# 25:2-184.3 to 26:2-184.5 et al.

## LEGISLATIVE HISTORY CHECKLIST

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**LAWS OF**: 2013 **CHAPTER:** 196

**NJSA:** 25:2-184.3 to 26:2-184.5 et al. (Requires insurers to cover breast evaluations and other additional medically necessary testing under certain circumstances and requires certain mammogram reports to contain information on breast density)

**BILL NO**: S792 (Substituted for A2022)

**SPONSOR(S)** Weinberg and others

**DATE INTRODUCED:** January 10, 2012

**COMMITTEE:** **ASSEMBLY:** Health and Senior Services
Appropriations

**SENATE:** Commerce
Budget and Appropriations

**AMENDED DURING PASSAGE:** Yes

**DATE OF PASSAGE:** **ASSEMBLY:** December 19, 2013

**SENATE:** January 13, 2014

**DATE OF APPROVAL:** January 17, 2014

**FOLLOWING ARE ATTACHED IF AVAILABLE:**

**FINAL TEXT OF BILL** (Sixth reprint enacted)

**S792**

**SPONSOR'S STATEMENT**: (Begins on page 8 of introduced bill) Yes

**COMMITTEE STATEMENT:** **ASSEMBLY**: Yes Health
Appropriations

**SENATE:** Yes Commerce
Budget

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

**FLOOR AMENDMENT STATEMENT:** Yes 6-21-12
9-9-13

**LEGISLATIVE FISCAL NOTE:** Yes 6-11-12
6-25-12
8-3-12
7-5-13
12-23-13

(continued)

**A2022**

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|---|---|---|---|
| **SPONSOR'S STATEMENT:** (Begins on page 8 of introduced bill) | | Yes | |
| **COMMITTEE STATEMENT:** | **ASSEMBLY**: | Yes | Health<br>Appropriations |
| | **SENATE:** | No | |
| **FLOOR AMENDMENT STATEMENT:** | | Yes | |
| **LEGISLATIVE FISCAL NOTE:** | | Yes | 6-27-13<br>12-23-13 |
| **VETO MESSAGE:** | | No | |
| **GOVERNOR'S PRESS RELEASE ON SIGNING:** | | No | |

**FOLLOWING WERE PRINTED:**

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|---|---|
| **REPORTS:** | No |
| **HEARINGS:** | No |
| **NEWSPAPER ARTICLES:** | Yes |

"Christie's 'pocket veto' kills bill requiring health workers to get flu shots," NJSpotlight, January 22, 2014

LAW/RWH

§§10-12 - C.26:2-184.3 to 26:2-184.5
§§13-14 - C.17B:27D-10 & 17B:27D-11
§15 - Note

P.L.2013, CHAPTER 196, ***approved January 17, 2014***
Senate, No. 792 ***(Sixth Reprint)***

**AN ACT** concerning mammograms, amending P.L.1991, c.279 and P.L.2004, c.86, and supplementing Title 26 of the Revised Statutes [5]and P.L.2003, c.193 (C.17B:27D-1 et seq.)[5].

**BE IT ENACTED** *by the Senate and General Assembly of the State of New Jersey:*

1. Section 1 of P.L.1991, c.279 (C.17:48-6g) is amended to read as follows:

1. a. No group or individual hospital service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are [6]**[**at least 35 but less than**]**[6] 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) [5]**[**comprehensive**]** an[5] ultrasound [5]**[**screening**]** evaluation, a magnetic resonance imaging scan, a three-dimensional mammography[5] [4], or other [5]**[**screening**]** additional testing[5] [6]**[**deemed medically necessary by the [5]**[**woman's**]** patient's[5] health care provider,[4]**]**[6] of an entire breast or breasts [4], after a baseline mammogram examination,[4] if [4]**[**a**]** the[4] mammogram demonstrates [4]**[**heterogeneous**]** [5]**[**heterogeneously[4] or**]**[5] [1]extremely[1] dense breast

**EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.**

**Matter underlined thus is new matter.**
**Matter enclosed in superscript numerals has been adopted as follows:**
**[1]Senate SCM committee amendments adopted May 17, 2012.**
**[2]Senate SBA committee amendments adopted June 7, 2012.**
**[3]Senate floor amendments adopted June 21, 2012.**
**[4]Assembly AHE committee amendments adopted March 7, 2013.**
**[5]Assembly AAP committee amendments adopted May 6, 2013.**
**[6]Assembly floor amendments adopted September 9, 2013.**

tissue [5]⟦based on the Breast Imaging Reporting and Data System established by the American College of Radiology⟧ , if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue,[5] or if [4]⟦a⟧ the[4] [5]⟦woman is believed to be at increased⟧ patient has additional[5] risk [5]factors[5] for breast cancer [5]⟦due to⟧ including but not limited to[5] family history [5]⟦or⟧ of breast cancer,[5] prior personal history of breast cancer, positive genetic testing, [5]extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology,[5] or other indications as determined by [4]⟦a⟧ the[4] [5]⟦woman's⟧ patient's[5] [4]⟦physician or advanced practice nurse⟧ health care provider. The coverage required under this paragraph may be subject to utilization review, including periodic review, by the hospital service corporation of the medical necessity of the [5]⟦comprehensive ultrasound screenings or other screenings⟧ additional screening and diagnostic testing[5] [6]⟦if the provider has been determined by the hospital service corporation to have overutilized the coverage required under this paragraph[4]⟧[6].

b. These benefits shall be provided to the same extent as for any other sickness under the contract.

c. The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.1)

2. Section 2 of P.L.1991, c.279 (C.17:48A-7f) is amended to read as follows:

2. a. No group or individual medical service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are [6]⟦at least 35 but less than⟧[6] 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) [5]⟦comprehensive⟧ an[5] ultrasound [5]⟦screening⟧ evaluation, a magnetic resonance imaging scan, a three-dimensional mammography[5] [4], or other [5]⟦screening⟧ additional testing[5] [6]⟦deemed medically necessary by the [5]⟦woman's⟧ patient's[5] health

care provider,[4]][6] of an entire breast or breasts [4], after a baseline mammogram examination,[4] if [4][a]] the[4] mammogram demonstrates [4][heterogeneous]] [5][heterogeneously[4] or]][5] [1]extremely[1] dense breast tissue [5][based on the Breast Imaging Reporting and Data System established by the American College of Radiology]] , if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue,[5] or if [4][a]] the[4] [5][woman is believed to be at increased]] patient has additional[5] risk [5]factors[5] for breast cancer [5][due to]] including but not limited to[5] family history [5][or]] of breast cancer,[5] prior personal history of breast cancer, positive genetic testing, [5]extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology,[5] or other indications as determined by [4][a]] the[4] [5][woman's]] patient's[5] [4][physician or advanced practice nurse]] health care provider. The coverage required under this paragraph may be subject to utilization review, including periodic review, by the medical service corporation of the medical necessity of the [5][comprehensive ultrasound screenings or other screenings]] additional screening and diagnostic testing[5] [6][if the provider has been determined by the medical service corporation to have overutilized the coverage required under this paragraph[4]][6].

b. These benefits shall be provided to the same extent as for any other sickness under the contract.

c. The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.2)

3. Section 3 of P.L.1991, c.279 (C.17:48E-35.4) is amended to read as follows:

3. a. No group or individual health service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are [6][at least 35 but less than]][6] 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) [5][comprehensive] an[5] ultrasound [5][screening] evaluation, a magnetic resonance imaging scan, a three-dimensional mammography[5] [4], or other [5][screening] additional testing[5] [6][deemed medically necessary by the [5][woman's] patient's[5] health care provider,[4]][6] of an entire breast or breasts [4], after a baseline mammogram examination,[4] if [4][a] the[4] mammogram demonstrates [4][heterogeneous] [5][heterogeneously[4] or]][5] [1]extremely[1] dense breast tissue [5][based on the Breast Imaging Reporting and Data System established by the American College of Radiology] , if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue,[5] or if [4][a] the[4] [5][woman is believed to be at increased] patient has additional[5] risk [5]factors[5] for breast cancer [5][due to] including but not limited to[5] family history [5][or] of breast cancer,[5] prior personal history of breast cancer, positive genetic testing, [5]extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology,[5] or other indications as determined by [4][a] the[4] [5][woman's] patient's[5] [4][physician or advanced practice nurse] health care provider. The coverage required under this paragraph may be subject to utilization review, including periodic review, by the health service corporation of the medical necessity of the [5][comprehensive ultrasound screenings or other screenings] additional screening and diagnostic testing[5] [6][if the provider has been determined by the health service corporation to have overutilized the coverage required under this paragraph[4]][6].

b. These benefits shall be provided to the same extent as for any other sickness under the contract.

c. The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.3)

4. Section 4 of P.L.1991, c.279 (C.17B:26-2.1e) is amended to read as follows:

4. a. No individual health insurance policy providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the policy provides benefits to any named insured or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are [6][at least 35 but less than]][6] 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history

of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) [5][comprehensive] an[5] ultrasound [5][screening] evaluation, a magnetic resonance imaging scan, a three-dimensional mammography[5] [4], or other [5][screening] additional testing[5] [6][deemed medically necessary by the [5][woman's] patient's[5] health care provider,[4]][6] of an entire breast or breasts [4], after a baseline mammogram examination,[4] if [4][a] the[4] mammogram demonstrates [4][heterogeneous] [5][heterogeneously[4] or]][5] [1]extremely[1] dense breast tissue [5][based on the Breast Imaging Reporting and Data System established by the American College of Radiology] , if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue,[5] or if [4][a] the[4] [5][woman is believed to be at increased] patient has additional[5] risk [5]factors[5] for breast cancer [5][due to] including but not limited to[5] family history [5][or] of breast cancer,[5] prior personal history of breast cancer, positive genetic testing, [5]extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology,[5] or other indications as determined by [4][a] the[4] [5][woman's] patient's[5] [4][physician or advanced practice nurse] health care provider. The coverage required under this paragraph may be subject to utilization review, including periodic review, by the insurer of the medical necessity of the [5][comprehensive ultrasound screenings or other screenings] additional screening and diagnostic testing[5] [6][if the provider has been determined by the insurer to have overutilized the coverage required under this paragraph[4]][6].

b. These benefits shall be provided to the same extent as for any other sickness under the policy.

c. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.4)

5. Section 5 of P.L.1991, c.279 (C.17B:27-46.1f) is amended to read as follows:

5. a. No group health insurance policy providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the policy provides benefits to any named insured or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are [6][at least 35 but less than][6] 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) [5][comprehensive] an[5] ultrasound [5][screening] evaluation, a magnetic resonance imaging scan, a three-dimensional mammography[5] [4], or other [5][screening] additional testing[5] [6][deemed medically necessary by the [5][woman's] patient's[5] health care provider,[4]][6] of an entire breast or breasts [4], after a baseline mammogram examination,[4] if [4][a] the[4] mammogram demonstrates [4][heterogeneous] [5][heterogeneously[4] or][5] [1]extremely[1] dense breast tissue [5][based on the Breast Imaging Reporting and Data System established by the American College of Radiology] , if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue,[5] or if [4][a] the[4] [5][woman is believed to be at increased] patient has additional[5] risk [5]factors[5] for breast cancer [5][due to] including but not limited to[5] family history [5][or] of breast cancer,[5] prior personal history of breast cancer, positive genetic testing, [5]extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology,[5] or other indications as determined by [4][a] the[4] [5][woman's] patient's[5] [4][physician or advanced practice nurse] health care provider. The coverage required under this paragraph may be subject to utilization review, including periodic review, by the insurer of the medical necessity of the [5][comprehensive ultrasound screenings or other screenings] additional screening and diagnostic testing[5] [6][if the provider has been determined by the insurer to have overutilized the coverage required under this paragraph[4]][6].

b. These benefits shall be provided to the same extent as for any other sickness under the policy.

c. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.5)

