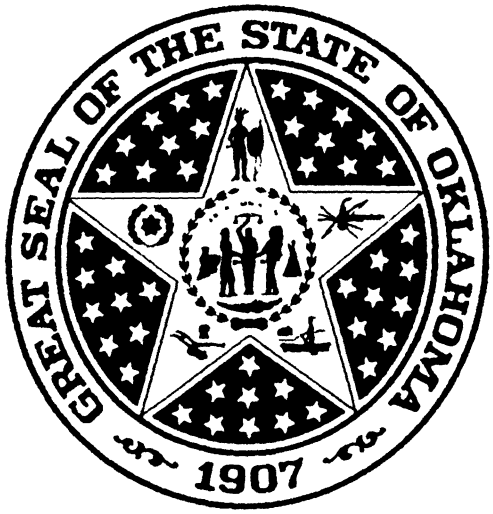
Final Report of the Joint Committee on Federal Health Care Law



Oklahoma Legislature

February 22, 2012

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Membership of the Joint Committee on Federal Health Care Law

Senate Appointees:

Senator Gary Stanislawski, Co-Chair
Senator Cliff Aldridge
Senator Bill Brown
Senator Sean Burrage
Senator Brian Crain
Senator John Sparks

House Appointees:

Representative Glen Mulready, Co-Chair
Representative Doug Cox
Representative Randy Grau
Representative Danny Morgan
Representative Jeannie McDaniel
Representative Jason Nelson

Introduction

The Joint Committee on Federal Health Care Law was jointly created by Senate President Pro Tempore Brian Bingman and House Speaker Kris Steele near the conclusion of the 2011 legislative session. The Joint Committee was tasked with studying how recent changes to health care and health insurance laws enacted through the federal Patient Protection and Affordable Care Act would affect Oklahomans. At the direction of the co-chairs, Senator Gary Stanislawski and Representative Glen Mulready, the Joint Committee convened in both Oklahoma City and Tulsa for a total of five public meetings spanning September, October, and November 2011.

The Joint Committee heard from over two dozen presenters from both the public and private sector who provided their input on the potential effects of the Patient Protection and Affordable Care Act. Many of the presentations from the public meetings may be found at the Joint Committee's website, www.okhealthcare.info. Additionally, a list of presenters may be found in the Joint Committee's meeting notices, which are included in the appendix. This report is intended to provide members of the public with a synopsis of the major findings presented by the speakers, as well as provide recommendations for Oklahomans and Oklahoma policymakers in addressing the recent changes to federal health care and health insurance laws.

Findings

The following findings were presented to the members of the Joint Committee on Federal Health Care Law.

Public Health Care

- Health behaviors are the largest contributing factor to overall health and premature death. The top three leading causes of death in Oklahoma are cardiovascular disease, cancer, and chronic obstructive pulmonary disease (COPD).
- The leading health behaviors and risk conditions include adult obesity, tobacco use, physical inactivity, and low fruit and vegetable consumption.
- Oklahoma Medicaid has the lowest error rate in the US after a five-year effort led by the Legislature.
- Recent reforms within the Oklahoma Medicaid program include the Patient-Centered Medical Home, where Oklahoma Medicaid's program serves as a national model.
- In 2009, 18 percent of Oklahoma's population was uninsured, which is equal to 658,862 Oklahomans.
- Insure Oklahoma is a public-private partnership and model program that provides coverage to 31,465 uninsured Oklahomans who are not eligible for Medicaid coverage.
- Approximately 20 percent of Oklahomans are currently on Medicaid, with a total per member cost of $4,595.

- Under the federal Patient Protection and Affordable Care Act (PPACA), it is estimated that an additional 200,000 Oklahomans would be eligible for the Medicaid program in 2014, with an additional 50,000 Oklahomans who were previously eligible for the program expected to "come out of the woodwork" and enroll. This would result in an additional annual cost of $41.6 million to the state. Using the Congressional Budget Office's standard participation rate, however, the Oklahoma Health Care Authority (OHCA) estimates that only 57 percent of eligible people will actually sign up for the program in 2014, which would be an additional annual cost of $23.8 million to the state.

