A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Bill Analysis Report: California Assembly Bill 1570 Diagnostic Imaging

MARCH 27, 2026

California Health Benefits Review Program (CHBRP)
University of California, Berkeley

chbrp.org

KEY FINDINGS

Analysis of California Assembly Bill 1570 Diagnostic Imaging

Summary to the 2025–2026 California State Legislature, March 27, 2026

CHBRP

Summary

The version of California Assembly Bill (AB) 1570 analyzed by the California Health Benefits Review Program (CHBRP) would require that state-regulated health plans and policies cover the following services related to breast cancer screening and diagnosis, in accordance with clinical guidelines, without cost sharing: screening mammography; medically necessary diagnostic or supplemental breast exams; diagnostic mammography; tests for screening or diagnostic purposes; and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee indicated to have a risk factor associated with breast cancer, including family history or known genetic mutation.

All **22.8 million Californians** enrolled in state-regulated health insurance in 2027 would have insurance subject to AB 1570. AB 1570 would take effect in January 2028.

Background

Breast cancer is the most common non-skin cancer diagnosis and the second leading cause of cancer deaths, after lung cancer, for women in California. Primary screening mammography is a first step in the detection of breast cancers for those at any risk level who do not have symptoms. People who are at intermediate or high risk of breast cancer may be recommended for additional screening, known as supplemental screening. People with primary screening abnormalities undergo further imaging or biopsy of the suspicious area(s) to investigate whether there is cancer in the breast tissue. People presenting with symptoms typically start at this diagnostic step.

Benefit Coverage

All women have coverage without cost sharing for primary screening for breast cancer. Women at average risk of breast cancer have coverage without cost sharing for supplemental screening and diagnostic imaging following a screening. AB 1570 would close this gap by providing **coverage without cost sharing for supplemental screening, diagnostic imaging, biopsy, and pathology evaluation for women at intermediate and high risk** of breast cancer. AB 1570 would also provide coverage without cost sharing for **diagnostic imaging for women at any risk level who receive diagnostic imaging without first receiving a primary screening mammography**. AB 1570 would not exceed essential health benefits (EHBs).

Medical Effectiveness

There is **some to very strong evidence** (depending on the modality) that nearly all modalities covered by AB 1570 are medically effective for supplemental screening or diagnostic imaging to detect breast cancer. Molecular breast imaging, which is a newer technology, has less evidence than other modalities.

Cost Impacts

CHBRP estimates that AB 1570 would result in fewer than **40,263[1] women** accessing supplemental screening and diagnostic imaging for breast cancer. AB 1570 would lead to an **additional 66,384 supplemental screenings, diagnostic imaging services, biopsies, and pathology evaluations** for breast cancer without cost sharing. CHBRP estimates an increase of **$93,957,000 in total annual premiums** paid by employers and enrollees for newly covered benefits. Average premiums would increase by <$0.01-$0.64 per member per month, depending on market segment. Premiums calculated include premiums for enrollees using and not using the benefit. CHBRP estimates that commercial and individual enrollees using the benefit would **save an average of $85.17 in enrollee expenses per year**, with variation by market segment.

Public Health Impacts

AB 1570 would produce an **unknown impact** on breast cancer morbidity and mortality for an approximate **1,840 enrollees who would avoid a delayed breast cancer diagnosis** that might otherwise occur with cost sharing in place.

[1] Some women will use more than one imaging service during their screening and/or diagnosis episode of care. However, the number of overlapping services used during that episode is unknown.

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Acronyms and Terminology

Acronyms

AB – Assembly Bill

ACA – Affordable Care Act

ACIP – Advisory Committee on Immunization Practices

BCSC – Breast Cancer Surveillance Consortium

CA – California

CalPERS – California Public Employees' Retirement System

CEM – contrast-enhanced mammography

CDI – California Department of Insurance

CHBRP – California Health Benefits Review Program

COHS – County Organized Health System

DBT – digital breast tomosynthesis

DHCS – Department of Health Care Services

DMHC – Department of Managed Health Care

EHBs – essential health benefits

HDHP – high-deductible health plan

HRSA – Health Resources and Services Administration

HSA – Health Savings Account

MBI – molecular breast imaging

MRI – magnetic resonance imaging

NCCN – National Comprehensive Cancer Network

OOP – out of pocket

PMPM – per member per month

US – ultrasound

USPSTF – United States Preventive Services Task Force

Bill-Specific Terminology

CHBRP uses the following terminology for this analysis:

- **Breast magnetic resonance imaging (MRI)**, as defined by AB 1570, is a diagnostic tool that uses a powerful magnetic field, radio waves, and a computer to produce detailed pictures of the structures within the breast. In clinical settings, breast MRI can be used for screening or diagnostic imaging to detect breast cancer.
- **Breast ultrasound**, as defined by AB 1570, is a noninvasive diagnostic tool that uses high-frequency sound. In clinical settings, breast ultrasound can be used for screening or diagnostic imaging to detect breast cancer.
- **Contrast-enhanced mammography:** mammography that uses intravenously injected iodine-based dye (contrast) to highlight abnormal blood vessels and hyperactive tissues that can occur when cancers develop. It can be used for screening or diagnosis of breast cancer.
- **Diagnostic breast examination**, as defined by AB 1570, is a medically necessary and appropriate, in accordance with the National Comprehensive Cancer Network (NCCN) guidelines, examination of the breast, including an examination using contrast-enhanced mammography, diagnostic mammography, breast magnetic resonance imaging, breast ultrasound, or molecular breast imaging, that is used to evaluate either: an abnormality seen or suspected from a screening examination for breast cancer; or an abnormality detected by another means of examination. CHBRP has determined that, in clinical terms, diagnostic breast examination is inclusive of diagnostic breast imaging tools as well as biopsy and pathology evaluation.
- **Diagnostic breast imaging**, as defined by AB 1570, is inclusive of breast magnetic resonance imaging (MRI), breast ultrasound, and other clinically indicated diagnostic testing. Although not specified in the bill definition, two-dimensional (2D) mammography and DBT can be used as diagnostic breast imaging tools.

- **Digital breast tomosynthesis (DBT):** a form of mammography that uses computer-generated, three-dimensional reconstruction of the breast image. DBT can be used for screening or diagnostic imaging to detect breast cancer. DBT is also commonly referred to as 3D mammography.
- **Diagnostic mammography**, as defined by AB 1570, is a diagnostic tool that uses x-ray and is designed to evaluate an abnormality in the breast.
- **Digital mammography**: digital x-rays of the breast used to detect breast cancer. 2D digital mammography is a process by which a machine takes two, two-dimensional x-ray images of each breast to form a single, flat image of the breast. Images are read by a radiologist in search of suspicious lesions. Digital mammography can also be 3D – see the definition of digital breast tomosynthesis (DBT) above.
- **Molecular breast imaging:** a tool that uses a radioactive tracer and a gamma camera to take images of breast tissue for the identification of breast cancer.
- **Primary screening**: an x-ray used to detect breast cancer in women without symptoms (asymptomatic). 2D mammography and DBT are commonly used x-rays for primary screening.
- **Supplemental breast examination**, as defined by AB 1570, is a medically necessary and appropriate, in accordance with the NCCN guidelines, examination of the breast, including contrast-enhanced mammography, breast magnetic resonance imaging, breast ultrasound, or molecular breast imaging, that is either: used to screen for breast cancer when an abnormality is not seen or suspected; or based on personal or family medical history or additional factors that increase the individual's risk of breast cancer, including heterogeneously or extremely dense breasts.
- **Supplemental screening**: exams conducted to improve cancer detection beyond standard mammography for some women at elevated risk of breast cancer. Supplemental screening may occur intermittently between or in conjunction with primary screening mammography.

For an explanation of how these terms differ between bill language and clinical use, see the *Analytic Approach and Assumptions* section below. For a detailed explanation of how these tests and services are used in clinical practice, see Table 3.

Health Insurance Terminology

- **Cost sharing:** Payment for use of covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium expenses[2]). AB 1570 specifically defines cost sharing as a deductible, coinsurance, or copayment, and any maximum limitation on the application of that deductible, coinsurance, or copayment, or a similar out-of-pocket expense.
- **High-deductible health plans (HDHPs):** HDHPs are a type of health plan with requirements set by federal regulation.[3] As the name implies, these plans include a deductible, but they are not allowed to have separate medical and pharmacy deductibles. For the 2026 plan year, the Internal Revenue Service (IRS) defines an HDHP as any plan with a deductible of at least $1,700 for an individual and $3,400 for a family.[4]
- **Health Savings Account (HSA)–qualified HDHPs:** To be eligible to establish a Health Savings Account (HSA) for taxable years beginning after December 31, 2003[5] (and so to be eligible to make tax-favored contributions to an HSA), a person must be enrolled in an HSA-qualified HDHP. In order for an HDHP to be HSA qualified, it must follow specified rules regarding cost sharing and deductibles, as set by the IRS.

[2] Premiums are paid by most enrollees, regardless of their use of any tests, treatments, or services. Some enrollees may not pay premiums for different reasons. For example, their employers cover the full premium, or they receive benefits through Medi-Cal.
[3] HealthCare.gov, Glossary: High Deductible Health Plan (HDHP). Accessed March 5, 2021.
[4] IRS Revenue Procedure 2025-19, 2025-18 IRB 1430.
[5] Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code.

Overview: AB 1570 and Diagnostic Imaging

On January 26, 2026, the California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[6] conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 1570, Diagnostic Imaging, as introduced on January 12, 2026.

