



# Senate

General Assembly

**File No. 356**

February Session, 2022

Substitute Senate Bill No. 358

*Senate, April 6, 2022*

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 FOR BREAST AND OVARIAN CANCER SUSCEPTIBILITY  
SCREENING.***

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

1 Section 1. Section 38a-503 of the 2022 supplement to the general  
2 statutes is repealed and the following is substituted in lieu thereof  
3 (*Effective January 1, 2023*):

4 (a) For purposes of this section:

5 (1) "Healthcare Common Procedure Coding System" or "HCPCS"  
6 means the billing codes used by Medicare and overseen by the federal  
7 Centers for Medicare and Medicaid Services that are based on the  
8 current procedural technology codes developed by the American  
9 Medical Association; and

10 (2) "Mammogram" means mammographic examination or breast  
11 tomosynthesis, including, but not limited to, a procedure with a HCPCS  
12 code of 77051, 77052, 77055, 77056, 77057, 77063, 77065, 77066, 77067,

13 G0202, G0204, G0206 or G0279, or any subsequent corresponding code.

14 (b) (1) Each individual health insurance policy providing coverage of  
15 the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section  
16 38a-469 delivered, issued for delivery, renewed, amended or continued  
17 in this state shall provide benefits for diagnostic and screening  
18 mammograms [to any woman covered under the policy] for insureds  
19 that are at least equal to the following minimum requirements:

20 (A) A baseline mammogram [, which may be provided by breast  
21 tomosynthesis at the option of the woman covered under the policy,] for  
22 [any woman] an insured who is: [thirty-five]

23 (i) Thirty-five to thirty-nine years of age, inclusive; [and] or

24 (ii) Younger than thirty-five years of age if the insured is believed to  
25 be at increased risk for breast cancer due to:

26 (I) A family history of breast cancer;

27 (II) Positive genetic testing for the harmful variant of breast cancer  
28 gene one, breast cancer gene two or any other gene variant that  
29 materially increases the insured's risk for breast cancer;

30 (III) Prior treatment for a childhood cancer if the course of treatment  
31 for the childhood cancer included radiation therapy directed at the  
32 chest; or

33 (IV) Other indications as determined by the insured's physician,  
34 advanced practice registered nurse, physician's assistant, certified nurse  
35 midwife or other medical provider; and

36 (B) [a mammogram] Mammograms, which may be provided [by  
37 breast tomosynthesis at the option of the woman covered under the  
38 policy,] every year for [any woman] an insured who is: [forty]

39 (i) Forty years of age or older; [,] or

40 (ii) Younger than forty years of age if the insured is believed to be at

41 increased risk for breast cancer due to:

42 (I) A family history, or prior personal history, of breast cancer;

43 (II) Positive genetic testing for the harmful variant of breast cancer  
44 gene one, breast cancer gene two or any other gene that materially  
45 increases the insured's risk for breast cancer;

46 (III) Prior treatment for a childhood cancer if the course of treatment  
47 for the childhood cancer included radiation therapy directed at the  
48 chest; or

49 (IV) Other indications as determined by the insured's physician,  
50 advanced practice registered nurse, physician's assistant, certified nurse  
51 midwife or other medical provider.

52 (2) Such policy shall provide additional benefits for:

53 (A) Comprehensive [ultrasound screening] diagnostic and screening  
54 ultrasounds of an entire breast or breasts if:

55 (i) A mammogram demonstrates heterogeneous or dense breast  
56 tissue based on the Breast Imaging Reporting and Data System  
57 established by the American College of Radiology; or

58 (ii) [a woman] An insured is believed to be at increased risk for breast  
59 cancer due to:

60 (I) A family history or prior personal history of breast cancer; [,]

61 (II) [positive] Positive genetic testing [, or (III) other] for the harmful  
62 variant of breast cancer gene one, breast cancer gene two or any other  
63 gene that materially increases the insured's risk for breast cancer;

64 (III) Prior treatment for a childhood cancer if the course of treatment  
65 for the childhood cancer included radiation therapy directed at the  
66 chest; or

67 (IV) Other indications as determined by [a woman's] the insured's

68 physician, [physician assistant or advanced practice registered nurse; or  
69 (iii) such screening is recommended by a woman's treating physician for  
70 a woman who (I) is forty years of age or older, (II) has a family history  
71 or prior personal history of breast cancer, or (III) has a prior personal  
72 history of breast disease diagnosed through biopsy as benign; and]  
73 advanced practice registered nurse, physician's assistant, certified nurse  
74 midwife or other medical provider;

