OHIO LEGISLATIVE SERVICE COMMISSION

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Office of Research and Drafting

Legislative Budget Office

H.B. 758
136th General Assembly

Fiscal Note & Local Impact Statement

Click here for H.B. 758's Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Sweeney and Manning

Local Impact Statement Procedure Required: Yes

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Highlights

- The Department of Insurance may realize a minimal increase in administrative costs to ensure health benefit plans comply with the bill's requirements. Any increase in such costs would be paid from the Department of Insurance Operating Fund (Fund 5540).
- State and local governments will likely realize an increase in costs to provide health benefits to employees and their dependents by undetermined amounts, which would depend on the number of individuals diagnosed with epilepsy who receive insurance coverage from public employee health benefit plans. To the extent that a particular local government's health benefit plan already complies with the bill's requirements, there would be no impact on its costs of providing health benefits to employees and their dependents.
- The Ohio Department of Medicaid (ODM) will experience an estimated annual cost of between $300,000 and $21.0 million ($105,000 to $7.3 million state share) to provide epilepsy-monitoring devices to eligible Medicaid enrollees.
- The Ohio Department of Health (ODH) will experience costs to provide guidance to health care practitioners in determining when an individual is at an elevated risk for sudden unexpected death in epilepsy (SUDEP) and to develop an education and information program for individuals with epilepsy regarding SUDEP dangers.
- The Bureau of Motor Vehicles (BMV) estimates additional costs of at least $75,000 to $100,000 to create and implement an epilepsy designation that may be included on a person's driver's license or state identification card.
- County coroners could have costs to investigate SUDEP in certain circumstances and to report specified information to SUDEP registries.

Detailed Analysis

The bill includes several provisions regarding sudden unexpected death in epilepsy (SUDEP) and individuals with epilepsy. The provisions and the fiscal impacts are described below.

Coverage and benefits of epilepsy provisions

The bill requires health benefit plans amended, issued, or renewed on or after the bill's effective date to provide the same coverage and benefits for an individual diagnosed with epilepsy as an individual who has not been diagnosed with epilepsy. The bill includes a provision that exempts its provisions from a mandated health benefits requirement under continuing law.[1] The bill also requires health benefit plans to include coverage for seizure detection devices that are prescribed to an enrollee by a physician who is a specialist in the treatment of epilepsy if the physician determines that the device is medically necessary. The bill prohibits a health plan issuer from terminating coverage or refusing to renew an individual's coverage under a health benefit plan on the sole basis that the individual has been diagnosed with epilepsy.

Under the bill, health benefit plans apply to a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including benefit plans marketed in the individual or group market by all associations, whether bona fide or nonbona fide.[2] "Health benefit plan" also means a limited benefit plan. Generally, a "health plan issuer" includes sickness and accident insurance companies, health insuring corporations, fraternal benefit societies, self-funded multiple employer welfare arrangements, nonfederal government health plans, and certain third-party administrators licensed under Chapter 3959 of the Revised Code.

Health benefit plan impacts

The bill may minimally increase the Department of Insurance's administrative costs to ensure health benefit plans comply with the bill's requirements. Any increase in such costs would be paid from the Department of Insurance Operating Fund (Fund 5540).

The bill's provisions related to health insurance coverage, including requiring health benefit plans to provide the same coverage and benefits for an individual diagnosed with epilepsy as an individual who has not been diagnosed with epilepsy, are likely to increase costs to the state and local governments to provide health benefits to employees and their dependents by undetermined amounts. Any increase would depend on the number of individuals diagnosed with epilepsy enrolled in public employee health benefit plans and costs associated with epilepsy treatment.

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[1] 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.

[2] "Health benefit plan" and "health plan issuer" are defined under R.C. 3902.50 (not in the bill), which have the same meaning as in R.C. 3922.01.

Currently, the state administers a self-insured health benefits plan in which the state pays all benefit costs directly while contracting with private insurers to administer the benefits. The 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.

Information on the number of local governments' health benefit plans that do not currently comply with the bill's requirements is undetermined. According to the Annual Report on the Cost of Health Insurance in Ohio's Public Sector, 2025 (PDF), prepared by the State Employment Relations Board (SERB), about 22% of local governments statewide fully insured their plans while 78% of public employers, including the state, self-insured their plans. Thus, local governments that fully insured their employees' medical plans may experience an insurance premium increase, depending on the number of enrollees and current coverage under the plans (i.e., whether the plans already conformed with the required coverage). To the extent that a particular public employee health benefit plan complies with the bill's requirements, there would be no impact on its costs of providing health benefits to employees and their dependents.

