OHIO LEGISLATIVE SERVICE COMMISSION

www.lsc.ohio.gov

Office of Research and Drafting

Legislative Budget Office

H.B. 608
134th General Assembly

Fiscal Note & Local Impact Statement

Click here for H.B. 608's Bill Analysis

Version: As Reported by House Insurance

Primary Sponsors: Reps. White and West

Local Impact Statement Procedure Required: Yes

Ruhaiza Ridzwan, Senior Economist, and other LBO staff

Highlights

- Requiring health benefit plans to provide coverage for biomarker testing under certain circumstances is likely to increase costs to the state to provide health benefits to employees and their dependents. The state's costs to provide health benefits to employees and their dependents are paid from the Health Benefit Fund (Fund 8080). Fund 8080 receives funding through state employee payroll deductions and state agency contributions toward their employees' health benefits, which come out of the GRF and various other state funds.
- The required coverage is likely to increase costs to counties, municipalities, townships, and school districts statewide of providing health benefits to employees and their dependents. However, LBO staff could not determine the magnitude of the fiscal impact due to lack of information on the number of local government employers that will be affected by the requirement. Any local government that already provides the required coverage would experience no effect on costs.
- Requiring Medicaid coverage for biomarker testing under certain circumstances is likely to increase costs to the Ohio Department of Medicaid (ODM). The extent of this increase will depend on what tests may already be covered by ODM, and how many Medicaid recipients receive tests newly covered because of the legislation.

Detailed Analysis

Health insurance and Medicaid coverage

The bill requires health benefit plans and Ohio's Medicaid Program to provide coverage for biomarker testing[1] for the following purposes beginning on the effective date of the bill: (1) diagnosis, (2) treatment and appropriate management of a disease or condition, or (3) ongoing monitoring of a disease or condition, when the test is supported by certain medical and scientific evidence as specified under the bill. The bill requires a health plan issuer to ensure that the required testing coverage in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples. However, the bill clarifies that the Medicaid Program is not subject to this requirement. The bill also specifies that any appeal of the required coverage determination must be handled in accordance with the health plan issuer's or Medicaid Program's appeal policy and any other relevant provision of law, including those provisions governing internal and external review and Medicaid appeals. The appeal process must be made readily accessible to all participating providers and recipients in writing and online.

The bill includes a provision that exempts the bill's requirements from health insurance mandate restrictions in continuing law.[2] "Health benefit plan" is defined as an agreement offered by a health plan issuer to provide or reimburse the costs of health care services. "Health benefit plan" also means a limited benefit plan, except for a policy that covers only accident, dental, disability income, long-term care, hospital indemnity, supplemental coverage, specified disease, vision care, and other specified types of coverage. "Health benefit plan" does not include a Medicare, Medicaid, or federal employee plan. In addition, a health plan issuer includes a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, a nonfederal government health plan, or a third-party administrator.

Fiscal effect – insurance provisions

The bill's requirements are likely to increase costs of the state and local governments' employee health benefit plans, thereby increasing costs to provide health benefits to employees and their dependents. According to a Department of Administrative Services official, the state plans' costs of providing coverage for biomarker tests was approximately $665,000 during the past five years, or an average of about $133,000 per year. The official also noted that those costs included biomarker tests that are considered experimental. The state provides a self-insured health benefits plan in which the state pays all benefit costs directly while contracting with

[1] The bill defines "biomarker testing" as the analysis of tissue, blood, or another biospecimen for the presence of a biomarker, and includes, but is not limited to, single-analyte tests, multiplex panel tests, and whole genome sequencing.

[2] Under current law, no mandated health benefits legislation enacted by the General Assembly may be applied to sickness and accident or other health benefits policies, contracts, plans, or other arrangements until the Superintendent of Insurance determines that the provision can be applied fully and equally in all respects to employee benefit plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA) and employee benefit plans established or modified by the state or any political subdivision of the state.

private insurers to administer the benefits.[3] The state's costs to provide health benefits to employees and their dependents are paid from the Health Benefit Fund (Fund 8080). Fund 8080 receives funding through state employee payroll deductions and state agency contributions toward their employees' health benefits, which come out of the GRF and various other state funds.