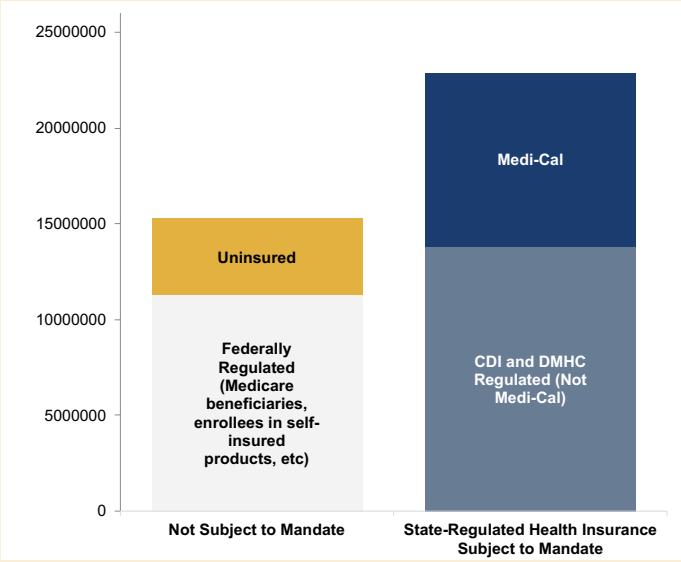
Bill Language of AB 1570

AB 1570 would require that state-regulated health plans and policies cover the following services related to breast cancer screening and diagnosis, in accordance with clinical guidelines, without cost sharing:

- Screening mammography
- Diagnostic mammography
- Medically necessary supplemental breast exams
- Medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee indicated to have a risk factor associated with breast cancer, including family history or known genetic mutation.
- Medically necessary diagnostic breast exams
- Tests for screening or diagnostic purposes

Coverage without cost sharing for the services listed above would only apply to an enrollee in a high-deductible health plan (HDHP) after the enrollee's deductible has been satisfied for the plan year.

Figure 1. Health Insurance in CA and AB 1570



Source: California Health Benefits Review Program, 2026.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.[1]
Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

AB 1570 would require that health plans and policies "arrange for the provision" of the services described above if they are unavailable within network, so as to ensure timely access to covered services.

AB 1570 would take effect January 1, 2028.

See the full text of AB 1570 in the Technical Brief on AB 1570, available at www.chbrp.org.

[6] See CHBRP's authorizing statute.

If enacted, AB 1570 would apply to the health insurance of approximately 22.8 million enrollees (60% of all Californians) (see Figure 1).

Includes: All enrollees in state-regulated health insurance, including commercial or CalPERS health insurance regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), and Medi-Cal beneficiaries enrolled in DMHC-regulated plans and county organized health systems (COHS) plans.

It should be noted that DMHC regulates the plans and policies of approximately 74% of enrollees associated with CalPERS, and 80% of Medi-Cal beneficiaries, in addition to commercial enrollees.[7]

HEALTH INSURANCE: SHARING RISK

Health insurance costs are shared between: 1) enrollees and/or their employers, and 2) health plans/insurers. Cost sharing is used to keep monthly premiums lower in two primary ways:

- Direct offsets of premiums by transferring payment from monthly payment to payment at the time of care.
- Promotion of more mindful health care spending by encouraging patients to reduce overutilization through shared cost of care.

CHBRP provides an overview of common cost-sharing practices that are addressed by AB 1570 in its explainer *What Is Cost Sharing?*.

Analytic Approach and Assumptions: Language Interpretation

CHBRP analyzes bills in the current environment given current law and regulations at both the state and federal levels. All estimates are based on current data and do not take into consideration any future or potential changes to factors that may influence the impacts of AB 1570, unless otherwise specifically mentioned.

CHBRP previously analyzed similar bill language for AB 2024 and SB 974 in 2022. Where applicable, this analysis builds from those previous analyses.

CHBRP made the following assumptions about the terminology included in AB 1570:

- AB 1570 mandates coverage without cost sharing for several tests and services that, as defined in the bill, require assumptions to determine what specific tests and services would be used in clinical practice. See Table 1 and the definitions below:
    - AB 1570 mandates coverage without cost sharing for "screening mammography." For clarity, CHBRP refers to "screening mammography" as "primary screening mammography."
    - CHBRP assumes that "diagnostic mammography" as mandated by AB 1570 refers to the use of 2D mammography and digital breast tomosynthesis (DBT) for diagnostic purposes (as opposed to screening purposes).
    - AB 1570 mandates coverage without cost sharing for "supplemental breast examinations." For clarity, CHBRP refers to "supplemental breast examinations" as "supplemental screening."
    - AB 1570 mandates coverage without cost sharing for diagnostic breast imaging, including magnetic resonance imaging (MRI), ultrasound, and "other clinically indicated diagnostic testing." CHBRP assumes that "other clinically indicated diagnostic testing" is inclusive of contrast-enhanced mammography (CEM) and molecular breast imaging (MBI).
    - AB 1570 mandates coverage without cost sharing for "diagnostic breast examinations." For clarity, CHBRP assumes this is inclusive of diagnostic breast imaging, biopsy, and pathology services.
    - CHBRP assumes "other clinically indicated diagnostic testing" and "tests for screening or diagnostic purposes" to be inclusive of biopsy and pathology services as recommended by National Comprehensive Cancer Network (NCCN) guidelines.

[7] For more detail, see CHBRP's resource *Sources of Health Insurance in California.*

Table 1. AB 1570 Tests and Services as Defined by CHBRP

Bill Language	CHBRP Definition
Screening mammography	Primary screening mammography
Diagnostic mammography	Mammography (2D or DBT) for diagnostic purposes
Supplemental breast exams	Supplemental screening
Diagnostic breast imaging, including MRI, ultrasound, and other clinically indicated diagnostic testing	Diagnostic breast imaging as defined in bill, plus CEM and MBI
Diagnostic breast exams	Diagnostic breast imaging as defined in bill, plus biopsy and pathology evaluation
Tests for screening or diagnostic purposes	CHBRP has determined that this language is inclusive of all services outlined above.

Source: California Health Benefits Review Program, 2026.
Key: 2D = two-dimensional; CHBRP = California Health Benefits Review Program; DBT = digital breast tomosynthesis; CEM = contrast-enhanced mammography; MBI = molecular breast imaging; MRI = magnetic resonance imaging.

For clinical definitions of these tests and services, see the *Terminology* section.

CHBRP made the following additional assumptions based on the language of AB 1570:

- AB 1570 states that the services impacted by this bill must be covered "to the extent it is consistent with nationally recognized evidence-based clinical guidelines." AB 1570 also cites the NCCN guidelines to define certain terms, including "diagnostic breast examination" and "supplemental breast examination." CHBRP relies upon NCCN guidelines to inform this analysis to remain consistent with the bill language.
- The Federal Preventive Services Mandate requires that certain preventive services be covered without cost sharing for enrollees in nongrandfathered health plans. Given existing recommendations that fall under this mandate, CHBRP assumes that primary screening mammography is covered without cost sharing at baseline for all populations for whom it is recommended by NCCN. As such, primary screening mammography would not be impacted by this bill and is excluded from CHBRP's analysis. Cost sharing is not currently prohibited for coverage for supplemental screening for all populations at baseline, and is thus included in CHBRP's analysis. For more information on the Federal Preventive Services Mandate, see the *Policy Context* section.
- CHBRP assumes that coverage without cost sharing for the services outlined in AB 1570 would extend up to the point of cancer diagnosis, but not beyond, as this bill does not cover breast cancer treatment.
- CHBRP refers to women in its analysis of AB 1570, as NCCN and other national clinical guidelines only recommend the services relevant to this bill for women. CHBRP recognizes that individuals who identify as male, transgender or nonbinary also experience breast cancer.
- Certain recommendations from the Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for women's preventive services are relevant to AB 1570. These HRSA guidelines are part of the Preventive Services Mandate mentioned above and described in detail in the *Policy Context* section. However, there is not consensus about how to interpret HRSA's recommendation for "Breast Cancer Screening for Women at Average Risk." CHBRP assumes that HRSA recommendations provide women at average risk of breast cancer with baseline coverage without cost sharing for diagnostic services "to complete the screening process or to address findings on the initial screening mammography," but that, given the specification for women at average risk in the

name of the recommendation, this coverage does not apply to women at intermediate or high risk of breast cancer. **If this assumption is incorrect and women at intermediate or high risk are covered by the HRSA recommendation, the impact of this bill would be smaller by magnitudes.** For more information on HRSA recommendations, see the *Policy Context* section.

Given these assumptions, as well as existing state and federal laws mandating coverage without cost sharing for certain services, CHBRP has determined that the populations and services impacted by AB 1570 would include the following (also see Table 2):

- Women at intermediate risk and high risk of breast cancer would gain coverage without cost sharing for diagnostic breast imaging following a screening, biopsy, and pathology evaluation. CHBRP determines that this would close the baseline gap in coverage without cost sharing between women at average risk and women at high and intermediate risk for these services.
- Women at any risk level who go straight to diagnostic services would gain coverage without cost sharing for those diagnostic services identified in NCCN guidelines and as defined in the bill language. Although the bill language does not specify risk level for these services, it is CHBRP's assumption that nearly all women who receive medically necessary diagnostic breast imaging services, without a primary screening mammography first, presented with symptoms.

Table 2. Existing Coverage Without Cost Sharing for AB 1570–Relevant Services, by Risk Level

Population (a)	Service	Baseline Coverage Without Cost Sharing	Postmandate Coverage Without Cost Sharing Gained?
Women at average risk (<15% lifetime risk) 71.2% of population	Primary screening mammography	Yes, via USPSTF and HRSA (b)	NA
	Supplemental screening	Yes, via HRSA	NA
	Diagnostic breast imaging	Yes, via HRSA	NA
	Biopsy and pathology evaluation	Yes, via HRSA	NA
	Diagnostic breast imaging first, without screening mammography	No	Yes
Women at intermediate risk (15-20% lifetime risk) 23.8% of population	Primary screening mammography	Yes, via USPSTF and HRSA (b)	NA
	Supplemental screening	No	Partial (c)
	Diagnostic breast imaging	No	Yes
	Biopsy and pathology evaluation	No	Yes
	Diagnostic breast imaging first, without screening mammography	No	Yes
Women at high risk (>20% lifetime risk) 5.1% of population	Primary screening mammography	Yes, via USPSTF and HRSA (b)	NA
	Supplemental screening	No	Yes

Population (a)	Service	Baseline Coverage Without Cost Sharing	Postmandate Coverage Without Cost Sharing Gained?
	Diagnostic breast imaging	No	Yes
	Biopsy and pathology evaluation	No	Yes
	Diagnostic breast imaging first, without screening mammography	No	Yes

Source: California Health Benefits Review Program, 2026; HRSA, 2025; NCCN, 2025; USPSTF, 2024.
Notes: (a) Percent of population at average, intermediate, and high risk of breast cancer are sourced from Sprague et al. (2017) and were adjusted by a content expert to reflect the 40- to 64-year age population.
(b) USPSTF and HRSA recommendations for screening mammography are largely age restricted. The USPSTF recommends screening mammography for women aged 40 to 74 years. HRSA recommends that screening mammography be initiated no earlier than 40 years and no later than 50 years, and should continue through at least 74 years for women at average risk. Guidelines are also organized by risk level: HRSA recommends "periodic mammography" for women at "increased" risk but does not specify age. NCCN recommends that women at average risk of breast cancer ages 40 and older receive screening mammography. NCCN recommends that women at high risk begin screening mammography no later than age 40, or 10 years prior to when the youngest family member was diagnosed with breast cancer, but not prior to age 30 (whichever comes first). NCCN does not provide a recommendation for women at intermediate risk (between 15% and 20%). CHBRP assumes that AB 1570 would provide coverage for specified services as consistent with NCCN guidelines. As such, the population that would be covered by AB 1570 already has coverage for primary screening mammography without cost sharing.
(c) Supplemental screening is recommended by NCCN for women at intermediate risk who received chest radiation treatment between ages 10 and 30 years and women with dense breasts.
Key: HRSA = Health Resources & Services Administration; NCCN = National Comprehensive Cancer Network; USPSTF = United States Preventive Services Task Force.

