



**State of Oklahoma
Oklahoma Employees Insurance and Benefits Board
Oklahoma Health Care Authority
OEIBB Commercial Carrier Policy**

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POLICY

SECTION I. Policy Objective

This policy defines the following items related to commercial carriers within the Oklahoma Employees Insurance and Benefits Act (OEIBA) Program:

1. Board involvement in the contracting of commercial health, dental, vision and TRICARE Supplement plan.
2. What constitutes excessive pricing for commercial health plans.
3. The calculation of administrative fees on all plans.
4. The application of the statutorily required risk adjustment factor for health plans.

SECTION II. Contracting

Pursuant to Title 74 O.S. § 1304.1, the Oklahoma Employees Insurance and Benefits Board (OEIBB) shall perform its oversight as follows for the purchase of benefits to be offered in addition to the State’s self-insured HealthChoice plans as part of the OEIBA Program:

1. This policy incorporates the Office of Management and Enterprise Services (OMES) Central Purchasing procedures to be used to competitively bid for additional plans from commercial Health Maintenance Organizations (HMO) and dental carriers, and for those vision plans to be offered pursuant to 74 O.S. § 1374.
2. At its choosing, the OEIBB may participate in the competitive bidding process for commercial carriers.
 - a. The OEIBB may designate up to three of its members to participate in a negotiation meeting. At no time during the negotiation meetings shall the number of OEIBB representatives constitute a quorum of the OEIBB.
 - b. The OEIBB may utilize independent benefit consultants to assist with contract negotiations.
 - c. Participating OEIBB representatives shall be provided with relevant bid data prior to the negotiation meetings. All data received will be handled in conformance with

the confidentiality requirements of OMES Central Purchasing.

- d. The OEIBB representatives shall provide recommendations to the OEIBB regarding the results of the negotiation process.

3. Excessive Pricing

- a. As provided in 74 O.S. §1371(C) (2011) as amended, a bid response from an HMO may be rejected or have its enrollment restricted due to excessive pricing. For purposes of evaluation, a bid response will be automatically deemed to have excessive pricing if the HMO's proposed premium increase is greater than the sum of the two following components:
 - i. The most current National Health Expenditure (NHE) projected health cost growth for the following year and
 - ii. A tiered margin based upon the previous calendar year loss ratio for the Supplier for its most recent plan year.
- b. While the overall increase is capped as described in Section 3a, this maximum increase also applies to each billing unit/tier (primary, spouse, child, and children). For example, if the overall permissible increase is 10% as defined in Section 3a, each billing unit/tier premium cannot exceed an increase greater than 10%.
- c. The loss ratio is defined as claims divided by premiums. The loss ratio utilized is a simplified version of the NAIC defined Medical Loss Ratio (MLR) as required for health insurance carriers under Health Care Reform.
 - i. The tiered margins are as follows:

Loss Ratio	Tiered Margin
<85	0.0%
85-90	4.0%
90-95	7.5%
95-100	10.5%
>100	13.0%

- ii. Example: If the NHE projection for the future year is 6.0%, and the loss ratio of the plan is below 85%, an increase over 6.0% (6.0% NHE + 0.0% Margin) in premium from the previous year would be deemed excessive. For a plan with a loss ratio of 94%, the increase cannot exceed 13.5% (6.0% NHE + 7.5% Margin).
- iii. For a current Supplier that does not have a full year of claims experience with the OEIBA Program, the loss ratio will be based on the Supplier's book of business for the most recent plan year. For a current Supplier with a full year of claims experience with the OEIBA Program, the loss ratio will be based upon OEIBA Program experience.
- iv. Calculations are based as follows:
 - 1. Loss Ratio = Total Claims /Total Premium

2. Total Claims = (Incurred Medical Claims for Most Recent CY) + (Incurred Rx Claims for Most Recent CY) + (Incurred Capitation Claims for Most Recent CY) – (Pharmacy Rebates)
3. Total Premium = (Premium Collected for Most Recent CY) - (Risk Adjustment Payment (Credit)) – (Federal taxes and assessments) – (State Premium Taxes)
- d. The National Health Expenditures Data is found at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>
- e. Stricter pricing criteria may be imposed by the OEIBB at its own discretion through the Committee that oversees the procurement process to ensure that there is equity between Suppliers.
- f. OMES has the authority to apply the following actions as a result of not complying with Section 3:
 - i. Reject the bid in whole.
 - ii. Reject a plan within a bid.
 - iii. Restrict enrollment in whole or in part.
 - iv. Restrict Supplier from participating in future bids.

SECTION III. Administration Fee

OHCA is granted the authority “to assess and collect reasonable fees from contracted health maintenance organizations and third-party insurance vendors to offset the costs of administration” [74 O.S. §1304.1(M)(15)]. These administrative activities include (but are not limited to) enrollment, record keeping, accounting, and employee communication functions. These functions are carried out by the OHCA Employees Group Insurance Division (EGID).

