S-3586.1

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**SENATE BILL 5906**

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**State of Washington 67th Legislature 2022 Regular Session**

**By** Senators Cleveland, Rivers, Stanford, and L. Wilson

AN ACT Relating to health plan coverage for contralateral prophylactic mastectomies; and adding a new section to chapter 48.43 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec.**  A new section is added to chapter 48.43 RCW to read as follows:

(1) Health plans issued or renewed on or after January 1, 2023, shall provide benefits or coverage for contralateral prophylactic mastectomies to covered individuals who:

(a) Are determined by their physician to be at a high risk of developing breast cancer in the contralateral breast, including those who:

(i) Have a lifetime risk of breast cancer of at least 20 percent based on assessment tools assessing family history;

(ii) Have a first degree relative with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves;

(iii) Had radiation therapy to the chest when they were between the ages of 10 and 30;

(iv) Have Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or have first degree relatives with one of these syndromes; or

(v) Have a genetic defect, based on genetic testing, that predisposes them to breast cancer, including having a known BRCA1 or BRCA2 gene mutation;

(b) Have a desire to eliminate the anxiety of developing breast cancer in the contralateral breast in the future; or

(c) Have a desire for symmetry and reconstruction of both breasts following removal of a breast due to breast cancer.

(2)(a) A health carrier is not required under this section to provide for a referral to a nonparticipating health care provider, unless the carrier does not have an appropriate health care provider that is available and accessible to administer the procedure and that is a participating health care provider with respect to such procedure.

(b) If a health carrier refers an individual to a nonparticipating health care provider pursuant to this section, screening services or a resulting procedure, if any, must be provided at no additional cost to the individual beyond what the individual would otherwise pay for services provided by a participating health care provider.

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