



Senate

General Assembly

File No. 255

February Session, 2008

Substitute Senate Bill No. 280

Senate, March 31, 2008

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR BONE MARROW TESTING AND PROSTHESES, AND REQUIRING A HEALTH BENEFITS IMPACT REVIEW OF HEALTH INSURANCE MANDATES IN THIS STATE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective January 1, 2009*) (a) Subject to the
2 provisions of subsections (b) and (c) of this section, each individual
3 health insurance policy providing coverage of the type specified in
4 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
5 statutes delivered, issued for delivery, amended, renewed or
6 continued in this state on or after January 1, 2009, shall provide
7 coverage for expenses arising from human leukocyte antigen testing,
8 also referred to as histocompatibility locus antigen testing, for A, B and
9 DR antigens for utilization in bone marrow transplantation.

10 (b) No such policy shall impose a coinsurance, copayment,
11 deductible or other out-of-pocket expense for such testing in excess of
12 thirty per cent of the cost for such testing per year. The provisions of

13 this subsection shall not apply to a high deductible plan as that term is
14 used in subsection (f) of section 38a-520 of the general statutes.

15 (c) Such policy may:

16 (1) Require that such testing be performed in a facility (A)
17 accredited by the American Association of Blood Banks, or its
18 successor, or the College of American Pathologists, or its successor, or
19 any other national accrediting body with requirements that are
20 substantially equivalent to or more stringent than those of the College
21 of American Pathologists, and (B) certified under the Clinical
22 Laboratory Improvement Act of 1967, 42 USC Section 263a, as
23 amended from time to time;

24 (2) Limit coverage to individuals who, at the time of such testing,
25 complete and sign an informed consent form that also authorizes the
26 results of the test to be used for participation in the National Marrow
27 Donor Program; and

28 (3) Limit such coverage to a lifetime maximum benefit of one
29 testing.

30 Sec. 2. (NEW) (*Effective January 1, 2009*) (a) Subject to the provisions
31 of subsections (b) and (c) of this section, each group health insurance
32 policy providing coverage of the type specified in subdivisions (1), (2),
33 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
34 issued for delivery, amended, renewed or continued in this state on or
35 after January 1, 2009, shall provide coverage for expenses arising from
36 human leukocyte antigen testing, also referred to as histocompatibility
37 locus antigen testing, for A, B and DR antigens for utilization in bone
38 marrow transplantation.

39 (b) No such policy shall impose a coinsurance, copayment,
40 deductible or other out-of-pocket expense for such testing in excess of
41 thirty per cent of the cost for such testing per year. The provisions of
42 this subsection shall not apply to a high deductible health plan as that
43 term is used in subsection (f) of section 38a-520 of the general statutes.

44 (c) Such policy may:

45 (1) Require that such testing be performed in a facility (A)
46 accredited by the American Association of Blood Banks, or its
47 successor, or the College of American Pathologists, or its successor, or
48 any other national accrediting body with requirements that are
49 substantially equivalent to or more stringent than those of the College
50 of American Pathologists, and (B) certified under the Clinical
51 Laboratory Improvement Act of 1967, 42 USC Section 263a, as from
52 time to time amended;

53 (2) Limit coverage to individuals who, at the time of such testing,
54 complete and sign an informed consent form that also authorizes the
55 results of the test to be used for participation in the National Marrow
56 Donor Program; and

57 (3) Limit such coverage to a lifetime maximum benefit of one
58 testing.

59 Sec. 3. Section 38a-504 of the general statutes is repealed and the
60 following is substituted in lieu thereof (*Effective January 1, 2009*):

61 (a) Each insurance company, hospital service corporation, medical
62 service corporation, health care center or fraternal benefit society
63 [which] that delivers, [or] issues for delivery, renews, amends or
64 continues in this state individual health insurance policies providing
65 coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and
66 (12) of section 38a-469, shall provide coverage under such policies for
67 the surgical removal of tumors and treatment of leukemia, including
68 outpatient chemotherapy, reconstructive surgery, cost of any
69 nondental prosthesis including any maxillo-facial prosthesis used to
70 replace anatomic structures lost during treatment for head and neck
71 tumors or additional appliances essential for the support of such
72 prosthesis, prosthetic devices, outpatient chemotherapy following
73 surgical procedure in connection with the treatment of tumors, and a
74 wig if prescribed by a licensed oncologist for a patient who suffers hair
75 loss as a result of chemotherapy. Such benefits shall be subject to the

76 same terms and conditions applicable to all other benefits under such
77 policies, except that benefits payable for prosthetic devices shall not be
78 applied to any policy maximums for durable medical equipment. For
79 the purpose of this section, "prosthetic device" means an artificial
80 device to replace, in whole or in part, an arm or a leg, except that it
81 does not include a device that contains a microprocessor or that is
82 designed exclusively for athletic purposes.

