L.D. 1556

DATE: 5-22-97 (Filing No. H-669)

MINORITY

**BANKING AND INSURANCE**

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**STATE OF MAINE**
**HOUSE OF REPRESENTATIVES**
**118TH LEGISLATURE**
**FIRST SPECIAL SESSION**

COMMITTEE AMENDMENT "B" to H.P. 1113, L.D. 1556, Bill, "An Act to Establish the Breast Care Patient Protection"

Amend the bill by striking out the title and substituting the following:

'**An Act to Establish Breast Cancer Patient Protection**'

Further amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

'**Sec. 1. 24 MRSA §2320-A, sub-§2, ¶¶A and B,** as enacted by PL 1989, c. 875, Pt. I, §2, are amended to read:

A. At least once every 2 years for women between the ages of 40 and 49; ~~and~~

B. At least once a year for women age 50 and over.; and

**Sec. 2. 24 MRSA §2320-A, sub-§2, ¶C** is enacted to read:

C. At least once a year for women with a family history of breast cancer upon the recommendation of a physician.

Sec. 3. **24 MRSA §2320-C,** as corrected by RR 1995, c. 1, §13, is repealed and the following enacted in its place:

**§2320-C. Coverage for breast cancer treatment**

1. **Inpatient care.** All individual and group nonprofit hospital and medical services plan contracts providing coverage for medical and surgical benefits must ensure that inpatient

coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual and group nonprofit hospital and medical services plan contract may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All individual and group nonprofit hospital and medical services plan contracts must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

2. **Reconstruction.** All individual and group nonprofit hospital and medical services plan contracts providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 4. **24-A MRSA §2745-A, sub-§2, ¶¶A and B,** as enacted by PL 1989, c. 875, Pt. I, §3, are amended to read:

A. At least once every 2 years for women between the ages of 40 and 49; ~~and~~

B. At least once a year for women age 50 and over.; and

Sec. 5. **24-A MRSA §2745-A, sub-§2, ¶C** is enacted to read:

C. At least once a year for women with a family history of breast cancer upon the recommendation of a physician.

Sec. 6. **24-A MRSA §2745-C,** as corrected by RR 1995, c. 1, §15, is repealed and the following enacted in its place:

**§2745-C. Coverage for breast cancer treatment**

**1. Inpatient care.** All individual health policies providing coverage for medical and surgical benefits, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual health policy may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All individual health policies must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

**2. Reconstruction.** All individual health policies providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 7. **24-A MRSA §2837-A, sub-§2, ¶¶A and B,** as enacted by PL 1989, c. 875, Pt. I, §6, are amended to read:

A. At least once every 2 years for women between the ages of 40 and 49; ~~and~~

B. At least once a year for women age 50 and over.; and

Sec. 8. **24-A MRSA §2837-A, sub-§2, ¶C** is enacted to read:

C. At least once a year for women with a family history of breast cancer upon the recommendation of a physician.

Sec. 9. **24-A MRSA §2837-C**, as corrected by RR 1995, c. 1, §17, is repealed and the following enacted in its place:

**§2837-C. Coverage for breast cancer treatment**

1. **Inpatient care.** All group health policies providing coverage for medical and surgical benefits, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, a group health policy may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All group health policies must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

2. **Reconstruction.** All group health policies providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 10. **24-A MRSA §4237**, as corrected by RR 1995, c. 1, §21, is repealed and the following enacted in its place:

**§4237. Coverage for breast cancer treatment**

1. **Inpatient care.** All individual and group coverage subject to this chapter that provides coverage for medical and surgical benefits must ensure that inpatient coverage with

respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual or group coverage contract may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All individual and group coverage subject to this subsection must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

2. **Reconstruction.** All individual and group coverage subject to this chapter that provides coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

**Sec. 11. 24-A MRSA §4237-A** is enacted to read:

**§4237-A. Screening mammograms**

1. **Definition.** For purposes of this section, "screening mammogram" means a radiologic procedure that is provided to an asymptomatic woman for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast.

2. **Required coverage.** All individual and group coverage subject to this chapter that cover radiologic procedures, except those policies that cover only dental procedures, accidental injury or specific diseases, must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Human Services relating to

radiation protection. The policies must reimburse for screening mammograms performed:

A. At least once every 2 years for women between the ages of 40 and 49;

B. At least once a year for women age 50 and over; and

C. At least once a year for women with a family history of breast cancer upon the recommendation of a physician.

**Sec. 8. Application.** This Act applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 1998. For purposes of this Act, all policies, contracts and certificates are deemed to be renewed no later than the next yearly anniversary of the contract date.'

Further amend the bill by inserting at the end before the summary the following:

## 'FISCAL NOTE

This bill will not increase the State's costs for employee health insurance because the State's current contract provides this level of coverage.'

## SUMMARY

This amendment is the minority report. It replaces the bill and requires that medical insurance coverage provide inpatient coverage for a period of time determined by the physician and patient to be medically appropriate following a mastectomy, lumpectomy or a lymph node dissection for treatment of breast cancer.

The amendment also requires insurance coverage for annual mammograms for women with a family history of breast cancer if recommended by a physician and extends to health maintenance organizations the provisions requiring coverage for screening mammograms in current law.

The amendment adds an application provision stating that the bill applies to all policies and contracts issued or renewed on or after January 1, 1998.

The amendment also adds a fiscal note to the bill.