Helping Ohioans with Healthcare Benefit Choices

NEOHUA

Legislative Update

Presented by: Barb Gerken, OAHU Legislative Chair

3/16/2022

Federal Priorities

Capitol Conference - 2022

- OAHU Member Attendance
  - 11 in-person
  - 16 virtual
- Meetings – 11 scheduled

Rep. Troy Balderson
Sen. Sherrod Brown
Rep. Mike Carey
Rep. Steve Chabot
Rep. Anthony Gonzalez
Rep. Bill Johnson
Rep. Jim Jordan
Rep. Dave Joyce
Rep. Marcy Kaptur
Rep. Bob Latta
Rep. Tim Ryan
Rep. Brad Wenstrup

Preserving the Employer Tax Exclusion

- The employer-sponsored health insurance system provides private-sector, market-based coverage for more than 175 million Americans, including those covered by unions
- Eliminating the tax exclusion would be detrimental to the stability of the employer-sponsored health plan market and would negatively affect middle-class Americans.
- COVID-19 has proven how important the employer-sponsored market is, and the failure to preserve the tax exclusion would put all of those covered lives in jeopardy.
- Employees benefit the most from the tax exclusion since it allows their employers to pay for all or part of their health plan coverage without those payments being considered taxable compensation. A repeal or cap of the exclusion would destabilize the risk profile in employer-sponsored plans for over 175 million employees and their dependents currently benefiting from the exclusion.

COBRA as Creditable Coverage

- Allow COBRA coverage to count as creditable coverage for Medicare beneficiaries just as employer-sponsored coverage does.
- This will allow beneficiaries to have access to Part B on a timely basis without penalties for late entry into the program, which increase the cost of Medicare to the beneficiary for life.
- Reps. Kurt Schrader and Gus Bilirakis are leading the conversations in the House.

Employee Retention Tax Credit Reinstatement Act

- Support extension of the employer retention tax credit from the CARES Act.
- The employer retention tax credit is a credit against certain employer taxes for eligible employers impacted by COVID-19.
- Many employers benefitted from the employer retention tax credit by using those funds to maintain their employees on payroll while using the tax credit to continue to offer access to the group health plans for their employees.

H.R. 6161

- Introduced on 12/7/2021
- Sponsor – Rep. Carol Miller (R-WV)
- Cosponsors – 67
  - None from Ohio

S. 3625

- Introduced 2/10/2022
- Sponsor – Margaret Wood Hassan (D-NH)
- Cosponsors – 7
  - None from Ohio

Employer Reporting
Common Sense Reporting Act of 2022

Operation Shout
9/21/2021 – H.R. 5318
2/18/2022 – S. 3673

- Establish a new voluntary reporting system;
- Reduce the number of individuals and amount of information reported:
- Eliminate the requirement to collect dependent Social Security Numbers; and
- Ease reporting provisions.

- Easing these requirements would eliminate a compliance barrier employers are struggling with in order to provide group coverage.

H.R. 5318

- Introduced on 9/21/2021
- Sponsor – Rep. Mike Thompson (D-CA)
- Cosponsors – 5
  - None from Ohio

S. 3673

- Introduced 2/17/2022
- Sponsor – Mark Warner (D-VA)
- Cosponsors – Sen. Rob Portman (R-OH)

Telehealth Expansion Act

- Would allow first-dollar coverage of virtual care under high-deductible health plans (HDHPs) so that every American has access to telehealth services without the burden of first meeting a deductible.
- The ability to do so was put in place during the pandemic but expired at the end of 2021. Reinstatement could benefit millions of Americans with HDHPs.

H.R. 5981

- Introduced on 11/15/2021
- Sponsor – Rep. Michelle Steele (R-CA)
- Cosponsors – 27
  - None from Ohio

S. 1704

- Introduced 5/19/2021
- Sponsor – Sen. Steve Daines
- Cosponsors – Sen Catherine Cortez Masto (D-NV)

Protecting Rural Telehealth Access

- Allow health providers to continue to reach patients at their home for medical check-ups and screenings by extending telehealth flexibilities in the CARES Act.
- Would ensure that rural and underserved community healthcare providers are able to continue offering telehealth services after the current public health emergency ends.

