



## STATE STATUTES ON BREAST CANCER SCREENING AND COVERAGE

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### HEALTH INSURANCE POLICIES

- Unless specified, benefit mandates referenced in this report apply to (1) individual limited benefit health policies and (2) individual and group policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; or (d) hospital or medical services, including coverage under an HMO plan.
- Some benefit mandates require that services be "medically necessary," as defined by state law (CGS §§ [38a-482a](#) & [38a-513c](#)).
- Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans. For more information about ERISA preemption, see OLR Report [2005-R-0753](#).

### ISSUE

This report summarizes Connecticut statutes on (1) health insurance coverage for breast cancer screening and (2) other breast cancer-related programs.

### SUMMARY

Connecticut law generally requires an insurance company or health plan to cover:

1. preventative care, including mammograms, ultrasounds, and magnetic resonance imaging (MRIs);
2. treatment, including mastectomies, inpatient care, tumor removal, surgical reconstructive services, and prosthesis; and
3. certain breast cancer survivors, regardless of pre-existing conditions.

The law prescribes minimum annual benefit levels for certain treatments and services. It also limits the copays insurers can charge for mammograms, MRIs, computer axial tomography (i.e., CAT scans), or positron emission tomography (i.e. PET scans).

The law also requires the Medicaid state plan and Medicare supplement policies to cover mammograms. (A Medicare supplement policy is an individual health insurance policy for someone who is eligible for Medicare.)

Connecticut statutes also address certain breast cancer education, programs, and funds.

This report does not include statutes that could apply to breast cancer but do not specifically reference the term.

## **SCREENING**

Connecticut law generally requires insurance policies to cover mammograms, ultrasounds, and MRIs.

### ***Mammograms***

Health insurance policies (see sidebar) must cover baseline mammograms for women age 35 to 39 and annual mammograms for women age 40 and older. They also require any mammography report (e.g., the written results of a mammography) given to a patient to include information about breast density and, when applicable, a notice regarding dense breast tissue (CGS §§ [38a-503](#) & [38a-530](#)).

Medicaid must cover (1) baseline mammograms for women age 35 to 39 and (2) annual mammograms for women age 40 and older ([CGS § 17b-278c](#)).

Medicare supplement policies must cover mammograms every year, or more frequently if recommended by the woman's physician, when such examinations are not paid for by Medicare ([CGS § 38a-495\(e\)](#)).

### ***Ultrasounds and MRIs***

Health insurance policies must cover comprehensive ultrasound screenings if a mammogram demonstrates heterogeneous or dense breast tissue or if a woman is believed to be at increased risk for breast cancer due to certain factors. Effective January 1, 2015, a policy cannot impose a copay of more than \$20 for a breast ultrasound screening (see below).

Coverage must also be provided for MRIs in accordance with guidelines established by the American Cancer Society (CGS §§ [38a-503](#) & [38a-530](#)).

## **TREATMENT**

Connecticut law generally requires health insurers to cover the care and treatment associated with breast cancer, including chemotherapy, tumor removal, reconstructive surgery, and inpatient care.

## ***Chemotherapy and Reconstructive Services After Mastectomy***

Individual and group comprehensive health insurance policies, as a minimum standard benefit, must cover outpatient chemotherapy associated with the removal of tumors ([CGS § 38a-553\(a\)](#)).

Individual and group health insurance policies must cover reconstructive surgery, chemotherapy, and other services related to the surgical removal of tumors, including outpatient chemotherapy (CGS §§ [38a-504](#) & [38a-542](#)). They must cover a minimum 48-hour hospital stay after a mastectomy or lymph node dissection or longer if recommended by a physician (see below) (CGS §§ [38a-503d](#) & [38a-530d](#)).

They must also cover the reasonable costs of reconstructive surgery on each breast on which a mastectomy has been performed and reconstructive surgery on a nondiseased breast to produce a symmetrical appearance (CGS §§ [38a-504\(c\)](#) & [38a-542\(c\)](#)).

