system. The proposal is made that the balance of a punitive damage award (the portion not going to the attorney) should go into some type of state fund. The subcommittee rejects this proposal because it does not have confidence that such an approach will appropriately reduce punitive damage awards or serve any broad public purpose. In fact, especially where states are operating under fiscal restraints, putting punitive damages into a public fund may be simply giving juries taxing authority. Where juries understand they are awarding monies which will be used for public purposes, they may be (even if unconsciously) encouraged to increase awards, thereby offsetting the need to obtain public funds from other sources such as taxes. The subcommittee is unwilling to propose changes where it does not have high confidence in the results.

C. *Caps on Non-economic Damages - Recommendation - Changes in the statutes limiting recovery of non-economic damages if not suggested.*

Proposals are frequently made to limit the amount of damages that can be awarded for non-economic damages in tort litigation. This category includes other items, but it is primarily made up of what is referred to as "pain and suffering". Since pain and suffering is a rather difficult concept to quantify the proponents of caps suggest that they be limited either to some multiple of actual damages or some specific dollar mounts. Some jurisdictions, notably Indiana, have instituted dollar caps on non-monetary damages. The result of such limits appears to be exactly the opposite of what was intended. In practice, the caps have come to be treated by juries as "targets". As a result, juries have tended to reward the maximum amounts permitted as a matter of course. The unintended consequence in Indiana of the caps is that awards for non-economic damages tend to be notably higher than those in surrounding states without such caps. However,

limits on non-economic damages in medical negligence cases in California appear to have had the desired effect and the rising cost of liability coverage in that state has abated as a result of the MICRA reforms passed in 1976. The courts have held the California laws constitutional; other jurisdictions have not fared as well and scholarly interpretation of the Oklahoma Constitution, as well as Oklahoma case law on similar issues, would indicate that such an effort in Oklahoma would not be favorably received by the court.

D. Joint and Several Liability - Recommendation - The legislature should abolish the current rules which hold parties fully responsible for all damages irrespective of their degree of culpability.

In practice, as a result of the concept of joint and several liability, plaintiffs tend to bring in a variety of parties who are to some degree remote to the claimed negligence in a given case. These collateral parties are invariably those perceived to have "deep pockets". Where plaintiffs can show that a deep pocket defendant had any responsibility for injuries, no matter how slight, such a defendant can become fully responsible for the financial consequences of actions taken by other parties. This effectively puts deep pocket defendants in the position of insurers for other parties, particularly those having more modest resources. The concept of joint and several liability not only compounds the cost of litigation, it is manifestly unfair.

To replace the existing rule the subcommittee recommends the adoption of a standard of "relative negligence". Such a rule would properly apportion damages based upon the relative degree of culpability involved. Many jurisdictions already have a standard referred to as comparative negligence. Under this approach, the culpability of the plaintiff and defendant(s) are weighed against each other. Where the plaintiff's responsibility exceeds certain thresholds (often 50%), no recovery is permitted even if the defendant has also been negligent. Therefore, the concept of assigning relative responsibility is already known and accepted in American law. The concept can easily be extended to apply to all types of tort litigation. Where there are multiple defendants the court should instruct the jury to specifically delineate the degree to which each defendant's negligence has been the proximate cause of damages suffered by the plaintiff. Each defendant would then only be liable for damages in relationship to its relative negligence. Thus, a defendant who was responsible for 15% of a plaintiff's damages would only be required to pay a like proportion of those damages as calculated by the jury.

E. The Collateral Source Rule - Recommendation - The Legislature should change the statutes so as to permit evidence of collateral sources after damages have been determined and awarded by the jury. At such time, the defendant(s) shall be entitled to introduce any and all information regarding appropriately defined collateral sources and such amounts as are accepted by the court shall be offset against awards made by the jury.

Under current tort practice, it is not permissible for a defendant to introduce any evidence regarding compensation received by the plaintiff. Such compensation might include workers' compensation awards, payment of heath benefits, and settlements by or judgments against other

defendants. This creates the very real possibility in both theory and practice that plaintiffs will be compensated more than once for damages suffered. The subcommittee does not advocate changing the rule in a way which would permit the introduction into evidence of collateral sources of payments during the trial stage of litigation. We believe that such information might be presented as a trial tactic by defense counsel and have the effect of prejudicing the jury into believing that irrespective of the liability of the current defendant(s) the plaintiff has already been compensated.