H.R. 5425

- Introduced on 9/29/2021
- Sponsor – Rep. Tom O'Halleran (D-AZ)
- Cosponsors – 3
  - None from Ohio

S. 1988

- Introduced 6/9/2021
- Sponsor – Sen. Joe Manchin (D-WV)
- Cosponsors – 11
  - None from Ohio

Medicare as Creditable Coverage

- Many Medicare beneficiaries are classified as being on “observation,” which can result in significantly higher claims and prevent Medicare coverage from being applied for nursing-home care for patients who do not have a three-day inpatient hospital stay.
- Would allow observation stays to be counted toward the three-day mandatory inpatient stay for Medicare coverage of a skilled nursing facility.
- Observation status also adversely affects beneficiaries’ costs for medication while hospitalized. Maintenance drugs would be covered under Part D rather than Part B, adding undue burden on the beneficiary.
- Policies around observation status are not uniform and could leave beneficiaries with unexpected out-of-pocket expenses.

Medicare as Creditable Coverage

Improving Access to Medicare Coverage Act of 2021

H.R. 3650

- Introduced on 6/1/2021
- Sponsor – Rep. Joe Courtney (D-CT)
- Cosponsors – 51
  - Rep. Anthony Gonzales (R-OH)

S. 2048

- Introduced 6/15/2021
- Sponsor – Sen. Sherrod Brown (D-OH)
- Cosponsors – 6

Long-Term Care Affordability Act

- Allow individuals to use existing retirement accounts to pay for long-term insurance – a commonsense change to enhance financial security in retirement.
- Permits individuals to pay up to $2,500 each year for long-term care insurance with their 401(k)s, 403(b)s and IRAs without a tax penalty.

S. 2415

- Introduced on 7/21/2021
- Sponsor – Sen. Patrick Toomey (R-PA)
- Cosponsors – None

Surprise Billing Federal Update

Surprise Billing - Federal

- Interim final rule regarding the independent dispute resolution (IDR) process was release on September 30, 2021.
  - Under the rule, if a provider and a health plan cannot come to an agreement during the IDR process, the certified IDR entity must select the payment offer closest to the qualifying payment amount (QPA) (generally, the health plan's median contract rate for the item or service in the geographic area), unless the certified IDR entity determines that information submitted warrants a different rate.
- February 23, 2022 - U.S. District Court for the Eastern District of Texas struck down this portion of the rules.

Broker Disclosure Rules

Consolidated Appropriations Act of 2021

Broker Disclosure Rules

- Requires brokers to disclose to group health plan
- Reasonably expects $1,000 or more in compensation (direct or indirect) for services provided.
  - Includes medical, dental and vision coverage;
  - Services include selection of insurance products, recordkeeping services, medical management vendor, benefits administration, stop-loss insurance, pharmacy benefit management, wellness service, transparency tools and vendors, disease management vendors and products, compliance services, EAP programs or TPA services.

Broker Disclosure Rules

- Does not include non-monetary compensation valued at $250 or less, in aggregate, during the term of the contract or arrangement;
- May be expressed as a monetary amount, formula or a per capita charge for each enrollee or by any other reasonable method;
- May include a disclosure that additional compensation may be earned but may not be calculated at the time of the contract
- The disclosure must state how this additional compensation may be earned.

Broker Disclosure Rules

- Must disclose the following to the group plan:
  - Description of the service to be provided pursuant to the contract;
  - Statement that covered service provider, an affiliate, or subcontractor will provide services pursuant to the contract;
  - Description of all direct compensation, either in aggregate or by service, that you expect to receive in connection with the services;
  - Description of all indirect compensation, either in aggregate or by service, that you expect to receive in connection with the services;
  - Includes incentives earned not solely related to the contract with the group

Broker Disclosure Rules

- Must be delivered to the group health plan no later than the date that is reasonably in advance of the date on which the contract is entered into and renewed.
- Changes must be disclosed as soon as practicable, but not later than 60 days from the date on which you are informed of such change;
- Group is REQUIRED to report you if you don’t provide the information;
- Rules required no later than 1 year after enactment (December 27, 2021)

[AGENCY LOGO]

BROKER COMPENSATION DISCLOSURE FORM

The following constitutes AGENCY NAME's (the "Company") disclosure of direct and indirect compensation the Company will receive or reasonably expects to receive for the period of _____, 2022 through _____ 2022 in connection with the below referenced services it provides to CLIENT'S NAME (the "Client" or "you"):

- [Insert a description of the services you provide to your clients. This should align with any services agreement you may have with the client]

The Company [does not provide] [provides] the above-referenced services to Client in the capacity of a plan fiduciary.

