BILL ANALYSIS

C.S.H.B. 495
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

While a mammogram serves as an effective early detection method for breast cancer, an individual with dense breast tissue may require supplemental screening to detect if a tumor is present. Currently, a notice is sent to such a patient on completion of a mammogram regarding the condition and the potential necessity of supplemental screening. Interested parties report that insurance coverage is essential in these cases because those who cannot afford the additional testing may lose treatment advantages available to an individual whose breast cancer is detected in its early stages. Interested parties assert that the use of additional screenings in determining whether tumors are present is a simple preventive measure that could save lives. C.S.H.B. 495, known as Henda's Law, seeks to address this concern.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 9 of this bill.

ANALYSIS

C.S.H.B. 495 amends the Insurance Code to require the issuer of a health benefit plan that provides coverage for mammography, including coverage for low-dose mammography, to also offer to provide coverage for supplemental breast cancer screening as part of an annual well-woman examination covered under the plan if a licensed health care professional treating or screening the enrollee for breast cancer finds that the enrollee has dense breast tissue, as defined by the Breast Imaging Reporting and Database System (Fourth Edition) established by the American College of Radiology, and has additional risk factors for breast cancer, as determined by the commissioner of insurance by rule based on scientific research and models for breast cancer, that warrant supplemental breast cancer screening beyond mammography. The bill authorizes an additional premium to be charged for supplemental breast cancer screening coverage. The bill defines "supplemental breast cancer screening" as a method of screening, including ultrasound imaging, that is designed to supplement mammography by detecting breast cancers that may not be visible using only mammography.

C.S.H.B. 495 makes the requirement for certain health benefit plans to include additional coverage for supplemental breast cancer screening applicable to specified types of providers, coverages, and plans. The bill exempts from its provisions specified types of health benefit plans, coverages, and policies.

C.S.H.B. 495 applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2014.

EFFECTIVE DATE

September 1, 2013.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 495 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and highlighted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
No equivalent provision.	SECTION 1. This Act shall be known as Henda's Law.
SECTION 1. Section 1201.005, Insurance Code, is amended.	SECTION 2. Same as introduced version.
SECTION 2. The heading to Chapter 1356, Insurance Code, is amended.	SECTION 3. Same as introduced version.
SECTION 3. Sections 1356.001 through 1356.005, Insurance Code, are designated as Subchapter A, Chapter 1356, Insurance Code, and a heading is added to Subchapter A.	SECTION 4. Same as introduced version.
SECTION 4. Section 1356.001, Insurance Code, is amended.	SECTION 5. Same as introduced version.
SECTION 5. Section 1356.002, Insurance Code, is amended.	SECTION 6. Same as introduced version.
SECTION 6. Section 1356.003, Insurance Code, is amended	SECTION 7. Same as introduced version.
SECTION 7. Section 1356.004, Insurance Code, is amended.	SECTION 8. Same as introduced version.
SECTION 8. Chapter 1356, Insurance Code, is amended by adding Subchapter B to read as follows: SUBCHAPTER B. SUPPLEMENTAL BREAST CANCER SCREENING Sec. 1356.051. DEFINITION.	SECTION 9. Chapter 1356, Insurance Code, is amended by adding Subchapter B to read as follows: SUBCHAPTER B. SUPPLEMENTAL BREAST CANCER SCREENING Sec. 1356.051. DEFINITIONS. In this subchapter: (1) "Health benefit exchange" means an American Health Benefit Exchange administered by the federal government or created pursuant to Section 1311(b), Patient Protection and Affordable Care Act (42 U.S.C. Section 18031). (2) "Qualified health plan" has the meaning assigned by Section 1301(a), Patient Protection and Affordable Care Act (42 U.S.C. Section 18021).
In this subchapter, "supplemental breast cancer screening" means a method of screening designed to supplement	(3) "Supplemental breast cancer screening" means a method of screening, including ultrasound imaging, that is designed to

