PA 22-90—sSB 358
Insurance and Real Estate Committee
Appropriations Committee

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

SUMMARY: This act expands coverage requirements under certain commercial health insurance policies for specified procedures used to treat or prevent breast or ovarian cancer. Specifically, it:

1. expands health insurance coverage requirements for breast mammograms, ultrasounds, and magnetic resonance imaging (MRIs);
2. requires coverage of certain procedures related to breast cancer treatment, including breast biopsies; certain prophylactic mastectomies; and breast reconstruction surgery, subject to certain conditions; and
3. requires coverage for certain (a) genetic testing, including for breast cancer gene one (BRCA1) and breast cancer gene two (BRCA2), under certain circumstances; (b) post-treatment CA-125 monitoring (i.e., a test measuring the amount of the cancer antigen 125 protein); and (c) routine ovarian cancer screenings, including surveillance tests for certain insureds.

The act prohibits the policies from imposing cost sharing (i.e., coinsurance, copayments, deductibles, or other out-of-pocket expenses) for the above 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.

Lastly, the act makes minor changes, including adopting gender-neutral language (i.e., specifying that mammography, ultrasound, and certain other coverage requirements apply to any insured and not just women).

The act's requirements apply to fully insured 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.

EFFECTIVE DATE: January 1, 2023

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

Mammograms

Existing law requires the affected insurance policies to cover a baseline mammogram for a woman aged 35 to 39 and an annual mammogram for a woman aged 40 or older. The act expands the benefit to any insured of those ages and specifies that these covered mammograms may be diagnostic or screening mammograms.

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 they are 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 harmful variant of BRCA1, BRCA2, or another 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 assistant, certified nurse midwife, or other medical provider determines.

Breast Ultrasounds

The act requires these policies to cover diagnostic and screening ultrasounds for insureds at increased breast cancer risk due to:

1. positive genetic testing for the harmful variant of BRCA1, BRCA2, or other gene that materially increases the insured's breast cancer risk, rather than unspecified genetic testing as under prior law;
2. prior childhood cancer treatment that included radiation therapy to the chest; or
3. other indications the insured's certified nurse midwife or other medical provider determines, in addition to determinations made by a physician, APRN, or physician's assistant as under prior law.

Unchanged by the act, these policies must still cover ultrasounds if (1) a mammogram demonstrates the insured has dense breast tissue or (2) the insured is at increased risk for breast cancer based on family or personal breast cancer history. The act expands the coverage requirement to include diagnostic breast ultrasounds, rather than only screening ultrasounds as under prior law.

Breast MRIs

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

The act 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 act 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 harmful variant of 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 RELATED SERVICES

In addition to requiring the affected health insurance policies to cover CA-125 monitoring for ovarian cancer after treatment, the act also requires coverage of 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 U.S. Preventive Services Task Force testing recommendations.

Additionally, these policies must cover routine ovarian cancer screenings, including any associated office or facility visit, when ordered or provided by a physician in accordance with standard medical practice. 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 for ovarian cancer using the following:

1. CA-125 serum tumor marker testing,
2. transvaginal ultrasound,
3. pelvic examination, or
4. any other ovarian cancer screening tests currently being evaluated by the U.S. Food and Drug Administration or the National Cancer Institute.