Private Health Care

- Approximately 81 percent of the population under age 65 has some form of either private or public coverage, and nearly all Oklahomans over age 65 have some form of federal or employer-sponsored coverage.
- Oklahoma has 38 insurance mandates, ranking it 21st in the nation (from lowest to highest).
- Currently, three companies write 78 percent of the individual market in Oklahoma, and three companies write 70 percent of the small group market in Oklahoma.
- There is a concern that the 3-to-1 age band mandate under PPACA, which requires premiums for the oldest person in the pool to be no more than three times higher than the youngest person in the pool, will disrupt the market and substantially increase premiums for younger people. Most states currently have an age band of 5-to-1.

- The 3-to-1 age banding provisions under PPACA have the potential to drive younger consumers to pay the penalty in lieu of participating in mandated insurance plans, thus keeping them out of the risk pool.
- For one insurance company, over 80 percent of the customers in the individual market currently purchase insurance that is below the mandated minimum level of coverage under PPACA. Therefore, premiums are expected to grow substantially due to PPACA mandates.
- By 2014, all plans will be required to cover preventive women's health and well-being services, including all contraceptive methods and sterilization procedures approved by the federal Food and Drug Administration, without any cost sharing.
- PPACA is mostly about insurance reform and coverage and less about health care delivery reform.
- Patients with insurance have better access to physicians and can avoid shifting the cost of care to commercial payers.
- Approximately 70 percent of the people in hospitals today are there as a direct result of their own behaviors, such as smoking, diet and obesity, and lack of exercise. Oklahoma ranks 48th in the nation for smoking and 46th in the nation for diet and obesity (from lowest prevalence to highest prevalence).
- Hospitals in Oklahoma will lose over $2.6 billion over the next ten years to help pay for PPACA.

- Doctors see approximately 4,000 patients per year. Each patient sees their physician approximately twice per year. Therefore, if Oklahoma adds 250,000 new Medicaid recipients, 125 new doctors would be needed. Oklahoma already has a doctor shortage and is ranked 49th in the nation in the number of primary care physicians per capita.

Legal and Constitutional Issues

- A recent amendment to the Oklahoma Constitution provides individuals with the right to be free from being compelled to buy health insurance. PPACA's individual mandate is in direct conflict with Oklahoma's new amendment. However, the supremacy clause of the United States Constitution requires that, if state and federal law conflict, the state law must yield, provided that the federal law is constitutional.
- More than 25 states, including Oklahoma, have challenged PPACA's individual mandate as being unconstitutional. The United States Supreme Court is expected to hear arguments in one of those cases in March 2012, and an opinion should be rendered by July 2012.
- The exchanges, provisions of PPACA, have not been challenged by any of the lawsuits.
- In addition to utilizing judicial review as a challenge to federal oppression, the Joint Committee also addressed the issue of whether there may be some sort of nullification of the federal health care law.
- The concept of nullification provides that states can use their state powers to not corroborate. In the end, however, it is likely that states will still be subject to the provisions of PPACA even if they engage in potential nullification efforts.

Tribal Issues

- The American Indian population in Oklahoma is 415,371.
- There is no cost sharing allowed for American Indians enrolled in an exchange with an income less than or equal to 300 percent of the Federal Poverty Level.
- The tribes would like to designate all Urban Indian Health Programs, also referred to as I/T/U's, as Qualified Health Providers under PPACA.

A Look at the States

- Six states have returned federal PPACA grant money: Florida, Kansas, Louisiana, New Hampshire, Oklahoma and Wisconsin.
- Massachusetts developed a Commonwealth Health Insurance Connector Authority in 2006 with a board charged with implementing the exchange and establishing procedures for selecting and approving private plans to be offered in the Connector. Massachusetts has the highest rate of insured residents and already has in place many of the laws now required by PPACA.
- Utah also has the Utah Health Exchange that is administered and facilitated by the Office of Consumer Health Services, an existing state agency. Utah's exchange, however, is not PPACA-compliant.
- Ten states have enacted legislation relating to exchanges, and three states - Florida, Louisiana and Texas - have stated that they will go the federal exchange route. Florida, however, has recently established a non-compliant small business exchange.

