February 17, 1998

ENGROSSED
SENATE BILL No. 294

DIGEST OF SB 294 (Updated February 17, 1998 10:13 am - DI 97)

Citations Affected: IC 5-10; IC 27-8; IC 27-13; noncode.

Synopsis: Coverage for breast and prostate cancer screening, and infertility. Requires coverage by group insurance for public employees, group insurers, and health maintenance organizations to provide for the following: (1) Periodic prostate specific antigen screening in men in certain age and risk groups. (2) An annual mammography to a woman who is at least 40 years of age. (Current law provides this coverage only if the woman is at least 50 years of age.) Requires health maintenance organizations toprovide breast cancer mammography screening for women in certain age groups. (Current law requires coverage of breast cancer mammography screening services under group insurance for public employees and group accident and sickness insurance policies issued in Indiana.) Requires coverage by group insurance for public employees, group insurers, and health maintenance organizations to provide for additional mammography views necessary for a physician to make a proper evaluation and for

(Continued next page)

Effective: July 1, 1998.

Miller, Gard, Wyss, Paul

(HOUSE SPONSOR — SUMMERS)

January 8, 1998, read first time and referred to Committee on Health and Environmental Affairs.
January 22, 1998, amended, reported favorably — Do Pass.
January 29, 1998, read second time, amended, ordered engrossed.
January 30, 1998, engrossed. Read third time, passed. Yeas 48, nays 2.

HOUSE ACTION

February 4, 1998, read first time and referred to Committee on Public Health; reassigned to Committee on Insurance and Corporations.
February 17, 1998, amended, reported — Do Pass.

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ultrasound services if those services are determined to be medically necessary by the insured's or enrollee's treating physician. Prohibits the issuance, delivery, amendment, or renewal of a group policy of accident and sickness insurance providing pregnancy related benefits unless the insurer offers to provide coverage for the diagnosis and treatment of infertility. Specifies certain infertility treatment procedures for which coverage must be offered, but provides that the offer of coverage of an insured individual for certain procedures is required only under certain circumstances. Does not apply to a group policy issued to a religious institution or organization that finds the fertility treatment procedures incompatible with its religious and moral teachings and beliefs. Provides that a group health maintenance organization (HMO) contract that provides pregnancy related benefits may not be entered into, delivered, amended, or renewed in Indiana unless the HMO offers coverage for the diagnosis and treatment of infertility. Specifies certain infertility treatment procedures for which coverage must be offered as in-plan covered services or out-of-plan covered services, but provides that the offer of coverage of an enrollee for certain procedures is required only under certain circumstances. Does not apply to a group HMO contract entered into with a religious institution or organization that finds the fertility treatment procedures incompatible with its religious and moral teachings and beliefs.

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February 17, 1998

Second Regular Session 110th General Assembly (1998)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 1997 General Assembly.

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ENGROSSED
SENATE BILL No. 294

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 5-10-8-7.2, AS AMENDED BY P.L.26-1994, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 7.2. (a) As used in this section, "breast cancer diagnostic service" means a procedure intended to aid in the diagnosis of breast cancer. The term includes procedures performed on an inpatient basis and procedures performed on an outpatient basis, including the following:

(1) Breast cancer screening mammography.

(2) Surgical breast biopsy.

(3) Pathologic examination and interpretation.

(b) As used in this section, "breast cancer outpatient treatment services" means procedures that are intended to treat cancer of the human breast and that are delivered on an outpatient basis. The term includes the following:

(1) Chemotherapy.

(2) Hormonal therapy.
(3) Radiation therapy.
(4) Surgery.
(5) Other outpatient cancer treatment services prescribed by a physician.
(6) Medical follow-up services related to the procedures set forth in subdivisions (1) through (5).

(c) As used in this section, "breast cancer rehabilitative services" means procedures that are intended to improve the results of or to ameliorate the debilitating consequences of the treatment of breast cancer and that are delivered on an inpatient or outpatient basis. The term includes the following:
(1) Physical therapy.
(2) Psychological and social support services.
(3) Reconstructive plastic surgery.

(d) As used in this section, "breast cancer screening mammography" means a standard, two (2) view per breast, low-dose radiographic examination of the breasts that is:
(1) furnished to an asymptomatic woman; and
(2) performed by a mammography services provider using equipment designed by the manufacturer for and dedicated specifically to mammography in order to detect unsuspected breast cancer.
The term includes the interpretation of the results of a breast cancer screening mammography by a physician.