Despite the uncertainties caused by data limitations, the estimated costs may be in the tens of millions of dollars annually based on results from an epilepsy study[3] as well as data and assumptions below. Results from the study, which estimates the health care costs incurred by adults with epilepsy based on all-payer claims data from Colorado, Virginia, and Massachusetts, stated that "adjusted analyses revealed that costs attributable to epilepsy ranged from $12,000 to $31,000, depending on the covariates included." The study also indicated that "adults with epilepsy incurred higher costs than matched controls across all types of care," and "people with epilepsy were more likely to have Medicaid coverage or be dually eligible for Medicaid and Medicare than their counterparts without epilepsy."

According to information from the Facts & Statistics About Epilepsy, posted on the Epilepsy Foundation's website, "1 in 26 people will develop epilepsy during their lifetime." In addition, based on information from the Epilepsy Facts and Stats, posted on the U.S. Centers for Disease Control and Prevention's (CDC) website, "during 2011 and 2022, about 1% U.S. adults 18 and older having active epilepsy," and "about 0.6% U.S. children 17 and younger have active epilepsy." Using Ohio's total population, derived from the Annual Estimates of the Resident Population for Selected Age Groups by Sex: April 1, 2020 to July 1, 2024, prepared by the U.S. Census Bureau, there were about 7.1 million adults between age 18 and 64 and about 2.6 million children under 18 years residing in Ohio. According to information in Table HI05 ACS. Health Insurance Coverage Status and Type of Coverage by State and Age for All Persons: 2024, 57.3% of Ohioans under age 19 and 63.5% of Ohioans under age 65 received employment-based insurance coverage.

Using estimates of individuals who have active epilepsy and who will develop epilepsy above, as multiplied by the estimated percentage of Ohioans who receive employment-based insurance coverage, roughly between 53,551 and 290,277 individuals could be directly affected

[3] Ioannis Karakis, Lidia MVR Moura, Nada Boualam, Martha Wetzel, David Howard, The health care costs of epilepsy: Evidence from all-payer claims data, Epilepsy Research Volume 218, December 2025, 107661.

by the bill. Based on estimates from the U.S. Bureau of Labor Statistics (BLS), in 2025 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 governments (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 who receive employment-based insurance coverage and may have or will develop epilepsy, roughly between 773 and 4,191 of such individuals may be covered by the state health benefit plans, between 2,205 and 11,953 by a local government health benefit plan, and between 2,731 and 14,801 by a school district health benefit plan.

Using the lower bound of the estimated number of individuals who both receive employment-based insurance coverage from public employee health benefit plans and develop epilepsy, as multiplied by the lower bound of the estimated costs attributable to epilepsy, the resulting fiscal effect to the state health benefit plans, local government health benefit plans, and school district health benefit plans would range between $9.3 million and $32.8 million per year. Actual costs to these plans would depend on the actual number of individuals with epilepsy enrolled in each plan and actual costs of medical services and prescriptions utilized by such individuals.

Medicaid requirements

The bill requires the Medicaid Program to provide coverage for seizure detection devices as durable medical equipment if: (1) the device is determined to be medically necessary by a health care provider, and (2) the health care provider has determined that the device would likely assist in reducing bodily harm or death to a Medicaid recipient. The coverage must include the full cost of the device, including any related service or subscription supporting the device. The payment rate for a service or subscription supporting the use of the device must equal 100% of the rate for monthly remote monitoring services or subscriptions afforded to other remote monitory devices. Lastly, the Ohio Department of Medicaid (ODM) is required to conduct a biennial review of the list of covered devices and update the list as necessary.

Medicaid impacts

If ODM received approval from the U.S. Centers for Medicare & Medicaid Services (CMS) to cover epilepsy-monitoring devices, ODM will experience an estimated annual cost of between $300,000 and $21.0 million ($105,000 to $7.3 million state share) to provide devices to eligible Medicaid enrollees. The range is broad because of the range of possible conditions, as mentioned below.

