GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

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SENATE BILL 132

Short Title:	Health Insurance/Colorectal Cancer Screening.	(Public)
Sponsors:	Senators Carpenter, Martin of Guilford, Odom; Albertson, Allran, Bingham, Carrington, Dalton, Dannelly, Forrester, Garwood, Gulley, Kinnaird, Metcalf, Moore, Purcell, Rucho, Shaw of Guilford, Warren, and Wellons.	
Referred to:	Insurance and Consumer Protection.	

February 13, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH INSURANCE PLANS TO PROVIDE COVERAGE FOR COLORECTAL CANCER SCREENING.

The General Assembly of North Carolina enacts:

SECTION 1. Article 51 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-51-63. Coverage for colorectal cancer screening.**

(a) Every policy or contract of accident and health insurance and every preferred provider benefit plan under G.S. 58-50-56 shall provide coverage for colorectal cancer examinations and laboratory tests for cancer, in accordance with the most recently published American Cancer Society guidelines for colorectal cancer screening, for any nonsymptomatic covered individual who is:

(1) At least 50 years of age, or

(2) Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American Cancer Society.

The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for colorectal examinations and laboratory tests required to be covered under this section.

(b) If the policy, contract, or plan does not have an appropriate health care provider that is available and accessible to administer the examinations and tests required under this section and that is a participating provider with respect to the examinations, tests, or treatment, then the policy, contract, or plan shall refer the covered individual to a nonparticipating provider. If a covered individual is referred by the policy, contract, or plan to a nonparticipating health care provider for the examinations or tests required

under this section, then services provided pursuant to the examinations, tests, or resulting treatment, if any, shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services rendered by a participating health care provider.

(c) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the policy, contract, or plan upon initial coverage under the policy, contract, or plan and annually thereafter."

SECTION 2. Article 65 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-97. Coverage for colorectal cancer screening.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56 shall provide coverage for colorectal cancer examinations and laboratory tests for cancer, in accordance with the most recently published American Cancer Society guidelines for colorectal cancer screening, for any nonsymptomatic covered individual who is:

(1) At least 50 years of age, or

(2) Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American Cancer Society.

The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate, contract, or plan shall apply to coverage for colorectal examinations and laboratory tests required to be covered under this section.

(b) If the certificate, contract, or plan does not have an appropriate health care provider that is available and accessible to administer the examinations and tests required under this section and that is a participating provider with respect to the examinations, tests, or treatment, then the certificate, contract, or plan shall refer the covered individual to a nonparticipating provider. If a covered individual is referred by the certificate, contract, or plan to a nonparticipating health care provider for the examinations or tests required under this section, then services provided pursuant to the examinations, tests, or resulting treatment, if any, shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services rendered by a participating health care provider.

(c) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the certificate, contract, or plan upon initial coverage under the certificate, contract, or plan and annually thereafter."

SECTION 3. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-67-81. Coverage for colorectal cancer screening.**

(a) Every health care plan written by a health maintenance organization that is subject to this Article shall provide coverage for colorectal cancer examinations and laboratory tests for cancer, in accordance with the most recently published American

Cancer Society guidelines for colorectal cancer screening, for any nonsymptomatic covered individual who is:

(1) At least 50 years of age, or

(2) Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American Cancer Society.

The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for colorectal examinations and laboratory tests required to be covered under this section.

(b) If the plan does not have an appropriate health care provider that is available and accessible to administer the examinations and tests required under this section and that is a participating provider with respect to the examinations, tests, or treatment, then the plan shall refer the covered individual to a nonparticipating provider. If a covered individual is referred by the plan to a nonparticipating health care provider for the examinations or tests required under this section, then services provided pursuant to the examinations, tests, or resulting treatment, if any, shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services rendered by a participating health care provider.

(c) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the plan upon enrollment and annually thereafter."

SECTION 4. 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 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.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-51-63.

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

SECTION 5. Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies.

SECTION 6. This act becomes effective January 1, 2002.