DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

September 03, 2026

Melissa Miller
Medicaid Director
Oklahoma Health Care Authority
4345 N Lincoln Blvd.
Oklahoma City, OK 73105

Dear Director Miller:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Oklahoma's Final Report for the COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "SoonerCare" (Project No: 11-W-00048/6). This report covers the demonstration period from March 1, 2020 to September 30, 2024 CMS determined that the Final Report, submitted on September 22, 2025 is in alignment with the CMS-approved Evaluation Design, and therefore, approves the state's Final Report.

In accordance with STC #86, the approved Final Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Final Report on Medicaid.gov.

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX of the Social Security Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and

safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE amendment under these extraordinary circumstances. We look forward to our continued partnership on the Oklahoma SoonerCare section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

Digitally signed by DANIELLE DALY -S
Date: 2026.09.03 10:21:06 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Stacey Steiner, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

OKLAHOMA
Health Care Authority

SoonerCare COVID-19 PHE
Section 1115 Waiver Evaluation

FINAL REPORT

Prepared by the Pacific Health Policy Group for:

State of Oklahoma
Oklahoma Health Care Authority

SEPTEMBER 2025

INDEPENDENT EVALUATION

The independent evaluation of the SoonerCare Demonstration was conducted by The Pacific Health Policy Group (PHPG). PHPG is solely responsible for the analysis and findings presented in this report.

PHPG wishes to acknowledge the cooperation of the Oklahoma Health Care Authority in obtaining the necessary data for completion of the evaluation.

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COMMONLY-USED ABBREVIATIONS & ACRONYMS

ABD	Aged, Blind, Disabled
CMS	Centers for Medicare and Medicaid Services
ESI	Employer-Sponsored Insurance
FPL	Federal Poverty Level
IBNR	Incurred but not Received
MEG	Medicaid Eligibility Group
MMIS	Medicaid Management Information System
NEMT	Non-Emergency Medical Transportation
OHCA	Oklahoma Health Care Authority
PHE	Public Health Emergency
PMPM	Per Member Per Month
STCs	Special Term(s) and Conditions

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EXECUTIVE SUMMARY

Introduction

The COVID-19 pandemic was declared a national public health emergency (PHE) on March 13, 2020. The pandemic posed a serious threat to millions of vulnerable persons, even as it greatly disrupted the health care delivery system. Over 1.2 million Oklahomans contracted the virus between January 2020 and December 2022; the COVID-19 related death toll in the state during the same period exceeded 15,000.

In March 2020, the Centers for Medicare and Medicaid Services (CMS) offered states the opportunity to select from a variety of options to deliver the most effective care to their beneficiaries in light of the COVID-19 PHE. In response to CMS' invitation, the Oklahoma Health Care Authority (OHCA) requested approval under a Section 1115 demonstration to exempt SoonerCare members from certain point-of-service cost-sharing and premium obligations.

The OHCA applied the exemption authority in two ways. First, it suspended the point-of-service cost-sharing (copayment) requirement that normally applies to adults. Cost sharing requirements were suspended for treatment related to COVID-19 or for services/treatments of any condition that could seriously complicate the treatment. SoonerCare copayments range from $4.00 per visit for most professional and outpatient hospital services to $10.00 per day for inpatient hospital stays.

Second, the OHCA suspended monthly premium payments for a portion of the SoonerCare members enrolled in the state's premium subsidy program known as Insure Oklahoma. This program offered SoonerCare coverage to low-income adults who otherwise were ineligible for Medicaid (prior to the state's eligibility expansion in 2021). Monthly premium amounts were income-based and averaged close to $36.00 per month in the period leading up to the PHE.

By suspending point-of-service and premium cost-sharing, the OHCA sought to remove potential barriers to care among members diagnosed with the COVID-19 virus. This was done in concert with other OHCA actions to facilitate access for beneficiaries diagnosed with, or suspected of having, COVID-19.

Evaluation Scope

Section 1115 demonstrations must be evaluated to assess their effectiveness in achieving program objective(s), in this case whether the cost share exemptions facilitated access to care. The OHCA retained the Pacific Health Policy Group (PHPG) to conduct an independent assessment of the demonstration.

The evaluation included three specific areas of inquiry:

1. The OHCA's performance in implementing the exemptions, and whether the agency identified any "lessons learned" for the future.
2. The impact of the point-of-service (copayment) exemption.
3. The impact of the premium exemption.

PHPG evaluated demonstration implementation primarily through agency stakeholder interviews and a review of communications with beneficiaries and providers. The interviews were used to document the implementation process and its challenges, and to explore how these challenges were overcome. Lessons learned and recommendations for responding effectively to future public health emergencies also were documented.

The impact of the two exemptions was evaluated using a pre/post methodology, starting in January 2019 and running to 2024. March 2020 (the cost-sharing exemption effective month) served as the inflection point.

For research question 2, beneficiary utilization and expenditures were trended both on a category-of-service basis and in total. The value of services subject to the exemption, and the value of the waived copayments, were documented for informational purposes.

The exemption applied to all SoonerCare adults, eliminating the option of using a comparison group still subject to cost sharing as a component of the evaluation. Instead, PHPG selected as a "proxy" comparison group children/adolescents under age 21; these beneficiaries have never been subject to point-of-service cost sharing.

Trendlines for the two populations were examined to assess the impact of the PHE on utilization of those services still subject to cost sharing among adults. If adult service use during the pandemic declined more severely than child/adolescent use, it could be inferred that application of the cost sharing exemption to COVID-related services facilitated member access to care, subject to the methodological limitations discussed below.

For research question 3, new Insure Oklahoma enrollment was trended from January 2019 through June 2021, when the population was transitioned to Medicaid under the eligibility expansion. Findings from a Massachusetts study of the relationship between premiums and enrollment into subsidized insurance programs was used to estimate the impact of the exemption on enrollment.

Methodological Limitations

The response to the COVID-19 PHE greatly disrupted patterns of care throughout the nation. The federal and state governments responded through multiple initiatives intended to facilitate access to care. It was not possible to control for all changes in member and provider behavior or for the effects of other financial and state initiatives when quantifying the impact of the cost sharing exemption. For example, concurrent with implementation of the exemptions, the OHCA also expanded use of telehealth and relaxed prior authorization requirements, among other actions.

Both the pre- and post-implementation time periods for the evaluation were relatively short, which limited the available data for the analysis. This was an unavoidable artifact of the speed with which the pandemic emerged and the rapidity with which both the state and federal governments responded.

Evaluation Findings by Research Topic

Implementation of the Cost Share Exemption

At the time of the PHE, the SoonerCare program was almost entirely fee-for-service, with the OHCA processing and paying adjudicated claims directly to providers. Provider payment rates are loaded into the system and set to be net of point-of-service cost share amounts, unless the care is excluded from cost sharing; emergent care is one basis of exclusion.

The emergent care flag can be toggled on or off within the OHCA system on a per-claim basis. If a claim is flagged as emergent, the adjudicated claim is paid in full, with no deduction for the point-of-service cost share amount that normally would apply and be collected from the member by the provider.

The OHCA exploited this functionality to implement the point-of-service cost sharing exemption. The system was set to recognize all COVID-19 related claims as emergent and, therefore, to be paid in full. The OHCA used a CMS-recommended list of diagnoses to implement the policy.

Implementation of the premium exemption was similarly straightforward. The OHCA ceased collection of monthly premiums from Individual Plan members at the outset of the demonstration and maintained this policy throughout the PHE.

The OHCA used existing channels to communicate the policy changes. Beneficiaries were informed through the agency website and member newsletter. Providers were notified through an electronic “global messaging” system, as well as part of a series of virtual Q & A sessions.

Notwithstanding the success of the implementation, OHCA staff did identify one "lesson learned" for responding to any future health emergencies of a sustained duration. Time was of the essence at the outset of the PHE, and its duration was not anticipated to be years-long. Use of diagnosis codes was considered the most expedient method for implementing the change, even if it meant capturing some claims that carried a COVID-19 diagnosis, but for which the service was not COVID-19 related.

Use of procedure codes, in conjunction with diagnosis codes, would have been a more precise method. However, the agency did not want to delay implementation to allow the additional time that would have been required to construct a list of procedure codes and develop guidelines for their application.

In any future event, use of procedure codes would be preferable, if the duration is expected to be lengthy. This approach could include using diagnosis codes at the outset and transitioning to a procedure code-based policy once it has been developed.

Impact of the Point-of-Service Cost Share Exemption

The services subject to the copayment exemption were substantial. OHCA expenditures for adult COVID-related services began in the first quarter of 2020, exceeded $10 million in the first quarter of 2021 and peaked at $35 million in the first quarter of 2022. Total COVID-related paid claims through the first quarter of 2024 exceeded $240 million. (Most beneficiaries transitioned to the SoonerSelect capitated managed care program in April 2024.)

The point-of-service cost share exemption allowed adult members to retain discretionary dollars that otherwise would have been paid to providers, assuming their care was not deferred. The value of the waived copayments totaled nearly $3 million.

PHPG examined non-COVID service use rates per member (adults and children/adolescents) during the period January 2019 through December 2023. The adult and child/adolescent trend lines were normalized by setting utilization rates in the first quarter of 2019 equal to 1 (expressed as 100 percent), and all subsequent quarters as a percent of the baseline period. The analysis was performed for inpatient hospital, outpatient hospital and physician/clinic services.

The utilization trendline data for services still subject to cost sharing was mixed. Hospital utilization for adults showed a relatively steep decline as compared to children/adolescent utilization, but outpatient and physician/clinic services did not. No conclusion could be drawn from the analysis.

Impact of the Premium Cost Share Exemption

The PHE and associated economic disruption had a profound effect on Oklahoma's economy. The state's unemployment rate more than doubled in the second quarter of 2020, to over 12 percent. Forty-five percent of adults in the same period experienced a loss of income.

The Insure Oklahoma Individual Plan offered coverage to low-income adults and spouses without a categorical linkage to Medicaid or access to subsidized employer-sponsored coverage. Prior to expansion of the Medicaid program in July 2021, Insure Oklahoma was the primary safety-net for unemployed and low-income individuals seeking affordable health coverage.

Enrollment in the program was stable throughout calendar year 2019 and into the first quarter of 2020, averaging around 3,000 new members per quarter, with total enrollment hovering at 5,000 members. Both new and total enrollments surged in the second quarter of 2020 and reached nearly 10,000 new members in the third quarter. Enrollment continued to exceed historical levels for the remainder of the analysis period.

The premium cost share exemption allowed Insure Oklahoma members to retain discretionary dollars that otherwise would have been paid to the state. The value of the waived premiums totaled nearly $10 million.

Research consistently has found that imposition of even a small premium will reduce the health insurance take-up rate among low-income adults. The premium structure for Insure Oklahoma was similar to a Massachusetts subsidized insurance program known as Commonwealth Care. A 2017 study conducted jointly by faculty at Harvard and MIT Universities used data from the Massachusetts program to model the impact of monthly premium amounts on subsidized health insurance take-up rates.

The Massachusetts model projects that a $36.00 premium reduces insurance take-up rates by 17 percent. Applying this percentage to Insure Oklahoma data suggests that retention of the program's premium would have dissuaded over 7,000 eligible adults from enrolling. Instead, by waiving premiums, the OHCA made coverage affordable at a time of need to uninsured, low-income adults throughout the state.

Conclusion

The OHCA was able to implement the point-of-service cost share exemption rapidly by adapting existing functionality within the claims system and by relying on existing channels of communication to members and providers. In a situation where time was of the essence, the OHCA (and CMS) acted promptly to remove potential barriers to care and facilitate uninterrupted access to services.

The point-of-service cost sharing exemption, at a minimum, allowed low-income beneficiaries to retain nearly $3 million in discretionary funds during a time of great economic uncertainty. The premium cost sharing exemption facilitated enrollment at a time of rising unemployment and wage losses and allowed members to retain nearly $10 million in savings.

Taken together, Oklahoma's actions mitigated the impact of COVID-19 on beneficiary access to care while providing financial support to the state's most vulnerable residents.

A. EVALUATION QUESTIONS AND HYPOTHESES

1. Background

The COVID-19 pandemic was declared a national public health emergency (PHE) on March 13, 2020. The pandemic posed a serious threat to millions of vulnerable persons, even as it greatly disrupted the health care delivery system. Over 1.2 million Oklahomans contracted the virus between January 2020 and December 2022; the COVID-19 related death toll in the state during the same period exceeded 15,000[1].

In March 2020, the Centers for Medicare and Medicaid Services (CMS) offered states the opportunity to select from a variety of options to deliver the most effective care to their beneficiaries in light of the COVID-19 PHE. States could apply for various types of program flexibility under Section 1115 demonstration authority, with the proviso that such authority would expire no later than 60 days after the termination of the PHE[2].

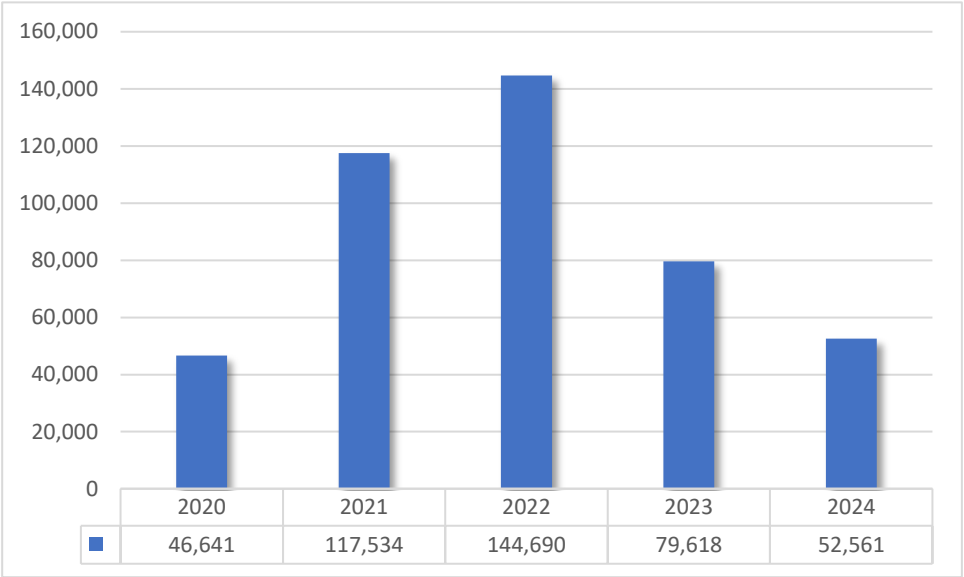
The Oklahoma Health Care Authority (OHCA) is Oklahoma's Single State Agency for Medicaid, which is known in the state as SoonerCare. Medicaid is the largest health insurer in Oklahoma. In March 2020, at the onset of the PHE, the program provided coverage to approximately 800,000 Oklahomans, out of a total population of nearly four million (20 percent)[3].

The number of SoonerCare members contracting COVID (based on adjudicated claims[4]) peaked at nearly 145,000 in calendar year 2022, as shown in Exhibit A-1 on the following page. The count remained above 50,000 in 2024.

(Note that the relatively small count in 2020 is an artifact of the program's demographic mix that year. Adults accounted for only about 20 percent of SoonerCare enrollment that year[5].)

[1] 2023.01.12 Weekly Epi Report.pdf
[2] COVID-19 Public Health Emergency Section 1115(a) Opportunity for States
[3] Oklahoma expanded eligibility for Medicaid in 2021 under provisions of the Affordable Care Act. Enrollment peaked in April 2023 at approximately 1.4 million members, both as a result of the expansion and suspension of procedure disenrollments during a portion of the PHE. In June 2025, following resumption of procedural disenrollments, SoonerCare enrollment stood at approximately one million members.
[4] Members with COVID who did not have an adjudicated claim containing the diagnosis are not reflected in the counts.
[5] Percent of population enrolled in demonstration. Post-expansion, the adult population grew by over 200,000.

Exhibit A-1 – Demonstration Members with a COVID-19 Diagnosis[6]



In response to CMS' invitation, the OHCA requested, and was granted the authority under Section 1115 to exempt SoonerCare members from cost-sharing for treatment related to COVID-19 or for services/treatment of any condition that may seriously complicate the treatment.

Specifically, CMS approved the following waiver authority, covering the period March 1, 2020 to September 30, 2024:

> ***Comparability: Section 1902(a)(17).*** *To the extent necessary to enable the state to vary cost sharing requirements for title XIX state plan beneficiaries from cost sharing to which they otherwise would be subject under the state plan. This waiver specifically enables the state to exempt cost sharing for treatment of COVID-19, or for services/treatment of any condition that may seriously complicate the treatment of COVID-19, for individuals who are diagnosed with or presumed to have COVID-19 during the period such an individual has (or is presumed to have) COVID-19.* [7]

CMS concurrently approved the following Medicaid expenditure authority for the same time period:

> ***Cost Sharing for COVID-19 Treatment.*** *Expenditures to exempt beneficiary cost-sharing for the treatment of COVID-19, or for services and/or*

[6] Unique member count within each calendar year.
[7] See: Approval letter to Traylor Rains, Chief Medicaid Director, OHCA, dated July 28, 2023, page 2.