83 (b) Except as provided in subsection (c) of this section, the coverage
84 required by subsection (a) of this section shall provide at least a yearly
85 benefit of five hundred dollars for the surgical removal of tumors, five
86 hundred dollars for reconstructive surgery, three hundred dollars for
87 nondental prosthesis, except that for purposes of the surgical removal
88 of breasts due to tumors, the yearly benefit for prosthesis shall be at
89 least three hundred dollars for each breast removed, two thousand five
90 hundred dollars for a prosthetic device per limb, five hundred dollars
91 for outpatient chemotherapy [,] and three hundred fifty dollars for a
92 wig. [and three hundred dollars for prosthesis, except that for
93 purposes of the surgical removal of breasts due to tumors the yearly
94 benefit for prosthesis shall be at least three hundred dollars for each
95 breast removed.]

96 (c) The coverage required by subsection (a) of this section shall
97 provide benefits for the reasonable costs of reconstructive surgery on
98 each breast on which a mastectomy has been performed, and
99 reconstructive surgery on a nondiseased breast to produce a
100 symmetrical appearance. Such benefits shall be subject to the same
101 terms and conditions applicable to all other benefits under such
102 policies. For the purposes of this subsection, reconstructive surgery
103 includes, but is not limited to, augmentation mammoplasty, reduction
104 mammoplasty and mastopexy.

105 Sec. 4. Section 38a-542 of the general statutes is repealed and the
106 following is substituted in lieu thereof (*Effective January 1, 2009*):

107 (a) Each insurance company, hospital service corporation, medical
108 service corporation, health care center or fraternal benefit society

109 [which] that delivers, [or] issues for delivery, renews, amends or
110 continues in this state group health insurance policies providing
111 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)
112 of section 38a-469 shall provide coverage under such policies for
113 treatment of leukemia, including outpatient chemotherapy,
114 reconstructive surgery, cost of any nondental prosthesis, including any
115 maxillo-facial prosthesis used to replace anatomic structures lost
116 during treatment for head and neck tumors or additional appliances
117 essential for the support of such prosthesis, prosthetic devices,
118 outpatient chemotherapy following surgical procedures in connection
119 with the treatment of tumors, a wig if prescribed by a licensed
120 oncologist for a patient who suffers hair loss as a result of
121 chemotherapy, and costs of removal of any breast implant which was
122 implanted on or before July 1, 1994, without regard to the purpose of
123 such implantation, which removal is determined to be medically
124 necessary. Such benefits shall be subject to the same terms and
125 conditions applicable to all other benefits under such policies, except
126 that benefits payable for prosthetic devices shall not be applied to any
127 policy maximums for durable medical equipment. For the purpose of
128 this section, "prosthetic device" means an artificial device to replace, in
129 whole or in part, an arm or a leg, except that it does not include a
130 device that contains a microprocessor or that is designed exclusively
131 for athletic purposes.

132 (b) Except as provided in subsection (c) of this section, the coverage
133 required by subsection (a) of this section shall provide at least a yearly
134 benefit of one thousand dollars for the costs of removal of any breast
135 implant, five hundred dollars for the surgical removal of tumors, five
136 hundred dollars for reconstructive surgery, three hundred dollars for
137 nondental prosthesis, except that for purposes of the surgical removal
138 of breasts due to tumors, the yearly benefit for prosthesis shall be at
139 least three hundred dollars for each breast removed, two thousand five
140 hundred dollars for a prosthetic device per limb, five hundred dollars
141 for outpatient chemotherapy [,] and three hundred fifty dollars for a
142 wig. [and three hundred dollars for prosthesis, except that for
143 purposes of the surgical removal of breasts due to tumors the yearly

144 benefit for prosthesis shall be at least three hundred dollars for each
145 breast removed.]

