

As Introduced

135th General Assembly

Regular Session

2023-2024

H. B. No. 619

Representatives Schmidt, Denson

A BILL

To amend sections 1751.62, 3923.52, 3923.53, 1
5162.20, and 5164.08 of the Revised Code to 2
revise the law governing insurance and Medicaid 3
coverage of breast cancer screenings and 4
examinations. 5

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

Section 1. That sections 1751.62, 3923.52, 3923.53, 6
5162.20, and 5164.08 of the Revised Code be amended to read as 7
follows: 8

Sec. 1751.62. (A) As used in this section: 9

(1) "Screening mammography" means a radiologic examination 10
that, in accordance with applicable American college of 11
radiology guidelines, is utilized to detect ~~unsuspected~~ breast 12
cancer ~~at an early stage in an asymptomatic woman~~ and includes 13
the x-ray examination of the breast using equipment that is 14
dedicated specifically for mammography, including, but not 15
limited to, the x-ray tube, filter, compression device, screens, 16
film, and cassettes, and that has an average radiation exposure 17
delivery of less than one rad mid-breast. "Screening 18
mammography" includes digital breast tomosynthesis. "Screening 19

mammography" includes two views for each breast. The term also 20
includes the professional 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) "Diagnostic breast examination" means any examination~~ 29
~~that, in accordance with applicable American college of~~ 30
~~radiology guidelines, is deemed medically necessary by a~~ 31
~~treating health care provider to diagnose breast cancer,~~ 32
~~including diagnostic mammography, magnetic resonance imaging,~~ 33
~~ultrasound, or biopsy.~~ 34

(3) "Supplemental breast cancer screening" means any 35
additional screening method deemed medically necessary by a 36
treating health care provider for proper breast cancer screening 37
in accordance with applicable American college of radiology 38
guidelines, including magnetic resonance imaging, ultrasound, 39
contrast enhanced mammography, or molecular breast imaging. 40

(4) "Cost-sharing" means the cost to an enrollee under an 41
individual or group health insuring corporation policy, 42
contract, or agreement according to any coverage limit, 43
copayment, coinsurance, deductible, or other out-of-pocket 44
expense requirements imposed by the policy, contract, or 45
agreement. 46

(B) Notwithstanding section 3901.71 of the Revised Code, 47
every individual or group health insuring corporation policy, 48

contract, or agreement providing basic health care services that 49
is delivered, issued for delivery, or renewed in this state 50
shall provide benefits for the expenses of all of the following: 51

(1) To detect the presence of breast cancer in adult 52
~~women~~individuals, a screening mammography; 53

(2) To detect the presence of breast cancer in adult ~~women~~ 54
individuals meeting either or both of the conditions described 55
in division (C) (2) of this section, supplemental breast cancer 56
screening; 57

(3) To diagnose breast cancer in adult individuals meeting 58
the condition described in division (C) (3) of this section, a 59
diagnostic breast examination; 60

(4) To detect the presence of cervical cancer, cytologic 61
screening. 62

(C) (1) The benefits provided under division (B) (1) of this 63
section shall cover expenses for one screening mammography every 64
year, including digital breast tomosynthesis. 65

(2) The benefits provided under division (B) (2) of this 66
section shall cover expenses for supplemental breast cancer 67
screening for an adult ~~woman~~individual who meets either or both 68
of the following conditions: 69

(a) The ~~woman's~~individual's screening mammography 70
demonstrates, based on the breast imaging reporting and data 71
system established by the American college of radiology, that 72
the ~~woman~~individual has dense breast tissue; 73

(b) The ~~woman~~individual is at an increased risk of breast 74
cancer due to family history, prior personal history of breast 75
cancer, ancestry, genetic predisposition, or other reasons as 76

determined by the ~~woman's~~individual's health care provider. 77

(3) The benefits provided under division (B) (3) of this 78
section shall cover expenses for diagnostic breast examination 79
for an adult individual who has an abnormality seen or suspected 80
from, or detected by, a screening mammography, supplemental 81
breast cancer screening, or another means of examination. 82

