

Ohio Association of Health Underwriters
Legislative Update
March 15, 2010
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Congress Extends COBRA Subsidy for involuntary terminations through March 31, 2010
Below is the U.S. Department of Labor's fact sheet concerning the COBRA extension recently passed by Congress.

Fact Sheet

COBRA Premium Reduction

U.S. Department of Labor
Employee Benefits Security Administration
March 12, 2010



The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act (2010 DOD Act) on December 19, 2009 and the Temporary Extension Act of 2010 (TEA) on March 2, 2010, provides for premium reductions for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA. Eligible individuals pay only 35 percent of their COBRA premiums; the remaining 65 percent is reimbursed to the coverage provider through a tax credit. The premium reduction applies to periods of health coverage that began on or after February 17, 2009 and lasts for up to 15 months.

To qualify, individuals must experience a COBRA qualifying event that is the involuntary termination of a covered employee's employment. The involuntary termination must generally occur during the period that began September 1, 2008 and ends on March 31, 2010. However, TEA also provides that an involuntary termination of employment is a qualifying event for purposes of ARRA if the involuntary termination:

- occurs on or after March 2, 2010 and no later than March 31, 2010; and
- follows a qualifying event that was a reduction of hours that occurred at any time from September 1, 2008 through March 31, 2010.

What is COBRA?

COBRA gives workers and their families who lose their health benefits the right to purchase group health coverage provided by the plan under certain circumstances.

If the employer continues to offer a group health plan, the employee and his/her

family can retain their group health coverage for up to 18 months by paying group rates. The COBRA premium may be higher than what the individual was paying while employed, but generally the cost is lower than that for private, individual health insurance coverage.

The plan administrator must notify affected employees of their right to elect COBRA. The employee and his/her family each have 60 days to elect the COBRA coverage; otherwise, they lose all rights to COBRA benefits.

COBRA generally does not apply to plans sponsored by employers with fewer than 20 employees. Many States have similar requirements for insurance companies that provide coverage to small employers. The premium reduction is available for insurers covered by these State laws.

Changes Regarding COBRA Continuation Coverage Under ARRA, as amended by the Temporary Extension Act of 2010

TEA extended the COBRA premium reduction eligibility period for one month until March 31, 2010. TEA also expanded eligibility to individuals who experience a qualifying event that is a reduction of hours occurring at any time from September 1, 2008 through March 31, 2010, which is followed by an involuntary termination of employment on or after March 2, 2010 through March 31, 2010. This expansion also includes a second election opportunity for these individuals who had a reduction of hours qualifying event followed by an involuntary termination, if they did not elect COBRA continuation coverage when it was first offered OR elected but subsequently discontinued COBRA.

Eligibility for the Premium Reduction

The premium reduction for COBRA continuation coverage is available to "assistance eligible individuals". An "assistance eligible individual" is the employee or a member of his/her family who elects COBRA coverage timely following a qualifying event related to an involuntary termination of employment that occurs at any point from:

- September 1, 2008 through March 31, 2010; or
- March 2, 2010 through March 31, 2010 if:
 - the involuntary termination follows a qualifying event that was a reduction of hours; and
 - the reduction of hours occurred at any time from September 1, 2008 through March 31, 2010.
- A reduction of hours is a qualifying event when the employee and his/her family lose coverage because the employee, though still employed, is no longer working enough hours to satisfy the group health plan's eligibility requirements.
- Generally, the maximum period of continuation coverage is measured from the date of the original qualifying event (for Federal COBRA, this is generally 18 months). However, ARRA, as amended by TEA,

provides that the 15 month premium reduction period begins on the first day of the first period of coverage for which an individual is “assistance eligible.” This is of particular importance to individuals who experience an involuntary termination following a reduction of hours. Only individuals who have additional periods of COBRA (or state continuation) coverage remaining after they become assistance eligible are entitled to the premium reduction.

