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H.B. 271
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Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Schmidt and Williams

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SUMMARY

- Revises the law governing health insurance and Medicaid coverage of breast or cervical cancer screenings and examinations, including by requiring coverage of diagnostic breast examinations when certain conditions are met.
- Prohibits health insurers and the Medicaid program from imposing cost-sharing requirements on covered breast or cervical cancer screenings and examinations.
- Eliminates the Medicare benchmark for reimbursing providers for breast cancer screenings and instead prohibits insurers from reducing the reimbursement rate, as compared to the rate previously paid by the same insurer to the same provider for the same service.
- Requires the Director of Health to notify each hospital and physician, and the Superintendent of Insurance to notify each health insurer, of the bill's provisions, if the bill is enacted.
- Names the bill the Breast Examination and Screening Transformation Act, or BEST Act.

DETAILED ANALYSIS

Diagnostic breast examination coverage

The bill requires health insuring corporations, sickness and accident insurers, and public employee benefit plans (collectively, "health insurers"), and the Medicaid program to cover expenses for diagnostic breast examination for an adult individual who has an abnormality seen or suspected from, or detected by, a screening mammography, supplemental breast cancer screening, or another means of examination.[1] For purposes of the bill, ***diagnostic breast***

[1] R.C. 1751.62(C)(3), 3923.52(C)(3), 3923.53(B)(3), and 5164.08(C)(3).

examination is any examination that, in accordance with applicable American College of Radiology (ACR) guidelines, is deemed medically necessary by a treating health care provider to diagnose breast cancer, including diagnostic mammography, magnetic resonance imaging, ultrasound, or biopsy.[2]

Existing law coverage of breast cancer screenings

Current Ohio law requires a health insurer and the Medicaid program to cover expenses for one screening mammography every year.[3] The law also requires coverage for expenses for supplemental breast cancer screening under the following circumstances:

- Screening mammography demonstrates that the individual has dense breast tissue;
- The individual is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the individual's health care provider.[4]

Definitions

The bill modifies the existing law definitions of screening mammography and supplemental breast cancer screening. In the case of ***screening mammography***, the bill removes *unsuspected* and *at an early stage in asymptomatic women* from the definition's description of breast cancer. It also refers to a radiologic examination that accords with ACR guidelines.[5]

With respect to the ***supplemental breast cancer screening*** definition, the bill includes contrast enhanced mammography as an example of one such screening method.[6]

American College of Radiology accreditation

Under existing law, coverage for screening mammographies and supplemental breast cancer screenings depend on the procedures being performed in facilities or mobile units accredited under the ACR mammography accreditation program or in hospitals. The bill extends this condition of coverage to diagnostic breast examinations, except when a diagnostic breast examination is a biopsy, it may be performed in a location other than a hospital or an ACR-accredited facility or unit.[7]

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[2] R.C. 1751.62(A)(2), 3923.52(A)(2), and 5164.08(A)(1).

[3] R.C. 1751.62(B)(1) and (C)(1), 3923.52(B)(1) and (C)(1), 3923.53(A)(1) and (B)(1), and 5164.08(B)(1) and (C)(1).

[4] R.C. 1751.62(B)(2) and (C)(2), 3923.52(B)(2) and (C)(2), 3923.53(A)(2) and (B)(2), and 5164.08(B)(2) and (C)(2).

[5] R.C. 1751.62(A)(1), 3923.52(A)(1), and 5164.08(A)(2).

[6] R.C. 1751.62(A)(3), 3923.52(A)(4), and 5164.08(A)(3).

[7] R.C. 1751.62(E), 3923.52(E), 3923.53(E), and 5164.08(E).

Reimbursement rates

Under current law, the required reimbursement rate for breast cancer screenings must not exceed 130% of the Medicare reimbursement rate in Ohio. The bill eliminates the Medicare benchmark, and instead specifies that the reimbursement rate for a covered benefit must not be less than any reimbursement rate previously paid by the same insurer to the same provider for the same service.

Under continuing law, a provider does not need to perform the whole service to obtain reimbursement. The provider may perform a component of the service and submit a separate claim for that component. The insurer is then required to issue a separate reimbursement payment to that provider, subject to the same minimums described above.[8]

Health insurer cost sharing

The bill prohibits a health insurer from imposing cost-sharing requirements on any of the following covered services related to breast or cervical cancer:

- Screening mammography to detect the presence of breast cancer;
- Supplemental breast cancer screening to detect the presence of breast cancer;
- Diagnostic breast examination to diagnose breast cancer when an abnormality is seen or suspected from or detected by screening mammography, supplemental breast cancer screening, or another means of examination;
- Cytologic screening to detect the presence of cervical cancer.[9]

Medicaid cost sharing

The bill prohibits the Medicaid program from imposing cost-sharing requirements on the same covered services related to breast or cervical cancer described in the preceding paragraph.[10]

Adult individual

The bill replaces references to adult women in the law governing coverage of breast cancer screenings with references to adult individuals.

Notice to health plan issuers, hospitals, and physicians

If H.B. 271 is enacted, the Director of Health must notify each hospital and physician. Similarly, the Superintendent of Insurance also must notify each health plan issuer. The notice must (1) occur not later than three months after the act's effective date, (2) be completed by certified mail, and (3) summarize the changes made by the act. The bill authorizes the Director

[8] R.C. 1751.62(D), 3923.52(D), and 3923.53(C).

[9] R.C. 1751.62(H), 3923.52(G), and 3923.53(F).

[10] R.C. 5162.20 and 5164.08(D).

to consult with the State Medical Board to assist the Director in identifying physicians and determining their business addresses in order for the Director to satisfy the notice requirement.[11]

Exemption from review by the Superintendent of Insurance

The bill's provisions requiring health benefit plans to cover breast cancer screenings might be considered a mandated health benefit. Under R.C. 3901.71, if the General Assembly enacts a provision for mandated health benefits, that provision cannot be applied to any health benefit plan 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),[12] and to employee benefit plans established or modified by the state or any of its political subdivisions. ERISA appears to preempt any state regulation of such plans.[13] The bill contains provisions that exempt its requirements from this restriction.[14]

Applicability to future health plans

The bill specifies that its provisions apply only to arrangements, policies, contracts, and agreements that are created, delivered, issued for delivery, renewed, or modified after the effective date of the bill.[15]

HISTORY

Action	Date
Introduced	05-13-25

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[11] Section 4.

[12] 29 United States Code (U.S.C.) 1001, as amended.

[13] 29 U.S.C. 1144.

[14] R.C. 1751.62(B), 3923.52(B), and 3923.53(A).

[15] Section 3.