### ***Inpatient Care***

Individual and group health insurance policies must cover at least 48 hours of inpatient care following a mastectomy, or longer if recommended by the patient's treating physician. Insurers are prohibited from cancelling service, requiring additional documentation, or otherwise penalizing or providing financial disincentives to any health care provider for ordering longer inpatient care (CGS §§ [38a-503d](#) & [38a-530d](#)).

### ***Medicaid***

Medicaid must provide coverage for women diagnosed with breast or cervical cancer ([CGS § 17b-278b](#)).

## **ANNUAL BENEFITS AND COPAYS**

### ***Annual Benefits***

The law also limits the amount an insurer may charge for copays for mammograms, ultrasounds, and certain imaging services.

Certain health insurance plans must provide yearly benefits of at least:

1. \$1,000 for the costs of removing of any breast implant;
2. \$500 for the surgical removal of tumors;
3. \$500 for reconstructive surgery;

4. \$500 for outpatient chemotherapy;
5. \$350 dollars for a wig;
6. \$300 for a nondental prosthesis; and
7. at least \$300, per removed breast, for prosthesis (CGS §§ [38a-504\(b\)](#) & [38a-542\(b\)](#)).

### **Copays**

Individual and group health insurance policies are prohibited from charging more than a \$20 copay for mammograms or comprehensive ultrasound screenings completed because the woman has dense breast tissue or is believed to be at increased risk for breast cancer due to certain factors (CGS §§ [38a-503](#) & [38a-530](#)).

Individual and group health insurance policies provided by entities that cover MRIs, CAT scans, or PET scans are prohibited from charging copays more than:

1. \$75 for each in-network MRI or CAT scan, or \$375 per year for all in-network MRIs or CAT scans (CGS §§ [38a-511\(a\)](#) & [38a-550\(a\)](#)) and
2. \$100 copay for each in-network PET scan, or \$400 per year for all in-network pet scans (CGS §§ [38a-511\(b\)](#) & [38a-550\(b\)](#)).

This statute applies to insurance policies provided by health insurers, health care centers, hospital service corporations, medical service corporations or fraternal benefit societies.

### **PRE-EXISTING CONDITION EXEMPTIONS**

Connecticut law prohibits insurers from denying coverage to breast cancer survivors because of pre-existing conditions. The federal Affordable Care Act generally prohibits insurers from denying coverage based on a preexisting condition ([45 C.F.R. § 147.108](#)).

Routine breast cancer follow-up care for individuals who are breast cancer free is not considered a pre-existing condition, unless evidence of breast cancer is found during or as a result of the follow-up service ([CGS § 38a-476\(a\)\(3\)](#)).

Individual and group health insurance plans and insurance arrangements are prohibited from refusing to cover an individual due to a history of breast cancer if he or she has remained free from breast cancer for at least five years prior to applying for coverage (CGS §§ [38a-503a](#) & [38a-530a](#)).

## OTHER BREAST CANCER PROGRAMS

Connecticut also has several breast cancer education programs, funds, and other programs. Table 1 lists the statutes for the programs we identified.

**Table 1: Other Breast Cancer Programs**

<i>Statute</i>	<i>Description</i>
<a href="#">CGS § 10-29a</a>	Proclaims October 30th as "Are You Dense? Breast Cancer Awareness Day."
CGS §§ <a href="#">12-743</a> & <a href="#">19a-32b</a>	Creates the breast cancer research and education fund and allows taxpayers to contribute to it from their tax refund.
<a href="#">CGS § 19a-73a</a>	Requires the Department of Public Health (DPH) to create a comprehensive cancer plan for the state, which among other things must identify services for cancer survivors.
<a href="#">CGS § 19a-127(c)(2)</a>	Establishes the quality of care program within DPH and requires it to create a subcommittee to, among other things, review and make recommendations concerning breast cancer screening best practices.
<a href="#">CGS § 19a-266</a>	Establishes, within DPH, a breast and cervical cancer early detection and treatment referral program to: <ul style="list-style-type: none"> <li>• promote screening, detection, and treatment of breast and cervical cancer among unserved or underserved populations;</li> <li>• educate the public on breast and cervical cancer and the benefits of early detection; and</li> <li>• provide counseling and referral services for treatment.</li> </ul>

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