Oklahoma First Healthcare

A Comprehensive, Modernized State Healthcare Framework for Families

Executive Summary

Oklahoma First Healthcare is a **state-administered, family-focused health coverage option** designed to stabilize costs, expand access, and modernize delivery without disrupting federal programs or imposing new taxes. The plan builds on **proven public healthcare models**—specifically the stability of **Medicare** and the integrated care efficiency of the **Veterans Health Administration**—while applying modern data systems and transparent provider contracting.

This framework is **incremental, fiscally disciplined, and legally grounded**, targeting inefficiencies in administration rather than rationing care or shifting costs to families.

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1. The Problem: Cost Instability and Administrative Failure

1.1 Family Coverage Is Financially Unsustainable

- Employer-sponsored family premiums nationally exceed **$23,000 annually**, with workers paying roughly **$6,500–$7,000 out of pocket**, and significantly more in small-group and public-sector plans
  (Source: Kaiser Family Foundation Employer Health Benefits Survey, 2024)
- Deductibles in Oklahoma routinely range from **$3,000 to $6,000**, effectively pricing families out of care even when insured
  (Source: KFF State Health Facts; CMS actuarial summaries)

Healthcare inflation is being driven **not by care utilization**, but by:

- Fragmented risk pools
- Redundant administrative systems
- Uncoordinated provider pricing
  (Source: Centers for Medicare & Medicaid Services National Health Expenditure Accounts)

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2. Design Principles of Oklahoma First Healthcare

This plan is built on five non-negotiable principles:

1. **Cost predictability beats complexity**
2. **Families are insured as units—not line items**
3. **Providers must be paid fairly and transparently**
4. **Federal programs remain untouched**
5. **Modernization funds care—not bureaucracy**

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3. Eligibility and Participation

3.1 Who Can Enroll

- Working families
- State employees
- Teachers
- Small business employees
- Independent workers

This is a **state option**, not a mandate.

3.2 Federal Program Protection

- Seniors **remain on Medicare**
- Veterans **remain in VA care**
- SoonerCare continues to serve:
    - Disabled populations
    - Medically complex individuals
    - Low-income residents who qualify

(Medicare and VA outcomes cited from CMS and VHA annual performance reports)

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4. Coverage Structure and Cost Controls

4.1 Family-Based Premium Model

Component	Oklahoma First Target
Monthly family premium	$0–$300 (income-based)
Deductible	$500–$1,000 max
Primary care copay	$20–$30
Specialist copay	$40–$50
Preventive care	$0

Why this works:
Medicare Part B premiums are nationally standardized (~$174/month in 2024) with low variance year-to-year, demonstrating that **public risk pooling stabilizes costs** without sacrificing access.
(Source: CMS Medicare Trustees Report)

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5. Provider Payment and Network Design

5.1 Medicare-Benchmarked Reimbursement

- Providers reimbursed at **120–150% of Medicare rates**
- This range is widely accepted by hospitals and physicians and already used by:
    - Oregon public option pilots
    - Washington Cascade Care
      (Sources: Oregon Health Authority; WA HCA)

Why not commercial rates?
Commercial rates vary by 200–300% for identical services within the same city. Medicare benchmarking removes price opacity while preserving provider margins.
(Source: RAND Hospital Price Transparency Study)

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6. State Care Centers (Optional, Not Exclusive)

6.1 Purpose

To supplement—not replace—private providers where:

- Rural access is limited

- Mental health services are insufficient
- Chronic care coordination is failing

6.2 Model Basis

- VA integrated clinics consistently outperform private systems in:
    - Care coordination
    - Chronic disease management
    - Cost per patient
      (Source: Annals of Internal Medicine, VHA comparative studies)

6.3 Oklahoma Implementation

- 3–5 centers statewide
- Repurposed existing infrastructure
- Focus on:
    - Primary care
    - Behavioral health
    - Long-term condition management

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7. Technology and Administrative Modernization

7.1 Where the Savings Come From

Administrative overhead consumes **15–25% of U.S. healthcare spending**.
Medicare operates at **~2–3% administrative cost**.
(Source: CMS; GAO Health Spending Reports)

Oklahoma First Healthcare implements:

- Unified enrollment
- Single claims platform
- Standardized billing logic
- Real-time eligibility verification

No new benefits are promised until administrative savings are realized first.

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8. Funding and Fiscal Impact

8.1 No New Taxes

Funding sources:

- Consolidated administration
- Reduced third-party vendor costs
- Claims standardization
- Fraud and duplication reduction

Texas and New York both documented **hundreds of millions in recoverable savings** through modernization alone.
(Sources: Texas HHSC modernization audits; NY Medicaid Redesign Team reports)

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9. Legal Authority and Governance

9.1 State Authority

States are legally authorized to:

- Administer public health plans
- Negotiate provider contracts
- Operate insurance pools
  (Source: McCarran-Ferguson Act; ACA Section 1332 waivers)

9.2 Oversight

- Independent actuarial audits
- Annual public reporting
- Legislative review
- Provider advisory boards

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10. Rollout Timeline

Phase I (2025–2027)

- State employees and teachers
- Technology modernization
- Cost stabilization pilots

Phase II (2027–2030)

- Voluntary statewide expansion
- Small business onboarding
- Performance-based refinements

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11. Common Questions Answered Directly

Is this socialized medicine?
No. Providers remain private. Patients choose providers. This is a **public insurance option**, not government-run care.

Will doctors leave the state?
Evidence from Medicare-benchmarked states shows **provider participation remains stable** when rates are fair and predictable.

Does this replace private insurance?
No. It competes with it—on transparency and efficiency.

What happens if costs rise?
Costs are capped structurally through benchmarking and risk pooling, not shifted to families.

Conclusion

Oklahoma First Healthcare is **structural reform**, not ideology. It applies systems that already work, corrects what clearly does not, and does so without federal disruption or new taxation.