- For purposes of ARRA, COBRA continuation coverage includes continuation coverage required under Federal law (COBRA or Temporary Continuation Coverage) or a State law that provides comparable continuation coverage (for example, so-called "mini-COBRA" laws).
- Those who are eligible for other group health coverage (such as a spouse's plan) or Medicare are not eligible for the premium reduction. There is no premium reduction for periods of coverage that began prior to February 17, 2009.
- Assistance eligible individuals who pay 35 percent of their COBRA premium must be treated as having paid the full amount. The premium reduction (65 percent of the full premium) is reimbursable to the employer, insurer or health plan as a credit against certain employment taxes.

Period of Coverage

The premium reduction applies to periods of coverage beginning on or after February 17, 2009. A period of coverage is a month or shorter period for which the plan charges a COBRA premium. The premium reduction for an individual ends upon eligibility for other group coverage (or Medicare), after 15 months of the reduction, or when the maximum period of COBRA coverage ends, whichever occurs first. Individuals paying reduced COBRA premiums must inform their plans if they become eligible for coverage under another group health plan or Medicare.

Notice Requirements

ARRA, as amended by TEA, mandates that plans notify certain current and former participants and beneficiaries about the premium reduction. The Department is updating its existing models and creating several additional models to help plans and individuals comply with these requirements. Each model notice will be designed for a particular group of individuals and will contain information to help satisfy ARRA’s notice provisions, including those added by TEA. As soon as the notices are complete, they will be available on EBSA's Web site at www.dol.gov/cobra.

Expedited Review of Denials of Premium Reduction

Individuals who are denied treatment as assistance eligible individuals and thus are denied eligibility for the premium reduction (whether by their plan,

employer or insurer) may request an expedited review of the denial by the U.S. Department of Labor. The Department must make a determination within 15 business days of receipt of a completed request for review. The official application form is available at www.dol.gov/COBRA and can be filed online or submitted by fax or mail.

Switching Benefit Options

If an employer offers additional coverage options to active employees, the employer may (but is not required to) allow assistance eligible individuals to switch the coverage options they had when they became eligible for COBRA. To retain eligibility for the ARRA premium reduction, the different coverage must have the same or lower premiums as the individual's original coverage. The different coverage cannot be coverage that provides only dental, vision, a health flexible spending account, or coverage for treatment that is furnished in an on-site facility maintained by the employer.

Income limits

If an individual's modified adjusted gross income for the tax year in which the premium assistance is received exceeds \$145,000 (or \$290,000 for joint filers), then the amount of the premium reduction during the tax year must be repaid. For taxpayers with adjusted gross income between \$125,000 and \$145,000 (or \$250,000 and \$290,000 for joint filers), the amount of the premium reduction that must be repaid is reduced proportionately. Individuals may permanently waive the right to premium reduction but may not later obtain the premium reduction if their adjusted gross incomes end up below the limits. If you think that your income may exceed the amounts above, consult your tax preparer or contact the IRS at www.irs.gov.

New Penalty Provision

TEA also provides that the appropriate Secretary may assess a penalty against a plan sponsor or health insurance issuer of up to \$110 per day for each failure to comply with such Secretary's determination 10 days after the date of the plan sponsor's or issuer's receipt of the determination.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice phone: 202.693.8664; TTY: 202.501.3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Enacted Legislation

S.B. 89 (Morano) – Advanced Practice Nurses Prescriptive Authority

On April 1, 2009 Senator Sue Morano (D-Lorain) introduced S.B. 89 to authorize out-of-state advanced practice nurses with prescriptive authority to obtain prescriptive authority in Ohio without completing an externship if they meet certain criteria. The bill was signed into law by Governor Strickland on December 28, 2009 and becomes effective in 90 days.

H.B. 300 (Dyer & Hottinger) – Insurance Agent Licensure

On October 6, 2009 Representatives Steve Dyer (D-Uniontown) and Jay Hottinger (R-Newark) introduced H.B. 300 to bring Ohio law into to compliance with national standards established by the National Association of Insurance Commissioners (NAIC) to provide uniformity in agent licensure and oversight. 46 other states have already adopted these standards. The bill was proposed after input from the Insurance Agent Education Advisory Council. The bill was signed into law on February 26, 2010.