(D) (1) Subject to divisions (D) (2) and (3) of this 83
section, if a provider, hospital, or other health care facility 84
provides a service that is a component of ~~the screening~~ 85
~~mammography a benefit in provided under division (B) (1), (2), or~~ 86
~~(3) of this section or a component of the supplemental breast~~ 87
~~cancer screening benefit in division (B) (2) of this section and~~ 88
submits a separate claim for that component, a separate payment 89
shall be made to the provider, hospital, or other health care 90
facility ~~in an amount that corresponds to the ratio paid by~~ 91
~~medicare in this state for that component.~~ 92

~~(2) Regardless of whether separate payments are made for~~ 93
~~the~~The total benefit provided under division (B) (1), ~~or~~ (2), or 94
(3) of this section, the total benefit for a screening 95
~~mammography or supplemental breast cancer screening shall not~~ 96
~~exceed one hundred thirty per cent of the medicare reimbursement~~ 97
~~rate in this state for screening mammography or supplemental~~ 98
~~breast cancer screening. If there is more than one medicare~~ 99
~~reimbursement rate in this state for screening mammography or a~~ 100
~~component of a screening mammography or supplemental breast~~ 101
~~cancer screening or a component of supplemental breast cancer~~ 102
~~screening, the reimbursement limit shall be one hundred thirty~~ 103
~~per cent of the lowest medicare~~and any separate payment for a 104
service that is a component of such a benefit under division (D) 105
(1) of this section, shall not be less than any reimbursement 106

rate previously paid by the same individual or group health 107
insuring corporation under a policy, contract, or agreement 108
providing basic health care services that is delivered, issued 109
for delivery, or renewed in this state after the effective date 110
of this amendment to the same provider, hospital, or other 111
health care facility for the same benefit or service that is a 112
component of such benefit. 113

(3) The benefit paid in accordance with ~~division~~ divisions 114
(D) (1) and (2) of this section shall constitute full payment. No 115
provider, hospital, or other health care facility shall seek or 116
receive remuneration in excess of the payment made in accordance 117
with ~~division~~ divisions (D) (1) and (2) of this section, ~~except~~ 118
~~for approved deductibles and copayments.~~ 119

~~(E) The~~ (E) (1) Except as provided in division (E) (2) of 120
this section, the benefits provided under division (B) (1) ~~or,~~ 121
(2), ~~or~~ (3) of this section shall be provided only for screening 122
mammographies ~~or,~~ supplemental breast cancer screenings, ~~or~~ 123
diagnostic breast examinations that are performed in a health 124
care facility or mobile mammography screening unit that is 125
accredited under the American college of radiology mammography 126
accreditation program or in a hospital as defined in section 127
3727.01 of the Revised Code. 128

(2) With respect to diagnostic breast examinations that 129
are biopsies, the policy shall not, as a condition of coverage, 130
require biopsies to be performed in a facility, mobile 131
mammography screening unit, or hospital as described in division 132
(E) (1) of this section. 133

(F) The benefits provided under division (B) of this 134
section shall be provided according to the terms of the 135
subscriber contract. 136

(G) The benefits provided under division ~~(B) (3)~~ (B) (4) of 137
this section shall be provided only for cytologic screenings 138
that are processed and interpreted in a laboratory certified by 139
the college of American pathologists or in a hospital as defined 140
in section 3727.01 of the Revised Code. 141

(H) No individual or group health insuring corporation 142
policy, contract, or agreement providing basic health care 143
services that is delivered, issued for delivery, or renewed in 144
this state shall impose a cost-sharing requirement for the 145
benefits provided under division (B) of this section. 146

Sec. 3923.52. (A) As used in this section and section 147
3923.53 of the Revised Code: 148

(1) "Screening mammography" means a radiologic examination 149
that, in accordance with applicable American college of 150
radiology guidelines, is utilized to detect ~~unsuspected~~ breast 151
cancer ~~at an early stage in asymptomatic women~~ and includes the 152
x-ray examination of the breast using equipment that is 153
dedicated specifically for mammography, including, but not 154
limited to, the x-ray tube, filter, compression device, screens, 155
film, and cassettes, and that has an average radiation exposure 156
delivery of less than one rad mid-breast. "Screening 157
mammography" includes digital breast tomosynthesis. "Screening 158
mammography" includes two views for each breast. The term also 159
includes the professional interpretation of the film. 160

