



Senate

General Assembly

File No. 18

February Session, 2012

Senate Bill No. 98

Senate, March 8, 2012

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 bill ought to pass.

AN ACT CONCERNING DEDUCTIBLES AND GUIDELINES FOR COLONOSCOPIES.

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

1 Section 1. Section 38a-492k of the 2012 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective January 1, 2013*):

4 (a) Each individual health insurance policy providing coverage of
5 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
6 38a-469 delivered, issued for delivery, amended, renewed or continued
7 in this state shall provide coverage for colorectal cancer screening,
8 including, but not limited to, (1) an annual fecal occult blood test, and
9 (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in
10 accordance with the recommendations established by the American
11 College of Gastroenterology, [after consultation with] the American
12 Cancer Society [and] or the American College of Radiology, based on
13 the ages, family histories and frequencies provided in the
14 recommendations. Except as specified in subsection (b) of this section,

15 benefits under this section shall be subject to the same terms and
16 conditions applicable to all other benefits under such policies.

17 (b) No such policy shall impose: [a]

18 (1) A deductible for a procedure that a physician initially
19 undertakes as a screening colonoscopy or a screening sigmoidoscopy;
20 or

21 (2) A coinsurance, copayment, deductible or other out-of-pocket
22 expense for any additional colonoscopy ordered in a policy year by a
23 physician for an insured. The provisions of this [subsection]
24 subdivision shall not apply to a high deductible health plan as that
25 term is used in subsection (f) of section 38a-493.

26 Sec. 2. Section 38a-518k of the 2012 supplement to the general
27 statutes is repealed and the following is substituted in lieu thereof
28 (*Effective January 1, 2013*):

29 (a) Each group health insurance policy providing coverage of the
30 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
31 469 delivered, issued for delivery, amended, renewed or continued in
32 this state shall provide coverage for colorectal cancer screening,
33 including, but not limited to, (1) an annual fecal occult blood test, and
34 (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in
35 accordance with the recommendations established by the American
36 College of Gastroenterology, [after consultation with] the American
37 Cancer Society [and] or the American College of Radiology, based on
38 the ages, family histories and frequencies provided in the
39 recommendations. Except as specified in subsection (b) of this section,
40 benefits under this section shall be subject to the same terms and
41 conditions applicable to all other benefits under such policies.

42 (b) No such policy shall impose: [a]

43 (1) A deductible for a procedure that a physician initially
44 undertakes as a screening colonoscopy or a screening sigmoidoscopy;
45 or

46 (2) A coinsurance, copayment, deductible or other out-of-pocket
47 expense for any additional colonoscopy ordered in a policy year by a
48 physician for an insured. The provisions of this subsection shall not
49 apply to a high deductible health plan as that term is used in
50 subsection (f) of section 38a-520.

This act shall take effect as follows and shall amend the following sections:		
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Section 1	<i>January 1, 2013</i>	38a-492k
Sec. 2	<i>January 1, 2013</i>	38a-518k

INS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None, See Below for Out-Years

Municipal Impact:

Municipalities	Effect	FY 13 \$	FY 14 \$
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

Explanation

The bill's provisions are not anticipated to result in a cost to the state employee health plan. The state employee plan does not currently charge a deductible for procedures initially undertaken as a colorectal cancer screening.

The bill may increase costs to certain fully insured municipal plans which charge a deductible for screenings which lead to other related services rendered in conjunction with the screening. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2013. Due to current federal law, municipalities with self-insured plans are exempt from state health insurance mandates.

Many municipal health plans are recognized as "grandfathered" health plans under the Patient Protection and Affordable Care Act (PPACA)¹. It is unclear what effect the adoption of certain health

¹ Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010. Pursuant to the PPACA, all health plans, including those with grandfathered status are required to provide the following as of September 23, 2010: 1) No lifetime limits on coverage, 2) No rescissions of coverage when individual gets sick or has previously made an

mandates will have on the grandfathered status of certain municipal plans under PPACA².

