

As Reported by the Senate Health Committee

134th General Assembly

Regular Session

2021-2022

Am. H. B. No. 371

Representatives Schmidt, Denson

Cosponsors: Representatives Galonski, Troy, Weinstein, Miller, J., Ingram, Creech, Abrams, Pavliga, White, Miranda, O'Brien, Bird, Miller, K., Ghanbari, Young, T., Hoops, Lampton, John, Liston, Click, Edwards, Ginter, Grendell, Baldrige, Blackshear, Boggs, Boyd, Brent, Brown, Callender, Carfagna, Carruthers, Crossman, Cutrona, Fraizer, Gross, Hall, Hicks-Hudson, Humphrey, Jarrells, Jones, Kelly, Koehler, Lanese, Leland, Lightbody, Loychik, Manning, Miller, A., Oelslager, Plummer, Robinson, Russo, Sheehy, Skindell, Smith, M., Sobecki, Stein, Sweeney, Sykes, Upchurch, West, Wilkin, Young, B., Speaker Cupp

Senator Huffman, S.

A BILL

To amend sections 1751.62, 3702.40, 3923.52, 1
3923.53, and 5164.08 of the Revised Code to 2
revise the laws governing coverage of screening 3
mammography and patient notice of dense breast 4
tissue and to make temporary changes regarding 5
certificates of need. 6

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

Section 1. That sections 1751.62, 3702.40, 3923.52, 7
3923.53, and 5164.08 of the Revised Code be amended to read as 8
follows: 9

Sec. 1751.62. (A) As used in this section: 10

(1) "Screening mammography" means a radiologic examination 11
utilized to detect unsuspected breast cancer at an early stage 12

in an asymptomatic woman and includes the x-ray examination of 13
the breast using equipment that is dedicated specifically for 14
mammography, including, but not limited to, the x-ray tube, 15
filter, compression device, screens, film, and cassettes, and 16
that has an average radiation exposure delivery of less than one 17
rad mid-breast. "Screening mammography" includes digital breast 18
tomosynthesis. "Screening mammography" includes two views for 19
each breast. The term also includes the professional 20
interpretation of the film. 21

"Screening mammography" does not include diagnostic 22
mammography. 23

(2) "Medicare reimbursement rate" means the reimbursement 24
rate paid in Ohio under the medicare program for screening 25
mammography that does not include digitization or computer-aided 26
detection, regardless of whether the actual benefit includes 27
digitization or computer-aided detection. 28

(3) "Supplemental breast cancer screening" means any 29
additional screening method deemed medically necessary by a 30
treating health care provider for proper breast cancer screening 31
in accordance with applicable American college of radiology 32
guidelines, including magnetic resonance imaging, ultrasound, or 33
molecular breast imaging. 34

(B) Every Notwithstanding section 3901.71 of the Revised 35
Code, every individual or group health insuring corporation 36
policy, contract, or agreement providing basic health care 37
services that is delivered, issued for delivery, or renewed in 38
this state shall provide benefits for the expenses of ~~both~~ all 39
of the following: 40

(1) ~~Screening mammography to~~ To detect the presence of 41

breast cancer in adult women, screening mammography; 42

(2) ~~Cytologic screening for~~ To detect the presence of 43
breast cancer in adult women meeting either of the conditions 44
described in division (C) (2) of this section, supplemental 45
breast cancer screening; 46

(3) To detect the presence of cervical cancer, cytologic 47
screening. 48

(C) (1) The benefits provided under division (B) (1) of this 49
section shall cover expenses ~~in accordance with all of the~~ 50
~~following:~~ 51

~~(1) If a woman is at least thirty-five years of age but~~ 52
~~under forty years of age, one screening mammography;~~ 53

~~(2) If a woman is at least forty years of age but under~~ 54
~~fifty years of age, either of the following:~~ 55

~~(a) One screening mammography every two years;~~ 56

~~(b) If a licensed physician has determined that the woman~~ 57
~~has risk factors to breast cancer, one screening mammography~~ 58
~~every year.~~ 59