(e) As used in this section, "covered individual" means a female individual who is:
(1) covered under a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or
(2) entitled to services under a contract with a health maintenance organization (as defined in IC 27-13-1-19) that is entered into or renewed under section 7(c) of this chapter.

(f) As used in this section, "mammography services provider" means an individual or facility that:
(1) has been accredited by the American College of Radiology;
(2) meets equivalent guidelines established by the state department of health; or
(3) is certified by the federal Department of Health and Human Services for participation in the Medicare program (42 U.S.C. 1395 et seq.).

~~(g) As used in this section, "woman at risk" means a woman who meets at least one (1) of the following descriptions:~~

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~~(1) A woman who has a personal history of breast cancer.~~

~~(2) A woman who has a personal history of breast disease that was proven benign by biopsy.~~

~~(3) A woman whose mother, sister, or daughter has had breast cancer.~~

~~(4) A woman who is at least thirty (30) years of age and has not given birth.~~

~~(h)~~ **(g)** A self-insurance program established under section 7(b) of this chapter to provide health care coverage must provide covered individuals with coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services. The coverage must provide reimbursement for breast cancer screening mammography at a level at least as high as:

(1) the limitation on payment for screening mammography services established in 42 CFR 405.534(b)(3) according to the Medicare Economic Index at the time the breast cancer screening mammography is performed; or

(2) the rate negotiated by a contract provider according to the provisions of the insurance policy;

whichever is lower. The costs of the coverage required by this subsection ~~(h)~~ may be paid by the state or by the employee or by a combination of the state and the employee.

~~(i)~~ **(h)** A contract with a health maintenance organization that is entered into or renewed under section 7(c) of this chapter must provide covered individuals with breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.

~~(j)~~ **(i)** The coverage required by subsection ~~(h)~~ **(g)** and services required by subsection ~~(i)~~ **(h)** may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to covered individuals than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the self-insurance program or contract with a health maintenance organization.

~~(k)~~ **(j)** The coverage for breast cancer diagnostic services required by subsection ~~(h)~~ **(g)** and the breast cancer diagnostic services required by subsection ~~(i)~~ **(h)** must include the following:

(1) In the case of a covered individual who is at least thirty-five (35) years of age but less than forty (40) years of age, at least one (1) baseline breast cancer screening mammography performed upon the individual before she becomes forty (40) years of age.

(2) ~~In the case of a covered individual who is~~

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~~(A) at least forty (40) but less than fifty (50) years of age and~~
~~(B) not a woman at risk;~~
~~at least one (1) breast cancer screening mammography performed upon the individual in every two (2) year period.~~
~~(3) In the case of a covered individual who is:~~
~~(A) at least forty (40) but less than fifty (50) years of age; and~~
~~(B) a woman at risk;~~
~~at least one (1) breast cancer screening mammography performed upon the covered individual every year.~~
~~(4)~~ In the case of a covered individual who is at least ~~fifty (50)~~ **forty (40)** years of age, ~~whether or not a woman at risk,~~ at least one (1) breast cancer screening mammography performed upon the individual every year.
(3) Any additional views that are required for proper evaluation.
(4) Ultrasound services, if determined medically necessary by the physician treating the covered individual.

~~(l)~~ **(k)** The coverage for breast cancer diagnostic services required by subsection ~~(h)~~ **(g)** and the breast cancer diagnostic services required by subsection ~~(i)~~ **(h)** shall be provided in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

SECTION 2. IC 27-8-14-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 6. (a) An insurer must offer to provide coverage for breast cancer screening mammography in any accident and sickness insurance policy that the insurer issues in Indiana.

(b) The coverage that an insurer must offer to provide under this section must include the following:

(1) If the insured is at least thirty-five (35) but less than forty (40) years of age, coverage for at least one (1) baseline breast cancer screening mammography performed upon the insured before she becomes forty (40) years of age.

(2) ~~If the insured is:~~
~~(A) at least forty (40) but less than fifty (50) years of age; and~~
~~(B) not a woman at risk;~~
~~coverage for one (1) breast cancer screening mammography performed upon the insured in every two (2) year period.~~
~~(3) If the insured is:~~
~~(A) at least forty (40) but less than fifty (50) years of age; and~~
~~(B) a woman at risk;~~
~~one (1) breast cancer screening mammography performed upon~~

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~~the insured every year.~~

~~(4)~~ If the insured is at least ~~fifty~~ ~~(50)~~ **forty (40)** years of age, ~~whether or not at risk,~~ one (1) breast cancer screening mammography performed upon the insured every year.

