House of Representatives

File No. 693

General Assembly

January Session, 2021

(Reprint of File No. 351)

Substitute House Bill No. 6626
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 14, 2021

AN ACT CONCERNING REQUIRED HEALTH INSURANCE COVERAGE FOR BREAST HEALTH BENEFITS.

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

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 Section 38a-503 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(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**]** insured, 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;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse; and

(B) **[**a mammogram**]** Mammograms, which may be provided by breast tomosynthesis at the option of the **[**woman covered under the policy**]** insured, 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;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse.

(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;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

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

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse;

(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 or advanced practice registered nurse's office and you should contact your physician or advanced practice registered nurse if you have any questions or concerns about this report.".

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 Section 38a-530 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(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), (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**]** insured, 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;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse; and

(B) **[**a mammogram**]** Mammograms, which may be provided by breast tomosynthesis at the option of the **[**woman covered under the policy**]** insured, 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;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or

advanced practice registered nurse.

(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;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

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

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse;

(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 or advanced practice registered nurse's office and you should contact your physician or advanced practice registered nurse if you have any questions or concerns about this report.".

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2022*	38a-503
Sec. 2	*January 1, 2022*	38a-530

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 22 $	FY 23 $
ACA – State Mandate	GF - Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 22 $	FY 23 $
Various Municipalities	Cost	Minimal	Minimal

Explanation

The bill as amended expands the criteria for which health insurance policies must provide coverage for mammograms and other treatments used to diagnose breast cancer, mandates coverage for prophylactic mastectomies and breast reconstructive surgery, and results in a cost to the state to defray costs of providing these benefits on the Exchange. The bill as amended will also result in a cost to fully-insured municipalities.

The bill as amended is anticipated to expand coverage under the Exchange and fully-insured municipal plans in only limited circumstance; federal and state law already mandate the included benefits for a variety of criteria.

There is a cost to fully-insured municipalities due to expanding coverage criteria for the included diagnostic treatments and procedures, to the extent that their policies are not currently in accordance with the provisions of the amendment. The cost to include any associated benefits not currently covered will be reflected in plan premiums for plan years starting on or after January 1, 2022. Premiums will increase

based on the projected utilization of benefits, as determined by plan actuaries.

The bill as amended will also result in a cost to the state pursuant to the Affordable Care Act to the extent the benefits are not currently covered under the Exchange's benchmark plan. 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 essential health benefits required under federal law, unless they are already part of the benchmark plan.

The bill as amended is not anticipated to result in a cost to the state employee and retiree health plans, as the plans generally cover the included benefits. While self-insured plans are exempt from state insurance mandates, the state employee and retiree health plans have traditionally adopted them.

House "A" struck the underlying bill and its associated fiscal impact, and results in the fiscal impact described above.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to future utilization and change to premiums.

OLR Bill Analysis

sHB 6626 (as amended by House "A")*

AN ACT CONCERNING REQUIRED HEALTH INSURANCE AND MEDICAID COVERAGE, AMBULANCE SERVICES AND COST TRANSPARENCY.

SUMMARY

This bill expands coverage requirements for mammograms, ultrasounds, and magnetic resonance imaging (MRIs) of an insured's breasts under certain commercial health insurance policies. It also requires the policies to cover breast biopsies; certain prophylactic mastectomies; and breast reconstruction surgery, subject to certain conditions.

As under existing law, 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.

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, 2022, 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. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

*House Amendment "A" replaces the underlying bill. In doing so, it

eliminates various mandated insurance benefits and related provisions.

EFFECTIVE DATE: January 1, 2022

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 instead requires the policies to cover diagnostic and screening mammograms at these age intervals for any insured, male or female.

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 personal breast cancer history);

2. positive genetic testing for the breast cancer gene one (BRCA1), breast cancer gene two (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;

4. prior or ongoing hormone treatment for gender reassignment; or

5. other indications the insured's physician or advanced practice registered nurse (APRN) 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 is at increased breast cancer due to any of the following:

1. a family or personal breast cancer history;

2. positive genetic testing for 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;

4. prior or ongoing hormone treatment for gender reassignment; or

5. other indications the insured's physician or APRN 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 five 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 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.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 17 Nay 1 (03/22/2021)

Appropriations Committee

Joint Favorable
Yea 32 Nay 15 (05/03/2021)