F. Alternative for Resolution of Medical Malpractice Claims - Recommendation - That the Commission take no specific action regarding alternatives for dispute resolutions.

The subcommittee considered various options to the current court system for resolving claims arising out of alleged medical practice. These included some type of no-fault compensation for all adverse medical events, mediation and/or arbitration, mechanisms for expedited negotiations between consumers and providers and medical adversity insurance. While it is easy to look at the current crowded court dockets and feel frustrated by the time and expense of bringing various claims to resolution, the subcommittee is reluctant to embrace any specific alternative. It is very easy to suggest speeding up resolution and reducing the cost of pursuing claims, but the fact is that many of the problems are inherent in the nature of the claims. Simply put, most malpractice claims involve various questions of law and significant and complex questions of fact. It is exceedingly difficult to ask plaintiffs and their representatives to quickly settle various claims before they have had the opportunity through discovery of exploring all evidence that can be adduced on their behalf. Unfortunately, by the time that discovery has been largely completed, a climate which would encourage simple resolution does not exist because much of the cost of litigation has already been incurred. Defendants, who may well have been interested in early settlement, often have little to lose as the process reaches the end of discovery. It is, therefore, difficult to identify a mechanism which will address the legitimate needs of the parties in an expeditious manner. The subcommittee does believe that society would be well served if medical malpractice claims were resolved by parties who fully understood all of the relevant factors in a given case. But medical malpractice litigation is not the only area in which juries are asked to resolve complex technical matters. And we recognize that the jury system is one of the cornerstones of our law under both federal and state constitutions. Perhaps one area in which progress could be made would involve an early stage screening of claims where it could be established that facts are not likely to sustain a recovery even if the case should proceed through the costly and time-consuming stages of discovery.

While alternative methods for dispute resolution may have merit, there is not a sufficient body of evidence available and known to us today that would suggest the Commission and the legislature take any affirmative action.

G. Judicial Competence - Recommendation - An appropriate government body should review the current standards and compensation for Oklahoma judges in an effort to achieve and maintain balance and competence on the bench. A fair, efficient and competent court will attract the confidence and support it deserves.

The subcommittee has concerns regarding not only the actual course of litigation in the state of Oklahoma, but also the public's perception of the judicial system. We believe that there is a decrease in public respect for the judicial system just as there is a great cynicism in our society regarding our political institutions. It is beyond the capabilities of the subcommittee to determine how much truth, if any, there is to the perception that our judicial system is somehow wanting. Nevertheless, we do believe that any steps which would enhance the public stature of the judiciary would help to bolster the confidence Oklahomans have in the products of the system. Belief in justice may be as important as the reality of justice. As a modest, somewhat unspecific recommendation in this area, the subcommittee encourages the legislature to explore any and all mechanisms which might tend to increase public confidence in the judicial system. Not the least of steps considered might be the increase of judicial salaries in order to enhance the likelihood that candidates for judicial appointment are as trustworthy and competent as possible. And just as important will be the increased perception that the judicial system operates independently of political considerations.

H. Volunteerism - Recommendation - The Oklahoma legislature should adopt a statute permitting broad standards of immunity for medical practitioners volunteering their services.

Although this is slightly oblique to the broader discussion of tort reform, the subcommittee would like to touch upon a related issue. In a system where universal access to medical care is not available all reasonable steps to promote it should be considered. Such immunity would apply whether services were volunteered on a regular basis or ad hoc, such as in "Good Samaritan" situations. Even it the Commission does not support this approach, reasoning that it somehow creates a two-tiered approach to health care, the subcommittee recommends that a standard of "gross negligence" apply in volunteer situations.

APPENDIX 7

RESPONSES TO REPORT FROM STAKEHOLDERS

Note: After the Commission voted on the Final Report, it was sent, minus this Appendix, to over 50 organizations and associations around the state for comment. Following are the response letters received.