(3) Any additional views that are required for proper evaluation.

(4) Ultrasound services, if determined medically necessary by the physician treating the insured.

(c) The coverage that an insurer must offer to provide under this section must provide reimbursement for breast cancer screening mammography at a level at least as high as:

(1) the limitation on payment for screening mammography services established in 42 CFR 405.534(b)(3) according to the Medicare Economic Index at the time the breast cancer screening mammography is performed; or

(2) the rate negotiated by a contract provider according to the provisions of the insurance policy;

whichever is lower.

(d) The coverage that an insurer must offer to provide under this section may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the accident and sickness insurance policy.

(e) The coverage that an insurer must offer is in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

SECTION 3. IC 5-10-8-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 7.5. (a) As used in this section, "covered individual" means an individual who is:**

(1) covered under a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) entitled to services under a contract with a health maintenance organization (as defined in IC 27-13-1-19) that is entered into or renewed under section 7(c) of this chapter.

(b) As used in this section, "man at risk" means a man who:

(1) is African-American; or

(2) has a family history of prostate cancer.

(c) As used in this section, "prostate specific antigen test" means a standard blood test performed to determine the level of prostate specific antigen in the blood.

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(d) A self-insurance program established under section 7(b) of this chapter to provide health care coverage must provide covered individuals with coverage for prostate specific antigen testing.

(e) A contract with a health maintenance organization that is entered into or renewed under section 7(c) of this chapter must provide covered individuals with prostate specific antigen screening.

(f) The coverage required under this section must include the following:

(1) If the covered individual is at least forty (40) years of age and is a man at risk, coverage for at least one (1) prostate specific antigen test annually.

(2) If the covered individual is at least fifty (50) years of age and a man, coverage for at least one (1) prostate specific antigen test annually, regardless of whether the covered individual is a man at risk.

(g) The coverage required under this section may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to covered individuals than the dollar limits, deductibles, copayments, or coinsurance provisions applying to physical illness generally under the self-insurance program or contract with a health maintenance organization.

(h) The coverage for prostate specific antigen screening shall be provided in addition to benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

SECTION 4. IC 27-8-14.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]:

Chapter 14.7. Coverage for Services Related to Prostate Cancer Screening

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) "Accident and sickness insurance policy" does not include accident only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance.

Sec. 2. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

Sec. 3. As used in this chapter, "man at risk" means a man who:

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(1) is African-American; or

(2) has a family history of prostate cancer.

Sec. 4. As used in this chapter, "prostate specific antigen test" means a standard blood test performed to determine the level of prostate specific antigen in the blood.

Sec. 5. (a) An insurer shall offer to provide coverage for prostate specific antigen testing in any accident and sickness insurance policy that the insurer issues in Indiana.

(b) The coverage that an insurer must offer to provide under this chapter must include the following:

(1) If the insured is at least forty (40) years of age and is a man at risk, coverage for at least one (1) prostate specific antigen test annually.

(2) If the insured is at least fifty (50) years of age and a man, coverage for at least one (1) prostate specific antigen test annually, regardless of whether the insured is a man at risk.

(c) An insured may not be required to pay an annual deductible or coinsurance that is greater than an annual deductible or coinsurance established for similar benefits under the accident and sickness insurance policy. If the policy does not cover a similar benefit, the deductible or coinsurance may not be set at a level that materially diminishes the value of the prostate specific antigen testing benefit required by this chapter.

(d) The coverage that an insurer must offer to provide under this chapter may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the accident and sickness insurance policy.

(e) The coverage that an insurer must offer is in addition to benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

SECTION 5. IC 27-8-27 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]:

Chapter 27. Group Policy Coverage for Infertility Treatment

Sec. 1. (a) As used in this chapter, "policy of accident and sickness insurance" means a policy or contract that:

(1) provides at least one (1) of the kinds of insurance described in Class 1(b) or Class 2(a) of IC 27-1-5-1; and

(2) is written on a group basis.

(b) The term does not include the following:

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(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Automobile medical payment insurance.
(4) A specified disease policy.
(5) A limited benefit health insurance policy.
(6) A short term insurance plan that:
(A) may not be renewed; and
(B) has a duration of not more than six (6) months.
(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.
(8) Worker's compensation or similar insurance.
(9) A student health insurance policy.

