Quality is Our Bottom Line

Insurance Committee Public Hearing

Thursday, March 3, 2016

Connecticut Association of Health Plans

Testimony in Opposition to

HB 5233 AA Requiring An Act Requiring Health Insurance Coverage for Tomosynthesis for Breast Cancer Screenings

The Connecticut Association of Health Plans respectfully urges the Committee's rejection of HB 5233. Last year, the Committee reported out a similar bill, HB 5832, and the Association would like to associate our remarks with those of Gregg Allen from MedSolutions presented last year which raised a number of questions about the effectiveness and appropriateness of using Tomosynthesis for breast cancer screenings. Until the science can speak to the clinical benefit of such procedures, the legislature should refrain from taking further action.

Furthermore, not only did last year's proposal qualify as a new state mandate under the Affordable Care Act (ACA) requiring that the State of Connecticut pick-up any associated costs, it also drew the following fiscal note which resulted in its eventual demise in the Appropriations Committee.

The bill will result in a cost to the state employee and retiree health plan, municipalities, and the state, for providing coverage for tomosynthesis in the event (1) a mammogram shows dense breast tissue, or (2) the woman is believed to be at increased risk for breast cancer. Under current law, coverage for ultrasound screenings is already required under the same conditions. The total estimated cost to the state in FY 16 is between $130,936 to $542,448 and $261,872 to $1,084,897 in FY 17. This cost is attributable to (1) the estimated cost to the state plan in FY 16 of between $87,673 to $363,216 and $175,346 to $726,433 in FY 17 and (2) the cost to the state pursuant to the federal Affordable Care Act (ACA) (see below) in FY 16 of between $43,263 to $179,232 and $86,526 to $358,464 FY 17. The cost to fully insured municipalities in FY 16 is between $53,330 to $220,938 and $106,660 to $441,876 in FY 17.2

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 experimental/investigational treatments except in specific circumstances involving individuals with cancer. Tomosynthesis is currently considered experimental under the state employee and retiree health plan and not medically necessary. Secondly, the

cost to the state pursuant to the ACA may be underrepresented as it is uncertain at this time if the enrollment information reported reflects the total number of covered lives by exchange plans or the number of individuals who purchased a policy. Lastly, 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, 2016. 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

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. 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 plan. However, neither the agency nor the mechanism for the state to pay these costs has been established.

It's important to understand that the ACA requires strict adherence to a particular timeline that would be undermined by the various mandates under consideration. Connecticut's Exchange is right now preparing their standard benefit designs and carriers are right now preparing their non-standard plan designs. Health carriers must then file the associated rates with the Department of Insurance. If any new mandates or other cost sharing provisions are adopted after the standard benefit design has been finalized and rates have been filed, the Exchange and the carriers will have to reopen the entire process allowing for adjustments to the AV calculator, re-submittal of all templates and the re-filing of all rates. The sheer volume of mandates and the other insurance provisions under consideration by the Committee add appreciable volatility to the overall process that is not conducive to an efficient, stable and predictable insurance market.

We urge your rejection.