- There are three models of health exchanges:
    - State exchange: State assumes responsibility for compliance and certification.
    - Partnership exchange: Some of the functions would be retained by the state.
    - Federal exchange: The state is not involved in the operation of the exchange.
- Within state exchanges, there are several options:
    - State governmental agency (may be existing or independent public agency)
    - Non-profit organization
    - Contract with other eligible entities to carry out functions
    - Governing body
    - State regulated insurers in the exchange
- Some states do not want to enforce the individual mandate or the tax credits and want the federal government to handle those areas.
- With a federal exchange, the state loses control of the:
    - Outreach to consumers
    - Navigator selection
- The opinion of one presenter was that April 2012 is the latest a state could wait to decide on what path to take regarding an exchange before the federal government will start moving into a state to set up an exchange.
- In addition, it is believed that if a state does not cooperate with the federal government in the establishment of an exchange, the federal government will design an enforcement strategy to force compliance.

Individual/Medicaid Exchange and Small Business Exchange

- If Oklahoma is not deemed exchange-ready by January 1, 2013, the federal government will establish a federally operated exchange in the state.
- If the federal government establishes the exchange, Oklahoma will lose regulatory authority over the plans sold on the exchange, including the authority to certify the Qualified Health Plans. In addition, the state would lose the ability to determine the role of navigators.
- State-Run Exchanges:
    - For a state-run exchange to be deemed in compliance with federal requirements, it must be able to do the following:
        - Eligibility and Enrollment: Web portal to shop, select and purchase plan; determine eligibility and apply premium tax credits; interoperability with public programs.
        - Consumer Assistance: Call center and grievance procedure; determine the role of navigators.
        - Planning and Governance: Public stakeholder engagement; authorize governing entity; establish conflict of interest procedures.
- One presenter believes that Oklahoma's share of Medicaid spending between 2014 and 2019 will increase from $212 million to $789 million.
- The federal version of an exchange is a medical welfare program, not health care.

- Since the states regulate insurance, they could offer, not require, a Small Business Exchange with the following benefits:
  - A Defined Contribution Model, which helps businesses control their costs.
  - The employee picks the coverage, therefore the individual controls choices.
  - Improved quality of insurance since the employee picks the company and can change the following year.
  - Allows companies to contribute even for part-time employees at reduced contribution levels. This allows more people to become insured in the private marketplace.
  - Could allow a Section 125 plan so the employees could have extra pre-tax money withheld from their paychecks to allow them to choose the plan best suited for their families.
- If the federal government imposes an exchange on the state, economic incentives in the marketplace would drive employers to eliminate health insurance coverage for workers. This would result in lower-income individuals using the federal exchange and more affluent individuals buying individual insurance.
- PPACA requires every health insurance exchange to have a Navigator Program to facilitate health plan enrollment. Navigators could be required to have the same education and training as current agents.
- Agents and brokers are permitted to serve as Navigators under the new law, but the language stipulates a compensation method that conflicts with traditional agent compensation structures.

- Independent Insurance Agents of Oklahoma (IIAO) does not support the federal health care plan or the need for a health insurance exchange; however, IIAO feels strongly that Oklahoma should have an exchange in place by January 1, 2014, so the federal government will not impose its plan on Oklahoma.
- IIAO believes that certain elements should be contained in any plan:
    - Governance of the plan should have a representative from insurance agents.
    - Any person selling, enrolling, contacting persons, etc. must be subject to all provisions of the Oklahoma Producer Licensing Act, including any person serving as a Navigator.
    - Any plan must include a plan to compensate agents for the service they provide. The Utah approach is recommended.
    - There should be a registration process for agents to access the exchange
    - There should be provisions for competitive exchanges and the system should not only allow a state-based exchange.
- Independent Insurance Agents and Brokers of America (IIABA) strongly encourages states to establish their own exchanges using the free market approach. The preferable approach would be to include every qualified plan possible on the state exchange.
- If the state does not establish an exchange, the state would lose control of defining the role of agents and brokers. In addition, the federal government could limit the number of insurance companies.
- IIABA urges states to provide information on agents and brokers to consumers on the exchange website.

- IIABA feels that anyone selling, soliciting, or negotiating insurance in an exchange should be duly licensed, complete all requisite continuing education requirements, and have obtained Errors and Omissions coverage. These licensing laws and other requirements should also apply to Navigators.
- The Joint Committee also heard from two exchange providers that demonstrated how an exchange would function with minimal up-front costs. One of the providers is setting up an exchange in Maryland, while the other provider is establishing a free market exchange in Florida.