"Screening mammography" does not include diagnostic 161
mammography. 162

(2) "Diagnostic breast examination" means any examination 163
that, in accordance with applicable American college of 164
radiology guidelines, is deemed medically necessary by a 165

treating health care provider to diagnose breast cancer, 166
including diagnostic mammography, magnetic resonance imaging, 167
ultrasound, or biopsy. 168

(3) "Cost-sharing" means the cost to an individual insured 169
under an individual or group policy of sickness and accident 170
insurance or a public employee benefit plan according to any 171
coverage limit, copayment, coinsurance, deductible, or other 172
out-of-pocket expense requirements imposed by the policy or 173
plan. 174

(4) "Supplemental breast cancer screening" means any 175
additional screening method deemed medically necessary by a 176
treating health care provider for proper breast cancer screening 177
in accordance with applicable American college of radiology 178
guidelines, including magnetic resonance imaging, ultrasound, 179
contrast enhanced mammography, or molecular breast imaging. 180

(B) Notwithstanding section 3901.71 of the Revised Code, 181
every policy of individual or group sickness and accident 182
insurance that is delivered, issued for delivery, or renewed in 183
this state shall provide benefits for the expenses of all of the 184
following: 185

(1) To detect the presence of breast cancer in adult 186
~~women~~individuals, a screening mammography; 187

(2) To detect the presence of breast cancer in adult ~~women~~ 188
individuals meeting either or both of the conditions described 189
in division (C) (2) of this section, supplemental breast cancer 190
screening; 191

(3) To diagnose breast cancer in adult individuals meeting 192
the condition described in division (C) (3) of this section, a 193
diagnostic breast examination; 194

| | |
|---|--|
| <u>(4)</u> To detect the presence of cervical cancer, cytologic screening. | 195 196 |
| (C) (1) The benefits provided under division (B) (1) of this section shall cover expenses for one screening mammography every year, including digital breast tomosynthesis. | 197 198 199 |
| (2) The benefits provided under division (B) (2) of this section shall cover expenses for supplemental breast cancer screening for an adult woman <u>individual</u> who meets either <u>or both</u> of the following conditions: | 200 201 202 203 |
| (a) The woman's <u>individual's</u> screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman <u>individual</u> has dense breast tissue; | 204 205 206 207 |
| (b) The woman <u>individual</u> 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 <u>individual's</u> health care provider. | 208 209 210 211 |
| <u>(3) The benefits provided under division (B) (3) of this section shall 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.</u> | 212 213 214 215 216 |
| (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. | 217 218 219 220 221 222 |
| (1) <u>(D) (1)</u> Subject to divisions (D) (2) and (3) of this | 223 |

section, if a provider, hospital, or other health care facility 224
provides a service that is a component of ~~the screening~~ 225
~~mammography a benefit in provided under division (B) (1), (2), or~~ 226
(3) of this section ~~or a component of the supplemental breast~~ 227
~~cancer screening benefit in division (B) (2) of this section and~~ 228
submits a separate claim for that component, a separate payment 229
shall be made to the provider, hospital, or other health care 230
facility ~~in an amount that corresponds to the ratio paid by~~ 231
~~medicare in this state for that component.~~ 232

