Ohio Commission on Minority Health

House Insurance Committee

H.B. 33 Proponent Testimony

Ohio Commission on Minority Health

May 6, 2025

Good morning, Chairman Lampton, Vice Chair Craig, Ranking Member Tims, and esteemed members of the House Insurance Committee. My name is Angela Dawson. I am the Director of the Ohio Commission on Minority Health where I am honored to serve. The Ohio Commission on Minority Health is dedicated to eliminating disparities in minority health through innovative strategies and financial opportunities, public health promotion, legislative action, public policy and systems change.

I appreciate the opportunity to provide proponent testimony for House Bill 33. House Bill 33 coverage of evidence-based preventative screenings, such as the prostate-specific antigen (PSA) test, for men at high risk of developing prostate cancer, without out-of-pocket costs. This legislation will remove the financial barriers that too often prevent men from accessing care and catching the disease early.

The Commission extends thanks to House Bill 33 sponsors Representative Jarrells and Representative Johnson for this important bill which can increase access to preventative screenings and facilitate early-stage diagnosis.

As policy makers, we must embrace a full understanding of both the burden of preventable cancers as well as the impact in the US and in Ohio. This must examine the full cancer control continuum to include cancer etiology, **prevention, early detection**, diagnosis, treatment, survivorship, and end of life. In addition, we must focus our attention on cancer trends, complications; and the predisposition for racial and ethnic minorities; as well as the impact of social determinants of health.

Prostate cancer is the most frequently diagnosed cancer among men in our state. Each year, approximately 10,000 Ohio men will receive the devasting news that they have a diagnosis of prostate cancer. Tragically, for far too many, these words will come too late. Prostate cancer often remains asymptomatic until it becomes metastatic, when treatment is less effective, and survival rates are dramatically lower.

The statistics surrounding this disease are sobering. Over the past decade, the percentage of Ohio men aged 40 and older who were screened for prostate cancer has dropped significantly—from 54.4% in 2010 to just 32% in 2020. During this same period, cases of metastatic prostate cancer increased by 5% annually, outpacing the overall rate of new diagnoses. This means more men are being diagnosed at advanced stages, where survival rates plummet and treatment becomes exponentially more expensive.

Prostate cancer does not affect all Ohioans equally. Black men in our state face the highest incidence rates, at 163.9 per 100,000. Rural Ohioans, veterans, and men with a family history or genetic predisposition are also at significantly higher risk. These disparities highlight the urgent need for equitable access to preventive care.

In Ohio, 71,925 new invasive cancer cases were diagnosed and reported among males and females in 2021. Over 25,000 cancer deaths among Ohioans occurred in 2021, at a rate that was 11% higher than the U.S. rate (160.1 vs. 144.2 per 100,000).[2]

Prostate cancer incidence rates were 66.6% higher among Black men compared to white men (Table 1).

Prostate cancer mortality rates were 81.7% higher among Black men compared to white men (Table 2).

Trends in Cancer Incidence and Mortality in Ohio

While progress has been made in reducing cancer incidence and mortality from 2000 to 2021, disparities by race and gender persist for across the six selected cancer types to include prostate cancer. Generally, mortality rates have declined across most cancer types, though rates remain consistently higher among males, more specifically Black males.

Age is the strongest risk factor for the development of prostate cancer, with men over the age of 65 being the most at-risk. Genetic risk factors include having a first-degree relative with prostate cancer. Racial disparities exist in prostate cancer development, with African American men have the highest incidence.

Prostate-specific antigen (PSA) testing is the most common type of prostate cancer (PC) screening. PSA is a protein that is produced by both normal and cancerous prostate tissue. The greatest potential benefit of PSA testing is that this screening can reduce the risk of mortality from PC.

It is estimated that 1 in 8 American men will be diagnosed with the disease and about 1 in 44 will die from it. Prostate cancer generally has high survival rates, especially when diagnosed early. Most (68%) prostate cancers in Ohio were diagnosed at a local stage with a five-year relative survival of nearly 100%.

Prostate cancer has the largest racial disparities of any cancer in the United States. Black men are 1.67 times more likely to be diagnosed with prostate cancer and have a 2.06 times higher risk of dying from the disease compared to white men. Key factors contributing to these disparities include lower screening and a higher frequency of preclinical disease, more aggressive tumor features (stage and grade) at diagnosis, and lower baseline cancer-specific survival among Black patients.