6. Section 7 of P.L.2004, c.86 (C.17B:27A-7.10) is amended to read as follows:

7. a. Every individual health benefits plan that is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or approved for issuance or renewal in this State, on or after the effective date of this act, shall provide

benefits to any [5][woman] person[5] covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are [6][at least 35 but less than][6] 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) [5][comprehensive] an[5] ultrasound [5][screening] evaluation, a magnetic resonance imaging scan, a three-dimensional mammography[5] [4], or other [5][screening] additional testing[5] [6][deemed medically necessary by the [5][woman's] patient's[5] health care provider,[4]][6] of an entire breast or breasts [4], after a baseline mammogram examination,[4] if [4][a] the[4] mammogram demonstrates [4][heterogeneous] [5][heterogeneously[4] or][5] [1]extremely[1] dense breast tissue [5][based on the Breast Imaging Reporting and Data System established by the American College of Radiology] , if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue,[5] or if [4][a] the[4] [5][woman is believed to be at increased] patient has additional[5] risk [5]factors[5] for breast cancer [5][due to] including but not limited to[5] family history [5][or] of breast cancer,[5] prior personal history of breast cancer, positive genetic testing, [5]extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology,[5] or other indications as determined by [4][a] the[4] [5][woman's] patient's[5] [4][physician or advanced practice nurse] health care provider. The coverage required under this paragraph may be subject to utilization review, including periodic review, by the carrier of the medical necessity of the [5][comprehensive ultrasound screenings or other screenings] additional screening and diagnostic testing[5] [6][if the provider has been determined by the carrier to have overutilized the coverage required under this paragraph[4]][6].

b. The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

c. The provisions of this section shall apply to all health benefit plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.7)

7. Section 8 of P.L.2004, c.86 (C.17B:27A-19.13) is amended to read as follows:

8. a. Every small employer health benefits plan that is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) or approved for issuance or renewal in this State, on or after the effective date of this act, shall provide benefits to any [5][woman] person[5] covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are [6][at least 35 but less than][6] 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) [5][comprehensive] an[5] ultrasound [5][screening] evaluation, a magnetic resonance imaging scan, a three-dimensional mammography[5] [4], or other [5][screening] additional testing[5] [6][deemed medically necessary by the [5][woman's] patient's[5] health care provider,[4]][6] of an entire breast or breasts [4], after a baseline mammogram examination,[4] if [4][a] the[4] mammogram demonstrates [4][heterogeneous] [5][heterogeneously[4] or][5] [1]extremely[1] dense breast tissue [5][based on the Breast Imaging Reporting and Data System established by the American College of Radiology] , if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue,[5] or if [4][a] the[4] [5][woman is believed to be at increased] patient has additional[5] risk [5]factors[5] for breast cancer [5][due to] including but not limited to[5] family history [5][or] of breast cancer,[5] prior personal history of breast cancer, positive genetic testing, [5]extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology,[5] or other indications as determined by [4][a] the[4] [5][woman's] patient's[5] [4][physician or advanced practice nurse] health care provider. The coverage required under this paragraph may be subject to utilization review, including periodic review, by the carrier of the medical necessity of the [5][comprehensive ultrasound screenings or other screenings] additional screening and diagnostic testing[5] [6][if the provider has been determined by the carrier to have overutilized the coverage required under this paragraph[4]][6].

b. The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

c. The provisions of this section shall apply to all health benefit plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.8)

8. Section 6 of P.L.1991, c.279 (C.26:2J-4.4) is amended to read as follows:

6. a. Notwithstanding any provision of law to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of [4][Health and Senior Services] Banking and Insurance[4] on or after the effective date of this act unless the health maintenance organization provides health care services to any enrollee for the conduct of:

(1) one baseline mammogram examination for women who are [6][at least 35 but less than][6] 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) [5][comprehensive] an[5] ultrasound [5][screening] evaluation, a magnetic resonance imaging scan, a three-dimensional mammography[5] [4], or other [5][screening] additional testing[5] [6][deemed medically necessary by the [5][woman's] patient's[5] health care provider,[4]][6] of an entire breast or breasts [4], after a baseline mammogram examination,[4] if [4][a] the[4] mammogram demonstrates [4][heterogeneous] [5][heterogeneously[4] or][5] [1]extremely[1] dense breast tissue [5][based on the Breast Imaging Reporting and Data System established by the American College of Radiology] , if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue,[5] or if [4][a] the[4] [5][woman is believed to be at increased] patient has additional[5] risk [5]factors[5] for breast cancer [5][due to] including but not limited to[5] family history [5][or] of breast cancer,[5] prior personal history of breast cancer, positive genetic testing, [5]extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology,[5] or other indications as determined by [4][a] the[4] [5][woman's] patient's[5] [4][physician or advanced practice nurse] health care provider. The coverage required under this paragraph may be subject to utilization review, including periodic review, by the health maintenance organization of the medical necessity of the [5][comprehensive ultrasound screenings or other screenings] additional screening and diagnostic testing[5] [6][if the provider has been determined by the health maintenance organization to have overutilized the coverage required under this paragraph[4]][6].

b. These health care services shall be provided to the same extent as for any other sickness under the enrollee agreement.

c. The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has

reserved the right to change the schedule of charges.
(cf: [4]⟦P.L.2004, c.86, s.6⟧ P.L.2012, c.17, s.263[4])

9. Section 9 of P.L.2004, c.86 (C.52:14-17.29i) is amended to read as follows:

9. a. The State Health Benefits Commission shall provide benefits to each person covered under the State Health Benefits Program for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are [6]⟦at least 35 but less than⟧[6] 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) [5]⟦comprehensive⟧ an[5] ultrasound [5]⟦screening⟧ evaluation, a magnetic resonance imaging scan, a three-dimensional mammography[5] [4], or other [5]⟦screening⟧ additional testing[5] [6]⟦deemed medically necessary by the [5]⟦woman's⟧ patient's[5] health care provider,[4]⟧[6] of an entire breast or breasts [4], after a baseline mammogram examination,[4] if [4]⟦a⟧ the[4] mammogram demonstrates [4]⟦heterogeneous⟧ [5]⟦heterogeneously[4] or⟧[5] [1]extremely[1] dense breast tissue [5]⟦based on the Breast Imaging Reporting and Data System established by the American College of Radiology⟧ , if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue,[5] or if [4]⟦a⟧ the[4] [5]⟦woman is believed to be at increased⟧ patient has additional[5] risk [5]factors[5] for breast cancer [5]⟦due to⟧ including but not limited to[5] family history [5]⟦or⟧ of breast cancer,[5] prior personal history of breast cancer, positive genetic testing, [5]extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology,[5] or other indications as determined by [4]⟦a⟧ the[4] [5]⟦woman's⟧ patient's[5] [4]⟦physician or advanced practice nurse⟧ health care provider. The coverage required under this paragraph may be subject to utilization review, including periodic review, by the carrier of the medical necessity of the [5]⟦comprehensive ultrasound screenings or other screenings⟧ additional screening and diagnostic testing[5] [6]⟦if the provider has been determined by the carrier to have overutilized the coverage required under this paragraph[4]⟧[6].

b. The benefits shall be provided to the same extent as for any other medical condition under the contract.
(cf: P.L.2004, c.86, s.9)

10. (New section) [1][Each mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. When applicable, the 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 office, and you should contact your physician if you have any questions or concerns about this report."] [4][Every provider of mammography services] A facility that provides a mammography report pursuant to the federal Mammography Quality Standards Act, 42 U.S.C. s.263b,[4] shall [6][, if a patient's mammogram demonstrates [4][heterogeneous or][4] extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology,][6] include the following information, at a minimum, in [4][any] the[4] mammography report sent [4][, pursuant to the federal Mammography Quality Standards Act, 42 U.S.C. s.263b,][4] to the patient and the patient's [6][physician] health care provider[6] : “Your mammogram [6][shows that your breast tissue is [5]extremely[5] dense] may show that you have dense breast tissue[6] [4]as determined by the Breast Imaging Reporting and Data System established by the American College of Radiology[4] . Dense breast tissue is very common and is not abnormal. However, [6][[5]extremely[5]] in some cases,[6] dense breast tissue can make it harder to find cancer on a mammogram [2][and may also increase your breast cancer risk][2] [3]and may also [4][increase your breast cancer risk[3]] be associated with a risk factor for breast cancer[4] . [6][This information about the result of your mammogram is given to you to raise your awareness. Use this information to talk to your [4][doctor] health care provider[4] about] Discuss[6] [5][your own] this and other[5] risks for breast cancer [5]that pertain to your personal medical history[5] [6]with your health care provider[6] . [5][At that time, ask your [4][doctor] health care provider[4] if more screening tests might be useful, based on your risk.][5] A report of your results was sent to your [6][physician] health care provider[6] .”[1] [6]You may also find more information about breast density at the website of the American College of Radiology, www.acr.org.”[6]

[5]11. (New section) Notwithstanding the provisions of any other law to the contrary, the provisions of section 10 of P.L. ,

c. (C. ) (pending before the Legislature as this bill) shall not impose a standard of care obligation upon a patient's health care provider. The information required to be provided by section 10 of P.L. , c. (C. ) (pending before the Legislature as this bill) is intended to increase awareness of breast cancer and help facilitate a conversation between a patient and a patient's health care provider regarding the patient's risks for breast cancer.[5]

[5][11] 12[5]. The Commissioner of Health [4][and Senior Services][4], pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to effectuate the purposes of [5][section] sections[5] 10 [5]and 11[5] of P.L. , c. (C. ) (pending before the Legislature as this bill).

[5]13. (New section) a. Notwithstanding the provisions of any other law to the contrary, the Mandated Health Benefits Advisory Commission established pursuant to section 3 of P.L.2003, c.193 (C.17B:27D-3), shall prepare a report regarding the implementation and administration of P.L. , c. (C. ) (pending before the Legislature as this bill) at least once in each five-year period following the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill).

b. The report shall provide a summary of the social and financial impact, as well as the medical efficacy, of the requirements imposed by P.L. , c. (C. ) (pending before the Legislature as this bill), and shall provide a summary of any recommendations the commission may have to improve the effectiveness of P.L. , c. (C. ) (pending before the Legislature as this bill).

c. The commission shall transmit a copy of a report prepared in accordance with this section to the Governor, and to the Legislature, in accordance with section 2 of P.L.1991, c.164 (C.52:14-19.1), within five days of the date the report is prepared.[5]

[6]14. (New section) a. The Department of Health, in conjunction with the Medical Society of New Jersey, shall convene a work group to review and report on strategies to improve the dialogue between patients and health care professionals regarding risk factors for breast cancer and breast imaging options. The work group shall review breast imaging standards, the federal Mammography Quality Standards Act and breast imaging results protocols, and shall recommend strategies to improve the dialogue between patients and health care professionals regarding breast density and breast imaging options.

b. The department shall invite to participate in the work group representatives of patient advocacy groups and health care

professionals' organizations. The work group shall organize as soon as practicable following the appointment of its members. The members of the work group shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties and within the limits of funds available to the work group.

c. The work group shall be entitled to call to its assistance and avail itself of the services of the employees of any State, county, or municipal department, board, bureau, commission, or agency as the work group may require and as may be available to the work group for its purposes.

d. The work group shall report its findings and recommendations to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), along with any legislative bills that it desires to recommend for adoption by the Legislature, on an annual basis. The work group shall submit its first report no later than 12 months after the initial meeting of the work group.[6]

[5][12.] [6][14.[5]] 15.[6] This act shall take effect on the first day of the fourth month next following the date of enactment. Sections 1 through 9 of this act shall apply to all contracts and policies that are delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the effective date. The [4]Commissioner of Banking and Insurance and the[4] Commissioner of Health [4][and Senior Services][4] may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of [4][section 10 of][4] this act.

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Requires insurers to cover breast evaluations and other additional medically necessary testing under certain circumstances and requires certain mammogram reports to contain information on breast density.

# SENATE, No. 792

# STATE OF NEW JERSEY

## 215th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2012 SESSION

**Sponsored by:**
**Senator LORETTA WEINBERG**
**District 37 (Bergen)**
**Senator NIA H. GILL**
**District 34 (Essex and Passaic)**

**SYNOPSIS**

Requires insurers to cover comprehensive ultrasound breast screening if a mammogram demonstrates dense breast tissue and requires mammogram reports to contain information on breast density.