> *treatment of any condition that may seriously complicate the treatment of COVID-19. This authority applies for current title XIX state plan beneficiaries and individuals in demonstration populations 1, 2, 3, 4, 12, 13, 14, 15, and 16 who are diagnosed with or presumed to have COVID-19, during the period such an individual has (or is presumed to have) COVID019.*[8]

CMS also concurrently approved the following Title XIX Requirements not Applicable to the Demonstration Expenditure Authority described above, for the same time period:

> ***Comparability: Section 1902(a)(17).*** *To the extent necessary to enable the state to vary cost sharing requirements for individuals in populations 12, 13, 14, 15, and 16 from cost sharing to which they otherwise would be subject. This non-applicable specifically enables the state to exempt cost sharing for treatment of COVID-19, or for services/treatment of any condition that may seriously complicate the treatment of COVID-19 for individuals who are diagnosed with or presumed to have COVID-19 during the period such an individual has (or is presumed to have) COVID-19.*[9]

Authority was granted as an amendment to the existing SoonerCare Section 1115 demonstration (Project Number 11-W-00048/6). Exhibit A-2 on the following page identifies the demonstration populations to which the cost sharing exemption applied.

The Medicaid Eligibility Group (MEG) numbers in column one of the exhibit correspond to each group's number in the demonstration's Special Terms and Conditions (STCs). MEGs with asterisks (12 – 16) are non-Title XIX populations funded under the authority of the demonstration, as discussed beneath the exhibit.

Note that Exhibit A-2 describes all of the beneficiaries within each MEG. However, point-of-service cost sharing applies only to adults; children are excluded. In addition, point-of-service cost sharing is waived for pregnant women receiving pregnancy-related services and American Indians/Alaska Natives receiving services at Indian Health Service, Tribal and Urban Indian clinics.

[8] Ibid, page 2.
[9] Ibid, page 3.

Exhibit A-2 – Demonstration Populations Subject to Exemption (Adults within MEGs)[10]

MEG	Description
1	**TANF-Urban** – includes low-income families, pregnant women and children who are eligible under the Breast and Cervical Cancer Treatment Program, receiving services in the designated Central, Northeast, and Southwest urban areas of the state[11].
2	**TANF-Rural** – includes low-income families, pregnant women and children who are eligible under the Breast and Cervical Cancer Treatment Program, receiving services in the rural areas of the state.
3	**ABD-Urban** – includes the Aged, Blind, and Disabled receiving services in the designated Central, Northeast and Southwest urban areas of the state.
4	**ABD-Rural** – includes the Aged, Blind, and Disabled receiving services in the rural areas of the state.
12*	**Non-Disabled Working Adults** – includes non-disabled low-income workers and their spouses, with household incomes no greater than 100 percent of Federal Poverty Level (FPL)[12].
13*	**Working Disabled Adults** – includes low-income working disabled adults with household incomes no greater than 100 percent of the FPL.
14*	**Full-Time College Students** – includes full-time college students ages 19 – 22, up to any including 100 percent of the FPL.
15*	**Foster Parents** – includes working foster parents with household incomes no greater than 100 percent of Federal Poverty Level (FPL).
16*	**Not-for-Profit Employees** – includes employees and spouses of not-for-profit business with 500 or fewer employees with household incomes no greater than 100 percent of Federal Poverty Level (FPL).

* Non-Title XIX population funded solely under demonstration authority.

The OHCA applied the exemption authority in two ways. First, it suspended the point-of-service cost-sharing (copayment[13]) requirement that normally applies to adults. Second, it suspended monthly premium payments for a portion of the SoonerCare members enrolled in the state's premium subsidy program known as Insure Oklahoma. This program offered SoonerCare coverage to low-income adults who otherwise were ineligible for Medicaid.

[10] Pregnant women receiving pregnancy-related services and American Indians/Alaska Natives receiving services at I/T/U locations are not subject to point-of-service cost sharing.
[11] Central – Oklahoma City and surrounding area; Northeast – Tulsa and surrounding area; Southwest – Lawton and surrounding area.
[12] The Insure Oklahoma program also includes an Employer Sponsored Insurance (ESI) component, under which the OHCA pays a portion of the qualifying employee's (and spouse's) premium, while the employee and employer pay the remainder of the premium. Income limits for the ESI component exceed 100 percent of FPL. Premium cost sharing was not suspended for these beneficiaries.
[13] Terms are used interchangeably throughout the document.

Insure Oklahoma was open to the groups described above in MEGs 12 – 16. The program offered direct enrollment into an OHCA-administered "Individual Plan" for qualifying adults with incomes no greater than 100 percent of the Federal Poverty Level (FPL) . (Oklahoma expanded Medicaid eligibility for adults to 138 percent of FPL (including income disregards) in July 2021. Members enrolled in the Individual Plan portion of Insure Oklahoma transitioned to Medicaid at that time and were no longer subject to a monthly premium.)

The specific cost-sharing schedule that was suspended is presented below in Exhibit A-3. Note that preventive services for adults are not subject to cost sharing, even if the category (e.g., physician services) is included below.

Exhibit A-3 – SoonerCare Cost Sharing Requirements (Adult Non-Preventive Care)[14]

Service (Alphabetical Order)	Cost Share
Alternative Treatment for Pain Management	$4.00 copay per visit
Diabetic Supplies	$4.00 copay per claim
Durable Medical Equipment	$4.00 copay per claim
Habilitation Services	$4.00 copay per visit
Inpatient Hospital Services	$10.00 copay per day – first seven days $5.00 on the eighth day
Laboratory and X-Ray	$4.00 copay per visit
Mental Health or Substance Use Disorder Medical Detoxification – Inpatient	$10.00 per day, up to a maximum of $75.00
Mental Health or Substance Use Disorder – Outpatient	$3.00 copay per visit (select services)
Outpatient Hospital and Surgery Services	$4.00 copay per visit
Personal Care	$4.00 copay per visit
Physician Services	$4.00 copay per visit
Primary Care Provider/Primary Care Medical Home	$4.00 copay per visit
Prosthetics and Orthotics	$4.00 copay per prescription
Therapy Services (Physical, Speech, Occupational)	$4.00 copay per visit
Premiums (Demonstration Populations 12 – 16)	Member-specific, based on income

[14] Prescription drugs also are subject to a $4.00 copayment but their claims do not carry diagnosis codes.

The OHCA implemented the cost sharing exemption on March 16, 2020. The exemption applied both to point-of-service cost sharing (copayments) for all populations and monthly premiums for demonstration populations 12 – 16.

2. Purpose of the Demonstration

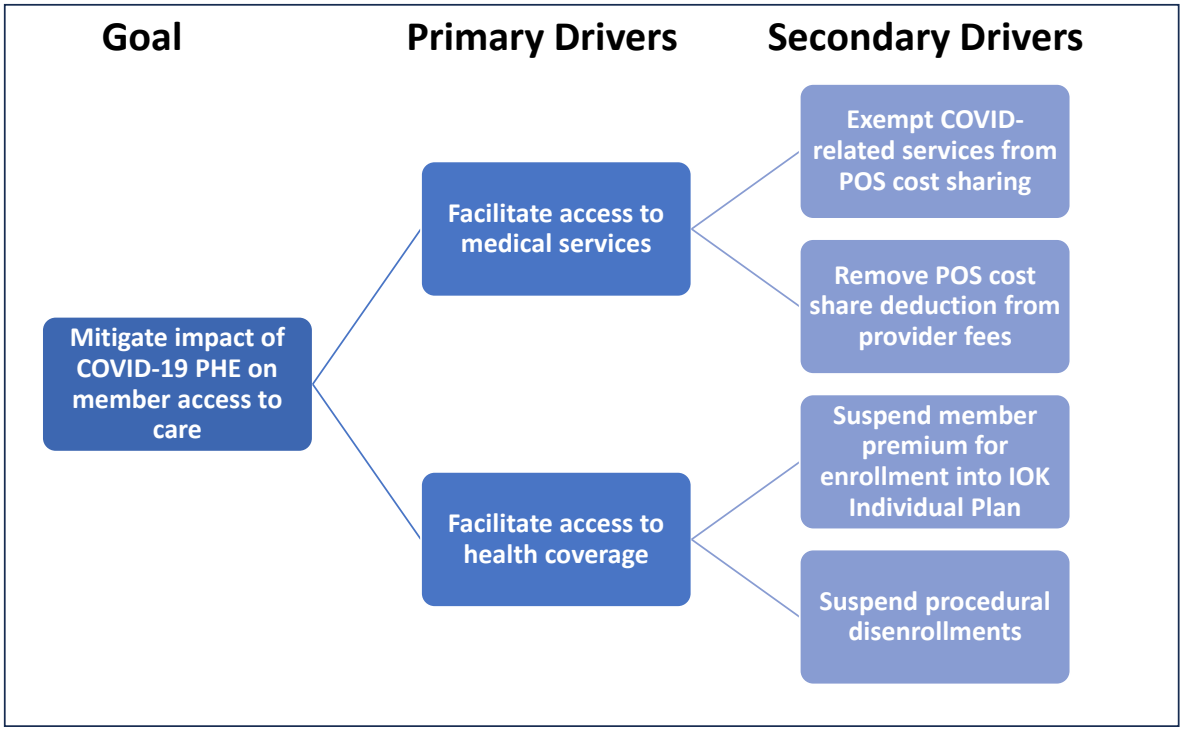
CMS, in its approval letter for the demonstration, stated that the authority being granted was necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE. CMS concluded that the demonstration would be likely to assist in promoting the objectives of the Medicaid statute because it would help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety and welfare of individuals affected by COVID-19.

By suspending point-of-service and premium cost-sharing, the demonstration sought to remove a potential barrier to care among members diagnosed with the COVID-19 virus. This was done in concert with other actions to facilitate care for beneficiaries diagnosed with, or suspected of having, COVID-19[15].

The evaluation design for the demonstration includes a hypothesis, related research questions and discrete measures to be used in determining the effectiveness of the cost-sharing exemption with respect to promoting access to care. The Driver Diagram presented in Exhibit A-4 on the following page illustrates the relationship between the OHCA's goal for the demonstration and the primary and secondary drivers for achieving this goal.

[15] See Section D – Methodological Limitations for more detail on the state's other actions to promote access to care.

Exhibit A-4 – Driver Diagram



3. *Demonstration Hypothesis and Research Questions*

The evaluation examined the steps taken by the OHCA to implement the cost-sharing exemptions for the purpose of documenting "lessons learned". It also tested the hypothesis that the suspension of cost-sharing facilitated access to care by removing a potential barrier for members diagnosed with COVID-19.

The evaluation included three research questions, the first of which contained a series of subcomponents:

1. What were the lessons learned from the OHCA's implementation of cost sharing exemptions?
    a. How did the OHCA inform current and potential beneficiaries of the exemption?
    b. How did the OHCA inform providers of the exemption?
    c. How did the OHCA monitor provider compliance with the cost sharing exemption and ensure reconciliation of any inappropriate copay collections?

   d. What operational challenges did the OHCA encounter during implementation?
   e. How were these challenges overcome?

2. What impact did the suspension of point-of-service cost-sharing have on COVID-19 related service utilization?

3. What impact did the suspension of premiums for demonstration populations 12 - 16 have on beneficiary enrollment?

Section B, starting on the following page, outlines the evaluation methodology used to test the demonstration hypothesis and answer the three research questions.

B. EVALUATION METHODOLOGY

1. *Evaluation Design & Analytic Methods*

The COVID-19 PHE evaluation used a mixed methods (qualitative and quantitative) analysis to document lessons learned from the state's implementation of the waiver authority and to measure the impact of the cost-sharing exemption on beneficiary access to care.

Qualitative Analysis

Agency stakeholder interviews were conducted using a structured format. The interviews served to document the implementation process and its challenges, and to explore how these challenges were overcome. Lessons learned and recommendations for responding effectively to future public health emergencies also were documented.

Relevant agency internal documents and communications with beneficiaries and providers were examined prior to the interviews. The materials helped to inform the content of the interview guides and the interviews themselves.

Quantitative Analysis

The quantitative analysis was performed using a pre/post methodology, with March 2020 (cost-sharing exemption effective month) serving as the inflection point. The analysis relied on descriptive statistics only, because the impact of other access-related initiatives occurring alongside the cost share exemption could not be isolated or quantified. (See Methodological Limitations for a more detailed discussion.)

Research Question 2 – Point-of-Service Cost Sharing

For research question 2, beneficiary utilization and expenditures were trended by month and quarter, both on a category-of-service basis and in total. Although a true comparison group did not exist for the evaluation, utilization and expenditure trends were developed both for adults covered under the demonstration and for children/adolescents under age 21, who never have been subject to point-of-service cost sharing[16].

Trendlines for the two populations were examined to assess the impact of the PHE on utilization, for those services still subject to cost sharing among adults. If services still

[16] For a true comparison group analysis, PHPG typically would apply Propensity Score Matching, or a similar statistical technique, to control for relevant demographic characteristics. However, it would not be possible to control for the key demographic characteristic of age in this instance, so matching was not performed.

subject to cost sharing were affected more severely than those exempt from cost sharing, it could be inferred that application of the exemption to COVID-related services facilitated member access to care.

(The scope of COVID-related services subject to the exemption also was quantified, but these services began during the PHE, making it impossible to perform any type of pre/post analysis.)

Research Question 3 – Premium Cost Sharing

For research question 3, new Insure Oklahoma enrollment was trended by month and quarter. Findings from a Massachusetts study of the relationship between premiums and enrollment into subsidized insurance programs was used to estimate the impact of the exemption on enrollment.

Exhibit C-1 below summarizes the evaluation design, including research questions, measures, data sources and analysis methods.

Exhibit C-1 – Evaluation Design Summary

Research Question	Measure	Data Source	Analysis Method
What are the lessons learned from implementation of the cost share exemption?	Stakeholder experience	OHCA stakeholders and related documents	Structured interviews and document review
What impact did the suspension of point-of-service cost sharing have on COVID-19 related service utilization?	Monthly utilization per beneficiary by category-of-service	OHCA MMIS paid claims data	Comparison of pre/post implementation periods for non-COVID related services, stratified by age cohort
What impact did the suspension of premiums for demonstration populations 12 - 16 have on beneficiary enrollment?	Monthly new enrollments	OHCA enrollment file	Comparison of pre/post implementation periods and estimation of impact of premium exemption through application of findings from Massachusetts study

2. Evaluation Period

The demonstration ran from March 2020 to September 2024. In order to have a relevant baseline period for the pre-post analysis, the enrollment and paid claims portion of the evaluation was extended back to January 2019.

The majority of SoonerCare members transitioned out of the 1115 demonstration and into a Section 1915b capitated managed care program (SoonerSelect), starting in February 2024 for dental services, followed by medical services in April 2024.

The point-of-service cost sharing analysis, which relied on adjudicated claims data, was truncated at the end of 2023. The total period examined ran for 60 months, from January 2019 through December 2023, sufficient for evaluating the impact of the point-of-service cost share exemption. (Some exhibits include data into 2024, for informational purposes only.)

The Insure Oklahoma program was supplanted by Oklahoma's Medicaid expansion in July 2021. during the demonstration. The analysis of the impact of suspending premium cost-sharing was truncated to the end of June 2021, to coincide with the implementation of the expansion. The total period examined ran for 30 months, from January 2019 through June 2021, sufficient for evaluating the impact of the premium exemption.

3. Evaluation Measures

Research question 1 and its subcomponents (implementation lessons learned) are qualitative and do not have discrete measures. Findings are discussed in narrative form. Demonstration evaluation measures for research questions 2 and 3 are listed in Exhibit C-3 on the following page.

Exhibit C-3 – Evaluation Measures

Research Questions	Measures	Source
What impact did the suspension of point-of-service cost sharing have on COVID-19 related service utilization?	• Utilization rates per member by Category of Service – COVID-19 related care versus other care	MMIS
	• Utilization rates per member by Category of Service – adults versus children/adolescents – COVID-19 related care and other care	MMIS
What impact did the suspension of premiums for demonstration populations 12 - 16 have on beneficiary enrollment?	• Monthly Insure Oklahoma enrollments – new and total	MMIS

4. Data Sources

Research Question 1 – Implementation Activities and Lessons Learned

The data sources for research question 1 were qualitative. These included interviews with OHCA managers and staff responsible for implementation of the cost sharing exemption, supplemented by policies/procedures and other internal documents related to implementation. The evaluation also included a review of communications to beneficiaries and providers regarding the policy change.

Research Question 2 – Point-of-Service Cost Sharing Exemption

The data source for research question 2 was quantitative. PHPG analysts were granted access to the OHCA MMIS and extracted eligibility and adjudicated claims data for calculation of utilization and payment trends over the study period.

PHPG has worked within the OHCA MMIS for over two decades and performs routine quality checks to validate the completeness of the claims data, including comparison of month-to-month variance in expenditures by category-of-service, to identify and research potential data gaps. PHPG uses data smoothing and similar techniques to close gaps, if necessary.

PHPG also accounts for incurred but not received (IBNR) claims when performing utilization and expenditure calculations. The paid claims data for January 2019 – September 2024 was extracted in May 2025, making it unnecessary to apply claims completion factors to the data in this instance.

Research Question 3 – Insure Oklahoma Premium Exemption

The data source for research question 2 also was quantitative. The OHCA published monthly enrollment data for Insure Oklahoma throughout the life of the program. PHPG relied on the OHCA's enrollment reports for the analysis.

5. Other Additions

None.

D. METHODOLOGICAL LIMITATIONS

The response to the COVID-19 PHE encompassed multiple, concurrent policy changes at both the federal and state levels. It was not possible to control for the effects of these policy changes when quantifying the impact of the cost sharing exemption.