These factors suggest that Black men may benefit from earlier and more frequent screening. Factors such as living in deprived areas, lower education levels, and differences in healthcare utilization significantly impact these disparities.[214]

In Ohio, the prostate cancer screening rates for men over age 40 shows significant differences, with screening rates for Blacks at 22.5% compared to Whites at 33.7%.

House Bill 33 is a significant solution to address these disparities. This legislation requires health insurers to cover evidence-based preventive screenings, such as the prostate-specific antigen (PSA) test, for men at high risk of developing prostate cancer, without out-of-pocket costs.

This provides an opportunity for health benefit plans to cover all expenses associated with these screenings, to remove the financial barriers that too often prevent men from accessing care and catching the disease early.

For the uninsured, the price of a PSA test ranges from $100 to $300, depending on the clinic. For many families, even this relatively small expense can be a deterrent. But here's the stark contrast—by investing in a $100 to $300 test, we are saving families hundreds of thousands of dollars in medical bills, lost wages, and economic burden.

Late-stage prostate cancer impacts health outcomes but also creates significant financial burdens on the family and the health system. Treating advanced prostate cancer costs $77,333 more per year than treating it early.

A cancer diagnosis significantly impacts families emotionally and economically. Emotionally, family members experience stress, depression, and anxiety, impacting their overall well-being. Economically, cancer treatments and related costs can lead to financial strain, including reduced income, increased debt, and challenges with basic needs. Given the high mortality rates, a late-stage diagnosis often results in the loss of a grandfather, father, brother, nephew and cousin which is devasting to the family and their future.

The benefits of early detection cannot be overstated. Early-stage prostate cancer has a six-year survival rate of 99%. When detected late, that survival rate drops to just 28.7%.

By passing House Bill 33, we can prevent hundreds of metastatic cases, detect over 10,000 additional early-stage cases in men aged 55-69, and save nearly $100 million in treatment costs over the next 13 years. Most importantly, we can save the lives of men across Ohio— fathers, brothers, sons, and friends who deserve the chance to live longer and healthier lives.

Ohio has an opportunity to join other states like Tennessee, Illinois, Rhode Island, and Kentucky who have already passed similar bipartisan measures. These states have demonstrated that such policies have no significant impact on insurance premiums or state spending.

The Ohio Commission on Minority Health hosted a Medical Expert Panel on Preventable Cancers earlier this year. The panel which consisted of over 33 experts from across Ohio including state agency staff, medical experts, universities and organizations whose critical analysis provided a foundation for the development of evidence-based recommendations which included increased access to prostate cancer screenings.

The Ohio Commission on Minority Health is appreciative of the opportunity to provide proponent testimony and encourages support for the passage of this legislation.

Table 1. New Invasive Cancer Cases and Incidence Rates by Cancer Site/Type, Race, and Ethnicity, Ohio, 2021

Primary Cancer Site/Type	WHITE		BLACK		A/PI		HISPANIC	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
All Cancer Sites/Types	**62,137**	**466.8**	**7,596**	**459.5**	**732**	**257.2**	**914**	**273.1**
Bladder	2,999	21.5	210	12.9	21	8.7	31	10.7
Brain and Other CNS	771	6.8	60	3.6	9	3.0	20	4.1
Breast (Female)	9,188	137.9	1,167	132.5	173	109.6	139	78.6
Cervix	392	7.7	65	7.9	6	3.6	12	6.5
Colon and Rectum	4,964	38.6	585	36.7	57	20.4	80	24.8
Esophagus	787	5.7	61	3.6	10	3.6	12	3.9
Hodgkin Lymphoma	273	2.6	49	3.1	1	*	6	1.0
Kidney and Renal Pelvis	2,444	18.8	324	20.4	25	8.5	54	15.0
Larynx	504	3.6	71	4.3	4	*	12	3.3
Leukemia	1,557	12.4	152	9.6	13	4.3	28	7.2
Liver and Intrahepatic Bile Duct	1,008	7.0	199	10.9	18	6.4	32	10.6
Lung and Bronchus	8,686	60.6	1,063	63.9	78	30.5	73	25.6
Melanoma of the Skin	3,703	29.2	17	1.0	4	*	19	6.6
Multiple Myeloma	699	5.0	197	12.2	7	2.7	16	5.5
Non-Hodgkin Lymphoma	2,454	18.7	236	14.5	40	14.0	42	13.6
Oral Cavity and Pharynx	1,784	13.1	171	10.2	28	9.7	20	6.0
Ovary	688	10.6	72	8.2	10	6.9	11	6.5
Pancreas	1,812	13.0	253	15.6	19	7.4	19	5.6
Prostate	7,708	110.8	1,436	184.6	53	44.4	109	74.3
Stomach	709	5.3	155	9.7	19	6.8	18	5.3
Testis	284	6.4	13	1.7	4	*	10	3.4
Thyroid	1,577	14.7	176	11.2	37	10.5	48	11.0
Uterus	2,142	31.1	273	28.2	37	22.2	38	22.8
Other Sites/Types	5,004	**	591	**	59	**	65	**

Source: Ohio Cancer Incidence Surveillance System, Ohio Department of Health, 2024.

