As Reported by the House Health Committee

136th General Assembly
Regular Session **Am. H. B. No. 8**
2025-2026

Representative White, A.
Cosponsors: Representatives Schmidt, Somani

A BILL

To enact sections 3902.65 and 5164.13 of the Revised Code to require health benefit plan and Medicaid program coverage of biomarker testing.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 3902.65 and 5164.13 of the Revised Code be enacted to read as follows:

Sec. 3902.65. (A) As used in this section, "biomarker," "biomarker testing," and "nationally recognized clinical practice guidelines" have the same meanings as in section 5164.13 of the Revised Code.

(B) Notwithstanding section 3901.71 of the Revised Code, a health benefit plan issued, renewed, or modified in this state on or after the effective date of this section shall cover biomarker testing for any of the following purposes:

(1) Diagnosis;

(2) Treatment and appropriate management of a disease or condition;

(3) Ongoing monitoring of a disease or condition.

(C) A health benefit plan shall cover biomarker testing ordered and deemed medically necessary by a qualified treating health care provider working within the provider's scope of practice for the purposes included in division (B) of this section when the test is supported by medical or scientific evidence, as defined by section 3922.01 of the Revised Code, including at least one of the following:

(1) Labeled indications for a United States food and drug administration approved or cleared test;

(2) Indicated tests for a drug approved by the United States food and drug administration;

(3) Warnings and precautions for United States food and drug administration approved drug labels;

(4) National coverage determinations made by the United States centers for medicare and medicaid services;

(5) Medicare administrative contractor local coverage determinations;

(6) Nationally recognized clinical practice guidelines;

(7) Nationally recognized and peer reviewed studies indicating that the test materially improves health outcomes.

(D) If there are multiple available biomarker tests that offer comparable information, include all needed biomarkers, and are supported by medical or scientific evidence as required by division (C) of this section, a health benefit plan required to provide coverage under division (B) of this section shall cover at least one such test at the appropriate scope, duration, and frequency for the purposes described in that division. A provider ordering the biomarker test may request a coverage

exception for any reason, including time necessary to analyze a sample.

(E) A health plan issuer shall ensure coverage as required in division (B) of this section in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

(F) Any appeal of a biomarker testing coverage determination shall be handled in accordance with the health plan issuer's appeal policy and any other relevant provision of law, including section 1751.82 or Chapter 3922. of the Revised Code. The appeal process shall be made readily accessible to all participating providers and recipients in writing and online.

(G) Nothing in this section shall be construed to require coverage of biomarker testing for screening purposes.

(G)(1) Within ninety days after the effective date of this section, again not later than February 1, 2027, and not later than the first day of February of each year thereafter, the superintendent of insurance shall submit to the standing committees of both the house of representatives and of the senate with primary responsibility for insurance legislation a report on health benefit plan provider reimbursement rates for biomarker testing provided in this state by health benefit plans during the previous year.

(2) The report shall include the following statewide aggregate information for both calendar year 2024 and the calendar year immediately preceding the year the report is submitted:

(a) The total number of insured patients who received biomarker testing;

(b) The number of prior authorization requests for biomarker testing that were approved by the health plan issuer;

(c) The number of prior authorization requests for biomarker testing that were denied by the health plan issuer;

(d) The average and median amounts billed by providers per biomarker test and the average and median amounts reimbursed to providers by health benefit plans per biomarker test;

(e) The ten most common conditions for which or reasons why biomarker testing was ordered;

(f) The number of patients who switched or avoided certain treatments as a result of biomarker testing results;

(g) Cost savings as a result of covering biomarker testing under health benefit plans in this state.

(3) If any of the above data is not available, the report shall indicate why the data is unavailable.

(4) The report also shall provide recommendations on future reporting and cost considerations for the committee.

Sec. 5164.13. (A) As used in this section:

(1) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to specific therapeutic intervention, including known gene-drug interactions for drugs being considered for use or already available for use. Biomarkers include, but are not limited to, gene mutations, characteristics of genes, or protein expression.

