

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

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SENATE BILL 388
Health and Human Resources Committee Substitute Adopted 4/28/03
House Committee Substitute Favorable 5/21/03

Short Title: Update Cervical Cancer Screening Coverage.

(Public)

Sponsors:

Referred to:

March 12, 2003

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

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

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

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

- (1) Mammograms and ~~pap smears examinations~~ and laboratory tests for the screening for the early detection of cervical cancer at least equal to the coverage required by G.S. 58-51-57.
- (2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.
- (3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.
- (4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.
- (5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

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

3 (a1), (a2) Repealed by Session Laws 1999-197, s. 2.

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

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

9 "**§ 58-51-57. Coverage for mammograms and ~~pap smears~~. cervical cancer**
10 **screening.**

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

19 (a1) As used in this section, "examinations and laboratory tests for the screening
20 for the early detection of cervical cancer" means conventional PAP smear screening,
21 liquid-based cytology, and human papilloma virus (HPV) detection methods for women
22 with equivocal findings on cervical cytologic analysis that are subject to the approval of
23 and have been approved by the United States Food and Drug Administration.

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

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

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

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

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

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

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

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

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

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

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

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

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

27 "**§ 58-65-92. Coverage for mammograms and ~~pap smears.~~ cervical cancer**
28 **screening.**

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

39 (a1) As used in this section, "examinations and laboratory tests for the screening
40 for the early detection of cervical cancer" means conventional PAP smear screening,
41 liquid-based cytology, and human papilloma virus (HPV) detection methods for women
42 with equivocal findings on cervical cytologic analysis that are subject to the approval of
43 and have been approved by the United States Food and Drug Administration.

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 at risk for breast cancer. For purposes of this
9 subdivision, a woman is at risk for breast cancer if any one or more of
10 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 or guidelines adopted by the North~~
37 ~~Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall~~
38 include the examination, the laboratory fee, and the physician's interpretation of the
39 laboratory results. Reimbursements for laboratory fees shall be made only if the
40 laboratory meets accreditation standards adopted by the North Carolina Medical Care
41 Commission. ~~When the screening pap smear accreditation standards adopted by the~~
42 ~~North Carolina Medical Care Commission become effective, reimbursement for~~
43 ~~laboratory fees shall be made only if the laboratory meets those standards. Facilities~~
44 ~~utilizing services of laboratories that do not meet accreditation standards for screening~~

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

3 **SECTION 4.** G.S. 58-67-76 reads as rewritten:

4 **"§ 58-67-76. Coverage for mammograms and pap screens.cervical cancer**
5 **screening.**

6 (a) Every health care plan written by a health maintenance organization and in
7 force, issued, renewed, or amended on or after January 1, 1992, that is subject to this
8 Article, shall provide coverage for pap smears examinations and laboratory tests for the
9 screening for the early detection of cervical cancer and for low-dose screening
10 mammography. The same deductibles, coinsurance, and other limitations as apply to
11 similar services covered under the plan shall apply to coverage for pap smears
12 examinations and laboratory tests for the screening for the early detection of cervical
13 cancer and low-dose screening mammography.

14 (a1) As used in this section, "examinations and laboratory tests for the screening
15 for the early detection of cervical cancer" means conventional PAP smear screening,
16 liquid-based cytology, and human papilloma virus (HPV) detection methods for women
17 with equivocal findings on cervical cytologic analysis that are subject to the approval of
18 and have been approved by the United States Food and Drug Administration.

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

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

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

41 (d) Reimbursement for a mammogram authorized under this section shall be
42 made only if the facility in which the mammogram was performed meets
43 mammography accreditation standards. ~~Mammography accreditation standards shall be~~
44 ~~those standards~~ established by the North Carolina Medical Care Commission ~~unless~~

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

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

21 **SECTION 5.(a)** G.S. 135-40.5(e) reads as rewritten:

22 "(e) Routine Diagnostic Examinations. – The Plan will pay one hundred percent
23 (100%) of allowable charges for routine diagnostic examinations and tests, including
24 breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood
25 pressure checks, urine tests, tuberculosis tests, and general health checkups that are
26 medically necessary for the maintenance and improvement of individual health but no
27 more often than once every three years for covered individuals to age 40 years, once
28 every two years for covered individuals to age 50 years, and once a year for covered
29 individuals age 50 years and older, unless a more frequent occurrence is warranted by a
30 medical condition when such charges are incurred in a medically supervised facility.
31 Routine diagnostic examinations and tests covered under this subsection also include
32 one Pap smear per year examinations and tests for the screening for the early detection
33 of cervical cancer. The coverage shall be in accordance with the most recently published
34 American Cancer Society guidelines or guidelines adopted by the North Carolina
35 Advisory Committee on Cancer Coordination and Control for any covered female. For
36 the purposes of this subsection, "examinations and laboratory tests for the screening for
37 the early detection of cervical cancer" means conventional PAP smear screening,
38 liquid-based cytology, and human papilloma virus (HPV) detection methods for women
39 with equivocal findings on cervical cytologic analysis that are subject to the approval of
40 and have been approved by the United States Food and Drug Administration. Provided,
41 however, that charges for such examinations and tests are not covered by the Plan when
42 they are incurred to obtain or continue employment, to secure insurance coverage, to
43 comply with legal proceedings, to attend schools or camps, to meet travel requirements,
44 to participate in athletic and related activities, or to comply with governmental licensing

1 requirements. The maximum amount payable under this subsection for a covered
2 individual is one hundred fifty dollars (\$150.00) per fiscal year."

3 **SECTION 5.(b)** G.S. 135-40.6(8)s. reads as rewritten:

4 " ...

5 s. Routine Diagnostic Examinations: Allowable charges for
6 routine diagnostic examinations and tests, including ~~Pap~~
7 ~~smears~~, examinations and tests for the screening for the early
8 detection of cervical cancer, breast, colon, rectal, and prostate
9 exams, X rays, mammograms, blood and blood pressure checks,
10 urine tests, tuberculosis tests, and general health checkups that
11 are medically necessary for the maintenance and improvement
12 of individual health but no more often than once every three
13 years for covered individuals to age 40 years, once every two
14 years for covered individuals to age 50 years, and once a year
15 for covered individuals age 50 years and ~~older~~, older and, for
16 examinations and tests for the screening for the early detection
17 of cervical cancer, in accordance with the most recently
18 published American Cancer Society guidelines or guidelines
19 adopted by the North Carolina Advisory Committee on Cancer
20 Coordination and Control, unless a more frequent occurrence is
21 warranted by a medical condition when such charges are
22 incurred in a medically supervised facility. Provided, however,
23 that charges for such examinations and tests are not covered by
24 the Plan when they are incurred to obtain or continue
25 employment, to secure insurance coverage, to comply with
26 legal proceedings, to attend schools or camps, to meet travel
27 requirements, to participate in athletic and related activities or
28 to comply with governmental licensing requirements. For the
29 purposes of this sub-subdivision, "examinations and laboratory
30 tests for the screening for the early detection of cervical cancer"
31 means conventional PAP smear screening, liquid-based
32 cytology, and human papilloma virus (HPV) detection methods
33 for women with equivocal findings on cervical cytologic
34 analysis that are subject to the approval of and have been
35 approved by the United States Food and Drug Administration.

36 " ..."

37 **SECTION 6.** This act becomes effective January 1, 2004, and applies to all
38 health benefit plans that are delivered, issued for delivery, or renewed on and after that
39 date. For the purposes of this act, renewal of a health benefit plan is presumed to occur
40 on each anniversary of the date on which coverage was first effective on the person or
41 persons covered by the health benefit plan.