

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 11-225—sSB 396

*Insurance and Real Estate Committee
Appropriations Committee*

**AN ACT CONCERNING INSURANCE COVERAGE FOR THE
SCREENING AND TREATMENT OF PROSTATE CANCER AND
PROHIBITING DIFFERENTIAL PAYMENT RATES TO HEALTH CARE
PROVIDERS FOR COLONOSCOPY OR ENDOSCOPIC SERVICES
BASED ON SITE OF SERVICE**

SUMMARY: Existing law requires certain health insurance plans to cover laboratory and diagnostic tests to detect prostate cancer in men who are (1) symptomatic or in high-risk categories or (2) age 50 or older. This act 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 act 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. Existing law already applies to such policies delivered, issued, continued, or renewed in the state. (Due to the federal Employee Retirement Income Security Act (ERISA), state health insurance mandates do not apply to self-insured plans.)

Finally, the act 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 act 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 and 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.

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

BACKGROUND

OLR PUBLIC ACT SUMMARY

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.

OLR Tracking: ND:JKL:PF:df