146 (c) The coverage required by subsection (a) of this section shall
147 provide benefits for the reasonable costs of reconstructive surgery on
148 each breast on which a mastectomy has been performed, and
149 reconstructive surgery on a nondiseased breast to produce a
150 symmetrical appearance. Such benefits shall be subject to the same
151 terms and conditions applicable to all other benefits under such
152 policies. For the purposes of this subsection, reconstructive surgery
153 includes, but is not limited to, augmentation mammoplasty, reduction
154 mammoplasty and mastopexy.

155 Sec. 5. (*Effective from passage*) (a) The Insurance Commissioner shall
156 contract with an independent entity to conduct an impact review of all
157 benefits required to be provided by insurers in health insurance
158 policies pursuant to chapter 700c of the general statutes in effect on
159 October 1, 2008. Such review shall include, but not be limited to, an
160 evaluation of (1) the financial impact of such benefits, and (2) the
161 impact of such benefits on the access and availability of insurance
162 coverage.

163 (b) Not later than July 1, 2009, the commissioner shall submit a
164 report on such review to the joint standing committee of the General
165 Assembly having cognizance of matters relating to insurance, in
166 accordance with section 11-4a of the general statutes.

167 Sec. 6. (NEW) (*Effective October 1, 2008*) (a) For the purpose of this
168 section, "benefit or service mandate" means a general statute or
169 proposed legislation that requires an insurer to: (1) Permit a person
170 insured or covered under the policy or contract to obtain health care
171 treatment or services from a particular type of health care provider; (2)
172 offer or provide coverage for the screening, diagnosis or treatment of a
173 particular disease or condition; or (3) offer or provide coverage for a
174 particular type of health care treatment or service, medical equipment,
175 medical supplies or drugs in connection with a health care treatment
176 or service.

177 (b) Upon request by the joint standing committee of the General
 178 Assembly having cognizance of matters relating to insurance, the
 179 Insurance Commissioner shall contract with an independent entity to
 180 conduct an impact review of (1) any legislation proposing a benefit or
 181 service mandate in health insurance policies on or after January 1,
 182 2009; (2) any legislation proposing to repeal a benefit or service
 183 mandate on or after January 1, 2009, that was in effect prior to January
 184 1, 2009; or (3) any change proposed in the scope or terms of coverage
 185 of a benefit or service mandate in effect at the time of such proposed
 186 change.

187 (c) Such review shall include, but not be limited to, an evaluation of
 188 (1) the financial impact of such benefits; and (2) the impact of such
 189 benefits on the access and availability of insurance coverage.

190 (d) Not later than December 31, 2009, and annually thereafter, the
 191 commissioner shall submit a report on any requested impact reviews,
 192 in accordance with section 11-4a of the general statutes, to the joint
 193 standing committee of the General Assembly having cognizance of
 194 matters relating to insurance.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2009</i>	New section
Sec. 2	<i>January 1, 2009</i>	New section
Sec. 3	<i>January 1, 2009</i>	38a-504
Sec. 4	<i>January 1, 2009</i>	38a-542
Sec. 5	<i>from passage</i>	New section
Sec. 6	<i>October 1, 2008</i>	New section

Statement of Legislative Commissioners:

In subsection (b) of section 3 and subsection (b) of section 4, "per limb" was moved after "prosthetic device" for accuracy.

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 09 \$	FY 10 \$
State Comptroller - State Employee Health Service Account	Various - Cost	None	See Below
Insurance Dept.	IF - Cost	\$300,000 - 420,000	\$315,000 - 435,000

Note: IF=Insurance Fund

Municipal Impact:

Municipalities	Effect	FY 09 \$	FY 10 \$
Various Municipalities	Cost	Potential	Potential

Explanation

The bill's provisions related to prostheses may impact the state employee health plan costs when the required coverage becomes effective in FY 10. The bill's proposed changes to prostheses coverage to the current state plan and the associated fiscal impact to the state's FY 10 premium are under review by the actuary and are not available at this time. The bill's mandate related to bone marrow testing is not anticipated to have any impact on the state health plan costs.

