GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

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SENATE BILL 310*
Human Resources Committee Substitute Adopted 5/13/91

Short Title: Mammogram/Pap Smear Coverage. (Public)

Sponsors:

Referred to:

March 27, 1991

A BILL TO BE ENTITLED

AN ACT TO REQUIRE MAMMOGRAM AND PAP SMEAR COVERAGE IN HEALTH AND ACCIDENT INSURANCE POLICIES, IN HOSPITAL OR MEDICAL SERVICES PLANS, IN HMO PLANS, AND IN THE STATE EMPLOYEES COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-51-57. Coverage for mammograms and pap smears.**

(a) Every policy or contract of accident or health insurance, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for pap smears and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to other services covered under the policy, contract, or plan shall apply to coverage for pap smears and low-dose screening mammography.

(b) As used in this section, 'low-dose screening mammography' means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
a. The woman has a personal history of breast cancer;
b. The woman has a personal history of biopsy-proven benign breast disease;
c. The woman's mother, sister, or daughter has or has had breast cancer; or
d. The woman has not given birth prior to the age of 30;
(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;
(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and
(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards. Mammography accreditation standards shall be those established by the North Carolina Medical Care Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective. Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.

(e) Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursement for laboratory fees for screening pap smears shall be made only if the laboratory meets screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening pap smears shall apply until Medical Care Commission standards become effective. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered."

Sec. 2. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-92. Coverage for mammograms and pap smears.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider contract, policy, or plan as defined and regulated under G.S.

58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for pap smears and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to other services covered under the certificate or contract shall apply to coverage for pap smears and low-dose screening mammography.

(b) As used in this section, 'low-dose screening mammography' means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;

b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or

d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for mammograms authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards. Mammography accreditation standards shall be those established by the North Carolina Medical Care Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective. Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.

(e) Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursement for laboratory fees for screening pap smears shall be made only if the laboratory meets screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human

Services for Medicare/Medicaid coverage of screening pap smears shall apply until Medical Care Commission standards become effective. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered."

Sec. 3. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-67-76. Coverage for mammograms and pap smears.**

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1992, that is subject to this Article, shall provide coverage for pap smears and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to other services covered under the plan shall apply to coverage for pap smears and low-dose screening mammography.

(b) As used in this section, 'low-dose screening mammography' means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;

b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or

d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for mammograms authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards. Mammography accreditation standards shall be those established by the North Carolina Medical Care Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective. Facilities that do not meet required mammography accreditation standards shall so

inform the patient or the patient's legally responsible person prior to performing the mammogram.

(e) Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursement for laboratory fees for screening pap smears shall be made only if the laboratory meets screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening pap smears shall apply until Medical Care Commission standards become effective. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered."

Sec. 4. Effective January 1, 1992, G.S. 135-40.6(4) reads as rewritten:

"(4) Outpatient Benefits. – The Plan pays for services rendered in the outpatient department of a hospital, in a doctor's office, in an ambulatory surgical facility, or elsewhere as determined by the Executive Administrator, as follows:

a. Accidental injury: All covered services. Dental services are excluded except for oral surgery specifically listed in subsection (5)c of this section.

b. Operative procedures.

c. All hospital services for radiation therapy, treatment by use of x-rays, radium, cobalt and other radioactive substances.

d. Pathological examinations of tissue removed by resection or biopsy. ~~Routine Pap smears are not covered.~~

e. Charges for diagnostic x-rays, clinical laboratory tests, and other diagnostic tests and procedures such as electrocardiograms and electroencephalograms.

f. Low-dose screening mammography as defined in G.S. 58-51-57(b), and pap smears. Coverage for low-dose screening mammography and for pap smears shall be as follows:

1. One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this sub-subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

I. The woman has a personal history of breast cancer;

II. The woman has a personal history of biopsy-proven benign breast disease;

III. The woman's mother, sister, or daughter has or has had breast cancer; or

IV. The woman has not given birth prior to the age of 30;

2. One baseline mammogram for any woman 35 through 39 years of age, inclusive;

3. A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

4. A mammogram every year for any woman 50 years of age or older.

5. Reimbursement for a mammogram authorized under this sub-subdivision shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards. Mammography accreditation standards shall be those established by the North Carolina Medical Care Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective. Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.

6. Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursement for laboratory fees for screening pap smears shall be made only if the laboratory meets screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening pap smears shall apply until Medical Care Commission standards become effective. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.

Except as provided in sub-subdivision f. of this subdivision, no ~~No~~ benefits are provided for screening examinations and routine physical examinations to assess general health status in the absence of specific symptoms of active illness, routine office visits or for doctor's services for diagnostic procedures covered under surgical benefits."

Sec. 5. G.S. 143B-165 is amended by adding the following new subdivision to read:

"(12) The Commission shall adopt rules, including temporary rules pursuant to G.S. 150B-13, providing for the accreditation of facilities that perform mammography procedures. Accreditation standards shall address, but are not limited to, the quality of mammography equipment used and the skill levels and other qualifications of personnel who administer mammographies and personnel who interpret mammogram results. The Commission's standards shall be no less stringent than those adopted by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography. The Commission shall adopt rules, including temporary rules pursuant to G.S. 150B-13, providing for the accreditation of facilities that perform laboratory tests for screening pap smears. The Commission's standards for laboratory accreditation shall be no less stringent than those adopted by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening pap smears."

Sec. 6. G.S. 58-54-10 is amended by adding the following new subsection to read:

"(e) Notwithstanding coverage provided by Medicare for mammograms and pap smears, every policy in force in this State shall provide coverage at least equal to the coverage required by G.S. 58-51-57."

Sec. 7. Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies.

Sec. 8. This act is effective upon ratification.