Revised 5/11/2023

# OAHU Legislative Priorities – April 2023

Helping Ohioans with Healthcare Benefit Choices OAHU

# Legislative Update – May 2022

## STATE ISSUES

### MEDICAL COVERAGE CHANGES

#### H.B. 24 – Require health plan and Medicaid coverage of biomarker testing

Summary – *Require health plans and Medicaid to cover biomarker testing for any of the following reasons: diagnosis, treatment and appropriate management of a disease or condition or ongoing monitoring of a disease or condition when it is supported by medical and scientific evidence..*

**Introduced:** 2/15/2023
**Sponsors:** Reps. Andrea White (R – Kettering)
**Cosponsors:** 12 cosponsors
**Eff. date:** Benefit plans issue, renewed or modified on or after effective date of new section
**Details**

- Requires health benefit plans and the Medicaid program to ensure biomarker testing coverage in a manner that limits disruptions in care.
- Requires that any appeal of a biomarker testing coverage determination be handled in accordance with the health plan issuer's appeal policy and any relevant provision of the laws governing insurance and Medicaid appeals.

**Actions:**

- 2/16/2023 - Referred to House Insurance Committee
- 3/15/2023 – Sponsor testimony
- 3/167/2023 – proponent testimony

#### H.B. 99 – Regards reducing benefits related to certain emergency services

Summary – *To amend sections 1753.28 and 3923.65 of the Revised Code to regulate the practice of reducing benefits related to emergency services if a condition is determined, after the fact, to not be an emergency.*

**Introduced:** 3/9/2023
**Sponsors:** Reps. Susan Manchester
**Cosponsors:** n/a
**Eff. date:** Benefit plans issue, renewed or modified on or after effective date of new section
**Details**

- Adds language that enrollees are not required to self-diagnose

- Prohibits an insurer from reducing or denying a claim for ER services based solely on the final diagnosis code or impression, current ICD code or select procedure code relating to the enrollee's condition.
- Prohibits an insurer from reducing or denying a claim for ER services in the absence of an emergency medical condition if a prudent layperson with an average knowledge of health and medicine would have reasonably expected the presence of a medical emergency.
- An emergency services utilization review must be performed prior to reducing or denying an ER claim.
  - Must be performed by a board certified physician in good standing with the state medical board and cannot be directly or indirectly employed by the insurer unless it is strictly for utilization reviews.
  - Physician must have substantial professional experience, within the two year previous, in an acute care hospital emergency department.
- Ultilization review must include the compliant in question with presenting symptoms, patient's medical history (including history of ER visits), diagnostic testing, consideration of prudent layperson's language.
- Updates definition of medical emergency to match ORC 1753.28

**Actions:**

- 3/14/2023 - Referred to House Insurance Committee

## H.B. 142 – Require Health Plan Issuers and Medicaid to cover PANDAS, PANS

Summary – *Require health plan issuers and the Medicaid program to cover treatments and services related to Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and Pediatric Acute-onset Neuropsychiatric Syndrome.*

**Introduced:** 3/28/2023
**Sponsors:** Reps. Bob Young (R-Green) and Tom Young (R-Washington Township)
**Cosponsors:** 4 cosponsors
**Eff. date:** Benefit plans issue, renewed or modified on or after effective date of new section
**Details**

- Provide coverage for the screening, diagnosis, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute onset neuropsychiatric syndrome (PANS)
- Health plan issurer cannot apply a cost-sharing requirement to the coverage outlined above that is less favorable than the cost-sharing requirement that applies to all medical and surgical benefits provided under the health benefit plan.
- Must cover all of the following:
  - Comprehensive diagnostic evaluation, symptomatic relief, and related services, including laboratory, radiology, psychiatric, and behavioral services;
    - Immunomodulatory therapies, including all of the following:
    - Immunoglobulin therapy, including both high dose and low dose infusions, as well as the cost of related medications, administration, and monitoring;
    - Corticosteroids;
    - Plasmapheresis;
    - Rituxmab or similar products.
  - Antimicrobial treatment, including antibiotics and antivirals;

- Therapeutic care, including services provided by a speech therapist, speech-language pathologist, occupational therapist, or physical therapist licensed or certified in the state in which the therapist practices.
- Coverage cannot be subject to step therapy or prior authorization
- NOTE: a section was added to state that the section shall be inoperative if the state must cover the cost of coverage under current ACA rules.

