Helping Ohioans with Healthcare Benefit Choices OAHU

OAHU Legislative Priorities – May 2020

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Legislative Update – May 2020

STATE ISSUES

Day at the Statehouse – proposed date – 5/19/2020 – cancelled due to COVID-19

COVID-19 Department of Insurance Actions

Bulletin 2020-02 Access to Coverage for Ohioans Impacted by COVID-19 Virus FAQ

Bulletin 2020-03 Health Insurance Flexibility for Ohio Employees FAQ

Bulletin 2020-04 Temporary Suspension of Pharmacy Audits During Declared State of Emergency

Bulletin 2020-05 COVID-19 Testing and Treatment: Out-of-Network Coverage

Bulletin 2020-06 Coverage for individuals with Expired Driver Licenses

Bulletin 2020-07 Property and Casualty, Life, and Long Term Care Insurance Premium Payments During State of Emergency

Bulletin 2020-08 Temporary Licenses During State of Emergency

S.B. 9 Employer Claims Reporting

Summary – Require carriers to provide claims data to employers who not receive information today.

Introduced: 2/12/2019
Sponsors: Sen. Matt Huffman (Lima)
Eff. date: Original – 7/1/2020 / Revised as of June 2020 – January 1, 2021

Details

- net claims paid by month,
- claims over $30,000 amount paid toward each claim and claimant health condition or diagnosis.
- enrollment data by month,
- Monthly prescription claim information

Actions

- 11/15/2017 - Introduced as SB227 11/2/2017, referred to committee
- 5/23/2018 - The bill unanimously passed out of Committee and passed the Senate unanimously the same day.
- 6/27/2018 - the bill received sponsor testimony in the House Insurance Committee – Brian Thompson
- Worked extensively with OAHP to refine language
- 11/14/2018 the bill received sponsor testimony in the House Insurance Committee – Barb Gerken

- 12/12/2018 - The bill unanimously passed out of the House Insurance Committee
- The bill did not make it to the House floor for vote on the last day of sessions.
- Reintroduced as SB9
- 3/13/2019 - Senate Insurance & Financial Institutions Committee Testimony
  - Chair – Sen. Bob Hackett – OAHU Member
- 3/20/2019 - Approved by the Senate Insurance Committee
- 3/21/2019 - Passed by a vote of 31-0 in the Senate
- 4/30/2019 - Sponsor testimony in the House Insurance Committee
- 5/2019 - Passed out of the House Insurance Committee with an amendment to remove diagnosis.
- 7/2019 - Senate amendment added to Ohio budget bill removed prior to vote
- 9/2019 - John McGough and Kevin Conrad met with Jonathon McGee to review options to move SB9 forward without House amendment to remove diagnosis from high claims listing.
- 9/11/2019 - John McGough and Lee Nathans met with Representative Kristin Boggs, Minority member of the House Insurance Committee to discuss importance of restoring language back to Senate version with diagnosis included in high claims listing.
- 9/2019 - Rep. Brinkman plans to meet with the representative from the National MS Society to discuss concerns on inclusion of diagnosis in reporting. John will request to be included in the meeting.
- 10/9/2019 – meeting held with Rep. Brinkman, John McGough, Barb Gerken and Holly Pendell of MS Society to review options for restoring original language.
- 10/29/2019 – referred to House Insurance Committee
- 10/30/2019 – House Insurance Committee Chair, Tom Brinkman plans to restore SB9 to Senate-passed version as next Committee hearing (possibly on 11/12 or 11/13)
- 11/12/2019 – House Insurance Committee amended language back to the Senate-passed version but did not vote it out of committee. The vote was unanimous to restore the original language.
- 12/10/2019 – House Insurance Committee scheduled discussion and potential vote.
- 12/10/2019 – Passed House Insurance Committee unanimously
- 12/11/2019 – Passed House with an amendment adding PEO language.
- 5/15/2020 – Senate named the conferees for the SB9 conference committee. Our sponsor, Matt Huffman is a conferee.
- 5/20/2020 - The House appointed representatives Derek Merrin, Jon Cross and Kristin Boggs to the S.B. 9 Conference Committee. The Senate conferees are SB 9 sponsor Matt Huffman, Matt Dolan and Hearcel Craig.
- 6/2/2020 – Joint House-Senate Conference Committee meeting at 3:30 p.m. to discuss differences in language
- 6/9/2020 – Conference Committee meeting at 4:15p.m. – House members refused to participate.

Status

- Per John McGough, the language in SB9 has been agreed to by the PEOs and the bill may be passed during Summer Session or in Fall.

S.B. 198 Surprise Billing

Summary – Hold patients harmless from surprise balance billing

Introduced: 9/18/2019

Sponsors: Sens. Steve Huffman and Nickie Antonio

Co-Sponsors: Sens. Matt Huffman, Stephanie Kunze, Nathan Manning, Kristina Roegner, Vernon Sykes, Cecil Thomas, Sandra Williams

Eff. date: Proposed – 4/1/2020

Details

- Initial payment of out-of-network claim at in-network facility, insure pays, within 30 days,
- The provider's charges, or attempt to negotiate
- If claim is not subject to arbitration, insurer must pay lesser or:
  - The provider's charge
  - The 80% percentile of all provider CHARGES in the same or similar specialty for the health care service provided in the same geographical area
- A provider would be able to balance bill if several conditions are met, namely: statement of out-of-network status, cost estimate provided and affirmative consent by the patient.
- Arbitration option available for services over $700 (or a combination of several charges with similar characteristics totaling $700).
- Arbitrator must award either the provider's final offer or the insurer's final offer.
- Arbitrator cannot consider Medicare, Medicaid or other government rates when making decisions.
- Requires printed directories