The main elements of determining ODM's costs are the number of Medicaid enrollees participating and the cost of a device for each participant. We used two methods to estimate the number of participants; one is based on data from Minnesota which enacted similar legislation in 2024, while the other is based solely on Ohio demographic data.

Conveniently, Minnesota's population is nearly half that of Ohio (48.4% according to data from the 2020 Census). If Minnesota's estimate of around 500 possible users is applied to Ohio, we should expect 1,000 eligible users. Minnesota assumed a 50% uptake rate among qualified patients, which if applied to Ohio would indicate 500 expected devices. The estimated device cost used by Minnesota was $316. Current market research indicates the typical device now costs around $400 and requires a subscription plan beginning at $16 per month. This indicates a

year-one cost of around $600. The expected lifespan of the device is unclear; a second year using an already-provided device would cost less than $200, but we do not know how frequently the device will need replacement. Assuming an annual cost of $600 for 500 devices would lead to ODM facing annual costs of approximately $300,000.

If we use Ohio demographic data we reach a different conclusion. Ohio has an estimated 140,000 epilepsy patients. ODM's most recent caseload estimate is nearly one-quarter of the state's population (24.3%). If epilepsy patients were just as likely to be enrolled in Medicaid as other Ohioans, we should expect 35,000 of them to be in Medicaid. The Epilepsy Foundation estimates around 30% of epilepsy patients have drug-resistant epilepsy, which makes them candidates for a device. If Ohio experienced the 50% uptake forecasted in Minnesota, then we should expect 5,250 devices. At an annual cost of $600 per unit, this would lead to an annual cost for ODM of approximately $3.2 million.

The Epilepsy Foundation estimates an annual cost of coverage of between $1,000 and $2,500. For 5,250 devices, this would be an annual cost of between $5.3 million and $13.1 million. The Foundation also estimates that epilepsy patients participate in Medicaid at a higher rate than the general population, at around 40%. That would indicate ODM should expect to serve 16,800 drug-resistant epilepsy patients, who would use approximately 8,400 devices. The highest estimate applies a treatment cost of $2,500 to 8,400 devices, creating an estimated cost of $21.0 million.

ODM spending on Medicaid services qualifies for federal reimbursement according to the current Federal Medicaid Assistance Percentage (FMAP). Ohio's FMAP for FY 2027 will be 65.12%. Thus, $300,000 in Medicaid spending would result in a state share of approximately $105,000, and $21.0 million would have a state share of $7.3 million.

Estimated ODM Costs for Seizure-Detection Devices

Number of Devices	$600/Year	$1,000/Year	$2,500/Year
500 (MN method)	$300,000	$500,000	$1,250,000
5,250 (OH general rate)	$3,150,000	$5,250,000	$13,125,000
8,400 (OH special rate)	$5,040,000	$8,400,000	$21,000,000

ODH responsibilities

The bill requires ODH, in consultation with local and national organizations that provide education or services related to epilepsy conditions, to provide guidance to health care practitioners who have the primary responsibility for treating individuals with epilepsy to assist practitioners in determining when an individual is at an elevated risk for SUDEP. The bill also requires ODH to develop an information and education program to notify individuals with epilepsy concerning the danger of SUDEP, including educational awareness initiatives, risk counseling for patients to support continuity of care, and referrals to other appropriate services based on care plans determined by health care providers. Additionally, the bill requires this information to be provided to health care professionals and posted on ODH's website. A health care practitioner who provides treatment to a patient diagnosed with epilepsy is not liable for an

injury or death arising from SUDEP if the professional provides education and counseling to a patient as required above and maintains proper documentation.

The bill also requires ODH to post on its website information concerning SUDEP that is accessible to all persons eligible to sign death certificates and permits ODH to provide educational training regarding SUDEP. Lastly, the bill requires ODH to conduct outreach to the American Medical Association (AMA) to recommend adding a current procedural terminology (CPT) code for epilepsy education and counseling provided by a health care professional to a patient diagnosed with epilepsy.