**CURRENT VERSION OF TEXT**

Introduced Pending Technical Review by Legislative Counsel

**AN ACT** concerning mammograms, amending P.L.1991, c.279 and P.L.2004, c.86, and supplementing Title 26 of the Revised Statutes.

**BE IT ENACTED** *by the Senate and General Assembly of the State of New Jersey:*

1. Section 1 of P.L.1991, c.279 (C.17:48-6g) is amended to read as follows:

1. a. No group or individual hospital service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These benefits shall be provided to the same extent as for any other sickness under the contract.

c. The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.1)

2. Section 2 of P.L.1991, c.279 (C.17:48A-7f) is amended to read as follows:

2. a. No group or individual medical service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the

**EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.**

**Matter underlined thus is new matter.**

contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These benefits shall be provided to the same extent as for any other sickness under the contract.

c. The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.2)

3. Section 3 of P.L.1991, c.279 (C.17:48E-35.4) is amended to read as follows:

3. a. No group or individual health service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive

genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These benefits shall be provided to the same extent as for any other sickness under the contract.

c. The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.3)

4. Section 4 of P.L.1991, c.279 (C.17B:26-2.1e) is amended to read as follows:

4. a. No individual health insurance policy providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the policy provides benefits to any named insured or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These benefits shall be provided to the same extent as for any other sickness under the policy.

c. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.4)

5. Section 5 of P.L.1991, c.279 (C.17B:27-46.1f) is amended to read as follows:

5. a. No group health insurance policy providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the policy provides benefits to

any named insured or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These benefits shall be provided to the same extent as for any other sickness under the policy.

c. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.5)

6. Section 7 of P.L.2004, c.86 (C.17B:27A-7.10) is amended to read as follows:

7. a. Every individual health benefits plan that is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or approved for issuance or renewal in this State, on or after the effective date of this act, shall provide benefits to any woman covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

c. The provisions of this section shall apply to all health benefit plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.7)

7. Section 8 of P.L.2004, c.86 (C.17B:27A-19.13) is amended to read as follows:

8. a. Every small employer health benefits plan that is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) or approved for issuance or renewal in this State, on or after the effective date of this act, shall provide benefits to any woman covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

c. The provisions of this section shall apply to all health benefit plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.8)

8. Section 6 of P.L.1991, c.279 (C.26:2J-4.4) is amended to read as follows:

6. a. Notwithstanding any provision of law to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of Health and Senior Services on or after the effective date of this act unless the health maintenance organization provides health care services to any enrollee for the conduct of:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination

every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These health care services shall be provided to the same extent as for any other sickness under the enrollee agreement.

c. The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

(cf: P.L.2004, c.86, s.6)

9. Section 9 of P.L.2004, c.86 (C.52:14-17.29i) is amended to read as follows:

9. a. The State Health Benefits Commission shall provide benefits to each person covered under the State Health Benefits Program for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. The benefits shall be provided to the same extent as for any other medical condition under the contract.

(cf: P.L.2004, c.86, s.9)

10. (New section) Each mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the

American College of Radiology. When applicable, the 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 office, and you should contact your physician if you have any questions or concerns about this report."

11. The Commissioner of Health and Senior Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to effectuate the purposes of section 10 of P.L. , c. (C. )(pending before the Legislature as this bill).

12. This act shall take effect on the first day of the fourth month next following the date of enactment. Sections 1 through 9 of this act shall apply to all contracts and policies that are delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the effective date. The Commissioner of Health and Senior Services may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of section 10 of this act.

STATEMENT

This bill requires health insurers to cover comprehensive ultrasound breast screening if a mammogram demonstrates dense breast tissue, and also requires mammogram reports to contain information on breast density.

The bill provides specifically as follows:

- In addition to the existing health benefits coverage requirement for mammograms under State law, health insurers are to provide health benefits coverage for comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.
- The provisions of the bill apply to: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans

issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; and the State Health Benefits Program (which by law requires coverage under the School Employees' Health Benefits Program as well).

- The insurance coverage requirement takes effect on the first day of the fourth month following enactment of the bill and applies to all health insurance contracts and policies that are delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the effective date.
- In addition, the bill requires that each mammography report provided to a patient include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. (Federal law requires a mammography facility to provide a mammography report containing the imaging results to the patient and the patient's provider within 30 days of the exam.)
- When applicable, the mammography report is to 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 office, and you should contact your physician if you have any questions or concerns about this report."

The need for this bill is predicated on the following facts:

-- Two-thirds of pre-menopausal and one fourth of post-menopausal women have dense breast tissue, and many do not even know it;

-- Cancer is five times more likely in women with extremely dense breasts;

-- A mammogram will detect only about 48 percent of tumors in women with dense breast tissue, and so the rest will elude early detection;

-- Breast density is one of the strongest predictors of the failure of mammography screening to detect cancer;

-- Cancer recurrence is four times more likely in women with dense breasts; and

-- A May, 2010 national survey conducted by Harris Interactive found that 95 percent of women ages 40 and older did not know their breast density, and nearly 90 percent did not know that breast density increases the risk of developing breast cancer.

SENATE COMMERCE COMMITTEE

STATEMENT TO

# SENATE, No. 792

with committee amendments

# STATE OF NEW JERSEY

DATED: MAY 17, 2012

The Senate Commerce Committee reports favorably and with committee amendments Senate Bill No. 792.

This bill, with committee amendments, requires health insurers to cover comprehensive ultrasound breast screening if a mammogram demonstrates certain dense breast tissue, and also requires certain mammogram reports to contain information on breast density.

The bill, as amended, provides specifically as follows:

- In addition to the existing health benefits coverage requirement for mammograms under State law, health insurers are to provide health benefits coverage for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.
- The provisions of the bill apply to: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; and the State Health Benefits Program (which by law requires coverage under the School Employees' Health Benefits Program as well).
- The insurance coverage requirement takes effect on the first day of the fourth month following enactment of the bill and applies to all health insurance contracts and policies that are delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the effective date.

In addition, if a patient's mammogram demonstrates heterogeneous or extremely dense breast tissue, the bill requires the mammogram report to include information about breast density. (Federal law requires a mammography facility to provide a mammography report

containing the imaging results to the patient and the patient's provider within 30 days of the exam.)

The mammography report is to include the following notice: "Your mammogram shows that your breast tissue is dense. Dense breast tissue is very common and is not abnormal. However, dense breast tissue can make it harder to find cancer on a mammogram and may also increase your breast cancer risk. This information about the result of your mammogram is given to you to raise your awareness. Use this information to talk to your doctor about your own risks for breast cancer. At that time, ask your doctor if more screening tests might be useful, based on your risk. A report of your results was sent to your physician."

This bill was pre-filed for introduction in the 2012-2013 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

Committee Amendments:

The committee amended the bill to:

- clarify that the requirement for health insurers to cover comprehensive ultrasound breast screening would only apply if a mammogram demonstrates heterogeneous or extremely dense breast tissue; and

- modify the language required to be included in a mammography report pursuant to section 10 of the bill and clarify that the notice is required only if a patient's mammogram demonstrates heterogeneous or extremely dense breast tissue.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]
**SENATE, No. 792**

with committee amendments

# STATE OF NEW JERSEY

DATED: JUNE 7, 2012

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 792 (1R), with committee amendments.

This bill requires health insurers to cover comprehensive ultrasound breast screening if a mammogram demonstrates certain dense breast tissue, and also requires certain mammogram reports to contain information on breast density.

In addition to the existing health benefits coverage requirement for mammograms under State law, the bill requires health insurers to provide health benefits coverage for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

The provisions of the bill apply to: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; and the State Health Benefits Program (which by law requires coverage under the School Employees' Health Benefits Program as well).

In addition, the bill requires the mammogram report to contain information about breast density, as specified in the bill. Federal law requires a mammography facility to provide a mammography report containing the imaging results to the patient and the patient's provider with 30 days of the exam. The bill takes effect on the first day of the fourth month following enactment and applies to all health insurance contracts and policies that are delivered, issued, executed, or renewed approved for issuance or renewal in the State on or after the effective date.

COMMITTEE AMENDMENTS:

The committee amendments clarify the statement to be included on a mammography report to state that dense breast tissue can make it harder to find cancer on a mammogram, but deletes the phrase “and may also increase your breast cancer risk.”

FISCAL IMPACT:

According to the Division of Pensions and Benefits in the Department of the Treasury, the SHBP and the SEHBP already provide coverage for comprehensive ultrasound breast screening if a mammogram demonstrates certain dense breast tissue or if a woman is believed to be at increased risk for breast cancer under other circumstances, as specified.

# FISCAL NOTE

[First Reprint]

# SENATE, No. 792

# STATE OF NEW JERSEY
# 215th LEGISLATURE

DATED: JUNE 11, 2012

## SUMMARY

**Synopsis:** Requires insurers to cover comprehensive ultrasound breast screening if a mammogram demonstrates certain breast tissue and requires certain mammogram reports to contain information on breast density.

**Type of Impact:** No impact on the State General Fund or local government funds.

**Agencies Affected:** Division of Pensions and Benefits in the Department of the Treasury, local government entities.

**Executive Estimate**

| Fiscal Impact | FY 2013 | FY 2014 | FY 2015 |
|---|---|---|---|
| **State Cost** | | No fiscal impact | |
| **Local Cost** | | No fiscal impact | |

- The Office of Legislative Services (OLS) **concurs** with the Executive fiscal estimate.

- This bill requires the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP) to provide health benefits coverage for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or extremely dense breast tissue based on the Breast Imaging Reporting and Data systems established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practical nurse.

- To the extent that this type of coverage is already provided, the SHBP and the SEHBP would not incur additional costs as a result of the bill.

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## BILL DESCRIPTION

Senate Bill No. 792 (1R) of 2012 requires the SHBP and the SEHBP, in addition to the existing health benefits coverage requirement for mammograms under State law, to provide health benefits coverage for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or extremely dense breast tissue based on the Breast Imaging Reporting and Data systems established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practical nurse. In addition, the bill requires the mammogram report to contain information about breast density, as specified in the bill. Federal law requires a mammography facility to provide a mammography report containing the imaging results to the patient and the patient's provider with 30 days of the exam. The bill takes effect on the first day of the fourth month following enactment and applies to all health insurance contracts and policies that are delivered, issued, executed, or renewed approved for issuance or renewal in the State on or after the effective date.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

According to the Division of Pensions and Benefits in the Department of the Treasury, the SHBP and the SEHBP already provide coverage for comprehensive ultrasound breast screening if a mammogram demonstrates certain dense breast tissue or if a woman is believed to be at increased risk for breast cancer under other circumstances, as specified.

### *OFFICE OF LEGISLATIVE SERVICES*

The OLS concurs with the Executive fiscal estimate. To the extent that this type of coverage is already provided, the SHBP and the SEHBP would not incur additional costs as a result of the bill.

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|---|---|
| *Section:* | *State Government* |
| *Analyst:* | *Kimberly McCord Clemmensen*<br>*Senior Fiscal Analyst* |
| *Approved:* | *David J. Rosen*<br>*Legislative Budget and Finance Officer* |

This fiscal note has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

STATEMENT TO

[Second Reprint]
**SENATE, No. 792**

with Senate Floor Amendments
(Proposed by Senator WEINBERG)

ADOPTED: JUNE 21, 2012

These Senate amendments clarify the information to be included in any mammography report sent by a mammography services provider to a patient and a patient's physician when the patient's mammogram demonstrates heterogeneous or extremely dense breast tissue. In that situation, the report must state that dense breast tissue "may also increase your breast cancer risk," in addition to stating that dense breast tissue can make it harder to find cancer on a mammogram.

# FISCAL NOTE

[Second Reprint]

# SENATE, No. 792

# STATE OF NEW JERSEY
# 215th LEGISLATURE

DATED: JUNE 25, 2012

## SUMMARY

**Synopsis:** Requires insurers to cover comprehensive ultrasound breast screening if a mammogram demonstrates certain breast tissue and requires certain mammogram reports to contain information on breast density.

