
OLR Bill Analysis

sSB 396 (File 49, as amended by Senate "A" and "B")*

AN ACT CONCERNING INSURANCE COVERAGE FOR THE SCREENING AND TREATMENT OF PROSTATE CANCER.

SUMMARY:

Current law requires certain individual and group health insurance plans to cover laboratory and diagnostic tests to detect prostate cancer in men who are (1) symptomatic or in high-risk categories and (2) age 50 or older. This bill expands coverage to include prostate cancer treatment if it is “medically necessary” and in accordance with guidelines established by (1) the National Comprehensive Cancer Network, (2) the American Cancer Society, or (3) the American Society of Clinical Oncology.

The bill also extends prostate cancer screening requirements to individual and group health insurance policies amended in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan. Current law already applies to such policies delivered, issued, continued, or renewed in the state. (Due to federal law (ERISA), state health insurance mandates do not apply to self-insured plans.)

Finally, the bill requires insurers and other entities that contract with a physician or a physician’s group to provide services under a group or individual health insurance policy to establish a payment amount for the physician’s services component of the covered colonoscopy or endoscopic services that is the same, regardless of where the services are performed. The payment amount must be at least that which would otherwise be paid to the contracted physician or physician’s group if the services were performed at a facility other than an outpatient surgical facility. Entities must establish the payment

amount at the request of the contracted physician or physician's group. The bill specifies that it does not prohibit a contracted physician or physician's group from agreeing to a different payment method for these services.

This requirement applies to individual and group health insurance companies, HMOs, hospital medical service corporations, and fraternal benefit societies that deliver, issue, renew, amend, or continue individual and group health insurance policies providing the types of coverage listed above.

*Senate Amendment "A" adds the provision requiring insurers and other entities contracting with physicians and physicians' groups to establish an equal payment amount for physician services regardless of where they are performed.

*Senate Amendment "B" removes the provision in the original file limiting the expanded coverage for prostate cancer detection and treatment to a two-year period, from January 1, 2012 to December 31, 2013.

EFFECTIVE DATE: October 1, 2011, except that the provisions on prostate cancer screening and treatment take effect on January 1, 2012.

BACKGROUND

Medically Necessary

The law defines "medically necessary" as health care services that a physician, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient's illness, injury, or disease;

3. not primarily for the convenience of the patient, physician, or other health care provider; and
4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 9 Nay 7 (02/22/2011)

Appropriations Committee

Joint Favorable

Yea 35 Nay 19 (05/04/2011)