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, 5162.20, and 5164.08 of the Revised Code to revise the law governing insurance and Medicaid coverage of breast cancer screenings and examinations.

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

Section 1. That sections 1751.62, 3923.52, 3923.53, 5162.20, and 5164.08 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 that, in accordance with applicable American college of radiology guidelines, is 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, 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 digital breast tomosynthesis. "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~~.

~~(3)~~ "Diagnostic breast examination" means any examination that, in accordance with applicable American college of radiology guidelines, is deemed medically necessary by a treating health care provider to diagnose breast cancer, including diagnostic mammography, magnetic resonance imaging, ultrasound, or biopsy.

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

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

(B) Notwithstanding section 3901.71 of the Revised Code, 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 all of the following:

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

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

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

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

(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.

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

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

(b) The ~~woman~~ individual 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~~ individual's health care provider.

(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.

(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~~ a benefit ~~in~~ provided under division (B)(1), (2), or (3) of this section ~~or a component of the supplemental breast cancer screening benefit in division (B)(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~~.

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

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

(3) The benefit paid in accordance with ~~division~~ divisions (D)(1) and (2) 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~~ divisions (D)(1) and (2) of this section~~, except for approved deductibles and copayments~~.

~~(E) The~~ (E)(1) Except as provided in division (E)(2) of this section, the benefits provided under 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 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.

(2) With respect to diagnostic breast examinations that are biopsies, the policy 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.

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

(G) The benefits provided under 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 college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

(H) No 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 impose a cost-sharing requirement for the benefits provided under division (B) of this section.

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

(1) "Screening mammography" means a radiologic examination that, in accordance with applicable American college of radiology guidelines, is 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, 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 digital breast tomosynthesis. "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) "Diagnostic breast examination" means any examination that, in accordance with applicable American college of radiology guidelines, is deemed medically necessary by a

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

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

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

(B) Notwithstanding section 3901.71 of the Revised Code, 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 all of the following:

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

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

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

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

(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.

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

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

(b) The ~~woman~~ individual 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~~ individual's health care provider.

(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.

~~(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)~~ (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~~ a benefit ~~in~~ provided under division (B)(1), (2), or (3) of this section ~~or a component of the supplemental breast cancer screening benefit in division (B)(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~~.

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

(3) The benefit paid in accordance with ~~division~~ divisions (D)(1) and (2) 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~~ divisions (D)(1) and (2) of this section~~, except for approved deductibles and copayments~~.

~~(E) The~~ (E)(1) Except as provided in division (E)(2) of this section, the benefits provided under 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 policy 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.

(F) The benefits provided under 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 college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

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

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

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

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

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

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

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

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

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

(b) The ~~woman~~ individual 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~~ individual's health care provider.

(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.

~~(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~~.

~~(1)~~ (C)(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~~ a benefit ~~in~~ provided under division (A)(1), (2), or (3) 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~~.

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

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

(3) The benefit paid in accordance with ~~division~~ divisions (C)(1) and (2) 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~~ divisions (C)(1) and (2) of this section~~, except for approved deductibles and copayments~~.

~~(D) The~~(D)(1) Except as provided in division (D)(2) of this section, the benefits provided under division (A)(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 public employee benefit plan 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 (D)(1) of this section.

(E) The benefits provided under division ~~(A)(3)~~ (A)(4) 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.

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

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

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

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

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

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

(a) Relieve the medicaid recipient from the obligation to

pay a copayment;

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

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

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

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

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

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

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

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

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

(2) "Screening mammography" means a radiologic examination that, in accordance with applicable American college of radiology guidelines, is 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 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 digital breast tomosynthesis. "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)~~ (3) "Supplemental breast cancer screening" means any additional screening method deemed medically necessary by a treating health care provider for proper breast cancer screening

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

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

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

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

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

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

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

(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~~ individual who meets ~~any~~ either or both of the following conditions:

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

(b) The ~~woman~~ individual 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~~ 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 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, 3923.53, 5162.20, and 5164.08 of the Revised Code are hereby repealed.

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

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

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

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

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

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

(1) The Director of Health shall notify each hospital and physician of this act's enactment.

(2) The Superintendent of Insurance shall notify each health plan issuer of this act's enactment.

(3) The notice shall be completed by certified mail.

(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.

(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.