Also, language was added to the bill extending Ohio's Mini-COBRA law to 15 months to allow consumers to take advantage of the extension of the Federal premium assistance dollars. The extension to 15 months is in temporary law and will revert back to 12 months (current Ohio law) after the premium assistance expires. An emergency clause was added to the Mini-COBRA portion of the bill.

Recently Introduced legislation

H.B. 453 (Boyd) – Insurer Changes to Prescription Drug Coverage

On February 22, 2010 Representative Barbara Boyd (D-Cleveland Heights) introduced H.B. 453 to require health plans and public employee benefit plans to not remove a prescription drug from its formulary, move a covered drug to a higher co-pay, interchange a drug, or add utilization management requirements for a drug without providing prior notice in writing to all network providers, pharmacies, pharmacists and insureds covered under any affected health insurance policy. The bill received its second hearing in the House Health Committee on March 10, 2010.

H.B. 451 (Letson) – Colorectal Cancer Screenings

On February 17, 2010 Representative Tom Letson (D-Warren) introduced H.B. 451 to require health plans to provide benefits for colorectal examinations and laboratory tests for cancer according to American Cancer Society guidelines. The bill had its second hearing in the House Insurance Committee on March 10, 2010.

Active Pending Legislation (activity in the past 3 months)

H.B. 185 (DeGeeter & Book) – Material Amendments to Contracts

On May 19, 2009 Representatives Tim DeGeeter (D-Parma) and Todd Book (D-Portsmouth) introduced H.B. 185 to specify that a material amendment to a health care contract does not become part of the contract unless agreed upon by both parties. The bill passed out of the House on October 21, 2009 and has received its third hearing in the Senate Insurance, Commerce & Labor Committee on February 9, 2010.

H.B. 122 & S.B. 98 (Boyd & T. Patton) – Physician Designations Protections

On April 4 and April 8, 2009, Representative Barbara Boyd (D-Cleveland Heights) and Senator Tom Patton (R-Strongsville), introduced H.B. 122 and S.B. 98, respectively, to place various requirements on health insurers that operate a system for physician designations including what must be considered in the evaluations, disclosure requirements, appeal rights and legal remedies against an insurer if a

provider is adversely affected by a violation of the requirements. H.B. 122 passed the House on February 3, 2010 and received its first hearing in the Senate Insurance, Commerce & Labor Committee on March 9, 2010. Also on March 9th, S.B. 98 received its third hearing in the Senate Insurance, Commerce & Labor Committee.

H.B. 384 (Bolon) – Off-Label Drug Usage

On December 1, 2009 Representative Linda Bolon (D-Columbiana) introduced H.B. 384 to use the compendia adopted by the U.S. Department of Health & Human Services under 42 USC 1395x (t)(2), as amended, or in medical literature that meets certain criteria to determine whether an insurer may limit or exclude coverage for off-label drug usage. The bill passed out of the House Insurance Committee on February 17, 2010 and passed the House on March 3, 2010.

H.B. 198 (Lehner & Ujvagi) – Medical Home Demonstration Project

On June 2, 2009 Representatives Peggy Lehner (R-Kettering) and Peter Ujvagi (D-Toledo) introduced H.B. 198 to establish the Medical Home Model Demonstration Project and to provide for Choose Ohio First Scholarships to be awarded to medical students who agree to practice primary care in Ohio. The legislation contemplates the demonstration project being conducted in Montgomery and Lucas Counties. The bill passed out of the House Healthcare Access & Affordability Committee on February 24, 2010 and passed the House on March 3, 2010. It is scheduled to have its first hearing in the Senate Health Human Services & Aging Committee on March 16, 2010.

S.B. 133 (Gillmor) H.B. 237 (Newcomb) – Cancer Medications

On June 10, 2009 and June 23, 2009 Senator Karen Gillmor (R-Tiffin) and Representative Deborah Newcomb (D-Conneaut) introduced S.B. 133 and H.B. 237, respectively, which would do the following:

- (1) Prohibit health insurance contracts that provide coverage for cancer chemotherapy treatment from providing coverage for a prescribed, orally administered cancer medication on a less favorable basis than coverage for intravenously administered or injected cancer medications.
- (2) Prohibit health insurance contracts that provide coverage for non-self-injectable medications, medications that must be compounded immediately prior to administration, or both, from doing either of the following:
 - a. Requiring an enrollee to take possession of such a medication from a pharmacy that is a retail seller, or
 - b. Giving an enrollee the option of having such a medication delivered directly to the enrollee by mail or any means of commercial shipment.