(2) ~~Regardless of whether separate payments are made for~~ 233
~~the~~ The total benefit provided under division (B) (1), ~~or~~ (2), or 234
(3) of this section, the total benefit for a screening 235
~~mammography or supplemental breast cancer screening shall not~~ 236
~~exceed one hundred thirty per cent of the medicare reimbursement~~ 237
~~rate in this state for screening mammography or supplemental~~ 238
~~breast cancer screening. If there is more than one medicare~~ 239
~~reimbursement rate in this state for screening mammography or a~~ 240
~~component of a screening mammography or supplemental breast~~ 241
~~cancer screening or a component of supplemental breast cancer~~ 242
~~screening, the reimbursement limit shall be one hundred thirty~~ 243
~~per cent of the lowest medicare and any separate payment for a~~ 244
service that is a component of such a benefit under division (D) 245
(1) of this section, shall not be less than any reimbursement 246
rate previously paid by the same insurer under a policy of 247
individual or group sickness and accident insurance that is 248
delivered, issued for delivery, or renewed in this state after 249
the effective date of this amendment to the same provider, 250
hospital, or other health care facility for the same benefit or 251
service that is a component of such benefit. 252

(3) The benefit paid in accordance with ~~division~~ divisions 253
(D) (1) and (2) of this section shall constitute full payment. No 254

provider, hospital, or other health care facility shall seek or 255
receive compensation in excess of the payment made in accordance 256
with ~~division~~ divisions (D) (1) and (2) of this section, ~~except~~ 257
~~for approved deductibles and copayments.~~ 258

~~(E) The~~ (E) (1) Except as provided in division (E) (2) of 259
this section, the benefits provided under division (B) (1) ~~or~~, 260
(2), ~~or~~ (3) of this section shall be provided only for screening 261
mammographies ~~or~~, supplemental breast cancer screenings, ~~or~~ 262
diagnostic breast examinations that are performed in a facility 263
or mobile mammography screening unit that is accredited under 264
the American college of radiology mammography accreditation 265
program or in a hospital as defined in section 3727.01 of the 266
Revised Code. 267

(2) With respect to diagnostic breast examinations that 268
are biopsies, the policy shall not, as a condition of coverage, 269
require biopsies to be performed in a facility, mobile 270
mammography screening unit, or hospital as described in division 271
(E) (1) of this section. 272

(F) The benefits provided under division ~~(B) (3)~~ (B) (4) of 273
this section shall be provided only for cytologic screenings 274
that are processed and interpreted in a laboratory certified by 275
the college of American pathologists or in a hospital as defined 276
in section 3727.01 of the Revised Code. 277

(G) No policy of individual or group sickness and accident 278
insurance that is delivered, issued for delivery, or renewed in 279
this state shall impose a cost-sharing requirement for the 280
benefits provided under division (B) of this section. 281

(H) This section does not apply to any policy that 282
provides coverage for specific diseases or accidents only, or to 283

any hospital indemnity, medicare supplement, or other policy 284
that offers only supplemental benefits. 285

Sec. 3923.53. (A) Notwithstanding section 3901.71 of the 286
Revised Code, every public employee benefit plan that is 287
established or modified in this state shall provide benefits for 288
the expenses of all of the following: 289

(1) To detect the presence of breast cancer in adult 290
~~women~~individuals, a screening mammography; 291

(2) To detect the presence of breast cancer in adult ~~women~~ 292
individuals meeting ~~any~~either or both of the conditions 293
described in division (B) (2) of this section, supplemental 294
breast cancer screening; 295

(3) To diagnose breast cancer in adult individuals meeting 296
the condition described in division (B) (3) of this section, a 297
diagnostic breast examination; 298

(4) To detect the presence of cervical cancer, cytologic 299
screening. 300

(B) (1) The benefits provided under division (A) (1) of this 301
section shall cover expenses for one screening mammography every 302
year, including digital breast tomosynthesis. 303

(2) The benefits provided under division (A) (2) of this 304
section shall cover expenses for supplemental breast cancer 305
screening for an adult ~~woman~~individual who meets ~~any~~either or 306
both of the following conditions: 307

(a) The ~~woman's~~individual's screening mammography 308
demonstrates, based on the breast imaging reporting and data 309
system established by the American college of radiology, that 310
the ~~woman~~individual has dense breast tissue; 311

(b) The ~~woman~~individual is at an increased risk of breast 312
cancer due to family history, prior personal history of breast 313
cancer, ancestry, genetic predisposition, or other reasons as 314
determined by the ~~woman's~~individual's health care provider. 315

