OLR Bill Analysis

sHB 6626

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

SUMMARY

This bill requires certain individual and group commercial health insurance policies to cover the following benefits and services:

1. motorized wheelchairs, including used motorized wheelchairs, repairs, and replacement batteries (§§ 1 & 2);

2. cochlear implants and cochlear implant surgery, either unilateral or bilateral depending on the insured's hearing loss diagnosis (§§ 3 & 4);

3. medically necessary coronary calcium scan tests (§§ 5 & 6);

4. genetic cystic fibrosis screenings for women (§§ 7 & 8);

5. treatment of neurological conditions and diseases, including physical therapy to treat amyotrophic lateral sclerosis (§§ 9 & 10);

6. equine therapy for insureds who are veterans (§§ 11 & 12);

7. gambling disorder treatment (§§ 13 & 14);

8. audiologic, ophthalmologic, and optometric care (§§ 15 & 16);

9. specialized formula for insureds of any age (currently coverage is limited to children up to age 12) when it is medically necessary to treat a disease or condition and administered under a physician's direction (§§ 18 & 19);

10. colorectal cancer diagnosis, with no deductible for a procedure

that began as a diagnostic colonoscopy or sigmoidoscopy (the law already requires coverage for colorectal cancer screenings) (§§ 20 & 21); and

11. diagnostic and screening mammograms, ultrasounds, and magnetic resonance imaging (MRIs); breast biopsies; certain prophylactic mastectomies; and breast reconstruction surgery, subject to certain conditions (§§ 25 & 26).

The bill also requires the Department of Social Services (DSS) commissioner to provide Medicaid reimbursement for audiologic, ophthalmologic, and optometric care; seek federal approval for this, if necessary; and adopt implementing regulations (§ 17).

The bill expands coverage under certain commercial health insurance policies for ambulance services and requires coverage at the in-network level of benefits (§§ 22 & 23). It also specifies that a person is not liable for nonemergency transportation services unless the provider discloses the potential cost to the person and receives the person's written consent for the services (§ 27).

Additionally, the bill requires the insurance commissioner to establish a program that advances breast health and breast cancer awareness and promotes early breast cancer detection (§ 24). He must do this by January 1, 2022, and within available appropriations. As part of the program, he must provide outreach to individuals, including young women of color.

Lastly, the bill requires a health care provider who performs a mammogram on a patient to provide the patient (1) advance notice of whether a proposed test or examination following the mammogram is elective and covered under the patient's health care plan and (2) an opportunity to determine if the proposed test or examination is covered under his or her health care plan (§ 28). It authorizes the public health commissioner, in consultation with the insurance commissioner, to adopt implementing regulations.

EFFECTIVE DATE: January 1, 2022, except for the provisions

regarding Medicaid's reimbursement for audiologic, ophthalmologic, and optometric care, which are effective July 1, 2021; and the provisions requiring (1) the insurance commissioner to establish a breast health awareness program and (2) health care providers performing mammograms to provide advance notice to patients about proposed follow up testing, which are effective October 1, 2021.

§ 17 — MEDICAID REIMBURSEMENT REQUIREMENT

The bill requires the DSS commissioner to provide Medicaid reimbursement for audiologic, ophthalmologic, and optometric care and seek federal approval of a Medicaid state plan amendment or waiver for this, if necessary, in accordance with state law.

It also requires her to adopt implementing regulations. It authorizes her to adopt policies and procedures to implement these provisions while in the process of adopting regulations as long as the policies and procedures are posted on the DSS website and the state eRegulations system before they are adopted.

§§ 22-23 & 27 — AMBULANCE SERVICES

Commercial Insurance Coverage (§§ 22 & 23)

By law, certain individual and group health insurance policies must cover medically necessary ambulance services. The bill requires the policies to cover the ambulance services at the in-network level, including the in-network level of cost sharing.

Under existing law, the policies must cover, at a minimum, medically necessary ambulance services when an insured is transported to a hospital. The bill also requires the policies to cover medically necessary ambulance service from a hospital to the insured's residence.

By law, an ambulance service provider may bill a health carrier (e.g., insurer or HMO) for direct payment of emergency ambulance services if the provider has not been paid by any other source. In this case, the provider must indicate on the claim requesting payment that it is subject to assignment. The bill also authorizes the provider to

indicate that it is subject to assignment electronically if the claim is submitted electronically.

Liability for Nonemergency Ambulance Services (§ 27)

Under the bill, a person is not liable for nonemergency transportation services provided by a licensed or certified ambulance service or paramedic intercept service unless the provider, before providing the services, discloses their potential cost to the person and receives the person's written consent for the service.

§§ 25 & 26 — COMMERCIAL INSURANCE COVERAGE FOR BREAST CANCER SCREENINGS AND RELATED PROCEDURES

The bill expands coverage requirements for mammograms, ultrasounds, and MRIs under certain commercial health insurance policies and requires the policies to also cover specified related procedures.

As under existing law, the bill prohibits the policies from imposing cost sharing (coinsurance, copayment, deductible, or other out-of-pocket expenses) for the services. This cost-sharing prohibition applies to all affected policies, but only applies to high deductible health plans (1) to the extent federal law permits it and (2) as long as it does not disqualify a medical or health savings account from preferable tax treatment.

Mammograms

Under current law, the 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 in 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);

1. 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;

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

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

4. 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.

APPLICABILITY OF COMMERCIAL INSURANCE REQUIREMENTS

The bill's commercial insurance 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; or (4) hospital or medical services, including those provided under an HMO plan. The breast health benefit requirements (§§ 25 & 26) also apply to individual and group health insurance policies that provide limited benefit coverage.

Under current law, the ambulance services benefit requirements (§§ 22 & 23) also apply to (1) individual health insurance policies that cover limited benefits or accidents only and (2) group health insurance policies that cover accidents only. The bill eliminates this applicability.

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

COMMITTEE ACTION

Insurance and Real Estate Committee

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