

**GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2003**

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**SENATE BILL 388**

Short Title: Update Cervical Cancer Screening Coverage. (Public)

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Sponsors: Senators Foxx; Allran, Apodaca, Bingham, Blake, Brock, Carpenter, Carrington, Dorsett, Forrester, Garrou, Garwood, Gulley, Hagan, Hargett, Hartsell, Horton, Jenkins, Kerr, Kinnaird, Lucas, Queen, Shubert, Sloan, Stevens, Swindell, Thomas, Tillman, and Weinstein.

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Referred to: Health and Human Resources.

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March 12, 2003

A BILL TO BE ENTITLED

1  
2 AN ACT TO UPDATE NORTH CAROLINA GENERAL STATUTES IN RESPONSE  
3 TO RECENT MEDICAL ADVANCES IN SCREENING FOR THE EARLY  
4 DETECTION OF CERVICAL CANCER.

5 The General Assembly of North Carolina enacts:

6 **SECTION 1.** G.S. 58-50-155 reads as rewritten:

7 "**§ 58-50-155. Standard and basic health care plan coverages.**

8 (a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and  
9 approved under G.S. 58-50-125 shall provide coverage for all of the following:

- 10 (1) Mammograms and ~~pap smears~~ examinations and laboratory tests for  
11 screening for the early detection of cervical cancer at least equal to the  
12 coverage required by G.S. 58-51-57.
- 13 (2) Prostate-specific antigen (PSA) tests or equivalent tests for the  
14 presence of prostate cancer at least equal to the coverage required by  
15 G.S. 58-51-58.
- 16 (3) Reconstructive breast surgery resulting from a mastectomy at least  
17 equal to the coverage required by G.S. 58-51-62.
- 18 (4) For a qualified individual, scientifically proven bone mass  
19 measurement for the diagnosis and evaluation of osteoporosis or low  
20 bone mass at least equal to the coverage required by G.S. 58-3-174.
- 21 (5) Prescribed contraceptive drugs or devices that prevent pregnancy and  
22 that are approved by the United States Food and Drug Administration  
23 for use as contraceptives, or outpatient contraceptive services at least  
24 equal to the coverage required by G.S. 58-3-178, if the plan covers  
25 prescription drugs or devices, or outpatient services, as applicable. The

1 same exceptions and exclusions as are provided under G.S. 58-3-178  
2 apply to standard plans developed and approved under G.S. 58-50-125.

3 (6) Colorectal cancer examinations and laboratory tests at least equal to  
4 the coverage required by G.S. 58-3-179.

5 (a1), (a2) Repealed by Session Laws 1999-197, s. 2.

6 (b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans  
7 under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to  
8 cost-effective and life-saving health care services and to cost-effective health care  
9 providers."

10 **SECTION 2.** G.S. 58-51-57 reads as rewritten:

11 "**§ 58-51-57. Coverage for mammograms and ~~pap smears~~. cervical cancer**  
12 **screening.**

13 (a) Every policy or contract of accident or health insurance, and every preferred  
14 provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or  
15 after January 1, 1992, shall provide coverage for ~~pap smears examinations and~~  
16 laboratory tests for screening for the early detection of cervical cancer and for low-dose  
17 screening mammography. The same deductibles, coinsurance, and other limitations as  
18 apply to similar services covered under the policy, contract, or plan shall apply to  
19 coverage for ~~pap smears examinations and laboratory tests for screening for the early~~  
20 detection of cervical cancer and low-dose screening mammography.

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

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

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

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

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

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

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

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

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

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

43 (d) Reimbursement for a mammogram authorized under this section shall be  
44 made only if the facility in which the mammogram was performed meets

1 mammography accreditation standards. Mammography accreditation standards shall be  
2 ~~those standards~~ established by the North Carolina Medical Care Commission unless  
3 ~~such standards are not in effect, in which case standards established by the United States~~  
4 ~~Department of Health and Human Services for Medicare/Medicaid coverage of~~  
5 ~~screening mammography shall apply until Medical Care Commission standards become~~  
6 ~~effective.~~ Commission. Facilities that do not meet required mammography accreditation  
7 standards shall so inform the patient or the patient's legally responsible person prior to  
8 performing the mammogram.

9 (e) ~~Coverage for pap smears shall be provided for pap smears obtained once a~~  
10 ~~year, or more frequently if recommended by a physician. Coverage for the screening for~~  
11 ~~the early detection of cervical cancer shall be in accordance with the most recently~~  
12 ~~published American Cancer Society guidelines. Coverage shall include the examination,~~  
13 ~~the laboratory fee, and the physician's interpretation of the laboratory results.~~  
14 ~~Reimbursements for laboratory fees shall be made only if the laboratory meets~~  
15 ~~accreditation standards adopted by the North Carolina Medical Care Commission. When~~  
16 ~~the screening pap smear accreditation standards adopted by the North Carolina Medical~~  
17 ~~Care Commission become effective, reimbursement for laboratory fees shall be made~~  
18 ~~only if the laboratory meets those standards. Facilities utilizing services of laboratories~~  
19 ~~that do not meet accreditation standards for screening pap smears shall, prior to~~  
20 ~~performing the pap smear examination, inform the patient or the patient's legally~~  
21 ~~responsible person that such laboratory fees will not be covered."~~

22 SECTION 3. G.S. 58-65-92 reads as rewritten:

23 "**§ 58-65-92. Coverage for mammograms and pap smears cervical cancer**  
24 **screening.**

25 (a) Every insurance certificate or subscriber contract under any hospital service  
26 plan or medical service plan governed by this Article and Article 66 of this Chapter, and  
27 every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or  
28 amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~  
29 examinations and laboratory tests for the screening for the early detection of cervical  
30 cancer and for low-dose screening mammography. The same deductibles, coinsurance,  
31 and other limitations as apply to similar services covered under the certificate or  
32 contract shall apply to coverage for ~~pap smears examinations and laboratory tests for the~~  
33 screening for the early detection of cervical cancer and low-dose screening  
34 mammography.