**Type of Impact:** No impact on the State General Fund or local government funds.

**Agencies Affected:** Division of Pensions and Benefits in the Department of the Treasury, local government entities.

**Executive Estimate**

| Fiscal Impact | FY 2013 | FY 2014 | FY 2015 |
|---|---|---|---|
| **State Cost** | | No fiscal impact | |
| **Local Cost** | | No fiscal impact | |

- The Office of Legislative Services (OLS) **concurs** with the Executive fiscal estimate.

- This bill requires the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP) to provide health benefits coverage for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or extremely dense breast tissue based on the Breast Imaging Reporting and Data systems established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practical nurse.

- To the extent that this type of coverage is already provided, the SHBP and the SEHBP would not incur additional costs as a result of the bill.

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## BILL DESCRIPTION

Senate Bill No. 792 (2R) of 2012 requires the SHBP and the SEHBP, in addition to the existing health benefits coverage requirement for mammograms under State law, to provide health benefits coverage for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or extremely dense breast tissue based on the Breast Imaging Reporting and Data systems established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practical nurse. In addition, the bill requires the mammogram report to contain information about breast density, as specified in the bill. Federal law requires a mammography facility to provide a mammography report containing the imaging results to the patient and the patient's provider with 30 days of the exam. The bill takes effect on the first day of the fourth month following enactment and applies to all health insurance contracts and policies that are delivered, issued, executed, or renewed approved for issuance or renewal in the State on or after the effective date.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

According to the Division of Pensions and Benefits in the Department of the Treasury, the SHBP and the SEHBP already provide coverage for comprehensive ultrasound breast screening if a mammogram demonstrates certain dense breast tissue or if a woman is believed to be at increased risk for breast cancer under other circumstances, as specified.

### *OFFICE OF LEGISLATIVE SERVICES*

The OLS **concurs** with the Executive fiscal estimate. To the extent that this type of coverage is already provided, the SHBP and the SEHBP would not incur additional costs as a result of the bill.

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| *Section:* | *State Government* |
| *Analyst:* | *Kimberly McCord Clemmensen*<br>*Senior Fiscal Analyst* |
| *Approved:* | *David J. Rosen*<br>*Legislative Budget and Finance Officer* |

This fiscal note has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

# FISCAL NOTE

[Third Reprint]

# SENATE, No. 792

# STATE OF NEW JERSEY
# 215th LEGISLATURE

DATED: AUGUST 3, 2012

## SUMMARY

**Synopsis:** Requires insurers to cover comprehensive ultrasound breast screening if a mammogram demonstrates certain breast tissue and requires certain mammogram reports to contain information on breast density.

**Type of Impact:** No impact on the State General Fund or local government funds.

**Agencies Affected:** Division of Pensions and Benefits in the Department of the Treasury, local government entities.

**Executive Estimate**

| Fiscal Impact | FY 2013 | FY 2014 | FY 2015 |
|---|---|---|---|
| **State Cost** | | No fiscal impact | |
| **Local Cost** | | No fiscal impact | |

- The Office of Legislative Services (OLS) **concurs** with the Executive fiscal estimate.

- This bill requires the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP) to provide health benefits coverage for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or extremely dense breast tissue based on the Breast Imaging Reporting and Data systems established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practical nurse.

- To the extent that this type of coverage is already provided, the SHBP and the SEHBP would not incur additional costs as a result of the bill.

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## BILL DESCRIPTION

Senate Bill No. 792 (3R) of 2012 requires the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP), in addition to the existing health benefits coverage requirement for mammograms under State law, to provide health benefits coverage for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or extremely dense breast tissue based on the Breast Imaging Reporting and Data systems established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practical nurse. In addition, the bill requires the mammogram report to contain information about breast density, as specified in the bill. Federal law requires a mammography facility to provide a mammography report containing the imaging results to the patient and the patient's provider with 30 days of the exam. The bill takes effect on the first day of the fourth month following enactment and applies to all health insurance contracts and policies that are delivered, issued, executed, or renewed approved for issuance or renewal in the State on or after the effective date.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

According to the Division of Pensions and Benefits in the Department of the Treasury, the SHBP and the SEHBP already provide coverage for comprehensive ultrasound breast screening if a mammogram demonstrates certain dense breast tissue or if a woman is believed to be at increased risk for breast cancer under other circumstances, as specified.

### *OFFICE OF LEGISLATIVE SERVICES*

The OLS concurs with the Executive fiscal estimate. To the extent that this type of coverage is already provided, the SHBP and the SEHBP would not incur additional costs as a result of the bill.

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|---|---|
| *Section:* | *State Government* |
| *Analyst:* | *Kimberly McCord Clemmensen*<br>*Senior Fiscal Analyst* |
| *Approved:* | *David J. Rosen*<br>*Legislative Budget and Finance Officer* |

This fiscal note has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

ASSEMBLY HEALTH AND SENIOR SERVICES COMMITTEE

STATEMENT TO

[Third Reprint]
**SENATE, No. 792**

with committee amendments

# STATE OF NEW JERSEY

DATED: MARCH 7, 2013

The Assembly Health and Senior Services Committee reports favorably and with committee amendments Senate Bill No. 792 [3R].

As amended by the committee, the bill requires health insurers to cover comprehensive ultrasound breast screening or other screening if a mammogram demonstrates heterogeneously or extremely dense breast tissue, and also requires mammogram reports to contain information on breast density.

Specifically, the bill provides that, in addition to the existing health benefits coverage requirement for mammograms under State law, health insurers are to provide health benefits coverage for comprehensive ultrasound screening, or other screening deemed medically necessary by the woman's health care provider, of an entire breast or breasts if a mammogram demonstrates heterogeneously or extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology, or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's health care provider. This coverage may be subject to review of the medical necessity of the screenings if the provider has been determined by the insurer to have overutilized the coverage.

The insurance provisions of the bill apply to: health, hospital, and medical service corporations; commercial, individual, and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; and the State Health Benefits Program (which by law requires coverage under the School Employees' Health Benefits Program as well).

In addition, the bill requires that providers of mammography services must, if a patient's mammogram demonstrates extremely dense breast tissue, include the following information, at a minimum, in the mammography report sent to the patient and the patient's physician (required by federal law): "Your mammogram shows that

your breast tissue is dense as determined by the Breast Imaging Reporting and Data System established by the American College of Radiology. Dense breast tissue is very common and is not abnormal. However, dense breast tissue can make it harder to find cancer on a mammogram and may also be associated with a risk factor for breast cancer. This information about the result of your mammogram is given to you to raise your awareness. Use this information to talk to your health care provider about your own risks for breast cancer. At that time, ask your health care provider if more screening tests might be useful, based on your risk. A report of your results was sent to your physician."

The bill takes effect on the first day of the fourth month following enactment of the bill. The insurance provisions apply to all health insurance contracts and policies that are delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the effective date.

As reported by the committee, this bill is identical to Assembly Bill No. 2022 ACA (Singleton/Benson/Johnson/Lampitt/Quijano/Vainieri Huttle), which the committee also reported on this date.

COMMITTEE AMENDMENTS

The committee amendments to the bill require coverage of screening other than comprehensive ultrasound screening that is deemed medically necessary by the woman's health care provider.

The amendments also clarify that the required coverage only applies after a baseline mammogram examination.

The amendments further provide that the coverage of comprehensive ultrasound screening or other screening may be subject to utilization review, including periodic review, by the insurer of the medical necessity of the comprehensive ultrasound screenings or other screenings if the provider has been determined by the insurer to have overutilized the coverage.

The amendments modify the language required to be included in a mammography report to make clarifications regarding the significance of dense breast tissue and to remove language indicating that dense breast tissue may increase breast cancer risk, replacing it with language indicating that dense breast tissue may be associated with a risk factor for breast cancer.

Finally, the amendments make several grammatical and technical changes, and update references to the Commissioner of Health pursuant to current law.

MINORITY STATEMENT

By Assemblywomen Handlin, Angelini, and Munoz and
Assemblyman Peterson

The sponsors of this bill should be commended for their efforts to educate women about dense breast tissue and to ensure they receive the appropriate health care services. However, for the following reasons we cannot support the legislation before us today:

- The bill shifts the responsibility for informing the patient about breast density from a radiologist, who has expertise in this area, to the patient's primary care provider;

- The bill establishes a medical standard for ultrasound screenings, for which there is no consensus in the medical community as to the medical benefit;

- The language in the bill is unclear as to what the most appropriate supplemental screening modalities should be for women with dense breast tissue, leaving physicians with no guidance when to prescribe these procedures;

- There was an absence of testimony concerning women being denied supplemental screenings if prescribed by a physician due to dense breast tissue;

- The bill interferes with the sacrosanct patient-physician relationship and attempts to supplant a physician's medical advice with legislative dictates; and

- The bill has not yet been referred to the Mandated Health Benefits Advisory Commission, which was statutorily established to provide an objective, independent analysis of the medical, financial, and social impacts of proposed health insurance benefit mandates. The committee would have benefitted from the information provided by the commission.

Again, we strongly support the bill's secondary objective to raise awareness about breast density, but at the present time, there remain many outstanding medical issues that need to be addressed. Therefore, we are withholding our support for this legislation at this time.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[Fourth Reprint]
**SENATE, No. 792**

with committee amendments

# STATE OF NEW JERSEY

DATED: MAY 6, 2013

The Assembly Appropriations Committee reports favorably Senate Bill No. 792 (4R), with committee amendments.

As amended, the bill requires health insurers to cover certain additional breast screenings and diagnostic testing under certain circumstances, requires mammography reports sent to patients and patients' physicians to contain certain information on breast density, and directs the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill.

*REQUIRED HEALTH INSURANCE COVERAGE.* The bill requires health insurers to provide health benefits coverage for an ultrasound evaluation, a magnetic resonance imaging scan, a three-dimensional mammography, or other additional testing deemed medically necessary by a patient's health care provider, of an entire breast or breasts, after a baseline mammogram examination, if the mammogram demonstrates extremely dense breast tissue, if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue, or if the patient has additional risk factors for breast cancer. The bill provides that the additional risk factors include, but are not limited to, family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System, or other indications as determined by the patient's health care provider.

The bill provides that the health benefits coverage required by the bill may be subject to review. Under the bill, the additional coverage required to be provided by health insurers may be subject to utilization review, including periodic review, by the health insurer of the medical necessity of the additional breast screening and diagnostic testing, if the health care provider has been determined by the insurer to have overutilized the required coverage.

The bill provides that the health benefits coverage requirements apply to: health, hospital, and medical service corporations; commercial, individual, and group health insurers; health maintenance

organizations; and health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs. The bill provides the requirements for coverage also apply to the State Health Benefits Program, which by law requires similar health benefits coverage under the School Employees' Health Benefits Program.

*INFORMATION INCLUDED IN MAMMOGRAPHY REPORTS.* The bill requires providers of mammography services to include information on breast density in mammography reports sent to patients and physicians, if a patient's mammogram demonstrates extremely dense breast tissue based on the Breast Imaging Reporting and Data System. The bill provides that the information on breast density must include the following statement: "Your mammogram shows that your breast tissue is extremely dense as determined by the Breast Imaging Reporting and Data System established by the American College of Radiology. Dense breast tissue is very common and is not abnormal. However, extremely dense breast tissue can make it harder to find cancer on a mammogram and may also be associated with a risk factor for cancer. This information about the result of your mammogram is given to you to raise your awareness. Use this information to talk to your health care provider about this and other risks for breast cancer that pertain to your personal medical history. A report of your results was sent to your physician."

The bill provides that the information on breast density included in mammography reports will not impose a standard of care obligation upon a patient's health care provider. The bill stipulates that the information in the report is intended to increase awareness of breast cancer and help facilitate a conversation between a patient and a patient's health care provider regarding the patient's risks for breast cancer.

The bill authorizes the Commissioner of Health to adopt rules and regulations necessary to effectuate the requirements that pertain to breast density information included in mammography reports sent to patients and physicians. The bill provides that any rules and regulations adopted by the commissioner must be adopted in accordance with the "Administrative Procedure Act, P.L.1968, c.410 (C.52:14B-1 et seq.).