(2) "Biomarker testing" means the analysis of tissue, blood, or another biospecimen for the presence of a biomarker,

and includes, but is not limited to, single-analyte tests, multiplex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

(3) "Nationally recognized clinical practice guidelines" are evidence-based clinical practice guidelines establishing standards of care informed by a systematic review and assessment of benefits and risks of alternative care options and include recommendations intended to optimize patient care, developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy.

(B) The medicaid program shall cover biomarker testing, subject to division (C) of this section, for any of the following purposes:

(1) Diagnosis;

(2) Treatment and appropriate management of a disease or condition;

(3) Ongoing monitoring of a disease or condition.

(C) The medicaid program shall cover biomarker testing ordered and deemed medically necessary by a qualified treating health care provider working within the provider's scope of practice for the purposes included in division (B) of this section when the test is supported by medical or scientific evidence, as defined by section 3922.01 of the Revised Code, including at least one of the following:

(1) Labeled indications for a United States food and drug administration approved or cleared test;

(2) Indicated tests for a drug approved by the United

States food and drug administration;

(3) Warnings and precautions for United States food and drug administration approved drug labels;

(4) National coverage determinations made by the United States centers for medicare and medicaid services;

(5) Medicare administrative contractor local coverage determinations;

(6) Nationally recognized clinical practice guidelines;

(7) Nationally recognized and peer reviewed studies indicating that the test materially improves health outcomes.

(D) If there are multiple available biomarker tests that offer comparable information, include all needed biomarkers, and are supported by medical or scientific evidence as required by division (C) of this section, the medicaid program shall cover at least one such test at the appropriate scope, duration, and frequency for the purposes described in division (B) of this section. A provider ordering the test may request a coverage exception for any reason, including time necessary to analyze a sample.

(E) The Medicaid program shall ensure coverage as required in division (B) of this section in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

(F) Any appeal of a biomarker testing coverage policy shall be handled in accordance with section 5160.31 of the Revised Code. The appeal process shall be made readily accessible to all participating providers and recipients in writing and online.

(G) Nothing in this section shall be construed to require coverage of biomarker testing for screening purposes.

(G)(1) Within ninety days of the effective date of this section, again not later than February 1, 2027, and not later than the first day of February of each year thereafter, the medicaid director shall submit to the standing committees of both the house of representatives and of the senate with primary responsibility for insurance legislation a report on provider reimbursement rates for biomarker testing provided under the medicaid program in this state during the previous year.

(2) The report shall include the following statewide aggregate information for both calendar year 2024 and the calendar year immediately preceding the year the report is submitted:

(a) The total number of patients who received biomarker testing under the medicaid program;

(b) The number of prior authorization requests for biomarker testing that were approved under the medicaid program;

(c) The number of prior authorization requests for biomarker testing that were denied under the medicaid program;

(d) The average and median amounts billed by medicaid providers per biomarker test and the average and median amounts reimbursed by the medicaid program to medicaid providers for biomarker testing, along with the average medicare provider reimbursement for biomarker testing;

(e) The ten most common conditions for which or reasons why biomarker testing was ordered;

(f) The number of patients who switched or avoided certain

treatments as a result of biomarker testing results;

(g) Cost savings as a result of covering biomarker testing under the medicaid program during the applicable calendar year.

(3) If any of the above data is not available, the report shall indicate why the data is unavailable.

(4) The report also shall provide recommendations on future reporting and cost considerations for the committee.

Section 2. It is the intent of the General Assembly to ensure coverage for appropriate biomarker testing supported by medical or scientific evidence, as defined by section 3922.01 of the Revised Code, with the goal of producing long-term healthcare cost savings and improving health outcomes for Ohioans covered under this act. The General Assembly does not intend to create a landscape which allows manufacturers and administrators of biomarker tests to substantially increase pricing for existing and new biomarker tests as a result of the coverage requirements for certain health insurance markets under this act.