House Bill 8 – Biomarker Testing Mandate

Opposition Testimony

Ohio House Health Committee

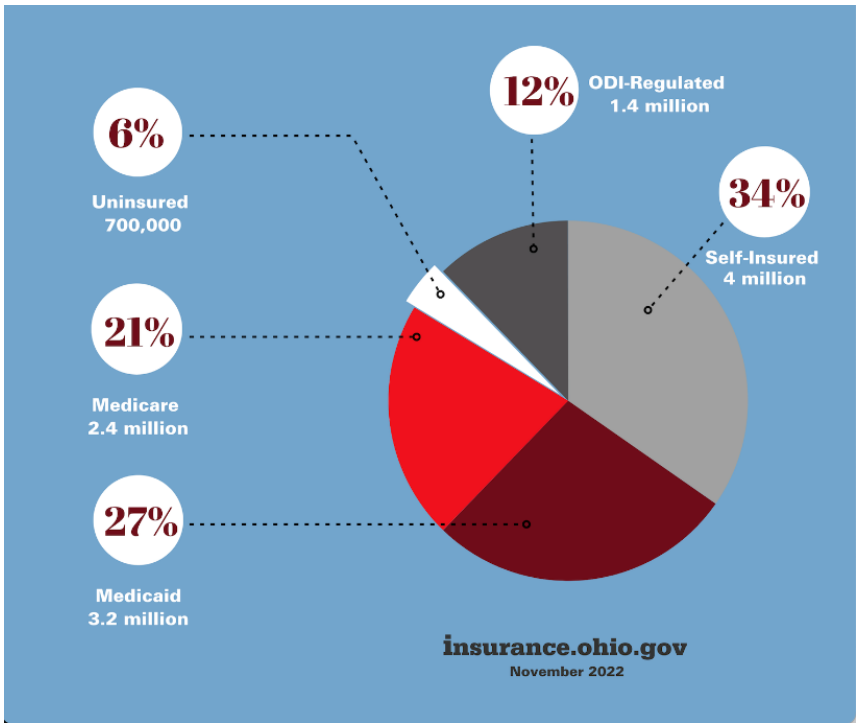
April 30, 2025

Chair Schmidt, Vice-Chair Deeter, Ranking-Member Somani and members of the Ohio House Health Committee, my name is Cameron Garczyk and I serve as the Assistant State Director for NFIB in Ohio. I am here on behalf of our nearly 21,000 small business members to express opposition to House Bill 8 as currently drafted. This legislation will mandate coverage of biomarker testing for private-sector fully-insured health, public employee benefit, and Medicaid plans.

We want to acknowledge that Rep. Andrea White has been very helpful discussing ideas on how to alleviate our concerns with House Bill 8, and its predecessor House Bill 24 from the 135th General Assembly. We are immensely appreciative of her willingness to try and address our concerns. One example is the addition of uncodified language that speaks to the intent of the General Assembly to not create a landscape that allows for substantially increased pricing. However, this does not completely mitigate one lingering issue: the costs of future tests.

I would like to give a little background on the health insurance landscape for a typical NFIB member and why our organization is concerned with public policy that may put upward pressure on premiums.

As with all health insurance mandates, there is an issue of equity. The typical NFIB member that can offer insurance purchases a fully-insured product. This portion of the private sector represents ~ 12% or 1.4 million Ohioans. The chart included in my testimony is the most recent we were able to locate as it is from 2022. Director French recently noted during her operating budget testimony the Department of Insurance-regulated plans now represent 11% of the market.



Some proponents claim that health insurance mandates will grant widespread coverage to Ohioans, however that is not accurate. Legislators have moved in a more equitable direction as most newly proposed mandates do include both Medicaid and public benefit plans. However, there will be significant gaps in coverage as private sector self-insured plans are exempt under federal ERISA law and thus not impacted by state-imposed health insurance mandates. To address this inequity, during the 121st General Assembly, Senate Bill 150 was enacted which addresses application of mandated health benefits. Ohio Revised Code §3901.71 prohibits the application of mandated health benefits until the Department of Insurance verifies that the mandate is applicable to ERISA plans. Of course, House Bill 8, like nearly every health insurance mandate, simply notwithstands this section of code.

We fully agree that it is short-sighted to not recognize the potential cost savings on the back end of House Bill 8. It is pennywise and pound foolish to think that getting appropriate treatment to individuals sooner rather than later will not result in better health outcomes for the patient (the most important thing to consider) as well as long-term cost savings. Proponents have admitted that there will be a premium impact associated with House Bill 8. We can argue over the significance of the amount, however, let's not ignore the idea that passing dozens of mandates results in real cost consequences. We regularly hear from our members that premiums continue to increase year over year.

In fact, the Kaiser Family Foundation reports in their 2024 Employer Health Benefits Survey the $25,572 average family premium in 2024 is 24% higher than the average family premium in 2019 and 52% higher than the average family premium in 2014. Additionally, the average premium for single coverage has grown 25% in the past five years.[1]

Also included with my testimony is a recent paper we released titled: *Addressing the Health Insurance Affordability Crisis for Small Businesses*[2]. This paper shares the troubling news that the small group market is in significant decline, going so far as to say it is in a death spiral. The number of participants has declined from 15 million in 2014 to 8.5 million in 2023. Additionally, the average number of health plan issuers in Ohio has declined from 13 in 2015 to 6 in 2022.

Small employers are then put in difficult situations: do they move to a plan that has higher deductibles and copays, do they ask employees to contribute more toward premium, or do they drop coverage altogether?