(3) The benefits provided under division (B) (3) of this 316
section shall cover expenses for diagnostic breast examination 317
for an adult individual who has an abnormality seen or suspected 318
from, or detected by, a screening mammography, supplemental 319
breast cancer screening, or another means of examination. 320

~~(C) As used in this division, "medicare reimbursement 321~~
~~rate" means the reimbursement rate paid in this state under the 322~~
~~medicare program for screening mammography that does not include 323~~
~~digitization or computer-aided detection, regardless of whether 324~~
~~the actual benefit includes digitization or computer-aided 325~~
~~detection. 326~~

~~(1) (C) (1) Subject to divisions (C) (2) and (3) of this 327~~
~~section, if a provider, hospital, or other health care facility 328~~
~~provides a service that is a component of the screening 329~~
~~mammography a benefit is provided under division (A) (1), (2), or 330~~
~~(3) of this section or a component of the supplemental breast 331~~
~~cancer screening benefit in division (A) (2) of this section and 332~~
~~submits a separate claim for that component, a separate payment 333~~
~~shall be made to the provider, hospital, or other health care 334~~
~~facility in an amount that corresponds to the ratio paid by 335~~
~~medicare in this state for that component. 336~~

~~(2) Regardless of whether separate payments are made for 337~~
~~the The total benefit provided under division (A) (1), or (2), or 338~~
~~(3) of this section, the total benefit for a screening 339~~
~~mammography or supplemental breast cancer screening shall not 340~~
~~exceed one hundred thirty per cent of the medicare reimbursement 341~~

~~rate in this state for screening mammography or supplemental- 342
breast cancer screening. If there is more than one medicare- 343
reimbursement rate in this state for screening mammography or a 344
component of a screening mammography or supplemental breast- 345
cancer screening or a component of supplemental breast cancer- 346
screening, the reimbursement limit shall be one hundred thirty- 347
per cent of the lowest medicare and any separate payment for a 348
service that is a component of such a benefit under division (D) 349
(1) of this section, shall not be less than any reimbursement 350
rate previously paid by the same insurer under a public employee 351
benefit plan that is delivered, issued for delivery, or renewed 352
in this state after the effective date of this amendment to the 353
same provider, hospital, or other health care facility for the 354
same benefit or service that is a component of such benefit. 355~~

(3) The benefit paid in accordance with ~~division~~ divisions 356
(C) (1) and (2) of this section shall constitute full payment. No 357
provider, hospital, or other health care facility shall seek or 358
receive compensation in excess of the payment made in accordance 359
with ~~division~~ divisions (C) (1) and (2) of this section, ~~except- 360
for approved deductibles and copayments. 361~~

~~(D)~~ The (D) (1) Except as provided in division (D) (2) of 362
this section, the benefits provided under division (A) (1) ~~or,~~ 363
(2), or (3) of this section shall be provided only for screening 364
mammographies ~~or,~~ supplemental breast cancer screenings, or 365
diagnostic breast examinations that are performed in a facility 366
or mobile mammography screening unit that is accredited under 367
the American college of radiology mammography accreditation 368
program or in a hospital as defined in section 3727.01 of the 369
Revised Code. 370

(2) With respect to diagnostic breast examinations that 371

are biopsies, the public employee benefit plan shall not, as a 372
condition of coverage, require biopsies to be performed in a 373
facility, mobile mammography screening unit, or hospital as 374
described in division (D) (1) of this section. 375

(E) The benefits provided under division ~~(A) (3)~~ (A) (4) of 376
this section shall be provided only for cytologic screenings 377
that are processed and interpreted in a laboratory certified by 378
the college of American pathologists or in a hospital as defined 379
in section 3727.01 of the Revised Code. 380

(F) No public employee benefit plan that is established or 381
modified in this state shall impose a cost-sharing requirement 382
for the benefits provided under division (A) of this section. 383

Sec. 5162.20. (A) The department of medicaid shall 384
institute cost-sharing requirements for the medicaid program. 385
The department shall not institute cost-sharing requirements in 386
a manner that does either of the following: 387