Other elements of the response within the SoonerCare program included (but were not limited to):

- Expanded use of telehealth;
- Waiving of certain provider enrollment requirements, such as enrollment fees;
- Flexibility in allowing providers to receive payments for services rendered to affected members in alternative physical settings, such as mobile testing sites and temporary shelters;
- Removal or modification of certain prior authorization requirements; and
- Expanded availability of 90-day supplies for maintenance drugs.

During the height of the pandemic, PHPG surveyed SoonerCare beneficiaries with chronic/complex health conditions enrolled in one of the OHCA's care management programs. The surveys inquired about whether beneficiaries were experiencing disruptions to their routine care.

Approximately 29 percent of respondents reported experiencing delayed or missed primary or specialty care visits. This was due to a combination of provider-initiated cancellations and beneficiary cancellations over fear of exposure to the virus. It was not possible to control for the effect of this care disruption when evaluating service utilization trends pre/post suspension of cost sharing.

The point-of-service cost-sharing exemption applied to all adults statewide, making it infeasible to evaluate the impact of the exemption against a true comparison group. Children/adolescent members were used as a proxy for a true comparison group, as this population has never been subject to point-of-service cost sharing.

Both the pre- and post-implementation time periods for the evaluation were relatively short, which limited the available data for the analysis. This was an unavoidable artifact of the speed with which the pandemic emerged and the rapidity with which both the state and federal governments responded.

E. RESULTS

1. *Implementation of Cost Sharing Exemption*

Overview

Prior to the COVID-19 PHE, the OHCA imposed premium cost sharing on persons enrolling into the Insure Oklahoma subsidized coverage program. The OHCA also had a longstanding policy of imposing point-of-service cost sharing (copayments) on adult members, subject to certain exclusions:

- Preventive services;
- Pregnancy-related care;
- Services for American Indians/Alaska Natives at IHS/tribal provider locations; and
- Services coded as emergent.

The waiver authorized exemption of beneficiary point-of-service cost sharing for COVID-19 related services. It also authorized exemption of Insure Oklahoma beneficiary premium payments for the duration of the PHE.

Implementation of the cost sharing exemption required actions related to internal operations and external communications. PHPG interviewed OHCA subject matter experts about the steps taken and lessons learned. PHPG also reviewed written records, including communications to beneficiaries and providers.

PHPG documented the internal (system-related) steps taken to implement the exemption and pursued five additional areas-of-inquiry:

a. How did the OHCA inform current and potential beneficiaries of the exemption?
b. How did the OHCA inform providers of the exemption?
c. How did the OHCA monitor provider compliance with the cost sharing exemption and ensure reconciliation of any inappropriate copay collections?
d. What operational challenges did the OHCA encounter during implementation?
e. How were these challenges overcome?

How were the point-of-service and premium cost sharing exemptions implemented?

At the time of the PHE, the SoonerCare program was almost entirely fee-for-service, with the exception of non-emergency transportation (NEMT), which operated under a capitated contract, and a small PACE long term care program with several hundred enrollees[17]. The OHCA processed and paid adjudicated claims directly to providers.

Provider payment rates are loaded into the system and set to be net of point-of-service cost share amounts, unless the care meets one of the exclusion criteria, such as being emergent in nature.

The emergent care flag can be toggled on or off within the OHCA system on a per-claim basis. If a claim is flagged as emergent, the adjudicated claim is paid in full, with no deduction for the point-of-service cost share amount that normally would apply and be collected from the member by the provider.

The OHCA exploited this functionality to implement the point-of-service cost sharing exemption. The system was set to recognize all COVID-19 related claims as emergent and, therefore, to be paid in full.

The OHCA identified COVID-19 related services by the diagnosis code on the claim, as this method was deemed most efficient for what was expected to be an emergency of short duration. (Procedure codes also were considered, as discussed later in the Operational Challenges section.) The OHCA relied on a CMS-recommended diagnosis list, as displayed in Exhibit E-1 below.

Exhibit E-1 – COVID-19 Related Diagnosis Codes and Descriptions

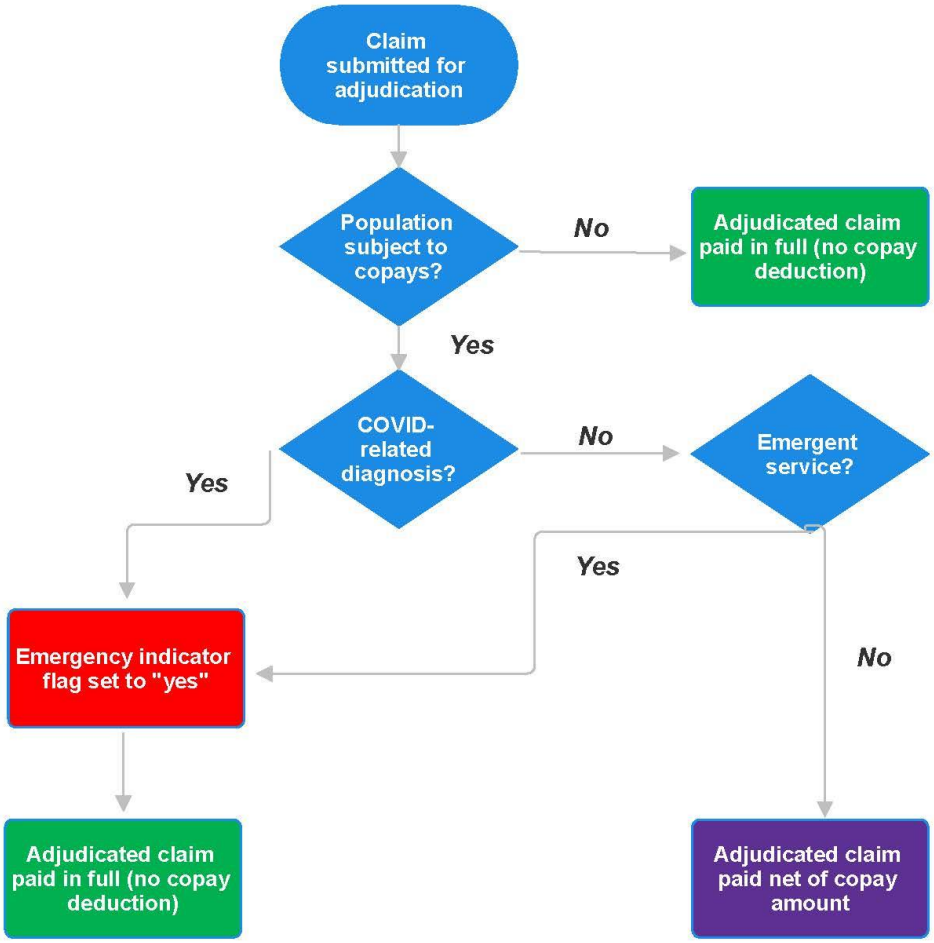
Diagnosis Code	Description
J1282	Pneumonia due to Coronavirus disease
M3581	Multisystem inflammatory syndrome
M3589	Other specified systemic involvement of connective tissue
U071	Confirmed diagnosis of COVID-19
U099	Post COVID-19 condition, unspecified
Z1152	Encounter for screening for COVID-19

[17] Patient Centered Medical Home providers received a monthly per member case management fee but billed all care on a fee-for-service basis.

Diagnosis Code	Description
Z20822	Contact with, and (suspected) exposure to COVID-19
Z8616	Personal history of COVID-19

Exhibit E-2 below illustrates the steps take to implement the point-of-service exemption. At the expiration of the PHE in September 2024, the OHCA reversed this process to restore point-of-service cost sharing.

Exhibit E-2 – Claims Adjudication Process



Implementation of the premium exemption was straightforward. The OHCA ceased collection of monthly premiums from Individual Plan members at the outset of the demonstration and maintained this policy throughout the PHE. Note that nearly all Individual Plan members transitioned into the SoonerCare program when Oklahoma expanded Medicaid in July 2021. Medicaid beneficiaries are not subject to premiums.

How did the OHCA Inform Beneficiaries of the Exemption?

The OHCA informed beneficiaries of the exemption in several ways. A banner was added the agency's website alerting beneficiaries to the change; this method also served to inform program applicants, as most SoonerCare applications are made electronically.

The OHCA created a COVID-19 section on its website, with information about all of the agency's actions, including those directed at beneficiaries. The OHCA also included information about the exemption in its beneficiary newsletter.

Exhibit E-3 presents an excerpt from the OHCA's website that also appeared in the May 2020 beneficiary newsletter, the first to be published after the onset of the PHE. (Note: emphasis added to copay language.[18])

Exhibit E-3 – Beneficiary Communication

What is OHCA doing for SoonerCare members?

The Oklahoma Health Care Authority is taking measures to ensure all SoonerCare members continue to have access to needed services during the COVID-19 pandemic. OHCA is focused on doing everything we can to ensure employee and member safety.

If you believe you have been exposed to coronavirus, please immediately contact your primary health care provider. SoonerCare will fully cover COVID-19 testing for any SoonerCare patient who meets the standards for testing.

- OHCA is allowing expanded use of telehealth through Oct. 31, 2021, for most SoonerCare reimbursable services. ***Testing and treatment services related to COVID-19 diagnoses will not have co-pays for SoonerCare members.***
- OHCA is allowing expanded use of telehealth through Apr. 30, 2021, for most SoonerCare reimbursable services.
- OHCA will assess the status of the coronavirus pandemic at the end of October to determine if the expansion should be continued.

[18] The information is still accessible on the OHCA website at: Coronavirus.

How did the OHCA Inform Providers of the Exemption?

The OHCA has an electronic "global messaging" system for communicating directly with providers; global messages also are viewable in the provider section of the agency's website. The OHCA transmitted a series of global messages in 2020 and 2021 concerning its activities to address the COVID-19 PHE, including the suspension of point-of-service cost sharing.

As an example, Exhibit E-4 below presents a global message sent in October 2020 notifying providers of the federal government's extension of the PHE, and what this meant with respect to OHCA policies. (Note: emphasis added to cost sharing language[19].)

Exhibit E-4 – Provider Communication (Example)

> The US Dept. of Health and Human Services has extended the public health emergency through Jan. 21, 2021.
>
> What does this mean for SoonerCare providers and members?
>
> - Expanded use of telehealth services through Jan. 31, 2021 for most SoonerCare services.
> - OHCA and DHS will not terminate SoonerCare coverage for members during this time.
> - ***No cost sharing for testing or treatment of COVID-19 for SoonerCare members.***
> - Some medicines may be prescribed for 90-days to reduce trips to the pharmacy.

At the outset of the PHE, the OHCA also scheduled virtual "Q and A" sessions, at which agency leadership shared updates and responded to queries from provider attendees. This included information about cost sharing exemptions for COVID-19 related services during the PHE.

How did the OHCA Monitor Provider Compliance with the Cost Sharing Exemption?

Agency staff in the Medical Administrative Support Services department stated that provider compliance was not monitored through direct oversight or auditing activities but rather through the member complaint system. Staff expressed confidence that provider communications reached their intended audience and that SoonerCare providers were

[19] An archive of global messages is accessible on the OHCA website at Global Messages. COVID-19/cost share related messages appeared in 2020 on April 3 and October 22, and in 2021 on January 15, April 19, July 20, September 13, October 27 and November 15.

well-informed of the OHCA's COVID-19 related activities to facilitate care, including the suspension of point-of-service cost sharing.

Member complaints are received and tracked within the Member Services department. Complaints can be filed by phone, email or postal mail. Member Services staff did not recall receiving any complaints from members during the PHE regarding provider collection of copayments in contravention of agency policy.

What Operational Challenges did the OHCA Encounter during Implementation and how were they Overcome?

OHCA staff reported they did not encounter challenges to implementation, primarily because the claims system could accommodate the new policy through use of an existing feature (the emergent service flag).

Member and provider communications similarly relied primarily on existing platforms. The targeted methods, such as website banners for beneficiaries and virtual Q & A sessions for providers, were not difficult to implement.

Notwithstanding this success, staff did identify one "lesson learned" for responding to any future health emergencies of a sustained duration. This was with respect to relying on diagnosis codes to implement the point-of-service cost share exemption within the claims system.

Time was of the essence at the outset of the PHE, and its duration was not anticipated to be years-long. Use of diagnosis codes was considered the most expedient method for implementing the change, even if it meant capturing some claims that carried a COVID-19 diagnosis, but for which the service was not COVID-19 related.

Use of procedure codes would have been a more precise method. However, the agency did not want to delay implementation to allow the additional time that would have been required to construct a list of procedure codes and develop guidelines for their application.

In any future event, use of procedure codes, in conjunction with diagnosis codes, would be preferable, if the duration is expected to be lengthy. This approach could include using diagnosis codes at the outset and transitioning to a procedure code-based policy once it has been developed.

Summary

The OHCA was able to implement the point-of-service cost share exemption rapidly by exploiting existing functionality within the claims system and by relying on existing channels of communication to members and providers. In a situation where time was of the essence, the OHCA (and CMS) acted promptly to remove potential barriers to care and facilitate uninterrupted access to services.

2. *Impact of Point-of-Service Cost Sharing Exemption*

Overview

The OHCA implemented the point-of-service cost sharing exemption for the purpose of removing a potential financial barrier-to-care, at a time of great medical and economic uncertainty. SoonerCare typically requires a copayment of only four dollars for most services (see Exhibit A-3) but it was theorized that even a nominal charge could affect member behavior, particularly if a member required multiple visits to treat a medical condition.

Studies examining the impact of point-of-service cost sharing on low-income populations are mixed. Some have concluded that point-of-service cost sharing reduces utilization, including for preventive care[20]; others have found that service use is not affected, although the copayments do have a negative impact on household disposable income[21].

COVID-Related Services and Point-of-Service Cost Sharing Exemption

PHPG analyzed the volume of COVID-related services furnished to adults during the PHE by identifying adjudicated claims with one or more of the CMS-recommended COVID-19 diagnosis codes (see Exhibit E-1).

The services subject to the exemption were substantial. OHCA payment for adult COVID-related services exceeded $10 million in the first quarter of calendar year 2021 and peaked at $35 million in the first quarter of 2022. Total COVID-related expenditures through the first quarter of 2024 exceeded $240 million.

Average per member per month (PMPM) COVID-related expenditures followed a similar trajectory, peaking at nearly $80.00 PMPM in the third quarter of 2021[22]. Average PMPM expenditures across the entire time period were approximately $24.00 (Exhibits E-5 and E-6 on the following page).

(Total COVID-related expenditures for children/adolescents were $272 million, higher in absolute terms than the amount for adults. However, this was an artifact of their greater representation in the program prior to Medicaid expansion. The average PMPM for children/adolescents was only about $8.00.)

[20] SoonerCare exempts preventive services from the copayment schedule.

[21] For a discussion of various studies, and their competing findings, see: The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings | KFF

[22] PMPM expenditures likely did not align with total expenditures due to the suspension of procedural disenrollments, which led to continuous growth in member months, including retention of eligibility for members who no longer required Medicaid.