*PERIODIC REPORTS BY MHBAC.* The bill directs the Mandated Health Benefits Advisory Commission to prepare a report regarding the administration and implementation of the bill at least once in each five-year period following the bill's effective date. The bill provides that the report must include a summary of the social and financial impact, as well as the medical efficacy, of the requirements imposed by the bill, and requires the commission to transmit a copy of the report to the Governor and the Legislature within five days of the date the report is made.

*EFFECTIVE DATE.* The bill takes effect on the first day of the fourth month next following the date of enactment, and applies to all contracts and policies delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the bill's effective date. The bill authorizes the Commissioner of Banking and Insurance and the Commissioner of Health to take anticipatory administrative actions prior to the effective date of the bill.

As amended and reported by the committee, this bill is identical to Assembly Bill No. 2022 (2R), which also was amended and reported by the committee on this date.

FISCAL IMPACT:

The Office of Legislative Services (OLS) expects the State to incur certain costs as a result of the additional coverage that may be required by the State Health Benefits Program and the School Employees' Health Benefits Program under the bill. However, the OLS lacks sufficient information regarding the additional breast screening and diagnostic testing currently covered by insurance, the cost of the additional screening, and the number of covered persons that may be eligible to undergo the additional screening to quantify the potential cost to the State.

COMMITTEE AMENDMENTS:

The amendments clarify the additional types of breast screening and diagnostic testing required to be covered by health insurers, and the conditions under which the additional screening and testing must be covered.

The amendments revise the information on breast density required to be included in mammography reports sent to patients and physicians by providers of mammography services, and stipulate that the additional information provided in mammography reports will not impose a standard of care obligation on the patient's health care provider.

The amendments direct the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill.

The amendments incorporate gender-neutral language to replace references to woman and woman's health care provider.

# FISCAL NOTE

[Fifth Reprint]

# SENATE, No. 792

# STATE OF NEW JERSEY
# 215th LEGISLATURE

DATED: JULY 5, 2013

## SUMMARY

| | |
|---|---|
| **Synopsis:** | Requires insurers to cover breast evaluations and other additional medically necessary testing under certain circumstances and requires certain mammogram reports to contain information on breast density. |
| **Type of Impact:** | Expenditure Increase to the State General Fund and local government funds. |
| **Agencies Affected:** | Division of Pensions and Benefits, Department of the Treasury; local government entities. |

**Executive Estimate**

| Fiscal Impact | FY 2014 | FY 2015 | FY 2016 |
|---|---|---|---|
| **State Cost** | Unknown – See comments below. | | |
| **Local Cost** | Unknown – See comments below. | | |

- The Office of Legislative Services (OLS) **concurs** with the Executive Branch fiscal estimate.

- This bill requires health insurers to cover breast evaluations and other medically necessary testing such as ultrasound evaluation, a magnetic resonance imaging scan (MRI), a three-dimensional (3-D) mammography, or other additional testing under certain circumstances, requires certain mammogram reports to contain certain information on breast density, and directs the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill.

- According to the Division of Pensions and Benefits in the Department of the Treasury, the procedures mandated by this bill, ultrasound evaluations, MRIs, and 3-D Mammographies, are currently covered under the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP). Limiting this estimate to the SHBP/SEHBP, the enactment of this bill will have no cost impact to the plans with regard to those procedures named in the bill.

- However, according to the Office of Management and Budget, this bill also stipulates that coverage for "other additional testing deemed medically necessary by the patient's health care provider" is required. This new language is potentially consequential, as it could mandate the SHBP/SEHBP to provide additional services not already covered by the benefits plans, which would potentially result in higher costs. The value of these additional services is not quantifiable because it is not known which additional tests will be requested by the patient's health care provider, or whether the supplementary services will be covered by the SHBP/SEHBP.

## BILL DESCRIPTION

Senate Bill No. 792 (5R) of 2012 requires health insurers to cover certain additional breast screenings and diagnostic testing under certain circumstances, requires mammography reports sent to patients and patients' physicians to contain certain information on breast density, and directs the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill.

*REQUIRED HEALTH INSURANCE COVERAGE.* The bill requires health insurers to provide health benefits coverage for an ultrasound evaluation, a magnetic resonance imaging scan, a three-dimensional mammography, or other additional testing deemed medically necessary by a patient's health care provider, of an entire breast or breasts, after a baseline mammogram examination, if the mammogram demonstrates extremely dense breast tissue, if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue, or if the patient has additional risk factors for breast cancer. The bill provides that the additional risk factors include, but are not limited to, family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System, or other indications as determined by the patient's health care provider.

The bill provides that the health benefits coverage required by the bill may be subject to review. Under the bill, the additional coverage required to be provided by health insurers may be subject to utilization review, including periodic review, by the health insurer of the medical necessity of the additional breast screening and diagnostic testing, if the health care provider has been determined by the insurer to have overutilized the required coverage.

The bill provides that the health benefits coverage requirements apply to: health, hospital, and medical service corporations; commercial, individual, and group health insurers; health maintenance organizations; and health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs. The bill's requirements for coverage also apply to the State Health Benefits Program; by law, similar health benefits coverage is required under the School Employees' Health Benefits Program;

*INFORMATION INCLUDED IN MAMMOGRAPHY REPORTS.* The bill requires providers of mammography services to include information on breast density in mammography reports sent to patients and physicians, if a patient's mammogram demonstrates extremely dense breast tissue based on the Breast Imaging Reporting and Data System.

The bill provides that the information on breast density included in mammography reports will not impose a standard of care obligation upon a patient's health care provider. The bill stipulates that the information in the report is intended to increase awareness of breast cancer and help facilitate a conversation between a patient and a patient's health care provider regarding the patient's risks for breast cancer.

*PERIODIC REPORTS BY MHBAC.* The bill directs the Mandated Health Benefits Advisory Commission to prepare a report regarding the administration and implementation of the bill at least once in each five-year period following the bill's effective date. The bill provides that the report must include a summary of the social and financial impact, as well as the medical efficacy, of the requirements imposed by the bill, and requires the commission to transmit a copy of the report to the Governor and the Legislature within five days of the date the report is made.

*EFFECTIVE DATE.* The bill takes effect on the first day of the fourth month next following the date of enactment, and applies to all contracts and policies delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the bill's effective date.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

According to the Division of Pensions and Benefits in the Department of the Treasury, the procedures mandated by this bill, ultrasound evaluations, MRIs, and 3-D Mammographies, are currently covered under the SHBP and the SEHBP. Limiting this estimate to the SHBP/SEHBP, the enactment of this bill will have no cost impact to the plans with regard to the procedures named in the bill. The division also mentioned that the consultants to the SHBP/SEHBP reviewed the amendments to this bill and have determined that it does not specifically provide coverage for medical procedures that are not already covered by the plan. The consultants did express some concern that the term "other additional testing" is very broad.

According to the Office of Management and Budget, this bill stipulates that coverage for "other additional testing deemed medically necessary by the patient's health care provider" is required. Hence, this new language is potentially consequential, as it could mandate the SHBP/SEHBP to provide additional services not already covered by the benefits plans, which would potentially result in higher costs. The value of these additional services is not quantifiable because it is not known which additional tests will be requested by the patient's health care provider, or whether the supplementary services will be covered by the SHBP/SEHBP.

### *OFFICE OF LEGISLATIVE SERVICES*

The OLS concurs with the Executive fiscal estimate. The OLS notes that other breast cancer screenings, as identified by the American Cancer Society, include, but are not limited to, ductograms, nipple discharge examinations, nipple aspiration, and ductal lavage, and other experimental imaging tests currently being developed such as optical imaging tests using light transmission, molecular breast imaging (MBI) tests using nuclear technology, and positron emission mammography tests (PET) using radioactive tracer isotopes. While ultrasounds, MRIs, and 3D Mammograms are covered under the SHBP/SEHBP as the consultants note, the bill does not specifically provide coverage for medical procedures that are not already covered by the plans. According to the Division of Pensions and Benefits, coverage under the SHBP/SEHBP is dependent on "standard medical necessity" to be considered acceptable for insurance reimbursement. As such, the OLS cannot determine the potential additional costs associated with requiring coverage for other testing deemed medically necessary by the woman's health care provider if after a baseline mammogram examination a patient is believed to be at increased risk for breast cancer. This is because it is not known how many and which additional other tests

will be deemed medically necessary and prescribed by the patients' healthcare providers and if, at this time, those tests are covered under the SHBP/SEHBP.

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| *Section:* | *State Government* |
| *Analyst:* | *Kimberly McCord Clemmensen*<br>*Senior Fiscal Analyst* |
| *Approved:* | *David J. Rosen*<br>*Legislative Budget and Finance Officer* |

This fiscal note has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

# STATEMENT TO

# [Fifth Reprint]
# **SENATE, No. 792**

with Assembly Floor Amendments
(Proposed by Assemblyman SINGLETON)

ADOPTED: SEPTEMBER 9, 2013

These amendments permit a health insurer to subject a provider of the coverage required under this bill to utilization review. The amendments also eliminate the requirement that a health insurance carrier determine that a provider has overutilized the coverage before subjecting the provider to a utilization review.

The amendments further specify that health insurers must cover a baseline mammogram examination for a woman at age 40, rather than between the ages of 35 and 40.

The amendments also require that a letter explaining the relationship between dense breast tissue and breast cancer in clear terms accompany a mammography report to any patient that receives a mammogram, rather than only to patients whose mammograms demonstrate extremely dense breast tissue. (This letter would be in addition to, or part of, the "lay letter" that must accompany a mammogram report, as required by federal law.) The amendments revise the content of the letter to reflect that it would be sent to patients who do not have dense breast tissue, and to refer patients to the website of the American College of Radiology for more information on breast density.

Finally, the amendments require the Department of Health, in conjunction with the Medical Society of New Jersey, to establish a stakeholder work group to review and report on strategies to improve the dialogue between patients and health care professionals regarding breast density and breast imaging options. The work group is to include representatives of patient advocacy groups and health care professionals' organizations, as invited by the department. The work group is to report its findings and recommendations to the Governor and the Legislature on an annual basis, the first report being submitted not more than 12 months after its initial meeting.

# FISCAL NOTE

[Sixth Reprint]

# SENATE, No. 792

# STATE OF NEW JERSEY
# 215th LEGISLATURE

DATED: DECEMBER 23, 2013

## SUMMARY

**Synopsis:** Requires insurers to cover breast evaluations and other additional medically necessary testing under certain circumstances and requires certain mammogram reports to contain information on breast density.

**Type of Impact:** Expenditure increase to the State General Fund and local government funds.

**Agencies Affected:** Division of Pensions and Benefits, Department of the Treasury; local government entities.

**Executive Estimate**

| Fiscal Impact | FY 2014 | FY 2015 | FY 2016 |
|---|---|---|---|
| **State Cost** | Unknown – See comments below | | |
| **Local Cost** | Unknown – See comments below | | |

- The Office of Legislative Services (OLS) **concurs** with the Executive Branch fiscal estimate.

- This bill requires health insurers to cover breast evaluations and other testing such as ultrasound evaluation, a magnetic resonance imaging scan (MRI), a three-dimensional (3-D) mammography, or other additional testing under certain circumstances; requires certain mammogram reports to contain certain information on breast density; and directs the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill.

- According to the Division of Pensions and Benefits in the Department of the Treasury, the procedures mandated by this bill, ultrasound evaluations, MRIs, and 3-D Mammographies, are currently covered under the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP). Limiting this estimate to the SHBP/SEHBP, the enactment of this bill will have no cost impact to the plans with regard to those procedures named in the bill.

- However, according to the Office of Management and Budget, this bill also stipulates that coverage for "other additional testing is required under certain circumstances. This new language is potentially consequential, as it could mandate the SHBP/SEHBP to provide additional services not already covered by the benefits plans, which would potentially result in higher costs. The value of these additional services is not quantifiable because it is not known which additional tests will be requested by the patient's health care provider, or whether the supplementary services will be covered by the SHBP/SEHBP.

## BILL DESCRIPTION

Senate Bill No. 792 (6R) of 2012 requires health insurers to cover certain additional breast screenings and diagnostic testing under certain circumstances; requires mammography reports sent to patients and patients' health care providers to contain certain information on breast density and to include an accompanying letter explaining the relationship between dense breast tissue and breast cancer in clear terms; requires and directs the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill; and establishes a work group to be convened by the Department of Health to review, report, and recommend strategies to improve the dialogue between patients and their health care providers regarding breast density and imaging options.