Actions

- 10/10/2019 - Sponsor testimony held. Ohio Association of Health Plans (OAHP) has serious concerns with the language. This Legislation may prompt an OAHU member Operation Shout if language is not amended. John McGough and Barb have made contact with Janet Trautwein to determine possibility of her providing OAHU proponent testimony in late October.
- 12/11/2019 – Marcy Buckner, NAHU VP of Legislative Affairs, provided opponent testimony in the Senate Insurance Committee hearings focusing on effects of the New York (arbitration) and California (benchmarking) laws. Miranda Motter provided testimony on behalf of OAHP focusing on effects on premiums if using billed charges as basis for payment.
- 1/21/2020 – Interested Party Meeting – John McGough and Barb Gerken to attend – Senate Majority Conference Room

H.B. 388 Surprise Billing

Summary - Hold patients harmless from surprise balance billing

Introduced: 11/5/2019

Sponsors: Rep. Adam Holmes

Eff. date: Effective 9 months following enactment

Initial Details

- Benchmark for payment, the greater of:
  - The median in-network rate;
  - the price paid for the out of network service (if there is out of network coverage, what a plan pays for the out of network service); or

- the Medicare rate

- Consumer cannot be billed for the difference between the plan's reimbursement and the provider's charge.

- Negotiation
  - In-lieu of a "greatest of 3" payment, the out of network provider/ER facility may negotiate reimbursement.
  - If the negotiation has not successfully concluded within 30 days, the out of network provider/ER facility may request arbitration.
- Arbitration – Baseball Style Based on Accuracy/Inaccuracy
  - If arbitration is requested, each party must submit their final offer based solely on the accuracy or inaccuracy of the greatest of 3 payment.
  - An arbitrator shall only award either party's final offer. In deciding the award, the arbitrator shall only consider the accuracy or inaccuracy of the greatest of 3 payment.
- The non-prevailing party is to pay 70% of the arbitrator's fees and costs and the prevailing party is to pay 30%.
- Bundling. A provider or emergency facility may bundle up to twenty-five claims from the same health plan that involve the same or similar services provided under similar circumstances.
- Parties may submit any additional documents/information to the arbitrator.

- For services covered by the health plan, but are provided by an individual out-of-network provider, an individual cannot be balanced billed unless:
  - The provider informs the individual they are out of their network.
  - They provide the consumer with a good faith estimate, including a disclaimer that they are not required to get the services at that location or from the provider.
  - The individual consents to the services.

Final Details

- Includes providers, facilities, ambulance (ground only) and clinical laboratories. Will use "provider" in the remaining bullet points but will include all stated.
- Benchmark ("fair market value") for payment, the greater of:
  - The median amount negotiated with in-network provides for the service in question in that geographic region under that health plan;
  - the price paid for the out of network service (if there is out of network coverage, what a plan pays for the out of network service); or
  - the Medicare rate

- Consumer cannot be billed for the difference between the plan's reimbursement and the provider's charge.

- Negotiation
  - In-lieu of a "greatest of 3" payment, the out of network provider/ER facility may negotiate reimbursement.
  - If the negotiation has not successfully concluded within 30 days, or if both parties agree that they are at an impasse, the out of network provider may request arbitration.
- Arbitration – Baseball Style Based on Accuracy/Inaccuracy

  - If arbitration is requested, each party must submit their final offer. The parties may submit, and the arbitrator may consider, evidence that relates to the factors described below:
    - In-network rates that other health benefit plans or health plan issuers reimburse, and have reimbursed, that particular provider and other providers, and the factors that went into those rates (guaranteed patient volume, availability of provider's geographic area.
    - Any in-network reimbursement rates previously agreed upon between the plan and the provider, if the health plan and the provider had a previous relationship in the past six years.
  - To be eligible for arbitration, the service in question could not have been provided more than one year prior to the request.
  - Bill, or combination of bills as listed in bundling below, must be greater than $750
- The non-prevailing party is to pay 70% of the arbitrator's fees and costs and the prevailing party is to pay 30%.
- Bundling. A provider or emergency facility may bundle up to fifteen claims from the same health benefit plan that involve the same or similar services provided under similar circumstances.
- Final arbitration decision will be binding except as to other remedies available at law.
- Superintendent of insurance is tasked with selecting one single arbitration entity.
  - Arbitration entity must submit annual reporting on the number of arbitrations conducted, the provider type, the specialty of the provider, the out-of-network situation and the percentage of times the arbitrator rules in favor of the health plan versus the provider.
- For services covered by the health plan, but are provided by an individual out-of-network provider, an individual cannot be balanced billed unless:
  - The provider informs the individual that the provider is not in the covered person's health benefit plan.
  - They provide the consumer with a good faith estimate, including a disclaimer that they are not required to get the services at that location or from the provider.
  - The individual consents to the services.

Actions

11/13/2019 – Proponent testimony – Kevin Conrad testified on behalf of OAHU. Keith Lake testified on behalf of the Ohio Chamber of Commerce and Miranda Motter testified on behalf of OAHP.
5/5/2020 – Testimony held in the House Finance Committee. The only in-person testimony was presented by the Ohio State Medical Association. Written opponent testimony was provided by the Ohio Society of Pathologists, American College of Emergency Physicians and a combination testimony from approximate 80 physician groups, Written proponent testimony was provided by the Ohio Association of Health Plans and American Health Insurance Plans and suggested language changes by AARP.
5/13/2020 – Revised language submitted to the House Finance Committee by Rep. Jim Butler. Major changes include:

- Adds ambulance (not air ambulance) and clinical laboratory services to the list of providers covered under the regulation.