75 (B) [Magnetic] Diagnostic and screening magnetic resonance imaging  
76 of an entire breast or breasts; [in]

77 (i) In accordance with guidelines established by the American Cancer  
78 Society [.] for an insured who is thirty-five years of age or older; or

79 (ii) If an insured is younger than thirty-five years of age and believed  
80 to be at increased risk for breast cancer due to:

81 (I) A family history, or prior personal history, of breast cancer;

82 (II) Positive genetic testing for the harmful variant of breast cancer  
83 gene one, breast cancer gene two or any other gene that materially  
84 increases the insured's risk for breast cancer;

85 (III) Prior treatment for a childhood cancer if the course of treatment  
86 for the childhood cancer included radiation therapy directed at the  
87 chest; or

88 (IV) Other indications as determined by the insured's physician,  
89 advanced practice registered nurse, physician's assistant, certified nurse  
90 midwife or other medical provider;

91 (C) Breast biopsies;

92 (D) Prophylactic mastectomies for an insured who is believed to be at  
93 increased risk for breast cancer due to positive genetic testing for the  
94 harmful variant of breast cancer gene one, breast cancer gene two or any  
95 other gene that materially increases the insured's risk for breast cancer;  
96 and

97 (E) Breast reconstructive surgery for an insured who has undergone:

98 (i) A prophylactic mastectomy; or

99 (ii) A mastectomy as part of the insured's course of treatment for  
100 breast cancer.

101 (c) Benefits under this section shall be subject to any policy provisions  
102 that apply to other services covered by such policy, except that no such  
103 policy shall impose a coinsurance, copayment, deductible or other out-  
104 of-pocket expense for such benefits. The provisions of this subsection  
105 shall apply to a high deductible health plan, as that term is used in  
106 subsection (f) of section 38a-493, to the maximum extent permitted by  
107 federal law, except if such plan is used to establish a medical savings  
108 account or an Archer MSA pursuant to Section 220 of the Internal  
109 Revenue Code of 1986 or any subsequent corresponding internal  
110 revenue code of the United States, as amended from time to time, or a  
111 health savings account pursuant to Section 223 of said Internal Revenue  
112 Code, as amended from time to time, the provisions of this subsection  
113 shall apply to such plan to the maximum extent that (1) is permitted by  
114 federal law, and (2) does not disqualify such account for the deduction  
115 allowed under said Section 220 or 223, as applicable.

116 (d) Each mammography report provided to [a patient] an insured  
117 shall include information about breast density, based on the Breast  
118 Imaging Reporting and Data System established by the American  
119 College of Radiology. Where applicable, such report shall include the  
120 following notice: "If your mammogram demonstrates that you have  
121 dense breast tissue, which could hide small abnormalities, you might  
122 benefit from supplementary screening tests, which can include a breast  
123 ultrasound screening or a breast MRI examination, or both, depending  
124 on your individual risk factors. A report of your mammography results,  
125 which contains information about your breast density, has been sent to  
126 your physician's, physician assistant's or advanced practice registered  
127 nurse's office and you should contact your physician, physician  
128 assistant or advanced practice registered nurse if you have any  
129 questions or concerns about this report."

130 Sec. 2. Section 38a-530 of the 2022 supplement to the general statutes  
131 is repealed and the following is substituted in lieu thereof (*Effective*  
132 *January 1, 2023*):

133 (a) For purposes of this section:

134 (1) "Healthcare Common Procedure Coding System" or "HCPCS"  
135 means the billing codes used by Medicare and overseen by the federal  
136 Centers for Medicare and Medicaid Services that are based on the  
137 current procedural technology codes developed by the American  
138 Medical Association; and

139 (2) "Mammogram" means mammographic examination or breast  
140 tomosynthesis, including, but not limited to, a procedure with a HCPCS  
141 code of 77051, 77052, 77055, 77056, 77057, 77063, 77065, 77066, 77067,  
142 G0202, G0204, G0206 or G0279, or any subsequent corresponding code.

