

**As Introduced**

**135th General Assembly**

**Regular Session**

**2023-2024**

**H. B. No. 619**

**Representatives Schmidt, Denson**

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**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 <del>woman</del> <u>individual</u> who meets either <u>or both</u> of the following conditions:	200 201 202 203
(a) The <del>woman's</del> <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 <del>woman</del> <u>individual</u> has dense breast tissue;	204 205 206 207
(b) The <del>woman</del> <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 <del>woman's</del> <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
<del>(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.</del>	217 218 219 220 221 222
<del>(1)</del> <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 in 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, 365  
supplemental breast cancer screenings, or 366  
diagnostic breast examinations~~ that are performed in a facility 367  
or mobile mammography screening unit that is accredited under 368  
the American college of radiology mammography accreditation 369  
program or in a hospital as defined in section 3727.01 of the 370  
Revised Code. 371

(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

(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