

First Regular Session 111th General Assembly (1999)

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 1998 General Assembly.

SENATE ENROLLED ACT No. 126

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 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: 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.

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(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:

- (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.

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

(h) 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) 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) The coverage required by subsection (h) and services required by subsection (i) 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) The coverage for breast cancer diagnostic services required by subsection (h) and the breast cancer diagnostic services required by subsection (i) 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 **forty (40) fifty (50)** years of age; and

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(B) a woman at risk;
at least one (1) breast cancer screening mammography performed upon the covered individual every year.

~~(4)~~ **(3)** 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.

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

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

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

SECTION 2. IC 5-10-8-7.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 7.5. (a) As used in this section, "covered individual" means a male 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, "prostate specific antigen test" means a standard blood test performed to determine the level of prostate specific antigen in the blood.

(c) 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.

(d) 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.

(e) The coverage required under subsections (c) and (d) must include the following:

(1) At least one (1) prostate specific antigen test annually for a covered individual who is at least fifty (50) years of age.

(2) At least one (1) prostate specific antigen test annually for a covered individual who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the

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most recent published guidelines of the American Cancer Society.

(f) 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.

(g) 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 3. IC 27-8-14-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 6. (a) **Except as provided in subsection (f)**, 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) **Except as provided in subsection (f)**, 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 **forty (40)** fifty (50) years of age; and
- (B) a woman at risk;

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

(4) (3) 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.

(4) **Any additional mammography views that are required for proper evaluation.**

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

(c) **Except as provided in subsection (f)**, the coverage that an

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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) **Except as provided in subsection (f)**, 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) **Except as provided in subsection (f)**, the coverage that an insurer must ~~offer provide~~ is in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

(f) In the case of insurance policies that are not employer based, the insurer must offer to provide the coverage described in subsections (a) through (e).

SECTION 4. IC 27-8-14.7 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

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 a male individual who is entitled to coverage under a policy of accident and sickness insurance.

Sec. 3. 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. 4. (a) Except as provided in subsection (f), an insurer shall

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provide coverage for prostate specific antigen testing in any accident and sickness insurance policy that the insurer issues in Indiana.

(b) Except as provided in subsection (f), the coverage required under subsection (a) must include the following:

(1) At least one (1) prostate specific antigen test annually for an insured who is at least fifty (50) years of age.

(2) At least one (1) prostate specific antigen test annually for an insured who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

(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) Except as provided in subsection (f), the coverage that an insurer must 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) Except as provided in subsection (f), the coverage that an insurer must provide is in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

(f) In the case of insurance policies that are not employer based, the insurer must offer to provide the coverage described in subsections (a) through (e).

SECTION 5. IC 27-13-7-15.3 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 15.3. (a) As used in this section, "breast cancer screening mammography" has the meaning set forth in IC 27-8-14-2.

(b) As used in this section, "woman at risk" has the meaning set forth in IC 27-8-14-5.

(c) Except as provided in subsection (g), a health maintenance organization issued a certificate of authority in Indiana shall provide breast cancer screening mammography as a covered service under every group contract that provides coverage for basic health care services.



(d) Except as provided in subsection (g), the coverage that a health maintenance organization must provide under this section must include the following:

(1) If the enrollee is at least thirty-five (35) years of age but less than forty (40) years of age and a female, 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 less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed upon the enrollee every year.

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

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

(5) Ultrasound services, if determined medically necessary by the physician treating the enrollee.

(e) Except as provided in subsection (g), the coverage that a health maintenance organization must provide under this section may not be subject to a contract provision that is less favorable to an enrollee or a subscriber than contract provisions applying to physical illness generally under the health maintenance organization contract.

(f) Except as provided in subsection (g), the coverage that a health maintenance organization must provide under this section is in addition to services specifically provided for x-rays, laboratory testing, or wellness examinations.

(g) In the case of coverage that is not employer based, the health maintenance organization must offer to provide the coverage described in subsections (c) through (f).

SECTION 6. IC 27-13-7-16 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 16. (a) 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.

(b) Except as provided in subsection (f), a health maintenance organization issued a certificate of authority in Indiana shall provide prostate specific antigen testing as a covered service under every group contract that provides coverage for basic health care services.

(c) Except as provided in subsection (f), the coverage required



under subsection (b) must include the following:

(1) At least one (1) prostate specific antigen test annually for a male enrollee who is at least fifty (50) years of age.

(2) At least one (1) prostate specific antigen test annually for a male enrollee who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

(d) Except as provided in subsection (f), the coverage that a health maintenance organization must 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.

(e) Except as provided in subsection (f), the coverage that a health maintenance organization must provide under this section is in addition to services specifically provided for x-rays, laboratory testing, or wellness examinations.

(f) In the case of coverage that is not employer based, the health maintenance organization must offer to provide the coverage described in subsections (b) through (e).

SECTION 7. [EFFECTIVE JULY 1, 1999] (a) IC 5-10-8-7.2, as amended 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, 1999.

(b) 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, 1999.

(c) IC 27-8-14-6, as amended by this act, applies to accident and sickness insurance policies that are issued, delivered, or renewed after June 30, 1999.

(d) 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, 1999.

(e) IC 27-13-7-15.3 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, 1999.

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