House of Representatives

General Assembly

File No. 273

February Session, 2016

Substitute House Bill No. 5233

House of Representatives, March 30, 2016

The Committee on Insurance and Real Estate reported through REP. MEGNA of the 97th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR TOMOSYNTHESIS FOR BREAST CANCER SCREENINGS.

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

Section 1. Subsection (a) of section 38a-503 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) (1) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for mammographic examinations to any woman covered under the policy that are at least equal to the following minimum requirements: (A) A baseline mammogram, which may be provided by breast tomosynthesis at the option of the woman covered under the policy, for any woman who is thirty-five to thirty-nine years of age, inclusive; and (B) a mammogram, which may be provided by breast tomosynthesis at the option of the woman covered under the policy, every year for any

woman who is forty years of age or older.

(2) Such policy shall provide additional benefits for:

(A) Comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse; and

(B) Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

Sec. 2. Subsection (a) of section 38a-530 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) (1) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for mammographic examinations to any woman covered under the policy that are at least equal to the following minimum requirements: (A) A baseline mammogram, which may be provided by breast tomosynthesis at the option of the woman covered under the policy, for any woman who is thirty-five to thirty-nine years of age, inclusive; and (B) a mammogram, which may be provided by breast tomosynthesis at the option of the woman covered under the policy, every year for any woman who is forty years of age or older.

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tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse; and

(B) Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2017*	38a-503(a)
Sec. 2	*January 1, 2017*	38a-530(a)

INS *Joint Favorable Subst.*

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:

Agency Affected	Fund-Effect	FY 17 $	FY 18 $
State Comptroller - Fringe Benefits (State Employees and Retiree Health Accounts)	GF&TF - Cost	Approximately $90,000 to $370,000	Approximately $178,000 to $738,000
The State	Uncertain - Cost	Approximately $49,000 to $202,000	Approximately $97,000 to $404,000

Note: GF&TF=General Fund & Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 17 $	FY 18 $
Various Municipalities	STATE MANDATE - Cost	Approximately $53,000 to $221,000	Approximately $107,000 to $442,000

Explanation

The bill will result in a cost to the state employee and retiree health plan[1], municipalities, and the state, for providing coverage for breast tomosynthesis at the option of the patient. The total estimated cost to the state in FY 17 is between $139,000 to $572,000 and $275,000 to $1,142,000 in FY 18. This cost is attributable to (1) the estimated cost to the state plan in FY 17 of between $90,000 to $370,000 and $178,000 to $738,000 in FY 18 and (2) the cost to the state pursuant to the federal Affordable Care Act (ACA) (see below) in FY 17 of between $49,000 to $202,000 and $97,000 to $404,000 FY 18. The cost to fully insured municipalities in FY 17 is between $53,000 to $221,000 and $107,000 to

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

$442,000 in FY 18.[2]

The fiscal impact assumes ultrasound claims will be replaced with tomosynthesis claims to some extent. The fiscal impact may be mitigated based on actual utilization and the availability of tomosynthesis.

The state plan does not currently provide coverage for tomosynthesis. The procedure is currently considered investigational under the state employee and retiree health plan and not medically necessary. In addition, the cost to the state plan and municipalities may be mitigated to the extent the plans are able to utilize administrative methods such as prior authorization to approve coverage for certain procedures.

Municipal Impact

As previously stated, the bill may increase costs to certain fully insured, municipal plans that do not currently provide coverage for tomosynthesis. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2017. In addition, many municipal health plans are recognized as "grandfathered" health plans under the ACA.[3] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, self-insured health plans are exempt from state health mandates.

The State and the federal ACA

[2] The estimated cost is based on the per member per month (PMPM) rate of $0.07 to $0.29, which assume 25% replacement of ultrasounds and 100% replacement respectively. The PMPM assumes a cost differential between ultrasounds and tomosynthesis. The cost estimate for the state employee plan is based on the plan membership as of January 2016; municipal impact is based on Dept. of Labor employment information as of January 2016; state impact based on Exchange enrollment is as of February 2016. Exchange enrollment excludes Medicaid enrollees.
[3] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

Lastly, the ACA requires that, the state's health exchange's qualified health plans (QHPs), include a federally defined essential health benefits package (EHB). The federal government is allowing states to choose a benchmark plan 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 defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. Absent further federal guidance, state mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB unless they are already part of the benchmark plan.[4] However, neither the agency nor the mechanism for the state to pay these costs has been established.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to (1) inflation, (2) the number of covered lives in the state, municipal and exchange health plans, and (3) the utilization of services.

Sources: *Department of Labor*
Office of the State Comptroller

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

OLR Bill Analysis

sHB 5233

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR TOMOSYNTHESIS FOR BREAST CANCER SCREENINGS.

SUMMARY:

This bill requires certain Connecticut health insurance policies to cover, at the option of the covered woman, mammograms provided by breast tomosynthesis. Breast tomosynthesis is a three-dimensional mammographic method. By law, such policies must cover baseline mammograms for women age 35 through 39, and annual mammograms for women age 40 or older.

The bill applies to (1) individual or group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; or (d) hospital or medical services, including those provided under an HMO plan; and (2) individual health insurance policies that provide limited benefit health coverage. Because of the federal Employee Retirement Income Security Act, state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2017

BACKGROUND

Related Federal Law

The federal Affordable Care Act (P.L. 111-148) allows states to require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required essential health benefits, provided the state defrays the cost of those additional benefits. The requirement applies to state benefit mandates enacted after December 31, 2011. Thus, the state must pay the insurance carrier or enrollee to defray the cost of any new benefits it mandates after that

date.

Related Bill

sHB 158, reported favorably by the Insurance and Real Estate Committee, prohibits certain health insurance policies from (1) charging copays or imposing deductibles for mammograms and comprehensive breast ultrasound exams and (2) placing annual or lifetime dollar or visitation limits on these services.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 17 Nay 1 (03/17/2016)