OLR Bill Analysis

sSB 358 (File 356, as amended by Senate "A")*

AN ACT CONCERNING REQUIRED HEALTH INSURANCE COVERAGE FOR BREAST AND OVARIAN CANCER SUSCEPTIBILITY SCREENING.

SUMMARY

This bill expands insurance coverage requirements for mammograms, ultrasounds, magnetic resonance imaging (MRIs) for breast screenings under certain commercial health insurance policies. It also requires the policies to cover certain procedures related to breast cancer treatment, including breast biopsies; certain prophylactic mastectomies; and breast reconstruction surgery, subject to certain conditions.

Additionally, the bill requires these health insurance policies to cover the following services related to the testing and treatment of ovarian cancer: (1) genetic testing, including for breast cancer gene one (BRCA1) and breast cancer gene two (BRCA2), under certain circumstances; (2) post-treatment CA-125 monitoring (i.e., a test measuring the amount of the cancer antigen 125 protein); and (3) routine ovarian cancer screenings, including surveillance tests for certain insureds.

The bill prohibits the policies from imposing cost sharing (coinsurance, copayments, deductibles, or other out-of-pocket expenses) for the covered services. This cost-sharing prohibition applies to all affected policies, but it only applies to high deductible health plans (1) to the extent federal law permits and (2) so long as it does not disqualify a medical or health savings account from preferable tax treatment. But it also subjects these benefits to provisions of the health insurance policy that apply to other covered benefits.

Finally, the bill makes minor changes, including adopting gender neutral language (specifying mammography, ultrasound, and certain other coverage applies to any insured and not just women).

The bill's requirements apply to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2023, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) limited benefits; or (5) hospital or medical services, including those provided under an HMO plan. They also apply to 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. (Even though the state employee health insurance plan is self-insured, in practice it adopts these mandates.)

*<u>Senate Amendment "A"</u> makes minor and technical changes, including (1) fixing incorrect references and (2) as current law requires but the underlying bill removed, specifying that mammograms may be provided by breast tomosynthesis at the insured's option.

EFFECTIVE DATE: January 1, 2023

§§ 1 & 2 — HEALTH INSURANCE COVERAGE FOR BREAST CANCER SCREENINGS AND RELATED PROCEDURES

Mammograms

Under current law, the affected insurance policies must cover a baseline mammogram for a woman aged 35 to 39 and an annual mammogram for a woman aged 40 or older. The bill also requires these policies to cover diagnostic and screening mammograms at these age intervals.

It also requires the policies to cover a baseline mammogram for an insured who is younger than age 35 and an annual mammogram for an insured who is younger than age 40 if the insured is believed to be at an increased risk for breast cancer due to any of the following:

1. a family breast cancer history (or, if an annual mammogram, a family or personal breast cancer history);

2. positive genetic testing for the BRCA1, BRCA2, or other gene that materially increases the insured's breast cancer risk;

3. prior childhood cancer treatment that included radiation therapy to the chest; or

4. other indications the insured's physician, advanced practice registered nurse (APRN), physician's assistant, certified nurse midwife, or other medical provider determines.

Breast Ultrasounds

Current law requires the policies to cover a comprehensive breast ultrasound screening if a mammogram demonstrates the woman has dense breast tissue or is at increased risk for breast cancer based on family or personal breast cancer history or other indications her physician or APRN determines.

The bill instead requires the policies to cover both diagnostic and screening breast ultrasounds for any insured whose mammogram demonstrates the insured has dense breast tissue or who is at increased breast cancer due to any of a list of four reasons expanded under the bill. The bill maintains a family or personal breast cancer history as a reason and adds or modifies the following three others:

1. positive genetic testing for the harmful variant of BRCA1, BRCA2, or other gene that materially increases the insured's breast cancer risk;

2. prior childhood cancer treatment that included radiation therapy to the chest; or

3. other indications the insured's physician, APRN, physician's assistant, certified nurse midwife, or other medical provider determines.

Breast MRIs

Current law requires the policies to cover a woman's breast MRI in accordance with American Cancer Society guidelines.

The bill instead requires the policies to cover both diagnostic and screening breast MRIs in accordance with the American Cancer Society guidelines for an insured who is (1) age 35 or older or (2) younger than age 35 who is at increased breast cancer risk due to the same four reasons listed above for ultrasound coverage.

Related Procedures

The bill requires the policies to also cover the following:

1. breast biopsies;

2. prophylactic mastectomies for an insured at increased breast cancer risk due to positive genetic testing for the BRCA1, BRCA2, or other gene that materially increases the insured's breast cancer risk; and

3. breast reconstructive surgery for an insured who has had a prophylactic mastectomy or mastectomy as part of breast cancer treatment.

§§ 3 & 4 — HEALTH INSURANCE COVERAGE FOR OVARIAN CANCER SCREENINGS AND SERVICES

In addition to covering CA-125 monitoring for ovarian cancer after treatment, the bill requires health insurance policies to cover genetic testing:

1. for insureds with a family history of breast or ovarian cancer and

2. of the BRCA1, BRCA2, or other gene variant that materially increases an insured's risk for breast and ovarian cancer or any other gynecological cancer to detect an increased risk when recommended by a health care provider in accordance with the United States Preventive Services Task Force testing recommendations.

Additionally, these policies must cover routine ovarian cancer screenings, including any associated office or facility visit. For at-risk insureds, the screening coverage includes surveillance tests. For these screenings, "at risk" means:

1. having one or more first- or second- degree blood relatives, including a parent, sibling, child, aunt, uncle, niece, nephew, half-siblings, or grandparents with ovarian or breast cancer;

2. a family history of nonpolyposis colorectal cancer; or

3. positive genetic testing for the harmful variant of BRCA1, BRCA2 or any other gene variant that materially increases the insured's risk for breast cancer, ovarian cancer, or any other gynecological cancers.

A "surveillance test" is annual screening using the following:

1. CA-125 serum tumor marker testing;

2. transvaginal ultrasounds;

3. pelvic examinations; or

4. when ordered by a physician in accordance with standard medical practice, any other ovarian screening tests currently being evaluated by the U.S. Food and Drug Administration or the National Cancer Institute.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 16 Nay 1 (03/22/2022)