What Are Screening and Diagnostic Imaging for Breast Cancer?

Breast cancer is the most common non-skin cancer diagnosis and the second leading cause of cancer deaths (after lung cancer) for females in California (CDPH, 2024). Ninety-nine percent of breast cancer occurs in females (ACS, 2026). Women experience different levels of risk of breast cancer based on factors such as age, personal and familial medical history, and genetics. Recommended screening schedules vary according to the three risk level categories: average (<15% lifetime risk); intermediate (15%-20% lifetime risk) or high (>20% lifetime risk). All women are recommended for primary mammography every 1 to 2 years starting at age 40 years, with some guidelines recommending an earlier start for women at high risk (ACOG, 2025; HRSA, 2025; NCCN, 2025; USPSTF, 2024). According to national data from the Breast Cancer Surveillance Consortium (BCSC), the majority of women are at average risk (71.2%), followed by 23.8% at intermediate risk and 5.1% at high risk of breast cancer (Sprague et al., 2017).[8]

Screening

Breast cancer screening is used to identify cancer in women with no symptoms (asymptomatic). There are two categories of breast cancer screening:

- **Primary screening** uses 2D mammography – a low-dose x-ray – to detect breast cancer early. Primary screening is recommended every 1 to 2 years by multiple national guidelines, including NCCN, for women starting at age 40 years.
- **Supplemental screening** exams are recommended for many, but not all women, identified to be at intermediate or high risk for breast cancer and are asymptomatic. Supplemental screening may occur intermittently between or in conjunction with primary screening mammography.

[8] Estimates adjusted to reflect the 40- to 64-year-old population for the purposes of this bill analysis. Provided by Diana Miglioretti, PhD, University of California, Davis.

Diagnostic Imaging and Pathology Evaluation

- **Diagnostic imaging** exams are conducted for people with symptoms of disease (e.g., lump, nipple discharge, pain) or abnormal results on clinical exams or screening tests.
- Although clinical terminology often refers to imaging used for this purpose as "diagnostic," breast cancer is diagnosed based on examination of breast tissue by a pathologist, following a biopsy. The **biopsy procedure** uses a fine-needled aspiration or core needle guided by ultrasound or MRI imaging, or surgery, to remove a sample of suspicious tissue. **Pathology evaluation** is part of the diagnostic process that examines tissue samples under a microscope to determine if they are cancerous. Once cancer is confirmed, other diagnostic tests can identify the receptor status to inform the most effective treatment options for that type of cancer.

Table 3 describes the imaging tools (modalities) that are commonly used for primary screening, supplemental screening, and/or diagnostic imaging.

Table 3. Breast Cancer Screening Modalities Covered by AB 1570

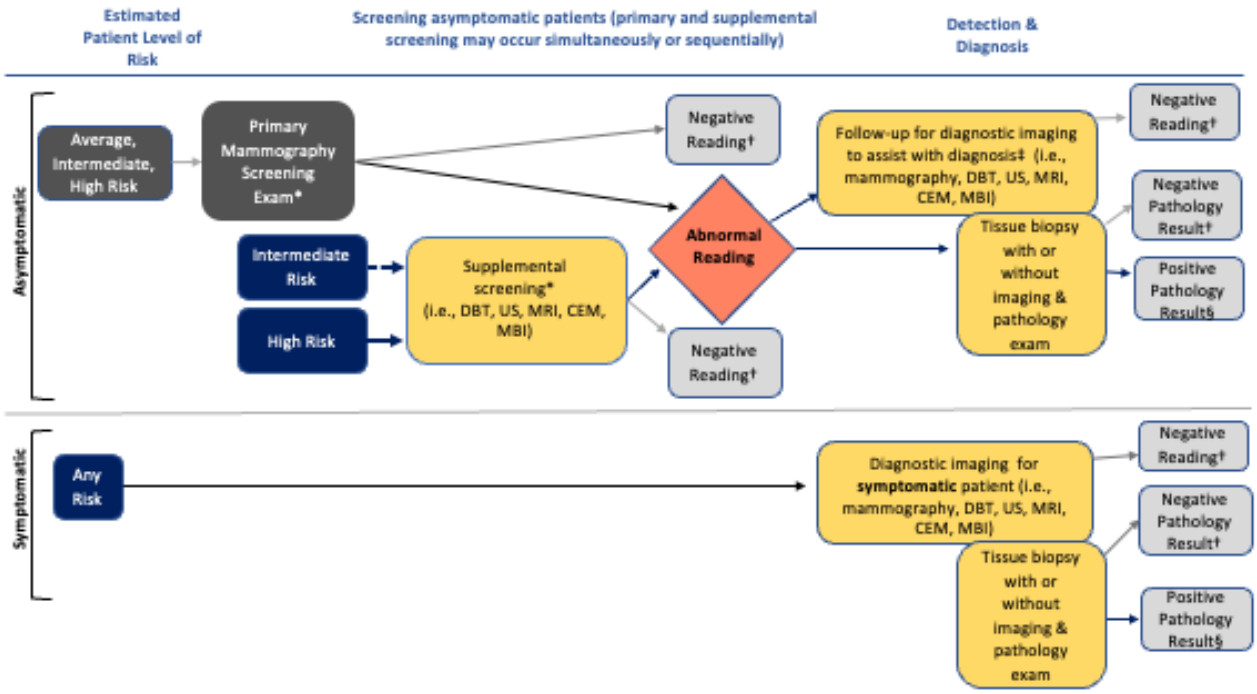
Modality (Type of Imaging)	Common Use Cases	Description
Digital mammography (2D)	• Primary screening • Diagnostic imaging	X-ray image includes two x-ray images of each breast that form a single, flat image of the breast. Images are read by a radiologist in search of suspicious lesions. If the image is too opaque to read properly (due to dense breast tissue), a supplemental screening will be ordered. If the image reveals abnormalities, the woman proceeds to diagnostic imaging, Mammography is also used to guide needle biopsy procedures to obtain cell samples of abnormal appearing areas.
DBT, or 3D mammography	• Primary screening • Supplemental screening • Diagnostic imaging	DBT is a type of mammography that creates 3D images. It is used in conjunction with 2D mammography or can provide reconstructed 2D images in addition to 3D for women at any risk of breast cancer. If suspicious lesions are found, the woman proceeds to diagnostic imaging.
Breast MRI	• Supplemental screening • Diagnostic imaging	MRI uses radio waves to create detailed images of soft tissue, bone, and organs. Therefore, it complements mammography/DBT x-ray images by capturing different perspective of tissue. It is used for women at intermediate to high lifetime risk of breast cancer and for some women whose mammography readings may be obscured due to dense breast tissue. MRI may also be used to guide needle biopsy procedures to obtain cell samples for diagnosis.
Breast US	• Supplemental screening • Diagnostic imaging	High-energy sound waves (ultrasound) bounce off internal tissues to form an image that differentiates tissue (fluid-filled vs. solid masses). Ultrasound may be used as supplemental screening in addition to mammography for women at intermediate and high lifetime risk of breast cancer or with dense breast tissue. Ultrasound may also be used to guide needle biopsy procedures to obtain cell samples for diagnosis.

CEM	• Supplemental screening • Diagnostic imaging	CEM is used following suspicious findings from primary screening or presence of physical symptoms. An iodine-based contrast agent is injected during the mammogram; it increases the visibility of blood vessels and enhances the contrast between normal and abnormal tissues. The procedure takes two sets of images—one before and one after the contrast injection—allowing radiologists to compare and detect changes through the uptake of the contrast agent by cancerous cells. CEM may also be used for supplemental screening if MRI is not available or, for women at high risk, not tolerable.
MBI	• Supplemental screening • Diagnostic imaging	MBI is a newer technology used much less commonly than other modalities for breast cancer supplemental screening or diagnosis. A radioactive tracer is injected into the bloodstream; images show the areas in the breast where the radiotracer accumulates, which indicates cancerous tissue. MBI may also be used for supplemental screening if MRI is not available or, for women at high risk, not tolerable.

Source: California Health Benefits Review Program, 2026.
Key: 2D = two-dimensional; 3D = three-dimensional; CEM = contrast-enhanced mammography; DBT = digital breast tomosynthesis; MBI = molecular breast imaging; MRI = magnetic resonance imaging.

There are multiple screening and diagnostic pathways that can be followed depending on a woman's breast cancer symptom status and level of risk (see Figure 2 for an overview). Asymptomatic women of any risk are recommended for primary mammography screening. Symptomatic women of any risk proceed directly to diagnostic imaging. Average risk women are not recommended for supplemental screening. Intermediate risk women may be recommended for supplemental screening (denoted by dotted arrow in Figure 2), such as some women with dense breast tissue. High risk women are commonly recommended for supplemental screening (denoted by solid arrow in Figure 2). The blue boxes in Figure 2 (below) represent the populations that would gain coverage without cost sharing from AB 1570, while the gold boxes represent services and tests for which AB 1570 would require coverage without cost sharing (supplemental screening for women at elevated risk and women at any risk level who undergo diagnostic imaging and tests).