ODAPCA - ODAPCCB

Oklahoma Drug and Alcohol Professional Counselor Association
Oklahoma Drug and Alcohol Professional Counselor Certification Board

December 7th, 1993

Garth L. Splinter, M.D.
Chairman of the Commission on Okla. Health Care
Rogers Building
800 N.E. 15th Street, Ste 342
Oklahoma City, OK 73104

Dear Dr. Splinter:

I received the Commission on Oklahoma Health Care Report to the Legislature and Governor yesterday and feel very pleased that you asked for some of my comments. First, let it be said that your Commission has done an excellent job. I tried to make the Town Meeting on June 22nd, but was unable to attend due to a schedule conflict.

Some comments: I am in favor of there being a legislatively appointed body created by January 1, 1995 if not SOONER (p. 1). National Health Care Reform may be upon us before then. When dealing with Accessm Health Personnel and Facilities (p. 7-8) I strongly support an Advisory Board or Council to deal with providers. When considering providers I believe that it is important to remember that Alcoholism and Other Drugs of Addiction require a specialist to treat this disease and therefore *strongly urge that Advisory Board to see that Certified Alcohol & Drug Counselors (CADC) be responsible for that service* and not a generic mental health care worker.

The Tort Reform (p. 11) is very inclusive of much being directed by the National Helath Care Security Act. Paragraphs two (2) & three (3) needs to be applauded for its brave attempts to find other financial resources normally held to the side, i.e. disability, workermans comp, or insurance payments. And limited liability in malpractice claims.

Again, thank you for sharing this report with me. Probably unknown to you, I also serve as Chairperson to the Alcohol & Drug Advisory Council to the Department of Mental Health & Substance Abuse Services. Much of what you are advocating we too stand behind.

Sincerely,

Randy VanNostrand, Ph.D., President
Oklahoma Drug & Alcohol Professional Counselors Assoc.

9301 South I-35 • Moore, Oklahoma 73160 • (405) 793-1545

OBC
OKLAHOMA BUSINESS COUNCIL
P.O. Box 20037 • Oklahoma City, Oklahoma 73156-0037
Phone/Fax 405/752-5595

December 10, 1993

Dr. Garth Splinter
Commission on Oklahoma Health Care
800 N.E. 15th St., Ste. 342
Oklahoma City, OK 73104

Dear Dr. Splinter:

Although the Oklahoma Business Council was not mailed a copy of the Commission's final report, one was faxed to me earlier today and I wanted to take the opportunity to at least briefly respond on behalf of the OBC's membership.

The OBC and it's members recognize that there is a great problem with health care and health care insurance today. In fact, in a survey of business owners conducted by the OBC this past summer, "Health Care Insurance / Medical Benefits" was the second biggest concern for employers. All parties involved know something must be done.

The OBC has not yet come out with our own position statement on health care reform (we hope to have done so by mid-spring), but I can say that we will not be able to support any kind of program that includes any kind of EMPLOYER MANDATES. 90% of Oklahoma employers have 50 or fewer employees -- 70% have fewer than 10. Oklahoma is small business, and small business cannot afford any more taxes, regulations, mandates or the like.

After reading your report I wonder why many of the things you call for cannot be absorbed by existing agencies, most employers are extremely skiddish of the idea of creating a new government bureaucracy. Additionally, I am not sure if Health Alliances or "co-operative buyers" are a good thing. We certainly couldn't support them if employers or individuals are forced to buy through them.

As you know, the OBC is committed to participating in the Health Care Reform discussions. And we are not just "nay-sayers." Although I've only had time to briefly read your report there were several points we would support, certainly any kind of malpractice and tort reform (where applicable).

Sincerely,

Chip Carter
OBC Director

OKLAHOMA EDUCATION ASSOCIATION

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

BARBARA SMITH
President

MARTHA McDONALD
Vice President

JOANN M. WALLER
Executive Director

December 9, 1993

Garth L. Splinter, M.D.
Chairman
Commission on Oklahoma Health Care
Rogers Building -- Suite 342
800 N.E. 15th Street
Oklahoma City, Oklahoma 73104

Dear Dr. Splinter,

First, I want to congratulate you and the members of the commission on your report -- your work -- your contribution to health care reform in Oklahoma. Whatever particular version of health care individuals or groups may prefer, we appreciate the commission for seeking solutions to this challenge.

