Illinois Insurance Facts

Illinois Department of Insurance

Coverage for the Detection and Treatment of Breast Cancer

July 2009

Note: This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

According to the Illinois Department of Public Health, one out of every eight American women will develop breast cancer sometime during her life. Early detection of the disease is critical to successful treatment, and can save the lives of many Illinois women each year.

Illinois has passed the following laws providing insurance coverage for the detection and treatment of breast cancer.

Coverage for the Detection of Breast Cancer

Breast Exams, Mammograms and Screenings

Clinical Breast Exams – All individual and group health insurance and HMO policies must provide coverage for a complete and thorough **clinical examination of the breast** according to the following schedule:

- Women age 20 to 39 – at least once every three years; and
- Women age 40 and older – annually.

[215 ILCS 5/356g.5 and 215 ILCS 125/5-3]

Mammograms – All individual and group health insurance and HMO policies must cover **routine mammograms** for all women age 35 and older. A routine mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. The insurance company or HMO must provide for routine mammograms according to the following schedule:

- Women age 35 to 39 – one baseline mammogram;
- Women age 40 or older – one mammogram annually.

For women under age 40 who have a family history of breast cancer or other risk factors, coverage must include a mammogram at the age and intervals considered medically necessary by the woman's health care provider.

If a routine mammogram reveals heterogeneous or dense breast tissue, coverage must provide for a **comprehensive ultrasound screening** of an entire breast or breasts, when determined to be medically necessary by a physician. [215 ILCS 5/356g and 215 ILCS 125/4-6.1]

Cost to Consumer (Public Act 95-1045)
Beginning March 27, 2009, the required coverage for mammograms and ultrasound screenings as described above must be provided **at no cost to the insured** (*i.e.*, co-pays or deductibles may not be applied). The cost of the mammogram or screening must not count against any annual or lifetime benefit limits contained in the insurance policy or HMO contract. [215 ILCS 5/356g(a-5) and 215 ILCS 125/4-6.1]

- **NOTE:** For policies issued prior to March 27, 2009, this cost-sharing prohibition will apply to your policy as soon as your policy is amended or renewed – check with your insurance agent, employer, or insurance company for the date this law will become effective for your policy.
  - Until this law applies to your policy, the insurance company or HMO must provide coverage for mammograms and screenings that is at least as favorable as coverage for other radiological examinations (*e.g.*, subject to the same dollar limits, deductibles and co-pay requirements).
- If the mammogram or screening is provided by an out-of-network provider, the cost-sharing prohibition does not apply. However, the insurance company or HMO must provide coverage that is at least as favorable as out-of-network coverage for other radiological examinations.

Breast Fibrocystic Condition

At least 50% of women of reproduction age have **fibrocystic condition**, the presence of lumps in the breast that may be painful and tender. An insurer or HMO may not refuse to cover an individual nor attach an exclusionary rider to a policy, *solely* because the individual has been diagnosed with fibrocystic condition, *unless* a breast biopsy indicates the individual is likely to incur breast cancer or the medical history shows the condition to be chronic. [215 ILCS 5/356n and 215 ILCS 125/4-16 – *This law does not apply to coverage provided through a self-insured state, county, municipal, or school district health plan.*]

Coverage for the Treatment of Breast Cancer

Mastectomy and Post-Mastectomy Care

The treatment of breast cancer often requires a surgical procedure known as a **mastectomy**, in which all or part of the breast is removed. All group and individual health insurance and HMO policies that provide coverage for mastectomies must also cover **prosthetic devices or reconstructive surgery** related to the mastectomy. Prosthetic devices include breast prostheses and bras. Reconstructive surgery includes reconstruction of the breast on which the mastectomy has been performed, as well as surgery and reconstruction of the other breast to produce symmetrical appearance. Coverage is also required for prosthetic devices and treatment for physical complications at all stages of the mastectomy, including lymphedemas. The coverage must be subject to the same deductible and coinsurance requirements applicable to the mastectomy. [215 ILCS 5/356g(b) and 215 ILCS 125/4-6.1]

Post-mastectomy hospital stay – All group and individual health insurance and HMO policies that provide surgical coverage must provide coverage for **inpatient care following a mastectom**y. The insurance company or HMO must provide coverage for a length of stay determined by the attending physician to be medically necessary, in accordance with protocols and guidelines based on sound scientific evidence and an evaluation of the patient. [215 ILCS 5/356t and 215 ILCS 125/4-6.5]

Pain Medication and Pain Therapy (Public Act 95-1045)

Beginning March 27, 2009, all group and individual health insurance and HMO policies must provide coverage for all medically necessary **pain medication and pain therapy** related to the treatment of breast cancer. The coverage must be provided on the same terms and conditions that are generally applicable to coverage provided for other conditions. [215 ILCS 5/356g.5-1 and 215 ILCS 125/5-3]

- "Pain therapy" is therapy that is medically based, includes reasonably defined goals (*e.g.*, stabilizing or reducing pain), and provides for the periodic evaluation of the therapy's effectiveness in meeting those goals.
- **NOTE:** For policies issued prior to March 27, 2009, this coverage requirement will apply to your policy as soon as your policy is amended or renewed – check with your insurance agent, employer, or insurance company for the date this requirement will become effective for your policy.

Breast Implant Removal

In Illinois, no individual or group health insurance or HMO policy may deny coverage for the **removal of breast implants** if:

- the implants were not inserted for purely cosmetic reasons; **and**
- it is medically necessary for the breast implants to be removed.

Implants inserted after a mastectomy due to sickness or injury are not considered purely cosmetic. [215 ILCS 5/356p and 215 ILCS 125/4-6.2 – *This law does not apply to coverage provided through a self-insured state, county, municipal, or school district health plan.*]

NOTE: The laws described above apply to all individual and group health insurance policies and HMO contracts issued in Illinois. Health coverage provided to state, county, and municipal employees, and employees subject to the Schools Code (105 ILCS 5/1-1 *et seq.*) must also comply with the laws above, unless indicated otherwise.

The laws described above do not apply to:

- Self-insured employers and self-insured health and benefit plans (such as union plans), which are subject to ERISA and regulated by the U.S. Department of Labor.
- Federal employee benefit plans.
- Insurance policies or trusts issued in other states.
  - For HMOs, the law does apply to contracts written outside of Illinois if the HMO member is a resident of Illinois and the HMO has established a provider network in Illinois. To determine if your HMO coverage provides Illinois dependent coverage rights, contact the HMO or check your certificate of coverage.

For More Information

Call the Department of Insurance Consumer Services Section at (312) 814-2427 or
our Office of Consumer Health Insurance toll free at (877) 527-9431
or visit us on our website at http://insurance.illinois.gov

Illinois Breast and Cervical Cancer Program

The Illinois Breast and Cervical Cancer Program offers free mammograms, breast exams, pelvic exams and Pap tests to eligible uninsured women in Illinois. For more information on this State program, call 1-888-522-1282 or visit the program's website at http://cancerscreening.illinois.gov

Related Department of Insurance Information

Maternity Benefits in Illinois
Insurance Coverage for Infertility Treatment
Women's Health Care Issues