(1) Disproportionately impacts the ability of medicaid 388
recipients with chronic illnesses to obtain medically necessary 389
medicaid services; 390

(2) Violates section 5164.08, 5164.09, or 5164.10 of the 391
Revised Code. 392

(B) (1) No provider shall refuse to provide a service to a 393
medicaid recipient who is unable to pay a required copayment for 394
the service. 395

(2) Division (B) (1) of this section shall not be 396
considered to do either of the following with regard to a 397
medicaid recipient who is unable to pay a required copayment: 398

(a) Relieve the medicaid recipient from the obligation to 399

pay a copayment; 400

(b) Prohibit the provider from attempting to collect an 401
unpaid copayment. 402

(C) Except as provided in division (F) of this section, no 403
provider shall waive a medicaid recipient's obligation to pay 404
the provider a copayment. 405

(D) No provider or drug manufacturer, including the 406
manufacturer's representative, employee, independent contractor, 407
or agent, shall pay any copayment on behalf of a medicaid 408
recipient. 409

(E) If it is the routine business practice of a provider 410
to refuse service to any individual who owes an outstanding debt 411
to the provider, the provider may consider an unpaid copayment 412
imposed by the cost-sharing requirements as an outstanding debt 413
and may refuse service to a medicaid recipient who owes the 414
provider an outstanding debt. If the provider intends to refuse 415
service to a medicaid recipient who owes the provider an 416
outstanding debt, the provider shall notify the recipient of the 417
provider's intent to refuse service. 418

(F) In the case of a provider that is a hospital, the 419
cost-sharing program shall permit the hospital to take action to 420
collect a copayment by providing, at the time services are 421
rendered to a medicaid recipient, notice that a copayment may be 422
owed. If the hospital provides the notice and chooses not to 423
take any further action to pursue collection of the copayment, 424
the prohibition against waiving copayments specified in division 425
(C) of this section does not apply. 426

(G) The department of medicaid may collaborate with a 427
state agency that is administering, pursuant to a contract 428

entered into under section 5162.35 of the Revised Code, one or 429
more components, or one or more aspects of a component, of the 430
medicaid program as necessary for the state agency to apply the 431
cost-sharing requirements to the components or aspects of a 432
component that the state agency administers. 433

Sec. 5164.08. (A) As used in this section: 434

(1) "Diagnostic breast examination" means any examination 435
that, in accordance with applicable American college of 436
radiology guidelines, is deemed medically necessary by a 437
treating health care provider to diagnose breast cancer, 438
including diagnostic mammography, magnetic resonance imaging, 439
ultrasound, or biopsy. 440

(2) "Screening mammography" means a radiologic examination 441
that, in accordance with applicable American college of 442
radiology guidelines, is utilized to detect ~~unsuspected~~ breast 443
cancer at an early stage in asymptomatic women and includes the 444
x-ray examination of the breast using equipment that is 445
dedicated specifically for mammography, including the x-ray 446
tube, filter, compression device, screens, film, and cassettes, 447
and that has an average radiation exposure delivery of less than 448
one rad mid-breast. "Screening mammography" includes digital 449
breast tomosynthesis. "Screening mammography" includes two views 450
for each breast. The term also includes the professional 451
interpretation of the film. 452

"Screening mammography" does not include diagnostic 453
mammography. 454

~~(2)~~ (3) "Supplemental breast cancer screening" means any 455
additional screening method deemed medically necessary by a 456
treating health care provider for proper breast cancer screening 457

in accordance with applicable American college of radiology 458
guidelines, including magnetic resonance imaging, ultrasound, 459
contrast enhanced mammography, or molecular breast imaging. 460

(B) The medicaid program shall cover all of the following: 461

(1) To detect the presence of breast cancer in adult 462
~~women~~individuals, screening mammography; 463

(2) To detect the presence of breast cancer in adult ~~women~~ 464
individuals meeting any either or both of the conditions 465
described in division (C) (2) of this section, supplemental 466
breast cancer screening; 467

(3) To diagnose breast cancer in adult individuals meeting 468
the condition described in division (C) (3) of this section, 469
diagnostic breast examination; 470