Rates are per 100,000 population and age-adjusted to the 2000 U.S. standard population. Rates are sex-specific for cancers of the breast, cervix, ovary, prostate, testis, and uterus. * Rates may be unstable and are not presented when the count is less than five. ** Rates are not calculated due to multiple cancer sites/types in this category. CNS = Central Nervous System; A/PI = Asian/Pacific Islander.

Table 2. Cancer Deaths and Mortality Rates by Cancer Site/Type, Race, and Ethnicity, Ohio, 2021

Primary Cancer Site/Type	WHITE		BLACK		A/PI		HISPANIC	
	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
All Cancer Sites/Types	**22,024**	**159.7**	**2,822**	**178.8**	**202**	**83.4**	**217**	**75.1**
Bladder	662	4.8	55	3.7	*	*	*	*
Brain and Other CNS	609	4.7	38	2.4	*	*	*	*
Breast (Female)	1,383	19.1	237	27.0	19	14.2	20	12.3
Cervix	129	2.3	26	3.1	*	*	*	*
Colon and Rectum	1,856	13.7	241	15.5	16	6.3	17	6.3
Esophagus	709	5.1	58	3.5	*	*	*	*
Hodgkin Lymphoma	24	0.2	*	*	*	*	*	*
Kidney and Renal Pelvis	548	3.9	49	3.3	*	*	*	*
Larynx	165	1.2	29	1.7	*	*	*	*
Leukemia	832	6.1	96	6.2	*	*	*	*
Liver and Intrahepatic Bile Duct	846	6.0	169	9.8	18	6.6	23	8.6
Lung and Bronchus	5,527	38.9	676	41.8	45	19.3	39	14.1
Melanoma of the Skin	380	2.9	*	*	*	*	*	*
Multiple Myeloma	392	2.8	80	5.3	*	*	*	*
Non-Hodgkin Lymphoma	764	5.7	66	4.3	11	4.9	13	4.5
Oral Cavity and Pharynx	436	3.1	38	2.3	*	*	*	*
Ovary	478	6.3	41	4.4	*	*	*	*
Pancreas	1,625	11.4	214	13.7	17	7.9	11	4.3
Prostate	1,049	18.6	191	33.8	*	*	*	*
Stomach	273	2.1	71	4.5	10	3.5	10	3.1
Testis	21	0.4	*	*	*	*	*	*
Thyroid	82	0.6	*	*	*	*	*	*
Uterus	373	4.9	88	9.1	*	*	*	*

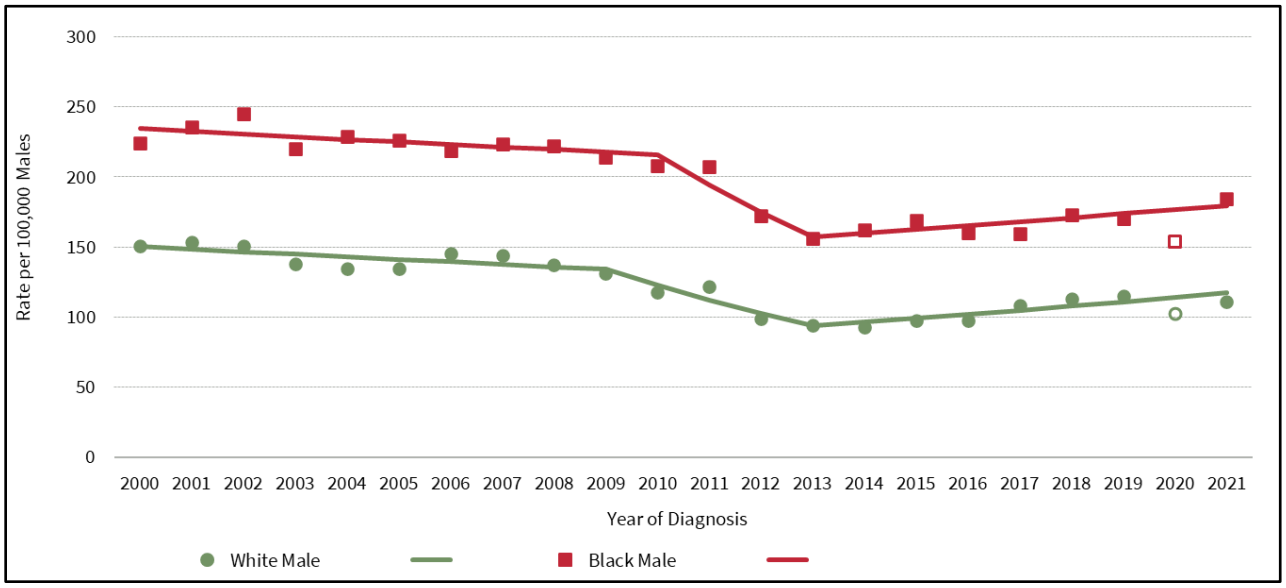
Source: Mortality - All Cause of Death, Aggregated With State, Total U.S. (1990-2022) <Katrina/Rita Population Adjustment> (SEER*Stat Database), National Cancer Institute, April 2024. Underlying mortality data provided by the National Center for Health Statistics (www.cdc.gov/nchs).