mammography by detecting breast cancers that may not be visible using only mammography. The term may include: (1) a breast MRI examination; or (2) any other screening method recommended by a professional association or agency with expertise in mammography, including the National Cancer Institute and the National Comprehensive Cancer Network, based on a patient's specific risk factors.	supplement mammography by detecting breast cancers that may not be visible using only mammography.
Sec. 1356.052. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by: (1) an insurance company; (2) a group hospital service corporation operating under Chapter 842; (3) a fraternal benefit society operating under Chapter 885; (4) a stipulated premium company operating under Chapter 884; (5) an exchange operating under Chapter 942; (6) a health maintenance organization operating under Chapter 843;	Sec. 1356.052. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by: (1) an insurance company; (2) a group hospital service corporation operating under Chapter 842; (3) a fraternal benefit society operating under Chapter 885; (4) a stipulated premium company operating under Chapter 884; (5) an exchange operating under Chapter 942; (6) a health maintenance organization operating under Chapter 843; or
(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or	
(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.	(7) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.
(b) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code. (c) Notwithstanding Section 172.014, Local Government Code, or any other law, this subchapter applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code. (d) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to: (1) a basic coverage plan under Chapter	

1551;
(2) a basic plan under Chapter 1575;
(3) a primary care coverage plan under Chapter 1579; and
(4) basic coverage under Chapter 1601.

(e) Notwithstanding Section 1501.251 or any other law, this subchapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.

Sec. 1356.053. APPLICABILITY TO CERTAIN GOVERNMENT PROGRAMS. To the extent allowed by federal law, the state Medicaid program and a managed care organization that contracts with the Health and Human Services Commission to provide health care services to Medicaid recipients through a managed care plan shall provide the benefits required under this subchapter to a Medicaid recipient.

Sec. 1356.054. EXCEPTION. This subchapter does not apply to:
(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
(B) as a supplement to a liability insurance policy;
(C) for credit insurance;
(D) only for dental or vision care;
(E) only for hospital expenses; or
(F) only for indemnity for hospital confinement;
(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss(g)(1));
(3) a workers' compensation insurance policy;
(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or
(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1356.052.

(b) Notwithstanding Section 1501.251 or any other law, this subchapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.

No equivalent provision.

Sec. 1356.053. EXCEPTION. This subchapter does not apply to:
(1) a plan that provides coverage:
(A) only for benefits for a specified disease or for another limited benefit;
(B) only for accidental death or dismemberment;
(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
(D) as a supplement to a liability insurance policy;
(E) for credit insurance;
(F) only for dental or vision care;
(G) only for hospital expenses; or
(H) only for indemnity for hospital confinement;
(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;
(4) medical payment insurance coverage provided under a motor vehicle insurance policy;
(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1356.052; or
(6) a qualified health plan offered through a

	health benefit exchange.
Sec. 1356.055. COVERAGE REQUIRED. A health benefit plan that provides coverage for mammography, including coverage for low-dose mammography required by Subchapter A, must also provide coverage for supplemental breast cancer screening if a physician treating the enrollee or screening the enrollee for breast cancer finds that the enrollee has: (1) dense breast tissue, as defined by the Breast Imaging Reporting and Database System (Fourth Edition) established by the American College of Radiology; and (2) additional risk factors for breast cancer that the physician believes warrant supplemental breast cancer screening beyond mammography.	Sec. 1356.054. OFFER OF OPTIONAL COVERAGE REQUIRED. (a) The issuer of a health benefit plan that provides coverage for mammography, including coverage for low-dose mammography required by Subchapter A, must also offer to provide coverage for supplemental breast cancer screening as part of an annual well-woman examination covered under the plan if a licensed health care professional treating the enrollee or screening the enrollee for breast cancer finds that the enrollee has: (1) dense breast tissue, as defined by the Breast Imaging Reporting and Database System (Fourth Edition) established by the American College of Radiology; and (2) additional risk factors determined under Subsection (c) for breast cancer that warrant supplemental breast cancer screening beyond mammography. (b) An additional premium may be charged for the coverage described by Subsection (a). (c) The commissioner by rule shall determine risk factors described by Subsection (a)(2) based on scientific research and models for breast cancer.
SECTION 9. This Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2014. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2014, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.	SECTION 10. Same as introduced version.
SECTION 10. This Act takes effect September 1, 2013.	SECTION 11. Same as introduced version.