In the Kaiser survey, you can see the disparity in coverage offered between larger and small businesses. We acknowledge that the ACA requires coverage or payment of penalties for those with 50 or more employees, however, it cannot be ignored that offer rates amongst smaller businesses is significantly lower. To compete in a competitive job market, employers need to offer a package that includes good compensation as well as a robust benefits package.

The smallest firms are least likely to offer health insurance: 46% of firms with 3-9 workers offer coverage, compared to 56% of firms with 10-24 workers, 68% of firms with 25-49 workers, and 92% of firms with 50-199 workers.

The NFIB Research Foundation's quadrennial publication Problems & Priorities shows the top issue not only in Ohio but across the nation for our members is the cost of healthcare. This has been the top issue since 1986![3]

Another challenge with any mandate is the distortion of the contractual negotiations between providers and health insurance plans. We acknowledge that there are hundreds of different conditions, services, etc. that are negotiated between providers and plans. When a health insurance mandate is enacted, the government has tipped the scale in the negotiations. They have given an advantage to the provider or coverage as to what health

[1] https://www.kff.org/report-section/ehbs-2024-section-1-cost-of-health-insurance/
[2] https://www.nfib.com/wp-content/uploads/2025/02/Health-Care-Coverage-Policy-Paper-07.pdf
[3] https://nfib.com/small-business-problems-and-priorities/

plans must now include in their fully insured plan product offerings. Thus, the true free negotiation between the parties is tilted in favor of one party.

This is where a real concern lies. We know the biomarker tests on the market today and their associated costs. What is unknown is future tests and what they may cost. The distortion of the contract negotiation process could create a landscape whereby manufacturers and/or administrators of these tests charge a significant amount of money for their new tests, particularly if their test is the only one for a given biomarker.

The LSC fiscal note indicates the average allowed unit cost per test is $224. This information was drawn from a Milliman Study. This same study shows the average unit cost per test for Medicaid is nearly 1/3 of the cost for the private sector, at roughly $80.[4] While it seems there is common recognition that Medicaid reimbursements are usually low with respect to covering costs of services, procedures, supplies, etc., private sector plans paying close to three times appears excessive. I would also point out the original fiscal note of HB 24 referenced a NCSL study that said the average biomarker test cost is $1,700.[5] There is also a NCSL brief on this topic that indicates costs range from $50 for a single test to more than $10,000 for the most complex tests.[6] And this committee heard testimony from proponents validating the out of pocket costs of these tests can be up to $10,000. There seems to be a huge disparity between average allowed unit cost and the upward end of out of pocket costs.

We would like to suggest a way to alleviate our fears of runaway costs which would move us to a position of neutral. We proposed this to the bill's sponsor but were not able to have an amendment added in the Ohio House last General Assembly.

If you look at Ohio Revised Code 3923.52 (D)(2) which relates to reimbursement for mammography screenings, you will see there is a 130% cap.

> *(2) Regardless of whether separate payments are made for the benefit provided under division (B)(1) or (2) of this section, the total benefit for a screening mammography or supplemental breast cancer screening shall not exceed one hundred thirty per cent of the Medicare reimbursement rate in this state for screening mammography or supplemental breast cancer screening. If there is more than one Medicare reimbursement rate in this state for screening mammography or a component of screening mammography or supplemental breast cancer screening or a component of supplemental breast cancer*

[4] https://www.milliman.com/-/media/milliman/pdfs/2022-articles/2-16-22_the_landscape_of_biomarker_testing_coverage_in_the_us.ashx
[5] https://www.legislature.ohio.gov/download?key=20671
[6] https://www.ncsl.org/health/biomarkers-and-advancements-in-cancer-care

screening, the reimbursement limit shall be one hundred thirty per cent of the lowest Medicare reimbursement rate in this state.

We welcome an honest discussion about what rate would be appropriate. Does this mean 130% is the correct number? Perhaps not, but let's find what providers and manufacturers could settle on. While this seems to go against free market principles, enacting a health insurance mandate distorts the free-market reimbursement negotiations that would otherwise take place. When we propose a mechanism to limit costs, we generally hear the proponents of these mandates suggesting these discussions be left to contractual negotiation between the provider and the health insurance plan. However, these same proponents seek state government intervention when they are unable to secure coverage through the same process.

Addition of this amendment would move us to neutral on the bill. This amendment would allow us to know that costs will not be runaway, and providers will be able to be reimbursed at an adequate level.

One additional thing for the General Assembly to consider is how the Centers for Medicare and Medicaid Services (CMS) will view passage of House Bill 8. The Affordable Care Act (ACA) required states to establish essential health benefits that must be provided for in qualified health plans (QHP). States are permitted to add additional required health benefits. However, the states must defray the costs of those additional benefits added after December 31, 2011.[7] The payments for defrayed costs can be made directly to the enrollee or the issuer of the enrollee's plan. The cost determination is required to be done by the QHP.[8] The state may likely be responsible for the costs associated with House Bill 8. We respectfully request the addition of language indicating the Ohio Department of Insurance will conduct their own actuarial analysis to determine the premium cost associated with House Bill 8 and defray those costs from impacted policyholders.

In closing, we recognize the long-term health benefits of identifying issues early and getting patients the appropriate treatment. Our members want the best health outcomes for their employees. We acknowledge that is the most important consideration of this legislation. However, we believe it is necessary to ensure that we do not create a landscape where biomarkers tests become prohibitively expensive, when government has mandated coverage. We believe we have identified a solution to this concern.

Thank you for your time and I am happy to try and address any questions.

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[7] https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/faq-defrayal-state-benefits.pdf
[8] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-155/subpart-B/section-155.170