Lastly, the bill requires insurers to cover tests in accordance with any of the following: the American College of Gastroenterology, American Cancer Society, or the American College of Radiology. These changes do not result in a fiscal impact.

The Out Years

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

In addition, the federal health care reform act requires that, effective January 1, 2014, all states must establish a health benefit exchange, which will offer qualified health plans that must include a federally defined essential health benefits package (EHB)³. The federal government is allowing states to choose a benchmark plan⁴ to serve as the EHB until 2016 when the federal government is anticipated to revisit the EHB.

While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to pay the cost of any such additional

unintentional error on an application, and 3) Extension of parents' coverage to young adults until age 26. (www.healthcare.gov)

² According to the PPACA, compared to the plans' policies as of March 23, 2010, grandfathered plans who make any of the following changes within a certain margin may lose their grandfathered status: 1) Significantly cut or reduce benefits, 2) Raise co-insurance charges, 3) Significantly raise co-payment charges, 4) Significantly raise deductibles, 5) Significantly lower employer contributions, and 5) Add or tighten annual limits on what insurer pays. (www.healthcare.gov)

³ EHB requires coverage in 10 categories. In addition, Section 2711 of the Public Service Act prohibits annual dollar limits or lifetime maximums on EHBs.

⁴ The state may choose one of the three largest plans by enrollment in one of the following categories to serve as the benchmark plan: 1) small group, 2) state employee health plans, 3) federal employee health plans, or 4) the largest HMO plan offered in the state's commercial market. If the state does not select one of the aforementioned options, the default plan will be the small group plan with the largest enrollment in the state. (Source: Dept. of Health and Human Services. *Essential Health Benefits: HHS Informational Bulletin Fact Sheet* (December 16, 2011)).

mandated benefits for **all plans** sold in the exchange⁵. The extent of these costs will ultimately depend on the mandates included in the federal essential benefit package, which have not yet been determined. If the benchmark plan chosen by the state to serve as the EHB includes all state health mandates there is no additional cost to the state. However, if the benchmark plan does not include certain state mandated health benefits the state would be responsible for the cost of those additional mandated benefits. Lastly, state mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB for 2014-2015 unless they are already part of the benchmark plan⁶.

⁵ As of December 2011, Connecticut had 32 mandated health benefits in law. Maryland has the most, with 35 and Indiana has the least with 6. (Source: The Blue Cross/Blue Shield Association. *State Legislative Healthcare and Insurance Issues 2011*. Prepared by: Susan S. Laudicina, Joan M. Gardner, Kim Holland. As reported by NCSL, <http://www.ncsl.org/issues-research/health/state-ins-mandates-and-aca-essential-benefits.aspx>. Accessed 3/2/12.)

⁶ Source: Dept. of Health and Human Services. *Frequently Asked Questions on Essential Health Benefits Bulletin* (February 21, 2012).

OLR Bill Analysis**SB 98*****AN ACT CONCERNING DEDUCTIBLES AND GUIDELINES FOR COLONOSCOPIES.*****SUMMARY:**

This bill bars insurers from charging a deductible for procedures a physician initially undertakes as a colorectal cancer screening colonoscopy or sigmoidoscopy. (A colonoscopy covers the entire lower intestine; a sigmoidoscopy extends only to the lower colon.) Some insurers currently charge a deductible when these screening procedures discover a polyp, which is removed at the same time.

By law, specified individual and group insurance policies must cover colonoscopies, sigmoidoscopies, and radiological imaging. Under current law, they must do so following recommendations established by the American College of Gastroenterology, after its consultation with the American Cancer Society and the American College of Radiology. The bill instead requires insurers to cover the tests in accordance with the recommendations of any one of these groups.

The affected individual and group health insurance policies are those issued, amended, renewed, or continued that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. Due to the federal Employee Retirement and Income Security Act (ERISA), state health insurance mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2013

Insurance and Real Estate Committee

Joint Favorable

Yea 15 Nay 5 (02/28/2012)