- Adds the term "geographic region for the specific health plan" to the first of three potential payment methodologies:
    - Original: The amount negotiated with individual in-network providers for the service in question, excluding any in-network cost sharing imposed under the health benefit plan
    - Revised: The amount negotiated with individual in-network providers, facilities, emergency facilities, or ambulances for the service in question in that geographic region under that health benefit plan , excluding any in-network cost sharing imposed under the health benefit plan.
- Adds additional arbitration language
    - Original language only allowed for arbitration based solely on the accuracy, or inaccuracy of the reimbursement methodology required by the new regulations. The revised language permits review of:
        - The circumstances, complexity, and severity of the particular case;
        - The distribution of in-network and non-network allowed amounts by the health plan for the service in question in the same geographic area;
        - Medicare reimbursement rate for the service in question in the same geographic area;
    - The nonprevailing party will be responsible for 100% of the arbitration costs versus 70% in the original language.
    - Sets a standard for minimum amount of $750 in billed charges to allow for arbitration. The provider would be able to bundle smaller claims of same or similar services to get to the $750 mimimum.
        - The previous language allowed for bundling of 25 claims but no dollar amount. The new limit for bundling is 10 claims.
    - Shortens the time period for the health plan to begin arbitration process from 90 days to 30 days.
    - Makes the arbitration decision binding in a court of law.
    - Requires the superintendent of insurance to contract with one arbitration entity to perform all arbitrations. Pages 9-12 outlines the process for selecting an arbitrator.

5/14/2020 – Meeting with Rep. Jim Butler, Ohio State Medical Association and Ohio Association of Health Plans. Meeting to review concept of "dual pathways" that are designed to stay close to "fair market value" of an out-of-network service, while addressing the OSMA concerns that in-network rates will continuously drop if the as-introduced version of the bill is adopted. Here is an outline of the "dual pathway" concept:

Path 1:

- An out-of-network provider accepts the greatest of three for reimbursement.

Path 2:

- An out-of-network provider rejects the greatest of three for reimbursement.
- This would trigger a negotiation period.
- If an agreement is not reached during the negotiation period, then arbitration would be initiated.
- When in arbitration, the arbiter can consider 3 factors:
    - What other plans are reimbursing that provider for a similar service (information provided by the provider).

- What that plan is reimbursing other providers in that geographic region for a similar service (information provided by the plan).
- If the doctor was previously in network, what that previous reimbursement was.
  - *all this information is to remain confidential.

- Both parties would make a final offer, the arbiter picks one final offer based on the 3 factors listed above (baseball style).

Arbitration would be 70/30 payment

5/15/2020 – Meeting with Ohio State Medical Association and Ohio Association of Health Plans staff to make final recommendations. Dewine Administration is hopeful for passage prior to summer break. No written changes to legislation was available as of 5/15/2020.

5/17/2020 – Revised language received. Changes from 5/13/2020 language:

- Includes language on prescribed claims process:
  - Requires provider to include proper billing codes
  - Health plan to send provider its intended reimbursement
  - Provider notifies plan of acceptance or desire to negotiate within prescribed time periods. Failure to timely notify of attempt to negotiate will be considered acceptance of plan reimbursement.
- Allows bundling of claims (15 maximum with total cumulative amount of $750)
- Parties to arbitration can submit and arbitrator can consider:
  - In-network rates other health plans reimburse, and have reimbursed, that particular provider or other providers for the service in question in that particular geographic area, including the factors that went into those rates, such as guaranteed patient volume or availability of providers in that geographic ara.
  - Any in-network reimbursement rates previously agreed upon between the plan and the provider if a previous contract relationship existed between the parties in the past 6-years.
- The nonprevailing party pays 70% of the arbitration fees and the prevailing party shall pay 30%.
- Final arbitration decision shall be binding except as to other remedies available at law.

5/19/2020 – House Insurance Committee hearing – Proponent testimony provided by Barb Gerken with approval from the OAHU board. Passed out of committee by unanimous vote.

5/20/2020 – passed the House unanimously.

6/5/2020 – No hearings have been held and will not be heard during week of 6/8. Senator Steve Huffman, sponsor of SB 198, likes the language in HB388 and may hold hearings in the fall.

H.B. 679 Establish/Modify Requirements for Telehealth Services

Summary – Prohibits a health benefit plan from imposing a cost-sharing requirement for telehealth services that are provided via telephone or email.

Introduced: 5/26/2020
Sponsors: Reps. Mark Fraizer and Adam Holmes
Co-Sponsors: Reps. Cindy Abrams, Jim Butler, Jeffrey Crossman, Thomas Patton, William Seitz and D. J. Swearingen
Eff. date: Immediate upon passage

Details

- Detailed analysis
- Prohibits a health benefit plan from imposing cost sharing for telehealth services provided via telephone or email.
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- Requires telehealth services provided via telephone or email to be tallied using minutes spent per patient on a running total and reimbursed for a block of time in a manner equivalent to the standard amount of time spent on a telehealth service.
- Allows the Superintendent of Insurance to adopt rules as necessary to carry out the bill's provisions governing insurance coverage of telehealth services.