~~(3) If a woman is at least fifty years of age but under~~ 60
~~sixty-five years of age, for one screening mammography every~~ 61
year, including digital breast tomosynthesis. 62

(2) The benefits provided under division (B) (2) of this 63
section shall cover expenses for supplemental breast cancer 64
screening for an adult woman who meets either of the following 65
conditions: 66

(a) The woman's screening mammography demonstrates, based 67
on the breast imaging reporting and data system established by 68

the American college of radiology, that the woman has dense 69
breast tissue; 70

(b) The woman is at an increased risk of breast cancer due 71
to family history, prior personal history of breast cancer, 72
ancestry, genetic predisposition, or other reasons as determined 73
by the woman's health care provider. 74

(D) (1) Subject to divisions (D) (2) and (3) of this 75
section, if a provider, hospital, or other health care facility 76
provides a service that is a component of the screening 77
mammography benefit in division (B) (1) of this section or a 78
component of the supplemental breast cancer screening benefit in 79
division (B) (2) of this section and submits a separate claim for 80
that component, a separate payment shall be made to the 81
provider, hospital, or other health care facility in an amount 82
that corresponds to the ratio paid by medicare in this state for 83
that component. 84

(2) Regardless of whether separate payments are made for 85
the benefit provided under division (B) (1) or (2) of this 86
section, the total benefit for a screening mammography or 87
supplemental breast cancer screening shall not exceed one 88
hundred thirty per cent of the medicare reimbursement rate in 89
this state for screening mammography or supplemental breast 90
cancer screening. If there is more than one medicare 91
reimbursement rate in this state for screening mammography or a 92
component of a screening mammography or supplemental breast 93
cancer screening or a component of supplemental breast cancer 94
screening, the reimbursement limit shall be one hundred thirty 95
per cent of the lowest medicare reimbursement rate in this 96
state. 97

(3) The benefit paid in accordance with division (D) (1) of 98

this section shall constitute full payment. No provider, 99
hospital, or other health care facility shall seek or receive 100
remuneration in excess of the payment made in accordance with 101
division (D) (1) of this section, except for approved deductibles 102
and copayments. 103

(E) The benefits provided under division (B) (1) or (2) of 104
this section shall be provided only for screening mammographies 105
or supplemental breast cancer screenings that are performed in a 106
health care facility or mobile mammography screening unit that 107
is accredited under the American college of radiology 108
mammography accreditation program or in a hospital as defined in 109
section 3727.01 of the Revised Code. 110

(F) The benefits provided under ~~divisions (B) (1) and (2)~~ 111
division (B) of this section shall be provided according to the 112
terms of the subscriber contract. 113

(G) The benefits provided under division ~~(B) (2)~~ (B) (3) of 114
this section shall be provided only for cytologic screenings 115
that are processed and interpreted in a laboratory certified by 116
the college of American pathologists or in a hospital as defined 117
in section 3727.01 of the Revised Code. 118

Sec. 3702.40. (A) As used in this section, "mammogram" and 119
"facility" have the same meanings as in section 263b(a) of the 120
"Mammography Quality Standards Act of 1992," 106 Stat. 3547 121
(1992), 42 U.S.C. 263b(a), as amended. 122

(B) As required by 21 C.F.R. 900.12(c) (2), a facility 123
shall send to each patient who has a mammogram at the facility a 124
summary of the written report containing the results of the 125
patient's mammogram. If, based on the breast imaging reporting 126
and data system established by the American college of 127

radiology, the patient's mammogram demonstrates that the patient 128
has dense breast tissue, the summary shall include the following 129
statement: 130