On behalf of 47,000 members of the Oklahoma Education Association, I will say that we laud your description of a state health care system that will fit into a national plan with health alliances. We agree with the principles of universal coverage along with cost containment, and consumer awareness of costs with emphasis on prevention of health care problems.

We believe that the commission's recommendations envision a guaranteed package of health benefits that would be a comprehensive package and that the controlling of costs be done while also assuring quality.

Rather than signing on to any single plan, nationally or in Oklahoma, OEA will work to assure than any final plan is consistent with those principles mentioned above and could move toward a single-payer system. We will continue to monitor progress of the Oklahoma plan, advocate for the interests of children and education employees, and work to strengthen both the Clinton plan and our state health care plan.

Sincerely,

Pat Smith

Pat Smith
OEA Government/Agency Specialist

The Voice of Education

323 East Madison P. O. Box 18485, Oklahoma City, OK 73154 405-528-7785 1-800-522-8091

A MEMBER OF THE AMERICAN NATIONAL FAMILY OF COMPANIES

JAMES T. FARHA
President & Chief Executive Officer

Standard Life
AND ACCIDENT
INSURANCE COMPANY

December 10, 1993

Dr. Garth Splinter, M.D.
Chairman
The Commission on Oklahoma Health Care
Rogers Building
800 N.E. 15th Street
Suite 342
Oklahoma City, OK 73104

Dear Dr. Splinter:

We have read the first draft of the proposed Commission report. We understand there have been second and third drafts with minor revisions.

These comments are made on behalf of the Oklahoma domiciled member companies of the Health Insurance Association of America (HIAA). Our Oklahoma members are American Fidelity Assurance Company, Globe Life and Accident Insurance Company, Reserve National Insurance Company and Standard Life And Accident Insurance Company.

We are in favor of, support and have been involved in insurance reform in Oklahoma. We welcome the opportunity to be part of the development of any specific proposals for additional health reform in Oklahoma.

We agree with standard benefit packages as long as our companies are permitted to offer additional benefits and market the products on a fair basis to those who choose them. We oppose any plan which includes mandatory health alliances. We also oppose a single payor system whether created initially or which could evolve from a system of mandatory health alliances

We are opposed to Community rating. We do not believe this is a logical extension of the development of health care reform with a market based approach.

We are concerned with and oppose the emphasis on the collection and dispersal of premiums by health alliances. Such alliances, particularly if government run, may not be efficient and may create a bureaucracy with more administrative problems than efficiencies. Our Insurance Department is responsible for insurance oversight and we do not feel there is the need for more government or quasi-government agencies.

While we do not see any reference to premium caps or price controls in the Commission report, we use this opportunity to voice our opposition.

We want to be part of the continuing health reform dialogue and thank you for your consideration of these comments.

Sincerely,

James T. Farha

JTF:gk

STANDARD LIFE BUILDING • 421 NORTHWEST 13TH STREET • P.O. BOX 25097 • OKLAHOMA CITY • OKLAHOMA 73103 • (405) 232 0001

The Association of Oklahoma Life Insurance Companies

201 Robert S. Kerr Avenue
Suite 600
Oklahoma City, Oklahoma 73102-4267

December 10, 1993

VIA HAND-DELIVERY

Garth L. Splinter, M.D., M.B.A.
Chairman
State of Oklahoma Commission on
Oklahoma Health Care
Rogers Building
800 N.E. 15th Street, Suite 342
Oklahoma City, Oklahoma 73104

Dear Dr. Splinter:

In view of your commendable exhortation to be brief concerning our response to the Commission on Oklahoma Health Care's "Report to the Legislature and Governor", I shall be somewhat more direct than is my want. A good number of our members write health insurance and Steven P. Garrett, Esquire, a senior vice president and corporate secretary for one of our member's companies, sat on the Commission. We applaud the efforts of you, the members and the staff over the past two years. We also believe that all Oklahomans are entitled to a basic level of health services. There is much in the report that we support without equivocation. We feel, however, that there are certain assumptions made that are incorrect and the conclusions drawn from them, in our opinion, are inconsistent and unfounded.