Rates are per 100,000 population and age-adjusted to the 2000 U.S. standard population. Rates are sex-specific for cancers of the breast, cervix, ovary, prostate, testis, and uterus. * Rates may be unstable and are not presented when the count is less than 10. CNS = Central Nervous System; A/PI = Asian/Pacific Islander.

Prostate:

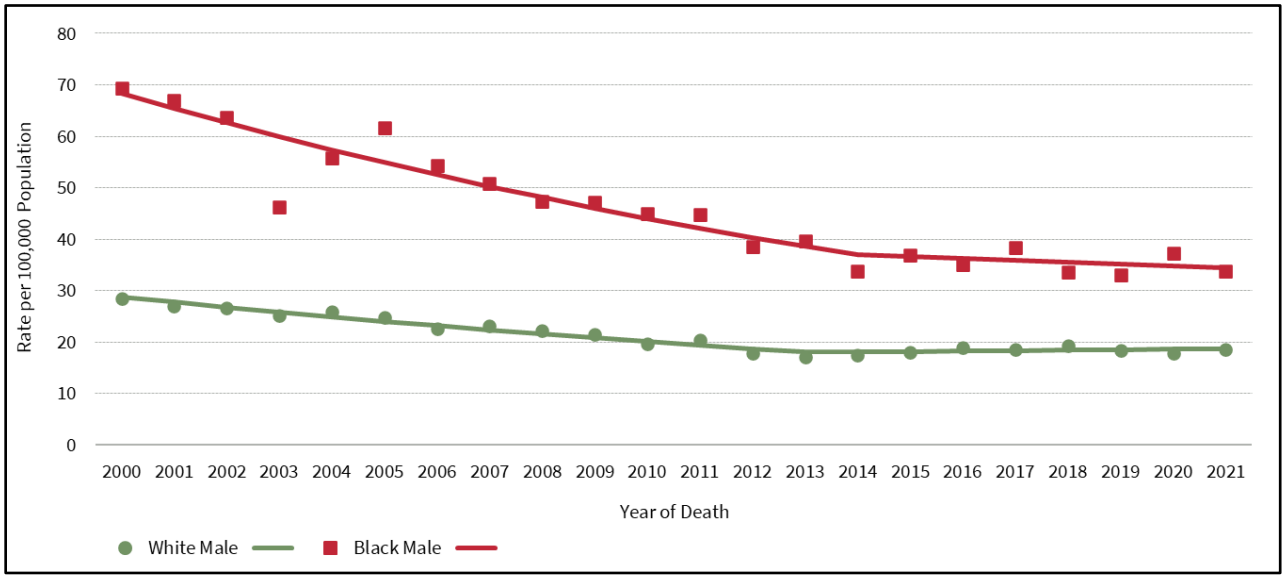
- Prostate cancer incidence rates have declined slightly after 2008 when a change in screening recommendations occurred, but incidence rates have now slightly increased from 2013 to 2021. Black males consistently have higher incidence rates than white males (Figure 2a). While overall mortality rates have declined, Black males continue to experience higher mortality rates compared to white males (Figure 2b).

Figure 2a. Prostate Cancer Incidence Trends, Ohio, 2000-2021



Source: Ohio Cancer Incidence Surveillance System, Ohio Department of Health, 2024.