Sec. 2. (a) Except as provided in subsection (b), a policy of accident and sickness insurance that provides pregnancy related benefits may not be issued, delivered, amended, or renewed in Indiana unless the insurer issuing the policy offers coverage for the diagnosis and treatment of infertility.

(b) This chapter does not require coverage for the diagnosis and treatment of infertility in a policy of accident and sickness insurance that is issued to:
(1) a religious institution or organization; or
(2) an entity sponsored by a religious institution or organization;
that finds the procedures in section 3 of this chapter incompatible with its religious and moral teachings and beliefs.

Sec. 3. Subject to section 4 of this chapter, the coverage for the diagnosis and treatment of infertility that must be offered with a policy of accident and sickness insurance under this chapter includes the following procedures:
(1) In vitro fertilization.
(2) Uterine embryo lavage.
(3) Embryo transfer.
(4) Artificial insemination.
(5) Gamete intrafallopian tube transfer.
(6) Zygote intrafallopian tube transfer.
(7) Low tubal ovum transfer.

Sec. 4. (a) If an offer described in section 3 of this chapter has been accepted, an insurer is required under this chapter to cover procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer for an insured

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individual only if:

(1) the individual has not been able to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments for which coverage is available under the policy;

(2) the individual has undergone not more than three (3) oocyte retrievals, except as provided in subsection (b); and

(3) the procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer are performed at medical facilities that conform to the:

(A) guidelines of the American College of Obstetricians and Gynecologists for in vitro fertilization clinics; or

(B) minimal standards of the American Fertility Society for programs of in vitro fertilization.

(b) Subsection (a)(2) does not relieve an insurer of the obligation to cover an individual who has accepted the offer of coverage described in section 3 of this chapter and has undergone at least four (4) oocyte retrievals if the individual, since giving birth to a living child, has had less than two (2) oocyte retrievals.

SECTION 6. IC 27-13-7-15 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 15. (a) As used in this section, "breast cancer screening mammography" has the meaning set forth in IC 27-8-14-2.**

(b) A health maintenance organization issued a certificate of authority in Indiana shall offer to provide coverage for breast cancer screening mammography.

(c) The coverage that a health maintenance organization must offer to provide under this section must include the following:

(1) If an enrollee is at least thirty-five (35) years of age but less than forty (40) years of age, coverage for at least one (1) baseline breast cancer screening mammography performed upon the enrollee before the enrollee becomes forty (40) years of age.

(2) If the enrollee is at least forty (40) years of age, one (1) breast cancer screening mammography performed upon the enrollee every year.

(3) Any additional views that are required for proper evaluation.

(4) Ultrasound services, if determined medically necessary by the provider treating the enrollee.

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(d) A health maintenance organization must offer to provide breast cancer screening mammography as a covered service under a group contract with the health maintenance organization.

(e) The coverage that a health maintenance organization must offer to provide under this section may not be subject to a contract provision that is less favorable to an enrollee or a subscriber than a contract provision applying to physical illness generally under the health maintenance organization contract.

(f) The coverage that a health maintenance organization must offer under this section is in addition to services specifically provided for x-rays, laboratory testing, or wellness examinations.

SECTION 7. IC 27-13-7-16 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 16. (a) As used in this section, "man at risk" means a man who:**

(1) is African-American; or

(2) has a family history of prostate cancer.

(b) As used in this section, "prostate specific antigen test" means a standard blood test performed to determine the level of prostate specific antigen in the blood.

(c) A health maintenance organization issued a certificate of authority in Indiana shall offer to provide coverage for prostate specific antigen testing.

(d) The coverage that a health maintenance organization must offer to provide under this section must include the following:

(1) If the enrollee is at least forty (40) years of age and is a man at risk, coverage for at least one (1) prostate specific antigen test annually.

(2) If the enrollee is at least fifty (50) years of age and a man, coverage for at least one (1) prostate specific antigen test annually, regardless of whether the enrollee is a man at risk.

(e) A health maintenance organization shall offer to provide prostate specific antigen testing as a covered service under a group contract with the health maintenance organization.

(f) The coverage that a health maintenance organization must offer to provide under this section may not be subject to a contract provision that is less favorable to an enrollee than a contract provision applying to physical illness generally under the health maintenance organization contract.