We believe the mission statement and the goals set out on page 5 of the draft are laudable and are things that we support. We believe, however, a good deal in the report probably will not be generally acceptable and is certainly not politically feasible to paraphrase the report statement. If the term community rating recommended in the report is as we understand it, we believe it is an irresponsible recommendation and will further exacerbate tensions between generations as well as hostility to those with

unhealthy lifestyles who would under community rating throw an added burden on those persons with healthy ones. My personal opinion is that when the inequities of community rating become apparent to the general public, it will not be deemed to be politically feasible either at the state or the federal level.

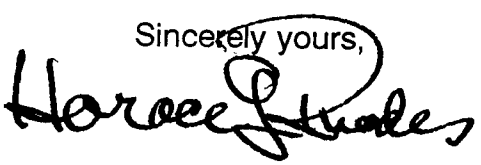
We heartily agree that tort reform in the area of health and health insurance is essential and like everyone involved, I suppose, we believe there should be an all out effort for the detection and detention of health care fraud. I am told ten cents of every dollar spent is due to fraud.

We feel the Commission must have an entirely different idea of the meaning of certain words and/or phrases than the meaning commonly understood in our business. Because with our definitions some recommendations are confusing, are often contradictory and sometimes mutually exclusive, e.g. the recommendation emphasizing freedom of choice of providers versus a recommendation of integrated service delivery networks which, by our definition, necessarily limits choice of providers. It could be this language is a compromise from opposing views on the Commission, but the recommendations have the affect of canceling one another. We are convinced the stated belief of the Commission that health care purchasing can be conducted most effectively through health alliances, but that the function of the health alliances should be that of a "passive price taker" not a purchaser is again confusing and if not mutually exclusive is contradictory.

Our guess is that the health alliances will create a new bureaucracy without a corresponding benefit to the public. Doctor, I have worked at every level of government except the county, and I believe government is, by its nature, an inefficient instrument. I believe that there are areas where the government as the resource of last resort must necessarily be both the leader and the administrator of certain functions, but only where these functions, by their nature, are intrinsictly and/or historically governmental. Such areas require governmental administration with concomitant inefficiencies. However, any function that can be performed by the private sector should be done by that sector.

Everything your Commission or the Nation's First Lady's Commission had in mind administratively for health alliances is being now performed by a large number of private firms in a highly competitive market, it should, with some standardization of forms and procedures, stay where competition will keep it honed to the sharpest degree of efficiency. Thank you for giving us the opportunity to express our views.

Sincerely yours,



Horace G. Rhodes
Executive Vice President and General Counsel

HGR/jdr

Oklahoma Dental Association
629 West I-44 Service Road, Oklahoma City, Oklahoma 73118-6098 405/848-8873

December 10, 1993

Garth L. Splinter, M.D.
Chairman, Commission on Oklahoma Health Care
800 N.E. 15th Street, Suite 342
Oklahoma City, Oklahoma 73104

Dear Dr. Splinter:

The Oklahoma Dental Association appreciates the opportunity to be included in the 1993 Report of the Commission on Oklahoma Health Care. The Commission has worked diligently to review the status of health care within the state and should be commended for its efforts.

Though dentistry was not specifically addressed in the report, reference was made of the goal to coordinate with and complement the federal plan. The federal plan does include dentistry.

We support the principle that every citizen should have access to health care and we agree with the need for comprehensive, system wide reform. The principle of tort reform is strongly endorsed, especially with caps on punitive judgments. We strongly support freedom of choice of providers and not taxing other health care benefits not included in the basic package.

There should be no discrimination by degree of provider. Financial incentives such as loan forgiveness should be established to enhance access to underserved areas. All employers should provide catastrophic and preventive medical health care coverage to employees as long as they are given five years to comply and adequate offsetting tax incentives.

Oral health care is an integral part of the overall primary health care of an individual. Dentistry, however, is not part of the health system

problem as there are significant differences between the delivery of dental and medical treatment. The public would be better served by expanding the private dental benefits system than by including dentistry in medical reform since dentistry already incorporates the following goals: disease prevention, "gatekeeper" system (80 percent of all dentists are in general practice and are the primary oral health care providers) encouraging cost-conscious treatment, dental benefits (not insurance) that hold down costs and enhance competition, and patient freedom to choose their doctors.

Treatment for children should be need based, not age based as in the federal plan. We strongly support the principle that all children should have access to basic preventive dental care to include sealants and simple restorations. Fluoridated water systems should be expanded legislatively.