Health Information Exchange

- MyHealth Access Network is a consortium of organizations which have come together to improve the health and quality of life for persons in the Tulsa area through the establishment of a Health Information Exchange in the greater Tulsa area. This program links more than 1,600 providers and their patients in a community-wide health information system that will help them better monitor and improve care.
- The problem in health care is that we currently have a highly fragmented health care system with many patients often seeing doctors in separate health systems. This leads to duplication of services and inefficiencies.
- A Health Information Exchange provides immediate benefits and greater cost savings. The value of the Health Information Exchange in Tulsa is that it is a community-controlled system.

- One of the goals of Health Information Exchanges is to establish patient-centered medical homes.

Senator Tom Coburn

The Joint Committee also asked Dr. Tom Coburn, U.S. Senator to Oklahoma, to present to the Joint Committee. Although he was unable to attend a meeting, he did meet with the co-chairs of the Joint Committee and provided the following recommendation based upon his knowledge of PPACA:

> "Dr. Coburn supports state-based efforts to create free-market, voluntary health insurance exchanges that encourage transparency, consumer choice, and individual control. States should be able to use state dollars to pursue innovative strategies to better equip consumers with information about their health coverage choices. In this model, consumers can compare plans via the Internet or a toll free number, so they can choose a plan tailored to their individual needs. In this way, state-based exchanges can help facilitate the purchase of private health insurance based on price and quality.
>
> The kind of market-based solution Dr. Coburn supports looks a lot like Utah's market-based health exchange. It does NOT resemble Massachusetts' heavily-regulated, state-level bureaucracy, or the federally-mandated exchanges required by the Patient Protection and Affordable Care Act (Obamacare) – both of which are built around an individual mandate and price controls on private health insurance that increase the cost of health insurance for consumers. The main problem with health insurance is that it costs too much – but the changes in Massachusetts and Obamacare

have been proven to simply increase the cost of coverage, while failing to improve access.

Dr. Coburn supports states using state dollars to tackle the challenges of their own population. He does not think that any state involved in a lawsuit against Obamacare should use Administration grant dollars to set up an exchange – regardless of whether that exchange looks more like Utah's model or Obamacare's model. He is glad that Oklahoma has filed a lawsuit against Obamacare and will continue to do everything he can at a federal level to overturn this unconstitutional $2.6 trillion law that fails to fix what is broken in our health care system."

Recommendations of the Joint Committee on Federal Health Care Law

We believe our recommendations should encourage personal responsibility and enrollment in private market coverage over entitlement programs. They should also preserve individual liberty. In addition, the Joint Committee on Federal Health Care Law's goal is to improve availability, accessibility, and affordability of health care.

Public Health

We must continue to educate our citizens on the price we pay as a society for our poor lifestyle decisions. We must focus on the youth of our state to have any kind of long-term impact. Physical and health education must be taught in schools with an emphasis on obesity, smoking, and heart health. We must also encourage more collaboration between the public and non-profit sectors that are already working in this area.

We must do all that we reasonably can to ensure that Oklahoma taxpayer dollars used for public health care are used wisely. Should the federal health care law stand, we are staring at a major expansion of our Medicaid population. This makes it even more critical for us to closely monitor the use of these dollars. Increased incentives for non-smokers, penalties for regular but unnecessary emergency room visits, drug testing and treatment, as well as strict auditing of enrollees, are some areas for focus. Some other recommended ideas for cost savings include increased copayments, limited name brand prescription drugs, and additional managed care. Oklahoma had some experience with managed care programs over ten years ago. There are a number of states moving in this direction to control costs. We would like to see the state Medicaid agency, the Oklahoma Health Care Authority (OHCA), try some additional managed care ideas, such as the medical home initiative that they are

already attempting with some small test groups. This would allow us to better understand what works and what does not work with our population and then implement these lessons on a broader basis if they are found to be effective. Another area to be tested would be payment for value as opposed to payment for services. Such a model has the potential to reduce overall costs while potentially improving health outcomes for the patients. We also encourage OHCA to increase their fraud division to continue their efforts to fight against crime in this area.