The Company reasonably expects to receive direct compensation for the placement of the below lines of coverage in the form of either a per employee per month ("PEPM") fee or a commission paid by the carrier or vendor, in the amount indicated below:

Coverage Line	**Carrier/Vendor**	**PEPM, Standard Commission, Commission Schedule, or Compensation Calculation**
		PEPM: $____ Commission: $____

Indirect Compensation

In addition to the above, the Company reasonable expects to receive the following indirect compensation:

Description of Indirect Compensation	Amount of, or Description of Calculation for, Indirect Compensation	Services for Which Indirect Compensation Will be Received	Payer of Indirect Compensation
	$		
	$		
	$		
	$		
	$		

Other Compensation

The Company may earn additional compensation from any of the above referenced insurers, vendors, or other third parties that cannot be calculated as of the time this disclosure is made to you, or prior to the date the Company's executed, extended, or renewed contract with you is effective. For example, the Company may receive additional compensation contingent upon certain conditions being met, including, but not limited to, profitability, growth, churn/retention, or the volume of services provided. Compensation may be in the form of additional commissions, bonuses or benefits ("compensation"). Furthermore, we may receive corporate sponsorships for webinars, training or other programming we provide for you and other clients, or for our own internal trainings. Whether we receive any of the above referenced compensation, or how much that compensation may be, cannot be discerned at this time. Should you have any questions about any of the above information or require additional information, please don't hesitate to contact [designate an agency contact person – this could be the producer or account manager or another member of the agency] at [email and phone].

The above information is accurate to the best of my knowledge as of the date this disclosure is executed above.

I acknowledge that I received the above referenced Broker Disclosure form from AGENCY NAME, and that I have read and understand the disclosures made. I understand that I can ask questions regarding the information included in this disclosure form at any time. Further, I understand that if I do not sign this acknowledgement within 15 business days from receipt, it will be deemed to be acknowledged and accepted by me.

ADD SIGNATURE LINES

Omnibus Bill Telehealth Services

Omnibus Bill – Telehealth Services

- Included Section 307 to extend telehealth flexibilities;
- The legislation only applies to the time period of March 31, 2022 through December 31, 2022
  - January 1, 2022 through March 30, 2022 services would not be covered
- The extension would permit these telehealth flexibilities to continue:
  - Medicare would cover the cost of telehealth visits, including some audio-only visits, for adults 65 and older.
  - All Medicare-enrolled providers could bill for telehealth services.
  - Medicare would cover all telehealth visits that take place in a patients' home and in medical facilities.

Omnibus Bill – Telehealth Services

The extension would permit these telehealth flexibilities to continue:

- The requirement that older adults who seek virtual mental health services must have an in-person visit six months after receiving a telehealth visit would be postponed.
- Federally qualified health centers and rural health clinics would be allowed to continue offering telehealth services, and the requirement that mental health patients meet a provider in-person before receiving virtual care would be waived.
- The types of practitioners eligible to provide telehealth services would be expanded to include occupational therapists, physical therapists, speech-language pathologists and audiologists.

State Priorities

Telehealth

H.B. 122 – Establish and Modify Requirements Regarding the Provisions of Telehealth Services Passed/Signed Into Law

- Allow an individual with developmental or permanent disability to have at least one parent/legal guardian present during treatments or hospitalizations during any pandemic or public health/safety emergency
- During any pandemic or public health/safety emergency, each long-term care facility shall provide residents and their families with a video-conference visitation option if in-person visits determined to be a risk to health of the residents.
- Health benefit plan cannot require cost-sharing for telehealth that exceeds the cost-sharing requirement for comparable in-person health care services.
- Health benefit plan cannot require any cost-sharing when ALL of the following applies
  - Communication initiated by the provider;
  - Patient consented to receive a telehealth service from that provider on any prior occasion;
  - The communication is conducted for the purpose of preventive health care services only.

