OHIO LEGISLATIVE SERVICE COMMISSION

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Office of Research and Drafting

Legislative Budget Office

H.B. 371
134th General Assembly

Final Fiscal Note & Local Impact Statement

Click here for H.B. 371's Bill Analysis

Primary Sponsors: Reps. Schmidt and Denson

Local Impact Statement Procedure Required: Yes

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Highlights

- The bill's coverage expansion would increase costs for the state and local governments to provide health benefits to employees and their dependents.
- Any increase in costs to the state health benefit plan would be 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 coverage expansion would also increase costs to local governments' health benefit plans, though LBO staff are uncertain about the extent of such increase.
- The coverage expansion may result in a slight increase in utilization for Medicaid services. The impact is likely to be minimal as Ohio Medicaid has already complied with these coverage requirements.
- The Ohio Department of Health (ODH) will incur minimal costs to provide notifications to specified Certificate of Need (CON) holders regarding project expiration dates. Any other impacts will depend on the number of CONs impacted and whether any fees or penalties would have been charged under current law.

Detailed Analysis

Health insurance

The bill requires health insurers, including public employee benefit plans, (1) to expand the current required screening mammography coverage by including digital breast tomosynthesis (also known as 3-D mammogram) and (2) to provide coverage for supplemental

breast cancer screening for adult women who meet certain conditions.[1] The bill defines supplemental breast cancer screening as any additional screening method deemed medically necessary by a treating health care provider for proper breast cancer screening in accordance with applicable American College of Radiology guidelines, including magnetic resonance imaging, ultrasound, or molecular breast imaging. Under the bill, one screening mammography must be covered every year, including digital breast tomosynthesis, for a patient without regard to age. Currently, health insurers must cover the following: (1) for a woman between age 35 and 39, one screening mammography, (2) for a woman between age 40 and 49, one screening mammography every two years or one screening mammography every year if a licensed physician has determined that the woman has risk factors for breast cancer, and (3) for a woman between age 50 and 64 one screening mammography per year.

The bill specifies that an adult woman must meet either of the following conditions for the required supplemental breast cancer screening coverage: (1) the woman's screening mammography demonstrates that the woman has dense breast tissue, according to the breast imaging reporting and data system established by the American College of Radiology,[2] or (2) the woman is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or another reason as determined by the woman's health care provider. The bill specifies that supplemental breast cancer screening coverage must be reimbursed at up to 130% of the lowest Medicare reimbursement rate in the state, the same reimbursement rate as the current screening mammography benefit.[3]

The bill includes provisions that exempt its requirements from an existing requirement related to mandated health benefits.[4]

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[1] The bill modifies the definition of screening mammography to include digital breast tomosynthesis and adds a definition for supplemental breast cancer screening.

[2] Under existing law, a mammography facility is required to send to each patient a written report summarizing the patient's mammogram results. If the patient's mammogram demonstrates that the patient has dense breast tissue, the summary must include certain statements.

[3] Based on the Centers for Medicare & Medicaid Services' (CMS) physician fee schedule, nonfacility prices for screening digital breast tomosynthesis bilateral (listed separately in addition to code for primary procedure; Healthcare Common Procedure Coding System (HCPCS) code 77063) in Ohio, ranged between $23.26 and $52.73 in 2021. Nonfacility prices for screening mammography bilateral two-view study of each breast, including computer detected-aided detection (CAD) when performed (HCPCS code 77067), ranged between $36.97 and $125.27 in 2021. Nonfacility prices for magnetic resonance imaging (MRI) with contrast, breast – unilateral (HCPCS code 77046), ranged between $69.45 and $226.95. Nonfacility prices for MRI with contrast, breast – bilateral (HCPCS code 77047) in Ohio, ranged between $76.60 and $233.46. Those prices are available at the CMS fee schedule.

[4] Under existing law, no mandated health benefits legislation enacted by the General Assembly after January 14, 1993, 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

Fiscal effect

The expansion of the current screening mammography coverage and the required supplemental breast cancer screening for eligible adult women are likely to increase insurance premiums of the state's self-insured health benefit plans and local governments' health benefit plans. Any increase in insurance premiums would increase costs to state and local governments to provide health benefits to employees and their dependents. The cost increases may be significant, though LBO staff are uncertain about the amount. Based on the prevalence of breast cancer and risks of breast cancer by age,[5] it is likely that utilization of screening mammographies, including digital breast tomosynthesis by certain women (i.e., women under age 35 and over age 64[6] that are not currently covered for any mammography benefits or all women who may utilize digital breast tomosynthesis and supplemental breast cancer screening) may increase.

Based on data from the state self-insured health benefit plans, in FY 2021 over 12,500 women and about 11,500 women had a routine screening mammography and a routine screening 3-D mammography, respectively. The average payment per patient paid by the state plans for a routine screening mammography ranged between $276 and $478 while the average payment per patient for a routine screening 3-D mammography ranged between $232 and $255. During the same period, about 2,000 women had a medically necessary screening mammography and about 1,500 women had a medically necessary screening 3-D mammography. The average payment per patient for a medically necessary mammography procedure was higher than a routine procedure (i.e., payments ranged between $436 and $609 for a medically necessary screening mammography and between $234 and $332 for a medically necessary screening 3-D mammography). In addition, 180 women had a medically necessary MRI with the average payment per patient between $1,237 and $1,410.

