OAHU Legislative Priorities – May 2020

Helping Ohioans with Healthcare Benefit Choices OAHU

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: 7/1/2020

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.

Status

- Language will now need referral to committee to address differences between House and Senate language. Potential for bill to pass before the break for summer.

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

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.

- Loser Pays. 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.

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.

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

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.

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

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