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Bill Analysis
Legislative Service Commission

Sub. H.B. 331*

125th General Assembly
(As Reported by H. Health)

Reps. Schmidt, Schneider, Hughes, Clancy, Raga, Schlichter, Webster, T. Patton, Grendell, Flowers, Barrett, J. Stewart, Miller, Allen, DeBose, McGregor, Latta, S. Patton, Key, Kearns, Brown, Jerse, Beatty, Harwood, Kilbane, Walcher

BILL SUMMARY

- Provides that the total benefit for a screening mammography under certain insurance policies and plans is not to exceed 130% of the Medicare reimbursement rate in this state for screening mammography.
- Provides that, if there is more than one Medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit is 130% of the lowest Medicare reimbursement rate in this state.
- Provides that, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit and submits a separate claim for that component, a separate payment must 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.

* *This analysis was prepared before the report of the House Health Committee appeared in the House Journal. Note that the list of co-sponsors and the legislative history may be incomplete.*

CONTENT AND OPERATION

Coverage for screening mammographies

(R.C. 1751.62, 3923.52, 3923.53, and 3923.54)

Background

Every health insuring corporation policy, contract, or agreement¹ providing basic health care services that is delivered, issued for delivery, or renewed in this state, every public employee benefit plan,² and every policy of sickness and accident insurance provided by an employer that is established or modified in this state must provide benefits for screening mammography to detect the presence of breast cancer in adult women. Every policy of individual or group sickness and accident insurance³ that is delivered, issued for delivery, or renewed in this state must *offer to* provide such benefits. Excepted from this requirement are individual or group sickness and accident insurance policies that provide coverage for specific diseases or accidents only, and hospital indemnity, medicare supplement, or other policies that offer only supplemental benefits.

Current law specifies the level of benefits that must be offered for screening mammography, which varies based on a woman's age:

- If a woman is at least age 35, but under age 40, the policy must cover one screening mammography.
- If a woman is at least age 40 but under age 50, either of the following:

¹ "Health insuring corporation" means a corporation formed under Revised Code Chapter 1701. (general corporation law) or 1702. (nonprofit corporation law), or the similar laws of another state, that pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan. R.C. § 1751.01(N).

² "Public employee benefit plan" is not defined in the Revised Code.

³ "Policy of sickness and accident insurance" includes any policy, contract, or certificate of insurance against loss or expense resulting from the sickness of the insured, or from the bodily injury or death of the insured by accident, or both, that is delivered, issued for delivery, renewed, or used in Ohio. Revised Code § 3923.01.

- One screening mammography every two years.
- If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.
- If a woman is at least age 50 but under age 65, one screening mammography every year.

Benefits for screening mammography must be provided only for screening mammographies 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.

Definition of "screening mammography"

"Screening mammography" is defined in current law as a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes that has an average radiation exposure delivery of less than one rad mid-breast. It includes two views for each breast. The term also includes the professional interpretation of the film, but does not include diagnostic mammography.

The bill modifies the definition of "screening mammography" to reflect that the definition includes x-ray examination of the breast using equipment dedicated specifically for mammography, including, *but not limited to*, the x-ray tube, filter, compression device, screens, film, and cassettes.

Sickness and accident insurance coverage

The bill requires every policy of individual or group sickness and accident insurance to provide, rather than offer to provide, the benefits for screening mammography.

Amount of cap for mammography benefit

Current law prescribes that the benefits for screening mammography must not exceed \$85 per year unless a lower amount is established pursuant to a provider contract.

The bill eliminates the \$85 cap and provides instead that the total benefit for a screening mammography is not to exceed 130% of the Medicare

reimbursement rate in this state for screening mammography.⁴ If there is more than one Medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit is 130% of the lowest Medicare reimbursement rate in this state. The bill defines "Medicare reimbursement rate" as the reimbursement rate paid in Ohio under the Medicare program for screening mammography that does not include digitalization or computer aided detection, regardless of whether the actual benefit includes digitalization or computer aided detection.

If a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit and submits a separate claim for that component, the bill requires that a separate payment 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.

Whereas current law prohibits an institutional or professional provider from seeking or receiving remuneration in excess of the cap for the mammography screening benefit, the bill provides that no provider, hospital, or other health care facility may seek or receive remuneration in excess of the cap. Approved deductibles and copayments are excepted from this prohibition under the law governing sickness and accident insurance, public employee benefit plans, and employer provided sickness and accident insurance. Current law governing health insurance corporations excepts only approved copayments. The bill adds approved deductibles to the exception, making the exception in the health insurance corporation law the same as the exception in the law governing the other forms of health insurance.

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	11-13-03	p. 1159
Reported, H. Health	---	---

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⁴ *The total Medicare reimbursement rate for screening mammography in Ohio (CPT code 76092) is \$81.57. (The technical component reimbursement rate is \$46.88 while the professional component reimbursement rate is \$35.69.) Telephone interview with Liz Cepero, Health Insurance Specialist, Centers for Medicare and Medicaid Services (May 17, 2004).*