We would like to be included in discussions of the proposed benefits package. Participation should not be mandatory and if dental benefits are added, appropriate funding should be included to ensure provider participation. Dentistry's share of total health dollars has shrunk to less than 5 percent, with only 4 percent of those dollars from public funds. We recognize that 53 percent of dental care is paid for directly out of pocket and that our system is superior to any other dental care delivery system in any country in the world.

Dentistry provides an outstanding example for the overall health care delivery system. We look forward to participating in the ongoing discussions of health system reform.

Sincerely,

Kenneth S. Gluski, D.D.S.
President

KSG/jd

Professional Independent Insurance Agents of Oklahoma, Inc.

December 10, 1993

Garth L. Splinter, M.D., M.B.A.
Chairman
Commission on Oklahoma Health Care
Rogers Building, Suite 342
800 Northeast 15th Street
Oklahoma City, OK 73104

Reference: **Final Report - 1993**
Commission on Oklahoma Health Care

Dear Dr. Splinter:

I have just received a copy of the "Report to the Legislature and Governor" from the Commission on Oklahoma Health Care. I apologize for the delay in my response, however, the report was just received today.

The **Professional Independent Insurance Agents of Oklahoma** is a trade association representing over 3,000 independent insurance agents and their employees. Most of our members are actively involved in the debate on health care reform. On a daily basis they help their clients evaluate and select the best health care coverages available.

I have not had an opportunity to completely digest the details of this report, however, I am concerned with the recomendation regarding purchasing alliances. Our association as well as our national affiliate, Independent Insurance Agents of America are opposed to exclusive purchasing alliances. However, rather than dwell on the negative, I would like to communicate to you what specific items of health care reform we do support:

- ☐ **Voluntary Health Alliances (Health Insurance Purchasing Cooperatives)**
- ☐ **Guaranteed issue**
- ☐ **Elimination of pre-existing condition exclusions**

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- ☐ **No exclusion of employees from employment-based groups**
- ☐ **Guaranteed renewability**
- ☐ **Portability of health insurance coverage between jobs**

We are eager to discuss these and other facets of health care reform with the Commission should you wish to do so. Thank you for an opportunity to offer our opinions on the report of the Commission.

Sincerely,

Bruce B. Coates
Chief Executive Officer

cc: Dan Ramsey, CIC
President-PIIAO

C.Courtney Wood
President - IIAA

Oklahoma Association of Community Mental Health Centers

4400 North Lincoln Boulevard
Oklahoma City, OK 73105

MEMBER AGENCIES:

Associated Centers for Therapy, Inc. - Tulsa
Edwin Fair Community Mental Health Center Ponca City
Chisholm Trail Mental Health Center - Yukon
Community Counseling Center - Oklahoma City
Creeks Mental Health Services, Inc. - Okmulgee
Family Mental Health Center - Tulsa
Grand Lake Mental Health Center - Nowata
Green Country Mental Health Services, Inc. - Muskogee
Hope Community Services, Inc. - Oklahoma City
Mental Health Services of Southern Oklahoma - Ardmore
New Horizons Community Counseling and Mental Health Services, Inc. - Clinton
North Care Center - Oklahoma City
Wheatland Professional Services, Inc. - Enid
[illegible] Inc. - Tulsa
Red Rock Mental Health Center - Oklahoma City
[illegible] Community Mental Health Center Inc. - Tulsa

December 9, 1993

Garth L. Splinter, M.D., Chairman
Commission on Oklahoma Health Care
Rogers Building
800 N.E. 15th Street, Suite 342
Oklahoma City, OK 73104

Dear Dr. Splinter:

Please accept our comments for inclusion in your 1993 Report of the Commission on Oklahoma Health Care which will soon be submitted to the Legislature and Governor. We appreciate the opportunity to review and weigh the recommendations included in that Report.

As you would expect, we are specifically committed to accessible mental health and substance abuse services for all Oklahomans. Our concerns, however, are much broader than those specific health care areas. Of primary interest to our member agencies is that the quality and availability of health care in general is guaranteed to all Oklahomans.

Each year approximately 40,000 Oklahomans are served by community mental health centers. A significant portion of our clients are indigent, uninsured, or for a variety of reasons do not have access to adequate primary health care. We are concerned about their health in general. Consequently, we support many of the recommendations offered in your recent Report.