(g) The coverage that a health maintenance organization must offer under this section is in addition to services specifically provided for x-rays, laboratory testing, or wellness examinations.

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SECTION 8. IC 27-13-7-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 17. (a) Except as provided in subsection (b), a group contract that provides pregnancy related benefits may not be entered into, delivered, amended, or renewed in Indiana unless the health maintenance organization issuing the group contract offers coverage for the diagnosis and treatment of infertility.**

(b) This chapter does not require coverage for the diagnosis and treatment of infertility in a group contract that is entered into with:

(1) a religious institution or organization; or

(2) an entity sponsored by a religious institution or organization;

that finds the procedures in subsection (c) incompatible with its religious and moral teachings and beliefs.

(c) Subject to subsection (d), the coverage for the diagnosis and treatment of infertility that must be offered with a group contract under this section includes the following procedures as in-plan covered services or out-of-plan covered services:

(1) In vitro fertilization.

(2) Uterine embryo lavage.

(3) Embryo transfer.

(4) Artificial insemination.

(5) Gamete intrafallopian tube transfer.

(6) Zygote intrafallopian tube transfer.

(7) Low tubal ovum transfer.

(d) If an offer described in subsection (c) has been accepted, a health maintenance organization is required under this section to cover procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer for an enrollee only if:

(1) the enrollee has not been able to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments that are in-plan covered services available under the group contract;

(2) the enrollee has undergone not more than three (3) oocyte retrievals, except as provided in subsection (e); and

(3) the procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer are performed at medical facilities that conform to the:

(A) guidelines of the American College of Obstetricians

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and Gynecologists for in vitro fertilization; or

(B) minimal standards of the American Fertility Society for programs of in vitro fertilization.

(e) Subsection (d)(2) does not relieve a health maintenance organization of the obligation to cover an individual who has accepted the offer of coverage described in subsection (c) and has undergone at least four (4) oocyte retrievals if the individual, since giving birth to a living child, has had less than two (2) oocyte retrievals.

SECTION 9. IC 27-8-14-5 IS REPEALED [EFFECTIVE JULY 1, 1998].

SECTION 10. [EFFECTIVE JULY 1, 1998] **(a) IC 5-10-8-7.5, as added by this act, applies to a self insurance program or a contract between the state and a health maintenance organization established, entered into, or renewed after June 30, 1998.**

(b) IC 27-8-14.7, as added by this act, applies to accident and sickness insurance policies that are issued, delivered, or renewed after June 30, 1998.

(c) IC 27-13-7-15 and IC 27-13-7-16, both as added by this act, apply to health maintenance organization contracts that are issued, delivered, or renewed after June 30, 1998.

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SENATE MOTION

Mr. President: I move that Senator Gard be added as second author of Senate Bill 294.

MILLER

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COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Environmental Affairs, to which was referred Senate Bill 294, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 5-10-8-7.2, AS AMENDED BY P.L.26-1994, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 7.2. (a) As used in this section, "breast cancer diagnostic service" means a procedure intended to aid in the diagnosis of breast cancer. The term includes procedures performed on an inpatient basis and procedures performed on an outpatient basis, including the following:

(1) Breast cancer screening mammography.
(2) Surgical breast biopsy.
(3) Pathologic examination and interpretation.

(b) As used in this section, "breast cancer outpatient treatment services" means procedures that are intended to treat cancer of the human breast and that are delivered on an outpatient basis. The term includes the following:

(1) Chemotherapy.
(2) Hormonal therapy.
(3) Radiation therapy.
(4) Surgery.
(5) Other outpatient cancer treatment services prescribed by a physician.
(6) Medical follow-up services related to the procedures set forth in subdivisions (1) through (5).

(c) As used in this section, "breast cancer rehabilitative services" means procedures that are intended to improve the results of or to ameliorate the debilitating consequences of the treatment of breast cancer and that are delivered on an inpatient or outpatient basis. The term includes the following:

(1) Physical therapy.
(2) Psychological and social support services.
(3) Reconstructive plastic surgery.

(d) As used in this section, "breast cancer screening mammography" means a standard, two (2) view per breast, low-dose radiographic examination of the breasts that is:

(1) furnished to an asymptomatic woman; and
(2) performed by a mammography services provider using

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equipment designed by the manufacturer for and dedicated specifically to mammography in order to detect unsuspected breast cancer.

The term includes the interpretation of the results of a breast cancer screening mammography by a physician.