Status:

- Referred to House Insurance Committee on 5/27/2020
- 6/3/2020 – Hearing in House Insurance Committee- 2 Proponents / 3 Opponents / 1 Interested Party
- 6/9/2020 – Hearing in House Insurance Committee - 4 Propronents / 4 Interested Parties
- 6/10/2020 – Passed House with Amendment
- 6/12/2020 – Introduced in Senate

H.B. 469 Prohibit Certain Health Insurance Cost-Sharing Practices

Summary – Requires health insuring corporations and sickness and accident insurers to apply amounts paid by or on behalf of covered individuals toward cost-sharing requirements.

Introduced: 1/14/2020
Sponsors: Reps. Susan Manchester and Thomas West
Eff. date: Applies to plans issued, modified or renewed 90 days after the bill's effective date
Details

- Detailed analysis
- Requires health insuring corporations and sickness and accident insurers to apply amounts paid by or on behalf of covered individuals toward cost-sharing requirements. i.e. when a drug manufacturer provides a coupon
- Exempts situations where a generic version of a brand name drug exists, but the prescribing physician prescribes the brand name drug without it being medically necessary.
- For example, if a covered individual receives a coupon for a drug which stipulates that the manufacturer of the drug will pay the copayment for the drug, then, under the bill, such a payment would have to be counted toward any costsharing requirement the covered individual's health benefit plan might impose.

Status:

- Referred to House Insurance Committee on 1/28/2020
- 6/2/2020 – Proponent hearing in House Insurance Committee -29
- 6/9/2020 - Opponent hearing in House Insurance Committee – 2 – AHIP and Pharmaceutical Care Management Association.

H.B. 606 Grant Immunity to Essential Workers Who Transmit COVID-19

Summary – would provide temporary immunity from civil actions resulting from injury, death, or loss caused by the exposure to COVID-19 or the transmission or contraction of, or lack of treatment during the pandemic. The lack of treatment provision covers providers unable to provide services during the pandemic due to executive orders or a local health order. It further creates a presumption, for purposes of the Workers' Compensation Law, that specified emergency responders, corrections officers, and certain food workers who contract COVID-19 contracted the disease in the course of and arising from their employment

Introduced: 4/10/2020
Sponsors: Rep. Diane Grendell
Co-Sponsors: 33
Eff. date: March 9, 2020 through December 31, 2020
Details

- Detailed analysis
- Grants temporary qualified immunity to specified health care providers who provide health care services or emergency services during a declared disaster or emergency as described below.
- Grants immunity from tort liability and professional discipline for such services provided as a result of and in response to a disaster or emergency that results in injury, death, or loss allegedly resulting from (1) actions or omissions in the provision, withholding, or withdrawal of those services, (2) decisions related to the provision, withholding, or withdrawal of those services, and (3) compliance with an executive order or director's order.
- Grants immunity from tort liability and professional discipline for injury, death, or loss that allegedly resulted because a health care provider was unable to treat a person, including the inability to perform any elective procedure, due to an executive or director's order or a local health order issued in relation to an epidemic or pandemic disease or other public health emergency.
- In uncodified law, generally prevents bringing a civil action for injury, death, or loss to person or property against any person if the cause of action on which the action is based, in whole or in part, is that the injury, death, or loss is caused by the exposure to, or the transmission or contraction of, "MERS-CoV," "SARS-CoV," or "SARS-CoV-2," or any mutation thereof.
- Creates a presumption, for purposes of the Workers' Compensation Law, that specified emergency responders, corrections officers, and certain food workers who contract COVID-19 contracted the disease in the course of and arising from their employment.

Status:

- Referred to House Insurance Committee on 5/5/2020
- 5/28/2020 – Passed House 84 – 9
- 6/2/2020 – Introduced in Senate
- 6/3/2020 – Referred to the Senate Judiciary Committee

S.B. 308 Regards Civil Liability of Service Providers in Emergency

Summary – Provide civil immunity for health care provider and EMTs who provide emergency services during a declared disaster.

Introduced: 5/5/2020
Sponsors: Sen. Matt Huffman
Co-Sponsors: 18
Eff. date: Immediate upon passage
Details

- Detailed analysis
- Grants a service provider qualified civil immunity for illness or for injury, death, or loss in providing services that are as a result of, or in response to, a disaster or emergency declared due to COVID-19 or are intended to assist persons to recover from such disaster or emergency during its period and ending on April 1, 2021.
- Grants a service provider qualified civil immunity for injury, death, or loss resulting from, or related to, a person's actual or alleged exposure to an illness in the course of that provider's provision of services during the period of the declared disaster or emergency due to COVID-19 and ending on April 1, 2021.
- Specifies that the immunities also apply to a cause of action against a service provider for contribution or indemnity for damages sustained by any person during the declared disaster or emergency due to COVID-19 and ending on April 1, 2021.

Status:

- 6/3/2020 – passed out of Senate Judiciary Committee by vote of 7 – 3 and the full Senate by vote of 24-9.

S.B. 97 Provider Cost Estimates

Summary – Requires a provider or insurer to provide patient with a cost estimate for scheduled services

Introduced: 9/18/2019
Sponsors: Sen. Steve Huffman
Co-Sponsors: Sen. Matt Huffman
Eff. date: Proposed – 1/1/2021

Details

- Requires a health care provider to provide a patient with a verbal or written cost estimate for scheduled services.
- Requires a health plan issuer to provide a patient with a written cost estimate for services for which the patient's health care provider seeks preauthorization.
- Specifies that the new estimate provisions take effect on September 1, 2019.
- Specifies that a patient is responsible to pay for a health care service or procedure even if the patient did not receive an estimate.
- Grants a health care provider or health plan issuer qualified immunity from civil and criminal liability, as well as professional disciplinary action, for failure to fulfill duties under the bill.
- Repeals the existing law governing cost estimates, which was permanently enjoined from enforcement in February 2019.