Legal Strategy

We recommend that the Office of the Attorney General continue to fight PPACA from every legal angle. We understand from our time spent with the Solicitor General that this is currently occurring, but we encourage them to continue to pursue every option and ask that they keep the Legislature apprised of any progress on our legal challenges.

Additionally, we would like to have a legal opinion from the Attorney General clarifying what was stated by the Solicitor General as well as a constitutional attorney who presented during the Joint Committee's meetings that "nullification" is indeed not a legal option for our state.

Health Insurance Exchanges

One of the critical decisions for our state is the requirement under PPACA for all states to have a health insurance exchange fully operational by January 1, 2014. If our state chooses not to implement our own state-based exchange, then the federal government will begin to implement a federal exchange on January 1, 2013. We are adamantly opposed to a federal health insurance exchange being implemented in our state. We do not believe that the federal government knows our citizens best, nor do we believe they have a good track record of doing things efficiently and cost-

effectively. We also believe that a PPACA exchange would be heavily regulated, thereby limiting choice to only four plans - the Bronze, Silver, Gold, and Platinum plans - and restricting competition.

In an effort to stop the implementation of a federal exchange and to provide better market-driven options for our citizens, we recommend that we establish a state-based private marketplace network. Private industry has not implemented this yet, so we believe the state has an obligation to improve health care choices for our citizens. This network would be along the lines of the Utah model for small businesses that pre-dates PPACA. The network would allow all insurance companies to participate ("any willing carrier") and would let the market drive what products are offered through this mechanism. Small businesses would not be required to participate, but would have the option for their employees. This model eases access for more insurance companies and encourages competition. It reduces the number of the uninsured, improves the accessibility and affordability of health insurance, and addresses a common problem that we have failed to address in our current system: portability. As one Joint Committee member pointed out, "portability is important for many of my constituents. It would be nice if they were not tethered to dead end jobs or lose hope due to health insurance restrictions. I would like them to be able to consider career/job moves that allow them to move up the economic ladder without the loss of insurance." We believe that our citizens should have the right to select the doctors and hospitals that they believe would be best suited for their families. We also value the defined contribution and premium aggregation features. We would like to see wellness programs being incorporated into the options, as well. Finally, we believe by allowing the employees to choose their own health care plans, they will be able to choose the plan that would best meet the needs of their own families.

In an effort to fend off a federal exchange and to build upon the success of Insure Oklahoma, we recommend moving Insure Oklahoma from the Oklahoma Health Care Authority to a public trust.

Insure Oklahoma is supported by insurers, small employers, hospitals, and doctors. It is funded by an increase in the tobacco tax which was passed by a statewide vote of the people in November 2004. Insure Oklahoma has:

-31,465 Oklahomans enrolled in the program

-5,109 businesses enrolled in the program

-20 insurance companies offering coverage

-56 percent of enrollees were previously uninsured

We believe that by separating Insure Oklahoma from the Oklahoma Health Care Authority, we can direct more people to private health insurance plans. In addition, we can offer more small business owners the choice to enroll in and begin a defined contribution model which, when combined with a cafeteria plan, would allow employees the opportunity to choose their own insurance plan using pretax dollars. Simplifying administrative burdens and establishing predictable insurance costs would make small businesses more likely to provide health coverage to their employees.

Other Recommendations

We would also recommend that the Legislature establish either a joint health reform committee or that each chamber establish its own such committee. This will enable us to continue to monitor this critical issue and be able to respond with legislative recommendations as needed.

Oklahoma needs to do more to retain doctors in rural settings. Therefore, we recommend that the Legislature place an emphasis on growing our residency programs and encouraging more doctors to practice in rural areas of our state.

Regarding Health Information Exchanges, the Joint Committee feels that there should not be a system where patients "opt out", as it is currently structured. Rather, due to the extremely personal information on the exchange, patients should "opt in" to allow their medical records to be placed on an exchange.

We believe that the Oklahoma Insurance Department should request a waiver to exempt insurance companies from the 3-to-1 age band and allow a 5-to-1 age band to avoid encouraging younger insured persons from dropping out and thereby increasing adverse selection.

Due to the significant Native American population and their unique health care systems, we recommend consulting the Tribal Nations throughout the process.