The administrative fee is:

1. Independent of the risk adjustment factor.
2. Determined annually and remains constant through the plan year.
3. Calculated on a per member per month (PMPM) basis, not a per employee per month (PEPM) basis. Each primary and every dependent is therefore assessed a fee.
4. Calculated separately for each type of plan (HMO/TRICARE Supplement, vision and dental). It shall be the same fee amount for all Suppliers offering similar plan types (for instance, all dental plans).
5. Subject to change each year. The fee may go up or down in pricing. Suppliers will be notified of any change in the assessed administrative costs no later than the May 1st preceding the year the fee is effective.
6. Deducted from the received premiums prior to remittance to the individual Supplier, so the Supplier’s should have the administrative fee built into its final proposed premium rates.

Example of HMO administrative fee:

1. Plan Year 2022 HMO PMPM is \$4.477 collected by EGID. A family plan with member, spouse and five children would be assessed \$31.339 per month for this plan.
 - a. $\$4.477 * 7 = \31.339

The OEIBB will require a report on an annual basis indicating the methodology, any changes from the previous year, and a review of appropriateness by the actuarial consultants employed by EGID for purposes of negotiating commercial benefit contracts.

At least once every five years, EGID staff is requested to have an independent study of its administrative costs performed. The purpose of this is to:

1. Determine EGID's administrative expense on a PMPM basis.
2. Serve as the basis of administration fee allocation.
3. Compare EGID to industry peers engaged in similar lines of business which are similar in scope of business.

SECTION IV. Risk Adjustment

In order to provide for an equitable distribution of risk to be assumed by all contracted health plan carriers offered to the participants in this program, the OEIBB shall provide for a risk adjustment process between all health plan carriers that employs the use of sound actuarial principles. [74 O.S. §1371 (H)]

The risk adjustment amounts are calculated by EGID's actuarial consultants using the following steps:

1. Take the program's entire fully insured and self-funded non-Medicare covered population (primaries and dependents) and apply an age/gender factor to each member utilizing the Society of Actuaries age and gender risk factors. [Yamamoto, Dale. Health Care Costs – From Birth to Death: Society of Actuaries (2013)]
2. Normalize the factors to the overall population so that the average is 1.0 across the carriers.
3. Calculate the premium volume (initial premiums multiplied by headcounts) by carrier and apply the normalized risk factor. The total balance to be reallocated among the carriers is the sum of all carriers' differences between the risk adjusted premium and the initial premium.
4. The sum of each carrier's balance and allocated balance equals the risk adjustment based on each carrier's risk factor. The risk adjustment is applied in the form of a payment or withholding (as appropriate) to each carrier.
 - a. The overall net effect is zero, such that there is fairness across the carriers with no one carrier observing all of the healthy risk, while another carrier observes the poor risk and where that might be happening this helps to offset that.

Risk Adjustment Allocation Example (Refer also to Attachment A):

Carrier A has a risk score of 1.022, which is 2.2% riskier than the average of the overall population, which indicates that a payment to Carrier A will be made to help offset their exposure to a riskier population than the average.

1. Initial Premiums – The final negotiated premiums for the plan year under consideration applied to membership (primaries and dependents).
2. Risk Adjusted Premium - Using Carrier A as an example, its initial premium of \$5 million is adjusted to reflect its underlying risk relative to the overall program covered population. In the instance of Carrier A, this is a 2.2% increase for total risk-adjusted premium of \$5.1 million.
3. Balance - The 2.2% adjustment for Carrier A is an increase or a balance of \$110,000. The total adjustments across all carriers are summed, so in this example the total balance equates to \$855,000.
4. Allocated Balance - The allocated balance is a function of the carrier's risk adjusted premium volume relative to the total risk adjusted premium. In the instance of Carrier A, they represent about 8.6% of the total risk adjusted premium volume (\$5.1 million/\$59.1

million). Therefore, the amount allocated back is ~8.6% of the total balance, which is \$73,870 for Carrier A.

5. Risk Adjustment - The resulting payment is then the sum of the carrier's balance and its allocated balance. In the example, this results in \$183,870 paid to Carrier A. Carriers with risk scores above 1.0 will receive additional funds, while those with risk scores below 1.0 will have funds withheld. The sum of the risk adjustments across all carriers is a net zero impact.

Attachment A

2019 Premium Transfer						
	Carrier A	Carrier B	Carrier C	Carrier D	Carrier E	Total
Member Months	10,000	10,000	10,000	10,000	10,000	50,000
Initial Premiums (Primary & Dependents)	\$5,000,000	\$20,000,000	\$10,000,000	\$15,000,000	\$10,000,000	\$60,000,000
Factor	1.022	0.905	1.302	1.041	0.730	
Risk Adj Premiums	\$5,110,000	\$18,100,000	\$13,020,000	\$15,615,000	\$7,300,000	\$59,145,000
(a) Balance	\$110,000	-\$1,900,000	\$3,020,000	\$615,000	-\$2,700,000	-\$855,000
(b) Allocated Balance	\$73,870	\$261,654	\$188,217	\$225,730	\$105,529	\$855,000
Risk Adjustment	\$183,870	-\$1,638,346	\$3,208,217	\$840,730	-\$2,594,471	\$0
Total Risk Adj Premium	\$5,183,870	\$18,361,654	\$13,208,217	\$15,840,730	\$7,405,529	\$60,000,000
Average Age:	40	38	48	41	35	