**Actions:**

## H.B. 152 – Enact Madeline's Law re: hearing aid coverage

Summary – *To enact section 3902.63 of the Revised Code to require health plan issuers to cover hearing aids and related services for persons twenty-one years of age and younger and to name this act Madeline's Law.*

**Introduced:** 4/12/2023
**Sponsors:** Reps. C. Allison Russo and Susan Manchester
**Cosponsors:** 18 cosponsors
**Eff. date:** On or after the effective date of the legislation
**Details**

- Provide full cost of both:
  - One hearing aid per hearing-impaired ear up to $2,500 every 48 months for a covered person 21 year of age or younger who is verified as being deaf or hearing impaired;
  - All related services prescribed by an otolaryngologist or recommended by a licensed audiologist and dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter, or an otolaryngologist

**Actions**

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# PRESCRIPTION DRUG

## H.B. 61 - Cap cost sharing for prescription insulin drugs

Summary – *To enact section 3902.63 of the Revised Code to cap cost sharing for prescription insulin drugs*

**Introduced:** 2/16/2023
**Sponsors:** Hearcel Craig (D-Columbus) and Nathan Manning (R-North Ridgeville)
**Cosponsors:** **6** cosponsors
**Eff. date:** Benefit plans amended, issued or renewed on or after the effective date of this section
**Details**

- Prohibits an insurer from requiring a cost sharing for a covered prescription insulin drug in an amount exceeding $35 for a 30-day supply of the drug regardless of the amount or type of insulin required.
- $35 will be charged on a per-prescription fill basis.

**Actions:**

- 2/22/2023 – referred to Senate Health Committee

## H.B. 73 - Enact Dave and Angie Patient and Health Provider Protection Act

Summary – *To enact section 3792.06 of the Revised Code to authorize the prescribing of off-label drugs and if prescribed, to require their dispensing.*

**Introduced:** 2/27/2023
**Sponsors:** Jennifer Gross (R-West Chester) and Mike Loychik (R-Bazetta)
**Cosponsors:** 14 cosponsors
**Eff. date:** not specified
**Details**

- Allows a provider to prescribe a prescription for any drug, including off-label drugs, if the prescriber has obtained the patient's informed consent.
- Prescriber is not required to obtain a test result before issuing the prescription for patient's use of drug at home or for other outpatient treatment.
- Patient is not required to have had a positive screen for a particular disease, illness, or infection before prescribing drug.
- Patient is not required to have been exposed to a disease, illness or infection before prescribing the drug for the patient's prophylactic use of the drug.
- Health-related licensing board or state board of pharmacy cannot consider any action taken by a prescriber or pharmacist under this section to be unlawful, unethical, unauthorized or unprofessional conduct.
- Political subdivision, public official or state agency cannot enforce any rule or order issued by a federal agency that prohibits the use of an off-label drug.
- Hospital or other health care facility cannot deny nutrition or fluids to a patient who has refused a hospital's/facility's treatment intervention or standard protocol.
- Hospital or other health care facility cannot deny a patient the standard daily medications as prescribed by the patient's prescriber unless medication conflicts with a medication or treatment administered by an employee or agent of the hospital/facility with the patient's informed consent.

**Actions:**

- 2/28/2023 - Referred to House Health Provider Services Committee
- 3/28/2023 – Sponsor Testimony

## H.B. 92 - Enact Save Ohio Safe RX Act

Summary – *To enact section 4729.71 of the Revised Code to establish the Canadian Prescription Drug Importation Program, to name this act the Save Ohio Safe Rx Act, and to make an appropriation.*

**Introduced:** 3/7/2023
**Sponsors:** Tom Young (R-Washington Township) and Nick Santucci (R – Howland Twp.)
**Cosponsors:** 12 cosponsors
**Eff. date:** not specified
**Details**

- Directs the state board of pharmacy to develop a program for the importation of prescription drugs from Canada.
- State board of pharmacy will contract with a third-party with experience in developing, establishing or administering a drug importation process in other states.

- The third-party will identify the drugs that are FDA approved and expected to generate substantial savings for consumers in Ohio and identify wholesalers able to import the drugs from Canada.
- The third-party entity is required to submit a request for approval to HHS within 4 months of effective date of the legislation.
  - If approved, the third-party entity will establish and administer the program within 6 months after receipt of approval and certification.
- Third-party entity will be required to:
  - maintain contracts with wholesalers and drug suppliers facilitating the transport from Canada;
  - develop a process for health plan issuers, pharmacies and providers to register to participate in the program;
  - Establish and update the list of drugs to be imported under the program;
  - Ensure that the imported drugs are only dispensed, sold or distributed in Ohio;
  - Provide information on the prices of drugs imported and the locations where the drugs are dispensed, distributed or sol;
  - Establish a toll-free line to answer questions and address the needs of consumers, employers, health plan issuers, pharmacies, health care providers and others impacted.
- Third-party entity will have the ability to negotiate prices on behalf of the state.