In closing, the Joint Committee agrees with the recent statement from Governor Mitch Daniels who said, "Many of us Governors are hoping for either a judicial or legislative rescue from this impending disaster, and recent court decisions suggest there's a chance of that. But we can't count on a miracle-that's only permitted in Washington policy making. We have no choice but to prepare for the very real possibility that the law takes effect in 2014."

Appendix

Oklahoma Legislature

Brian Bingman
President Pro Tempore
Senate

Kris Steele
Speaker
House of Representatives

MEETING NOTICE

September 7, 2011

JOINT COMMITTEE ON FEDERAL HEALTH CARE LAW

SUBJECT:	First Meeting
MEETING DATE:	**Wednesday, September 14, 2011**
MEETING TIME:	9:00 A.M.
LOCATION:	House Chamber, State Capitol Building

Agenda:

9:00 am – 11:30 am

1. **Welcome and Introductions**

2. **Present State of Health Outcomes and Health Care in Oklahoma**
   Julie Cox-Kain, Chief Operating Officer, Oklahoma State Department of Health
   Mike Fogarty, Chief Executive Officer, Oklahoma Health Care Authority

1:00 pm – 4:00 pm

3. **PPACA: Description of Mandates, Costs, and Other Implications for the State Concerning Public Health**
   Julie Cox-Kain, Chief Operating Officer, Oklahoma State Department of Health

4. **Medicaid and Accountable Care Organizations**
   Buffy Heater, Director of Planning and Development, Oklahoma Health Care Authority
   Cindy Roberts, Deputy Chief Executive Officer, Oklahoma Health Care Authority
   Jason Sutton, Policy Impact Director, Oklahoma Council of Public Affairs

5. **Other Business**

Senate Appointees:
Senator Gary Stanislawski, Co-Chair
Senator Cliff Aldridge
Senator Bill Brown
Senator Sean Burrage
Senator Brian Crain
Senator John Sparks

House Appointees:
Rep. Glen Mulready, Co-Chair
Rep. Doug Cox
Rep. Randy Grau
Rep. Danny Morgan
Rep. Jeannie McDaniel
Rep. Jason Nelson

Senate Staff:
Jennifer Mullens, Legislative Analyst
Alicia Emerson, Legislative Analyst
Lori Block, Staff Attorney
Andrew Messer, Staff Attorney
Anthony Sammons, Fiscal Analyst
Darrell D. Washington, Administrative Assistant

Oklahoma Legislature

Brian Bingman
President Pro Tempore
Senate

Kris Steele
Speaker
House of Representatives

MEETING NOTICE

September 30, 2011

JOINT COMMITTEE ON FEDERAL HEALTH CARE LAW

SUBJECT: Second Meeting
MEETING DATE: **Wednesday, October 5, 2011**
MEETING TIME: 9:00 A.M. – 4:30 P.M.
LOCATION: Tulsa Technology Center, Riverside Campus
801 East 91st Street
Tulsa, OK 74132
(918) 828-4000
Directions to center

Agenda:

9:00 am – 10:00 am
Review of Current Marketplace
Mike Rhoades, Deputy Commissioner, Oklahoma Insurance Department

10:00 am – 11:00 am
Impact on Employers
Mike Rogers, Health Care Committee Chair for the State Chamber of Commerce
Phillip Kennedy, MD, President, Comanche Home Center

11:00 am – 12:00 pm
Impact on Insurance Companies
Bert Marshall, President, BlueCross/BlueShield of Oklahoma
Richard Todd, CEO, Community Care

1:30 pm – 2:30 pm

Impact on Providers

George Caldwell, MD, Oklahoma State Medical Association
Craig Jones, President, Oklahoma Hospital Association

2:30 pm – 3:30 pm

Impact on Insurance Agents/Brokers

Janet Trautwein, CEO, National Association of Health Underwriters

3:30 pm – 4:30 pm

Impact on Private Health Care

Jonathan Small, CPA, Oklahoma Council of Public Affairs

Other Business

Senate Appointees:	House Appointees:
Senator Gary Stanislawski, Co-Chair	Rep. Glen Mulready, Co-Chair
Senator Cliff Aldridge	Rep. Doug Cox
Senator Bill Brown	Rep. Randy Grau
Senator Sean Burrage	Rep. Danny Morgan
Senator Brian Crain	Rep. Jeannie McDaniel
Senator John Sparks	Rep. Jason Nelson