~~"Your mammogram demonstrates shows that you have dense 131
your breast tissue, which could hide abnormalities is dense. 132
Dense breast tissue, in and of itself, is a relatively very 133
common condition. Therefore, this information is not provided to 134
cause undue concern; rather, it is to raise your awareness and 135
promote discussion with your health care provider regarding the 136
presence of dense breast tissue in addition to other risk 137
factors and is not abnormal. However, dense breast tissue can 138
make it harder to find cancer on a mammogram and also may 139
increase your risk of developing breast cancer. Because you have 140
dense breast tissue, you could benefit from additional imaging 141
tests such as a screening breast ultrasound or breast magnetic 142
resonance imaging. This information about your breast density is 143
being provided to you to raise your awareness. It is important 144
to continue routine screening mammograms and use this 145
information to speak with your health care provider about your 146
own risk for breast cancer. At that time, ask your health care 147
provider if more screening tests might be useful based on your 148
risk. A report of your mammogram results was sent to your health 149
care provider."~~ 150

As required by 21 C.F.R. 900.12(c) (3), the facility shall 151
send to the patient's health care provider, if known, a copy of 152
the written report containing the results of the patient's 153
mammogram not later than thirty days after the mammogram was 154
performed. 155

(C) This section does not do either of the following: 156

(1) Create a new cause of action or substantive legal 157

right against a person, facility, or other entity; 158

(2) Create a standard of care, obligation, or duty for a 159
person, facility, or other entity that would provide the basis 160
for a cause of action or substantive legal right, other than the 161
duty to send the summary and written report described in 162
division (B) of this section. 163

Sec. 3923.52. (A) As used in this section and section 164
3923.53 of the Revised Code, ~~"screening mammography":~~ 165

(1) "Screening mammography" means a radiologic examination 166
utilized to detect unsuspected breast cancer at an early stage 167
in asymptomatic women and includes the x-ray examination of the 168
breast using equipment that is dedicated specifically for 169
mammography, including, but not limited to, the x-ray tube, 170
filter, compression device, screens, film, and cassettes, and 171
that has an average radiation exposure delivery of less than one 172
rad mid-breast. "Screening mammography" includes digital breast 173
tomosynthesis. "Screening mammography" includes two views for 174
each breast. The term also includes the professional 175
interpretation of the film. 176

"Screening mammography" does not include diagnostic 177
mammography. 178

(2) "Supplemental breast cancer screening" means any 179
additional screening method deemed medically necessary by a 180
treating health care provider for proper breast cancer screening 181
in accordance with applicable American college of radiology 182
guidelines, including magnetic resonance imaging, ultrasound, or 183
molecular breast imaging. 184

(B) ~~Every~~ Notwithstanding section 3901.71 of the Revised 185
Code, every policy of individual or group sickness and accident 186

insurance that is delivered, issued for delivery, or renewed in 187
this state shall provide benefits for the expenses of ~~both~~all 188
of the following: 189

(1) ~~Screening mammography to~~To detect the presence of 190
breast cancer in adult women, screening mammography; 191

(2) ~~Cytologic screening for~~To detect the presence of 192
breast cancer in adult women meeting either of the conditions 193
described in division (C) (2) of this section, supplemental 194
breast cancer screening; 195

(3) To detect the presence of cervical cancer, cytologic 196
screening. 197

(C) (1) The benefits provided under division (B) (1) of this 198
section shall cover expenses ~~in accordance with all of the~~ 199
~~following~~: 200

~~(1) If a woman is at least thirty five years of age but~~ 201
~~under forty years of age, one screening mammography;~~ 202

~~(2) If a woman is at least forty years of age but under~~ 203
~~fifty years of age, either of the following:~~ 204

~~(a) One screening mammography every two years;~~ 205

~~(b) If a licensed physician has determined that the woman~~ 206
~~has risk factors to breast cancer, one screening mammography~~ 207
~~every year.~~ 208

~~(3) If a woman is at least fifty years of age but under~~ 209
~~sixty five years of age, for~~ one screening mammography every 210
year, including digital breast tomosynthesis. 211

(2) The benefits provided under division (B) (2) of this 212
section shall cover expenses for supplemental breast cancer 213

screening for an adult woman who meets either of the following 214
conditions: 215

(a) The woman's screening mammography demonstrates, based 216
on the breast imaging reporting and data system established by 217
the American college of radiology, that the woman has dense 218
breast tissue; 219

(b) The woman is at an increased risk of breast cancer due 220
to family history, prior personal history of breast cancer, 221
ancestry, genetic predisposition, or other reasons as determined 222
by the woman's health care provider. 223