S.B. 133 received its third hearing in the Senate Insurance, Commerce & Labor Committee on March 2, 2010. H.B. 237 received its third hearing in the House Healthcare Access & Affordability Committee on March 10, 2010.

S.B. 154 (Patton) – Pharmacy Benefit Manager Prohibition

On July 8, 2009 Senator Tom Patton (R-Strongsville) introduced S.B. 154 to prohibit a pharmacy benefit manager that has a relationship (ownership or under their control) with a retail pharmacy from using that relationship to the competitive disadvantage of other retail pharmacies, including allowing coverage of covered drugs dispensed by that retail pharmacy but not by other retail pharmacies. The bill has received its second hearing in the Senate Insurance, Commerce & Labor Committee on February 23, 2010.

H.B. 216 (Carney) – Regulation of Professional Employer Organizations

On June 6, 2009 Representative John Carney (D-Columbus) introduced H.B. 216 relating to the regulation of professional employer organizations (PEOs). There was language in the introduced version of the bill that would have authorized PEOs to treat “shared employees” from multiple employers as one employer for purposes of offering health insurance. In the House Commerce & Labor Committee the bill was amended to remove this language and passed out of the committee on January 26, 2010. The bill passed the House on March 3, 2010 and has been referred to the Senate Insurance, Commerce & Labor Committee.

S.J.R. 7 (Grendell) – Health Care Constitutional Amendment

On September 24, 2009 Senator Tim Grendell introduced S.J.R. 7 to amend Ohio’s constitution to prohibit a law or rule from compelling a person, employee or health care provider to participate in a health care system. Senator Grendell provided sponsor testimony on the resolution on March 2, 2010 in the Senate Insurance, Commerce & Labor Committee.

H.B. 331 (Hagan) & S.B. 205 (Hughes & Turner) – Medicaid Employer Information

On October 27, 2009 Representative Bob Hagan (D-Youngstown) introduced H.B. 331 and on November 12, 2009 Senators Jim Hughes (R-Columbus) and Nina Turner (D-Cleveland) introduced S.B. 205 to require applicant’s for CHIP, Medicaid, Ohio Work’s First and the Supplemental Nutrition Assistance Program to provide information about their employers and to require quarterly reports identifying the employers. H.B. 331 is scheduled to have its 5th hearing in the House State Government Committee on March 16, 2010 with a possible vote. S.B. 205 has been referred to the Senate Insurance, Commerce & Labor Committee.

S.B. 210 (Coughlin & Kearney) and H.B. 373 (Carney & Wachtmann) – Nutrition/Physical Activity in Schools

On November 17, 2009 Senators Kevin Coughlin (R-Cuyahoga Falls) and Eric Kearney (D-Cincinnati) introduced S.B. 210 and Representatives John Carney (D-Columbus) and Lynn Wachtmann (R-Napoleon) introduced H.B. 373 to establish nutritional standards for certain foods and beverages sold in public and chartered nonpublic schools; to require students to have periodic body mass index measurements; to require daily physical activity for students and to make other changes regarding physical education; and to establish the Health Choices for Health Children Council. S.B. 210 has received two hearings in the Senate Health, Human Services & Aging Committee and H.B. 373 has received two hearings in the House Health Committee.

H.B. 146 (Hagan) – Authorize Counties to Participate in State Employee Plan

On April 22, 2009 Representative Bob Hagan (D-Youngstown) introduced H.B. 146 to authorize county officers and employees to participate in the state employee health insurance plan sponsored by the Ohio Department of Administrative Services. The bill received its third hearing in the House Insurance Committee on January 26, 2010.