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Darrell D. Washington, Administrative Assistant

Oklahoma Legislature

Brian Bingman
President Pro Tempore
State Senate

Kris Steele
Speaker
House of Representatives

MEETING NOTICE

October 24, 2011

JOINT COMMITTEE ON FEDERAL HEALTH CARE LAW

SUBJECT: Third Meeting
MEETING DATE: **Wednesday, October 26, 2011**
MEETING TIME: 9:00 A.M – 4:30 P.M.
LOCATION: Senate Chamber, State Capitol Building

Agenda:

1. 9:00 – 10:00 - Affordable Care Act impact on Indian Health

   Jefferson Keel, Lt. Governor, Chickasaw Nation

2. 10:00 – 10:45 - Status of PPACA lawsuits, what the ballot question did for Oklahoma

   Pat Wyrick, Oklahoma Solicitor General

3. 10:45 – 11:30 - Comparison of Federal vs. State based Exchanges

   David Blatt, Director of Oklahoma Policy Institute

4. 1:00 – 1:45 - Constitutional issues

   Andy Spiropoulos, Professor of Law and Director of the Center for the Study of State Constitutional Law and Government, OCU School of Law

5. 1:45 – 3:00 - What other States are doing

Laura Tobler, Health Programs Director, Martha Salazar, Policy Associate, NCSL

6. Other Business

Senate Appointees:
Senator Gary Stanislawski, Co-Chair
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Senator Bill Brown
Senator Sean Burrage
Senator Brian Crain
Senator John Sparks

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Darrell D. Washington, Administrative Assistant

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Brian Bingman President Pro Tempore State Senate	Mary Fallin Governor	Kris Steele Speaker House of Representatives

MEETING NOTICE

November 2, 2011

JOINT COMMITTEE ON FEDERAL HEALTH CARE LAW

SUBJECT: Fourth Meeting
MEETING DATE: **Thursday, November 3, 2011**
MEETING TIME: **9:00 A.M.**
LOCATION: Tulsa Technology Center, 801 W. "K" Place, Jenks, Oklahoma.

Agenda:

1. 9:00 - 10:00 AM, Exchange options, federal, federal/state partnership, state – Krista Drobac, Director of Health Division, National Governors Association
2. 10:00 - 10:45 AM, Technology and privacy issues with exchanges - Amanda Teegarden
3. 10:45 - 11:30 AM, Current Technology - David Kendrick, Director of HIT
4. 1:00 - 1:45 PM, Agent Compensation - Ryan Young, Director, Federal Government Affairs, Independent Insurance & Brokers of America
5. 1:45 - 2:45 PM, Exchange Options - Ed Haisimaier, Heritage Foundation
6. 2:45 - 3:30 PM, Exchange Providers - Josh Beckett, Benefit Focus
7. 3:30 - 4:15 PM, Exchange providers - Ceridian
8. Other Business

Senate Appointees:
Sen. Gary Stanislawski, Co-Chair
Sen. Cliff Aldridge
Sen. Bill Brown
Sen. Brian Crain
Sen. John Sparks

House Appointees:
Rep. Glen Mulready, Co-Chair
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Anthony Sammons, Staff Attorney
Darrell D. Washington, Admin. Asst.

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Brian Bingman President Pro Tempore State Senate	Mary Fallin Governor	Kris Steele Speaker House of Representatives

REVISED MEETING NOTICE

November 14, 2011

JOINT COMMITTEE ON FEDERAL HEALTH CARE LAW

SUBJECT: FIFTH MEETING
MEETING DATE: **Tuesday, November 15, 2011**
MEETING TIME: **9:00 A.M – 12:00 P.M.**
LOCATION: House Chamber, State Capitol Building.

Agenda:

1. 9:00 a.m. – 10:00 a.m.

   Non Profit Exchange – Mark Tozzio

2. 10:00 a.m. – 11:00 am

   Non Profit Clinics

3. 11:00 a.m. – 12:00 pm

   Committee Discussions

4. Other Business and Adjournment

Senate Appointees:
Sen. Gary Stanislawski, Co-Chair
Sen. Cliff Aldridge
Sen. Bill Brown
Sen. Brian Crain
Sen. John Sparks
Sen. Sean Burrage

House Appointees:
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