Quick Facts on Medicaid Expansion in Oklahoma

1. Medicaid Expansion Costs More Than Expected

Other states' experiments with Medicaid expansion have consistently busted their budgets. Expansion states signed up **6 million** more able-bodied adults than what was projected by state officials, resulting in massive cost overruns in each state. In all, Obamacare Medicaid expansion has cost taxpayers **157 percent** more than expected.

2. The "Oklahoma Plan" Has Failed In Other States

So-called "conservative" Medicaid expansion plans in other states, similar to the "Oklahoma Plan" and "SoonerCare 2.0," have resulted in large cost overruns. **Arkansas's** "private option" expansion plan has accrued more than **$1.4. billion** in total cost overruns in the past three years. **Indiana** has also had massive cost overruns, resulting in increased state taxes. In fact, the "Oklahoma Plan" and "SoonerCare 2.0" would cost more to implement than ordinary Obamacare Medicaid expansion.

3. Oklahoma Has Already Expanded Medicaid

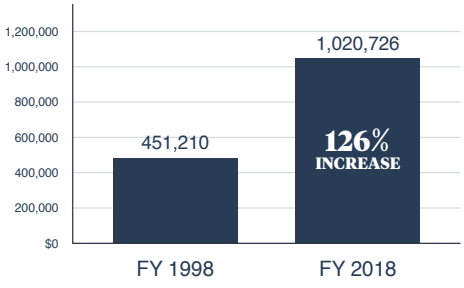
Oklahoma's Medicaid enrollment and costs have exploded over the past twenty years. Since 1998, enrollment has risen by **126 percent,** while our state's general population has only grown by 18 percent. During that same time, Oklahoma's annual share of Medicaid costs increased by 254 percent. If Oklahoma expanded Medicaid today, taxpayers could be on the hook for an additional **$374 million** annually.

4. Expanding Medicaid Hurts Those It Is Meant For

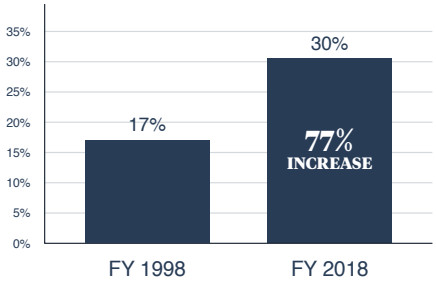
Expanding Medicaid in Oklahoma could divert state resources away from Oklahoma's traditional Medicaid population—children, pregnant women, the elderly, and the disabled—and instead favor the newly eligible population of **628,000** able-bodied, working age adults. It would also increase state costs and force lawmakers to either raise taxes, take away resources reserved for more needy Medicaid beneficiaries, or slash funding for priorities like education, transportation, and public safety.

Key Facts

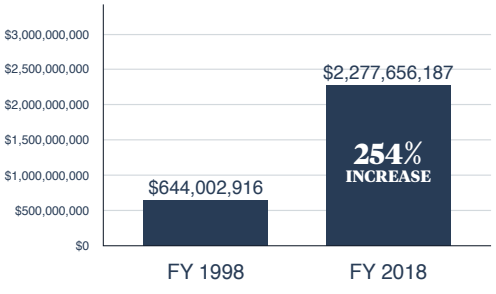
Total Medicaid Enrollment in Oklahoma



Total Oklahoma Medicaid Spending as a Percentage of Total State Spending



Oklahoma's Share of Medicaid Costs



**Figures adjusted for inflation*

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Reform Health Care, Don't Expand Welfare

1. Dedicate annual payments and endowment earnings from the 1998 Master Settlement Agreement with tobacco companies towards investing in rural health care infrastructure. Dedicating these funds would provide rural health care in Oklahoma a strategically directed additional $110 million in revenue annually. (HJR 1017)

a. $40 million: Direct funds to cover all tuition, fees, and room and board for OU and OSU medical students who agree to practice in rural areas for five years upon obtaining their medical license. These funds would pay for all related expenses for approximately 150 medical students each year. This will move Oklahoma up the rankings for primary care physicians per capita, a key determinant in health rankings.

b. $10 million: Provide capital infusion grants in amounts of $100,000 to general practitioners as seed capital to open direct primary care (DPC) offices in rural areas. DPC models are saving consumers hundreds of millions of dollars and providing better care, without forcing people to purchase health insurance and other products they don't need.

c. $60 million: Dedicate funds to provide hospital stabilization grants for rural health care infrastructure to strategically cover actual dollar losses at rural hospitals.

2. Decouple and adjust the various provider rates based on need, so that critical services like nursing home care, rural primary care, and other critical services with limited revenue streams can be prioritized for funding and higher reimbursement rates. A number of states currently pay rural providers higher reimbursement rates, since they generally have proportionally higher costs and fewer revenue streams than their urban counterparts. Federal guidelines for access adequacy allow states to pay higher rates to providers based on such factors.

3. Promote price transparency and protect patients from balance billing by requiring medical providers to give patients a good faith estimate of service prices upfront, and prohibit health care providers from reporting medical debt to credit collectors unless patients reviewed and agreed to the service charges before treatment. (SB 1646)

4. Require insurance companies to allow patients' DPC membership expenses to count towards patients' deductibles.

5. Incentivize employers to hire the uninsured and provide them health insurance by expanding Oklahoma's Quality Jobs Program. Employers who offer new uninsured employees with comprehensive medical insurance may receive a rebate equal to 5 percent of the new employee's salary.

6. Encourage general physicians to practice in rural areas by offering a five-year state income tax exemption for general physicians living in rural areas.

7. Promote economic development opportunity zones by eliminating personal income tax for any trained medical professional who relocates 100 miles or more to rural areas in Oklahoma.

8. Implement an aggressive health and value-added food program with the existing hundreds of millions in K-12 dollars in our schools and state nutrition programs. Oklahoma ranks poorly in national health statistics, significantly due to our obesity and physical inactivity rates. With 700,000 Oklahomans in our public K-12 system, this is a prime place to significantly move Oklahoma into the top 10 in health.

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