Senate

General Assembly

File No. 449

January Session, 2019

Substitute Senate Bill No. 838

Senate, April 4, 2019

The Committee on Insurance and Real Estate reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING REQUIRED HEALTH INSURANCE COVERAGE AND COST-SHARING FOR MAMMOGRAMS AND BREAST ULTRASOUNDS.

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

Section 1. Subsections (b) and (c) of section 38a-503 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(b) (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 mammograms 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**]** (i) 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**]** (ii) a woman is believed to be at increased risk for breast cancer due to (I) family history or prior personal history of breast cancer, (II) positive genetic testing, or (III) other indications as determined by a woman's physician or advanced practice registered nurse; or (iii) such screening is recommended by a woman's treating physician for a woman who (I) is forty years of age or older, (II) has a family history or prior personal history of breast cancer, or (III) has a prior personal history of breast disease diagnosed through biopsy as benign; and

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

(c) Benefits under this section shall be subject to any policy provisions that apply to other services covered by such policy, except that no such policy shall impose a coinsurance, copayment, **[**that exceeds a maximum of twenty dollars for an ultrasound screening under subparagraph (A) of subdivision (2) of subsection (b) of this section**]** deductible or other out-of-pocket expense for such benefits. The provisions of this subsection shall apply to a high deductible plan, as that term is used in subsection (f) of section 38a-493, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum

extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

Sec. 2. Subsections (b) and (c) of section 38a-530 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(b) (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 mammograms 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**]** (i) 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**]** (ii) a woman is believed to be at increased risk for breast cancer due to (I) family history or prior personal history of breast cancer, (II) positive genetic testing, or (III) other indications as determined by a woman's physician or advanced practice registered nurse; or (iii) such screening is recommended by a woman's treating physician for a woman who (I) is forty years of age or older, (II) has a family history or prior personal history of breast cancer, or (III) has a prior personal history of breast disease diagnosed through biopsy as benign; and

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

Society.

(c) Benefits under this section shall be subject to any policy provisions that apply to other services covered by such policy, except that no such policy shall impose a coinsurance, copayment, **[**that exceeds a maximum of twenty dollars for an ultrasound screening under subparagraph (A) of subdivision (2) of subsection (b) of this section**]** deductible or other out-of-pocket expense for such benefits. The provisions of this subsection shall apply to a high deductible plan, as that term is used in subsection (f) of section 38a-520, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2020*	38a-503(b) and (c)
Sec. 2	*January 1, 2020*	38a-530(b) and (c)

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 20 $	FY 21 $
State Comptroller - Fringe Benefits (State Employee and Retiree Health Plan)	GF&TF - Potential Cost	Less than $15,000	Less than $15,000

Note: GF&TF=General Fund & Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 20 $	FY 21 $
Various Municipalities	STATE MANDATE[1] - Potential Cost	See Below	See Below

Explanation

There may be a cost to the state employee and retiree health plan of less than $15,000 annually from eliminating cost-sharing for breast ultrasound examinations and mammograms.[2] The potential cost is attributable to out-of-network ultrasound examinations and mammograms for members enrolled in the state Point of Service (POS) plans[3] and those not currently enrolled in the Health Enhancement

[1] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

[2] Approximately 32% of active state employees are enrolled in a POS plan and 29% of plan members are females in the appropriate age cohort covered by the bill. The estimate assumes less than 10% of services may be subject to cost sharing.

[3] Members enrolled in a POS plan are required to pay 20% of allowable costs after satisfying the plan deductible and 100% of costs charged by the provider in excess of the allowable cost.

Program (HEP).[4] The state plan does not currently impose cost-sharing for in-network examinations for members in HEP. The vast majority of members use in-network services and are enrolled in HEP. The bill's expanded coverage of ultrasound services are not anticipated to change the utilization of plan members compared to current law.

The bill's elimination of cost-sharing may increase costs for certain fully insured municipalities which require member cost-sharing. The impact of the bill's requirements will be reflected in premium costs plans entered into on and after January 1, 2020. Pursuant to federal law, self-insured plans are exempt from state health insurance mandates.[5]

Lastly, many municipal plans may be recognized as "grandfathered"[6] plans under the federal Affordable Care Act (ACA). It is uncertain what the effect of this mandate will have on the grandfathered status of those municipal plans.

The bill is not anticipated to result in a fiscal impact to municipalities who operate a high deductible plan as the bill's provisions are preempted by federal law.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future based on the utilization of out-of-network services by members.

Source *Office of the State Comptroller State Health Plan, Plan Benefit Document as of January 2018*

[4] Members not enrolled in the HEP plan must satisfy the plan's deductible for services where there is no cost sharing.

[5] 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

[6] Grandfathered plans include most group health insurance plans and some individual plans created or purchased on or before March 23, 2010.

OLR Bill Analysis

sSB 838

AN ACT CONCERNING REQUIRED HEALTH INSURANCE COVERAGE AND COST-SHARING FOR MAMMOGRAMS AND BREAST ULTRASOUNDS.

SUMMARY

This bill requires certain health insurance policies to expand coverage for breast ultrasound screenings to include women whose physicians recommend it and who (1) are ages 40 and older, (2) have a family history or prior personal history of breast cancer, or (3) have a prior personal history of benign breast disease. Current law already requires these policies to cover breast ultrasounds for women with dense breast tissue, family or personal history of breast cancer, positive genetic testing, or other high risk indicators.

The bill also prohibits these policies from charging coinsurance, copayments, deductibles, and other out-of-pocket expenses for covered breast ultrasounds and mammograms. Current law only prohibits insurers from charging (1) copayments that exceed $20 for breast ultrasounds and (2) copayments or deductibles for mammograms for women ages 50 to 74 that are conducted according to national guidelines.

The bill applies the cost-sharing prohibition to high deductible health plans (HDHPs), to the maximum extent (1) permitted by federal law and (2) that does not disqualify someone who establishes a health savings account (HS) or Archer Medical Savings Account (MSA) from receiving the associated federal tax benefits. Under federal law, individuals with eligible HDHPs may make pre-tax contributions to HSAs or Archer MSAs and use the accounts for qualified medical expenses.

The bill applies to each insurer, hospital or medical service corporation, HMO, or fraternal benefit society that delivers, issues, renews, amends, or continues in Connecticut (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 (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2020

BACKGROUND

Related Bills

sHB 7124, favorably reported by the Insurance and Real Estate Committee, similarly expands ultrasound coverage, but does not include this bill's cost-sharing provisions.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 20 Nay 0 (03/19/2019)