(D) As used in this division, "medicare reimbursement 224
rate" means the reimbursement rate paid in this state under the 225
medicare program for screening mammography that does not include 226
digitization or computer-aided detection, regardless of whether 227
the actual benefit includes digitization or computer-aided 228
detection. 229

(1) Subject to divisions (D) (2) and (3) of this section, 230
if a provider, hospital, or other health care facility provides 231
a service that is a component of the screening mammography 232
benefit in division (B) (1) of this section or a component of the 233
supplemental breast cancer screening benefit in division (B) (2) 234
of this section and submits a separate claim for that component, 235
a separate payment shall be made to the provider, hospital, or 236
other health care facility in an amount that corresponds to the 237
ratio paid by medicare in this state for that component. 238

(2) Regardless of whether separate payments are made for 239
the benefit provided under division (B) (1) or (2) of this 240
section, the total benefit for a screening mammography or 241
supplemental breast cancer screening shall not exceed one 242

hundred thirty per cent of the medicare reimbursement rate in 243
this state for screening mammography or supplemental breast 244
cancer screening. If there is more than one medicare 245
reimbursement rate in this state for screening mammography or a 246
component of a screening mammography or supplemental breast 247
cancer screening or a component of supplemental breast cancer 248
screening, the reimbursement limit shall be one hundred thirty 249
per cent of the lowest medicare reimbursement rate in this 250
state. 251

(3) The benefit paid in accordance with division (D) (1) of 252
this section shall constitute full payment. No provider, 253
hospital, or other health care facility shall seek or receive 254
compensation in excess of the payment made in accordance with 255
division (D) (1) of this section, except for approved deductibles 256
and copayments. 257

(E) The benefits provided under division (B) (1) or (2) of 258
this section shall be provided only for screening mammographies 259
or supplemental breast cancer screenings that are performed in a 260
facility or mobile mammography screening unit that is accredited 261
under the American college of radiology mammography 262
accreditation program or in a hospital as defined in section 263
3727.01 of the Revised Code. 264

(F) The benefits provided under division ~~(B) (2)~~ (B) (3) of 265
this section shall be provided only for cytologic screenings 266
that are processed and interpreted in a laboratory certified by 267
the college of American pathologists or in a hospital as defined 268
in section 3727.01 of the Revised Code. 269

(G) This section does not apply to any policy that 270
provides coverage for specific diseases or accidents only, or to 271
any hospital indemnity, medicare supplement, or other policy 272

that offers only supplemental benefits.	273
Sec. 3923.53. (A) Every <u>Notwithstanding section 3901.71 of</u>	274
<u>the Revised Code, every public employee benefit plan that is</u>	275
<u>established or modified in this state shall provide benefits for</u>	276
<u>the expenses of both <u>all</u> of the following:</u>	277
(1) Screening mammography to <u>To detect the presence of</u>	278
<u>breast cancer in adult women, <u>screening mammography;</u></u>	279
(2) Cytologic screening for <u>To detect the presence of</u>	280
<u>breast cancer in adult women meeting any of the conditions</u>	281
<u>described in division (B) (2) of this section, <u>supplemental</u></u>	282
<u>breast cancer screening;</u>	283
(3) <u>To detect the presence of cervical cancer, <u>cytologic</u></u>	284
<u>screening.</u>	285
(B) (1) The benefits provided under division (A) (1) of this	286
section shall cover expenses in accordance with all of the	287
following:	288
(1) If a woman is at least thirty five years of age but	289
under forty years of age, one screening mammography;	290
(2) If a woman is at least forty years of age but under	291
fifty years of age, either of the following:	292
(a) One screening mammography every two years;	293
(b) If a licensed physician has determined that the woman	294
has risk factors to breast cancer, one screening mammography	295
every year.	296
(3) If a woman is at least fifty years of age but under	297
sixty five years of age, <u>for</u> one screening mammography every	298
year, <u>including digital breast tomosynthesis.</u>	299

