As Introduced

132nd General Assembly
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2017-2018

Senator Eklund
Cosponsors: Senators Yuko, Schiavoni

A BILL

To amend sections 1751.62, 3923.52, and 3923.54 of the Revised Code to include tomosynthesis as part of required screening mammography benefits under health insurance policies.

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

Section 1. That sections 1751.62, 3923.52, and 3923.54 of the Revised Code be amended to read as follows:

Sec. 1751.62. (A) As used in this section:

(1) "Screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, tomosynthesis, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic

mammography.

(2) "Medicare reimbursement rate" means the reimbursement rate paid in Ohio under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(B) Every individual or group health insuring corporation policy, contract, or agreement providing basic health care services that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(C) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under

sixty-five years of age, one screening mammography every year.

(D)(1) Subject to divisions (D)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

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

(3) The benefit paid in accordance with division (D)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive remuneration in excess of the payment made in accordance with division (D)(1) of this section, except for approved deductibles and copayments.

(E) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a health care facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(F) The benefits provided under divisions (B)(1) and (2) of this section shall be provided according to the terms of the subscriber contract.

(G) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. 3923.52. (A) As used in this section and section 3923.53 of the Revised Code, "screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, tomosynthesis, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(B) Every policy of individual or group sickness and accident insurance that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(C) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(D) As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (D)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for

the benefit provided under division (B)(1) of this section, the total benefit for a screening mammography shall not exceed one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

(3) The benefit paid in accordance with division (D)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive compensation in excess of the payment made in accordance with division (D)(1) of this section, except for approved deductibles and copayments.

(E) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(F) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

(G) This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, or other policy that offers only supplemental benefits.

Sec. 3923.54. (A) As used in this section, "screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography including, but not limited to, tomosynthesis, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(B) Each employer in this state that provides, in whole or in part, health care benefits for its employees under a policy of sickness and accident insurance issued in accordance with Chapter 3923. of the Revised Code shall also provide to its employees benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(C) An employer may comply with division (B) of this section in any of the following ways:

(1) By providing the benefits under a health insuring corporation contract issued in accordance with Chapter 1751. of the Revised Code or a policy of sickness and accident insurance issued in accordance with Chapter 3923. of the Revised Code;

(2) By reimbursing the employee for the direct health care

provider charges associated with receipt of the covered service;

(3) By making any other arrangement that provides the benefits described in division (B) of this section.

(D) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(E) As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (E)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in

an amount that corresponds to the ratio paid by medicare in this state for that component.

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

(3) The benefit paid in accordance with division (E)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive compensation in excess of the payment made in accordance with division (E)(1) of this section, except for approved deductibles and copayments.

(F) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(G) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Section 2. That existing sections 1751.62, 3923.52, and

3923.54 of the Revised Code are hereby repealed.