To the extent that the bill's required coverage is already provided in a public employee health plan, there would be no fiscal impact on that plan.[7] Any increase in costs to the state plan would be 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. Since the data from the state health plan appear to show that 3-D mammography is frequently covered under current law, the cost to the state may be primarily due to the increased frequency of required coverage for younger age groups, and may be minimal.

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modified by the state or any political subdivision of the state or by any agency or instrumentality of the state or any political subdivision of the state.

[5] Based on the prevalence of breast cancer and risks of breast cancer by age in a report, Ohio Annual Cancer Report 2021, prepared by the Ohio Department of Health, and data from National Cancer Institute Breast Cancer Risk in American Women.

[6] Based on U.S. Census Bureau, 2019 American Community Survey 1-Year Estimates data on private health insurance coverage by type and selected characteristics in Ohio.

[7] According to a state health benefit plan summary, Medical Mutual of Ohio: Ohio Med PPO Plan Description – July 1, 2021-June 30, 2022, routine gynecological services covered mammogram services, including 3-D mammograms.

Information on enrollees under local governments' health benefit plans is not available. Based on publicly available data on state retirement systems' active memberships, the estimated number of women between age 35 and age 49 who may be enrolled under the local governments' health benefit plans and who may be benefited by the bill's expansion of screening mammography coverage numbers in the tens of thousands,[8] but the precise total number of women enrolled in local governments' health benefit plans who may be benefited from the supplemental breast cancer screening is undetermined. However, with cost differentials which may be about $100 per procedure, and perhaps as many as 43.3% of women between age 35 and 64 covered by such plans being eligible for a supplemental breast cancer screening (see below), the tens of thousands of women employed by local governments translate into a statewide cost of up to $2 million to $3 million.

Background information

Nationwide survey results related to the percentage of women aged 40 and over having a preventive care cancer screening mammogram during the past two years, reported in Table 33 of National Center for Health Statistics, 2019,[9] found that 61.5% of women between age 40 and 49 had such a mammogram in 2018. During the same period, 71.8%, 75.0%, and 50.6% of women between age 50 and 64, between age 65 and 74, and age 75 and over had a mammogram, respectively. LBO staff found widely varying study results regarding the prevalence of dense breast tissue in U.S. women. One source, an article entitled*, Prevalence of Mammographically Dense Breasts in the United States,* using Center for the Breast Cancer Surveillance Consortium (BCSC) mammogram data of women aged 40 years and older, found prevalence rates ranging from 2.84% (for women between age 60 and 64) up to 6.31% for women between age 45 and 49. Another source cited findings of prevalence rates up to 43.3% (in women aged 40 to 74).[10]

Medicaid

The bill requires the same coverage of supplemental screening mammography for Medicaid as it requires for health insurers. Further, the modifications the bill makes to the definition of screening mammography also apply to Medicaid. According to the Ohio Department of Medicaid (ODM), Medicaid is already required by the federal government to comply with U.S. Preventive Services Task Force A and B Grade (USPSTF A & B) recommendations for preventive screenings, which includes breast cancer and cervical cancer screenings. In complying with USPSTF A & B, ODM has already been providing the required coverages of the bill. Additionally, ODM has covered digital breast tomosynthesis since 2017. For these reasons, it is anticipated that there will be no significant fiscal impact on Medicaid except there may be a slight increase in utilization of the services.

[8] The estimates are derived from the number of active female members of the state's five retirement systems included in their 2020 actuarial valuation reports, available at Annual Actuarial Valuation Report, by system.

[9] A copy of the table is available at: https://www.cdc.gov/nchs/data/hus/2019/033-508.pdf.

[10] Advani SM, Zhu W, Demb J, et al. Association of Breast Density With Breast Cancer Risk Among Women Aged 65 Years or Older by Age Group and Body Mass Index. JAMA Netw Open. 2021. A copy of the study is available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783508.

Certificate of Need changes

The bill makes several temporary changes for Certificates of Need (CONs) granted during the period of the COVID-19 state of emergency, including the following: (1) the Director of the Ohio Department of Health (ODH) is required to grant a CON holder a 24-month extension to obligate capital expenditures and commence construction for a proposed project, (2) ODH is required to notify the CON holder of the date on which the 24-month extension expires, and (3) provides that the transfer of a CON, or transfer of the controlling interest in an entity that holds a CON, prior to completion of the reviewable activity for which the CON was granted, does not void the CON, as long as recognizing the transfer would not result in a violation of existing law that prohibits a CON application from being approved in various circumstances.

Additionally, for a CON granted on or before the effective date of the bill, the bill prohibits the Director of Health from imposing a civil penalty against a CON holder for obligating a capital expenditure in an amount between 110% and 150% of the approved project cost (current rules allow a monetary penalty for obligating more than 110% of the approved project cost). This provision applies to any CON granted on or before the effective date of the bill for which ODH is still monitoring the activities of the person granted the certificate.

Fiscal effect

ODH may experience a minimal increase in administrative costs to provide the notification. Any other impacts will depend on the number of CONs impacted and whether any fees or penalties would have been charged under current law.

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