Figure 2. Breast Cancer Screening and Diagnostic Pathways Based on Estimated Patient Level of Risk



Source: **California Health Benefits Review Program, 2026.**
Notes: Blue boxes indicate which populations would be newly covered without cost-sharing per AB 1570. Gold boxes indicate services with cost sharing removed per AB 1570.
*Cancer not detected. **Cancer detected. †Imaging detects suspicious lesions and diagnosis occurs through tissue biopsy and pathology examination. Key: DBT = digital breast tomosynthesis. US = ultrasound. MRI = magnetic resonance imaging. CEM = contrast-enhanced mammography. MBI = molecular breast imaging (recommended by NCCN only if MRI is not an option).
†Cancer not detected. ‡Imaging detects suspicious lesions, and diagnosis occurs through tissue biopsy and pathology examination. §Cancer detected. Key: CEM = contrast-enhanced mammography; DBT = digital breast tomosynthesis; MBI = molecular breast imaging (recommended by NCCN only if MRI is not an option); MRI = magnetic resonance imaging; US = ultrasound.

Barriers to accessing screening and diagnostic imaging

There are a multitude of factors influencing why women delay or do not obtain breast cancer screening and/or diagnostic services including financial, patient, and clinician barriers (Capiro et al., 2025; Conley et al., 2025). Income level and insurance coverage can either facilitate or hinder access to screening and diagnostic imaging for breast cancer, depending on level of income and breadth of insurance coverage. Several sources note that higher out-of-pocket (OOP) costs are associated with delayed or skipped supplemental breast cancer screening or diagnostic imaging, especially among women with lower incomes as compared to women with higher incomes (ACS CAN, 2025; Ngo et al., 2023). There is also some conflicting evidence regarding the effect cost-sharing elimination has on screening rates. In a review of 18 articles focused on breast cancer screening, 8 reported increased screening utilization; 5 reported no significant utilization change; and 4 reported decreased screening rates (Norris et al., 2022). Reasons for little-to-no impact on elimination of cost sharing for screening include patients' perceived burden of costs for subsequent diagnostic tests and services, a ceiling effect of low cost-sharing already, or other barriers that are more significant than cost sharing.

Non-cost-sharing barriers include patients' perceived severity of breast cancer and benefits of screening; logistical challenges (e.g., childcare, transportation, time constraints); navigating health care (e.g., identifying proper imaging providers, making appointments) and insurance systems (e.g., referrals and prior authorization); and low confidence or weak clinician-patient relationships (Conley et al., 2025; Lawson et al., 2025). Clinician barriers include clinic visit time

constraints; variations in clinicians' familiarity with and use of risk assessment practices and tools or understanding the tool results; confusion with conflicting clinical guidelines; and concerns about overstepping scope of practice (Amornsiripanitch et al., 2021; Conley et al., 2024; Reichman et al., 2025).

How Effective Are Supplemental Screening and Diagnostic Imaging at Identifying Breast Cancer?

The following medical effectiveness review summarizes findings from evidence[9] regarding the effectiveness of the breast imaging modalities that would be available without cost sharing under AB 1570 and used for supplemental screening in women with dense breasts or at elevated (meaning intermediate or high) risk, or diagnostic imaging to evaluate an abnormality or suspicious lesion. These breast imaging modalities include: contrast enhanced mammography (CEM); breast magnetic resonance imaging (MRI); breast ultrasound (US); molecular breast imaging (MBI); and digital breast tomosynthesis (DBT, or 3D mammography).[10] As primary screening mammography is already covered without cost sharing by existing federal and state mandates, CHBRP's analysis does not address its medical effectiveness.

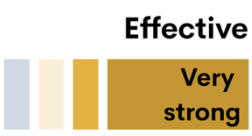
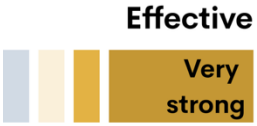
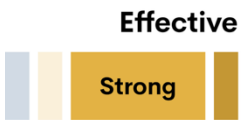
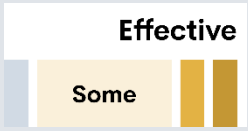
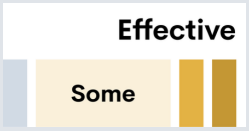
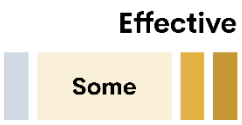
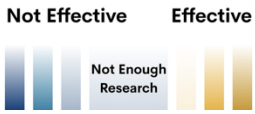
Measurable health outcomes relevant to AB 1570 include test performance of each respective modality when used to screen for breast cancer. Specific outcomes include cancer detection rates, diagnostic accuracy (sensitivity and specificity), and recall rates. CHBRP also reviewed literature on potential harms of each screening or diagnostic modality relevant to AB 1570.

CHBRP uses the terms and scale shown in Table 4 to characterize the body of evidence regarding an outcome (Table 4). See the detailed *Medical Effectiveness Review* in CHBRP's Technical Brief on AB 1570 for definitions of each term.

Table 4 summarizes the evidence for cancer detection rates for modalities used in supplemental breast screening and diagnostic breast imaging. No evidence was available on the impact of supplemental breast screening modalities on breast cancer stage at detection, morbidity or mortality. Evidence is reported separately by imaging modality (DBT, US, MRI, CEM, and MBI) and by imaging use (supplemental screening or diagnostic imaging). There is *very strong*[11] evidence that DBT can increase cancer detection during supplemental screening for women with dense breasts and during diagnostic imaging compared to standard 2D mammography alone. There is *strong*[12] evidence that breast US and breast MRI can increase cancer detection during supplemental screening for women with dense breasts or otherwise at elevated risk, and *some*[13] evidence that they can increase cancer detection during diagnostic imaging compared to standard 2D mammography alone. There is *some* evidence that CEM can improve cancer detection when used for supplemental screening or diagnostic breast imaging. There is *some* evidence supporting the use of MBI for supplemental screening, but *not enough research*[14] to evaluate its use in diagnostic breast imaging.

[9] Much of the discussion in this section is focused on reviews of the available literature. However, as noted in the section on Implementing the Hierarchy of Evidence on page 11 of the *Medical Effectiveness Analysis and Research Approach* document (posted at http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php), in the absence of fully applicable to the analysis peer-reviewed literature on well-designed randomized controlled trials (RCTs), CHBRP's hierarchy of evidence allows for the inclusion of other evidence.
[10] Although not explicitly addressed in the definitions for diagnostic or supplemental breast examinations, NCCN guidelines recommend annual screening mammograms with DBT for women at average and elevated risk of breast cancer.
[11] *Very strong evidence* indicates that there are multiple studies of a treatment, and the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.
[12] *Strong evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.
[13] *Some evidence* indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.
[14] *Not enough research* indicates that there are no studies of the treatment, or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

Table 4. Summary of Evidence of Medical Effectiveness of Supplemental Breast Screening and Diagnostic Breast Imaging for Cancer Detection

Modality	Supplemental Breast Screening	Diagnostic Breast Imaging
DBT, or 3D mammography	 (a)	
Breast US	 (a) (b)	
Breast MRI	 (a) (b)	
CEM	 (a) (b)	
MBI	 (a)	

Source: California Health Benefits Review Program, 2026.
Notes: (a) In women with dense breasts.
(b) In women with other risk factors.
Key: 3D = three-dimensional; CEM = contrast-enhanced mammography; DBT = digital breast tomosynthesis; MBI = molecular breast imaging; MRI = magnetic resonance imaging; US = ultrasound.

Based on the 2024 the United States Preventive Services Task Force (USPSTF) recommendation statement regarding supplemental breast screening, CHBRP determined that there is not enough research to assess the balance of benefits versus the risks and harms associated with supplemental screening for breast cancer in women who have dense breasts (Nicholson et al., 2024).

The current USPSTF recommendation statement concludes that there is insufficient evidence regarding the balance of benefits and harms of supplemental screening for breast cancer, but notes several harms associated with screening procedures (e.g., allergic reactions or leaking of contrast agents for MRI) and downstream consequences associated with increased false-positive rates. Primary screening and supplemental screening can result in false positive results from noncancerous lesions, cysts, or overdiagnosis of cancers that will not progress (Haas et al., 2016; Huang et al., 2021; Killelea et al., 2013). In these cases, it can lead to unnecessary interventions (further imaging, biopsies, treatment), as well as potential psychosocial consequences (NCCN, 2025).

Policy Context

Existing Law and Regulations

Preventive services

Both the California Preventive Services Mandate and the Federal Preventive Services Mandate require coverage of certain preventive services without cost sharing for enrollees in nongrandfathered[15] plans and policies following the USPSTF A and B recommendations[16] and the HRSA-supported health plan coverage guidelines for women's preventive services.[17,18] Additionally, in September 2025, Governor Newsom signed Assembly Bill 144, which requires nongrandfathered state-regulated health plans in California to cover preventive care services recommended by the federal government as of January 1, 2025, or recommended by the California Department of Public Health (CDPH), without cost sharing.[19]

Current as of March 2026, the USPSTF designates a Grade B recommendation to the following services relevant to AB 1570:

- Biennial screening mammography for women ages 40 to 74 years
- An "appropriate brief familial risk assessment tool" for breast cancer for women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with *BRCA*1 or *BRCA*2[20] gene mutation. Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

Current as of March 2026, the HRSA-supported health plan coverage guidelines for women's preventive services[21] recommend the following services relevant to AB 1570:

- Screening mammography – at least biennially and as frequently as annually – beginning between ages 40 and 50 years through at least age 74 years for women at average risk of breast cancer
- Additional imaging to complete the screening process or to address findings on the initial screening mammography for women at average risk of breast cancer. If additional imaging (e.g., magnetic resonance imaging, ultrasound, mammography) and pathology evaluation are indicated, these services also are recommended to complete the screening process for malignancies.
- Periodic screening mammography is indicated for women at elevated risk of breast cancer, but the guidelines specifically note that "additional services are beyond the scope of this recommendation" for this population.

While the services relevant to AB 1570 are recommended in some way by the USPSTF or HRSA, they are not recommended for all risk levels. For additional explanation of existing coverage without cost sharing, see Table 2 in the *Analytic Approach and Assumptions* section.