Telehealth

H.B. 122 – Establish and Modify Requirements Regarding the Provisions of Telehealth Services Passed/Signed Into Law

- Allows the following providers to provide telehealth services: physician, physician assistant, advanced practice registered nurse, optometrist, pharmacist, psychologist, school psychologist, chiropractor, audiologist, speech language pathologist, occupational/physical therapist, clinical counselor, independent social worker, independent marriage and family therapist, chemical dependency counselor, dietitian, respiratory care professional, genetic counselor.
- Provider has the ability to decline a patient's request for telehealth services and require an in-person visit.
- Provider cannot bill for a facility fee, origination fee or any fee associated with the cost of the equipment used. They can negotiate with the health plan issuer to establish a reimbursement rate for fees as long as the patient is not responsible for any portion of the fee.
- Provider must describe potential risks of telehealth services to the patient prior to the visit (clinical aspects, security and confidentiality)

Effective Date:
Plans that are in effect on the effective date of the amendment and to plans that are issued, renewed, modified or amended on or after 3/23/2022

RX Emergency Refills

H.B. 37 – Regards Emergency Prescription Refills
Passed/Signed Into Law

Requires insurers to provide coverage for a covered drug not more than three times during a twelve-month period when dispensed as an emergency without a prescription

- Cannot be at a greater cost sharing than if filled with a prescription;
- Pharmacist can fill without prescription in the following circumstances:
  - Pharmacy has record of the prescription for the patient but the RX does not provide a refill or refill time period has lapsed;
  - Pharmacist is unable to obtain authorization from prescriber;
  - The RX is essential to sustain the life of the patient or continue therapy for a chronic condition or
  - Failure to dispense could result in harm to the health of the patient.
- Cannot be greater than a 72 hour supply (once per year)
  - A 30-day supply may be provided if the drug is not a controlled substance and the patient has been on a consistent drug therapy (not more than 3x per year)
- Special rules for Naltrexone

Effective Date:
Plans delivered, issued for delivery, modified or renewed on or after 6/1/2022

RX "White-Bagging"

- The bill prohibits a health benefit plan from doing any of the following:
  - Requiring that physician-administered drugs or medications be dispensed by a pharmacy or affiliated pharmacy as a condition of coverage;
  - Limiting or excluding coverage for a physician-administered drug or medication when it is not dispensed by a pharmacy or affiliated pharmacy, if the drug is otherwise covered under the health benefit plan or pharmacy benefit plan; or
  - Covering the drug or medication at a different benefits tier or with cost-sharing requirements that impose greater expense for a covered individual if it is dispensed or administered at the physician's office, hospital outpatient infusion center, or other outpatient clinical setting rather than a pharmacy.

Application of Third-Party RX Payments to Deductible and OOP

- Would require an insurer to apply any amounts paid by another person, group or organization (pharmaceutical companies, associations) to apply towards deductible and out of pocket costs.
- Provision would not apply for a brand name drug when a medically appropriate generic equivalent is available, unless the prescriber determines the brand prescription drug is medically necessary.

Cap on Prescription Insulin

H.B. 305
S.B. 220
Cap Cost Sharing for
Prescription Insulin Drugs

- Cap cost sharing on prescription insulin drugs to $35 per 30-day supply, regardless of the amount or type of insulin
- Charged on a per-prescription fill basis

RX Medication Switching

H.B. 153 - Regards Prescription Drugs and Medication Switching

- Insurers would not be able to do any of the following during a plan year:
  - Increase a covered person's cost-sharing with respect to a drug;
  - Move a drug to a more restrictive tier of a health benefit plan's formulary unless:
    - FDA issues statement regarding clinical safety of drug
    - Drug manufacturer permanently discontinues a drug or removes it from sale
- Limit or reduce coverage of a drug , including subjecting it to a prior authorization requirement.
- For generic equivalents or interchangeable biological products, the legislation would not prevent:
  - Pharmacist from substituting generics/biological products;
  - Insurer from requiring a covered person to use the generic equivalent or interchangeable biological product

Refunded Tax Credit - Employer Group Health Plans

H.B. 443 – To amend current law to authorize a refundable tax credit for a portion of employer group health plan premiums

- Allow for refundable credits against taxed imposed under current Ohio laws for employer purchasing a group health benefits plan providing coverage for basic health care services to one or more of the their employees who are residents
  - Equal to 1.3% of the portion of the premiums paid during the calendar year
  - May claim the credit against one of the following business taxes: the commercial activity tax (CAT), income tax, financial institutions tax, insurance company premiums taxes, public utility excise tax, or petroleum activity tax.
  - Fully insured benefits only
  - Does not apply to non-resident premiums

Questions?