Actions:

Passed the Ohio Senate on 10/9/2019 by a vote of 32-0

S.B. 148 Dental Care Contracting

Summary – Prevent dental insurers from adding language to provider contracting which requires provider to accept fee schedules for non-covered services.

Introduced: 9/18/2019
Sponsors: Sen. Kirk Schuring
Co-Sponsors: Sens. John Eklund, Matt Huffman, Lou Terhar, Joe Uecker
Eff. date: Proposed – 4/1/2020

H.B. 390 Regards Health Insurance Premiums and Benefits

Summary - To amend Ohio regulations to save the protections of the Affordable Care Act benefits:

Introduced: 11/5/2019
Sponsors: Reps. Jeffrey Crossman and Randi Clites
Co-Sponsors: 37

Details

- Prohibits insurance policies from excluding coverage for preexisting conditions;
- Places limitations on premium charges;
- Bans annual and lifetime limits on coverage;
- Requires policies to cover what the ACA describes as "essential health benefits" in addition to coverage for preventative health services.
- Sample feedback to John McGough
  - Page 5 – line 131 – should it be 30 hours to match state and federal laws related to full-time employment?
  - Page 41 – lines 1159-1170 – there are several current policies with RX copayments over $100 per fill, especially specialty medications.
  - Page 49 – lines 1375-1390 – limits on out-of-pocket expenses are already set at a federal level. Why would we implement a second set of rules in the state? For 2020, the limit is $8,150 for self-only coverage and $16,300 for family. The amounts listed in this bill are the 2019 limits.
  - Page 72 – lines 2040-2049 - there are several current policies with RX copayments over $100 per fill, especially specialty medications

Actions

12/10/2019 – proponent testimony held

H.B. 469 Regarding application of RX drug coupon payments to member cost-sharing

Introduced: 1/4/2020
Sponsors: Reps. Susan Manchester and Thomas West

Details

- Requires health insuring corporations and sickness and accident insurers to apply amounts paid by or on behalf of covered individuals toward cost-sharing requirements.
- Exempts situations where a generic version of a brand name drug exists, but the prescribing physician prescribes the brand name drug without it being medically necessary.

Actions

- Referred to House Insurance Committee on 1/28/2020
- House Insurance Committee - Sponsor testimony – 2/13/2020

H.B. 547 Restrict Cost Sharing-Occupational/Physical Therapist

Introduced: 3/10/2020
Sponsors: Rep. Jeff LaRe

Details

- Requires the cost sharing requirement, on a per day basis, for an occupational therapist or physical therapist shall not be greater than for an office visit to a primary care physician or primary care osteopath physician.
- Requires an insurer to clearly state on websites and relevant literature that coverage for occupational and physical therapy is available under the health plan, as well as all related limitations, conditions and exclusions.

Actions

- Referred to House Insurance Committee on 5/5/2020
- First hearing on 5/12/2020

FEDERAL ISSUES

H.R. 7010 Paycheck Protection Program Flexibility Act of 2020

Introduced: 5/26/2020
Sponsors: Rep. Dean Phillips (D-MN)
Co-*sponsors:* 86, including Reps. David Joyce, Brand Wenstrup, Troy Balderson and Tim Ryan from Ohio.

Details

- Total of 5 years to pay back the loan.
- Total of 24 weeks after date of origination, or December 31, 2020, to use the funds
- Loan forgiveness is determined without regard to reduction in number of FT equivalent employees if an eligible recipient is unable to rehire an individual who was an employee of the eligible recipient on or before February 15, 2020 or is able to demonstrate an inability to hire similarly qualified employees on or before December 31, 2020.
- Changes limitation on the non-payroll portion of a forgivable loan amount from 25% to 40%.

Actions

- 05/28/2020 Passed by a vote of 417-1
- 6/3/2020 Passed in Senate without amendment by voice vote
- 6/5/2020 Signed into law by President Trump

COVID-19 COBRA Coverage -

Summary – 5/19/2020 OAHU signature added to the letter sent to support COBRA coverage premium relief during the COBRA pandemic.

Details

The Alliance to Fight the 40 has rebranded as Alliance to Fight for Health Care (AFHC). They requested our support for COBRA funding legislation. The purpose of this letter is to urge Congress to take immediate action to provide support for COBRA coverage to allow those who have lost jobs—or been furloughed—because of COVID-19, to remain in their employer-provided coverage.

Text for Letter

Dear Majority Leader McConnell and Minority Leader Schumer,

The undersigned organizations —a diverse group of employers, industries, health care stakeholders, unions, patient and disease groups and health care advocates — urge you to take immediate action to protect the health care of the millions of Americans who have lost their health care coverage due to the COVID-19 pandemic.

We are asking you to help the 30+ million recently unemployed Americans afford to stay on their employer-provided health care for a temporary time during this unprecedented public health and economic crisis.

The U.S. economy has suffered great losses because of COVID-19 and Congress has already taken steps to support business and provide stimulus checks to some Americans. But Congress must act swiftly to support health care coverage for workers who have lost their jobs due to COVID-19.