[15] Grandfathered health insurance was purchased on or before March 23, 2010. Grandfathered status may be lost if certain significant changes that reduce benefits or increase costs to consumers occur. A plan or policy becomes nongrandfathered if it does not fit this description.
[16] The USPSTF assigns one of five letter grades (A, B, C, D or I) to its recommendations. A grade A recommendation means the USPSTF recommends the service and finds high certainty that the net benefit is substantial. A grade B recommendation means the USPSTF recommends the service and finds high certainty that the net benefit is moderate or that there is moderate certainty that the net benefit is moderate to substantial.
[17] Health and Safety Code (HSC) 1367.002; Insurance Code (INS) 10112.2.
[18] More information about the state and federal requirements to cover specified preventive services is included in CHBRP's resource, *Federal Recommendations and the California and Federal Preventive Services Benefit Mandates*.
[19] HSC 120164.
[20] *BRCA1* (BReast CAncer gene 1) and *BRCA2* (BReast CAncer gene 2) are genes that produce proteins that help repair damaged DNA. People who inherit a harmful change (i.e., a mutation or pathogenic variant) in one of these genes have increased risks of several cancers, most notably breast and ovarian cancer. People who inherit a harmful change in *BRCA1* or *BRCA2* also tend to develop cancer at younger ages than people who do not have such a variant (NCI, 2024).
[21] The HRSA-supported health plan coverage guidelines for women's preventive services adopt certain recommendations from the Women's Preventive Services Initiative (WPSI). WPSI provides additional implementation considerations that are separate from clinical recommendations and not part of the guidelines as accepted by the Administrator.

Screening and diagnostic services

Separate from the preventive services mandates described above, California law requires that health plans and policies provide coverage for screening for, diagnosis of, and treatment for breast cancer.[22] Coverage for screening and diagnosis must be consistent with generally accepted medical practice and scientific evidence, upon the referral of the insured's participating physician.

California law also requires that health plans and policies provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.[23]

These state-specific laws do not include limitations on cost sharing for breast cancer screening, diagnostic, or treatment services.

Essential Health Benefits and the Affordable Care Act

Because the proposed mandate does not create a new coverage requirement, the screening and diagnostic services that are the subject of AB 1570 would not exceed the current definition of EHBs in California. For more details, see the Policy Framework under CHBRP's Technical Brief on AB 1570.

Similar Legislation in Other States

Thirty-one states have enacted legislation similar to AB 1570 to eliminate OOP costs for diagnostic and supplemental breast imaging for breast cancer in certain, if not all, state-regulated health plans.[24] Twelve states are currently considering similar legislation.[25]

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[22] HSC 1367.6, INS 10123.8.
[23] HSC 1367.65, INS 10123.81.
[24] This includes Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, New Hampshire, New Mexico, New York, Nevada, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Virginia, Vermont, Washington, and Wisconsin.
[25] This includes Indiana (HB 1061), New Jersey (S1275 and A3128), Kansas (SB 409), Rhode Island (H7276), Ohio (HB 271), North Carolina (H297), South Carolina (H3202), Arizona (SB 1165), Utah (HB 468), and Hawaii (HB 2366).

AB 1570 Impacts: Benefit Coverage, Utilization and Cost

CHBRP analyzes bills in the current environment given current law and regulations at both the state and federal levels. All estimates are based on current data and do not take into consideration any future or potential changes to factors that may influence the impacts of AB 1570, unless otherwise specifically mentioned.

CHBRP previously analyzed similar bill language for AB 2024 and SB 974 in 2022. Where applicable, this analysis builds from those previous analyses.

Cost-Related Analytic Approach and Assumptions

Baseline Coverage and Utilization

- As discussed in the *Overview* section, primary screening mammography (2D mammography or DBT) is currently covered without cost sharing under federal law and would not be impacted by this mandate. As such, CHBRP did not analyze the cost impacts of primary screening.
- As described in the *Overview* section, baseline coverage for supplemental screening and diagnostic breast imaging differs by risk level, with women at average risk of breast cancer having coverage without cost sharing for more services than women at intermediate or high risk of breast cancer. For the purposes of this analysis, women at intermediate and high risk of breast cancer are shown together as women at "elevated" risk, as they would gain coverage without cost sharing for the same services postmandate. Although there are minor differences in the supplemental screening guidelines for women at intermediate risk of breast cancer than for those at high risk, CHBRP determined that these differences are so small that they are unlikely to have a marginal impact on cost.
- As explained in the *Overview*, all enrollees in state-regulated health insurance are subject to AB 1570. However, CHBRP's modeling estimates utilization and cost impacts for women ages 40 to 64[26], given existing guideline recommendations for the services relevant to the bill. For additional information, see the *Analytic Approach and Assumptions: Language Interpretation* above.
- Given that baseline coverage for services relevant to AB 1570 differs by level of risk of breast cancer, CHBRP applies estimates from the Breast Cancer Surveillance Consortium (BCSC) to determine the percent of people who are at average, intermediate, or high risk of breast cancer nationally. Estimates for women ages 40 to 74 years were accessed through literature (Sprague et al., 2017) and adjusted by a content expert to reflect the 40- to 64-year-old population for the purposes of this bill analysis.[27] According to these estimates, 71.2% of women are at average risk, 23.8% are at intermediate risk, and 5.1% are at high risk of breast cancer.[28]
- CHBRP assumed 40% of commercial enrollees and 50% of Medi-Cal beneficiaries receive diagnostic services without a prior screening service at baseline, based on claims data in the 2023 Consolidated Health Cost Guidelines Database (CHSD). These factors are applied in the baseline to separate the average risk population into those who are and are not subject to cost sharing.
- CHBRP assumes that cost sharing is often applied to supplemental screening, diagnostic breast imaging, biopsy, and pathology evaluation for enrollees whose baseline coverage does not prohibit cost sharing.
- Starting October 1, 2028, the Department of Health Care Services (DHCS) will be required to implement cost sharing in Medi-Cal for certain tests, treatments, and services for the expansion population at or above 100% of the federal poverty level (FPL), per H.R. 1. CHBRP assumes that DHCS will impose a $5 copayment for Medi-Cal services as a result of H.R. 1 and incorporates this cost into its analysis of AB 1570, as Medi-Cal managed care and COHS plans are subject to this bill.

[26] CHBRP does not model impact for people over 64 years old, as Medicare is a federally regulated insurance market.
[27] Adjustments provided by Diana Miglioretti, PhD, University of California, Davis.
[28] These percentages add up to more than 100% due to rounding.

Postmandate Coverage and Utilization

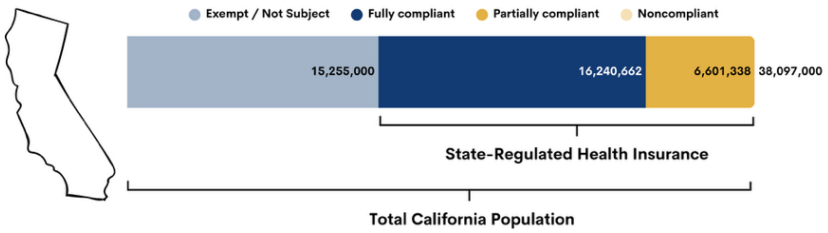
- CHBRP projects that utilization of supplemental screening, diagnostic breast imaging, biopsy, and pathology evaluation would increase postmandate among enrollees who would receive coverage for these services without cost sharing as a result of AB 1570. This change is attributable to the bill's elimination of cost-sharing for these services; utilization would increase based on the amount of cost sharing removed. For additional information on how increased utilization is estimated, see the Technical Brief on AB 1570.
- To estimate the percent of diagnostic services that are used without a primary screening, CHBRP uses estimates from the 2023 CHSD. For additional detail, see the Technical Brief on AB 1570.
- At baseline, 4% of enrollees in state-regulated health insurance are enrolled in HSA-eligible HDHPs. AB 1570 specifies that enrollees in HDHPs must meet their deductible for the plan year before receiving the services outlined in the bill without cost sharing. CHBRP incorporates this provision when projecting enrollee OOP spending and utilization changes. Should future changes to federal preventive services mandates change to cover enrollees in HDHPs without cost sharing for the services included in this analysis, the impacts found here would change.

For further details on the underlying data sources, methods, and assumptions used in this analysis, see the Technical Brief on AB 1570.

Benefit Coverage

CHBRP estimates that, at baseline, 6,601,338 Californians with state-regulated insurance subject to the mandate (29%) are enrolled in plans or policies that are not fully compliant with AB 1570, meaning they have coverage that allows for cost sharing for the mandated benefit. CHBRP estimates that 16,240,662 people are enrolled in plans or policies that are fully compliant (71%), meaning enrollees have coverage without cost sharing for the mandated benefit (Figure 3). Postmandate, CHBRP estimates that 22,842,000 Californians would have coverage compliant with AB 1570. For additional details on impacts to benefit coverage, see Table 10 in the Appendix.

Figure 3. Baseline Coverage Status for AB 1570



Utilization and Unit Cost

CHBRP estimates an increase in utilization of supplemental screening, diagnostic breast imaging, biopsy, and pathology evaluation among women at elevated risk of breast cancer postmandate. CHBRP also estimates an increase in utilization of diagnostic imaging, biopsy, and pathology evaluation services among women at any level of risk of breast cancer – including women at average risk – who do not receive a primary screening before seeking diagnostics, as women at all risk levels would gain coverage without cost sharing for such services. These increases are attributed to the bill's elimination of cost sharing for these services. This removal of cost sharing would impact both new and existing utilization. Percent increases in utilization for women at average risk of breast cancer are lower than for women at elevated risk because women at average risk have baseline coverage without cost sharing for more services (see Table 5).

CHBRP estimates changes in average per unit cost from AB 1570 due to the relative expected change in the proportion of utilization occurring in commercial plans relative to Medi-Cal. For more detail on this estimate, see the Technical Brief on AB 1570. Table 5 provides estimates of the impacts of AB 1570 on the number of enrollees who would newly utilize each service mandated by AB 1570 ("number of enrollees using mandated benefit") and the total number of services utilized ("total utilization"). CHBRP projects total utilization to be greater than the number of enrollees using services, as some

enrollees would likely use more than one service to complete an episode of care. Table 5 also shows the unit cost of relevant services.

For an outline of the impact of AB 1570 on cost sharing by test or service, see the Technical Brief on AB 1570.

