NEW YORK STATE OF OPPORTUNITY. Department of Health

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Frequently Asked Questions: Legislation to Improve Coverage for Breast Cancer Screening
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What is the new legislation (law) on breast cancer screenings?

In July 2016, Governor Andrew M. Cuomo signed new legislation to help more women get breast cancer screening and diagnostic imaging, if needed. The legislation prohibits insurers in New York from requiring cost-sharing for women who get these services. A copy of the letter that the New York Department of Financial Services sent to insurers about the new requirements can be found at: http://www.dfs.ny.gov/insurance/circltr/2016/cl2016_02.pdf

What does no cost-sharing mean?

No cost-sharing means that women who have health insurance policies covered by this law do not have to pay any out-of-pocket costs for breast cancer screening and diagnostic imaging. This means that insurers cannot apply the services against annual deductibles and also cannot charge patients a co-payment or coinsurance. **Important note: no cost-sharing applies only when services are delivered by a provider in your health plan's network. Services may not be covered at all if delivered by a provider outside of your health plan's network.**

What services does the law cover?

The law removes cost-sharing for mammograms, including:

- a single, baseline mammogram for women 35 to 39 years old,
- yearly mammograms for women 40 years of age or older, and
- mammograms for women at any age who are at an increased risk of breast cancer because they have a prior history of breast cancer, or they have a first degree relative (e.g., parent, sibling, child) with breast cancer.

The law also removes cost-sharing for women in need of imaging tests other than standard mammograms - such as diagnostic mammograms, breast ultrasounds, and breast magnetic resonance imaging (MRI) for the detection of breast cancer.

Does this law require insurers to cover digital tomosynthesis (also known as 3-dimensional, or 3-D, mammograms)?

No. As with most other tests, each insurer determines whether digital tomosynthesis (3D mammogram) is medically necessary. If the insurer determines digital tomosynthesis is medically necessary, the law requires the service to be covered at no cost to the patient when it is provided by a participating provider. If an insurer determines digital tomosynthesis (3D mammogram) is not medically necessary, the insured individual has the right to an internal and external appeal of that decision. An internal appeal is made directly to your insurer. An external appeal is made to the Department of Financial Services. For information regarding external appeals, please go to http://www.dfs.ny.gov/insurance/extapp/extappqa.htm

Does this law require insurers to cover all breast ultrasounds and breast MRIs?

No. As with most other tests, each insurer determines whether a breast ultrasound or breast MRI is medically necessary. If the insurer determines a breast ultrasound or breast MRI is medically necessary, the law requires the service to be covered at no cost to the patient when it is provided by a participating provider. If an insurer determines a breast ultrasound or breast MRI is not medically necessary, the insured individual has the right to an internal and external appeal of that decision. An internal appeal is made directly to your insurer. An external appeal is made to the Department of Financial Services. For information regarding external appeals, please go to http://www.dfs.ny.gov/insurance/extapp/extappqa.htm

When are breast ultrasounds and breast MRIs typically used?

Breast ultrasounds and breast MRIs can be used to screen women who are at high risk for breast cancer, usually due to a strong family history of breast cancer or a certain genetic mutation. Breast ultrasounds and breast MRIs can also be used to help diagnose breast cancer by providing more information about an area in the breast that is suspicious or already confirmed to be cancer.

Guidelines vary by organizations and professional societies about the situations in which women, including women with dense breasts, should receive breast ultrasounds or breast MRIs for screening or diagnosis. Research is underway to better define the role of these tests in breast cancer screening and diagnosis.

When does the legislation go into effect?

This law applies to health insurance policies or contracts that are issued or renewed on and after January 1, 2017. For example, if a health insurance policy or contract is renewed on March 1, 2017, the cost sharing must be removed from that date forward. The effective date could vary by health plan contract.

Does this law apply to all health insurers?

All plans that are subject to New York law, including plans that are offered through the NY State of Health (the state's Marketplace) are required to follow this new law. But not all health plans are governed by state laws. Some types of health plans (often called self-insured plans, or ERISA plans) are governed only by federal laws. These self-insured health plans are not required to follow the NY law, although some may choose to do so. The NY breast cancer law does not apply to Medicaid, Medicare or Medicare Advantage plans.

How do I know if my services will be covered?

Coverage depends on the type of health plan you have, the services you will be receiving, and your individual risk factors or medical situation. That is why it is important to check with your health insurer before you have the tests done, to make sure the services are covered under your health plan.

What other breast cancer-related services are insurers already required to cover in New York State?

Insurers are required by law to cover surgery for women diagnosed with breast cancer, including:

- Lumpectomy or lymph node dissection -- Removing lump(s) and nearby tissues or lymph nodes.
- Mastectomies -- Removing one or both breasts.
- Preventive mastectomies – Removing one or both breasts for women at high risk for breast cancer.
- In-patient hospital care after surgery -- For physical complications.
- Reconstruction -- Rebuilding one or both breasts.
- Prostheses -- A breast form that can be worn after a mastectomy.

Insurers may charge cost-sharing for these services.

Insurers must also cover at no cost to the patient:

- Screening (also known as genetic testing) for BRCA 1 or 2 gene mutations, for women at high risk of breast cancer or women with relatives with breast, ovarian, tubal or peritoneal cancer.
- Genetic counseling and more BRCA testing for women with positive BRCA test results.
- Medicine to lower breast cancer risk for women at increased risk for breast cancer.