SENATE COMMITTEE SUBSTITUTE

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

HOUSE BILLS NOS. 575 & 910

AN ACT

To repeal section 376.782, RSMo, and to enact in lieu thereof three new sections relating to breast examinations.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Section 376.782, RSMo, is repealed and three new sections enacted in lieu thereof, to be known as sections 192.775, 376.782, and 376.1183, to read as follows:

192.775. A mammography facility certified by the United States Food and Drug Administration (FDA) or by a certification agency approved by the FDA shall not require any person to obtain a referral from a primary care provider or other physician in order to receive a screening mammogram at the facility if providing the mammogram for the person is consistent with the recommendations in the most current breast cancer screening guidelines established by the American College of Radiology.

376.782. 1. As used in this section, the term "low-dose mammography screening" means the X-ray examination of the breast using equipment specifically designed and dedicated for mammography, including the X-ray tube, filter, compression device, detector, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast, and any fee charged by a radiologist or other physician for reading, interpreting or diagnosing based on such X-ray. As used in this section, the term "low-dose mammography screening"

shall also include digital mammography and breast tomosynthesis. As used in this section, the term "breast tomosynthesis" shall mean a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

2. All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed on or after August 28, 1991, and providing coverage to any resident of this state shall provide benefits or coverage for low-dose mammography screening for any nonsymptomatic woman covered under such policy or contract which meets the minimum requirements of this section. Such benefits or coverage shall include at least the following:

(1) A baseline mammogram for women age thirty-five to thirty-nine, inclusive;

(2) A mammogram every year for women age forty and over;

(3) A mammogram every year for any woman deemed by a treating physician to have an above-average risk for breast cancer in accordance with the American College of Radiology guidelines for breast cancer screening;

(4) Any additional or supplemental imaging, such as breast magnetic resonance imaging or ultrasound, deemed medically necessary by a treating physician for proper

breast cancer screening or evaluation in accordance with applicable American College of Radiology guidelines; and

(5) Ultrasound or magnetic resonance imaging services, if determined by a treating physician to be medically necessary for the screening or evaluation of breast cancer for any woman deemed by the treating physician to have an above-average risk for breast cancer in accordance with American College of Radiology guidelines for breast cancer screening.

3. Coverage and benefits required under this section shall be at least as favorable and subject to the same dollar limits, deductibles, and co-payments as other radiological examinations; provided, however, that:

(1) On and after January 1, 2019, providers of health care services specified under this section shall be reimbursed at rates accurately reflecting the resource costs specific to each modality, including any increased resource cost; and

(2) Cost-sharing requirements shall not apply if the provisions of section 376.1183 prohibit cost-sharing requirements with respect to such coverage.

4. A policy providing the coverage and benefits required under this section shall not require any person covered under the policy who is entitled to a screening mammogram under subdivision (1) or (2) of subsection 2 of this section to obtain a referral from a primary care provider or other physician in order to receive the screening mammogram.

376.1183. 1. For purposes of this section, the following terms mean:

(1) "Cost-sharing requirement", any deductible, coinsurance, co-payment, or maximum limitation on the

application of such deductible, coinsurance, co-payment, or similar out-of-pocket expense;

(2) "Diagnostic breast examination", any medically necessary and appropriate examination of the breast, including such an examination using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, that is:

(a) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or

(b) Used to evaluate an abnormality detected by another means of examination;

(3) "Health benefit plan", the same meaning given to the term in section 376.1350;

(4) "Health carrier", the same meaning given to the term in section 376.1350;

(5) "Supplemental breast examination", any medically necessary and appropriate examination of the breast, including such an examination using breast magnetic resonance imaging or breast ultrasound, that is:

(a) Used to screen for breast cancer when there is no abnormality seen or suspected; and

(b) Based on personal or family medical history or any additional factors that may increase the patient's risk of breast cancer.

2. Each health carrier or health benefit plan that offers or issues health benefit plans that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2024, and that provide coverage for diagnostic breast examinations, coverage for supplemental breast examinations, coverage required under section 376.782, or any combination of such coverages shall not impose any cost-sharing requirements with respect to any such coverage.

3. If, under federal law, application of the requirement under subsection 2 of this section would result in health savings account ineligibility under Section 223 of the Internal Revenue Code, the requirement under subsection 2 of this section shall apply to health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223, except with respect to items or services that are preventive care under Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirement of subsection 2 of this section shall apply regardless of whether the minimum deductible under Section 223 has been satisfied.