Figure 2b. Prostate Cancer Mortality Trends, Ohio, 2000-2021



Source: Surveillance, Epidemiology, and End Results (SEER) Program SEER*Stat Database: Mortality - All COD, Aggregated With State, Total U.S. (1990-2022) <Katrina/Rita Population Adjustment>, National Cancer Institute, April 2024. Underlying mortality data provided by NCHS (www.cdc.gov/nchs).

Table 3. Screening rates overall and by race for breast, colorectal, prostate, lung, and cervical cancers[a] in Ohio and nationally compared to Healthy People 2030 goals.

			Screening Rates (%)				
			Ohio			National	Healthy People 2030 Goals
			Overall	*Black/ African American*	*White*	*Overall*	*Overall*
Cancer Type	**Breast**	*Ages 50-74*	75.6%[b]	80.0%[b]	76.0%[b]	76.3%[h]	80.3%[m]
		Ages 40+	68.3%[c]	71.6%[c]	68.3%[c]	70.2%[h]	
	Colorectal		67.6%[d]	68.8%[d]	68.2%[d]	66.9%[i]	68.3%[n]
	Prostate		32.0%[e]	22.5%[e]	33.7%[e]	31.8%[j]	---- [o]
	Lung		12.5%[f]	---- [f]	12.9%[f]	9.9%[k]	7.5%[p]
	Cervical		77.4%[g]	85.2%[g]	76.1%[g]	77.7%[l]	79.2%[q]

[a]Multiple myeloma is not included in this table as no official screening guidelines currently exist for this cancer type.

[b]Estimates of the Ohio prevalence of women aged 50-74 who have had a mammogram within the past two years using **2022** Behavioral Risk Factor Surveillance System (**BRFSS**) data.[REF1, REF2]

[c]Estimates of the Ohio prevalence of women aged 40+ who have had a mammogram within the past two years using **2022 BRFSS** data.[REF1, REF2]

[d]Estimates of the Ohio prevalence of people aged 45-75 who have fully met the US Preventive Services Task Force (USPSTF) recommendation using **2022 BRFSS** data.[REF1, REF2] USPSTF recommendations among adults aged 45-75 include receiving either annual fecal occult blood testing (FOBT), annual fecal immunochemical testing (FIT), stool deoxyribonucleic acid (DNA) testing every three years, colonoscopy every 10 years, computed tomography (CT) colonography every five years, flexible sigmoidoscopy every five years, or flexible sigmoidoscopy every 10 years with annual FIT.[REF]

[e]Estimates of the Ohio prevalence of men aged 40+ who have had a prostate-specific antigen (PSA) test within the past two years using **2020 BRFSS** data.[REF1, REF2]

[f]Estimates of the Ohio prevalence of people aged 50-80 who are current and former smokers who had a CT scan in the last year using **2022 BRFSS** data. A prevalence estimate is not available for African Americans due to the unweighted sample size for the denominator being < 50 or the confidence interval width being > 10 for any cell.[REF1, REF2]

[g]Estimates of the Ohio prevalence of women aged 21-65 who have had a Pap test in the past three years using **2020 BRFSS** data.[REF1, REF2]

[h]Estimates of the national prevalence of women aged 50-74 and 40+ who have had a mammogram within the past two years using **2022 BRFSS** data.[REF]

[i]Estimates of the national prevalence of people aged 50-75 who were up-to-date with colorectal cancer screening using **2022 BRFSS** data. Up-to-date is defined as having received FOBT in the past year, having received stool DNA testing in the past three years, having had a sigmoidoscopy in the past five years, or having had a colonoscopy in the past 10 years.[REF]

[j]Estimates of the national prevalence of men aged 40+ who have had a PSA test within the past 2 years using **2020 BRFSS** data.[REF]

[k]Estimates of the national prevalence of people aged 50-80 who are current and former smokers who had a CAT/CT scan in the last year using **2022 BRFSS** data.[REF]

[l]Estimates of the national prevalence of women aged 21-65 who have had a Pap test in the past three years using **2020 BRFSS** data.[REF]

[m]Healthy People 2030 set a goal to increase the proportion of all eligible females who receive a breast cancer screening to 80.3%.[REF]

[n]Healthy People 2030 set a goal to increase the proportion of all eligible adults who receive a colorectal cancer screening to 68.3%.[REF]

[o]There is no Healthy People 2030 goal for prostate cancer screening.

[p]Healthy People 2030 set a goal to increase the proportion of all eligible adults who receive a lung cancer screening to 7.5%.[REF]

[q]Healthy People 2030 set a goal to increase the proportion of all eligible women who receive a cervical cancer screening to 79.2%.[REF]