(2) The benefits provided under division (A) (2) of this section shall cover expenses for supplemental breast cancer screening for an adult woman who meets any of the following conditions: 300
301
302
303

(a) The woman's screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman has dense breast tissue; 304
305
306
307

(b) The woman 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 woman's health care provider. 308
309
310
311

(C) 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. 312
313
314
315
316
317

(1) Subject to divisions (C) (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 (A) (1) of this section or a component of the supplemental breast cancer screening benefit in division (A) (2) 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. 318
319
320
321
322
323
324
325
326

(2) Regardless of whether separate payments are made for the benefit provided under division (A) (1) or (2) of this 327
328

section, the total benefit for a screening mammography or 329
supplemental breast cancer screening shall not exceed one 330
hundred thirty per cent of the medicare reimbursement rate in 331
this state for screening mammography or supplemental breast 332
cancer screening. If there is more than one medicare 333
reimbursement rate in this state for screening mammography or a 334
component of a screening mammography or supplemental breast 335
cancer screening or a component of supplemental breast cancer 336
screening, the reimbursement limit shall be one hundred thirty 337
per cent of the lowest medicare reimbursement rate in this 338
state. 339

(3) The benefit paid in accordance with division (C) (1) of 340
this section shall constitute full payment. No provider, 341
hospital, or other health care facility shall seek or receive 342
compensation in excess of the payment made in accordance with 343
division (C) (1) of this section, except for approved deductibles 344
and copayments. 345

(D) The benefits provided under division (A) (1) or (2) of 346
this section shall be provided only for screening mammographies 347
or supplemental breast cancer screenings that are performed in a 348
facility or mobile mammography screening unit that is accredited 349
under the American college of radiology mammography 350
accreditation program or in a hospital as defined in section 351
3727.01 of the Revised Code. 352

(E) The benefits provided under division ~~(A) (2)~~ (A) (3) of 353
this section shall be provided only for cytologic screenings 354
that are processed and interpreted in a laboratory certified by 355
the college of American pathologists or in a hospital as defined 356
in section 3727.01 of the Revised Code. 357

Sec. 5164.08. (A) As used in this section, ~~"screening"~~ 358

mammography": 359

(1) "Screening mammography" means a radiologic examination 360
utilized to detect unsuspected breast cancer at an early stage 361
in asymptomatic women and includes the x-ray examination of the 362
breast using equipment that is dedicated specifically for 363
mammography, including the x-ray tube, filter, compression 364
device, screens, film, and cassettes, and that has an average 365
radiation exposure delivery of less than one rad mid-breast. 366
"Screening mammography" includes digital breast tomosynthesis. 367
"Screening mammography" includes two views for each breast. The 368
term also includes the professional interpretation of the film. 369

"Screening mammography" does not include diagnostic 370
mammography. 371

(2) "Supplemental breast cancer screening" means any 372
additional screening method deemed medically necessary by a 373
treating health care provider for proper breast cancer screening 374
in accordance with applicable American college of radiology 375
guidelines, including magnetic resonance imaging, ultrasound, or 376
molecular breast imaging. 377

(B) The medicaid program shall cover ~~both~~ all of the 378
following: 379

(1) ~~Screening mammography to~~ To detect the presence of 380
breast cancer in adult women, screening mammography; 381

(2) ~~Cytologic screening for~~ To detect the presence of 382
breast cancer in adult women meeting any of the conditions 383
described in division (C) (2) of this section, supplemental 384
breast cancer screening; 385

(3) To detect the presence of cervical cancer, cytologic 386
screening. 387

~~(C) (1) The medicaid program's coverage of screening mammography pursuant to division (B) (1) of this section shall be provided in accordance with all of the following:~~ 388
389
390

~~(1) If a woman is at least thirty five years of age but under forty years of age, one screening mammography;~~ 391
392

~~(2) If a woman is at least forty years of age but under fifty years of age, either of the following:~~ 393
394

~~(a) One screening mammography every two years;~~ 395

~~(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.~~ 396
397
398

~~(3) If a woman is at least fifty years of age but under sixty five years of age, cover expenses for one screening mammography every year, including digital breast tomosynthesis.~~ 399
400
401