143 (b) (1) Each group health insurance policy providing coverage of the  
144 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469  
145 delivered, issued for delivery, renewed, amended or continued in this  
146 state shall provide benefits for diagnostic and screening mammograms  
147 [to any woman covered under the policy] for insureds that are at least  
148 equal to the following minimum requirements:

149 (A) A baseline mammogram [, which may be provided by breast  
150 tomosynthesis at the option of the woman covered under the policy,] for  
151 [any woman] an insured who is: [thirty-five]

152 (i) Thirty-five to thirty-nine years of age, inclusive; [and] or

153 (ii) Younger than thirty-five years of age if the insured is believed to  
154 be at increased risk for breast cancer due to:

155 (I) A family history of breast cancer;

156 (II) Positive genetic testing for the harmful variant of breast cancer  
157 gene one, breast cancer gene two or any other gene variant that  
158 materially increases the insured's risk for breast cancer;

159 (III) Prior treatment for a childhood cancer if the course of treatment  
160 for the childhood cancer included radiation therapy directed at the  
161 chest; or

162 (IV) Other indications as determined by the insured's physician,  
163 advanced practice registered nurse, physician's assistant, certified nurse  
164 midwife or other medical provider; and

165 (B) [a mammogram, which may be provided by breast tomosynthesis  
166 at the option of the woman covered under the policy,] Mammograms  
167 every year for [any woman] an insured who is: [forty]

168 (i) Forty years of age or older; [.] or

169 (ii) Younger than forty years of age if the insured is believed to be at  
170 increased risk for breast cancer due to:

171 (I) A family history, or prior personal history, of breast cancer;

172 (II) Positive genetic testing for the harmful variant of breast cancer  
173 gene one, breast cancer gene two or any other gene that materially  
174 increases the insured's risk for breast cancer;

175 (III) Prior treatment for a childhood cancer if the course of treatment  
176 for the childhood cancer included radiation therapy directed at the  
177 chest; or

178 (IV) Other indications as determined by the insured's physician,  
179 advanced practice registered nurse, physician's assistant, certified nurse  
180 midwife or other medical provider.

181 (2) Such policy shall provide additional benefits for:

182 (A) Comprehensive [ultrasound screening] diagnostic and screening  
183 ultrasounds of an entire breast or breasts if:

184 (i) A mammogram demonstrates heterogeneous or dense breast  
185 tissue based on the Breast Imaging Reporting and Data System  
186 established by the American College of Radiology; or

187 (ii) [a woman] An insured is believed to be at increased risk for breast  
188 cancer due to:

189 (I) A family history or prior personal history of breast cancer; [.]

190 (II) [positive] Positive genetic testing [, or (III) other] for the harmful  
191 variant of breast cancer gene one, breast cancer gene two or any other  
192 gene that materially increases the insured's risk for breast cancer;

193 (III) Prior treatment for a childhood cancer if the course of treatment  
194 for the childhood cancer included radiation therapy directed at the  
195 chest; or

196 (IV) Other indications as determined by [a woman's] the insured's  
197 physician, [physician assistant or advanced practice registered nurse; or  
198 (iii) such screening is recommended by a woman's treating physician for  
199 a woman who (I) is forty years of age or older, (II) has a family history  
200 or prior personal history of breast cancer, or (III) has a prior personal  
201 history of breast disease diagnosed through biopsy as benign; and]  
202 advanced practice registered nurse, physician's assistant, certified nurse  
203 midwife or other medical provider;

204 (B) [Magnetic] Diagnostic and screening magnetic resonance imaging  
205 of an entire breast or breasts: [in]

206 (i) In accordance with guidelines established by the American Cancer  
207 Society [.] for an insured who is thirty-five years of age or older; or

208 (ii) If an insured is younger than thirty-five years of age and believed  
209 to be at increased risk for breast cancer due to:

210 (I) A family history, or prior personal history, of breast cancer;

211 (II) Positive genetic testing for the harmful variant of breast cancer  
212 gene one, breast cancer gene two or any other gene that materially  
213 increases the insured's risk for breast cancer;

214 (III) Prior treatment for a childhood cancer if the course of treatment  
215 for the childhood cancer included radiation therapy directed at the



216 chest; or

217 (IV) Other indications as determined by the insured's physician,  
218 advanced practice registered nurse, physician's assistant, certified nurse  
219 midwife or other medical provider;

220 (C) Breast biopsies;

221 (D) Prophylactic mastectomies for an insured who is believed to be at  
222 increased risk for breast cancer due to positive genetic testing for the  
223 harmful variant of breast cancer gene one, breast cancer gene two or any  
224 other gene that materially increases the insured's risk for breast cancer;  
225 and

226 (E) Breast reconstructive surgery for an insured who has undergone:

227 (i) A prophylactic mastectomy; or

228 (ii) A mastectomy as part of the insured's course of treatment for  
229 breast cancer.