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

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

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

- 1 a. The woman has a personal history of breast cancer;
- 2 b. The woman has a personal history of biopsy-proven benign
- 3 breast disease;
- 4 c. The woman's mother, sister, or daughter has or has had breast
- 5 cancer; or
- 6 d. The woman has not given birth prior to the age of 30;
- 7 (2) One baseline mammogram for any woman 35 through 39 years of age,
- 8 inclusive;
- 9 (3) A mammogram every other year for any woman 40 through 49 years
- 10 of age, inclusive, or more frequently upon recommendation of a
- 11 physician; and
- 12 (4) A mammogram every year for any woman 50 years of age or older.

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

23 (e) ~~Coverage for pap smears shall be provided for pap smears obtained once a~~  
24 ~~year, or more frequently if recommended by a physician. Coverage for the screening for~~  
25 ~~the early detection of cervical cancer shall be in accordance with the most recently~~  
26 ~~published American Cancer Society guidelines. Coverage shall include the examination,~~  
27 ~~the laboratory fee, and the physician's interpretation of the laboratory results.~~  
28 ~~Reimbursements for laboratory fees shall be made only if the laboratory meets~~  
29 ~~accreditation standards adopted by the North Carolina Medical Care Commission. When~~  
30 ~~the screening pap smear accreditation standards adopted by the North Carolina Medical~~  
31 ~~Care Commission become effective, reimbursement for laboratory fees shall be made~~  
32 ~~only if the laboratory meets those standards. Facilities utilizing services of laboratories~~  
33 ~~that do not meet accreditation standards for screening pap smears shall, prior to~~  
34 ~~performing the pap smear examination, inform the patient or the patient's legally~~  
35 ~~responsible person that such laboratory fees will not be covered."~~

36 **SECTION 3.** G.S. 59-67-76 reads as rewritten:

37 (a) Every health care plan written by a health maintenance organization and in  
38 force, issued, renewed, or amended on or after January 1, 1992, that is subject to this  
39 Article, shall provide coverage for pap smears examinations and laboratory tests for the  
40 screening for the early detection of cervical cancer and for low-dose screening  
41 mammography. The same deductibles, coinsurance, and other limitations as apply to  
42 similar services covered under the plan shall apply to coverage for pap smears  
43 examinations and laboratory tests for the screening for the early detection of cervical  
44 cancer and low-dose screening mammography.

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

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

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

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

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

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

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

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

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

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

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

33 (e) ~~Coverage for pap smears shall be provided for pap smears obtained once a~~  
34 ~~year, or more frequently if recommended by a physician. Coverage for the screening for~~  
35 ~~the early detection of cervical cancer shall be in accordance with the most recently~~  
36 ~~published American Cancer Society guidelines. Coverage shall include the examination,~~  
37 ~~the laboratory fee, and the physician's interpretation of the laboratory results.~~  
38 Reimbursements for laboratory fees shall be made only if the laboratory meets  
39 accreditation standards adopted by the North Carolina Medical Care Commission. ~~When~~  
40 ~~the screening pap smear accreditation standards adopted by the North Carolina Medical~~  
41 ~~Care Commission become effective, reimbursement for laboratory fees shall be made~~  
42 ~~only if the laboratory meets those standards. Facilities utilizing services of laboratories~~  
43 ~~that do not meet accreditation standards for screening pap smears shall, prior to~~

1 performing the pap smear examination, inform the patient or the patient's legally  
2 responsible person that such laboratory fees will not be covered."

3 **SECTION 4.** G.S. 135-40.5(e) reads as rewritten:

4 "(e) Routine Diagnostic Examinations. – The Plan will pay one hundred percent  
5 (100%) of allowable charges for routine diagnostic examinations and tests, including  
6 breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood  
7 pressure checks, urine tests, tuberculosis tests, and general health checkups that are  
8 medically necessary for the maintenance and improvement of individual health but no  
9 more often than once every three years for covered individuals to age 40 years, once  
10 every two years for covered individuals to age 50 years, and once a year for covered  
11 individuals age 50 years and older, unless a more frequent occurrence is warranted by a  
12 medical condition when such charges are incurred in a medically supervised facility.  
13 Routine diagnostic examinations and tests covered under this subsection also include  
14 one Pap smear per year examinations and tests for the screening for the early detection  
15 of cervical cancer. The coverage shall be in accordance with the most recently published  
16 American Cancer Society guidelines for any covered female. Provided, however, that  
17 charges for such examinations and tests are not covered by the Plan when they are  
18 incurred to obtain or continue employment, to secure insurance coverage, to comply  
19 with legal proceedings, to attend schools or camps, to meet travel requirements, to  
20 participate in athletic and related activities, or to comply with governmental licensing  
21 requirements. The maximum amount payable under this subsection for a covered  
22 individual is one hundred fifty dollars (\$150.00) per fiscal year."

23 **SECTION 5.** This act becomes effective January 1, 2004, and applies to all  
24 health benefit plans that are delivered, issued for delivery, or renewed on and after that  
25 date. For the purposes of this act, renewal of a health benefit plan is presumed to occur  
26 on each anniversary of the date on which coverage was first effective on the person or  
27 persons covered by the health benefit plan.