GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

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HOUSE BILL DRH40155-MR-16A

Short Title:	Breast Cancer Prevention Imaging Parity.	(Public)
Sponsors:	Representative Belk.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO PROVIDE HEALTH COVERAGE PARITY FOR SUPPLEMENTAL AND DIAGNOSTIC BREAST IMAGING.

The General Assembly of North Carolina enacts:

PART I. HEALTH INSURANCE REGULATION CHANGES TO CREATE PARITY FOR SUPPLEMENTAL AND DIAGNOSTIC BREAST IMAGING

SECTION 1.1.(a) G.S. 58-51-57 is recodified as G.S. 58-3-271.

SECTION 1.1.(b) G.S. 58-65-92 is repealed.

SECTION 1.1.(c) G.S. 58-67-76 is repealed.

SECTION 1.2. G.S. 58-3-271, as enacted by Section 1.1(a) of this act, reads as rewritten:

"**§ 58-3-271. Coverage for diagnostic, screening, and supplemental examinations for breast cancer, including mammograms and other imaging, and cervical cancer screening.**

(a) The following definitions apply in this section:

(1) Breast magnetic resonance imaging. – A diagnostic tool that uses a powerful magnetic field, radio waves, and a computer to produce detailed pictures of the structures within the breast.

(2) Breast ultrasound. – A noninvasive diagnostic tool that uses high-frequency sound waves to produce detailed images of the breast.

(3) Cost-sharing. – A deductible, coinsurance, copayment, and any maximum limitation on the application of a deductible, coinsurance, copayment, or similar out-of-pocket expense.

(4) Diagnostic examination for breast cancer. – An examination for breast cancer that is determined by the healthcare provider treating the patient to be medically necessary and appropriate and that may include breast magnetic resonance imaging, breast ultrasound, and diagnostic low-dose mammography to evaluate the abnormality in the breast that meets one of the following criteria:

a. Is seen or suspected from a screening examination for breast cancer.

b. Is detected by another means of examination.

(5) High-deductible health plan. – As defined under the Internal Revenue Code.

(6) Low-dose mammography. – A radiologic procedure for the early detection of breast cancer using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(7) Screening examination for breast cancer. – Low-dose mammography, or an equivalent procedure, that is used to determine if there is abnormality in the breast.

(8) Screening of early detection of cervical cancer. – Examinations and laboratory tests used to detect cervical cancer, including conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

(9) Section 223. – Section 223 of the Internal Revenue Code or its equivalent.

(10) Supplemental examination for breast cancer. – An examination for breast cancer that is determined by the healthcare provider treating the patient to be medically necessary and appropriate and that may include breast magnetic resonance imaging or breast ultrasound to screen for cancer if the patient meets either of the following criteria:

a. The patient is at increased risk for breast cancer based on the patient's personal medical history or family medical history of breast cancer.

b. The patient has a breast cancer risk profile that qualifies the patient based on current recommendations of the United States Preventive Services Task Force, also known as USPSTF.

~~(a)~~(a1) Every ~~policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992,~~ health benefit plan offered by an insurer in this State shall provide coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

~~(a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.~~

~~(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.~~

(b1) Every health benefit plan offered by an insurer that provides benefits for a diagnostic or supplemental examination for breast cancer shall ensure that the cost-sharing requirements applicable to a diagnostic or supplemental examination for breast cancer are no less favorable than the cost-sharing requirements applicable to low-dose screening mammography for breast cancer.

(b2) An insurer shall not be required to reimburse a healthcare provider that is not a contracted provider in the provider network of a health benefit plan offered by the insurer any reimbursement rate more than the rate paid to a provider that has contracted with the insurer to participate in the provider network of the health benefit plan for any of the following services:

(1) Diagnostic, screening, or supplemental examination for breast cancer.

(2) Low-dose mammography.

(3) Breast ultrasound.

(4) Breast magnetic resonance imaging.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any ~~woman~~ individual who is at risk for breast cancer. For purposes of this subdivision, ~~a woman~~ an individual is at risk for breast cancer if any one or more of the following is true:
a. The ~~woman~~ individual has a personal history of breast ~~cancer;~~cancer.
b. The ~~woman~~ individual has a personal history of biopsy-proven benign breast ~~disease;~~disease.
c. The ~~woman's~~ individual's mother, sister, or daughter has or has had breast ~~cancer; or~~cancer.
d. The woman has not given birth prior to the age of ~~30;~~30.
(2) One baseline mammogram for any woman 35 through 39 years of age, ~~inclusive;~~inclusive.
(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a ~~physician; and~~physician.
(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards established by the North Carolina Medical Care Commission.

(e) Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.

(f) If the application of any provision of this section would render the insured ineligible for a health savings account under section 223, then that provision shall apply only for high-deductible health plans with respect to the deductible of that plan after the insured has satisfied the minimum deductible under section 223, except with respect to items or services that are preventative care. For items or services that are preventative care under section 223, all provisions of this section shall apply regardless of whether or not the minimum deductible under section 223 has been satisfied."

SECTION 1.3. G.S. 135-48.51 reads as rewritten:

"**§ 135-48.51. Coverage and operational mandates related to Chapter 58 of the General Statutes.**

The following provisions of Chapter 58 of the General Statutes apply to the State Health Plan:

…

(9a) G.S. 58-3-271, Coverage for diagnostic, screening, and supplemental examinations for breast cancer, including mammograms and other imaging, and cervical cancer screening.

…."

SECTION 1.4. Except as otherwise provided, this Part becomes effective October 1, 2025, and applies to insurance contracts issued, renewed, or amended on or after that date.

PART II. HEALTHCARE PROVIDER BILLING REGULATION CHANGES TO CREATE PARITY FOR SUPPLEMENTAL AND DIAGNOSTIC BREAST CANCER IMAGING

SECTION 2.1.(a) G.S. 90-701 is recodified as G.S. 90-705.

SECTION 2.1.(b) Article 41 of Chapter 90 of the General Statutes, as amended by subsection (a) of this section, reads as rewritten:

"Article 41.

"~~Pathology Services Billing.~~Transparency in Healthcare Provider Billing Practices.

"**§ 90-702. Definitions.**

The following definitions shall apply in this Article:

(1) Breast cancer prevention service. – All services listed under G.S. 58-3-271(b2).

(2) Cost-sharing. – As defined in G.S. 58-3-271.

(3) Reserved for future codification purposes.

(4) Health benefit plan. – As defined in G.S. 58-3-167.

(5) Healthcare provider. – A health services facility or a person who is licensed, registered, or certified under Chapter 90 or Chapter 90B of the General Statutes, or under the laws of another state, to provide healthcare services in the ordinary care of business or practice, or as a profession, or in an approved education or training program.

(6) Health services facility. – As defined in G.S. 131E-214.25

(7) Reserved for future codification purposes.

(8) Insurer. – As defined in G.S. 58-3-167.

"**§ 90-704. Billing for certain breast cancer prevention services.**

(a) A healthcare provider who has not contracted with an insurer to participate in the provider network of a health benefit plan shall accept as reimbursement for any breast cancer prevention service provided to an individual insured under a health benefit plan the amount of reimbursement provided by that insurer, including any cost-sharing required to be paid by the patient.

(b) No healthcare provider may bill a patient covered under a health benefit plan or request additional reimbursement from the insurer for any amount above the amount required to be accepted under subsection (a) of this section.

…."

SECTION 2.2. This Part is effective October 1, 2025, and applies to services provided on or after that date.

PART III. EFFECTIVE DATE

SECTION 3.1. Except as otherwise provided, this act is effective when it becomes law.