Employer-provided coverage has been the backbone of our health care system for decades. Before COVID-19, the employer-provided health care system protected more than half of all Americans and their families. With millions of Americans losing their jobs every week, we urge Congress to step in and provide additional COBRA support and similar continuation coverage to help people pay for health insurance, as you did during the 2009 recession and for workers losing coverage due to trade adjustments in 2019. This would allow millions of Americans to stay on the plans they like and want to keep.

Americans do not want to lose access to their doctor and they can't afford brand-new deductibles that would come with a new plan.

We want to get America's economy thriving and our workers back to work. But until we are safe from the public health and economic threats of COVID-19, it's time to give Americans the peace of mind that comes with maintaining affordable health insurance.

Let's work together to keep health care affordable and available.

Meeting with CMS – Dean Mohs – ICHRA

Summary – discussion of viability for ICHRA plans in Ohio.

Details

Barb Gerken, John Dodd and Frank Spinelli participated in a call with Dean Mohs, Director – Division of Small Business and Agent/Broker Innovation, Marketplace Plan Management Group, CMS on 5/12/2020. We discussed ideal clients, market appetite, current state of individual market in Ohio, compliance concerns and future education needs for brokers and employers.

S. (Discussion Draft) Monthly Economic Crisis Support Act

Introduced: 5/8/2020
Sponsors: Senators Kamala Harris, Bernie Sanders and Ed Markey

Details

- Monthly payments to individuals with an income below $120,000:
  - $2,000 to individuals earning
  - $4,000 to eligible individuals filing joint returns
  - Additional $2,000 for each child/Maximum of three
- Payments reduced by 10% of so much of the taxpayer's adjusted gross income as exceeds:
  - $100,000 for individuals
  - $200,000 for joint returns
  - $150,000 for head of household
- Payments would be retroactive to March and continue until three months after the end of the national state of emergency.

Actions

- Referred to House Insurance Committee on 1/28/2020
- House Insurance Committee - Sponsor testimony – 2/13/2020

H.R. 6800 Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act

Introduced: 5/15/2020
Sponsors: Rep. Nita Lowey (D-NY)

Details

- $1 trillion in assistance to state and local governments
- Hazard pay for frontline healthcare workers
- Renter and homeowner protection from evictions and foreclosures
- Extended family and medical leave provisions
- 100% payment for COBRA premiums
- Establish special enrollment periods for the ACA exchanges, Medicare and Medicare Advantage
- FSA carryover of $2,750 in unused benefits or contributions from 2020 to 2021
    - Terminated employees would be permitted to continue to receive FSA reimbursements for the rest of the plan year.
- Additional round of stimulus payments
- Additional PPP and EIDL funding

Actions

- Announced by Rep. Nancy Pelosi on 5/8/2020
- Passed out of House by a vote of 208-199, 14 Democrats voted no and one Republican voted yes.
- Senate representative from both parties state that the bill is in discussion and will not be resolved prior to the 5/22 Memorial Day break.

Transitional Relief for Grandmothered Plans

- January 31, 2020 - CMS extended the transitional policy through calendar year 2021, to policy years beginning on or before October 1, 2021, providing that all plans end by December 31, 2021.
- March 10, 2020 – ODI approves extension for Ohio grandmothered plans via Bulletin 2020-01

H.R. 6810 To establish a Health Care Protection Program Fund to provide grants to employers to ensure continuity of coverage under a group health plan through the COVID-19 pandemic, to provide for premium assistance for COBRA benefits, and for other purposes.

Summary – COBRA subsidies during pandemic

Introduced: 5/12/2020
Sponsors: Rep. Rodney Davis (R-IL)
Co-Sponsors: 6, 3 Democrats and 3 Republicans included Rep. Anthony Gonzales (R-OH)

Actions

5/12/2020 – referred to the Committee on Education and Labor and the Committees on Energy and Commerce, and Ways and Means.

H.R. 6824 To amend the Internal Revenue Code of 1986 to provide for the carryover of the remaining 2020 balance in health flexible spending arrangements.

Summary – Allow members to carryover remaining balance of 2020 FSA account to 2021

Introduced: 5/12/2020
Sponsors: Rep. Derek Kilmer (D-WA)

Co-Sponsors: Rep Cathy McMorris Rodgers (R-WA)

Actions

5/12/2020 – referred to the House Committee on Ways and Means.

Transparency in Coverage - Employer

Effective: January 1, 2021

Summary - Provide overview of coverage and out-of-pocket costs to members prior to scheduled treatments, including prescription. Includes:

- Estimated cost-sharing liability for specific procedures and conditions.
- The amount of cost-sharing liability a participant has incurred to-date relative to their maximum out-of-pocket limit and any deductible.
- The negotiated rate the carrier or group plan has agreed to pay an in-network provider for the specific covered service the plan participant is considering.
- The maximum reimbursement amount that the carrier or group plan would pay to an out-of-network provider for the specific covered service.
- An explanation of any prerequisite for the person's specific coverage request, such as step therapy or a preauthorization.

- Required of insurers for fully-insured plans and employers in the case of self-insured plans (including partial self-funded plans).
- Required of ICHRA, QSEHRA, FSA, MEWA and Level-Funded plans?
- Must make available a self-service tool available via the internet at no charge. The member should be able to search by provider, standard medical term or CPT code.
- The same information must be made available in a paper statement no later than 48 business hours after request.
- Current cost comparison tools are limited and would not meet the requirements under the proposed rules
- Current tools are estimated costs versus specific to participants and providers selected.
- Insurers have tools available to help them meet the guidance but the same would not apply for employers.
- Employers would have concerns regarding HIPAA privacy rules whether using internal tools or outsourcing the requirements to a third party administrator.