In light of your recommendations, we wish to underscore the following:

- Regardless of any mandated national reform, it is essential that the state mandate require core benefits to be included for coverage by all insurance carriers and the public health delivery system.

* Such a uniform benefits package should place a high priority on community based care that is preventative and early intervening in focus.

* Any revisions in the health delivery system should emphasize consumer choice and reward consumers who take responsibility for preventative health care and healthy living styles.

* We concur that the shortage of primary care physicians must be corrected. Further, we support the concept that training in primary care should emphasize a holistic and preventative focus.

* Managed care systems should be more fully utilized if, as such, they also emphasize quality of care, flexible access to care, and reasonable consumer choice and responsibility.

* Tort reform is also essential to cost reduction in our health care system. We particularly are supportive of immunity from nonfeasance litigation for practitioners for whom standards of care have been developed and monitored.

* Special attention must be given to a system of long term care for persons affected by a variety of conditions. Long term care issues must be recognized within the total array of services needed.

We appreciate the opportunity to comment on the documents you have produced thus far. Also, we are eager and available to review future recommendations that emerge from this crucial process you have implemented.

Sincerely,

John T. Hudgens,
President

Oklahoma Psychiatric Association

a district branch of the American Psychiatric Association

P.O. Box 1328 * Norman, OK 73070-1328 * (405) 329-1100

December 9, 1993

Carth L. Splinter, M. D., Chairman
Commission on Oklahoma Health Care
Rogers Building
800 NE 15th, Suite 342
Oklahoma City, OK 73104

Dear Doctor Splinter:

Thank you for sending me the 1993 Report of the Commission on Oklahoma Health Care. We appreciate the opportunity provided for input.

The Oklahoma Psychiatric Association would like to go on record that mental health and substance abuse prevention and care are major health problems and should be included in any health care proposal. Moreover, we wish to state that we would like to ensure that mental health and substance abuse services prevention and care be included in any benefits proposal on an equal basis with other illnesses.

Our concern is that those citizens who are experiencing problems with mental illness or substance abuse are allowed equal opportunities for prevention, care and treatment as someone who has cancer, diabetes or any other illness.

Thank you for your consideration of our concerns for the mentally ill of Oklahoma.

Sincerely,

Shree Vinekar, M. D.
President

SHREE VINEKAR, President, 608 NW 9th, Suite 6010, OKC 73102

KYLE STEWART, President-Elect, 408 Medical Park Center, Bartlesville, 74006

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MARK KELLEY, Alt. Delegate, 1725 E. 19th, #401, Tulsa 74104

THERESA FARROW, Parliamentarian, 1623 E. 15th, Ste 3, Tulsa 74120

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1st Councilman
Tulsa

JOAN WEBB
2nd Councilman
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JOHN CHELF
3rd Councilman
Tulsa

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OAHC

OKLAHOMA ASSOCIATION FOR HOME CARE
2212 N.W. 50th St., Suite 158
Oklahoma City, Oklahoma 73112
405-843-1828

Friday
December 10, 1993

Garth L. Splinter, M.D.
Commission on Oklahoma Heath Care
800 N.E. 15th St., Suite 342
Oklahoma City, OK 73104

Dear Dr. Splinter:

As representative of the Oklahoma Association for Home Care, I would like to commend the commission and its subcommittees for the work that has been accomplished resulting in the document, "Report to the Legislature and Governor."

There are two particular points upon which we feel compelled to comment. These are both in the area of cost containment and finance. In theory, we do not disagree with using capitation as a strategy to encourage cost-effective care. However, since the home care portion of health care is such a relatively new industry, we are concerned with the lack of data available to utilize in setting capitation rates. As we feel any health care reform must include home care, if the issues of cost containment, quality patient care and patient satisfaction are considered, we would suggest that the present mechanism used by managed care organizations might be a viable alternative for home care. This entails severely discounted fees with utilization controlled by the HMO case managers. As the data is tracked and more readily available, we could then move toward a capitation system.

The commission's belief in death with dignity and strategies involved to control health care costs in the last days of life are highly lauded by our organization. Hospice has been the proven choice to meet these cost effective strategies and still maintain the patient's right to death with dignity.