*REQUIRED HEALTH INSURANCE COVERAGE.* The bill requires health insurers to provide health benefits coverage for an ultrasound evaluation, a magnetic resonance imaging scan, a three-dimensional mammography, or other additional testing, of an entire breast or breasts, after a baseline mammogram examination, if the mammogram demonstrates extremely dense breast tissue, if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue, or if the patient has additional risk factors for breast cancer. The bill provides that the additional risk factors include, but are not limited to, family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System, or other indications as determined by the patient's health care provider.

The bill provides that the health benefits coverage required by the bill may be subject to review. Under the bill, the additional coverage required to be provided by health insurers may be subject to utilization review, including periodic review, by the health insurer of the medical necessity of the additional breast screening and diagnostic testing.

The bill provides that the health benefits coverage requirements apply to: health, hospital, and medical service corporations; commercial, individual, and group health insurers; health maintenance organizations; and health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs. The bill's requirements for coverage also apply to the State Health Benefits Program; by law, similar health benefits coverage is required under the School Employees' Health Benefits Program;

*INFORMATION INCLUDED IN MAMMOGRAPHY REPORTS.* The bill requires providers of mammography services to include information on breast density in mammography reports sent to patients and their health care providers.

The bill provides that the information on breast density included in mammography reports will not impose a standard of care obligation upon a patient's health care provider. The bill stipulates that the information in the report is intended to increase awareness of breast cancer and help facilitate a conversation between a patient and a patient's health care provider regarding the patient's risks for breast cancer.

*PERIODIC REPORTS BY MHBAC.* The bill directs the Mandated Health Benefits Advisory Commission to prepare a report regarding the administration and implementation of the bill at least once in each five-year period following the bill's effective date. The bill provides that the report must include a summary of the social and financial impact, as well as the medical efficacy, of the requirements imposed by the bill, and requires the commission to transmit a copy of the report to the Governor and the Legislature within five days of the date the report is made.

*DEPARTMENT OF HEALTH AND MEDICAL SOCIETY OF NEW JERSEY WORK GROUP* The bill requires the Department of Health, with the Medical Society of New Jersey, to convene a work group to review, report on, and recommend strategies to improve the dialogue between patients and health care professionals regarding risk factors for breast density and breast imaging options. The work group is required to report its findings and recommendations to the Governor and to the Legislature. The first report must be submitted no later than 12 months after the work group's initial meeting.

*EFFECTIVE DATE.* The bill takes effect on the first day of the fourth month next following the date of enactment, and applies to all contracts and policies delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the bill's effective date.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

According to the Division of Pensions and Benefits in the Department of the Treasury, the procedures mandated by this bill, ultrasound evaluations, MRIs, and 3-D Mammographies, are currently covered under the SHBP and the SEHBP. Limiting this estimate to the SHBP/SEHBP, the enactment of this bill will have no cost impact to the plans with regard to the procedures named in the bill. The division also mentioned that the consultants to the SHBP/SEHBP reviewed the amendments to this bill and have determined that it does not specifically provide coverage for medical procedures that are not already covered by the plan. The consultants did express some concern that the term "other additional testing" is very broad.

According to the Office of Management and Budget, this bill stipulates that coverage for "other additional testing" is required. Hence, this language is potentially consequential, as it could mandate the SHBP/SEHBP to provide additional services not already covered by the benefits plans, which would potentially result in higher costs. The value of these additional services is not quantifiable because it is not known which additional tests will be requested by the patient's health care provider, or whether the supplementary services will be covered by the SHBP/SEHBP.

### *OFFICE OF LEGISLATIVE SERVICES*

The OLS concurs with the Executive fiscal estimate. The OLS notes that other breast cancer screenings, as identified by the American Cancer Society, include, but are not limited to, ductograms, nipple discharge examinations, nipple aspiration, and ductal lavage, and other experimental imaging tests currently being developed such as optical imaging tests using light transmission, molecular breast imaging (MBI) tests using nuclear technology, and positron emission mammography tests (PET) using radioactive tracer isotopes. While ultrasounds, MRIs, and 3D Mammograms are covered under the SHBP/SEHBP as the consultants note, the bill does not specifically provide coverage for medical procedures that are not already covered by the plans. According to the Division of Pensions and Benefits, coverage under the SHBP/SEHBP is

dependent on “standard medical necessity” to be considered acceptable for insurance reimbursement. As such, the OLS cannot determine the potential additional costs associated with requiring coverage for other testing if after a baseline mammogram examination a patient is believed to be at increased risk for breast cancer. This is because it is not known how many and which additional other tests will be deemed medically necessary and prescribed by the patients’ healthcare providers and if, at this time, those tests are covered under the SHBP/SEHBP.

| | |
|---|---|
| *Section:* | *State Government* |
| *Analyst:* | *Kimberly McCord*<br>*Senior Fiscal Analyst* |
| *Approved:* | *David J. Rosen*<br>*Legislative Budget and Finance Officer* |

This fiscal note has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

# ASSEMBLY, No. 2022

# STATE OF NEW JERSEY

## 215th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2012 SESSION

**Sponsored by:**
**Assemblyman TROY SINGLETON**
**District 7 (Burlington)**
**Assemblyman DANIEL R. BENSON**
**District 14 (Mercer and Middlesex)**
**Assemblyman GORDON M. JOHNSON**
**District 37 (Bergen)**
**Assemblywoman PAMELA R. LAMPITT**
**District 6 (Burlington and Camden)**
**Assemblywoman ANNETTE QUIJANO**
**District 20 (Union)**
**Assemblywoman VALERIE VAINIERI HUTTLE**
**District 37 (Bergen)**

**Co-Sponsored by:**
**Assemblywoman Jimenez, Assemblyman Eustace, Assemblywoman Wagner, Assemblymen Amodeo, C.A.Brown, Assemblywoman Caride, Assemblymen Cryan, Caputo, DeAngelo, Chivukula, P.Barnes, III, Assemblywomen Jasey, Schepisi, Sumter, Riley, Assemblyman Giblin, Assemblywomen Angelini, Mosquera, Stender and Tucker**

**SYNOPSIS**

Requires insurers to cover comprehensive ultrasound breast screening if a mammogram demonstrates dense breast tissue and requires mammogram reports to contain information on breast density.

**CURRENT VERSION OF TEXT**

Introduced Pending Technical Review by Legislative Counsel

**(Sponsorship Updated As Of: 3/8/2013)**

**AN ACT** concerning mammograms, amending P.L.1991, c.279 and P.L.2004, c.86, and supplementing Title 26 of the Revised Statutes.

**BE IT ENACTED** *by the Senate and General Assembly of the State of New Jersey:*

1. Section 1 of P.L.1991, c.279 (C.17:48-6g) is amended to read as follows:

1. a. No group or individual hospital service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These benefits shall be provided to the same extent as for any other sickness under the contract.

c. The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.1)

2. Section 2 of P.L.1991, c.279 (C.17:48A-7f) is amended to read as follows:

2. a. No group or individual medical service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking

**EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.**

**Matter underlined thus is new matter.**

and Insurance, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These benefits shall be provided to the same extent as for any other sickness under the contract.

c. The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.2)

3. Section 3 of P.L.1991, c.279 (C.17:48E-35.4) is amended to read as follows:

3. a. No group or individual health service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive

genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These benefits shall be provided to the same extent as for any other sickness under the contract.

c. The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.3)

4. Section 4 of P.L.1991, c.279 (C.17B:26-2.1e) is amended to read as follows:

4. a. No individual health insurance policy providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the policy provides benefits to any named insured or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These benefits shall be provided to the same extent as for any other sickness under the policy.

c. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.4)

5. Section 5 of P.L.1991, c.279 (C.17B:27-46.1f) is amended to read as follows:

5. a. No group health insurance policy providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the policy provides benefits to

any named insured or other person covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These benefits shall be provided to the same extent as for any other sickness under the policy.

c. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.5)

6. Section 7 of P.L.2004, c.86 (C.17B:27A-7.10) is amended to read as follows:

7. a. Every individual health benefits plan that is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or approved for issuance or renewal in this State, on or after the effective date of this act, shall provide benefits to any woman covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

c. The provisions of this section shall apply to all health benefit plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.7)

7. Section 8 of P.L.2004, c.86 (C.17B:27A-19.13) is amended to read as follows:

8. a. Every small employer health benefits plan that is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) or approved for issuance or renewal in this State, on or after the effective date of this act, shall provide benefits to any woman covered thereunder for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

c. The provisions of this section shall apply to all health benefit plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.8)

8. Section 6 of P.L.1991, c.279 (C.26:2J-4.4) is amended to read as follows:

6. a. Notwithstanding any provision of law to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of Health and Senior Services on or after the effective date of this act unless the health maintenance organization provides health care services to any enrollee for the conduct of:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination

every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. These health care services shall be provided to the same extent as for any other sickness under the enrollee agreement.

c. The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

(cf: P.L.2004, c.86, s.6)

9. Section 9 of P.L.2004, c.86 (C.52:14-17.29i) is amended to read as follows:

9. a. The State Health Benefits Commission shall provide benefits to each person covered under the State Health Benefits Program for expenses incurred in conducting:

(1) one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider; and

(2) comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.

b. The benefits shall be provided to the same extent as for any other medical condition under the contract.

(cf: P.L.2004, c.86, s.9)

10. (New section) Each mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the

American College of Radiology. When applicable, the 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 office, and you should contact your physician if you have any questions or concerns about this report."

11. The Commissioner of Health and Senior Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to effectuate the purposes of section 10 of P.L. , c. (C. ) (pending before the Legislature as this bill).

12. This act shall take effect on the first day of the fourth month next following the date of enactment. Sections 1 through 9 of this act shall apply to all contracts and policies that are delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the effective date. The Commissioner of Health and Senior Services may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of section 10 of this act.

STATEMENT

This bill requires health insurers to cover comprehensive ultrasound breast screening if a mammogram demonstrates dense breast tissue, and also requires mammogram reports to contain information on breast density.

The bill provides specifically as follows:

- In addition to the existing health benefits coverage requirement for mammograms under State law, health insurers are to provide health benefits coverage for comprehensive ultrasound screening of an entire breast or breasts if 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 if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician or advanced practice nurse.
- The provisions of the bill apply to: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans

issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; and the State Health Benefits Program (which by law requires coverage under the School Employees' Health Benefits Program as well).

- The insurance coverage requirement takes effect on the first day of the fourth month following enactment of the bill and applies to all health insurance contracts and policies that are delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the effective date.
- In addition, the bill requires that each mammography report provided to a patient include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. (Federal law requires a mammography facility to provide a mammography report containing the imaging results to the patient and the patient's provider within 30 days of the exam.)
- When applicable, the mammography report is to 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 office, and you should contact your physician if you have any questions or concerns about this report."

The need for this bill is predicated on the following facts:

-- Two-thirds of pre-menopausal and one fourth of post-menopausal women have dense breast tissue, and many do not even know it;

-- Cancer is five times more likely in women with extremely dense breasts;

-- A mammogram will detect only about 48 percent of tumors in women with dense breast tissue, and so the rest will elude early detection;

-- Breast density is one of the strongest predictors of the failure of mammography screening to detect cancer;

-- Cancer recurrence is four times more likely in women with dense breasts; and

-- A May, 2010 national survey conducted by Harris Interactive found that 95 percent of women ages 40 and older did not know their breast density, and nearly 90 percent did not know that breast density increases the risk of developing breast cancer.

ASSEMBLY HEALTH AND SENIOR SERVICES COMMITTEE

STATEMENT TO

# ASSEMBLY, No. 2022

with committee amendments

# STATE OF NEW JERSEY

DATED: MARCH 7, 2013

The Assembly Health and Senior Services Committee reports favorably and with committee amendments Assembly Bill No. 2022.

As amended by the committee, the bill requires health insurers to cover comprehensive ultrasound breast screening or other screening if a mammogram demonstrates heterogeneously or extremely dense breast tissue, and also requires mammogram reports to contain information on breast density.