H.B. 331 (Hagan) & S.B. 205 (Hughes & Turner) – Medicaid Employer Information

On October 27, 2009 Representative Bob Hagan (D-Youngstown) introduced H.B. 331 and on November 12, 2009 Senators Jim Hughes (R-Columbus) and Nina Turner (D-Cleveland) introduced S.B. 205 to require applicant’s for CHIP, Medicaid, Ohio Work’s First and the Supplemental Nutrition Assistance Program to provide information about their employers and to require quarterly reports identifying the employers. H.B. 331 has received three hearings in the House State Government Committee and S.B. 205 has been referred to the Senate Insurance, Commerce & Labor Committee.

H.B. 310 (Garland & Driehaus) – Prostheses Mandate

Representatives Nancy Garland (D-New Albany) and Denise Driehaus (D-Cincinnati) introduced H.B. 310 on October 13, 2009 to require health insurers to provide coverage for prostheses benefits that are at least equal to the benefits provided under the Medicare program. The bill received its sixth hearing in the House Health Committee on March 3, 2010.

H.B. 8 (Celeste & Garland) – Autism Mandate

On December 8, 2009 the Ohio House of Representatives passed H.B. 8 (Autism coverage mandate). H.B. 8 passed the House by a vote of 57-39. An amendment by Representative Kevin Bacon (R-Columbus) was included in the bill that does the following;

- (1) \$36,000 annual cap per enrollee.
- (2) Insurer can review plan of treatment every 6 months.
- (3) Reimbursement is limited to someone licensed, certified or regulated by the state or someone working under their guidance.
- (4) Delayed effective date until Jan. 1, 2011.

The bill has been referred to the Senate Insurance, Commerce & Labor Committee.

H.B. 81 (Boyd & Gardner) – Diabetes Mandate

On December 8, 2009 the Ohio House passed H.B. 81 by a vote of 58-38. The bill mandates coverage for diabetes supplies, equipment and education. An amendment by Representative Randy Gardner (R-Bowling Green) that sets up a small business health care affordability task force was included in the bill. The amendment included provisions of Rep. Gardner's H.B. 256. The task force is to look at tax incentives for businesses and incentives for businesses to offer wellness and disease prevention programs. The bill has been referred to the Senate Insurance, Commerce & Labor Committee.

H.B. 357 (Carney) – Intrastate Mutual Aid Compact

On November 10, 2009 Representative John Patrick Carney (D-Columbus) introduced H.B. 357 regarding the Intrastate Mutual Aid Compact and the authority of certain EMS personnel to dispense drugs during an emergency that affects the public health; the authority of the governor to declare the existence of a health exigency; and information and guidelines issued by the Department of health concerning health exigencies; and to declare an emergency. The bill has received four hearings in the House Health Committee.

SCR 24 (Jones) – Unfunded Medicaid Mandates

On January 19, 2009 Senator Shannon Jones (R-Springboro) introduced SCR 24 which memorializes the Congress regarding unfunded federal Medicaid mandates, unfair distribution of Medicaid resources among the states, public funding of abortion, and healthcare coverage of abortion in the current versions of the federal health care reform bills. The bill received its third hearing in the Senate Health, Human Services & Aging Committee on February 9, 2010.

Other Pending Legislation

H.B. 287 (Burke & Sears) – Medicaid/Mandated Benefits

On September 29, 2009 Representatives David Burke (R-Marysville) and Barbara Sears (R-Sylvania) introduced H.B. 287 to require the Medicaid program to cover, subject to federal approval, all health benefits established as mandated benefits under the state's insurance laws and preclude application of additional mandated benefits until the Medicaid program covers the health benefits. The bill received its first hearing in the House Health Committee on February 24, 2010.

HCR 32 (Hagan) – Support Public Option

On November 12, 2009 Representative Bob Hagan (D-Youngstown) introduced HCR 32 to request all members of the General Assembly to support the public option as part of national health care reform. The bill has been referred to the House Health Care Access & Affordability Committee, but has not received a hearing.

S.B. 200 (Morano)

Senator Sue Moran (D-Lorain) introduced S.B. 200 on November 10, 2009 to authorize certified registered nurse anesthetists to issue prescriptions for the administration of drugs during certain phases of patient care. The bill is pending in the Senate Health, Human Services & Aging Committee.