Exhibit E-5 – Payment for COVID-related Services (Total Dollars)

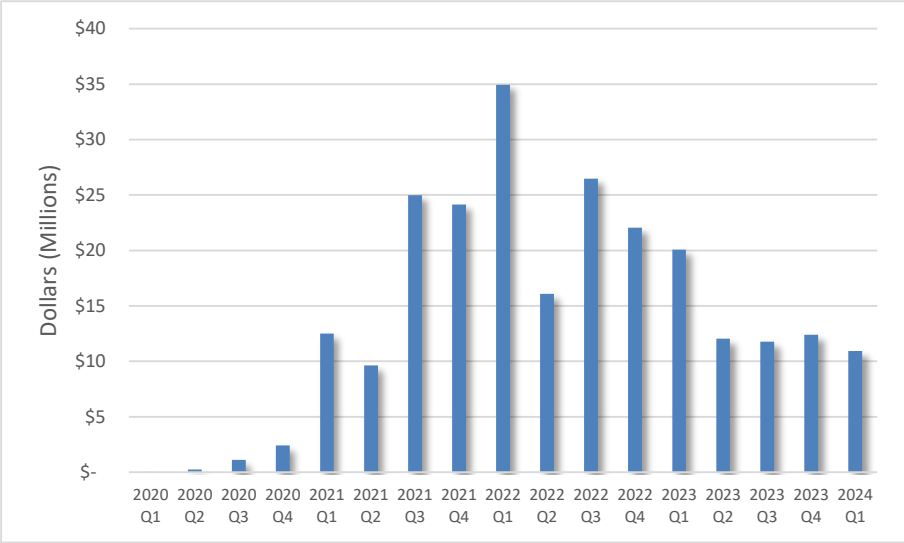


Exhibit E-6 – Payment for COVID-related Services (Average PMPM)

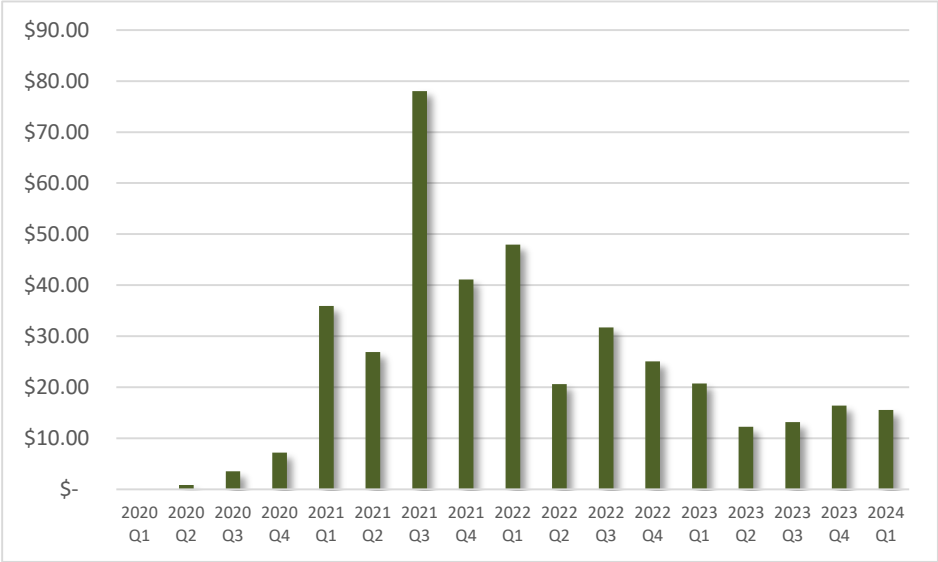


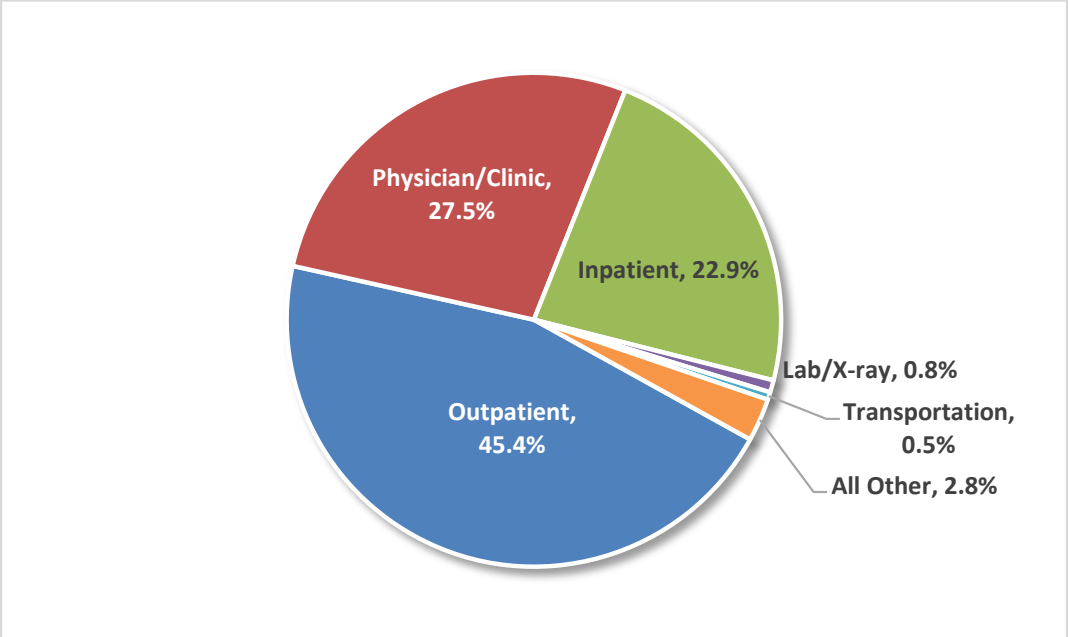
Exhibit E-7 on the following page presents expenditures within major categories-of-service and in total. Appendix 1 of the report presents monthly expenditures by category-of-service for COVID-related care and claim counts/expenditures for all other care.

Exhibit E-7 – Payments for COVID-related Services by Category-of-Service

Service[23]	2020	2021	2022	2023	2024	Total
Inpatient Hospital	$894,783	$16,850,810	$22,261,521	$13,726,989	$1,651,211	$55,385,314
Outpatient Hospital	$937,230	$32,091,795	$44,503,047	$26,499,952	$5,813,184	$109,845,207
Physician/Clinic	$1,626,992	$19,116,402	$28,740,878	$13,765,816	$3,316,955	$66,567,043
Lab/X-ray	$71,837	$975,333	$843,620	$114,507	$15,881	$2,021,177
Transportation[24]	$123,023	$633,304	$289,376	$61,080	$25,457	$1,132,239
All Other	$114,685	$1,580,965	$2,930,988	$2,125,210	$106,379	$6,858,227
TOTAL	**$3,768,549**	**$71,248,608**	**$99,569,429**	**$56,293,553**	**$10,929,067**	**$241,809,206**

Exhibit R-8 below shows the percentage of total dollars represented by each category-of-service across the total time period. Outpatient care accounted for over 45 percent of the total, followed by physician/clinic and inpatient care.

Exhibit E-8 – Payments for COVID-related Services (Percent of Total)



[23] Pharmacy claims were omitted from the analysis because they do not contain diagnosis codes. The estimate therefore understates total COVID-related service costs by an unknown amount.
[24] Transportation costs are for emergency-related services. Non-emergency transportation was provided through a capitated contract and is not reflected in the data.

The point-of-service cost share exemption allowed adult members to retain discretionary dollars that otherwise would have been paid to providers, assuming their care was not deferred. Exhibit E-9 below presents a conservative estimate of the value of the waived copayments for major services, based on claim counts[25].

Exhibit E-9 – Estimated Value of Cost Share Amounts Retained by Members

Category-of-Service	Claim Count	Retained Dollars
Inpatient Hospital ($10 per day[26])	50,240	$502,400
Outpatient Hospital ($4 per visit)	188,373	$753,492
Physician/Clinic ($4 per visit)	362,225	$1,448,900
Lab/X-ray ($4 per visit)	30,919	$123,676
TOTAL	631,757	**$2,828,468**

Impact of Exemption on Service Use

No data is available to evaluate the counterfactual of COVID-related service use subject to point-of-service cost sharing. However, adult beneficiaries did continue to make copayments for services without a COVID-related diagnosis, while children/adolescents were not subject to cost sharing for the same services.

Children/adolescents are not a true comparison group to the adult population. When identifying a comparison group for an evaluation, it is appropriate to employ a statistical method, such as Propensity Score Matching, to align the two populations on key demographic characteristics. It is not possible to do so in this case, since the two groups cannot be matched on age.

Adults in general were at greater risk of COVID-related health effects during the pandemic, which had the potential to affect health care utilization, even for non-COVID related care. PHPG surveyed SoonerCare adults enrolled in one of the agency's care

[25] The estimate is conservative in that inpatient claims typically include all days within one claim. However, members are subject to daily cost share obligations. Also, other COVID-related services, such as for therapies, are not included in the totals (the claim counts for these other services were nominal).
[26] $10 per day for first seven days; $5 per day thereafter.

management programs in 2020 and 2021 and found that a significant portion were delaying or canceling care out of concern about contracting COVID[27].

Despite these differences, there is utility in examining utilization trends within the two populations. The trended data can be used to observe whether adult service use for non-COVID related services declined at a comparable rate to children/adolescents during the worst of the public health emergency.

If adult utilization declined more severely than children/adolescents, it would be fair to consider whether one factor (among others) contributing to the decline was the cost sharing requirement at a time of economic uncertainty. This, in turn, would support the hypothesis that removal of the cost sharing requirement for COVID-related services eliminated a potential barrier to care.

PHPG examined service use rates per member during the period January 2019 through December 2023. The adult and child/adolescent trend lines were normalized, by setting utilization rates in the first quarter of 2019 equal to 1 (expressed as 100 percent), and all subsequent quarters as a percent of the starting period. The analysis was performed for inpatient hospital, outpatient hospital and physician/clinic services.

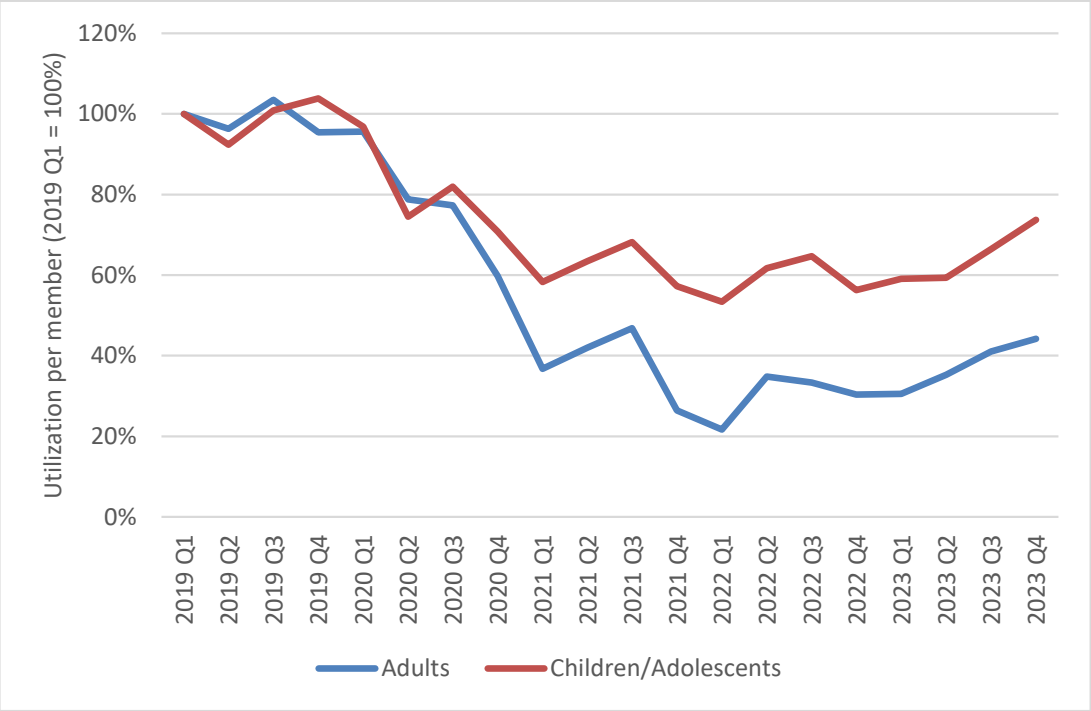
It is important to note that the suspension of procedural disenrollments during the PHE led to retention in the system of members who no longer required Medicaid services (e.g., persons who obtained private health insurance). Over time, the effect of the suspension would be expected to depress utilization rates, which are calculated on a per member month basis.

[27] PHPG surveyed 1,200 adults between June 2020 and May 2021. Approximately twenty-nine percent reported delaying/deferring care, with the primary reason cited being fear of exposure to COVID. See discussion in Section D – Methodological Limitations.

Inpatient Hospital

The inpatient hospitalization rate declined for both age cohorts in 2020 and 2021 before rebounding partially in 2022 and 2023. The two trendlines tracked closely to each other in 2019 and the first half of 2020, after which adult utilization declined at a steeper rate and remained further below its 2019 baseline rate (Exhibit E-10).

Exhibit E-10 – Inpatient Hospital Utilization Trend (2019 Q1 = 100)

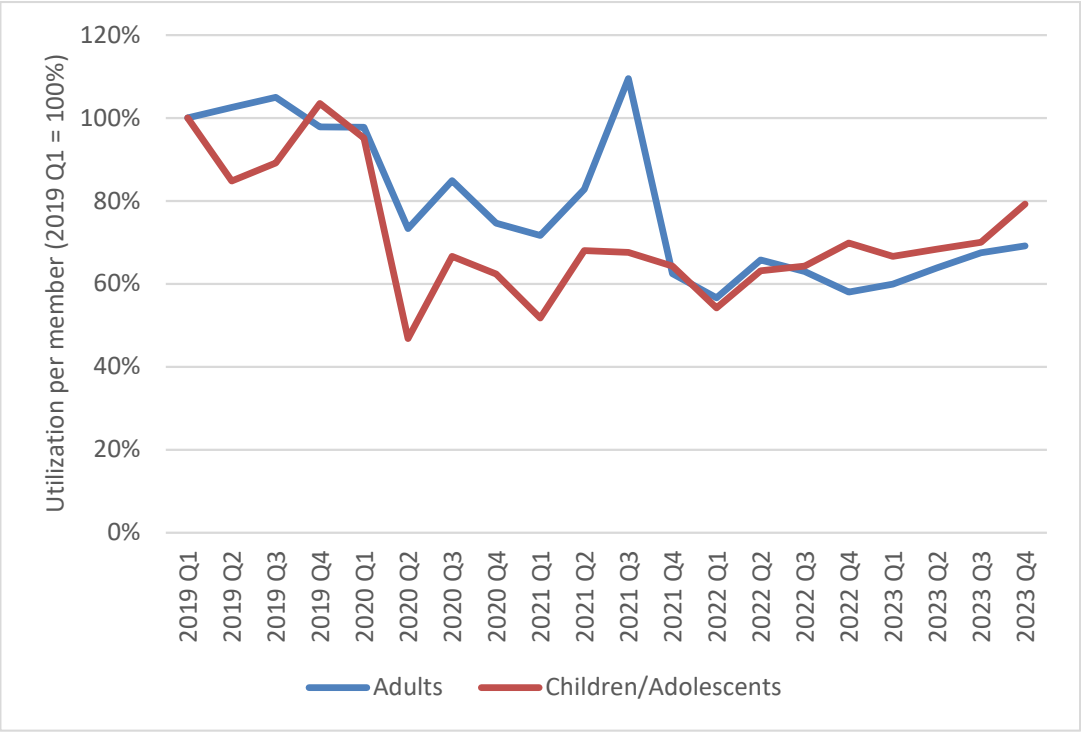


	2019				2020				2021				2022				2023			
Age Cohort	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Adults	100	96	103	95	96	79	77	60	37	42	47	26	22	35	33	30	31	35	41	44
Child/Adolescent	100	92	101	100	97	74	82	71	58	64	68	57	53	62	65	56	59	59	66	74

Outpatient Hospital

The outpatient hospitalization rate declined for both age cohorts in 2020 and remained below the baseline level through 2023, with the exception of a brief spike for adults in the third quarter of 2021[28]. Unlike inpatient hospitalization rates, the outpatient rate for adults trended higher or only slightly lower than the child/adolescent rate over the evaluation period (Exhibit E-11).

Exhibit E-11 – Outpatient Hospital Utilization Trend (2019 Q1 = 100)



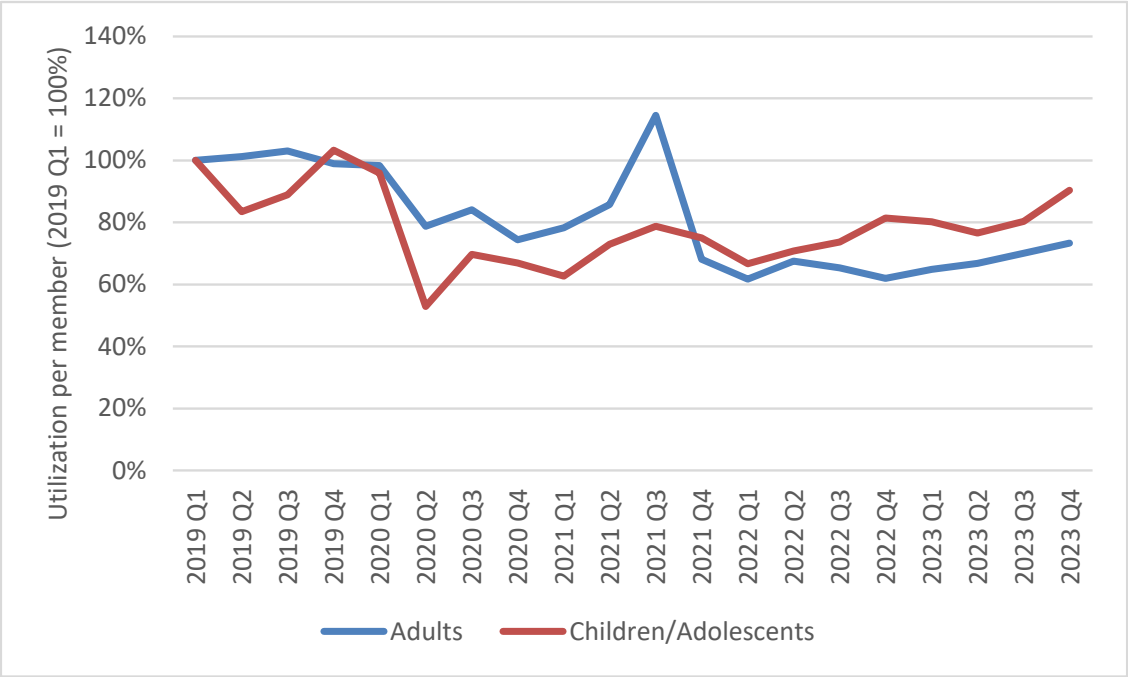
	2019				2020				2021				2022				2023			
Age Cohort	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Adults	100	103	105	98	98	73	85	75	72	83	110	62	57	66	63	58	60	64	68	69
Child/Adolescent	100	85	89	100	95	47	67	62	52	68	68	64	54	63	64	70	67	68	70	79

[28] The spike was in part an artifact of a drop in member months during the quarter. Member months began to grow rapidly starting in the fourth quarter of 2021, as the impact of the procedural disenrollment suspension grew. Inpatient hospital utilization declined to such an extent in 2021 that drop in member months did not have a comparable effect on the trendline.

Physician/Clinic

The trendline for physician/clinic services was similar to outpatient hospital. The visit rate declined for both age cohorts in 2020 and remained below the baseline level through 2023, with the exception of the spike for adults in the third quarter of 2021. The visit rate for adults again trended higher through 2021 and then modestly lower than the child/adolescent rate over the remainder of the evaluation period (Exhibit E-12).