The bill may impact municipalities that have fully insured health plans and do not currently cover the bone marrow testing and prostheses required by the bill. The coverage requirements may result in increased premium costs when municipalities enter into new contracts for health insurance.

The bill would result in a cost of between \$250,000 and \$350,000 in FY 09 to the Department of Insurance (DOI) as the agency would need to hire an outside consultant to complete the one-time benefit evaluation required by the bill. DOI does not have the resources in staff or systems capability to be able to fulfill this provision in-house.

Provisions of the bill require DOI to contract with an independent entity annually to conduct an impact review of proposed legislation related to health insurance mandates, resulting in an annual cost to the agency of between \$50,000 and \$70,000 both in FY 09 and FY 10.

The bill requires an annual report to be submitted to the joint standing committee of the General Assembly on matters relating to insurance not later than December 31, 2009. Estimated costs to hire an outside consultant to complete this annual report on proposed, repealed or changed benefits would be approximately \$15,000 in FY 10.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**sSB 280*****AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR BONE MARROW TESTING AND PROSTHESES, AND REQUIRING A HEALTH BENEFITS IMPACT REVIEW OF HEALTH INSURANCE MANDATES IN THIS STATE.*****SUMMARY:**

This bill requires certain health insurance policies to provide specified coverage for (1) human leukocyte antigen testing, which determines bone marrow compatibility for transplants, and (2) prosthetic devices. (Due to federal law, state benefit mandates do not apply to self-insured plans.)

The bill requires the insurance commissioner to contract with an independent entity to review (1) the benefits that Connecticut law, as of October 1, 2008, requires health insurance policies to provide and (2) upon the Insurance and Real Estate Committee's request, any (a) proposed change to a benefit or service mandate or (b) legislation proposing to enact or repeal a mandate on or after January 1, 2009. The reviews must evaluate each benefit's (1) financial impact and (2) impact on access to and availability of insurance coverage.

It requires the commissioner to report to the committee on the (1) review of existing benefit laws by July 1, 2009 and (2) requested reviews annually by December 31, 2009.

EFFECTIVE DATE: January 1, 2009, except for the provisions requiring a study of existing mandates and permitting the Insurance and Real Estate Committee to request a study of proposed mandates, which are effective upon passage and October 1, 2008, respectively.

BONE MARROW TESTING

The bill requires health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2009 to cover expenses for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for bone marrow transplantation purposes.

It prohibits a policy, except for a high-deductible policy defined in federal law, from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for the testing that is more than 30% of the cost for testing per year.

It permits a policy to:

1. require that testing be performed in a facility that (a) the American Association of Blood Banks, College of American Pathologists, or similar national body has accredited or (b) is certified under federal law;
2. limit coverage to people who, when being tested, sign up for the National Marrow Donor Program; and
3. impose a limit of one covered test in a person's lifetime.

The bill applies the coverage requirement to group and individual health insurance policies that cover basic hospital, medical-surgical, or major medical expenses, including HMO contracts covering hospital and medical expenses and hospital or medical service contracts.

PROSTHETIC DEVICES

The bill requires health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2009 to include coverage for prosthetic devices of at least \$2,500 each year, per limb. It requires coverage to be subject to the same terms and conditions as other policy benefits, except it prohibits benefits paid for prosthetic devices from applying toward a policy's durable medical equipment maximum.

It defines a "prosthetic device" as an artificial device to replace all or

part of an arm or leg. It excludes a device that (1) contains a microprocessor or (2) is designed exclusively for athletic purposes.

The bill applies the coverage requirement to group and individual health insurance policies that cover basic hospital, medical-surgical, major medical expenses, or limited benefits, including HMO contracts covering hospital and medical expenses and hospital or medical service contracts.

BENEFIT OR SERVICE MANDATE

The bill defines “benefit or service mandate” for a requested impact review as a general statute or proposed legislation that requires an insurer to (1) allow insureds to obtain health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or (3) offer or provide coverage for a particular type of health care treatment or service or medical equipment, supplies, or drugs.

BACKGROUND

Related Bills

HB 5514, which the Insurance and Real Estate Committee reported creates a prostheses loan program from which people can borrow to purchase prosthetics when their insurance coverage is inadequate.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 17 Nay 0 (03/13/2008)