(2) The medicaid program's coverage pursuant to division (B) (2) of this section shall cover expenses for supplemental breast cancer screening for an adult woman who meets any of the following conditions: 402
403
404
405

(a) The woman's screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman has dense breast tissue; 406
407
408
409

(b) The woman 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 woman's health care provider. 410
411
412
413

(D) The medicaid program's coverage of screening mammographies pursuant to division (B) (1) or (2) of this section 414
415

shall be provided only for screening mammographies or 416
supplemental breast cancer screenings that are performed in a 417
facility or mobile mammography screening unit that is accredited 418
under the American college of radiology mammography 419
accreditation program or in a hospital as defined in section 420
3727.01 of the Revised Code. 421

(E) The medicaid program's coverage of cytologic 422
screenings pursuant to division ~~(B) (2)~~ (B) (3) of this section 423
shall be provided only for cytologic screenings that are 424
processed and interpreted in a laboratory certified by the 425
college of American pathologists or in a hospital as defined in 426
section 3727.01 of the Revised Code. 427

Section 2. That existing sections 1751.62, 3702.40, 428
3923.52, 3923.53, and 5164.08 of the Revised Code are hereby 429
repealed. 430

Section 3. Section 1751.62 of the Revised Code, as amended 431
by this act, applies only to arrangements, policies, contracts, 432
and agreements that are created, delivered, issued for delivery, 433
or renewed in this state on or after the effective date of the 434
amendment. Section 3923.52 of the Revised Code, as amended by 435
this act, applies only to policies of sickness and accident 436
insurance delivered, issued for delivery, or renewed in this 437
state on or after the effective date of the amendment. Section 438
3923.53 of the Revised Code, as amended by this act, applies 439
only to public employee benefit plans that are established or 440
modified in this state on or after the effective date of the 441
amendment. 442

Section 4. Notwithstanding division (A) of section 443
3702.523 and divisions (A) and (B) of section 3702.524 of the 444
Revised Code, or any other conflicting provision in sections 445

3702.51 to 3702.62 of the Revised Code, all of the following 446
apply in the case of a certificate of need granted during the 447
period beginning March 9, 2020, and ending June 18, 2021: 448

(A) The Director of Health shall grant the holder of a 449
certificate of need a twenty-four-month extension to obligate 450
capital expenditures and commence construction for a proposed 451
project. The extension shall be effective during the twenty- 452
four-month period immediately following the expiration date of 453
the twenty-four-month period that otherwise would apply, as 454
described in division (A) of section 3702.524 of the Revised 455
Code. The Director shall notify the holder of the certificate of 456
need of the date on which the twenty-four-month extension 457
expires. 458

(B) (1) Subject to division (B) (2) of this section, the 459
transfer of a certificate of need, or the transfer of the 460
controlling interest in an entity that holds a certificate of 461
need, prior to completion of the reviewable activity for which 462
the certificate of need was granted, does not void the 463
certificate of need. 464

(2) In the event of a transfer as described in division 465
(B) (1) of this section, upon receipt of written notice from the 466
transferee that provides sufficient evidence to enable the 467
Director to determine that recognizing the new owner and 468
operator will not cause any of the circumstances specified in 469
division (B) of section 3702.59 of the Revised Code to occur, 470
the Director shall recognize the transfer of ownership of the 471
entity granted the certificate of need to the new owner. 472

Section 5. (A) Subject to division (B) of this section, 473
notwithstanding division (C) (8) of section 3702.52 of the 474
Revised Code and any rules adopted by the Director of Health to 475

the contrary, for a period of twenty-four months after the 476
effective date of this section, the Director of Health shall not 477
impose a civil monetary penalty against any person holding a 478
certificate of need for obligating under the certificate a 479
capital expenditure in an amount between one hundred ten and one 480
hundred fifty per cent of the approved project cost. 481

(B) This section applies to any certificate of need that 482
was granted on or before the effective date of this section and 483
for which the Director of Health is still monitoring the 484
activities of the person granted the certificate. 485