Exhibit E-12 – Physician/Clinic Utilization Trend (2019 Q1 = 100)



Age Cohort	2019				2020				2021				2022				2023			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Adults	100	101	103	99	98	79	84	74	78	86	115	68	62	68	65	62	65	67	70	73
Child/Adolescent	100	84	89	100	96	53	70	67	63	73	79	75	67	71	74	81	80	77	80	90

Summary

SoonerCare adults received a substantial volume of COVID-related services throughout the PHE and benefited financially from the point-of-service cost sharing exemption. The exemption was one of a series of steps taken by the OHCA to facilitate care, and it is not possible to isolate its effect from these other actions.

The utilization trendline data for services still subject to cost sharing was mixed; hospital utilization for adults showed a relatively steep decline as compared to children/adolescent utilization, but outpatient and physician/clinic services did not.

Although no findings can be made about the effect of the exemption on service use, it is fair to conclude that the exemption provided financial relief to adult members by allowing them to retain discretionary funds at a time of great economic uncertainty.

3. *Impact of Insure Oklahoma Premium Exemption*

Overview

Insure Oklahoma Individual Plan members were charged a monthly premium based on household income. Insure Oklahoma Individual Plan monthly premiums averaged approximately $36.00 in the period leading-up to the start of the PHE[29].

The OHCA suspended these premiums at the outset of the PHE and the premium exemption remained in place for the duration of the program. (The OHCA also suspended procedural disenrollments concurrent with suspension of disenrollments within the Medicaid MEGs.)

Individual Plan members transitioned to the Medicaid program in July 2021, when Oklahoma implemented its Medicaid expansion in accordance with Affordable Care Act provisions. New enrollments into the Individual Plan ceased in June 2021, in advance of the upcoming expansion.

Enrollment Trend

The OHCA publishes monthly enrollment data for all programs, including Insure Oklahoma[30]. PHPG examined the enrollment data pre/post the exemption, to determine if any impact could be discerned.

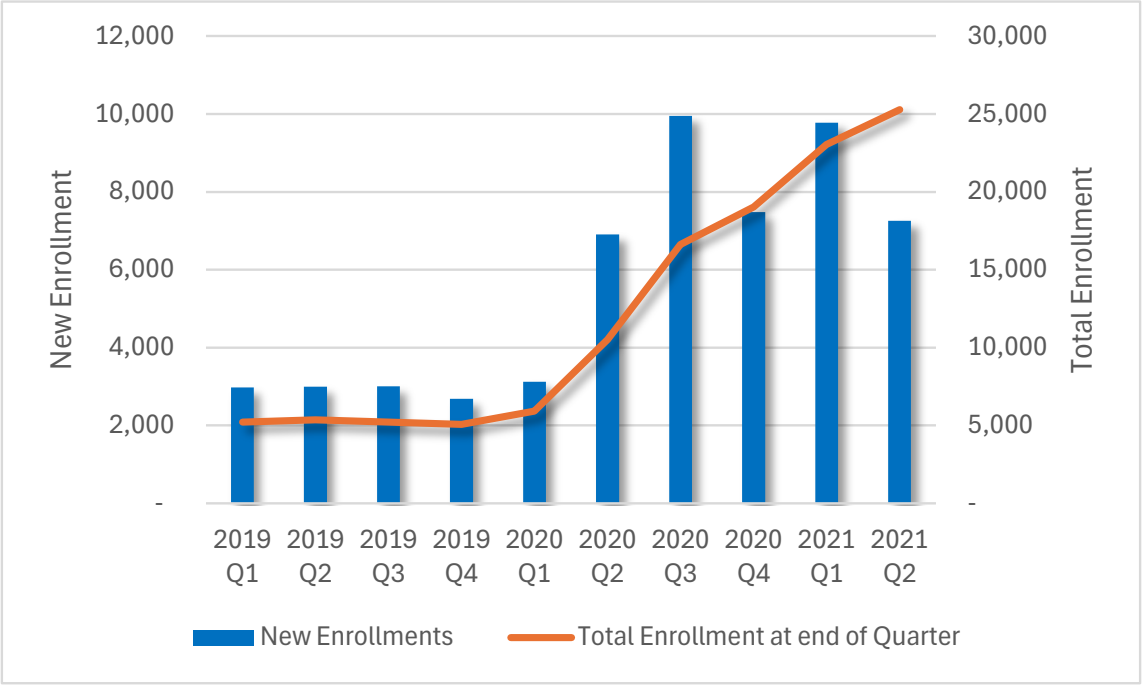
Exhibit E-13 on the following page presents Insure Oklahoma Individual Plan quarterly enrollment data. Separate trendlines are shown for new and total enrollment counts in the quarter. (Appendix 2 presents the same data by month.)

The trendlines start in the first quarter of 2019 (January – March) and continue through the second quarter of 2021 (April – June), after which program members transitioned to the Medicaid program and no longer were subject to premiums. The PHE began at the end of the first quarter of 2020 and was in effect for the entire second quarter of that year (and thereafter).

Enrollment in the program was stable throughout calendar year 2019 and into the first quarter of 2020. Both new and total enrollments surged in the second quarter of 2020 and continued to exhibit strong growth for the remainder of the analysis period.

[29] Based on Fast Facts data.
[30] Insure Oklahoma enrollment data can be found at: IO Fast Facts.

Exhibit E-13 – Insure Oklahoma New and Total Enrollment Trends



The premium cost share exemption allowed Insure Oklahoma members to retain discretionary dollars that otherwise would have been paid to the state. The value of the waived premiums totaled approximately $9.9 million[31].

Assessing the Impact of the Premium Exemption

The PHE and associated economic disruption had a profound effect on Oklahoma's economy. The state's unemployment rate more than doubled in the second quarter of 2020, to over 12 percent. Forty-five percent of adults in the same period experienced a loss of income[32].

The Insure Oklahoma Individual Plan offered coverage to low-income adults and spouses without a categorical linkage to Medicaid or access to subsidized employer-sponsored coverage (including the unemployed). Prior to expansion of the SoonerCare program in July 2021, Insure Oklahoma was the primary safety net for unemployed and low-income individuals seeking affordable health coverage.

In the absence of a comparison group, i.e., Insure Oklahoma eligible adults who continued to be charged a premium, it is challenging to quantify the impact of the premium

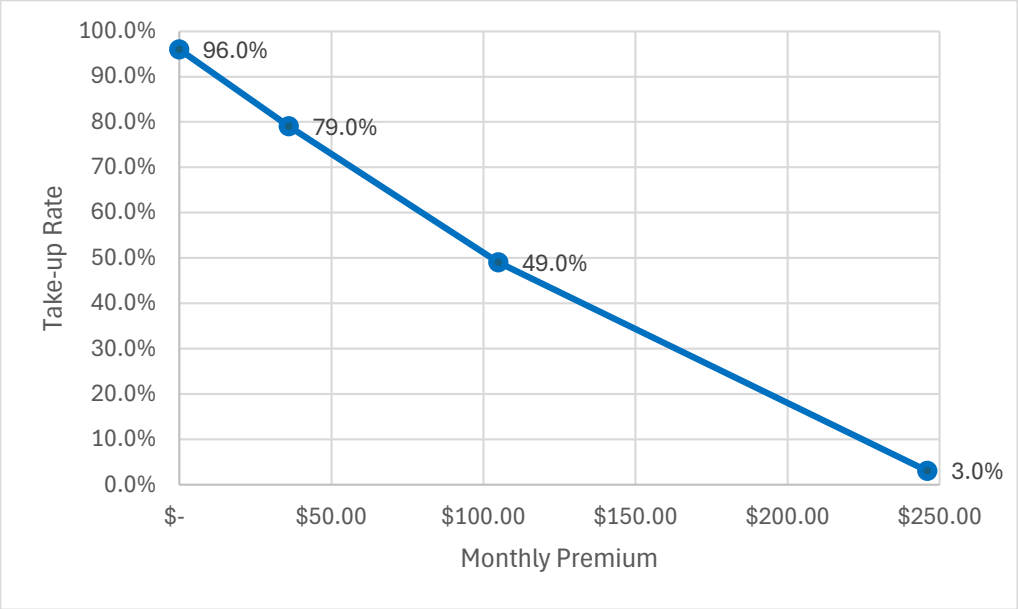
[31] $9,854,568 = $36 monthly premium x 273,738 enrolled months from Q2 of 2020 through Q2 of 2021. Does not adjust for impact of the premium on take-up rate.
[32] Source: Oklahoma Department of Commerce. See PowerPoint Presentation

exemption on new enrollments. However, research consistently has found that imposition of even a small premium will reduce the health insurance take-up rate among low-income adults[33].

The premium structure for Insure Oklahoma is similar to a Massachusetts subsidized insurance program known as Commonwealth Care. A 2017 study conducted jointly by faculty at Harvard and MIT Universities used data from the Massachusetts program to develop a regression model of the impact of monthly premium amounts on subsidized health insurance take-up rates ("Subsidizing Health Insurance for Low Income Adults: Evidence from Massachusetts")[34].

The study found a strong relationship between premiums and insurance take-up rates. Exhibit E-14 below illustrates the projected take-up rates at various premium levels[35]. The 79 percent take-up rate occurs at a premium level of $36.00 per month.

Exhibit E-14 – Relationship of Premiums to Take-up Rates for Subsidized Insurance

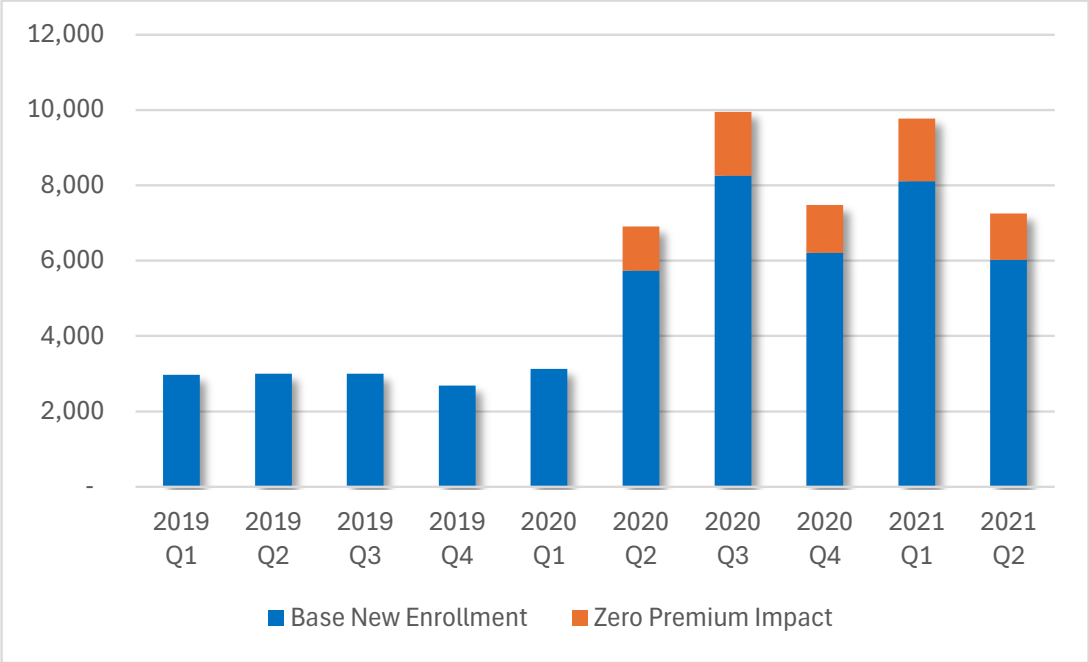


Applying the findings of the Massachusetts study to the program suggests that retention of the premiums during the PHE would have reduced the program take-up rate by 17 percent[36].

[33] For an overview of major studies on this topic, see: Health Insurance Premiums and Cost-Sharing Findings from the Research on Low-Income Populations.
[34] Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts
[35] Graphical representation of study Table 2 (page 27).
[36] 96 percent take-up rate at zero-dollar premium versus 79 percent take-up rate at $36 (96 – 79 = 17).

Exhibit E - 15 (chart and table) models the impact of a 17 percent reduction in new Insure Oklahoma enrollments during the PHE[37].

Exhibit E-15 – Impact of 17 Percent Reduction in Enrollment during PHE



New Enrollment Scenario	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	Total New
Actual	6,906	9,952	7,480	9,772	7,255	**41,365**
Impact of Retaining Premium						
Enrolled	5,732	8,260	6,208	8,111	6,022	**34,333**
Not Enrolled	1,174	1,692	1,272	1,661	1,233	**7,032**

Summary

The premium exemption removed a potential barrier to obtaining health coverage at a time of great uncertainty and risk for vulnerable Oklahomans. It extended a vital safety net for persons who otherwise would have been without coverage in the midst of an unprecedented pandemic.

[37] The exhibit is presented for illustration purposes only. No adjustment has been made for differences in the Massachusetts and Oklahoma programs, or for differences in demographics or income levels between the Massachusetts and Oklahoma populations.

F. CONCLUSIONS

Federal and state governments confronted an unprecedented challenge in responding to the COVID-19 public health emergency. CMS acted swiftly by granting states flexibility under Section 1115 to remove potential barriers to care for their Medicaid and demonstration populations. In Oklahoma, this took the form of suspended point-of-service and premium cost sharing requirements.

The OHCA also acted swiftly by exploiting existing information system functionality and communication channels to implement the policy change. The OHCA suspended cost sharing in conjunction with a series of other initiatives that did not require Section 1115 authority (e.g., expansion of telehealth services).

The point-of-service cost sharing exemption allowed low-income beneficiaries to retain nearly $3 million in discretionary funds during a time of great economic uncertainty. It is unclear as to whether the suspension affected utilization but it did provide a financial boost to SoonerCare members at a critical time.

The premium cost sharing exemption for Insure Oklahoma members took effect concurrent with tremendous COVID-related disruptions in the labor market. Enrollment grew rapidly throughout the pandemic after being stable for an extended period prior to the PHE. The premium cost sharing exemption allowed Insure Oklahoma members to retain nearly $10 million in discretionary funds that otherwise would have been paid to the state.

Data from a similar subsidized insurance program in Massachusetts suggests that the cost sharing exemption contributed to the scale of the enrollment increase. If the relationship between premiums and enrollment found in Massachusetts were to apply in Oklahoma, retention of premiums during the pandemic could have depressed enrollment by as much as 25 percent.

Exhibit F-1 on the following page summarizes evaluation findings with respect to the three research questions/areas. Taken together, they support the hypothesis that Oklahoma's actions mitigated the impact of COVID-19 on beneficiary access to care, while acknowledging that the precise impact, particularly for research question 2, is difficult to quantify.

Exhibit F-1 – Summary of Evaluation Findings

Research Area	Findings	Methodology Limitations
Implementation Performance	The OHCA successfully implemented the cost share exemptions by exploiting existing functionality.	N/A – qualitative only
Point-of-Service Cost Sharing Exemption	The exemption provided important financial support to low-income members. Its effect on utilization was uncertain.	- Lack of true comparison group - Challenge in isolating impact from that of other access-related initiatives
Premium Cost Sharing Exemption	Insure Oklahoma provided critical safety-net coverage at a time of economic disruption. Based on secondary research, the exemption appears to have contributed to enrollment growth.	- Unable to account for potential differences in demographics when applying research findings from Massachusetts

G. INTERPRETATIONS & POLICY LIMITATIONS/OTHER STATE INITIATIVES

The suspension of beneficiary cost sharing was one of a series of initiatives undertaken to facilitate access to care in the midst of an unprecedented public health emergency. Both cost share components – point-of-service and premium exemptions – provided important financial relief to low-income Oklahomans in need of coverage and health services. The premium exemption, in particular, removed what research has found to be a barrier to enrollment for many.

Oklahoma, through its Medicaid expansion, has eliminated premiums for the population previously covered through the Individual Plan segment of Insure Oklahoma. What was taken as an emergency step during the pandemic is now a permanent feature of the program.

The point-of-service cost sharing exemption remains a potential tool in a future crisis (subject to federal authority). Its purpose in such a circumstance should be in part to offer financial relief to low-income health care recipients. It also may facilitate use of health services, although the data is mixed.

H. LESSONS LEARNED & RECOMMENDATIONS

The OHCA's success in rapidly implementing the cost share exemptions was aided by the agency's decision to exploit existing functionality and communication platforms. This strategy is a sound one when time is of the essence, while recognizing that a more refined solution may be worth developing, if the crisis lasts for an extended time.

The suspension of beneficiary cost sharing is an effective way to provide financial relief, while removing a potential barrier to care or enrollment. The premium exemption, in particular, can be effective when the precipitating crisis has resulted in economic disruption and loss of income among those eligible to enroll.

I. APPENDICES

Two supporting appendices are presented, starting on the following page.