Specifically, the bill provides that, in addition to the existing health benefits coverage requirement for mammograms under State law, health insurers are to provide health benefits coverage for comprehensive ultrasound screening, or other screening deemed medically necessary by the woman's health care provider, of an entire breast or breasts if a mammogram demonstrates heterogeneously or extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology, or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's health care provider. This coverage may be subject to review of the medical necessity of the screenings if the provider has been determined by the insurer to have overutilized the coverage.

The insurance provisions of the bill apply to: health, hospital, and medical service corporations; commercial, individual, and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; and the State Health Benefits Program (which by law requires coverage under the School Employees' Health Benefits Program as well).

In addition, the bill requires that providers of mammography services must, if a patient's mammogram demonstrates extremely dense breast tissue, include the following information, at a minimum, in the mammography report sent to the patient and the patient's physician (required by federal law): "Your mammogram shows that your breast tissue is dense as determined by the Breast Imaging Reporting and Data System established by the American College of

Radiology. Dense breast tissue is very common and is not abnormal. However, dense breast tissue can make it harder to find cancer on a mammogram and may also be associated with a risk factor for breast cancer. This information about the result of your mammogram is given to you to raise your awareness. Use this information to talk to your health care provider about your own risks for breast cancer. At that time, ask your health care provider if more screening tests might be useful, based on your risk. A report of your results was sent to your physician."

The bill takes effect on the first day of the fourth month following enactment of the bill. The insurance provisions apply to all health insurance contracts and policies that are delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the effective date.

As reported by the committee, this bill is identical to Senate Bill No. 792 (3R) ACA (Weinberg/Gill), which the committee also reported on this date.

COMMITTEE AMENDMENTS

The committee amendments to the bill require coverage of screening other than comprehensive ultrasound screening that is deemed medically necessary by the woman's health care provider.

The amendments also clarify that the required coverage only applies after a baseline mammogram examination, and provide that the required coverage would apply if the mammogram demonstrates heterogeneously or extremely dense breast tissue.

The amendments further provide that the coverage of comprehensive ultrasound screening or other screening may be subject to utilization review, including periodic review, by the insurer of the medical necessity of the comprehensive ultrasound screenings or other screening if the provider has been determined by the insurer to have overutilized the coverage.

The amendments modify the language required to be included in a mammography report pursuant to section 10 of the bill and clarify that the notice is required only if a patient's mammogram demonstrates extremely dense breast tissue.

Finally, the amendments make several grammatical and technical changes.

MINORITY STATEMENT

By Assemblywomen Handlin, Angelini, and Munoz and
Assemblyman Peterson

The sponsors of this bill should be commended for their efforts to educate women about dense breast tissue and to ensure they receive

the appropriate health care services. However, for the following reasons we cannot support the legislation before us today:

- The bill shifts the responsibility for informing the patient about breast density from a radiologist, who has expertise in this area, to the patient's primary care provider;

- The bill establishes a medical standard for ultrasound screenings, for which there is no consensus in the medical community as to the medical benefit;

- The language in the bill is unclear as to what the most appropriate supplemental screening modalities should be for women with dense breast tissue, leaving physicians with no guidance when to prescribe these procedures;

- There was an absence of testimony concerning women being denied supplemental screenings if prescribed by a physician due to dense breast tissue;

- The bill interferes with the sacrosanct patient-physician relationship and attempts to supplant a physician's medical advice with legislative dictates; and

- The bill has not yet been referred to the Mandated Health Benefits Advisory Commission, which was statutorily established to provide an objective, independent analysis of the medical, financial, and social impacts of proposed health insurance benefit mandates. The committee would have benefitted from the information provided by the commission.

Again, we strongly support the bill's secondary objective to raise awareness about breast density, but at the present time, there remain many outstanding medical issues that need to be addressed. Therefore, we are withholding our support for this legislation at this time.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]
**ASSEMBLY, No. 2022**

with committee amendments

# STATE OF NEW JERSEY

DATED: MAY 6, 2013

The Assembly Appropriations Committee reports favorably Assembly Bill No. 2022 (1R), with committee amendments.

As amended, the bill requires health insurers to cover certain additional breast screenings and diagnostic testing under certain circumstances, requires mammography reports sent to patients and patients' physicians to contain certain information on breast density, and directs the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill.

*REQUIRED HEALTH INSURANCE COVERAGE.* The bill requires health insurers to provide health benefits coverage for an ultrasound evaluation, a magnetic resonance imaging scan, a three-dimensional mammography, or other additional testing deemed medically necessary by a patient's health care provider, of an entire breast or breasts, after a baseline mammogram examination, if the mammogram demonstrates extremely dense breast tissue, if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue, or if the patient has additional risk factors for breast cancer. The bill provides that the additional risk factors include, but are not limited to, family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System, or other indications as determined by the patient's health care provider.

The bill provides that the health benefits coverage required by the bill may be subject to review. Under the bill, the additional coverage required to be provided by health insurers may be subject to utilization review, including periodic review, by the health insurer of the medical necessity of the additional breast screening and diagnostic testing, if the health care provider has been determined by the insurer to have overutilized the required coverage.

The bill provides that the health benefits coverage requirements apply to: health, hospital, and medical service corporations; commercial, individual, and group health insurers; health maintenance

organizations; and health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs. The bill provides the requirements for coverage also apply to the State Health Benefits Program, which by law requires similar health benefits coverage under the School Employees' Health Benefits Program.

*INFORMATION INCLUDED IN MAMMOGRAPHY REPORTS.* The bill requires providers of mammography services to include information on breast density in mammography reports sent to patients and physicians, if a patient's mammogram demonstrates extremely dense breast tissue based on the Breast Imaging Reporting and Data System. The bill provides that the information on breast density must include the following statement: "Your mammogram shows that your breast tissue is extremely dense as determined by the Breast Imaging Reporting and Data System established by the American College of Radiology. Dense breast tissue is very common and is not abnormal. However, extremely dense breast tissue can make it harder to find cancer on a mammogram and may also be associated with a risk factor for cancer. This information about the result of your mammogram is given to you to raise your awareness. Use this information to talk to your health care provider about this and other risks for breast cancer that pertain to your personal medical history. A report of your results was sent to your physician."

The bill provides that the information on breast density included in mammography reports will not impose a standard of care obligation upon a patient's health care provider. The bill stipulates that the information in the report is intended to increase awareness of breast cancer and help facilitate a conversation between a patient and a patient's health care provider regarding the patient's risks for breast cancer.

The bill authorizes the Commissioner of Health to adopt rules and regulations necessary to effectuate the requirements that pertain to breast density information included in mammography reports sent to patients and physicians. The bill provides that any rules and regulations adopted by the commissioner must be adopted in accordance with the "Administrative Procedure Act, P.L.1968, c.410 (C.52:14B-1 et seq.).

*PERIODIC REPORTS BY MHBAC.* The bill directs the Mandated Health Benefits Advisory Commission to prepare a report regarding the administration and implementation of the bill at least once in each five-year period following the bill's effective date. The bill provides that the report must include a summary of the social and financial impact, as well as the medical efficacy, of the requirements imposed by the bill, and requires the commission to transmit a copy of the report to the Governor and the Legislature within five days of the date the report is made.

*EFFECTIVE DATE.* The bill takes effect on the first day of the fourth month next following the date of enactment, and applies to all contracts and policies delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the bill's effective date. The bill authorizes the Commissioner of Banking and Insurance and the Commissioner of Health to take anticipatory administrative actions prior to the effective date of the bill.

As amended and reported by the committee, this bill is identical to Senate Bill No. 792 (5R), which also was amended and reported by the committee on this date.

FISCAL IMPACT:

The Office of Legislative Services (OLS) expects the State to incur certain costs as a result of the additional coverage that may be required by the State Health Benefits Program and the School Employees' Health Benefits Program under the bill. However, the OLS lacks sufficient information regarding the additional breast screening and diagnostic testing currently covered by insurance, the cost of the additional screening, and the number of covered persons that may be eligible to undergo the additional screening to quantify the potential cost to the State.

COMMITTEE AMENDMENTS:

The amendments clarify the additional types of breast screening and diagnostic testing required to be covered by health insurers, and the conditions under which the additional screening and testing must be covered.

The amendments revise the information on breast density required to be included in mammography reports sent to patients and physicians by providers of mammography services, and stipulate that the additional information provided in mammography reports will not impose a standard of care obligation on the patient's health care provider.

The amendments direct the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill.

The amendments incorporate gender-neutral language to replace references to woman and woman's health care provider.

# FISCAL NOTE

[Second Reprint]

# ASSEMBLY, No. 2022

# STATE OF NEW JERSEY
# 215th LEGISLATURE

DATED: JUNE 27, 2013

## SUMMARY

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|---|---|
| **Synopsis:** | Requires insurers to cover breast evaluations and other additional medically necessary testing under certain circumstances and requires certain mammogram reports to contain information on breast density. |
| **Type of Impact:** | Expenditure Increase to the State General Fund and local government funds. |
| **Agencies Affected:** | Division of Pensions and Benefits, Department of the Treasury; local government entities. |

**Executive Estimate**

| Fiscal Impact | FY 2014 | FY 2015 | FY 2016 |
|---|---|---|---|
| **State Cost** | | Unknown – See comments below. | |
| **Local Cost** | | Unknown – See comments below. | |

- The Office of Legislative Services (OLS) **concurs** with the Executive Branch fiscal estimate.

- This bill requires health insurers to cover breast evaluations and other medically necessary testing such as ultrasound evaluation, a magnetic resonance imaging scan (MRI), a three-dimensional (3-D) mammography, or other additional testing under certain circumstances, requires certain mammogram reports to contain certain information on breast density, and directs the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill.

- According to the Division of Pensions and Benefits in the Department of the Treasury, the procedures mandated by this bill, ultrasound evaluations, MRIs, and 3-D Mammographies, are currently covered under the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP). Limiting this estimate to the SHBP/SEHBP, the enactment of this bill will have no cost impact to the plans with regard to those procedures named in the bill.

- However, according to the Office of Management and Budget, this bill also stipulates that coverage for "other additional testing deemed medically necessary by the patient's health care provider" is required. This new language is potentially consequential, as it could mandate the SHBP/SEHBP to provide additional services not already covered by the benefits plans, which would potentially result in higher costs. The value of these additional services is not quantifiable because it is not known which additional tests will be requested by the patient's health care provider, or whether the supplementary services will be covered by the SHBP/SEHBP.

## BILL DESCRIPTION

Assembly Bill No. 2022 (2R) of 2012 requires health insurers to cover certain additional breast screenings and diagnostic testing under certain circumstances, requires mammography reports sent to patients and patients' physicians to contain certain information on breast density, and directs the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill.

*REQUIRED HEALTH INSURANCE COVERAGE.* The bill requires health insurers to provide health benefits coverage for an ultrasound evaluation, a magnetic resonance imaging scan, a three-dimensional mammography, or other additional testing deemed medically necessary by a patient's health care provider, of an entire breast or breasts, after a baseline mammogram examination, if the mammogram demonstrates extremely dense breast tissue, if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue, or if the patient has additional risk factors for breast cancer. The bill provides that the additional risk factors include, but are not limited to, family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System, or other indications as determined by the patient's health care provider.

The bill provides that the health benefits coverage required by the bill may be subject to review. Under the bill, the additional coverage required to be provided by health insurers may be subject to utilization review, including periodic review, by the health insurer of the medical necessity of the additional breast screening and diagnostic testing, if the health care provider has been determined by the insurer to have overutilized the required coverage.

The bill provides that the health benefits coverage requirements apply to: health, hospital, and medical service corporations; commercial, individual, and group health insurers; health maintenance organizations; and health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs. The bill's requirements for coverage also apply to the State Health Benefits Program; by law, similar health benefits coverage is required under the School Employees' Health Benefits Program;

*INFORMATION INCLUDED IN MAMMOGRAPHY REPORTS.* The bill requires providers of mammography services to include information on breast density in mammography reports sent to patients and physicians, if a patient's mammogram demonstrates extremely dense breast tissue based on the Breast Imaging Reporting and Data System.