(e) As used in this section, "covered individual" means a female individual who is:

(1) covered under a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) entitled to services under a contract with a health maintenance organization (as defined in IC 27-13-1-19) that is entered into or renewed under section 7(c) of this chapter.

~~(f) As used in this section, "mammography services provider" means an individual or facility that:~~

~~(1) has been accredited by the American College of Radiology;~~

~~(2) meets equivalent guidelines established by the state department of health; or~~

~~(3) is certified by the federal Department of Health and Human Services for participation in the Medicare program (42 U.S.C. 1395 et seq.).~~

~~(g) As used in this section, "woman at risk" means a woman who meets at least one (1) of the following descriptions:~~

~~(1) A woman who has a personal history of breast cancer.~~

~~(2) A woman who has a personal history of breast disease that was proven benign by biopsy.~~

~~(3) A woman whose mother, sister, or daughter has had breast cancer.~~

~~(4) A woman who is at least thirty (30) years of age and has not given birth.~~

~~(h)~~ **(f)** A self-insurance program established under section 7(b) of this chapter to provide health care coverage must provide covered individuals with coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services. The coverage must provide reimbursement for breast cancer screening mammography at a level at least as high as:

(1) the limitation on payment for screening mammography services established in 42 CFR 405.534(b)(3) according to the Medicare Economic Index at the time the breast cancer screening mammography is performed; or

(2) the rate negotiated by a contract provider according to the provisions of the insurance policy;

whichever is lower. The costs of the coverage required by this

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subsection ~~(h)~~ may be paid by the state or by the employee or by a combination of the state and the employee.

~~(i)~~ **(g)** A contract with a health maintenance organization that is entered into or renewed under section 7(c) of this chapter must provide covered individuals with breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.

~~(j)~~ **(h)** The coverage required by subsection ~~(h)~~ **(f)** and services required by subsection ~~(i)~~ **(g)** may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to covered individuals than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the self-insurance program or contract with a health maintenance organization.

~~(k)~~ **(i)** The coverage for breast cancer diagnostic services required by subsection ~~(h)~~ **(f)** and the breast cancer diagnostic services required by subsection ~~(i)~~ **(g)** must include the following:

(1) In the case of a covered individual who is at least thirty-five (35) years of age but less than forty (40) years of age, at least one (1) baseline breast cancer screening mammography performed upon the individual before she becomes forty (40) years of age.

(2) ~~In the case of a covered individual who is~~

~~(A) at least forty (40) but less than fifty (50) years of age and~~

~~(B) not a woman at risk;~~

~~at least one (1) breast cancer screening mammography performed upon the individual in every two (2) year period.~~

~~(3) In the case of a covered individual who is:~~

~~(A) at least forty (40) but less than fifty (50) years of age; and~~

~~(B) a woman at risk;~~

~~at least one (1) breast cancer screening mammography performed upon the covered individual every year.~~

~~(4)~~ In the case of a covered individual who is at least ~~fifty (50)~~ **forty (40)** years of age, whether or not a woman at risk, at least one (1) breast cancer screening mammography performed upon the individual every year.

(3) Any additional views that are required for proper evaluation.

(4) Ultrasound services, if determined medically necessary by the physician treating the covered individual.

~~(l)~~ **(k)** The coverage for breast cancer diagnostic services required by subsection ~~(h)~~ **(g)** and the breast cancer diagnostic services required by subsection ~~(i)~~ **(h)** shall be provided in addition to any benefits

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specifically provided for x-rays, laboratory testing, or wellness examinations.

SECTION 2. IC 27-8-14-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 6. (a) An insurer must offer to provide coverage for breast cancer screening mammography in any accident and sickness insurance policy that the insurer issues in Indiana.

(b) The coverage that an insurer must offer to provide under this section must include the following:

(1) If the insured is at least thirty-five (35) but less than forty (40) years of age, coverage for at least one (1) baseline breast cancer screening mammography performed upon the insured before she becomes forty (40) years of age.

(2) ~~If the insured is:~~

~~(A) at least forty (40) but less than fifty (50) years of age; and~~

~~(B) not a woman at risk;~~

~~coverage for one (1) breast cancer screening mammography performed upon the insured in every two (2) year period.~~

~~(3) If the insured is:~~

~~(A) at least forty (40) but less than fifty (50) years of age; and~~

~~(B) a woman at risk;~~

~~one (1) breast cancer screening mammography performed upon the insured every year.~~

~~(4)~~ If the insured is at least ~~fifty (50)~~ **forty (40)** years of age, whether or not at risk, one (1) breast cancer screening mammography performed upon the insured every year.