**Actions:**

- 3/14/2023 – Referred to House Public Health Policy Committee

## PRIOR AUTHORIZATION

### H.B. 130 – Establish an exemption to prior authorization requirements

Summary – *To amend section 5160.34 and to enact sections 1751.721, 1751.722, 1751.723, 3923.042, 3923.043, 3923.044, 5160.341, and 5160.342 of the Revised Code to establish an exemption to prior authorization requirements.*

**Introduced:** 3/23/2023
**Sponsors:** Kevin Miller (R-Newark)
**Cosponsors:** 13 cosponsors
**Eff. date:** not specified
**Details**

- Requires an insurer that applies a prior authorization requirement to make prior authorization data available on its public website.
- The data should include:
  - Specialty of the health care provider request the prior auth;
  - Whether prior authorization is for a health care services, medical device or drug,
  - The indication for use of the service, device or drug;
  - If prior auth was denied, reason for denial;
  - The amount of time between submission of request and response from insurer.
- If insurer has a prior auth requirement and, during the previous 12 months, has approved at least 80% of the requests submitted by a provider for that service, device or

drug, the insurer (or designee) shall not require the health care provider to comply with the requirement for that service, device or drug.

- Above exemption shall be provided for at least 12 months but can be longer than 12 months.
- An insurer would be required to provide evidence to the provider if they are unwilling to provide the exemption.
- The health care provider may make such a request at any time but not more than once for the same service, device or drug in a calendar year.
- Insurer must notify providers, in writing, of an approval for an exemption.
- The insurer can rescind the exemption after the 12-month period if they conduct a random audit of 10 relevant claims in the preceding three months and determine that less than 80% of the requests would have been approved.
  - Exemption must remain in place for 30 days following the notification to the provider.
- Decisions to grant/revoke an exemption can only be made by health care providers licensed in Ohio and practice the same/similar specialty as the health care provider being considered for an exemption.

**Actions:**

- Referred to House Insurance Committee
- 4/19/2023 – Sponsor Testimony scheduled

## TRANSPARENCY

### H.B. 49 - Regards availability of hospital price information

Summary – *Requires each hospital to maintain and make public a machine-readable format list of all standard charges for all hospital items or services. Also requires the hospital to maintain and make public a consumer-friendly list of standard charges for the hospital's shoppable services.*

**Introduced:** 2/15/2023
**Sponsors:** Ron Ferguson (R – Wintersville) and Tim Barhorst (R – Fort Loramie)
**Cosponsors:** 29 cosponsors
**Eff. date:** not specified
**Details**

- Requires the Director of Health to monitor each hospital's compliance with the bill's requirements and in cases of noncompliance, to impose penalties, including fines.
- Prohibits a noncompliant hospital from taking a collection action against a patient for debts owed for hospital items or services provided during the period of noncompliance.
- Lists will include:
  - Description of each hospital item or service provided by the hospital;
  - The following charges (expressed in dollar amounts)
    - Gross charge
    - De-identified minimum negotiated charge;
    - De-identified maximum negotiated charge;
    - Discounted cash price;

        - Payor-specific negotiated charge;
        - Any code used by the hospital for purposes of accounting or billing for the hospital item or service including CPT code, HCPCS code, DRG, NDC or other common identifier.
    - List must be prominent displayed, free of charge without need for credentials or submitting personal identifying information.
    - Director of Health will develop template with consideration for any federal guidelines for similar lists.
    - List must be updated annually.
    - Through December 2024, Shoppable service list must include at least 300 services and include the 70 services listed as shoppable services by CMS. Shoppable service list should include those services provided most frequently by the hospital.
        - Eff. 1/1/2025 – all shoppable services the hospital provides must be listed.
    - Proposed minimum fines:
        - $600 – per day – hospital with a bed count of 30 or fewer;
        - $20 per bed, per day – hospital with bed count over 30 but less than/equal to 550
        - $11,000 per day – hospital with bed count over 550

