

Kentucky Department of Insurance
Initial Cost Defrayal
Statement

After reviewing BR 1202/ HB 135 as currently drafted, the Department's initial determination is that this bill contains a mandated health benefit that may result in the state being required to make payments to defray costs under 42 U.S.C sec 18031(d)(3) and 45 C.F.R. sec 155.170, as amended. The provisions of the bill that may trigger are on page 3, lines 4-7, and page 5, line 11 thru page 6, line 6 as the minimum coverage outlined may be in excess of the minimum coverage currently required under the Essential Health Benefits, as defined by the current State's Benchmark plan. Therefore, in accordance with KRS 304.17A-099(2), if the bill is enacted this provision will not be effective until it no longer triggers cost defrayal under 42 U.S.C sec 18031(d)(3) and 45 C.F.R. sec 155.170, as amended.

Therefore, a cost defrayal analysis will be performed within the statutorily required timeframe.

Sharon P. Clark

1/28/2026

(Signature of Commissioner/Date)

Fiscal Impact Report – BR1202

Breast Cancer Screening Coverage

PREPARED FOR THE KENTUCKY DEPARTMENT OF INSURANCE

JANUARY 29, 2026

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Introduction

Lewis & Ellis, LLC (L&E) was engaged by the Kentucky Department of Insurance (KY DOI) to perform a fiscal impact analysis of BR1202, which would expand insurance coverage requirements related to breast cancer screening and imaging. Specifically, the bill would remove cost-sharing requirements for all covered breast examinations, expand coverage of supplemental breast imaging based on risk-based criteria, and prohibit frequency limits for certain preventive breast cancer screenings.

Kentucky Revised Statute (KRS) 6.948^a mandates that the sponsor of any bill proposing a health benefit mandate must request a financial impact statement from the Kentucky Department of Insurance (DOI). This statement must be completed within 30 days of the request and should include the following:

1. An assessment of the impact of the mandated health benefit on administrative expenses, premiums, and the overall cost of healthcare including any potential future cost savings.
2. Supporting documentation, including studies, written opinions, calculations, and citations that validate the findings and conclusions.
3. An estimate of any potential cost savings in the future, along with an explanation of why the bill would or would not lead to such savings, and
4. A certification confirming the accuracy of the information provided.

Additionally, KRS 6.948 mandates that the sponsor of any bill proposing a health benefit mandate must also request a federal cost defrayal impact statement from the Kentucky DOI. This statement must be completed within 30 days of the request. The federal defrayal cost impact statement shall:

1. Indicate whether a bill or amendment that contains a mandated health benefit may result in the state being required to make payments to defray costs.
2. If applicable, indicate which provision(s) of the bill or amendment may trigger the requirement to make payments to defray the costs.
3. If applicable, include an estimate of the payment amount that the state may be required to make if the bill or amendment is enacted into law.

L&E is tasked with performing the health mandate fiscal impact and federal cost defrayal impact analyses for the Kentucky insurance market, excluding the Kentucky Employee Health Plan (KEHP) and the Kentucky Medicaid programs. The fiscal impact analyses for these programs are performed by other entities. For this analysis, L&E reviewed literature, gathered statistics from public sources^b, and used data from the KY DOI's 2024 Insurer Annual Data report.

Administrative Expense Impact Analysis

The proposed bill is estimated to have **an immaterial (within +/- 0.05%) impact on administrative expenses** as a percentage of premium, based upon our analysis of the proposed mandate and our experience with similar health insurance benefits. While health plans may be

^a As amended by 2024 House Bill 635.

^bIncluding reports for other states who have considered or passed similar legislation.

required to update medical policies, utilization management criteria, and benefit designs related to breast cancer screening and imaging, these changes are not expected to materially affect administrative costs relative to current levels. Based on L&E’s experience with similar coverage mandates, any additional administrative requirements associated with implementation of the bill are expected to be absorbed within existing operational structures.

Premium Impact Analysis

To estimate BR1202’s premium impact, L&E evaluated data from KY DOI’s 2024 Insurer Annual Data report and publicly available sources. L&E used the collected information and data to estimate low-end and high-end assumptions for each variable that could impact cost or utilization. The ranges for each variable were then used to estimate the aggregate premium impact range.

While L&E selected specific assumptions to develop a range for the estimated premium impact, it is not intended to represent only the low- and high- scenarios illustrated. Each assumption range is intended to capture the various uncertainties inherent in each assumption and to provide an estimated range of resulting potential outcomes. Therefore, the final estimated aggregate premium impact range implicitly captures a wide range of scenarios and assumptions.

Each of the following sections discuss the data used to inform each assumption evaluated by L&E.