(3) Any additional views that are required for proper evaluation.

(4) Ultrasound services, if determined medically necessary by the physician treating the insured.

(c) The coverage that an insurer must offer to provide under this section must provide reimbursement for breast cancer screening mammography at a level at least as high as:

(1) the limitation on payment for screening mammography services established in 42 CFR 405.534(b)(3) according to the Medicare Economic Index at the time the breast cancer screening mammography is performed; or

(2) the rate negotiated by a contract provider according to the provisions of the insurance policy;

whichever is lower.

(d) The coverage that an insurer must offer to provide under this section may not be subject to dollar limits, deductibles, or coinsurance

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provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the accident and sickness insurance policy.

(e) The coverage that an insurer must offer is in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.".

Page 4, delete lines 7 through 8.

Page 4, line 9, delete "(d)" and insert "**(c)**".

Page 4, line 12, delete "(e)" and insert "**(d)**".

Page 4, delete lines 19 through 30.

Page 4, line 31, delete "(4)" and insert "**(2)**".

Page 4, line 31, delete "fifty (50)" and insert "**forty (40)**".

Page 4, line 33, delete ", regardless of whether the enrollee is a" and insert "**.**".

Page 4, delete line 34, begin a new line block indented and insert:

"**(3) Any additional views that are required for proper evaluation.**

(4) Ultrasound services, if determined medically necessary by the provider treating the enrollee.".

Page 4, line 35, delete "(f)" and insert "**(e)**".

Page 4, line 38, delete "(g)" and insert "**(f)**".

Page 5, line 1, delete "(h)" and insert "**(g)**".

Page 5, between lines 34 and 35, begin a new paragraph and insert:

"SECTION 7. IC 27-8-14-5 IS REPEALED [EFFECTIVE JULY 1, 1998].".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to Senate Bill 294 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 8, Nays 0.

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SENATE MOTION

Mr. President: I move that Senate Bill 294 be amended to read as follows:

Page 2, reset in roman lines 33 through 40.

Page 3, line 8, delete "(f)" and insert "**(g)**".

Page 3, line 23, delete "(g)" and insert "**(h)**".

Page 3, line 28, before "The" delete "(h)" and insert "**(i)**".

Page 3, line 28, delete "(f)" and insert "**(g)**".

Page 3, line 29, delete "(g)" and insert "**(h)**".

Page 3, line 35, delete "(i)" and insert "**(j)**".

Page 3, line 36, delete "(f)" and insert "**(g)**".

Page 3, line 37, delete "(g)" and insert "**(h)**".

Page 4, line 11, strike "whether or not a woman at risk,".

Page 4, line 19, delete "(g)" and insert "**(h)**".

Page 4, line 20, delete "(h)" and insert "**(i)**".

Page 5, line 3, strike "whether or not at risk,".

Page 7, line 33, delete "means a standard, two (2) view per" and insert "**has the meaning set forth in IC 27-8-14-2.**".

Page 7, delete lines 34 through 42.

Page 8, delete lines 1 through 7.

Page 8, line 8, delete "(c)" and insert "**(b)**".

Page 8, line 11, delete "(d)" and insert "**(c)**".

Page 8, line 25, delete "(e)" and insert "**(d)**".

Page 8, line 25, delete "shall" and insert "**must**".

Page 8, line 28, delete "(f)" and insert "**(e)**".

Page 8, line 29, after "offer" insert "**to provide**".

Page 8, line 30, after "enrollee" insert "**or a subscriber**".

Page 8, line 33, delete "(g)" and insert "**(f)**".

(Reference is to Senate Bill 294 as printed January 23, 1998.)

MILLER

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SENATE MOTION

Mr. President: I move that Senator Paul be added as coauthor of Senate Bill 294.

MILLER

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred Senate Bill 294, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 4, line 19, delete "(h) (h)" and insert "~~(h)~~ **(g)**".

Page 4, line 20, delete "(i) (i)" and insert "~~(i)~~ **(h)**".

Page 6, line 31, before "As" insert "**(a)**".

Page 6, between lines 35 and 36, begin a new paragraph and insert:

"**(b) "Accident and sickness insurance policy" does not include accident only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance.**".

