

Health Insurance Breast Ultrasound Law in Connecticut

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September 24, 2018 | 2018-R-0250

Issue

Describe Connecticut's breast ultrasound insurance coverage law, including any cost to the state for providing additional coverage by reducing or eliminating deductibles. Provide examples from other states that have such laws.

Summary

Connecticut law requires certain health insurance policies to cover a comprehensive ultrasound of a woman's entire breast(s) if:

1. a mammogram shows heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System (BI-RADS) established by the American College of Radiology or
2. she is at increased risk for breast cancer due to family history, her own history, genetic testing, or other indications determined by her physician or advanced-practice registered nurse (APRN) (CGS §§ [38a-503](#) & [530](#)).

Under state law, benefits payable for breast screening services, which include mammograms, magnetic resonance imaging (MRI), and ultrasounds, are subject to any policy provisions applying to other covered services, except a policy cannot impose a copayment of more than \$20 for a breast ultrasound screening. (Under federal law, some mammograms must be covered with no cost sharing, as described in the Connecticut Insurance Department's [Bulletin HC-114](#).)

State law applies to (1) individual or group health insurance policies issued, delivered, renewed, amended, or continued in Connecticut that cover basic hospital expenses; basic medical-surgical expenses; major medical expenses; or hospital or medical services, including those provided under an HMO plan and (2) individual health insurance policies that provide limited benefit health coverage. For more information, see [OLR Report 2016-R-0201](#), “Connecticut’s Breast Screening Insurance Coverage Requirement.”

Connecticut has considered eliminating cost sharing requirements for breast ultrasounds in the past. However, such efforts generally must consider cost (including direct cost to the state and possible increased premiums for insureds) and any impact on high deductible health plans’ (HDHPs) eligibility for favorable tax treatment (see below).

At least two nearby states, New York and Vermont, have laws that require insurers to cover certain breast ultrasounds with no cost sharing.

Eliminating Cost Sharing

Since 2016, Connecticut considered at least two bills to eliminate or reduce cost sharing for breast ultrasounds, as shown in Table 1. Neither became law.

Table 1: Proposed Bills Reducing Breast Ultrasound Cost Sharing Since 2016

<i>Year</i>	<i>Bill</i>	<i>Brief Summary</i>	<i>Last Action</i>
2017	sSB 810	Eliminated coinsurance, copayments, deductibles, or other out-of-pocket expenses (i.e., cost-sharing) for covered mammograms and ultrasounds, excluding coverage provided under high deductible health plans	Insurance and Real Estate Committee Joint Favorable Change of Reference to Appropriations
2016	sSB 158	Eliminated copayments and deductibles for mammograms and ultrasounds	Senate referred to Appropriations

Copayments and Deductibles

Under state law, a health insurance policy’s copayments and deductibles apply to breast ultrasounds, except that a policy cannot impose a copayment of more than \$20. The law does not address limiting other forms of cost sharing, such as deductibles.

High Deductible Health Plans and the Safe Harbor Provision. Generally, state policy changes to deductible requirements are limited by federal law. Specifically, lowering or eliminating deductibles impacts HDHPs. In order to meet federal Internal Revenue Service (IRS) qualifications, HDHPs cannot limit deductibles except for certain preventive care items provided for in a safe harbor provision. Thus, with certain exceptions noted below, eliminating deductibles on non-preventive care services jeopardizes the tax benefits of HDHPs.

According to the IRS, a preventive care service does not include “any service or benefit intended to treat an existing illness, injury, or condition.” In addition, any service defined as preventive under the federal Affordable Care Act (ACA), which generally includes any service the U.S. Preventive Services Task Force (USPTF) rates “A” or “B”, is also considered preventive for the HDHP safe harbor provision ([IRS Notice 2018-12](#)).

Neither the IRS nor the ACA explicitly define ultrasounds as preventive care. The USPTF, for example, rates ultrasounds for women with dense breasts as “I,” meaning there is insufficient evidence to make a recommendation. As a result, it is unclear whether a law eliminating deductibles for breast ultrasounds would protect HDHPs under the safe harbor provision ([USPTF January 2016 Task Force FINAL Recommendation](#)).

Furthermore, the IRS specifically notes that “state law requirements do not determine whether health care constitutes preventive care” ([IRS Notice 2004-23](#)). As a result, state efforts to define ultrasounds as preventive would not appear to successfully avoid this concern.

For more information, see [IRS Notices 2018-12](#) and [2004-23](#), and [IRS Publication 969](#).

ERISA Limitations. Finally, because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans. This means that a state effort to eliminate breast ultrasound deductibles would apply only to fully insured plans.

Cost to the State

The state self-insures coverage for state employees and individuals covered by the retiree health plan. This means that the state directly pays the cost of health care services for these individuals (i.e., the state acts as the insurer). As a result, decreasing the out-of-pocket costs for covered individuals increases the cost the state must pay to the health care provider, assuming the cost of the health service (e.g., ultrasound) remains the same.

According to the Office of Fiscal Analysis (OFA), eliminating breast ultrasound cost sharing for individuals on the state employee health plan who use out-of-network providers would result in a cost of approximately \$25,000. There is also a potential fiscal impact to municipal health plans that currently impose cost sharing requirements as well. (For example, see the [fiscal note](#) for sSB 158 (2016), which provides more detail on how OFA estimates the cost of a similar measure).

Please note that cost to the state does not address the impact in the private market, including, the impact to premiums from changes to out-of-pocket requirements.

Examples in Other States

We looked at breast ultrasound cost-sharing laws in three regional states: Massachusetts, New York, and Vermont.

Massachusetts. Massachusetts law generally requires insurers cover “cytologic screenings” and mammograms, but does not specifically reference ultrasounds. The law does not address limiting copayments, deductibles, or coinsurance ([Mass. Gen. Laws Chap. 175 § 47g](#)).

New York. New York law generally requires insurers cover “screening and diagnostic imaging for the detection of breast cancer,” including ultrasounds, without deductibles or coinsurance (NY Insurance Law §§ [3216\(i\)\(11\)\(F\)](#), [3221\(l\)\(11\)\(F\)](#), and [4303\(p\)\(5\)](#)).

Vermont. Effective January 1, 2019, Vermont requires insurers to cover ultrasounds for patients with dense breast tissue or inconclusive mammograms without any copayment, deductible, or coinsurance ([8 V.S.A. § 4100a](#), as amended by Vermont Law No. 141 (2018).)

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