ODH and associated impacts

ODH will realize costs to perform these duties. However, some of these costs could be reduced if ODH utilizes publicly available information on SUDEP to meet the bill's education and guidance requirements. For example, the Epilepsy Foundation offers a wide range of educational resources on SUDEP that are publicly available and may be used by states at no cost. Other national or state organizations maintain educational materials and professional networks that can support awareness and provider education efforts as well. Even if these documents could be used, ODH will still have costs to provide the information to health care professionals. Oklahoma has similar SUDEP legislation and estimated that dissemination of this information alone would be $10,000. Ohio has more medical professionals than Oklahoma, so costs would likely be more depending on how the information is actually distributed. If any awareness campaigns are conducted, there would be costs to do these. These costs would vary depending on the medium chosen (television, radio, billboards, social media, etc.). The costs to conduct outreach to AMA to recommend adding a CPT code for epilepsy education and counseling are also indeterminate. However, Oklahoma's SUDEP legislation anticipated their costs to do this would be in the thousands of dollars.

As stated above, a health care practitioner who provides education and counseling to a patient with epilepsy has immunity in the result of an injury or death from SUDEP if proper documentation is maintained. However, the immunity does not apply if an injured party can prove that the education and counseling were not adequately provided. As a result, there could be court costs if any related civil cases were brought forward. The section below provides a brief description of costs associated with Oklahoma and Colorado SUDEP education and awareness legislation.

SUDEP education and awareness legislation in other states

Legislation enacted in Oklahoma in May 2025 requires the Oklahoma Department of Health to: consult with local and national organizations that provide education or services related to epilepsy conditions to provide guidance to health care practitioners, develop an information program to be disseminated to the public and licensed medical professionals about SUDEP, and encourage AMA to add a CPT code for epilepsy education.[4] The fiscal impact of the bill was estimated to be about $45,000. The costs would be broken down as follows: $20,000 for the development of an information program, $10,000 for the dissemination of information to public

[4] See Oklahoma's HB 2013 (PDF) and the bill summary (PDF).

and medical professionals, $10,000 for the consultation with national and local organizations,[5] and $5,000 to pursue a CPT code.

Recently introduced legislation in Colorado requires the Colorado Department of Public Health and Environment to conduct a statewide public health campaign to expand public awareness of, and to educate the public about, epilepsy and its risks.[6] This public awareness campaign is estimated to cost around $50,000 in each state fiscal year. The bill requires other actions as well, such as coordinating and overseeing a training contractor and to provide technical assistance to county coroners to report epilepsy-related death information. The costs to provide assistance to county coroners was estimated to be up to $100,000 per fiscal year. The Department would contract with a third party to provide the latest epilepsy-related death investigation training.

BMV provision

Current law requires an applicant for a driver's license to state whether they are or have ever been afflicted with epilepsy. The bill expands that requirement to also include state identification (ID) cards. If an applicant for a driver's license or state ID card is or has ever been afflicted with epilepsy, the bill requires that person to specify whether their driver's license (DL) or state ID card should display a unique symbol chosen by the Registrar of Motor Vehicles to indicate such. State credentials (i.e., DL and state ID card) are issued by the BMV, housed under the Ohio Department of Public Safety, and are currently produced using preprinted color card stock and then the data is engraved with a laser that is black and white.

BMV impacts

Based on costs incurred for prior driver's license and state ID card updates, the BMV estimates that it will incur at least $75,000 to $100,000 to implement a black and white symbol or emblem indicating that the holder of a DL or state ID card is or has ever been afflicted with epilepsy. These costs primarily consist of BMV system updates to include the required symbol in the credential manufacturing process, which will likely necessitate vendor contract modifications, and BMV form modification (including DL and state ID card applications), as well as deputy registrar training. Additionally, the existing credentials will need to be redesigned to incorporate the bill's required symbol while still retaining existing requirements, including other legislative, identification, and security requirements.

Coroner requirements

The bill requires that if a coroner, deputy coroner, or pathologist, is informed that an individual who is the subject of an autopsy has epilepsy or a history of seizures, that the autopsy must include an investigation and determination as to whether the individual suffered SUDEP. If it is determined that the individual did suffer from SUDEP, the professional must ensure the information is included in the death certificate and report that information to the appropriate state or national SUDEP registry.

[5] Ohio has many more physicians, physician assistants, and nurses than Oklahoma, so dissemination costs would be much higher.

[6] See Colorado's SB 26-077 (PDF) and the fiscal note (PDF).

County coroner impacts

County coroners could have costs to investigate SUDEP and to report specified information. Costs would depend on current practice (e.g., are any of these duties currently done) and the number of cases in which a coroner is made aware that the person who is the subject of an autopsy has epilepsy.

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