Appendix	Applies to	Contents
Appendix 1	POS Cost Sharing	Monthly expenditures by age cohort and category-of-service for COVID-related services and claim counts/expenditures for all other (non-COVID related) services
Appendix 2	Premium Cost Sharing	Monthly enrollment data for Insure Oklahoma Individual Plan program

Appendix 1

Adults – COVID-Related Expenditures

Year	Age Cohort	Month	Inpatient Hospital	Outpatient Hospital	Physician	Clinic	Laboratory	X-Ray	Transportation	All Other	Total
2020	Adults	MAR	$643		$282					$0	$925
2020	Adults	APR	$21,736	$2,985	$12,153	$1,941	$1,634	$188		$14	$40,651
2020	Adults	MAY	$5,082	$11,395	$15,091	$3,651	$2,523	$150	$1,150	$277	$39,319
2020	Adults	JUN	$39,692	$30,672	$69,238	$7,038	$7,046	$746	$4,434	$0	$158,866
2020	Adults	JUL	$163,762	$83,024	$182,105	$24,668	$7,930	$1,644	$10,366	$2,649	$476,148
2020	Adults	AUG	$97,615	$101,797	$117,815	$26,915	$4,662	$1,329	$5,491	$5,657	$361,281
2020	Adults	SEP	$55,227	$76,159	$112,109	$20,405	$5,220	$1,300	$8,310	$4,565	$283,295
2020	Adults	OCT	$108,881	$100,509	$153,676	$33,317	$7,038	$2,236	$17,018	$20,207	$442,882
2020	Adults	NOV	$140,711	$226,801	$287,051	$57,472	$9,636	$2,972	$26,848	$25,878	$777,369
2020	Adults	DEC	$262,077	$303,887	$416,754	$85,594	$9,903	$5,679	$49,407	$55,438	$1,188,738
2021	Adults	JAN	$1,233,430	$2,094,732	$1,045,457	$368,887	$73,928	$7,148	$52,234	$121,973	$4,997,789
2021	Adults	FEB	$984,338	$1,659,857	$688,614	$185,467	$29,726	$5,230	$17,588	$84,131	$3,654,951
2021	Adults	MAR	$986,144	$1,943,655	$566,377	$159,087	$19,766	$2,253	$17,400	$153,881	$3,848,563
2021	Adults	APR	$968,399	$1,766,965	$502,491	$140,605	$16,909	$1,305	$20,744	$116,797	$3,534,213
2021	Adults	MAY	$905,067	$1,630,807	$427,753	$124,086	$14,285	$1,058	$5,166	$75,080	$3,183,303
2021	Adults	JUN	$768,328	$1,577,111	$363,678	$118,394	$18,531	$678	$2,122	$54,723	$2,903,566
2021	Adults	JUL	$1,617,281	$2,335,854	$896,462	$292,305	$57,803	$5,413	$64,829	$90,240	$5,360,188
2021	Adults	AUG	$2,134,295	$4,369,530	$2,434,070	$832,174	$194,059	$17,767	$118,836	$110,902	$10,211,632
2021	Adults	SEP	$1,848,186	$3,935,157	$2,357,140	$761,845	$162,844	$16,981	$134,652	$203,357	$9,420,161
2021	Adults	OCT	$1,730,300	$3,493,820	$1,685,050	$450,301	$85,761	$11,315	$65,851	$183,640	$7,706,039
2021	Adults	NOV	$1,660,407	$3,317,944	$1,584,986	$423,724	$78,112	$7,451	$55,773	$195,765	$7,324,162
2021	Adults	DEC	$2,014,635	$3,966,362	$2,173,234	$534,218	$136,534	$10,474	$78,108	$190,475	$9,104,040
2022	Adults	FEB	$2,333,484	$3,744,271	$1,527,444	$763,707	$58,233	$8,254	$44,489	$195,857	$8,675,738
2022	Adults	MAR	$1,762,135	$3,976,693	$999,505	$521,308	$31,287	$3,193	$8,706	$298,527	$7,601,354
2022	Adults	APR	$1,232,379	$2,605,676	$722,381	$362,738	$17,897	$1,343	$1,751	$201,200	$5,145,365
2022	Adults	MAY	$1,133,642	$2,149,964	$719,419	$392,706	$20,149	$965	$1,353	$136,224	$4,554,423
2022	Adults	JUN	$1,501,175	$2,857,467	$1,022,680	$700,632	$36,269	$2,740	$9,242	$264,500	$6,394,705
2022	Adults	JUL	$2,071,586	$4,335,214	$1,562,343	$1,033,462	$66,572	$2,809	$32,296	$287,683	$9,391,964
2022	Adults	AUG	$2,419,090	$3,908,433	$1,636,553	$1,218,061	$72,783	$4,956	$25,508	$294,206	$9,579,589
2022	Adults	SEP	$1,943,344	$3,157,102	$1,253,903	$842,598	$36,797	$3,207	$17,948	$245,206	$7,500,104
2022	Adults	OCT	$1,335,880	$2,699,917	$1,042,198	$519,594	$26,334	$2,477	$6,561	$253,208	$5,886,169
2022	Adults	NOV	$1,662,422	$3,475,943	$1,384,690	$464,092	$20,862	$2,315	$11,225	$290,830	$7,312,380
2022	Adults	DEC	$1,960,601	$4,141,961	$1,872,579	$630,828	$23,293	$2,060	$6,256	$227,581	$8,865,159
2023	Adults	JAN	$1,613,192	$3,740,720	$1,551,722	$559,314	$22,222	$1,788	$9,301	$223,904	$7,722,163
2023	Adults	FEB	$1,616,800	$2,667,139	$1,154,385	$394,332	$16,367	$2,305	$7,480	$223,717	$6,082,524
2023	Adults	MAR	$1,694,433	$2,802,885	$1,110,641	$434,699	$13,673	$971	$3,925	$201,941	$6,263,168
2023	Adults	APR	$1,444,068	$2,252,344	$778,589	$295,230	$9,268	$664	$1,113	$204,970	$4,986,247
2023	Adults	MAY	$1,121,499	$1,922,627	$584,913	$218,163	$4,332	$490	$1,979	$203,181	$4,057,185
2023	Adults	JUN	$946,481	$1,442,781	$353,212	$113,958	$2,406	$214	$1,206	$140,279	$3,000,537
2023	Adults	JUL	$750,188	$1,429,474	$370,927	$121,036	$2,047	$619	$753	$245,856	$2,920,901
2023	Adults	AUG	$655,317	$2,046,196	$695,280	$340,046	$6,035	$1,205	$4,767	$204,612	$3,953,457
2023	Adults	SEP	$966,608	$2,507,320	$840,072	$399,318	$6,740	$1,682	$24,846	$161,824	$4,908,408
2023	Adults	OCT	$964,612	$1,755,816	$682,292	$276,599	$5,035	$964	$1,842	$125,572	$3,812,732
2023	Adults	NOV	$952,916	$1,727,818	$790,291	$309,565	$4,978	$2,085	$678	$98,956	$3,887,288
2023	Adults	DEC	$1,000,876	$2,204,831	$986,114	$405,117	$5,932	$2,485	$3,189	$90,396	$4,698,941
2024	Adults	FEB	$713,122	$2,029,045	$883,922	$325,099	$5,024	$1,164		$40,528	$3,997,904
2024	Adults	MAR	$311,471	$1,283,051	$539,698	$208,484	$2,680	$850		$34,041	$2,380,275

Children/Adolescents – COVID-Related Expenditures

Year	Age Cohort	Month	Inpatient Hospital	Outpatient Hospital	Physician	Clinic	Laboratory	X-Ray	Transportation	All Other	Total
2020	Children	MAR	$425							$0	$425
2020	Children	APR		$6,731	$4,028	$2,332	$1,667	$19	$454	$0	$15,230
2020	Children	MAY	$4,031	$13,659	$7,761	$4,158	$4,841	$35		$29,310	$63,795
2020	Children	JUN	$51,911	$35,772	$31,919	$19,536	$28,838	$127	$1,418	$0	$169,520
2020	Children	JUL	$77,327	$105,527	$117,671	$53,451	$25,368	$259	$7,884	$1,111	$388,598
2020	Children	AUG	$53,123	$91,936	$107,486	$66,951	$9,889	$239	$2,043	$6,034	$337,700
2020	Children	SEP	$74,212	$98,634	$113,373	$89,637	$11,668	$698	$1,869	$3,477	$393,567
2020	Children	OCT	$83,862	$140,437	$161,838	$73,120	$8,043	$452	$7,473	$13,416	$488,641
2020	Children	NOV	$101,222	$286,865	$321,162	$168,035	$12,564	$532	$15,968	$3,790	$910,138
2020	Children	DEC	$227,720	$379,802	$461,423	$252,757	$11,183	$1,136	$32,054	$22,282	$1,388,356
2021	Children	JAN	$738,378	$2,605,728	$2,061,870	$1,271,489	$240,308	$2,148	$20,526	$189,050	$7,129,495
2021	Children	FEB	$665,438	$2,132,396	$1,241,762	$650,163	$103,924	$444	$14,396	$159,391	$4,967,915
2021	Children	MAR	$776,922	$2,218,455	$954,423	$385,442	$54,357	$190	$14,502	$150,286	$4,554,578
2021	Children	APR	$740,279	$2,321,815	$1,155,049	$336,151	$59,334	$341	$18,992	$93,128	$4,725,089
2021	Children	MAY	$716,546	$2,132,282	$832,046	$174,733	$40,926	$209	$1,447	$61,937	$3,960,127
2021	Children	JUN	$912,472	$2,106,408	$637,155	$224,332	$39,015	$248	$31,621	$79,127	$4,030,377
2021	Children	JUL	$977,792	$2,562,076	$1,437,088	$571,599	$100,161	$938	$32,426	$117,039	$5,799,118
2021	Children	AUG	$986,371	$5,439,364	$4,619,769	$2,480,361	$454,951	$2,401	$63,861	$184,497	$14,231,575
2021	Children	SEP	$1,085,636	$5,098,033	$4,672,135	$2,199,482	$412,547	$2,904	$50,918	$265,500	$13,787,155
2021	Children	OCT	$976,994	$3,547,989	$2,902,996	$930,398	$171,432	$1,155	$43,206	$239,242	$8,813,412
2021	Children	NOV	$859,888	$3,837,414	$3,509,699	$903,914	$155,554	$754	$59,669	$247,640	$9,574,532
2021	Children	DEC	$972,412	$4,231,835	$3,676,129	$845,487	$183,793	$1,588	$26,108	$329,050	$10,266,401
2022	Children	JAN	$1,206,711	$6,920,398	$6,599,686	$5,385,177	$515,815	$2,731	$90,813	$374,055	$21,095,386
2022	Children	FEB	$740,725	$2,912,466	$1,851,911	$998,020	$69,463	$463	$14,225	$291,063	$6,878,336
2022	Children	MAR	$937,155	$3,171,699	$1,385,523	$659,120	$32,526	$148	$1,305	$360,812	$6,548,288
2022	Children	APR	$579,369	$2,120,913	$1,113,565	$407,061	$19,872	$206	$4,363	$339,179	$4,584,527
2022	Children	MAY	$609,763	$1,648,912	$1,018,253	$351,734	$21,470	$87	$7,454	$352,462	$4,010,135
2022	Children	JUN	$609,765	$1,954,472	$1,218,364	$631,936	$29,083	$336	$13,705	$300,555	$4,758,217
2022	Children	JUL	$625,211	$2,611,468	$1,886,091	$985,755	$52,824	$745	$42,054	$590,325	$6,794,471
2022	Children	AUG	$640,599	$3,219,305	$3,064,595	$1,827,862	$72,198	$1,022	$31,832	$495,646	$9,353,059
2022	Children	SEP	$633,918	$3,125,552	$2,628,973	$1,300,253	$53,516	$869	$19,534	$459,503	$8,222,118
2022	Children	OCT	$906,260	$3,375,756	$2,530,026	$888,571	$30,008	$418	$24,424	$335,560	$8,091,023
2022	Children	NOV	$908,000	$4,871,155	$3,461,426	$1,102,667	$24,365	$376	$13,342	$365,591	$10,746,922
2022	Children	DEC	$743,633	$4,724,932	$3,495,565	$1,157,010	$19,356	$315	$5,816	$422,205	$10,568,831
2023	Children	JAN	$644,717	$2,835,662	$2,279,974	$885,200	$18,868	$203	$20,674	$362,426	$7,047,724
2023	Children	FEB	$628,875	$2,312,967	$1,869,165	$631,282	$15,984	$114	$3,715	$235,753	$5,697,855
2023	Children	MAR	$691,100	$2,294,730	$1,704,419	$650,044	$13,688	$241	$15,127	$291,110	$5,660,461
2023	Children	APR	$536,406	$2,003,728	$1,289,081	$496,372	$6,937	$76	$2,399	$173,410	$4,508,408
2023	Children	MAY	$523,572	$1,591,406	$870,222	$288,954	$3,699	$83	$1,347	$200,942	$3,480,226
2023	Children	JUN	$230,787	$987,753	$373,042	$92,209	$2,122	$18	$6,645	$108,306	$1,800,881
2023	Children	JUL	$243,312	$837,639	$356,600	$100,919	$947	$59	$7,190	$215,965	$1,762,632
2023	Children	AUG	$254,541	$1,693,676	$1,422,972	$724,327	$5,246	$72	$14,968	$190,555	$4,306,356
2023	Children	SEP	$306,084	$2,016,347	$1,660,757	$704,217	$8,390	$132	$2,927	$133,628	$4,832,482
2023	Children	OCT	$194,756	$1,461,814	$1,303,829	$469,350	$7,004	$233	$2,465	$119,943	$3,559,394
2023	Children	NOV	$226,134	$1,687,080	$1,806,954	$624,287	$7,066	$287	$2,827	$114,981	$4,469,616
2023	Children	DEC	$309,752	$2,239,023	$2,123,586	$808,061	$5,253	$411	$2,790	$107,235	$5,596,111
2024	Children	JAN	$176,604	$2,243,752	$2,210,040	$855,959	$5,455	$212	$453	$81,361	$5,573,837
2024	Children	FEB	$55,913	$2,038,721	$2,303,814	$869,691	$4,441	$241		$29,918	$5,302,739
2024	Children	MAR	$15,249	$1,081,528	$1,173,642	$380,973	$1,971	$162		$31,085	$2,684,609

