Quality is Our Bottom Line

Insurance Committee

Public Hearing

Thursday, February 21, 2019

Connecticut Association of Health Plans

Testimony in Opposition to

S.B. No. 838 (RAISED) AN ACT CONCERNING REQUIRED HEALTH INSURANCE COVERAGE AND COST-SHARING FOR MAMMOGRAMS AND BREAST ULTRASOUNDS.

H.B. No. 7124 (RAISED) AN ACT CONCERNING REQUIRED HEALTH INSURANCE COVERAGE FOR MAMMOGRAMS AND BREAST ULTRASOUNDS.

The Connecticut Association of Health Plans respectfully urges opposition to S.B 838 and H.B. 7124. As you can see from the attached, Connecticut has taken a number of significant steps in the past several years passing a variety of coverage mandates for mammograms and other types of breast screenings.

While well intended, the proposals above go above and beyond what is currently provided for under the Affordable Care Act and current state statute and would therefore have a negative fiscal impact for both current insureds and the state at-large. Please note testimony provided by the Insurance Department last year on a similarly proposed mandate:

> *While well-intended, [this bill] if enacted, would create a new mandate and subsequently new costs for state of Connecticut under the federal Affordable Care Act (ACA) for health plans sold on the Exchange (Access Health CT). Under the ACA, Essential Health Benefits are those mandated benefits that states enacted on or before December 31, 2011. The state is required to defray the cost of any new mandated benefit or expanded benefit added after this date. Section 1311(d)(3)(B) of the ACA permits a state to require Qualified Health Plans, which are sold through the Exchange, to offer benefits in addition to the Essential Health Benefits already selected by Connecticut, but it requires the state to defray the cost of these additional benefits for Exchange plans and the State Employee Health Plan. The Department of Health and Human Services (HHS) issued a final rule on February 25, 2013 that recognizes only those mandated benefits that were enacted on or before December 31, 2011 to be considered part of the Essential Health Benefits. The state would be required to make payment to the enrollee or insurance*

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carrier to defray the cost of any new benefits specific to care, treatment and services which are enacted this session. While the Connecticut Insurance Department appreciates the intent of this bill, it cautions the Insurance and Real Estate Committee that any new state mandated benefits enacted in 2018 can have a fiscal impact to the State of Connecticut.

It's also important to note that Connecticut only has authority to regulate the fully insured market which represents roughly 35% of the state's population. The fully insured marked is made up predominantly of individual and small group policy holders who are the most price sensitive to premium increases. As such, they can ill afford the costs associated with any new mandates and we while we understand that the intentions are laudable, we would urge your rejection of S.B. 838 and H.B. 7124.

Office of Legislative Research **Research Report**

September 30, 2016 2016-R-0201 (Revised)

CONNECTICUT'S BREAST SCREENING INSURANCE COVERAGE REQUIREMENT

By: Janet Kaminski Leduc, Senior Legislative Attorney

ISSUE

Describe Connecticut's breast screening insurance coverage law and briefly summarize any changes to it.

SUMMARY

Connecticut law requires certain health insurance policies to cover a baseline mammogram for a woman age 35 to 39 and one every year for a woman age 40 or older (CGS §§ 38a-503 and 38a-530, as amended by PA 16-82). Beginning January 1, 2017, it allows the covered mammogram to be provided by breast tomosynthesis (a three-dimensional mammogram) at the woman's option.

Policies must additionally cover a comprehensive ultrasound of a woman's entire breast(s) if (1) a mammogram shows heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System (BI-RADS) established by the American College of Radiology or (2) the woman is at increased risk for breast cancer due to family history, her own history, genetic testing, or other indications determined by her physician or advanced-practice registered nurse (APRN). They must also cover magnetic resonance imaging (MRI) of a woman's breast(s) in accordance with American Cancer Society guidelines.

Under the state law, benefits payable for breast screening services are subject to any policy provisions applying to other covered services, except a policy cannot impose a copayment of more than $20 for a breast ultrasound screening. (Under federal law, some mammograms must be covered with no cost sharing, as described in the Connecticut Insurance Department's Bulletin HC-114.)

State law applies to (1) individual or group health insurance policies delivered, renewed, amended, or continued in Connecticut that cover basic hospital expenses; basic medical-surgical expenses; major medical expenses; or hospital or medical services, including those provided under an HMO plan and (2) individual health insurance policies that provide limited benefit health coverage.

Table 1 outlines the development of the breast screening insurance coverage law, beginning with its implementation in 1988.

Table 1: Development of Connecticut's Breast Screening Insurance Coverage Law

Public Act (PA) and Effective Date	***Brief Summary***
PA 88-124 October 1, 1988	Establishes the requirement that policies cover mammograms to detect breast cancer in women, as follows: one initial exam for women age 35 to 39; one exam every two years for women age 40 to 49, or more frequently if recommended by a physician; and one exam annually for women age 50 or older.
PA 90-243 October 1, 1990	Separates the law between individual and group policies and transfers citation from CGS § 38-174gg to CGS §§ 38a-503 and 38a-530.
PA 01-171 October 1, 2001	Requires policies to cover annual mammograms beginning at age 40, instead of age 50.
PA 05-69 October 1, 2005	Requires policies to cover a physician-recommended comprehensive ultrasound screening of an entire breast or breasts for a woman classified as category 2, 3, 4, or 5 on BI-RADS, as established by the American College of Radiology.
PA 06-38 October 1, 2006	Changes when policies must cover a comprehensive ultrasound screening of a woman's entire breast or breasts. Requires such coverage if (1) a mammogram shows heterogeneous or dense breast tissue on BI-RADS or (2) a woman is at increased risk of breast cancer because of family history, her own breast cancer history, positive genetic testing, or other determinations by her physician or APRN.
PA 09-41 October 1, 2009	Requires mammography reports (i.e., written results of a mammogram) given to a patient to include information about breast density based on BI-RADS. When applicable, a report must include a notice about breast density specified in the law.
PA 11-67 January 1, 2012	Requires policies to cover an MRI of a woman's entire breast or breasts if (1) a mammogram shows heterogeneous or dense breast tissue on BI-RADS or (2) a woman is at increased risk of breast cancer because of family history, her own breast cancer history, positive genetic testing, or other determinations by her physician or APRN.
PA 11-171 January 1, 2012	Requires policies to cover an MRI of a woman's breasts in accordance with guidelines established by the American Cancer Society or American College of Radiology.
PA 12-150 June 15, 2012	Reconciles PA 11-67 and PA 11-171. Requires policies to cover breast MRIs in accordance with the American Cancer Society guidelines.
PA 14-97 January 1, 2015	Prohibits policies from imposing a copayment of more than $20 for a breast ultrasound screening for which the policies are required to provide coverage (e.g., presence of dense breast tissue or increased risk of breast cancer).
PA 16-82 January 1, 2017	Requires policies to cover mammograms provided by breast tomosynthesis at the insured woman's option.

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