Table 5. Impacts of AB 1570 on Utilization and Unit Cost, 2028

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Number of enrollees using mandated benefit – Average Risk Population				
2D mammogram	113,184	119,927	6,743	5.96%
DBT, or 3D mammography	69,049	73,162	4,114	5.96%
CEM (a)	66	66	0	0.00%
Breast MRI	24,370	25,822	1,452	5.96%
Breast US	128,462	136,116	7,653	5.96%
MBI	146	155	9	5.96%
Breast biopsy	61,283	64,934	3,651	5.96%
Pathology evaluation	61,283	64,934	3,651	5.96%
Number of enrollees using mandated benefit – Elevated Risk Population				
2D mammogram	46,006	52,858	6,852	14.89%
DBT, or 3D mammography	28,066	32,246	4,180	14.89%
CEM (a)	27	27	0	0.00%
Breast MRI	9,906	11,381	1,475	14.89%
Breast US	52,216	59,993	7,777	14.89%
MBI	59	68	9	14.89%
Breast biopsy	24,910	28,620	3,710	14.89%
Pathology evaluation	24,910	28,620	3,710	14.89%
Total utilization – Average Risk Population				
2D mammogram	171,553	178,562	7,009	4.09%
DBT, or 3D mammography	147,287	154,346	7,059	4.79%
CEM (a)	5,042	5,042	0	0.00%
Breast MRI	31,725	33,263	1,538	4.85%
Breast US	186,186	194,543	8,358	4.49%

	Baseline	Postmandate	Increase/Decrease	Percentage Change
MBI	202	208	6	3.10%
Breast biopsy	109,086	113,726	4,640	4.25%
Pathology evaluation	109,086	113,726	4,640	4.25%
Total utilization – Elevated Risk Population				
2D mammogram	69,731	76,734	7,003	10.04%
DBT, or 3D mammography	59,868	66,917	7,049	11.77%
CEM (a)	2,049	2,049	0	0.00%
Breast MRI	12,895	14,453	1,558	12.08%
Breast US	75,679	83,993	8,314	10.99%
MBI	82	88	6	7.33%
Breast biopsy	44,340	48,942	4,602	10.38%
Pathology evaluation	44,340	48,942	4,602	10.38%
Average per unit cost (b)				
2D mammogram	$249.28	$251.80	$2.53	1.01%
DBT, or 3D mammography	$191.40	$192.72	$1.32	0.69%
CEM (a)	$6.33	$6.33	$0.00	0.00%
Breast MRI	$1,272.18	$1,280.27	$8.09	0.64%
Breast US	$175.71	$177.21	$1.49	0.85%
MBI	$150.77	$153.24	$2.47	1.64%
Breast biopsy	$893.26	$901.95	$8.69	0.97%
Pathology evaluation	$111.35	$112.44	$1.09	0.98%

Source: California Health Benefits Review Program, 2026.
Notes: Although clinical guidelines recommend supplemental screenings for various risk levels, CHBRP found that the services outlined in Table 5 are rarely billed as supplemental screenings. It is common in clinical practice for services used as supplemental screening tools to be coded as diagnostic tools.[29]
(a) CHBRP estimates that CEM utilization and unit cost would increase as a result of AB 1570; however, given low baseline utilization and unit cost, the percent change for both estimates is a fraction of a percent that rounds to zero.
(b) Average unit costs for the services relevant to AB 1570 are expected to increase due to the relative expected change in the proportion of utilization occurring in commercial plans relative to Medi-Cal. Because a greater share of use will occur in commercial plans relative to Medi-Cal plans, the average unit cost will rise even though there is no change in any given individual unit cost.
Key: 2D = two-dimensional; CEM = contrast-enhanced mammography; DBT = digital breast tomosynthesis; MRI = magnetic resonance imaging; US = ultrasound.

[29] Conversation with Content Expert, Laura Esserman, MD, MBA, University of California, San Francisco. February 10, 2026.

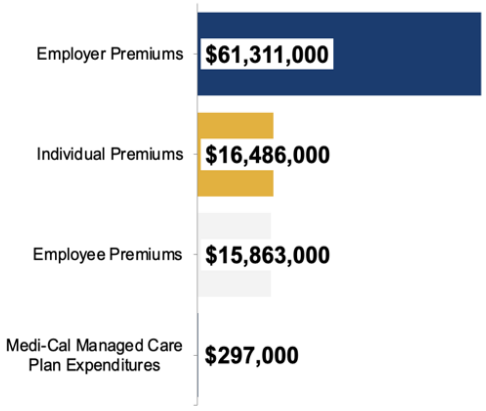
Expenditures and Premium Impacts

Insurance benefit coverage mandates impact stakeholders in distinct ways. In terms of direct costs, these stakeholders can generally be grouped into two categories: (1) enrollees who utilize the benefit,[30] and (2) those who pay for the benefit but do not utilize it. Enrollees who use a benefit may be responsible for paying premiums and any OOP expenses related to the benefit. All enrollees within a risk pool share in these costs through the benefit's impact on plan premiums.

Expenditure Impacts on Employers and All Enrollees

As shown in Figure 4, for DMHC-regulated plans and CDI-regulated policies, AB 1570 would increase total premiums paid by employers and enrollees for newly covered benefits by approximately $93,957,000. For more details, see Table 12 in the Appendix. Enrollee premiums calculated include premiums for enrollees using the benefit and for enrollees not using the benefit. No measurable offsets are projected. Changes in per member per month (PMPM) premiums as a result of AB 1570 would vary by market segment (Table 6; see also Table 11 and Table 12 in Appendix).

Figure 4. Expenditure Impacts of AB 1570 on Employers and Enrollees



Insurance premiums are shared between an employer and their employee or paid exclusively by an enrollee (individually purchased insurance) or public insurance programs. Below, Table 7 provides estimates of the aggregate impacts of AB 1570 on premiums for non-enrollees (i.e., employers, public insurance) and enrollees.

Table 6. Premium Impact Ranges of AB 1570 by Market Segment

Market Segment	Premium Impact Range (PMPM)
Commercial plans/policies	$0.56 – $0.59
Covered California – individually purchased	$0.55 – $0.64
CalPERS	$0.60
Medi-Cal	<$0.01

Source: California Health Benefits Review Program, 2026.
Key: CalPERS = California Public Employees' Retirement System.

Table 7. Impacts of AB 1570 on Premiums, 2028

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Non-enrollee premiums				

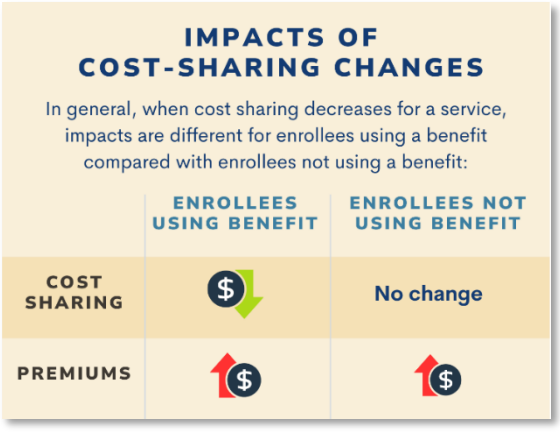
[30] Depending on their health insurance and the benefit in question, enrollees may or may not also pay for the benefit. For example, most Medi-Cal beneficiaries do not have cost sharing and do not pay health insurance premiums, whereas enrollees with health insurance a plan in the individual market may pay both insurance premiums and cost sharing or other OOP expenses.

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Employer-sponsored (a)	$75,730,916,000	$75,786,595,000	$55,679,000	0.07%
CalPERS employer (b)	$8,611,855,000	$8,617,487,000	$5,632,000	0.07%
Medi-Cal	$42,982,384,000	$42,982,681,000	$297,000	<0.01%
Enrollee premiums				
Enrollees, individually purchased insurance	$25,775,325,000	$25,791,811,000	$16,486,000	0.06%
Outside Covered California	$9,551,761,000	$9,557,971,000	$6,210,000	0.07%
Through Covered California	$16,223,564,000	$16,233,840,000	$10,276,000	0.06%
Enrollees, group insurance (c)	$21,828,135,000	$21,843,998,000	$15,863,000	0.07%
Total premiums	**$174,928,615,000**	**$175,022,572,000**	**$93,957,000**	**0.05%**

Source: California Health Benefits Review Program, 2026.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 49.0% are state retirees, state employees, or their dependents. About one in five (20.4%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated or COHS plan.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

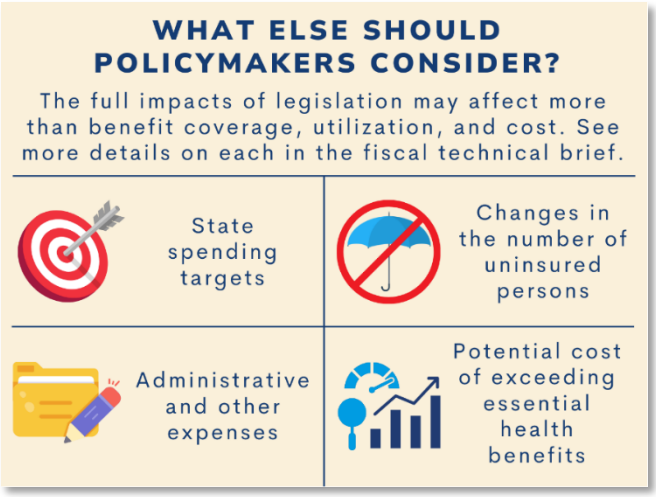
Enrollee Expenses for Benefit Users

AB 1570 would reduce average annual enrollee expenses – defined as cost sharing for covered benefits and OOP expenses for non-covered benefits – for enrollees who receive and utilize new benefit coverage without cost sharing from the bill. These reductions average to $85.17 per year for commercial and individual plan enrollees, with variation by market segment: large group enrollees would see annual enrollee expenses reduced by $84.11, small group enrollees by $82.29, individual plan enrollees by $84.47, CalPERS enrollees by $89.92, and Medi-Cal beneficiaries by $1.04. Enrollee expenses would not change for users who have baseline coverage without cost sharing, although their premiums would increase (see above). For more information and a comparison of enrollee expense changes for users who would and would not gain new coverage without cost sharing, see Table 8.