The bill provides that the information on breast density included in mammography reports will not impose a standard of care obligation upon a patient's health care provider. The bill stipulates that the information in the report is intended to increase awareness of breast cancer and help facilitate a conversation between a patient and a patient's health care provider regarding the patient's risks for breast cancer.

*PERIODIC REPORTS BY MHBAC.* The bill directs the Mandated Health Benefits Advisory Commission to prepare a report regarding the administration and implementation of the bill at least once in each five-year period following the bill's effective date. The bill provides that the report must include a summary of the social and financial impact, as well as the medical efficacy, of the requirements imposed by the bill, and requires the commission to transmit a copy of the report to the Governor and the Legislature within five days of the date the report is made.

*EFFECTIVE DATE.* The bill takes effect on the first day of the fourth month next following the date of enactment, and applies to all contracts and policies delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the bill's effective date.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

According to the Division of Pensions and Benefits in the Department of the Treasury, the procedures mandated by this bill, ultrasound evaluations, MRIs, and 3-D Mammographies, are currently covered under the SHBP and the SEHBP. Limiting this estimate to the SHBP/SEHBP, the enactment of this bill will have no cost impact to the plans with regard to the procedures named in the bill. The division also mentioned that the consultants to the SHBP/SEHBP reviewed the amendments to this bill and have determined that it does not specifically provide coverage for medical procedures that are not already covered by the plan. The consultants did express some concern that the term "other additional testing" is very broad.

According to the Office of Management and Budget, this bill stipulates that coverage for "other additional testing deemed medically necessary by the patient's health care provider" is required. Hence, this new language is potentially consequential, as it could mandate the SHBP/SEHBP to provide additional services not already covered by the benefits plans, which would potentially result in higher costs. The value of these additional services is not quantifiable because it is not known which additional tests will be requested by the patient's health care provider, or whether the supplementary services will be covered by the SHBP/SEHBP.

### *OFFICE OF LEGISLATIVE SERVICES*

The OLS concurs with the Executive fiscal estimate. The OLS notes that other breast cancer screenings, as identified by the American Cancer Society, include, but are not limited to, ductograms, nipple discharge examinations, nipple aspiration, and ductal lavage, and other experimental imaging tests currently being developed such as optical imaging tests using light transmission, molecular breast imaging (MBI) tests using nuclear technology, and positron emission mammography tests (PET) using radioactive tracer isotopes. While ultrasounds, MRIs, and 3D Mammograms are covered under the SHBP/SEHBP as the consultants note, the bill does not specifically provide coverage for medical procedures that are not already covered by the plans. According to the Division of Pensions and Benefits, coverage under the SHBP/SEHBP is dependent on "standard medical necessity" to be considered acceptable for insurance reimbursement. As such, the OLS cannot determine the potential additional costs associated with requiring coverage for other testing deemed medically necessary by the woman's health care provider if after a baseline mammogram examination a patient is believed to be at increased risk for breast cancer. This is because it is not known how many and which additional other tests

will be deemed medically necessary and prescribed by the patients' healthcare providers and if, at this time, those tests are covered under the SHBP/SEHBP.

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| *Section:* | *State Government* |
| *Analyst:* | *Kimberly McCord Clemmensen*<br>*Senior Fiscal Analyst* |
| *Approved:* | *David J. Rosen*<br>*Legislative Budget and Finance Officer* |

This fiscal note has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

# STATEMENT TO

# [Second Reprint]
# **ASSEMBLY, No. 2022**

with Assembly Floor Amendments
(Proposed by Assemblyman SINGLETON)

ADOPTED: SEPTEMBER 9, 2013

These amendments permit a health insurer to subject a provider of the coverage required under this bill to utilization review. The amendments also eliminate the requirement that a health insurance carrier determine that a provider has overutilized the coverage before subjecting the provider to a utilization review.

The amendments further specify that health insurers must cover a baseline mammogram examination for a woman at age 40, rather than between the ages of 35 and 40.

The amendments also require that a letter explaining the relationship between dense breast tissue and breast cancer in clear terms accompany a mammography report to any patient that receives a mammogram, rather than only to patients whose mammograms demonstrate extremely dense breast tissue. (This letter would be in addition to, or part of, the "lay letter" that must accompany a mammogram report, as required by federal law.) The amendments revise the content of the letter to reflect that it would be sent to patients who do not have dense breast tissue, and to refer patients to the website of the American College of Radiology for more information on breast density.

Finally, the amendments require the Department of Health, in conjunction with the Medical Society of New Jersey, to establish a stakeholder work group to review and report on strategies to improve the dialogue between patients and health care professionals regarding breast density and breast imaging options. The work group is to include representatives of patient advocacy groups and health care professionals' organizations, as invited by the department. The work group is to report its findings and recommendations to the Governor and the Legislature on an annual basis, the first report being submitted not more than 12 months after its initial meeting.

# FISCAL NOTE

[Third Reprint]

# ASSEMBLY, No. 2022

# STATE OF NEW JERSEY
# 215th LEGISLATURE

DATED: DECEMBER 23, 2013

## SUMMARY

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| **Synopsis:** | Requires insurers to cover breast evaluations and other additional medically necessary testing under certain circumstances and requires certain mammogram reports to contain information on breast density. |
| **Type of Impact:** | Expenditure increase to the State General Fund and local government funds. |
| **Agencies Affected:** | Division of Pensions and Benefits, Department of the Treasury; local government entities. |

**Executive Estimate**

| Fiscal Impact | FY 2014 | FY 2015 | FY 2016 |
|---|---|---|---|
| **State Cost** | Unknown – See comments below | | |
| **Local Cost** | Unknown – See comments below | | |

- The Office of Legislative Services (OLS) **concurs** with the Executive Branch fiscal estimate.

- This bill requires health insurers to cover breast evaluations and other testing such as ultrasound evaluation, a magnetic resonance imaging scan (MRI), a three-dimensional (3-D) mammography, or other additional testing under certain circumstances; requires certain mammogram reports to contain certain information on breast density; and directs the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill.

- According to the Division of Pensions and Benefits in the Department of the Treasury, the procedures mandated by this bill, ultrasound evaluations, MRIs, and 3-D Mammographies, are currently covered under the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP). Limiting this estimate to the SHBP/SEHBP, the enactment of this bill will have no cost impact to the plans with regard to those procedures named in the bill.

- However, according to the Office of Management and Budget, this bill also stipulates that coverage for "other additional testing is required under certain circumstances. This new language is potentially consequential, as it could mandate the SHBP/SEHBP to provide additional services not already covered by the benefits plans, which would potentially result in higher costs. The value of these additional services is not quantifiable because it is not known which additional tests will be requested by the patient's health care provider, or whether the supplementary services will be covered by the SHBP/SEHBP.

## BILL DESCRIPTION

Assembly Bill No. 2022 (3R) of 2013 requires health insurers to cover certain additional breast screenings and diagnostic testing under certain circumstances; requires mammography reports sent to patients and patients' health care providers to contain certain information on breast density and to include an accompanying letter explaining the relationship between dense breast tissue and breast cancer in clear terms; requires and directs the Mandated Health Benefits Advisory Commission to report on the implementation and administration of the bill; and establishes a work group to be convened by the Department of Health to review, report, and recommend strategies to improve the dialogue between patients and their health care providers regarding breast density and imaging options.

*REQUIRED HEALTH INSURANCE COVERAGE.* The bill requires health insurers to provide health benefits coverage for an ultrasound evaluation, a magnetic resonance imaging scan, a three-dimensional mammography, or other additional testing, of an entire breast or breasts, after a baseline mammogram examination, if the mammogram demonstrates extremely dense breast tissue, if the mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue, or if the patient has additional risk factors for breast cancer. The bill provides that the additional risk factors include, but are not limited to, family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System, or other indications as determined by the patient's health care provider.

The bill provides that the health benefits coverage required by the bill may be subject to review. Under the bill, the additional coverage required to be provided by health insurers may be subject to utilization review, including periodic review, by the health insurer of the medical necessity of the additional breast screening and diagnostic testing.

The bill provides that the health benefits coverage requirements apply to: health, hospital, and medical service corporations; commercial, individual, and group health insurers; health maintenance organizations; and health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs. The bill's requirements for coverage also apply to the State Health Benefits Program; by law, similar health benefits coverage is required under the School Employees' Health Benefits Program;

*INFORMATION INCLUDED IN MAMMOGRAPHY REPORTS.* The bill requires providers of mammography services to include information on breast density in mammography reports sent to patients and their health care providers.

The bill provides that the information on breast density included in mammography reports will not impose a standard of care obligation upon a patient's health care provider. The bill stipulates that the information in the report is intended to increase awareness of breast cancer and help facilitate a conversation between a patient and a patient's health care provider regarding the patient's risks for breast cancer.

*PERIODIC REPORTS BY MHBAC.* The bill directs the Mandated Health Benefits Advisory Commission to prepare a report regarding the administration and implementation of the bill at least once in each five-year period following the bill's effective date. The bill provides that the report must include a summary of the social and financial impact, as well as the medical efficacy, of the requirements imposed by the bill, and requires the commission to transmit a copy of the report to the Governor and the Legislature within five days of the date the report is made.

*DEPARTMENT OF HEALTH AND MEDICAL SOCIETY OF NEW JERSEY WORK GROUP* The bill requires the Department of Health, with the Medical Society of New Jersey, to convene a work group to review, report on, and recommend strategies to improve the dialogue between patients and health care professionals regarding risk factors for breast density and breast imaging options. The work group is required to report its findings and recommendations to the Governor and to the Legislature. The first report must be submitted no later than 12 months after the work group's initial meeting.

*EFFECTIVE DATE.* The bill takes effect on the first day of the fourth month next following the date of enactment, and applies to all contracts and policies delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the bill's effective date.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

According to the Division of Pensions and Benefits in the Department of the Treasury, the procedures mandated by this bill, ultrasound evaluations, MRIs, and 3-D Mammographies, are currently covered under the SHBP and the SEHBP. Limiting this estimate to the SHBP/SEHBP, the enactment of this bill will have no cost impact to the plans with regard to the procedures named in the bill. The division also mentioned that the consultants to the SHBP/SEHBP reviewed the amendments to this bill and have determined that it does not specifically provide coverage for medical procedures that are not already covered by the plan. The consultants did express some concern that the term "other additional testing" is very broad.

According to the Office of Management and Budget, this bill stipulates that coverage for "other additional testing" is required. Hence, this language is potentially consequential, as it could mandate the SHBP/SEHBP to provide additional services not already covered by the benefits plans, which would potentially result in higher costs. The value of these additional services is not quantifiable because it is not known which additional tests will be requested by the patient's health care provider, or whether the supplementary services will be covered by the SHBP/SEHBP.

### *OFFICE OF LEGISLATIVE SERVICES*

The OLS concurs with the Executive fiscal estimate. The OLS notes that other breast cancer screenings, as identified by the American Cancer Society, include, but are not limited to, ductograms, nipple discharge examinations, nipple aspiration, and ductal lavage, and other experimental imaging tests currently being developed such as optical imaging tests using light transmission, molecular breast imaging (MBI) tests using nuclear technology, and positron emission mammography tests (PET) using radioactive tracer isotopes. While ultrasounds, MRIs, and 3D Mammograms are covered under the SHBP/SEHBP as the consultants note, the bill does not specifically provide coverage for medical procedures that are not already covered by the

plans. According to the Division of Pensions and Benefits, coverage under the SHBP/SEHBP is dependent on "standard medical necessity" to be considered acceptable for insurance reimbursement. As such, the OLS cannot determine the potential additional costs associated with requiring coverage for other testing if after a baseline mammogram examination a patient is believed to be at increased risk for breast cancer. This is because it is not known how many and which additional other tests will be deemed medically necessary and prescribed by the patients' healthcare providers and if, at this time, those tests are covered under the SHBP/SEHBP.

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| *Section:* | *State Government* |
| *Analyst:* | *Kimberly McCord*<br>*Senior Fiscal Analyst* |
| *Approved:* | *David J. Rosen*<br>*Legislative Budget and Finance Officer* |

This fiscal note has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).