H.R. 3630 No Surprises Act

Summary - Limits patient cost-sharing to the in-network amount for emergency services

Introduced: 7/9/2019

Sponsors: Rep. Frank Pallone (D-NJ)

Co-Sponsors: Rep. Greg Walden (R-OR)

Details

- Prohibits surprise medical bills:
  - from facility-based providers that patients cannot reasonably choose, whether arising from emergency care or scheduled care.
  - for services that may occur post-stabilization (after emergency care) but before a patient is able to travel without emergency transport to a facility or provider in their network
  - from all out-of-network services that occur during the course of a medical visit that they did not explicitly consent to including: the use of equipment, devices, telemedicine services, imaging services, laboratory services, and other

treatments or services, regardless of whether the provider furnishing the services is at the facility
    - for unforeseen medical services that arise during the course of treatment or when there is no in-network provider available to deliver the service at the in-network facility
- For all other scheduled care at an in-network facility, the legislation would require that patients receive notice and provide their consent to out-of-network care 72 hours (changed from 24 hours) prior to treatment. Such consent must include information about the network status of any, and all, providers who will be treating the patient, and an estimate of the out of network provider's charges for each item or service that will be provided. If a patient did not receive adequate notice and consent to the services, the provider could not balance bill the patient.
- Establishes a payment benchmark to resolve out-of-network payment disputes between providers and insurers.
    - requires that the insurer pay, at minimum, the median contracted rate (in-network rate) for the services in the geographic area where the services were delivered.
    - That rate may also account for differences in sites of care.
    - It also preserves a state's ability to determine its own solution to resolve out-of-network payment between insurers and providers for plans regulated by the state.
    - Requires the Secretary of HHS to establish a process to audit the accuracy of the median contracted rate
- Requires insurers to maintain more accurate provider directories.
- Amendments: Added by Reps. Raul Ruiz (D-CA) and Larry Bucshon (R-IN.) creating a "backstop" to the benchmarking approach.
    - A provider can appeal to an arbitrator if they do not agree with the benchmarking payment. An appeal is only available for amounts higher than $1,250. The arbitrator can only review the appeal based on the complexity of the service provided and the quality of care.

S. 1895 Lower Health Care Costs Act

Introduced: in the Senate HELP Committee 6/19/2019
Sponsors: Sen. Lamar Alexander (R-TN)
Co-Sponsors: Sens. Patty Murray (D-WA) and Joni Ernst (R-IA)

Details

- End surprise billing
    - Includes implementing a federal benchmark of the median in-network rate for geographic area. CBO assessment found benchmarking to the most effective approach to lowering healthcare costs (over requirements for all providers at the same facility to be in network or mandatory arbitration.
    - Provider groups are lobbying 20:1 for arbitration, even by providers not directly affected.
    - Senator Cassidy was upset that arbitration was not included in the final language from discussion draft.
- Reduce the prices of prescriptions drugs
- Create more transparency
    - Broker compensation transparency – updated to include language that establishes a disclosure requirement for indirect compensation that is not

known at the time a contract is signed and to prevent duplicity in reporting that is already required by state laws and the 5500 form.

- Boost public health
- Improve the exchange of health information technology

Actions

- 6/26/2019 Markup meeting:
  - Raise minimum age from 18-21 to purchase tobacco products
  - Added language from CREATES Act (increase availability of lower-cost generics and biosimilars
  - Senators Bill Cassidy (R-LA), Maggie Hassan (D-NH) and Lisa Murkowski (R-AK) amendment to require insurance plans to post network status on a real-time basis was adopted by voice vote.
  - Last minute decision by committee to not include arbitration language as supported by Senator Cassidy.
  - Adopted the FAIR Drug Pricing Act to require pharmaceutical companies to disclose and justify their planned prices hikes.
- HELP Committee voted 20-3 to advance the legislation on 6/26/2019 (dissenting Senators Bernie Sanders, Elizabeth Warren and Rand Paul)
- 12/10/2019 - **SURPRISE BILLING COMPROMISE -** reached week of December 10, 2019.. Benchmarking will remain as the payment model with arbitration as a backstop. The minimum amount for a bill to go to arbitration was lowered from $1250 to $700 without bundling ability. More to follow once the announcement is released.

H.R. 5826 Consumer Protections Against Surprise Medical Bills Act of 2020

Summary - Prohibits balance billing

Introduced: 2/7/2020 in House Ways and Means Committee
Sponsors: Rep. Richard Neal (D-MA)
Co-Sponsors: 37, including Rep. Brad Wenstrup (R-OH)

Details

- Effective in 2022
- Requires an "Advance Explanation of Benefits"
- Any claim can be sent to arbitration
- Includes arbitration process:
  - insurers would be required to provide median contracted rates
  - providers would be required to provide median total reimbursement rates
-

H.R. 5800 Ban Surprise Billing

Summary - Prohibit balance billing in emergency and non-emergency services

Introduced: 2-7-2020 - House Education and Labor Committee
Sponsors: Rep. Bobby Scott (D-VA)
Co-Sponsors: Rep. Virginia Foxx (R-NC)

Details

- Payment of non-network provide claims includes two options:
  - For amounts less than or equal to $750, the reimbursement rate would be determined by the median in-network rate.

- For amounts greater than $750, providers and payers may elect to use either the benchmark or move to arbitration.
- Includes arbitration process:
  - insurers would be required to provide median contracted rates
  - providers would be required to provide median total reimbursement rates
- 90-day wait between filing an arbitration request and filing another request.