Thank you very much for the opportunity to comment upon this extremely important issue.

Respectfully,

Phyllis A. Donley

Phyllis A. Donley
Director, Home Health Services
Baptist Medical Center

Oklahoma Nurses Association

6414 N. Santa Fe #A • Oklahoma City, OK 73116-9114 • 405/840-3476

December 13, 1993

Garth L. Splinter, M.D., M.B.A., Chairman
Commission on Oklahoma Health Care
800 NE 15th Street, Room 342
Oklahoma City, OK 73104

Dear Dr. Splinter:

As a member of the Technical Support Staff of the Commission on Oklahoma Health Care, I was very pleased to take part in such an important endeavor. The Oklahoma Nurses Association believes this Report can provide a solid framework for future reform of Oklahoma's health care system.

The Commission should be commended for addressing the problem of availability and accessibility of mid-level providers. Mid-level practitioners such as Nurse Practitioners, Clinical Nurse Specialists, Nurse Midwives, Nurse Anesthetists, as well as other specialty groups, are encouraged by the Commissions' position on this significant detail.

Oklahoma Nurses have long supported efforts to create a health care system that assures access, quality, and services at affordable costs for all citizens. As a member of the Coordinating Council of Oklahoma Nurses for Health Care Reform, we advocate a restructured, consumer-focused health care system with multi-disciplinary providers for cost-effectiveness.

Our coalition members, listed on the attached position statement, have agreed the major issues presented in the Report to the Legislature and Governor are those we will support in the upcoming years.

I look forward to working with you towards completion of our task.

Respectfully,

Katherine A. Choate

Katherine A. Choate, RN, CPNP, MSN
President

KAC/co
splinter.123

POSITION STATEMENT
OF
OKLAHOMA NURSES FOR HEALTH CARE REFORM

Oklahoma Nurses for Health Care Reform, a coalition representing a variety of nursing organizations, speaks for the 18,855 registered professional nurses in our state. Registered nurses comprise the largest group of health care providers in the state and are found in many health care settings, including rural and medically underserved areas. Oklahoma's nurses have long supported efforts to create a health care system that assures access, quality, and services at affordable costs for our citizens. We advocate a restructured, consumer-focused health care system with multi-disciplinary providers for cost effectiveness.

We call for:

1. *a basic core of essential health care services to be available to everyone.*
2. *a health care system that will focus on consumers and their health, with services to be delivered in familiar, convenient sites, such as schools, workplaces, and homes.*
3. *a shift from the predominant focus on illness and cure to an orientation toward health promotion and disease prevention.*
4. *the inclusion of registered nurses as an essential part of the basic core of services.*

As priorities, we call for:

1. *increased consumer access to nurse providers.*
2. *inclusion of registered nurses on boards, commissions, committees, and task forces involved in decision-making at the state and local level.*
3. *establishment of prescriptive authority for advanced practitioners as defined in the Oklahoma Nurse Practice Act.*
4. *utilization of nurses in expanding roles.*
5. *reimbursement for nursing services.*

Nursing organizations that support the Position Statement include:

Central Oklahoma Chapter of the Association of Operating Room Nurses
Oklahoma Emergency Nurses Association
Oklahoma Nursing Student Association
Oklahoma Association of Pediatric Nurse Associates and Practitioners
Northeast Oklahoma Oncology Nursing Society
Oklahoma Inservice Educators Association
Oklahoma Public Health Association - Nursing Section
Oklahoma Nurses Association - Political Action Committee
Oklahoma Nurses Association
Oklahoma Association of Nurse Practitioners
Oklahoma Association of Clinical Nurse Specialists
Greater Tulsa Area Chapter of the American Association of Critical Care Nurses
Oklahoma Association of Nurse Anesthetists
Oklahoma City Chapter of the American Society of Post Anesthesia Nurses
Oklahoma Association of Occupational Health Nurses
Oklahoma League for Nursing
Oklahoma Association of Women's Health, Obstetric, and Neonatal Nurses
Oklahoma Nurse Assistance Program
Oklahoma Council of Directors of Practical Nursing Programs
Oklahoma Society of Health Care Recruiters
Oklahoma Association for Home Care
Oklahoma Council of Deans and Directors of Baccalaureate and Higher Degree Programs