OHIO LEGISLATIVE SERVICE COMMISSION

www.lsc.ohio.gov

Office of Research and Drafting

Legislative Budget Office

H.B. 33
136th General Assembly

Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Jarrells and Johnson

Abby Gerty, Research Analyst

SUMMARY

- Requires health benefit plans to provide coverage of preventative prostate cancer screenings for certain men at higher risk of developing prostate cancer.
- Prohibits health benefit plans from imposing cost-sharing requirements on covered screenings.

DETAILED ANALYSIS

Preventative prostate cancer screening coverage

The bill requires health plan issuers to provide coverage for all expenses associated with prostate cancer screenings for any covered person who is male, at least 40 years old, and at high risk of developing prostate cancer. As described below, health plan issuers must provide coverage for at least one covered screening every 12 months.[1]

A health plan issuer may not impose any cost-sharing requirements for the coverage required by the bill. However, the bill stipulates that, if the cost-sharing prohibition would result in the loss of the federal income tax deduction for contributions to a health savings account, then the prohibition applies after the enrollee has satisfied the minimum deductible under federal law.[2] Pursuant to continuing law, "cost-sharing" means the cost to a covered person under a health benefit plan according to any copayment, coinsurance, deductible, or other out-of-pocket expense requirement.[3]

[1] R.C. 3902.66(B) and (D)(2).

[2] R.C. 3902.66(E); 26 United States Code (U.S.C.) 223.

[3] R.C. 3902.66(C); R.C. 3902.50(C), not in the bill.

The bill defines a "prostate cancer screening" as any evidence-based preventive care or screening procedure performed for the purpose of identifying prostate cancer, including prostate-specific antigen (PSA) tests and digital rectal examination. A PSA test is a blood test which measures the amount of prostate-specific antigen in the bloodstream. Both normal and cancerous cells in the prostate gland produce PSA, meaning that PSA levels are often higher in individuals with prostate cancer. As such, PSA tests are considered a reliable component in identifying and monitoring prostate cancer.[4]

Eligibility

Under the bill, a person is eligible for the required coverage when they are a male who is at least 40 years of age, and who is considered to be at high risk of developing prostate cancer based on one or both of the following factors:

1. The individual or a first-degree relative has been diagnosed with a genetic alteration or cancer associated with increased risk of prostate cancer. The bill defines a "first-degree relative" as a biological parent, full biological sibling, or biological child.
2. The individual has a family history of prostate cancer. This means that a first-degree relative of the individual was diagnosed with, developed, or died as a result of prostate cancer.[5]

Adoption of rules

Under the bill, the Superintendent of Insurance must adopt rules which will identify which PSA tests must be covered by health benefit plans, and how long the interval shall be between covered preventative prostate cancer screenings, so long as that interval is not longer than one year. The Superintendent may require the minimum interval between covered screenings to be less than one year.[6]

Applicability

The provisions of this bill apply to any health benefit plan issued, renewed, or modified in this state on or after the bill's effective date. It does not apply to any health benefit plan entered into prior to that effective date unless that plan is subsequently renewed or modified.[7]

Exemption from Superintendent of Insurance review

The bill exempts its cost-sharing limitations from an existing law that could prevent them from being applied until a review by the Superintendent of Insurance has been conducted with

---

[4] R.C. 3902.66(A)(3); Prostate-Specific Antigen (PSA) Test, which may be accessed by conducting a keyword "Prostate-Specific Antigen (PSA) Test" search on the National Cancer Institute's website: cancer.gov.

[5] R.C. 3902.66(A) and (B).

[6] R.C. 3902.66(D).

[7] R.C. 4902.66(B) and (C).

respect to mandated health benefits.[8] Under current law, if the General Assembly enacts a statute mandating health benefits, that statute cannot be applied to any health benefit plan until the Superintendent of Insurance holds a hearing and determines that it can be applied fully and equally in all respects to (1) employee benefit plans subject to regulation by the federal "Employee Retirement Income Security Act of 1974" (ERISA),[9] and (2) employee benefit plans established or modified by the state or its political subdivisions.[10] ERISA appears to preempt any state regulation of such plans.[11]

HISTORY

Action	Date
Introduced	02-03-25

ANHB0033IN-136/sb

[8] R.C. 3902.63(B).

[9] 29 U.S.C. 1001.

[10] R.C. 3901.71, not in the bill.

[11] 29 U.S.C. 1144.