For enrollees in HDHPs, the requirement to meet the deductible for the year before receiving coverage without cost sharing[31] could

[31] For estimates of enrollees in plans and policies with deductibles, see CHBRP's resource *Deductibles in State-Regulated Health Insurance.*



result in different annual enrollee expenses. HDHP enrollees would have no further cost sharing once meeting their deductible or hitting their annual OOP maximum.

Average enrollee expenses for those enrollees not utilizing the benefit would not change, as they would not experience the elimination of cost sharing realized by enrollees using the services with new coverage without cost sharing (see Table 9). However, enrollees not utilizing the benefit would still experience an increase in premiums (see above). CHBRP estimates are based on claims data and may underestimate the cost savings for enrollees due to plans and insurers negotiating discounted rates that are unavailable to patients and their families.

See more information in the Technical Brief on AB 1570, including what else policymakers should consider such as state spending targets, impacts to the number of uninsured in California, changes in public program enrollment, and administrative and other expenses.

Table 8. Average Annual Enrollee Expenses for Users

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
Users with baseline benefit coverage					
% of population with enrollee expenses impact due to AB 1570	3.78%	3.78%	3.78%	3.78%	2.18%
Average annual enrollee expenses impact for users	$0.00	$0.00	$0.00	$0.00	$0.00
Users with new benefit coverage					
% of population with enrollee expenses impact due to AB 1570	5.08%	5.08%	5.08%	5.08%	2.93%
Average annual enrollee expenses impact for users	−$84.11	−$82.29	−$84.47	−$89.82	−$1.04

Source: California Health Benefits Review Program, 2026.
Notes: Average enrollee expenses includes cost sharing (e.g., deductibles, copays, etc.) for covered benefits and OOP expenses for noncovered benefits. Average annual enrollee premium impact includes the employee portion of the premium only. CHBRP assumes a uniform distribution of the elevated risk populations in commercial insurance markets.
Key: CalPERS = California Public Employees' Retirement System; OOP =out of pocket.

Table 9. Average Annual Enrollee Expenses and Premium Impact for Non-Users

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
% of population without enrollee expenses impact due to AB 1570	94.92%	94.92%	94.92%	94.92%	97.07%
Average annual enrollee premium expenses impact for non-users	$6.74	$6.97	$6.63	$7.19	$0.03
Average annual enrollee expenses impact for non-users	$0.00	$0.00	$0.00	$0.00	$0.00

Source: California Health Benefits Review Program, 2026.
Notes: Average enrollee expenses includes cost sharing (e.g., deductibles, copays, etc.) for covered benefits and OOP expenses for noncovered benefits. Average annual enrollee premium impact includes the employee portion of the premium only. CHBRP assumes a uniform distribution of the elevated risk populations in commercial insurance markets.
Key: CalPERS = California Public Employees' Retirement System; OOP =out of pocket.

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Public Health Impacts

The public health impact analysis includes estimated impacts in the short term (within 12 months of full implementation) and in the long term (beyond the first 12 months following full implementation). This section estimates the short-term impact of AB 1570 on coverage without cost sharing for supplemental screening, diagnostic breast imaging, biopsy, and pathology evaluation for breast cancer on health outcomes, disparities, harms, and financial burden.

Estimated Health Outcomes

As presented in the *Overview* section, CHBRP finds a range of *very strong* to *some* evidence that the modalities used for supplemental screening for breast cancer are effective for detecting abnormalities, and *some* evidence of their effectiveness for diagnostic imaging to evaluate an abnormality or suspicious lesion. CHBRP finds *not enough research* to determine the effectiveness of MBI for diagnostic imaging (see Table 4).

As presented in Table 5 in the *Benefit Coverage, Utilization, and Cost Impacts* section, CHBRP estimates that, postmandate, fewer than 40,263[32] women would newly access supplemental screening and diagnostic imaging for breast cancer without cost sharing. AB 1570 would lead to an additional 66,384 supplemental screenings, diagnostic imaging services, biopsies, and pathology evaluations for breast cancer without cost sharing. As described above and in the Technical Brief on AB 1570, cost sharing is reported as a primary, but not exclusive, barrier to obtaining supplemental screening and diagnostic imaging for breast cancer. The removal of this barrier by AB 1570 would lead to this increased utilization.

Breast Cancer Diagnoses

Although most new users would receive negative readings from supplemental screenings and diagnostic images, those who receive positive readings indicating suspicious abnormalities would progress to biopsy. Based on national data, between 70% and 80% of breast biopsies have negative findings (Vlahiotis et al., 2018). Using this estimate, along with CHBRP's estimated 7,361 additional biopsies as a result of AB 1570, the bill could result in approximately 1,840 breast cancer cases being diagnosed[33] earlier due to the removal of cost sharing for imaging services. However, the impact of reducing delayed cancer diagnoses on morbidity and mortality outcomes is unknown.

Implications of Delayed Breast Cancer Diagnoses

Delayed diagnostic evaluations typically lead to delayed treatment, which can – but does not always – have an adverse effect on breast cancer outcomes. For example, triple-negative breast cancer is a hard-to-treat, aggressive cancer that comprises 10% to 15% of breast cancer cases and occurs more commonly in younger women and those who are Black, Hispanic or of Indian descent. It has a high risk of recurrence and poor outcomes (Leon-Ferre et al., 2024; Luckstein, 2024). Earlier diagnosis of triple-negative breast cancer usually results in better outcomes with earlier treatment, which can reduce the chance of breast cancer recurrence and mortality (Chaudhary, 2020). By contrast, despite a delayed diagnosis, slow-growing cancers would be diagnosed eventually through regular primary screening schedules and receive similar treatment and similar health outcomes. For example, increased screening following AB 1570 would detect more ductal carcinoma *in situ* (DCIS), which is a noninvasive, pre-cancerous finding. Evidence shows that, despite increasing detection of DCIS and subsequent treatment over the last 20 years, its identification and treatment has not been found to reduce advanced-stage cancer incidence or reduce mortality rates (van der Borden et al., 2019). Studies following DCIS outcomes over 15 to 25 years reported that between 25% and 50% of DCIS progresses to invasive stages (Co, 2020).

[32] Some women will use more than one imaging service during their screening and/or diagnosis episode of care. However, the number of overlapping services used during that episode is unknown. CHBRP estimates the maximum number of unique new users by summing the marginal change in number of enrollees using the mandated benefit by modality as presented in Table 5, excluding biopsy and pathology evaluation, as those services would be used only by women already accounted for through their use of supplemental screening and diagnostic imaging.
[33] Total increase in biopsies for average- and elevated-risk enrollees = 7,361 biopsies (Table 1). National data estimates that 25% of breast biopsies have cancer findings (0.25 x 7,361=1,840).

Thus, some enrollees could be overtreated by incurring unnecessary treatment and cost for cancers that would not have become invasive. Clinical research is still being conducted to better predict which DCIS lesions progress to invasive breast cancer (van der Borden et al., 2019).

Health Outcomes: Postmandate, AB 1570 would remove cost sharing for covering supplemental screening, diagnostic imaging, biopsy, and pathology evaluation for breast cancer, which would result in increased use of supplemental screening and diagnostic imaging for fewer than 40,263 women. Approximately 1,840 women would avoid a delay in breast cancer diagnosis that might otherwise occur with cost sharing in place.

AB 1570 would produce an unknown impact on breast cancer morbidity and mortality due to unknown types and stages of breast cancers diagnosed.

Potential Effects of AB 1570 on Disparities in Breast Cancer Diagnosis

Differences exist in breast cancer incidence and mortality rates by race and ethnicity. This is likely due to the complex interplay among an unequal distribution of breast cancer molecular subtypes, genetic and lifestyle factors (both protective and risk factors), screening rates, socioeconomic factors, and access to follow-up care and treatment (Hill et al., 2019; Newman, 2017). In California, Black and Hispanic women are more likely than White women to be diagnosed with more advanced cancer stages at younger ages and experience higher mortality rates (Hendrick et al., 2021). One estimate showed that 23% of breast cancers diagnosed in Black women occur in those younger than screening guideline recommendations as compared with 16% of White women (Oppong et al., 2021).

Some diagnostic and mortality disparities are linked to the presence of certain cancer subtypes; those with the most favorable outcomes (HR-positive/*HER2*-negative) occur 23% more often in White women than Black women (age-adjusted) (Gehlert et al., 2021). By contrast, triple-negative breast cancer, an aggressive form of cancer with poorer outcomes, is significantly more prevalent among Black women aged 50 years and younger (21%) than in White women (10%) (Rebner and Pai, 2020). The prevalence of mutations in the BRCA1/BRCA2 genes, which are associated with the highest risk for breast cancer, also vary by race/ethnicity, with highest rates found among Ashkenazi Jewish women and Black women, and lowest rates found among Asian American women (John et al., 2007; Rebner and Pai, 2020).

Disparities: The impact of AB 1570 on health disparities by race/ethnicity, income, or insurance status is unknown. To the extent that lower income women are more likely to forgo medically necessary breast imaging and related tests due to cost sharing at baseline, AB 1570 could reduce disparities in access to breast cancer screening and diagnosis. Similarly, to the extent that Black and Hispanic women at higher risk of breast cancer are more likely to forgo medically necessary breast imaging and related tests due to cost sharing at baseline, AB 1570 could reduce disparities in access to care. The impact on enrollees in HSA-eligible HDHPs is unknown because annual deductibles (ranging from $1,650 - $10,150) must be met before coverage without cost sharing for screening and diagnostic testing becomes effective.

Potential Harms Associated With Supplemental Screening and Diagnostic Imaging

As noted above, primary and supplemental screening can result in false-positive findings where lesions, such as cysts, lead to more tests but are ultimately found to be non-cancerous. Additionally, breast cancer overdiagnoses occur for some cancers that will never become invasive. In both situations, adverse effects can occur from unnecessary follow-up testing and treatment (Elmore and Lee, 2026). A USPSTF systematic review identified several harms associated with supplemental screening, including allergic reactions to contrast agents or leaking of contrast agents (for MRI or CEM) and downstream consequences including increased false positive rates. However, as noted above, the USPSTF recommendation statement concludes that the evidence regarding the balance of benefits and harms is insufficient (Henderson et al., 2024). The NCCN notes that people in higher risk categories have a lower likelihood of a false-positive

test and therefore have lower potential for harms; thus, their recommendations for supplemental screening focus on higher risk categories (NCCN, 2025). Other potential harms from additional imaging and biopsy can result in greater OOP expenses, psychological stress/anxiety, and physical pain associated with the imaging or biopsy test (e.g., bruising, scarring, etc.) (Ontario Health Quality, 2023).