LBO staff could not determine the magnitude of the fiscal impact of the required coverage on local governments due to lack of information on the details related to such plans, including the cost and the number of tests that may be utilized by covered persons under such plans. If some local government plans already provide the required coverage, the bill would not affect their costs. However, based on the approach below LBO staff believe the estimated costs associated with the required coverage on local governments could be roughly $2.1 million per year. The actual costs could be lower or higher than the estimated amount depending on the cost of such tests and number of tests that may be utilized by covered persons under local governments' employee health benefit plans per year.

Based on a book, Biomarker Test for Molecularly Targeted Therapies,[4] "biomarker tests have many different uses in clinical practice including disease screening tests (e.g., prostate-specific antigen), diagnostic tests (e.g., pathologic or histologic assessment of a tissue biopsy), treatment and posttreatment monitoring tests (detection of treatment complications or subsequent disease advancement), and prognostic tests for estimating risk or time to clinical outcomes (e.g., aggressive cancers have a poorer prognosis than more indolent cancers). In addition, biomarker tests are used to predict patient response to specific treatments." According to a report, Ohio Annual Cancer Report 2021, published by Ohio Department of Health in July 2021, in 2018, a total of 68,371 new incident of various types of cancer cases were diagnosed and reported among all Ohioans or at an age-adjusted rate of 461.1 per 100,000 Ohio population. Using the age-adjusted rate and the estimated Ohio population in 2019, approximately 53,898 Ohioans could be newly diagnosed with cancer per year. In addition, according to information on the National Cancer Institute website, "The cost of biomarker testing varies widely depending on the type of test you get, the type of cancer you have, and your insurance plan." Based on an online source, Biomarkers and Advancements in Cancer Care, published by National Conference of State Legislatures (NCSL) website, "the average price for a biomarker test is $1,700."

Based on data from the 2019 American Community Survey (ACS), published by the U.S. Census Bureau, approximately 59.1% of Ohioans received health insurance coverage through their employer. Assuming this percentage applies to the estimated 53,898 individuals who may be diagnosed with cancer above, approximately 31,854 of such individuals also received health insurance coverage through their employer. Based on estimates from the U.S. Bureau of Labor Statistics (BLS), 1.4% of the Ohio nonfarm workforce was employed by state government (not including those employed by an educational institution), 4.1% were employed by local

[3] According to a report, 2021 Health Insurance The Cost of Health Insurance in Ohio's Public Sector, prepared by the State Employment Relations Board (PDF), approximately 78% of public sector employers in Ohio, including the state, self-insured their health benefit plans.

[4] National Academies of Sciences, Engineering, and Medicine. 2016. *Biomarker tests for molecularly targeted therapies: Key to unlocking precision medicine*. Washington, DC: The National Academies Press. doi: 10.17226/21860.

government (not including those employed by an educational institution or a local government hospital), and 5.1% were employed in local government education. Applying those BLS percentages to the estimated number of individuals with new cancer incidence and who also received health insurance coverage through their employer about 445 of such individuals may be covered by the state health benefit plans, 1,302 by a local government health benefit plan, and 1,636 by a school district health benefit plan. Assuming these individuals utilized one biomarker test per plan year and the $1,700 price per test above, the estimated costs to the state could be roughly about $756,000 per year, school districts could be roughly $2.8 million per year, and the cost to other local governments could be roughly $2.2 million per year. Actual costs could be lower or higher than these estimates depending on the actual costs of such test and the actual number of tests utilized by covered persons in each plan per year.

Fiscal effect – Medicaid provisions

The bill will likely increase costs for the Ohio Department of Medicaid (ODM) to the extent that the coverage requirements for biomarker testing require additional coverages beyond what ODM currently already covers for Medicaid recipients. Currently, all medically necessary services are covered by Medicaid, including biomarker testing. Federal law also requires Medicaid to cover all drugs approved by the U.S. Food and Drug Administration. However, Medicaid is exempted by federal Early and Periodic Screening, Diagnostic, and Treatment guidelines from covering experimental or investigational treatments or services. For any biomarker testing which is classified as a medically necessary procedure, the testing would already be covered by ODM and the legislation would not have a fiscal impact. For testing which is not currently covered by Medicaid but would be covered because of the bill, ODM would incur increases in costs to provide coverage of these tests. In general, ODM will receive reimbursement from the federal government for about 64% of the costs for allowable services approved by the U.S. Centers for Medicare and Medicaid Services.

HB0608HR/lb