Actions Approved by voice vote of 32-13

H.R. 3796 Health Savings for Seniors Act

Summary – allow Medicare beneficiaries to own and contribute to HSA
Introduced: 7/17/2019
Sponsors: Rep. Ami Bera (D-CA)
Co-Sponsors: 7 – none from Ohio
Summary: allow Medicare beneficiaries to own and contribute to HSA

H.R. 1682 Improving Access to Medicare Coverage Act of 2019

Summary – deems an individual receiving outpatient observation services in a hospital as an inpatient for purposes of satisfying the three-day inpatient hospital-stay requirements with response to Medicare coverage of skilled nursing facility services.
Introduced: 3/12/2019
Sponsors: Rep. Joe Courtney (D-CT)
Co-Sponsors: 60 – none from Ohio

S.753 Improving Access to Medicare Coverage Act of 2019

Summary – deems an individual receiving outpatient observation services in a hospital as an inpatient for purposes of satisfying the three-day inpatient hospital-stay requirements with response to Medicare coverage of skilled nursing facility services.
Introduced: 3/12/2019
Sponsors: Sen. Sherrod Brown (D-OH)
Co-Sponsors: 23 – none from Ohio

Trump Administration is considering options for CMS regulatory changes to fix the issue if H.R. 3796 and S.753 are not progressing.

H.R. 1922 Restoring Access to Medication Act of 2019

Summary – Repeals the ACA provision disallowing OTC medications from health savings accounts. Would also allow accounts to be used for menstrual care products.
Introduced: 3/27/2019
Sponsors: Rep. Ron Kind (D-WI)
Co-Sponsors: 13 – 8 Democrats/5 Republicans
Status Permanent repeal passed in CARES Act. Repeal effective retroactive to January 1, 2020.

S. 2897 Restoring Access to Medication Act of 2019

Summary – Repeals the ACA provision disallowing OTC medications from health savings accounts. Would also allow accounts to be used for menstrual care products.

Introduced: 11/19/2019
Sponsors: Sen. Mark Warner (D-VA)
Co-Sponsors: Sens. Bill Cassidy (R-LA), Chris VanHollen (D-MD), Shelley Moore Capito (R-WV)
Status Permanent repeal passed in CARES Act. Repeal effective retroactive to January 1, 2020.

H.R. 4070 Commonsense Reporting Act of 2019

Summary – Establish a voluntary reporting system. Allows an ALE to certify offer of coverage 45 days prior to start of federal open enrollment period.

Introduced: 7/25/2019
Sponsors: Rep. Mike Thompson (D-CA)
Co-Sponsors: 6 – none from Ohio
Status 7/26/2019 - referred to the House Committee on Energy and Commerce

S. 2366 Commonsense Reporting Act of 2019

Summary – Establish a voluntary reporting system. Allows an ALE to certify offer of coverage 45 days prior to start of federal open enrollment period.

Introduced: 7/31/2019
Sponsors: Sen. Mark Warner (D-VA)
Co-Sponsors: 5 – including Sen. Rob Portman (R-OH)
Status introduced on 7/31/2019

Comment Letters

COBRA Emergency Rule – sent to IRS on May 29, 2020
Summary:

- Letter sent regarding recent COVID-19 guidance, including emergency final regulation regarding the COBRA election period.

Details:

- The definition of qualified paid sick leave and family leave wages in FFCRA and CARES Act excludes employee pre-tax elections for retirement benefits and other purposes. NAHU requested clarification on whether amounts elected by the employee to be paid on a pre-tax basis towards retirement plans and other qualified benefits (that are not group health plan benefits) are ultimately reimbursable to the employer.
- The new rule provides employers with flexibility regarding required notices that occur during the outbreak period yet also creates many new deadline changes for employees. NAHU requested clarification for employers about notifying employees and how employers can uphold their fiduciary duties to both their plan and its participants, and asked the Administration for notice templates for employers to use. We requested that the IRS and DOL jointly announce that they will use a good faith compliance standard for any employer group plan administrator that already provided a new notice to COBRA-eligible individuals.
- The regulation makes it clear that if a person was enrolled in COBRA continuation coverage on March 1, 2020, and made their February payment but failed to make a March 2020 payment or other payments, the outbreak period does not apply when calculating the 30-day payment grace period. NAHU asked for clarification on how the person is notified that they are still eligible for coverage.

- NAHU noted that there are varying opinions in circulation about the ability of a group plan to "pend" a person's eligibility in the outbreak period until premiums are paid. The regulation seemingly implies that retroactive reinstatements might be permissible, but only if affected providers are aware and affected COBRA beneficiaries are in a suspended state of plan eligibility pending premium payment. We requested additional follow-up guidance addressing how such situations should be handled by employer-sponsored plans, COBRA administrators, insurers, reinsurers, and providers alike.
- We brought up the confusion surrounding how to handle people with COBRA eligibility and delinquent premiums as per the new regulation. We emphasized how critical it is for employers, health plans, and providers to get an immediate resolution to the issue of handling the claims of people in the outbreak period with unpaid premiums.
- NAHU stated the challenges that self-funded group health plans face, since they do not include immediate access to reinsurance funding and generally have no means of properly recouping uncompensated claim costs. We provided a real-life example of this problem, offered by a NAHU member.
- NAHU noted that the HIPAA special enrollment deadline extension rules only apply to major medical plans, and since employers align SEPs with the HIPAA-required SEP dates, further guidance is needed.