Potential Harms: Postmandate, additional imaging from the covered modalities would result in proportionately more false-positive findings; however, CHBRP is unable to quantify the impact of AB 1570 on the number or effect of the increased number of false positive findings on adverse effects, such as physical pain, anxiety, added biopsy expense, and/or overtreatment.

Potential Enrollee Financial Impacts

Perceptions of cost sharing can affect care-seeking behavior and provide context for the role that cost sharing may play for women needing to complete recommended supplemental screening and/or diagnostic imaging (see the Technical Brief on AB 1570 for details). Health care costs comprise an increasing proportion of household income, and medical debt is reported by many California households. For example, according to a California Heath Care Foundation report, 60% of California adult respondents reported they or a family member avoided care in the last 12 months to save money (70% of low income; 55% with higher income) (Joynt et al., 2026). Thirty-six percent reported the major reason they skipped care was because they could not afford the insurance copayment or other costs despite insurance coverage (32% reported it as a minor reason). Among those with medical debt, 49% reported that diagnostic tests such as MRIs contributed to their debt (Joynt et al., 2026).

More specifically, evidence shows that higher OOP costs are associated with delayed or skipped supplemental breast cancer screening or diagnostic imaging, especially among people with lower incomes and/or HDHPs (ACS CAN, 2025; Ngo et al. 2023). In California, OOP costs for supplemental imaging and diagnostic imaging and tests accounted for an estimated 24% of total cost of that bundle of care (ACS CAN, 2025). Delays in diagnosis may lead to delays in treatment and might affect health outcomes adversely for some women while others would see no difference outcomes due to delays (Hoveling et al., 2025).

Potential Financial Impacts: Postmandate, fewer than 40,263 women would newly access supplemental or diagnostic breast imaging services and tests through the elimination of cost sharing, a known barrier to access. Enrollees using the benefit would save an estimated average of $85.17 in annual enrollee expenses per year among commercial and individual enrollees. Enrollees in HDHPs would need to meet their deductible before the $0 cost-share provision became active.

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AB 1570 Impacts: Long-Term

In this section, CHBRP addresses the long-term impact of AB 1570, which CHBRP defines as impacts occurring beyond the first 12 months after legislation is fully implemented.[34] These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

CHBRP projects that long-term utilization and cost impacts may vary with the evolution of breast cancer screening guidelines and breast screening technology, potentially resulting in more precisely targeted screening and thus less utilization, or promotion of new technologies resulting in increased utilization.[35]

Long-Term Public Health Impacts

Assuming that current imaging technology and guidelines remain stable, CHBRP estimates that the use of supplemental screening, diagnostic imaging and related testing would remain relatively stable beyond the first year postmandate. As in the first postmandate year, CHBRP does not anticipate long-term population-level measurable change in the annual number of cancer treatments, because the additional imaging would result in earlier, but not additional, diagnoses. Similar to the short-term impacts, on the person-level, some women might receive less intensive cancer treatments in the future because cancers were identified at an earlier stage due to the elimination of cost sharing. However, others might experience adverse impacts due to unnecessary treatment related to false-positive imaging results.

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[34] Full-scale implementation typically requires a “ramp up” period which may include educating enrollees, providers and insurance carriers on the new benefits or coverage, updating procedures and policies, and increasing provider capacity for marginal utilization resulting from AB 1570, Furthermore, some policies may have staggered implementation or longer-term changes in utilization. The short-term, incremental impact estimated by CHBRP assumes there is no “ramp up” period and represent ongoing annual costs at full-scale implementation of AB 1570, including potential short-term offsets. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.
[35] Discussion with content expert Laura Esserman, MD, MBA, University of California, San Francisco. February 10, 2026.

Appendix. Impacts of AB 1570 on Benefit Coverage and Expenditures, 2028

Table 10. Impacts of AB 1570 on Benefit Coverage, 2028

	Baseline	Postmandate	Increase / Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	22,842,000	22,842,000	0	0.00%
Total enrollees with health insurance subject to AB/SB 1570	22,842,000	22,842,000	0	0.00%
Percentage of enrollees with coverage for mandated benefit	71%	100%	29%	40.65%
Number of enrollees with fully compliant coverage for mandated benefit	16,240,662	22,842,000	6,601,338	40.65%

Source: California Health Benefits Review Program, 2026.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[36]
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

[36] For more detail, see CHBRP's resource Sources of Health Insurance in California.

Table 11. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to AB 1570	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Premium costs										
Average portion of premium paid by employer (e)	$619.33	$539.05	$0.00	$770.84	$367.89	$632.17	$780.34	$573.31	$0.00	$127,325,155,000
Average portion of premium paid by enrollee	$134.02	$263.52	$864.90	$145.41	$0.00	$0.00	$184.88	$242.16	$832.16	$47,603,460,000
Total premium	**$753.35**	**$802.56**	**$864.90**	**$916.25**	**$367.89**	**$632.17**	**$965.22**	**$815.47**	**$832.16**	**$174,928,616,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$56.38	$184.07	$271.63	$70.59	$0.00	$0.00	$126.72	$213.52	$192.93	$19,432,815,000
Expenses for noncovered benefits (f)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$809.72**	**$986.63**	**$1,136.53**	**$986.84**	**$367.89**	**$632.17**	**$1,091.94**	**$1,029.00**	**$1,025.09**	**$194,361,431,000**

Source: California Health Benefits Review Program, 2026.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[37]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

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[37] For more detail, see CHBRP's resource Sources of Health Insurance in California.

Table 12. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to AB 1570	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Premium costs (postmandate change										
Average portion of premium paid by employer (e)	$0.4612	$0.3897	$0.0000	$0.5041	$0.0027	$0.0027	$0.4715	$0.4154	$0.0000	$61,608,000
Average portion of premium paid by enrollee	$0.0998	$0.1905	$0.5514	$0.0951	$0.0000	$0.0000	$0.1117	$0.1754	$0.6378	$32,349,000
Total premium	$0.5610	$0.5803	$0.5514	$0.5992	$0.0027	$0.0027	$0.5832	$0.5908	$0.6378	**$93,957,000**
Enrollee expenses (postmandate change)										
Cost sharing for covered benefits (deductibles, copays, etc.)	-$0.3558	-$0.3478	-$0.3574	-$0.3800	-$0.0025	-$0.0025	-$0.3577	-$0.3664	-$0.3556	-$59,316,000
Expenses for noncovered benefits (f)	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
Total expenditures	$0.2052	$0.2325	$0.1940	$0.2192	$0.0002	$0.0002	$0.2255	$0.2244	$0.2822	**$34,641,000**
Postmandate percent change										
% change insured premiums	0.0745%	0.0723%	0.0638%	0.0654%	0.0007%	0.0004%	0.0604%	0.0724%	0.0766%	0.0537%
% change total expenditures	0.0253%	0.0236%	0.0171%	0.0222%	0.0001%	0.0000%	0.0207%	0.0218%	0.0275%	0.0178%

Source: California Health Benefits Review Program, 2026.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents.
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[38]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

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[38] For more detail, see CHBRP's resource Sources of Health Insurance in California.

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CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research. A group of faculty, researchers, and staff complete the analysis that informs CHBRP reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with an independent actuarial firm, **Milliman, Inc.**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

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Acknowledgments

CHBRP gratefully acknowledges the efforts of the team contributing to this analysis:

Joy Melnikow, MD, MPH, and Meghan Soulsby Weyrich, MPH, of the University of California, Davis, prepared the medical effectiveness analysis. Megan Van Noord, MS, of the University of California, Davis, conducted the literature search. Joy Melnikow, MD, MPH, and Dominique Ritley, MPH, of the University of California, Davis, prepared the background and public health impact analysis. Timothy T. Brown, PhD, of the University of California, Berkeley, prepared the cost impact analysis. Dan Henry, FSA, MAAA, and Addison Luria-Roberson of Milliman provided actuarial analysis. Laura Esserman, MD, MBA, of the University of California, San Francisco, and Diana Miglioretti, PhD, of the University of California, Davis, provided technical assistance with the literature search and expert input on the analytic approach. Anna Pickrell, MPH, of CHBRP staff prepared the Overview and Policy Context and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see previous page of this report) and members of the CHBRP Faculty Task Force, Sylvia Guendelman, PhD, LCSW, of the University of California, Berkeley; Nadereh Pourat, PhD, of the University of California, Los Angeles; and Elizabeth Magnan, MD, PhD, of the University of California, Davis, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program, MC 3116, Berkeley, CA 94720-3116; info@chbrp.org; or chbrp.org.

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. CHBRP's mission is to inform and support policymaking in California through the creation of impartial, evidence-based resources. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. CHBRP is dedicated to providing academic rigor on a Legislature's timeline.

The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. An independent actuarial firm helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

Disclaimer

CHBRP analyzes bills in the current environment given current law and regulations at both the state and federal levels. Each analysis assumes that policy frameworks and stakeholder behaviors remain constant, unless otherwise noted. All estimates are based on current data and do not take into consideration any future or potential changes to factors that may influence the impacts of the legislation, unless otherwise specifically mentioned. Differences between CHBRP's estimated impacts and actual impacts of legislation will depend on alignment with the assumptions used in this analysis, the timeline of implementation, and the final language of the legislation, should it be signed into law. Since actual experience is unlikely to match assumptions perfectly, final impacts will differ from those projected in this analysis.

This analysis is based on existing literature and public sources identified through systematic search methods. This evidence informs the California Legislature about potential impacts of proposed health benefit legislation and does not constitute a policy recommendation from CHBRP.

CHBRP utilized Artificial Intelligence for this analysis to support a calculation estimating the potential value of cost sharing for Medi-Cal starting in 2028. This calculation was human verified for accuracy, reliability, and safety in compliance with University of California, Berkeley AI policies.

For more information about CHBRP's methods and approach, please visit our website.

Suggested Citation

California Health Benefits Review Program (CHBRP). (2026). *Analysis of California Assembly Bill 1570 Diagnostic Imaging*. Berkeley, CA.