INCREASED MAMMOGRAM FREQUENCY FOR AGES 40-49

OVERVIEW OF COVERAGE CHANGES AND COST IMPLICATIONS

Under current practice, insurers follow the Affordable Care Act (ACA) preventive care requirements, which include services rated “A” or “B” by the U.S. Preventive Services Task Force (USPSTF). Under these guidelines, breast cancer screening is recommended biennially for women ages 40–75¹. Kentucky law already mandates more generous coverage, requiring annual screenings for women age 50 and older. The proposed changes under BR1202 would further expand coverage by requiring annual screenings for women ages 40–49, rather than the current biennial schedule. As a result, increased screening utilization among women ages 40–49 would be expected to generate additional claim costs

INCREASED UTILIZATION OF BREAST CANCER SCREENING

L&E used publicly available research and actuarial judgment to estimate the new utilization of preventive breast cancer screenings across the insured population²³. The assumed utilization rate for new utilizers accounts for the percentage of the population that are women aged 40-49, preventive care guidelines compliance rates, and how the proposed new guidelines compare to the current guidelines. Based on this data, L&E selected the following range for the increased utilization rate of preventative breast cancer screening:

New Preventive Breast Cancer Screening Utilization	
Low	High
0.8%	1.2%

UNIT COST FOR PREVENTIVE BREAST CANCER SCREENING

L&E estimated the average unit cost of a preventive breast cancer screening based on publicly available research⁴⁵. Based on this data, L&E selected the following range for the unit cost of a preventative breast cancer screening:

Preventive Breast Cancer Screening Unit Cost	
Low	High
\$200	\$400

INCREASED MAMMOGRAM FREQUENCY FOR AGES 40-49 CLAIM COST IMPACT ESTIMATE

The following tables illustrate the range of assumptions selected by L&E and the resulting estimated claim cost impact range for increasing the frequency guidelines for preventive breast cancer screening for women aged 40-49.

Increased Mammogram Frequency for Ages 40-49 Claim Cost Impact Calculation		
Assumption	Low	High
Increase Utilization of Breast Cancer Screening (a)	0.8%	1.2%
Unit Cost for Preventive Breast Cancer Screening (b)	\$200	\$400
Removing Cost Sharing Claim Cost Impact PMPY (c)=(a)*(b)	\$1.50	\$4.88
Removing Cost Sharing Claim Cost Impact PMPM (d)=(c)/12	\$0.13	\$0.41

INCREASED MAMMOGRAM FREQUENCY FOR HIGH-RISK

OVERVIEW OF COVERAGE CHANGES AND COST IMPLICATIONS

The proposed changes under BR1202 would further expand coverage by requiring preventive screenings for the detection of breast cancer for certain high-risk individuals, including women with heterogeneously or extremely dense breast tissue. This coverage would be prohibited from frequency limitations, and would include additional means of screening, such as MRI, as necessary for dense tissue.

INCREASED UTILIZATION OF BREAST CANCER SCREENING

L&E used publicly available research and actuarial judgment to estimate the new utilization of preventive breast cancer screenings across the insured population²³⁶. The assumed utilization rate for new utilizers focuses on women aged 35-49, since current regulations already mandate annual preventive screenings for women aged 50+, and account for preventive care guidelines compliance rates, and how the proposed new guidelines compare to the current guidelines. Based on this data,

L&E selected the following range for the increased utilization rate of preventative breast cancer screening:

New Preventive Breast Cancer Screening Utilization	
Low	High
0.3%	1.1%

UNIT COST FOR PREVENTIVE BREAST CANCER SCREENING

L&E estimated the average unit cost of a preventative breast cancer screening based on publicly available research⁷⁸. Note that the unit cost range is slightly higher due to the allowance of MRIs and other necessary imaging methods, when necessary. Based on this data, L&E selected the following range for the unit cost of a preventative breast cancer screening:

Preventive Breast Cancer Screening Unit Cost	
Low	High
\$400	\$750

INCREASED MAMMOGRAM FREQUENCY FOR HIGH-RISK CLAIM COST IMPACT ESTIMATE

The following tables illustrate the range of assumptions selected by L&E and the resulting estimated claim cost impact range for increasing the frequency guidelines for preventative breast cancer screening for certain high risk women as outlined in BR1202.

Increased Mammogram Frequency for High-Risk Claim Cost Impact Calculation		
Assumption	Low	High
Increase Utilization of Breast Cancer Screening (e)	0.3%	1.2%
Unit Cost for Preventive Breast Cancer Screening (f)	\$400	\$750
Removing Cost Sharing Claim Cost Impact PMPY (g)=(e)*(f)	\$1.23	\$8.13
Removing Cost Sharing Claim Cost Impact PMPM (h)=(g)/12	\$0.10	\$0.68

BR1202 TOTAL RESULTING PREMIUM IMPACT ESTIMATE

The total premium impact estimate for BR1202 is equal to the sum of the impact estimate sections above. This is illustrated in the table below.

