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:

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 Section 38a-503 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2023*):

(a) For purposes of this section:

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

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

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

(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 diagnostic and screening mammograms **[**to any woman covered under the policy**]** for insureds 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**]** an insured who is: **[**thirty-five**]**

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

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

(I) A family history of breast cancer;

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

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

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

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

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

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

increased risk for breast cancer due to:

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

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

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

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

(2) Such policy shall provide additional benefits for:

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

(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

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

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

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

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

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

physician, **[**physician assistant 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**]** advanced practice registered nurse, physician's assistant, certified nurse midwife or other medical provider;

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

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

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

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

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

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

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

(C) Breast biopsies;

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

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

(i) A prophylactic mastectomy; or

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

(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, deductible or other out-of-pocket expense for such benefits. The provisions of this subsection shall apply to a high deductible health 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.

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

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

(a) For purposes of this section:

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

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

(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 diagnostic and screening mammograms **[**to any woman covered under the policy**]** for insureds 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**]** an insured who is: **[**thirty-five**]**

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

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

(I) A family history of breast cancer;

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

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

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

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

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

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

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

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

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

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

(2) Such policy shall provide additional benefits for:

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

(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

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

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

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

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

(IV) Other indications as determined by [a woman's] the insured's physician, [physician assistant 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] advanced practice registered nurse, physician's assistant, certified nurse midwife or other medical provider;

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

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

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

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

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

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

chest; or

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

(C) Breast biopsies;

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

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

(i) A prophylactic mastectomy; or

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

(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, deductible or other out-of-pocket expense for such benefits. The provisions of this subsection shall apply to a high deductible health 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.

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

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

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

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

(A) Having a family history:

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

(ii) Of nonpolyposis colorectal cancer; or

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

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

(A) CA-125 serum tumor marker testing;

(B) Transvaginal ultrasound;

(C) Pelvic examination; or

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

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

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

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

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

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

(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, deductible or other out-of-pocket expense for such benefits. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-520 of the general statutes, 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. 4. (NEW) (*Effective January 1, 2023*) (a) For purposes of this section:

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

(A) Having a family history:

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

(ii) Of nonpolyposis colorectal cancer; or

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

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

(A) CA-125 serum tumor marker testing;

(B) Transvaginal ultrasound;

(C) Pelvic examination; or

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

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

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

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

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

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

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

(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, deductible or other out-of-pocket expense for such benefits. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-520 of the general statutes, 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, 2023*	38a-503
Sec. 2	*January 1, 2023*	38a-530
Sec. 3	*January 1, 2023*	New section
Sec. 4	*January 1, 2023*	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[1] - 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).**2** It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA.

[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.

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)