(4) To detect the presence of cervical cancer, cytologic 471
screening. 472

(C) (1) The medicaid program's coverage pursuant to 473
division (B) (1) of this section shall cover expenses for one 474
screening mammography every year, including digital breast 475
tomosynthesis. 476

(2) The medicaid program's coverage pursuant to division 477
(B) (2) of this section shall cover expenses for supplemental 478
breast cancer screening for an adult ~~woman~~individual who meets 479
~~any either or both~~ of the following conditions: 480

(a) The ~~woman's~~individual's screening mammography 481
demonstrates, based on the breast imaging reporting and data 482
system established by the American college of radiology, that 483
the ~~woman~~individual has dense breast tissue; 484

(b) The ~~woman~~individual is at an increased risk of breast 485

cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the ~~woman's~~ individual's health care provider.

(3) The medicaid program's coverage pursuant to division (B) (3) of this section shall cover expenses for diagnostic breast examination for an adult individual who has an abnormality seen or suspected from, or detected by, any of the following: screening mammography, supplemental breast cancer screening, or another means of examination.

(D) The medicaid program shall not impose cost-sharing requirements on the coverage described in division (B) of this section.

(E) (1) Except as provided in division (E) (2) of this section, the medicaid program's coverage of screening mammographies pursuant to division (B) (1) ~~or, (2), or (3)~~ of this section shall be provided only for screening mammographies ~~or, supplemental breast cancer screenings, or diagnostic breast examinations~~ 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.

(2) With respect to diagnostic breast examinations that are biopsies, the medicaid program shall not, as a condition of coverage, require biopsies to be performed in a facility, mobile mammography screening unit, or hospital as described in division (E) (1) of this section.

~~(E)~~ (F) The medicaid program's coverage of cytologic screenings pursuant to division ~~(B) (3)~~ (B) (4) of this section shall be provided only for cytologic screenings that are

processed and interpreted in a laboratory certified by the 515
college of American pathologists or in a hospital as defined in 516
section 3727.01 of the Revised Code. 517

Section 2. That existing sections 1751.62, 3923.52, 518
3923.53, 5162.20, and 5164.08 of the Revised Code are hereby 519
repealed. 520

Section 3. Section 1751.62 of the Revised Code, as amended 521
by this act, applies only to arrangements, policies, contracts, 522
and agreements that are created, delivered, issued for delivery, 523
or renewed in this state on or after the effective date of the 524
amendment. Section 3923.52 of the Revised Code, as amended by 525
this act, applies only to policies of sickness and accident 526
insurance delivered, issued for delivery, or renewed in this 527
state on or after the effective date of the amendment. Section 528
3923.53 of the Revised Code, as amended by this act, applies 529
only to public employee benefit plans that are established or 530
modified in this state on or after the effective date of the 531
amendment. 532

Section 4. (A) As used in this section: 533

(1) "Health plan issuer" has the same meaning as in 534
section 3922.01 of the Revised Code. 535

(2) "Hospital" has the same meaning as in section 3722.01 536
of the Revised Code. 537

(3) "Physician" means an individual authorized under 538
Chapter 4731. of the Revised Code to practice medicine and 539
surgery or osteopathic medicine and surgery. 540

(B) Not later than three months after the effective date 541
of this section, all of the following apply: 542

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| (1) The Director of Health shall notify each hospital and physician of this act's enactment. | 543 544 |
| (2) The Superintendent of Insurance shall notify each health plan issuer of this act's enactment. | 545 546 |
| (3) The notice shall be completed by certified mail. | 547 |
| (C) When notifying a health plan issuer, hospital, or physician under this section, the Director or Superintendent shall summarize the provisions of sections 1751.62, 3923.52, 3923.53, 5162.20, and 5164.08 of the Revised Code, each as amended by this act, and shall describe the act's impact on those provisions. | 548 549 550 551 552 553 |
| (D) The Director of Health may consult with the State Medical Board of Ohio to assist the Director in identifying physicians and determining their business addresses for purposes of satisfying the notice requirements of this section. | 554 555 556 557 |