**Actions:**

- 2-16-2023: Referred to House Insurance Committee
- 3-1-2023: Sponsor Testimony
- 3-15-2023: Proponent Testimony
- 3-22-2023: 3rd Hearing
- 3-29-2023: Opponent/Interested Party Testimony
- 3-29-2023: Amended version passed House Insurance Committee by vote of 11-1

## NABIP OHIO CHAPTER - PAC REQUESTS

| Member | Appointments | Date | Contribution |
|---|---|---|---|
| Tim Barhorst<br>R-Fort Laramie<br>Tim Barhorst for Ohio | Vice-Chair, Insurance Committee | 3-14-2023 | $500 |
| Brian Lampton<br>R- Beavercreek<br>Citizens for Lampton | Chair, Insurance Committee | 3-14-2023 | $500 |
| Rep. Jeff LaRe<br>R – Violet Township<br>LaRe for Ohio | Vice Chair, Finance Committee | 3-24-2023 | $500 |

# FEDERAL ISSUES

## END OF NATIONAL/PUBLIC HEALTH EMERGENCY

- Both previously set to end on May 11, 2023
- National Emergency impacts the extension of certain health plan deadlines
  - Outbreak period ending July 10, 2023
- Public Health Emergency impacts coverage of vaccines, testing and treatment of Covid-19 as well as telehealth services.
  - End of PHE – May 11, 2023
- President Biden signed a bi-partisan Congressional resolution to end the National Emergency immediately (day of signing – 4/10/2023)
  - Could potentially change the end of the Outbreak Period to June 9, 2023
  - Tri Departments are citing the Stafford Act for the possibility of leaving the end of the Outbreak period as July 10, 2023 regardless of National Emergency end date.

## EMPLOYER REPORTING

### H.R. 1264 - To streamline the employer reporting process and strengthen the eligibility verification process for the premium assistance tax credit and cost-sharing subsidy.

***Summary*** – *Updates the 1094/1095 reporting process.*

**Introduced:** 2/28/2023
**Sponsors:** Rep. Adrian Smith (R-NE)
**Cosponsors:** Rep. Mike Thompson (D-CA)
**Eff. date:** One year after enactment
**Details**

- **LANGUAGE HAS NOT BEEN RELEASED BUT ASSUME THAT IT WILL BE THE SAME AS PREVIOUS VERSIONS** (H.R. 5318 and S.3673)
- Establish a new voluntary reporting system for employers to report to the IRS information about their health plans. Exchanges will use the federal data hub to access this data for individual verification for tax credits.
- Require that employers report to the IRS only those employees (and/or their dependents) who are not receiving healthcare from their employer, greatly simplifying the requirement that all employees be reported.
- Specify that information that would be reported would include name and employer identification, who has been extended an offer of minimum essential coverage, whether coverage meets minimum value and the affordability safe harbor, and months that coverage is available without waiting periods.
- Allow employers to deliver reports to employees electronically without another consent form.
- Instruct the Government Accountability Office to conduct a study on the notifications, HHS appeals process and the prospective reporting system.
- Require HHS to review the most recent tax filing for individuals automatically reenrolled in exchange-based coverage and adjust their tax credits accordingly.

**Actions**

- 2/28/2023 – Referred to the Committee on Ways and Means, Committee on Energy and Commerce
- 3/16/2023 – Operation Shout

## Telehealth

### H.R. 1843 – Telehealth Expansion Act of 2023

***Summary*** *– Permanently exempts high deductible health plans from the requirement of a deductible for telehealth and other remote care services*

**Introduced:** 3/28/2023
**Sponsors:** Rep. Michelle Steel (R-CA)
**Cosponsors:** 11, none from Ohio
**Eff. date:** on the date of the enactment of the Act
**Details**

- Amends Internal Revenue Code of 1986 to state that a health plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for telehealth and other remote care services.

**Actions**

- 3/28/2023 – Referred to the House Committee on Ways and Means
- 4/13/2023 - Operation Shout sent to NABIP members

### S. 1001 – Telehealth Expansion Act of 2023

***Summary*** *– Permanently exempts high deductible health plans from the requirement of a deductible for telehealth and other remote care services*

**Introduced:** 3/28/2023
**Sponsors:** Sen. Steve Daines (R-MT)
**Cosponsors:** Sen. Catherine Cortez Masto (D-NV)
**Eff. date:** on the date of the enactment of the Act
**Details**

- Amends Internal Revenue Code of 1986 to state that a health plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for telehealth and other remote care services.

**Actions**

- 4/13/2023 – Operation Shout sent to NABIP members