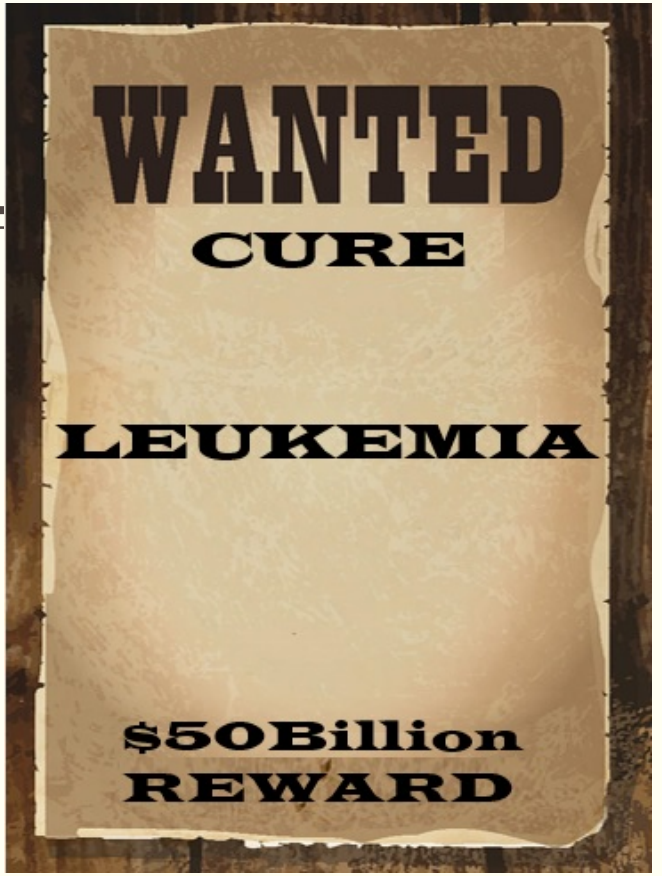
POLICY OPPORTUNITIES TO REDUCE HEALTHCARE COSTS AND PROMOTE HEALTHY BEHAVIORS IN OHIO

Speaker Pro Tempore Jim Butler
Of the Ohio House of Representatives

Cure Bill



- Current R&D system (over $100B/yr in US):
  - $38B NIH, $5-6B Charities – Basic Science Research
    - Generally from initial discovery to animal studies
  - Rest is private sector – Applied Research/Human trials
    - Driven by need to maximize ROI and profit
    - Currently, treatments offer much greater ROI than cures
- Would set up prizes for the cures for major diseases.
  - Calculated by compact states' 5-year savings if a disease is cured
  - If no cure, then no payment – no appropriation, no risk to taxpayers
  - If cure found, states pay only actual savings - no risk to taxpayers
  - Potential to save lives and money if cure is found - huge reward
- ROI for development of cure would spur massive numbers of new clinical trials
- Worst case – more research and economic activity
- Best case – finally discover a cure which will lead to happier, healthier, and longer lives—while saving money for taxpayers.

Healthy Ohio Plan 2.0

- Incentivizes patients to get Preventative Care
  - Great success with the Healthy Indiana Plan
    - For Example in 2018 Indiana saw 28.77% of women (age 40-64) get mammograms on the plus plan as compared to only 6.34% on the basic plan. Equaling to thousands more getting preventative exams.
- Creates a “bridge” over the “benefit cliff”
  - Buckeye Savings Account has 15,000-point limit (1 point = $1 to be used for health care)
  - Medicaid contributes 2,500 points per year
  - Up to 1,000 points a year for improving health outcome
  - Becomes Bridge Account if no longer qualify for Medicaid
  - Can Transfer back into a Buckeye Savings Account if requalify for Medicaid
- Gives People on Medicaid more flexibility and responsibility in their healthcare. Helps them bridge benefit cliff and afford services not traditionally covered by Medicaid.

Health Care Price Transparency 2.0

- Requires that a Patient be given a reasonable, good faith cost estimate for each health care product, service, or procedure at least 24 hours in advance without asking
  - Does not apply to emergency services or office visits
  - Health plan provides estimate if insured, health care provider if uninsured
- Estimate includes
  - Total amount to be charged
  - Reimbursement from health plan issuer
  - Patient's responsibility
  - Uninsured out-of-pocket rate
- Abolishes gag clauses on insurance companies, allowing them to inform patients about alternative high-quality providers
- Allows patients the ability to compare prices between different providers
  - Opening up the industry to be more competitive—driving down costs

Medicaid Managed Care Organization (MCO) Reform

- Establish a quality incentive program which randomly assigns Medicaid recipients to MCOs based on quality performance.
  - Giving more recipients to MCOs who perform the best
- Also includes transparency for Medicaid recipients, so that they can obtain cost estimates in advance without asking.
- Ability to reward recipients who chose more efficient, high quality providers

Surprise Billing

- When an out-of-network practitioner bills a patient who receives services at an in-network hospital
- This would allow the insurance company to reimburse the practitioner the greater of the two:
  - The average contracted rate for the same service
  - Or the amount the issuer would pay under benefit plan for out-of-network emergency services
- The patient would pay no more than if the services had been provided by an in-network practitioner.

Facility Fees

- Permits facility fee only if:
  - A single hospital, not part of a network
  - Or own by a hospital and 250 yards from hospital's main building
  - Any federally qualified health center
- Phase out facility fees all together by reducing amount able to be charged by 20% each year until 2024
- This will reduce unnecessary fees and prevent the facility fee from being abused
  - Saving patients money

340B Drug Pricing

- Require drug companies to pass along any savings/discounts from 340B Drug Pricing Program to patients
- Helps to remove any potential abuse of the 340B Drug Pricing Program
- Brings Program closer to what it was originally intended for—allowing drugs to reach more patients at an affordable rate.

Pharmacy/PBM Reform

- Have One Pharmacy Benefit Management (PBM) for the state
- This will increase Ohio's purchasing power and give Ohio new leverage to negotiate drug prices
- Will give us more flexibility when working with other states to reduce prices

Direct Patient Care

- Providers can at times charge less than contracted rate
- Allows someone with a high deductible to pay less.
- Gives patients more options to pay than just having to go through insurance.

Key Takeaways

- Competition
  - Transparency and competition can help transform health care into more of a free market like every other industry in the U.S.
  - Allows people to shop and compare
  - Drive down costs, while raising standards and quality
- Incentives
  - Giving patient more incentive to improve their health care
  - Leads to healthier outcomes and being more cost effective
  - Also lead to developing new cures as researchers and companies are given new incentives to develop them
- Removing Unnecessary Costs
  - By reducing facility fees, passing on 340B discounts
  - Saves money for patients, allowing for greater access