Adults – All Other (Non-COVID) Claim Counts

Year	Age Cohort	Month	Member Months	Inpatient Hospital	Outpatient Hospital	Physician	Clinic	Laboratory	X-Ray	Transportation	All Other	Total
2019	Adults	JAN	86,049	3,142	28,109	82,847	12,431	16,436	12,932	8,889	61,337	226,123
2019	Adults	FEB	85,955	2,763	25,821	74,083	10,487	13,718	12,010	8,283	55,597	202,762
2019	Adults	MAR	83,928	3,026	27,038	77,284	11,227	14,257	12,802	8,699	58,010	212,343
2019	Adults	APR	85,261	2,849	28,204	82,221	12,347	15,976	13,495	9,123	60,758	224,973
2019	Adults	MAY	86,982	3,009	28,479	80,800	11,784	15,731	13,544	9,030	59,999	222,376
2019	Adults	JUN	85,394	2,799	26,921	75,406	10,922	15,132	12,717	8,730	57,170	209,797
2019	Adults	JUL	86,020	3,093	28,679	81,854	11,869	16,521	13,133	9,551	63,053	227,753
2019	Adults	AUG	86,919	3,075	28,541	80,936	11,719	15,205	13,071	9,602	62,798	224,947
2019	Adults	SEP	80,433	2,980	26,945	76,440	11,070	14,412	12,429	9,299	58,814	212,389
2019	Adults	OCT	82,867	2,829	27,583	81,895	12,638	15,828	12,450	10,106	62,394	225,723
2019	Adults	NOV	83,900	2,628	24,492	70,293	10,099	12,540	11,397	8,499	56,592	196,540
2019	Adults	DEC	81,258	2,803	24,700	72,174	10,216	12,298	11,564	8,598	57,407	199,760
2020	Adults	JAN	83,908	3,044	28,270	80,639	12,865	15,699	13,025	8,865	57,742	220,149
2020	Adults	FEB	85,379	2,681	25,821	73,318	11,170	13,732	12,060	8,197	52,952	199,931
2020	Adults	MAR	81,984	2,660	23,616	70,495	10,504	12,511	11,149	7,724	55,085	193,744
2020	Adults	APR	92,134	2,359	16,343	59,574	9,313	10,189	7,832	5,328	57,357	168,295
2020	Adults	MAY	95,520	2,667	22,843	66,867	10,328	12,442	10,634	6,010	55,976	187,767
2020	Adults	JUN	98,725	2,851	27,255	77,688	12,868	15,656	12,788	7,410	60,125	216,641
2020	Adults	JUL	103,633	2,909	28,668	79,864	13,286	15,798	13,121	7,993	61,377	223,016
2020	Adults	AUG	106,726	2,872	28,524	79,158	13,387	15,493	12,893	7,750	60,893	220,970
2020	Adults	SEP	108,189	2,816	28,313	80,813	14,515	16,164	12,994	7,816	62,711	226,142
2020	Adults	OCT	109,652	2,503	27,694	77,240	14,153	14,994	11,809	7,639	61,953	217,985
2020	Adults	NOV	112,307	2,359	26,308	72,469	13,215	14,350	11,455	6,975	58,555	205,686
2020	Adults	DEC	114,966	2,164	25,576	72,717	12,994	15,115	11,198	6,726	61,744	208,234
2021	Adults	JAN	115,042	1,423	26,281	77,773	15,094	17,762	11,436	6,739	67,432	223,940
2021	Adults	FEB	116,143	1,377	22,091	68,163	13,061	13,076	10,605	5,427	60,878	194,678
2021	Adults	MAR	116,696	1,661	30,456	91,729	19,870	19,294	13,977	7,423	75,440	259,850
2021	Adults	APR	117,929	1,581	30,914	90,148	18,479	17,873	14,158	7,096	72,248	252,497
2021	Adults	MAY	118,700	1,725	31,188	86,886	16,856	16,556	14,726	7,270	68,956	244,163
2021	Adults	JUN	121,448	1,946	31,738	91,560	18,242	18,708	15,681	7,455	73,728	259,058
2021	Adults	JUL	105,815	2,061	36,778	99,240	23,211	21,291	18,516	8,106	75,385	284,588
2021	Adults	AUG	106,888	1,575	37,511	104,880	26,600	23,552	20,897	8,894	83,995	307,904
2021	Adults	SEP	107,597	1,599	36,686	104,685	26,036	22,367	19,588	8,787	84,492	304,240
2021	Adults	OCT	173,305	1,733	38,357	110,030	26,340	19,891	21,639	9,559	82,886	310,435
2021	Adults	NOV	199,189	1,916	38,595	115,241	27,359	20,697	21,860	9,302	84,075	319,045
2021	Adults	DEC	214,428	1,765	39,020	112,597	27,520	20,115	22,082	9,609	84,962	317,670
2022	Adults	JAN	239,487	1,622	40,979	120,860	31,261	25,011	24,469	9,282	92,628	346,112
2022	Adults	FEB	243,596	1,631	37,671	108,496	26,838	20,976	21,603	8,283	87,053	312,551
2022	Adults	MAR	246,069	2,265	51,997	145,120	38,877	29,846	28,153	11,084	111,298	418,640
2022	Adults	APR	253,431	2,798	51,900	140,634	36,839	27,752	28,043	10,995	105,879	404,840
2022	Adults	MAY	258,254	3,379	54,553	146,562	37,461	28,266	29,270	11,152	109,761	420,404
2022	Adults	JUN	268,335	3,300	55,745	151,510	39,583	29,673	28,973	10,787	112,143	431,714
2022	Adults	JUL	273,908	3,244	53,025	140,790	35,100	26,186	28,074	12,459	102,443	401,321
2022	Adults	AUG	276,298	3,276	57,385	160,903	41,494	30,881	30,074	13,728	118,214	455,955
2022	Adults	SEP	284,702	3,191	56,010	154,047	39,701	28,959	28,217	12,506	113,620	436,251
2022	Adults	OCT	289,289	3,253	56,124	157,847	39,665	28,508	28,672	12,049	115,784	441,902
2022	Adults	NOV	291,050	3,133	54,251	153,754	38,011	27,465	27,927	13,018	113,387	430,946
2022	Adults	DEC	299,089	2,929	50,941	146,087	35,776	24,823	27,937	12,342	108,872	409,707
2023	Adults	JAN	319,227	3,391	58,343	168,168	43,854	32,094	31,148	13,128	121,440	471,566
2023	Adults	FEB	320,556	3,293	58,236	166,521	43,110	32,597	29,999	13,085	117,947	464,788
2023	Adults	MAR	328,186	3,632	66,907	186,296	50,407	36,156	34,323	14,865	132,631	525,217
2023	Adults	APR	333,042	3,649	62,887	175,566	45,556	32,561	32,211	13,995	123,202	489,627
2023	Adults	MAY	330,614	4,182	68,748	192,287	49,718	35,712	34,315	15,757	131,034	531,753
2023	Adults	JUN	321,515	4,298	67,336	180,827	46,281	32,718	32,856	15,152	125,888	505,356
2023	Adults	JUL	315,657	4,439	64,193	173,252	41,750	29,883	31,701	14,961	123,663	483,842
2023	Adults	AUG	299,373	4,481	68,306	189,507	49,052	34,678	33,323	16,522	133,993	529,862
2023	Adults	SEP	282,098	3,938	59,148	164,161	41,113	29,273	30,403	14,503	123,076	465,615
2023	Adults	OCT	266,083	4,216	60,468	170,919	43,238	30,755	31,151	15,076	130,334	486,157
2023	Adults	NOV	244,039	3,835	54,389	154,500	38,025	27,261	27,827	13,328	121,729	440,894
2023	Adults	DEC	247,409	3,630	50,759	141,663	34,212	24,335	26,170	13,022	113,746	407,537

Adults – All Other (Non-COVID) Expenditures

Year	Age Cohort	Month	Member Months	Inpatient Hospital	Outpatient Hospital	Physician	Clinic	Laboratory	X-Ray	Transportation	All Other	Total
2019	Adults	JAN	86,049	$3,822,710	$21,009,335	$25,725,163	$5,022,622	$1,944,128	$1,134,350	$2,374,085	$12,399,629	$73,432,021
2019	Adults	FEB	85,955	$3,563,803	$19,714,659	$22,877,764	$4,301,308	$1,741,362	$1,038,401	$2,031,682	$11,533,785	$66,802,764
2019	Adults	MAR	83,928	$3,796,934	$20,786,532	$24,268,151	$4,658,022	$1,807,223	$1,115,355	$2,362,650	$12,618,415	$71,413,283
2019	Adults	APR	85,261	$3,430,179	$22,515,218	$25,678,140	$5,196,586	$2,093,651	$1,245,009	$2,362,786	$13,253,037	$75,774,607
2019	Adults	MAY	86,982	$3,393,993	$22,520,401	$25,676,665	$4,857,735	$2,038,195	$1,313,899	$2,501,228	$13,198,828	$75,500,945
2019	Adults	JUN	85,394	$2,698,127	$20,987,728	$23,234,742	$4,592,410	$1,839,009	$1,182,900	$2,323,127	$12,526,330	$69,384,372
2019	Adults	JUL	86,020	$3,903,251	$23,123,374	$27,164,435	$5,432,842	$2,067,394	$1,353,085	$2,569,405	$13,655,428	$79,269,214
2019	Adults	AUG	86,919	$3,545,099	$22,864,702	$26,867,290	$5,430,619	$1,815,553	$1,358,586	$2,576,894	$13,734,225	$78,192,969
2019	Adults	SEP	80,433	$3,456,947	$21,529,355	$24,817,307	$5,180,288	$1,882,810	$1,305,752	$2,448,663	$13,288,801	$73,909,923
2019	Adults	OCT	82,867	$3,416,386	$23,107,703	$27,040,550	$5,869,283	$2,090,159	$1,332,402	$2,250,279	$14,669,378	$79,776,140
2019	Adults	NOV	83,900	$3,015,592	$21,214,061	$23,159,841	$4,563,497	$1,645,198	$1,221,890	$2,205,411	$13,511,608	$70,537,098
2019	Adults	DEC	81,258	$2,930,820	$20,847,959	$23,628,563	$4,540,377	$1,463,331	$1,117,105	$2,154,088	$13,506,473	$70,188,715
2020	Adults	JAN	83,908	$2,734,557	$12,587,376	$15,216,653	$3,424,007	$959,609	$705,684	$1,282,823	$7,469,411	$44,380,120
2020	Adults	FEB	85,379	$1,859,058	$11,292,928	$13,979,939	$2,969,399	$835,048	$633,452	$1,176,311	$7,161,098	$39,907,234
2020	Adults	MAR	81,984	$1,948,704	$10,740,655	$13,431,870	$2,649,917	$733,013	$616,050	$1,208,442	$7,360,702	$38,689,353
2020	Adults	APR	92,134	$1,974,138	$7,630,170	$11,475,725	$2,179,066	$596,036	$441,254	$973,519	$7,252,507	$32,522,416
2020	Adults	MAY	95,520	$2,301,657	$10,981,925	$12,870,879	$2,553,087	$740,737	$604,460	$1,123,589	$7,364,767	$38,541,099
2020	Adults	JUN	98,725	$2,053,817	$12,978,385	$14,520,864	$3,304,945	$950,617	$707,433	$1,344,149	$7,794,313	$43,654,523
2020	Adults	JUL	103,633	$2,771,879	$12,694,902	$14,880,830	$3,522,144	$1,006,565	$726,349	$1,492,654	$8,195,840	$45,291,163
2020	Adults	AUG	106,726	$2,768,520	$13,031,201	$14,884,421	$3,559,911	$974,289	$699,530	$1,415,699	$8,203,490	$45,537,063
2020	Adults	SEP	108,189	$2,438,311	$12,538,785	$15,065,850	$3,901,383	$996,881	$700,382	$1,360,861	$8,563,197	$45,565,649
2020	Adults	OCT	109,652	$2,056,982	$12,460,413	$13,989,342	$3,800,702	$914,951	$659,380	$1,313,307	$8,540,218	$43,735,293
2020	Adults	NOV	112,307	$1,647,764	$11,485,926	$13,100,558	$3,536,143	$928,215	$620,174	$1,208,553	$8,198,456	$40,725,787
2020	Adults	DEC	114,966	$1,740,332	$11,679,355	$13,307,748	$3,449,691	$961,921	$613,821	$1,189,346	$8,689,181	$41,631,395
2021	Adults	JAN	115,042	$1,836,954	$11,642,277	$14,782,917	$4,184,589	$1,080,344	$607,017	$1,296,345	$9,331,964	$44,762,406
2021	Adults	FEB	116,143	$1,204,283	$10,435,327	$13,033,567	$3,634,886	$758,555	$557,322	$1,152,242	$9,056,384	$39,832,566
2021	Adults	MAR	116,696	$1,642,199	$13,850,620	$16,951,830	$5,538,296	$1,139,565	$774,767	$1,357,202	$11,037,540	$52,292,019
2021	Adults	APR	117,929	$1,678,744	$14,368,331	$16,684,115	$5,078,780	$1,093,776	$809,680	$1,335,309	$10,801,358	$51,850,093
2021	Adults	MAY	118,700	$1,170,240	$14,149,760	$16,294,354	$4,628,597	$1,033,396	$811,141	$1,464,022	$10,795,582	$50,347,091
2021	Adults	JUN	121,448	$1,390,072	$14,293,744	$17,161,946	$5,011,823	$1,093,390	$827,889	$1,498,728	$10,675,169	$51,952,761
2021	Adults	JUL	105,815	$1,779,330	$16,445,054	$19,223,346	$6,515,392	$1,293,050	$952,123	$1,792,835	$12,653,927	$60,655,058
2021	Adults	AUG	106,888	$1,402,608	$16,796,443	$20,157,239	$7,521,299	$1,473,641	$1,046,415	$1,860,182	$14,221,517	$64,479,344
2021	Adults	SEP	107,597	$1,330,537	$16,805,703	$20,203,561	$7,366,956	$1,378,339	$1,032,819	$1,742,420	$14,479,207	$64,339,541
2021	Adults	OCT	173,305	$1,767,841	$17,739,287	$20,809,107	$7,618,234	$1,160,549	$1,126,833	$1,972,192	$16,215,448	$68,409,491
2021	Adults	NOV	199,189	$1,974,343	$18,172,979	$21,651,257	$7,816,169	$1,232,233	$1,085,418	$1,948,896	$16,243,263	$70,124,557
2021	Adults	DEC	214,428	$1,549,037	$18,277,873	$21,207,025	$7,847,683	$1,166,583	$1,137,946	$1,911,989	$16,318,530	$69,416,666
2022	Adults	JAN	239,487	$2,061,658	$19,813,911	$22,918,210	$10,336,301	$1,530,616	$1,234,134	$2,071,759	$17,942,998	$77,909,588
2022	Adults	FEB	243,596	$1,503,133	$18,351,801	$20,867,671	$8,667,457	$1,308,683	$1,118,483	$1,825,971	$17,413,660	$71,056,860
2022	Adults	MAR	246,069	$3,243,290	$25,784,064	$27,685,526	$12,763,573	$1,814,356	$1,494,244	$2,434,198	$21,768,015	$96,987,266
2022	Adults	APR	253,431	$2,512,101	$26,054,099	$26,233,712	$12,197,098	$1,732,234	$1,485,205	$2,282,922	$22,016,223	$94,513,594
2022	Adults	MAY	258,254	$2,553,448	$28,030,876	$26,996,068	$12,587,818	$1,744,930	$1,569,941	$2,543,033	$22,960,254	$98,986,367
2022	Adults	JUN	268,335	$2,977,283	$28,614,922	$27,911,392	$13,189,479	$1,804,346	$1,588,593	$2,771,160	$23,548,017	$102,405,193
2022	Adults	JUL	273,908	$4,184,771	$26,920,968	$26,259,453	$11,980,590	$1,605,403	$1,538,365	$3,005,881	$24,162,567	$99,657,998
2022	Adults	AUG	276,298	$2,831,453	$30,149,176	$29,927,624	$14,359,539	$1,934,170	$1,668,541	$2,849,655	$27,045,519	$110,765,677
2022	Adults	SEP	284,702	$2,554,740	$28,564,464	$28,193,032	$13,593,305	$1,810,685	$1,613,476	$2,666,157	$26,151,600	$105,147,458
2022	Adults	OCT	289,289	$3,521,898	$29,116,872	$28,907,277	$13,736,770	$1,781,677	$1,624,702	$2,468,312	$27,351,379	$108,508,888
2022	Adults	NOV	291,050	$3,103,128	$27,968,026	$27,847,999	$12,767,541	$1,715,678	$1,518,440	$2,436,231	$26,673,997	$104,031,040
2022	Adults	DEC	299,089	$3,476,116	$25,882,782	$26,718,313	$11,830,410	$1,541,128	$1,507,594	$2,184,541	$25,831,940	$98,972,823
2023	Adults	JAN	319,227	$3,669,905	$30,510,590	$30,753,158	$15,216,198	$2,023,588	$1,743,010	$2,850,191	$29,574,457	$116,341,097
2023	Adults	FEB	320,556	$3,668,745	$30,835,705	$30,578,811	$15,123,713	$2,063,290	$1,704,656	$2,664,046	$29,066,637	$115,705,603
2023	Adults	MAR	328,186	$3,751,584	$36,430,142	$34,185,957	$18,066,860	$2,262,742	$1,968,526	$2,898,811	$32,157,914	$131,722,536
2023	Adults	APR	333,042	$3,191,169	$34,016,876	$32,172,952	$16,135,307	$2,100,046	$1,826,715	$2,951,585	$30,503,227	$122,897,877
2023	Adults	MAY	330,614	$4,311,906	$37,567,530	$34,908,712	$17,801,593	$2,277,317	$1,981,647	$3,162,574	$31,999,776	$134,011,054
2023	Adults	JUN	321,515	$3,598,067	$36,654,157	$33,075,727	$16,548,432	$2,052,110	$1,913,044	$3,205,821	$30,384,833	$127,432,192
2023	Adults	JUL	315,657	$4,585,363	$34,441,059	$31,580,127	$15,112,828	$1,835,302	$1,785,257	$3,503,708	$31,664,238	$124,507,883
2023	Adults	AUG	299,373	$5,072,404	$36,801,888	$34,774,293	$17,522,839	$2,162,597	$1,925,113	$3,429,919	$33,867,527	$135,556,581
2023	Adults	SEP	282,098	$5,243,254	$31,900,772	$30,666,083	$14,553,071	$1,852,545	$1,744,292	$2,918,783	$31,999,890	$120,878,690
2023	Adults	OCT	266,083	$4,029,414	$32,532,925	$31,698,199	$15,318,583	$1,909,173	$1,793,416	$2,860,627	$33,041,463	$123,183,799
2023	Adults	NOV	244,039	$3,765,720	$30,006,834	$28,741,214	$13,104,277	$1,663,300	$1,545,714	$2,302,048	$31,238,026	$112,367,135
2023	Adults	DEC	247,409	$4,165,353	$27,592,179	$26,661,578	$11,782,300	$1,478,274	$1,460,916	$2,182,109	$30,179,727	$105,502,437