Breast Cancer Screening Claim Cost Impact Calculation		
Assumption	Low	High
Breast Cancer Screening Claim Cost Impact PMPY (i)=(c)+(g)	\$2.74	\$13.02
Breast Cancer Screening Claim Cost Impact PMPM (j)=(i)/12	\$0.23	\$1.08
Projected 2026 Total Claims Costs PMPM (k)	\$626.28	\$626.28
Breast Cancer Screening Claim Cost % Impact (l)=(j)/(k)	0.0%	0.2%

Breast Cancer Screening Premium Impact Calculation		
Assumption	Low	High
Projected 2026 KY Average Loss Ratio (m) ^c	91.1%	91.1%
Projected 2026 KY Average Premium PMPM (n)=(k)/(m)	\$687.81	\$687.81
Breast Cancer Screening Premium Impact PMPM (o)=(j)/(m)	\$0.25	\$1.19
Breast Cancer Screening Premium % Impact (p)=(o)/(n)	0.0%	0.2%
Projected 2026 KY Insured Members ^d (q)	343,644	343,644
Breast Cancer Screening Premium Total Annual Impact (r) = (o)*(q)*12	\$1.0M	\$4.9M

Total Cost of Health Care Impact Analysis

L&E defines ‘Total Cost of Health Care’ as being equal to the sum of the Allowed Cost (i.e., the amount paid by the insurer plus the amount paid by the insured) and the insurer Non-Benefit Expenses. Additionally, as required by KRS 6.948, L&E considered the impact of potential future cost savings.

BREAST CANCER SCREENING FUTURE COST SAVINGS

L&E acknowledges the potential for long-term cost savings if breast cancer screenings were to replace or prevent higher-severity claims, such as treatment of late-stage breast cancer. However, given the level of current coverage, L&E does not anticipate this mandate to materially alter the current mix of services. While earlier detection of breast cancer has the potential to reduce future treatment costs, quantifying such savings requires assumptions about disease progression and treatment patterns that are subject to significant uncertainty. Based on available information and actuarial judgment, any potential future cost savings associated with BR1202 are estimated to be immaterial (within +/- 0.05%).

RESULTING TOTAL COST OF HEALTH CARE IMPACT ESTIMATE

Since all of the estimated impact for this proposed mandate is for increased utilization that is a direct result of the mandate, we expect the impact to total cost of care to be equal to the claim cost impact. The calculation is shown in the table below.

Total Cost of Health Care (TCoHC) Calculation		
Assumption	Low	High
TCoHC Impact PMPM (s)=(j)	\$0.23	\$1.08
Projected 2026 KY TCoHC PMPM (t)	\$828.33	\$828.33
Mandate TCoHC % Impact (u)=(j)/(t)	0.0%	0.1%
Projected 2026 KY Insured Members (x)	343,644	343,644
Mandate TCoHC Total Annual Impact (ac) = (z)*(x)*12	\$940K	\$4.5M

^c Based on 2024 Insurer Annual Data report provided by the KY DOI. Excludes KEHP and Medicaid.

^d Excluding the Kentucky Employee Health Plan (KEHP) and the Kentucky Medicaid programs.

Cost Defrayal Impact Analysis

Based on L&E’s research and actuarial judgment, L&E determined that this bill may contain a mandated health benefit that would result in the state being required to make payments to defray costs under 42 U.S.C sec 18031(d)(3) and 45 C.F.R. sec 155.170, as amended. The provisions of the bill that may trigger the requirement are on page 3, lines 4-7 and Page 5, line 11 thru Page 6, line 6, as the minimum coverage outlined may be in excess of the minimum coverage currently required under the Essential Health Benefits, as defined by the State’s Benchmark Plan.

The estimated annual cost defrayal payment that the state may be required to make is between \$361K and \$1.7M, which is based on the portion of the mandate claims cost estimate that is attributed to the individual and small group markets.

L&E has disclosed its defrayal determination based on its earnest interpretation of federal guidance available as of the date of this report. However, determination of defrayal is ultimately under the regulatory purview of Centers for Medicare and Medicaid Services (CMS).

Certification of Accuracy

L&E believes the estimates are accurate based on the information disclosed in the report. To the extent that there are material inaccuracies, misrepresentations, or lack of adequate disclosure in the data, the results may be accordingly affected. Several of the assumptions made in this analysis are subject to uncertainty and it is expected that actual results could differ from the calculated estimates.



Traci Hughes, FSA, MAAA
Vice President & Principal
Lewis & Ellis, LLC



Robert Dorman, ASA, MAAA
Vice President & Consulting Actuary
Lewis & Ellis, LLC



1/28/2026

(Signature of Commissioner/Date)

ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations^e, promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct^f, to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary

The responsible actuaries are:

- Traci Hughes, FSA, MAAA, Vice President & Principal
- Bobby Dorman, ASA, MAAA, Vice President & Consulting Actuary

These actuaries are available to provide supplementary information and explanation.

Identification of Actuarial Documents

The date of this document is January 29, 2026. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is January 29, 2026.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Kentucky Department of Insurance. The authors of this report are aware that it may be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis, LLC is financially and organizationally independent from the health insurers and providers involved in this analysis. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Kentucky Department of Insurance in assessing the financial impact and federal cost defrayal impact of proposed legislation that includes a proposed health benefit mandate.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- L&E has reviewed the data provided by the insurers and Kentucky Department of Insurance for reasonableness, but the data has not been audited. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

^e The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

^f These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

- Several of the assumptions made in this analysis are subject to uncertainty and it is not unexpected that actual results could differ from the calculated estimates.
- L&E is not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.

Actuarial Findings

The actuarial findings of the report can be found in the body of this report.

Bibliography

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