H.B. 332 (D. Stewart) – Contraception Coverage

On October 27, 2009 Representative Dan Stewart (D-Columbus) introduced H.B. 332 to prohibit health insurers and public employee benefit plans from limiting or excluding coverage for prescription contraceptive drugs and devices and outpatient services related to the provision of such drugs and devices. The bill has received one hearing in the House Health Care Access & Affordability Committee.

S.B. 138 (R. Miller) – Cancer Medications

On June 16, 2009 Senator Ray Miller introduced S.B. 138 to require health insurers that provide coverage for cancer chemotherapy treatment to provide coverage for certain prescribed, orally administered anti-cancer medications on a basis no less favorable than intravenously administered or injected cancer medications that are covered under the health insurance policy. The bill has been referred to the Senate Insurance, Commerce & Labor Committee.

H.B. 51 (Miller) – Breast Cancer

Representative Eugene Miller (D-Cleveland) introduced H.B. 51 on February 26, 2009 to create the Triple Negative Breast Cancer Commission. The commission would promote the study of this cancer which is defined as “the subtype of breast cancer characterized by cells that lack receptors for the hormones estrogen and progesterone and the protein receptor known as the human epidermal growth factor receptor2, or HER2, and therefore cannot be treated with breast cancer drugs that target these receptors, including such drugs as tamoxifen and trastuzumab”. The bill has been referred to the House Health Committee.

H.B. 56 (Miller) – Colorectal Cancer Screenings

On March 3, 2009 Representative Eugene Miller (D-Cleveland) introduced H.B. 56 to require health insurers to provide benefits for colorectal exams and laboratory tests for cancer in accordance with the most recent published guidelines of the American Cancer Society. The bill received its second hearing in the House Insurance Committee on May 20, 2009.

S.B. 64 – (Coughlin) - Colorectal Cancer Screenings

Senator Kevin Coughlin (R-Cuyahoga Falls) introduced S. B. 64 on March 4, 2009 to require health insurers to cover colorectal cancer screenings. The bill, which is the same as S.B. 278 which passed the Senate last session, specifies the specific colorectal cancer screenings which insurers must cover. The bill has been referred to the Senate Insurance, Commerce & Labor Committee.

H.B. 134, H.B. 135, & H.B. 136 (DeBose) – Mandatory Offering – Cancer Screenings

On April 16, 2009 Representative Michael DeBose (D-Cleveland) introduced three bills relating to various cancer screenings. All three bills would require that insurers offer to provide, as a supplemental health care service, benefits for the expenses of examinations and laboratory test for certain cancers. The offering must be to “any nonsymptomatic individual” and the examinations and tests offered must be in accordance with the most recently published American Cancer Society Guidelines. H.B. 134 relates to prostate, colorectal, ovarian and cervical cancer screenings; H.B. 135 relates to prostate cancer screenings; and H.B. 136, which also has Representative Lorraine Fende (D-Willowick) as a principal sponsor, relates to ovarian cancers screenings. All three bills have received sponsor testimony in the House Healthcare Access & Affordability Committee.

H.J.R. 3 (Maag & Sears) – Health Care Constitutional Amendment

On August 26, 2009 Representatives Ron Maag (R-Lebanon) and Barbara Sears (R-Sylvania) introduced House Joint Resolution 3 to amend Ohio’s Constitution to prohibit a law or rule from compelling a person, employer, or health care provider to participate in a health care system. The bill has received sponsor testimony in the House Insurance Committee.

S.B. 159 (R. Miller) – Health Insurer Prohibition

Senator Ray Miller (D-Columbus) introduced S.B. 159 on August 6, 2009 to prohibit health insurers from denying payment for a service during or after the performance of the service if the insurer provided prior authorization for the service. The bill has been referred to the Senate Insurance, Commerce, & Labor Committee.