Children/Adolescents – All Other (Non-COVID) Claim Counts

Year	Age Cohort	Month	Member Months	Inpatient Hospital	Outpatient Hospital	Physician	Clinic	Laboratory	X-Ray	Transportation	All Other	Total
2019	Children	JAN	415,616	4,063	43,375	196,209	37,069	14,573	12,032	3,791	272,464	583,576
2019	Children	FEB	418,810	3,696	46,541	204,018	36,626	14,424	11,432	3,431	245,121	565,289
2019	Children	MAR	413,521	3,812	41,461	179,092	32,221	13,185	11,271	3,522	255,278	539,842
2019	Children	APR	420,279	3,697	40,132	182,432	33,901	13,420	12,296	3,735	278,543	568,156
2019	Children	MAY	424,465	3,669	38,251	163,924	29,837	12,224	10,611	3,565	250,904	512,985
2019	Children	JUN	420,234	3,466	34,545	144,014	25,923	11,420	8,858	3,344	223,199	454,769
2019	Children	JUL	422,645	3,766	36,742	158,453	31,289	12,778	9,253	4,013	248,415	504,709
2019	Children	AUG	423,787	3,986	39,642	175,564	38,168	13,509	10,584	3,927	261,708	547,088
2019	Children	SEP	416,055	4,053	42,077	177,958	34,809	13,133	12,198	3,804	253,479	541,511
2019	Children	OCT	419,983	4,005	44,680	209,296	43,349	13,974	12,833	4,434	290,836	623,407
2019	Children	NOV	423,603	3,821	42,324	188,005	35,762	11,903	11,888	3,751	246,021	543,475
2019	Children	DEC	415,159	4,287	50,161	201,201	35,883	12,622	13,375	3,698	236,606	557,833
2020	Children	JAN	416,332	4,081	48,724	212,288	41,837	15,517	12,885	4,108	265,805	605,245
2020	Children	FEB	420,625	3,576	43,372	188,005	37,187	13,834	11,164	3,649	243,540	544,327
2020	Children	MAR	414,063	3,576	33,247	151,100	28,464	10,967	9,010	2,873	216,993	456,230
2020	Children	APR	441,023	2,970	14,878	89,214	15,923	7,205	5,333	1,316	169,009	305,848
2020	Children	MAY	449,405	3,080	22,808	107,615	19,562	8,971	6,620	1,859	199,379	369,894
2020	Children	JUN	456,016	3,248	28,682	133,020	26,053	12,445	7,946	2,774	231,356	445,524
2020	Children	JUL	464,578	3,593	31,491	140,226	29,118	15,055	8,179	2,847	235,797	466,306
2020	Children	AUG	471,230	3,578	32,668	148,134	33,349	15,311	8,545	2,930	243,062	487,577
2020	Children	SEP	475,243	3,552	34,862	154,718	34,262	16,887	9,686	3,002	252,948	509,917
2020	Children	OCT	481,523	3,376	33,915	159,198	33,914	14,942	9,217	2,908	246,830	504,300
2020	Children	NOV	486,855	3,257	32,637	147,176	31,419	17,509	8,852	2,551	225,280	468,681
2020	Children	DEC	492,454	2,963	29,322	134,168	30,510	16,870	7,577	2,314	229,682	453,406
2021	Children	JAN	488,993	2,699	26,269	139,452	32,302	16,478	7,657	2,567	237,465	464,889
2021	Children	FEB	493,008	2,433	21,895	112,133	25,372	11,052	6,891	2,153	200,543	382,472
2021	Children	MAR	497,380	2,863	32,477	160,251	39,574	14,779	10,061	3,121	275,001	538,127
2021	Children	APR	500,269	2,742	35,352	166,313	39,994	15,427	11,274	3,057	261,775	535,934
2021	Children	MAY	501,548	2,975	35,758	157,249	34,918	13,352	11,050	3,077	236,246	494,625
2021	Children	JUN	509,011	3,179	37,057	168,014	39,079	13,613	10,498	3,363	244,710	519,513
2021	Children	JUL	498,658	3,304	35,941	164,226	38,371	13,321	10,278	3,297	235,229	503,967
2021	Children	AUG	504,859	3,185	36,189	182,291	48,096	20,394	11,822	3,320	255,777	561,074
2021	Children	SEP	507,560	3,060	35,430	174,341	45,903	18,937	12,683	3,246	256,311	549,911
2021	Children	OCT	520,326	2,809	35,830	173,617	42,938	14,748	12,470	3,309	253,900	539,621
2021	Children	NOV	533,726	2,868	37,091	184,017	45,512	15,227	12,771	3,318	252,370	553,174
2021	Children	DEC	537,545	2,765	34,839	166,881	42,511	14,061	12,181	3,214	236,390	512,842
2022	Children	JAN	523,771	2,509	27,539	148,802	40,879	18,674	10,058	2,546	233,786	484,793
2022	Children	FEB	526,973	2,416	25,702	127,274	34,927	11,718	9,032	2,353	214,256	427,678
2022	Children	MAR	516,786	2,840	36,241	173,701	48,765	14,626	11,812	3,256	281,384	572,625
2022	Children	APR	519,624	2,899	35,637	167,905	46,087	13,916	12,482	3,137	258,802	540,865
2022	Children	MAY	523,500	2,983	34,942	158,099	42,614	12,846	11,679	2,911	241,848	507,922
2022	Children	JUN	528,325	3,106	33,909	153,568	42,833	12,403	10,430	3,082	243,750	503,081
2022	Children	JUL	530,498	3,313	31,512	142,444	38,925	13,678	9,493	3,426	224,279	467,070
2022	Children	AUG	533,745	3,425	37,431	181,104	52,325	17,070	11,835	4,014	277,750	584,954
2022	Children	SEP	537,267	2,873	39,481	179,598	53,604	15,837	13,392	3,544	266,306	574,635
2022	Children	OCT	540,084	2,962	41,303	193,312	54,626	15,641	13,908	3,626	269,966	595,344
2022	Children	NOV	543,496	2,930	41,875	200,978	56,418	15,660	13,226	3,872	259,588	594,547
2022	Children	DEC	545,451	2,612	36,560	173,847	49,346	14,151	11,294	3,202	230,210	521,222
2023	Children	JAN	528,460	3,013	35,558	173,642	50,711	14,872	11,255	3,591	261,299	553,941
2023	Children	FEB	530,098	2,726	35,366	173,453	51,414	14,139	10,927	3,446	258,453	549,924
2023	Children	MAR	534,100	2,987	40,832	193,712	58,002	16,119	12,440	3,965	291,444	619,501
2023	Children	APR	537,005	2,742	39,112	178,287	53,575	14,960	12,322	3,845	265,545	570,388
2023	Children	MAY	532,649	2,990	40,034	181,933	53,268	14,381	12,147	4,061	269,653	578,467
2023	Children	JUN	523,449	3,035	35,544	155,895	46,970	13,518	9,750	3,915	244,824	513,451
2023	Children	JUL	517,948	3,176	34,256	151,425	46,727	13,550	9,049	3,692	234,227	496,102
2023	Children	AUG	502,185	3,074	39,126	183,120	60,686	16,711	10,903	4,414	279,791	597,825
2023	Children	SEP	484,336	3,022	37,497	168,826	53,078	14,755	11,741	3,949	250,384	543,252
2023	Children	OCT	466,396	3,281	40,054	184,190	56,272	14,858	11,936	4,400	275,997	590,988
2023	Children	NOV	454,502	3,126	38,225	177,705	54,442	14,558	11,677	3,884	258,872	562,489
2023	Children	DEC	456,701	3,007	36,666	162,540	48,557	12,935	10,904	3,610	223,566	501,785

Children/Adolescents – All Other (Non-COVID) Expenditures

Year	Age Cohort	Month	Member Months	Inpatient Hospital	Outpatient Hospital	Physician	Clinic	Laboratory	X-Ray	Transportation	All Other	Total
2019	Children	JAN	415,616	$7,356,086	$21,366,717	$40,691,760	$13,563,819	$1,054,734	$518,917	$1,458,354	$58,614,782	$144,625,169
2019	Children	FEB	418,810	$6,783,687	$21,925,659	$42,050,333	$13,102,418	$1,026,504	$491,116	$1,438,415	$53,157,897	$139,976,030
2019	Children	MAR	413,521	$6,662,319	$21,657,316	$37,945,787	$11,696,975	$1,010,754	$510,899	$1,676,386	$55,658,849	$136,819,285
2019	Children	APR	420,279	$6,132,075	$21,428,964	$38,084,572	$12,373,312	$1,076,481	$560,048	$1,725,424	$59,545,123	$140,925,998
2019	Children	MAY	424,465	$5,877,894	$20,773,009	$34,055,853	$11,113,717	$993,738	$501,611	$1,628,876	$56,648,031	$131,592,728
2019	Children	JUN	420,234	$6,046,090	$19,521,241	$30,749,261	$9,497,924	$963,517	$440,395	$1,456,845	$50,819,198	$119,494,471
2019	Children	JUL	422,645	$6,815,440	$20,690,217	$36,264,403	$12,225,900	$1,033,388	$501,086	$1,790,929	$57,056,129	$136,377,491
2019	Children	AUG	423,787	$7,065,718	$21,283,130	$39,510,712	$15,374,455	$1,045,447	$558,416	$1,486,676	$58,270,035	$144,594,590
2019	Children	SEP	416,055	$6,905,018	$20,995,975	$38,683,456	$13,687,763	$962,269	$594,336	$1,763,064	$56,835,668	$140,427,549
2019	Children	OCT	419,983	$7,204,997	$23,471,404	$44,760,324	$17,554,165	$1,114,966	$661,166	$1,716,417	$65,698,874	$162,182,313
2019	Children	NOV	423,603	$6,055,197	$22,293,315	$40,728,009	$13,842,215	$963,117	$581,469	$1,486,821	$57,990,192	$143,940,335
2019	Children	DEC	415,159	$6,561,929	$24,938,116	$44,332,855	$13,563,611	$1,015,040	$585,990	$1,994,354	$55,410,384	$148,402,279
2020	Children	JAN	416,332	$4,165,448	$15,866,682	$29,228,488	$10,393,011	$712,156	$354,693	$1,046,876	$34,437,234	$96,204,588
2020	Children	FEB	420,625	$3,926,341	$13,942,204	$26,052,535	$9,348,953	$643,555	$333,495	$931,283	$32,153,346	$87,331,714
2020	Children	MAR	414,063	$3,800,540	$11,759,755	$21,352,704	$6,915,650	$509,849	$282,930	$788,231	$29,133,824	$74,543,482
2020	Children	APR	441,023	$3,210,960	$5,367,495	$12,783,695	$3,798,810	$437,267	$182,869	$648,128	$22,457,885	$48,887,109
2020	Children	MAY	449,405	$3,234,979	$9,511,910	$16,329,514	$4,794,977	$504,947	$218,483	$726,321	$27,371,570	$62,692,701
2020	Children	JUN	456,016	$3,521,579	$11,560,033	$20,000,274	$6,621,747	$750,249	$284,538	$910,638	$31,045,163	$74,694,222
2020	Children	JUL	464,578	$3,878,681	$11,474,998	$20,513,269	$7,646,661	$1,048,091	$292,148	$877,944	$32,591,439	$78,323,230
2020	Children	AUG	471,230	$3,955,726	$11,598,899	$21,229,160	$8,809,257	$943,285	$290,191	$863,435	$33,326,595	$81,016,548
2020	Children	SEP	475,243	$3,999,236	$12,149,174	$21,958,301	$9,003,149	$1,095,724	$316,243	$866,768	$34,746,099	$84,134,694
2020	Children	OCT	481,523	$3,774,892	$12,502,595	$22,182,157	$9,074,141	$975,403	$320,153	$893,971	$34,336,914	$84,060,227
2020	Children	NOV	486,855	$3,775,468	$11,488,000	$20,811,185	$8,358,866	$1,261,086	$292,761	$779,722	$31,972,291	$78,739,380
2020	Children	DEC	492,454	$3,396,375	$10,912,614	$19,589,403	$8,161,098	$1,188,096	$257,068	$747,139	$32,729,104	$76,980,897
2021	Children	JAN	488,993	$3,284,871	$9,409,064	$20,368,330	$8,664,320	$1,000,469	$267,129	$693,189	$32,438,096	$76,125,469
2021	Children	FEB	493,008	$3,007,312	$8,039,233	$16,866,660	$6,664,869	$641,410	$230,762	$693,446	$28,946,923	$65,090,615
2021	Children	MAR	497,380	$3,346,818	$11,427,840	$23,606,906	$10,741,199	$880,218	$339,022	$995,326	$37,612,256	$88,949,586
2021	Children	APR	500,269	$3,419,660	$12,457,081	$23,995,300	$10,843,220	$949,783	$375,659	$966,637	$35,835,824	$88,843,162
2021	Children	MAY	501,548	$3,533,722	$12,206,476	$22,807,395	$9,623,971	$775,799	$348,334	$978,706	$33,204,406	$83,478,809
2021	Children	JUN	509,011	$3,988,456	$13,211,055	$24,217,139	$10,728,634	$748,003	$327,511	$1,069,072	$33,895,002	$88,184,873
2021	Children	JUL	498,658	$4,278,307	$12,262,078	$24,608,105	$10,710,538	$749,167	$310,140	$1,184,847	$33,429,524	$87,532,707
2021	Children	AUG	504,859	$3,931,323	$12,667,306	$26,694,539	$13,343,245	$1,186,865	$344,794	$1,116,015	$34,808,890	$94,092,978
2021	Children	SEP	507,560	$3,983,323	$12,149,778	$25,702,155	$12,497,815	$1,032,055	$384,286	$1,195,386	$34,554,168	$91,498,965
2021	Children	OCT	520,326	$4,086,843	$12,645,856	$25,171,886	$11,830,641	$782,592	$378,593	$938,264	$35,212,852	$91,047,528
2021	Children	NOV	533,726	$3,647,260	$13,107,683	$26,245,033	$12,259,558	$791,976	$374,214	$976,604	$35,369,890	$92,772,218
2021	Children	DEC	537,545	$3,557,259	$12,456,884	$24,605,003	$11,282,276	$728,736	$367,595	$1,001,723	$34,191,162	$88,190,639
2022	Children	JAN	523,771	$3,263,004	$10,776,719	$22,260,267	$11,951,045	$1,140,828	$306,273	$738,825	$32,406,599	$82,843,560
2022	Children	FEB	526,973	$3,048,865	$10,131,321	$19,319,685	$10,044,431	$655,244	$292,711	$694,952	$30,472,276	$74,659,484
2022	Children	MAR	516,786	$3,627,859	$14,705,835	$26,196,248	$14,526,459	$726,764	$388,228	$909,449	$38,602,382	$99,683,224
2022	Children	APR	519,624	$4,084,511	$13,895,492	$24,982,992	$13,825,722	$660,994	$400,478	$871,392	$36,622,949	$95,344,529
2022	Children	MAY	523,500	$3,906,367	$13,974,798	$23,782,329	$12,923,398	$595,021	$405,523	$920,560	$34,824,045	$91,332,041
2022	Children	JUN	528,325	$3,956,508	$14,366,438	$23,507,595	$13,016,031	$547,084	$351,583	$1,021,499	$35,004,957	$91,771,696
2022	Children	JUL	530,498	$4,450,801	$13,603,365	$22,129,123	$12,210,050	$755,929	$324,791	$1,019,799	$34,099,591	$88,593,449
2022	Children	AUG	533,745	$4,598,747	$15,847,040	$27,065,848	$16,541,201	$901,132	$423,802	$1,072,812	$40,263,709	$106,714,289
2022	Children	SEP	537,267	$4,017,601	$15,793,952	$26,166,799	$16,711,982	$770,222	$464,397	$1,039,952	$38,940,840	$103,905,746
2022	Children	OCT	540,084	$4,109,754	$16,219,389	$27,699,537	$16,816,023	$742,864	$474,007	$1,157,944	$40,308,253	$107,527,770
2022	Children	NOV	543,496	$4,058,380	$16,192,974	$28,205,724	$16,582,001	$736,838	$453,918	$993,534	$39,190,348	$106,413,718
2022	Children	DEC	545,451	$3,915,626	$14,531,366	$25,313,680	$14,410,199	$666,270	$383,290	$672,271	$36,428,661	$96,321,364
2023	Children	JAN	528,460	$4,442,088	$15,047,330	$25,962,775	$15,634,730	$739,279	$394,338	$917,678	$39,081,848	$102,220,066
2023	Children	FEB	530,098	$4,197,690	$14,964,869	$25,595,149	$16,217,430	$633,192	$382,363	$918,050	$39,414,470	$102,323,212
2023	Children	MAR	534,100	$4,688,755	$18,200,832	$28,928,222	$18,634,145	$735,468	$429,058	$1,079,554	$43,877,540	$116,573,573
2023	Children	APR	537,005	$4,602,822	$17,020,367	$26,454,542	$17,089,872	$694,296	$413,243	$1,099,332	$40,699,941	$108,074,414
2023	Children	MAY	532,649	$5,042,472	$18,225,351	$27,166,637	$16,890,434	$643,072	$432,754	$1,083,127	$42,117,795	$111,601,640
2023	Children	JUN	523,449	$4,040,685	$16,532,505	$23,924,477	$15,327,414	$688,417	$358,837	$954,570	$38,868,032	$100,694,938
2023	Children	JUL	517,948	$4,704,769	$15,346,488	$22,876,132	$15,407,512	$688,118	$355,664	$1,039,893	$38,604,074	$99,022,650
2023	Children	AUG	502,185	$4,891,464	$17,353,860	$27,091,062	$20,109,241	$766,149	$417,510	$1,155,434	$43,854,429	$115,639,148
2023	Children	SEP	484,336	$4,958,782	$15,411,766	$24,876,821	$17,256,811	$691,893	$425,461	$999,517	$40,340,260	$104,961,311
2023	Children	OCT	466,396	$5,338,691	$17,201,904	$26,834,057	$18,148,642	$684,883	$433,825	$980,437	$44,116,068	$113,738,505
2023	Children	NOV	454,502	$4,744,151	$15,656,739	$25,793,953	$16,816,181	$679,928	$405,118	$781,851	$42,151,284	$107,029,205
2023	Children	DEC	456,701	$4,703,031	$15,098,002	$24,001,563	$14,944,060	$637,925	$356,126	$707,529	$38,530,866	$98,979,103

Appendix 2 – Insure Oklahoma Enrollment

Year	Total Enrollment			New Enrollments		
	Month	Quarter	Year	Month	Quarter	Year
2019	5,107	15,588	63,176	976	2,972	11,665
	5,266			988		
	5,215			1,008		
	5,327	16,124		1,061	2,999	
	5,432			1,022		
	5,365			916		
	5,216	15,761		930	3,005	
	5,333			1,135		
	5,212			940		
	5,301	15,703		951	2,689	
	5,321			887		
	5,081			851		
2020	5,199	16,509	145,303	1,021	3,126	27,464
	5,388			1,093		
	5,922			1,012		
	7,662	27,530		2,184	6,906	
	9,343			2,571		
	10,525			2,151		
	14,160	46,341		4,640	9,952	
	15,562			2,694		
	16,619			2,618		
	17,389	54,923		2,350	7,480	
	18,495			2,945		
	19,039			2,185		
2021 (First Half)	20,390	65,459	139,022	3,308	9,772	17,027
	22,027			3,480		
	23,042			2,984		
	23,685	73,563		2,128	7,255	
	24,591			2,410		
	25,287			2,717		