SPONSOR: Rep. Stone & Sen. Vaughn

HOUSE OF REPRESENTATIVES

140th GENERAL ASSEMBLY

HOUSE BILL NO. 561

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO INSURANCE COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 35, Title 18 of the Delaware Code by adding thereto a new section to read:

"§3559. Required coverage for reconstructive surgery following mastectomies.

(a) All group and blanket health benefit plans delivered or issued for delivery in this State that provide medical and surgical benefits with respect to a mastectomy must provide to a participant or beneficiary who is receiving benefits in connection with a mastectomy the following coverage in a manner determined through consultation with the attending physician and the patient:

(1) coverage for all stages of reconstruction of the breast on which the mastectomy has been performed;

(2) coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) coverage for prostheses and physical complications of mastectomy, including lymphedemas.

The coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan

of coverage. Written notice of the availability of this coverage must be delivered to a plan participant upon enrollment and annually thereafter.

(b) Every carrier that provides health insurance in this State, including insurance companies, health service corporations, health maintenance organizations, and any other entities providing a plan of health insurance or health benefits subject to State insurance regulation, offering group or blanket health benefit plans must provide notice to each participant under a health benefit plan regarding the coverage required by this section. Notice must be in writing and prominently positioned in health benefit plan literature or correspondence made available or distributed by the carrier and must be transmitted (1) in the next mailing made by the carrier to the participant, or (2) as part of any yearly informational packet sent to the participant, or (3) not later than January 1, 2001, whichever is earliest.

(c) A carrier offering group or blanket health benefit plans may not deny to a patient eligibility or continued eligibility to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this section, and may not penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, or induce an attending provider to provide care to a participant or beneficiary in any manner inconsistent with this section.

(d) Nothing in this section may be construed to prevent a carrier offering group or blanket health benefit plans from negotiating with a provider over the level and type of reimbursement for care provided in accordance with this section.”.

Section 2. Amend Chapter 36, Title 18 of the Delaware Code by adding thereto a new section to read:

"§3609. Required coverage for reconstructive surgery following mastectomies.

(a) All individual health benefit plans delivered or issued for delivery in this State that provide medical and surgical benefits with respect to a mastectomy must provide to a policyholder, subscriber, or dependant beneficiary who is receiving benefits in connection with a mastectomy the following coverage in a manner determined through consultation with the attending physician and the patient:

(1) coverage for all stages of reconstruction of the breast on which the mastectomy has been performed;

(2) coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) coverage for prostheses and physical complications of mastectomy, including lymphedemas.

The coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan of coverage. Written notice of the availability of this coverage must be delivered to the policyholder or subscriber upon enrollment and annually thereafter.

(b) Every carrier that provides health insurance in this State, including insurance companies, health service corporations, health maintenance organizations, and any other entities providing a plan of health insurance or health benefits subject to State insurance regulation, offering individual health benefit plans must provide notice to each policyholder or subscriber under a health benefit plan regarding the coverage required by this section. Notice must be in writing and prominently positioned in health benefit plan literature or correspondence made available or distributed by the carrier and must be transmitted (1) in the next mailing made by the

carrier to the policyholder or subscriber, or (2) as part of any yearly informational packet sent to the policyholder or subscriber, or (3) not later than January 1, 2001, whichever is earliest.

(c) A carrier offering individual health benefit plans may not deny to a patient eligibility or continued eligibility to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this section, and may not penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, or induce an attending provider to provide care to a policyholder, subscriber, or dependant beneficiary in any manner inconsistent with this section.

(d) Nothing in this section may be construed to prevent a carrier offering individual health benefit plans from negotiating with a provider over the level and type of reimbursement for care provided in accordance with this section.”.

Section 3. If a carrier offering group or blanket health benefit plans or individual health benefit plans reformed its policy provisions prior to the effective date of this Act and the reformed policy provisions comply with the coverage standards set forth in this Act, and, if the carrier gave notice of such in accordance with the notice requirements set forth in this Act, the notice requirements of this Act are deemed to be met.

Section 4. If any provision if this Act or the application of any section or part thereof to any person or circumstance is held invalid, such invalidity shall not effect other provisions or applications of this Act that can be given effect without the invalid provision or application, and to this end the provisions of this Act are declared to be severable.

Section 5. This Act takes effect for group, blanket, and individual health benefit plans issued or renewed after July 15, 2000.

SYNOPSIS

This Act requires that certain breast reconstructive procedures be covered by group, blanket, and individual health insurance plans in conjunction with mastectomy procedures. The adoption of these standards brings the State of Delaware into compliance with federal standards governing insurance coverage for breast

reconstruction. Failure to adopt the standards may lead to Delaware's loss of jurisdiction to an agency of the federal government.