H.B. 256 (Gardner) – Small Business Health Care

On July 23, 2009 Representative Randy Gardner (R-Bowling Green) introduced H.B. 256 to create the Small Business Health Care Affordability Task Force to look at tax incentives for businesses, incentives for businesses to offer health wellness and disease prevention programs, what other states are doing in this area, and consider federal legislation regarding the provision of health insurance by small businesses and then report its findings and any recommendations to the Speaker and Minority Leader of the House, the president and Minority leader of the Senate and governor not later than six months following its initial organizational meeting. The Task Force is comprised of three House and three Senate members and up to five additional members who represent small business employers or employees or who are otherwise relevant to the duties of the Task Force. The bill, which is pending in the House Insurance Committee, was amended into H.B. 8 (autism coverage) on the House floor.

H.B. 240 (Sears) – Medicaid Program

On June 23, 2009 Representative Barbara Sears (R-Sylvania) introduced H.B. 240 to require ODJFS to do the following things: (1) Issue a report on its efforts to minimize waste, fraud and abuse, (2) Create an alternative care management program, (3) create a disease management component of Medicaid and (4) impose a surety bond requirement on certain Medicaid providers. In addition, the bill requires local Medicaid agencies to report their costs associated with operating the Medicaid program. The bill has been referred to the House Health Committee.

S. B. 136 (R. Miler) - Telemedicine

On June 16, 2009 Senator Ray Miller (D-Columbus) introduced H.B. 136 to require health insurers and the Medicaid program to provide coverage for telemedicine services in the same manner that coverage is provided for face-to-face consultations. The bill has been referred to the Senate Insurance, Commerce & Labor Committee.

S.B. 137 (R. Miller) – Prompt Pay

Senator Ray Miller (D-Columbus) introduced S.B. 137 on June 16, 2009 to specify that Ohio’s prompt pay law applies to Medicaid Managed Care Plans. The bill has been referred to the Senate Health, Human Services & Aging Committee.

H.B. 125 (Williams) – Establish Family Health Plus Component of Medicaid Program

On April 8, 2009 Representative Sandra Williams (D-Cleveland) introduced H.B. 125 to require the Director of Job and Family Services to seek a federal Medicaid waiver to establish the Family Health Plus component of the Medicaid program, and imposes an assessment on hospitals to help fund the program. The program establishes criteria to allow individuals 18 – 64 whose income or resources exceed the Medicaid program’s eligibility requirements to qualify for health care coverage under the Medicaid Family Plus component. The bill has been referred to the House Healthcare Access & Affordability Committee.

H.B. 159 (Skindell & Hagan) – Establish Government-run Health Insurance System

Representatives Michael Skindell (D-Lakewood) Bob Hagan (D-Youngstown) jointly introduced H.B. 159 to establish a single-payer health care system for Ohio. The bill has received sponsor testimony in the House Healthcare Access & Affordability Committee.

S.B. 15 (D. Miller) – Enhanced Mental Health Parity

On February 10, 2009 Senator Dale Miller (D-Cleveland) introduced S.B. 15, the “enhanced mental health parity” legislation that mandates coverage for the diagnosis and treatment of all mental illnesses and substance abuse and drug addictions. It has been referred to the Senate Health, Human Services & Aging Committee.

S.B. 25 (Schaffer) – Deductibility of Medical Expenses

On February 10, 2009 Senator Tim Schaffer (R-Lancaster) introduced S.B. 25 to authorize the deduction of unreimbursed medical expenses to the extent the expenses exceed 1% of federal adjusted gross income. The current standard is unreimbursed expenses that exceed 7.5%. The bill received sponsor testimony in Senate Ways & Means & Economic Development Committee on February 18th.

S.B. 34 (D. Miller) – Group Health Insurance

Senator Dale Miller (D-Cleveland) introduced S.B. 34 on February 10, 2009 to require the Ohio Department of Administrative Services to create a health insurance program that allows municipalities, small employers and nonprofit corporations or associations to purchase for their employees the same policies provided to state employees. The bill has been referred to the Senate Insurance, Commerce & Labor Committee.

S.J.R. 2 (Coughlin) – Health Care Resolution

On February 24, 2009 Senator Kevin Coughlin (R-Cuyahoga Falls) introduced Senate Joint Resolution 2 to enact Section 43 of Article II of the Ohio Constitution to provide rights to people to enter into private contracts with health care providers for health care services and to purchase private health care coverage. The resolution has been referred to the Senate Insurance, Commerce & Labor Committee.