230 (c) Benefits under this section shall be subject to any policy provisions  
231 that apply to other services covered by such policy, except that no such  
232 policy shall impose a coinsurance, copayment, deductible or other out-  
233 of-pocket expense for such benefits. The provisions of this subsection  
234 shall apply to a high deductible health plan, as that term is used in  
235 subsection (f) of section 38a-520, to the maximum extent permitted by  
236 federal law, except if such plan is used to establish a medical savings  
237 account or an Archer MSA pursuant to Section 220 of the Internal  
238 Revenue Code of 1986 or any subsequent corresponding internal  
239 revenue code of the United States, as amended from time to time, or a  
240 health savings account pursuant to Section 223 of said Internal Revenue  
241 Code, as amended from time to time, the provisions of this subsection  
242 shall apply to such plan to the maximum extent that (1) is permitted by  
243 federal law, and (2) does not disqualify such account for the deduction  
244 allowed under said Section 220 or 223, as applicable.

245 (d) Each mammography report provided to [a patient] an insured

246 shall include information about breast density, based on the Breast  
247 Imaging Reporting and Data System established by the American  
248 College of Radiology. Where applicable, such report shall include the  
249 following notice: "If your mammogram demonstrates that you have  
250 dense breast tissue, which could hide small abnormalities, you might  
251 benefit from supplementary screening tests, which can include a breast  
252 ultrasound screening or a breast MRI examination, or both, depending  
253 on your individual risk factors. A report of your mammography results,  
254 which contains information about your breast density, has been sent to  
255 your physician's, physician assistant's or advanced practice registered  
256 nurse's office and you should contact your physician, physician  
257 assistant or advanced practice registered nurse if you have any  
258 questions or concerns about this report."

259 Sec. 3. (NEW) (*Effective January 1, 2023*) (a) For purposes of this  
260 section:

261 (1) "At risk for ovarian cancer" means:

262 (A) Having a family history:

263 (i) With one or more first degree blood relatives, including a parent,  
264 sibling or child, or one or more second degree blood relatives, including  
265 an aunt, uncle, grandparent, grandchild, niece, nephew, half-brother or  
266 half-sister with ovarian or breast cancer; or

267 (ii) Of nonpolyposis colorectal cancer; or

268 (B) Positive genetic testing for the harmful variant of breast cancer  
269 gene one, breast cancer gene two or any other gene variant that  
270 materially increases the insured's risk for breast cancer, ovarian cancer  
271 or any other gynecological cancers.

272 (2) "Surveillance tests for ovarian cancer" means annual screening  
273 using:

274 (A) CA-125 serum tumor marker testing;

275 (B) Transvaginal ultrasound;

276 (C) Pelvic examination; or

277 (D) Other ovarian cancer screening tests currently being evaluated by  
278 the United States Food and Drug Administration or by the National  
279 Cancer Institute.

280 (b) Each individual health insurance policy providing coverage of the  
281 type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section  
282 38a-469 of the general statutes delivered, issued for delivery, renewed,  
283 amended or continued in this state shall provide benefits for:

284 (1) Genetic testing for insureds having a family history of breast or  
285 ovarian cancer;

286 (2) Routine screening procedures for ovarian cancer and the office or  
287 facility visit for such screening, including surveillance tests for ovarian  
288 cancer for insureds who are at risk for ovarian cancer, when ordered or  
289 provided by a physician in accordance with the standard practice of  
290 medicine;

291 (3) CA-125 monitoring of ovarian cancer subsequent to treatment;  
292 and

293 (4) Genetic testing of the breast cancer gene one, breast cancer gene  
294 two, any other gene variant that materially increases the insured's risk  
295 for breast and ovarian cancer or any other gynecological cancer to detect  
296 an increased risk for breast and ovarian cancer when recommended by  
297 a health care provider in accordance with the United States Preventive  
298 Services Task Force recommendations for testing.

299 (c) Benefits under this section shall be subject to any policy provisions  
300 that apply to other services covered by such policy, except that no such  
301 policy shall impose a coinsurance, copayment, deductible or other out-  
302 of-pocket expense for such benefits. The provisions of this subsection  
303 shall apply to a high deductible health plan, as that term is used in  
304 subsection (f) of section 38a-520 of the general statutes, to the maximum

305 extent permitted by federal law, except if such plan is used to establish  
306 a medical savings account or an Archer MSA pursuant to Section 220 of  
307 the Internal Revenue Code of 1986 or any subsequent corresponding  
308 internal revenue code of the United States, as amended from time to  
309 time, or a health savings account pursuant to Section 223 of said Internal  
310 Revenue Code, as amended from time to time, the provisions of this  
311 subsection shall apply to such plan to the maximum extent that (1) is  
312 permitted by federal law, and (2) does not disqualify such account for  
313 the deduction allowed under said Section 220 or 223, as applicable.