Page 7, between lines 29 and 30, begin a new paragraph and insert:

"SECTION 5. IC 27-8-27 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]:

Chapter 27. Group Policy Coverage for Infertility Treatment

Sec. 1. (a) As used in this chapter, "policy of accident and sickness insurance" means a policy or contract that:

(1) provides at least one (1) of the kinds of insurance described in Class 1(b) or Class 2(a) of IC 27-1-5-1; and

(2) is written on a group basis.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A limited benefit health insurance policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

Sec. 2. (a) Except as provided in subsection (b), a policy of accident and sickness insurance that provides pregnancy related benefits may not be issued, delivered, amended, or renewed in Indiana unless the insurer issuing the policy offers coverage for the diagnosis and treatment of infertility.

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(b) This chapter does not require coverage for the diagnosis and treatment of infertility in a policy of accident and sickness insurance that is issued to:

(1) a religious institution or organization; or

(2) an entity sponsored by a religious institution or organization;

that finds the procedures in section 3 of this chapter incompatible with its religious and moral teachings and beliefs.

Sec. 3. Subject to section 4 of this chapter, the coverage for the diagnosis and treatment of infertility that must be offered with a policy of accident and sickness insurance under this chapter includes the following procedures:

(1) In vitro fertilization.

(2) Uterine embryo lavage.

(3) Embryo transfer.

(4) Artificial insemination.

(5) Gamete intrafallopian tube transfer.

(6) Zygote intrafallopian tube transfer.

(7) Low tubal ovum transfer.

Sec. 4. (a) If an offer described in section 3 of this chapter has been accepted, an insurer is required under this chapter to cover procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer for an insured individual only if:

(1) the individual has not been able to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments for which coverage is available under the policy;

(2) the individual has undergone not more than three (3) oocyte retrievals, except as provided in subsection (b); and

(3) the procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer are performed at medical facilities that conform to the:

(A) guidelines of the American College of Obstetricians and Gynecologists for in vitro fertilization clinics; or

(B) minimal standards of the American Fertility Society for programs of in vitro fertilization.

(b) Subsection (a)(2) does not relieve an insurer of the obligation to cover an individual who has accepted the offer of coverage described in section 3 of this chapter and has undergone at least four (4) oocyte retrievals if the individual, since giving birth to a

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living child, has had less than two (2) oocyte retrievals.".

Page 9, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 8. IC 27-13-7-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 17. (a) Except as provided in subsection (b), a group contract that provides pregnancy related benefits may not be entered into, delivered, amended, or renewed in Indiana unless the health maintenance organization issuing the group contract offers coverage for the diagnosis and treatment of infertility.**

(b) This chapter does not require coverage for the diagnosis and treatment of infertility in a group contract that is entered into with:

(1) a religious institution or organization; or

(2) an entity sponsored by a religious institution or organization;

that finds the procedures in subsection (c) incompatible with its religious and moral teachings and beliefs.

(c) Subject to subsection (d), the coverage for the diagnosis and treatment of infertility that must be offered with a group contract under this section includes the following procedures as in-plan covered services or out-of-plan covered services:

(1) In vitro fertilization.

(2) Uterine embryo lavage.

(3) Embryo transfer.

(4) Artificial insemination.

(5) Gamete intrafallopian tube transfer.

(6) Zygote intrafallopian tube transfer.

(7) Low tubal ovum transfer.

(d) If an offer described in subsection (c) has been accepted, a health maintenance organization is required under this section to cover procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer for an enrollee only if:

(1) the enrollee has not been able to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments that are in-plan covered services available under the group contract;

(2) the enrollee has undergone not more than three (3) oocyte retrievals, except as provided in subsection (e); and

(3) the procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer are performed at medical facilities that conform to

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the:

(A) guidelines of the American College of Obstetricians and Gynecologists for in vitro fertilization; or

(B) minimal standards of the American Fertility Society for programs of in vitro fertilization.

(e) Subsection (d)(2) does not relieve a health maintenance organization of the obligation to cover an individual who has accepted the offer of coverage described in subsection (c) and has undergone at least four (4) oocyte retrievals if the individual, since giving birth to a living child, has had less than two (2) oocyte retrievals.".

Page 9, line 17, after "delivered" insert "**,**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to Senate Bill 294 as reprinted January 30, 1998.)

FRY, Chair

Committee Vote: yeas 8, nays 4.

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