314 Sec. 4. (NEW) (*Effective January 1, 2023*) (a) For purposes of this  
315 section:

316 (1) "At risk for ovarian cancer" means:

317 (A) Having a family history:

318 (i) With one or more first degree blood relatives, including a parent,  
319 sibling or child, or one or more second degree blood relatives, including  
320 an aunt, uncle, grandparent, grandchild, niece, nephew, half-brother or  
321 half-sister with ovarian or breast cancer; or

322 (ii) Of nonpolyposis colorectal cancer; or

323 (B) Positive genetic testing for the harmful variant of breast cancer  
324 gene one, breast cancer gene two or any other gene variant that  
325 materially increases the insured's risk for breast cancer, ovarian cancer  
326 or any other gynecological cancers.

327 (2) "Surveillance tests for ovarian cancer" means annual screening  
328 using:

329 (A) CA-125 serum tumor marker testing;

330 (B) Transvaginal ultrasound;

331 (C) Pelvic examination; or

332 (D) Other ovarian cancer screening tests currently being evaluated by

333 the United States Food and Drug Administration or by the National  
334 Cancer Institute.

335 (b) Each group health insurance policy providing coverage of the  
336 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469  
337 of the general statutes delivered, issued for delivery, renewed, amended  
338 or continued in this state shall provide benefits for:

339 (1) Genetic testing for insureds having a family history of breast or  
340 ovarian cancer;

341 (2) Routine screening procedures for ovarian cancer and the office or  
342 facility visit for such screening, including surveillance tests for ovarian  
343 cancer for insureds who are at risk for ovarian cancer, when ordered or  
344 provided by a physician in accordance with the standard practice of  
345 medicine;

346 (3) CA-125 monitoring of ovarian cancer subsequent to treatment;  
347 and

348 (4) Genetic testing of the breast cancer gene one, breast cancer gene  
349 two, any other gene variant that materially increases the insured's risk  
350 for breast and ovarian cancer or any other gynecological cancer to detect  
351 an increased risk for breast and ovarian cancer when recommended by  
352 a health care provider in accordance with the United States Preventive  
353 Services Task Force recommendations for testing.

354 (c) Benefits under this section shall be subject to any policy provisions  
355 that apply to other services covered by such policy, except that no such  
356 policy shall impose a coinsurance, copayment, deductible or other out-  
357 of-pocket expense for such benefits. The provisions of this subsection  
358 shall apply to a high deductible health plan, as that term is used in  
359 subsection (f) of section 38a-520 of the general statutes, to the maximum  
360 extent permitted by federal law, except if such plan is used to establish  
361 a medical savings account or an Archer MSA pursuant to Section 220 of  
362 the Internal Revenue Code of 1986 or any subsequent corresponding  
363 internal revenue code of the United States, as amended from time to

364 time, or a health savings account pursuant to Section 223 of said Internal  
365 Revenue Code, as amended from time to time, the provisions of this  
366 subsection shall apply to such plan to the maximum extent that (1) is  
367 permitted by federal law, and (2) does not disqualify such account for  
368 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	<i>January 1, 2023</i>	38a-503
Sec. 2	<i>January 1, 2023</i>	38a-530
Sec. 3	<i>January 1, 2023</i>	New section
Sec. 4	<i>January 1, 2023</i>	New section

**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 23 \$	FY 24 \$
Resources of the General Fund	GF - Cost	See Below	See Below

Note: GF=General Fund

**Municipal Impact:**

Municipalities	Effect	FY 23 \$	FY 24 \$
Various Municipalities	STATE MANDATE <sup>1</sup> - Cost	See Below	See Below

**Explanation**

There is no fiscal impact to the State resulting from the bill, which covers breast and ovarian screening and various procedures related to breast and ovarian cancer. The state employee and retiree health plans already provide coverage in accordance with the bill.

The bill will increase health insurance premiums for fully insured municipalities and will be realized in premiums when they enter a new policy after January 1, 2023.

In addition, many municipal health plans are recognized as "grandfathered" health plans under the Affordable Care Act (ACA).<sup>2</sup> It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA.

<sup>1</sup> 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.

Pursuant to federal law, municipalities with self-insured plans are exempt from state insurance mandates.

Lastly, the bill may result in a cost to the state pursuant to the ACA, to the extent the provisions of the bill are interpreted to require the expansion of the pediatric dental and vision benefits provided to comply with the essential health benefit (EHB) requirement. While states can mandate benefits in excess of the EHB, 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.

### ***The Out Years***

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.



**OLR Bill Analysis****sSB 358****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.)

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)