TECHNICAL BRIEF

AB 1570

Diagnostic Imaging

CHBRP

About the Technical Brief

This document provides further detail on the analytical foundation for CHBRP's analysis of AB 1570. While the main report synthesizes key findings for immediate policy consideration, this document is designed to support a deeper understanding of the background of the topic of the legislation and CHBRP's methodology and research in conducting its analysis. It contains the data sources, methods, assumptions, and other bill-specific considerations necessary for legislative staff, fiscal analysts, and other stakeholders to fully understand the scope and impact of the proposed measure.

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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. 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* below. For a detailed explanation of how these tests and services are used in clinical practice, see Table 3 Breast Cancer Screening Modalities Covered by AB 1570 in the Analysis of California Assembly Bill 1570.

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[1]). 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.[2] 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.[3]
- **Health Savings Account–qualified HDHPs:** To be eligible to establish a Health Savings Account (HSA) for taxable years beginning after December 31, 2003[4] (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.

[1] 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.
[2] HealthCare.gov, Glossary: High Deductible Health Plan (HDHP). Accessed March 5, 2021.
[3] IRS Revenue Procedure 2025-19, 2025-18 IRB 1430.
[4] 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.

Legislative Text Analyzed

SECTION 1.

Section 1367.65 of the Health and Safety Code is amended to read:

1367.65.

(a) ~~On or after January 1, 2000, each~~ *(1) A* health care service plan ~~contract, except~~ *contract issued, amended, or renewed on or after January 1, 2000, excluding* a specialized health care service plan contract, ~~that is issued, amended, delivered, or renewed shall be deemed to~~ *shall* 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.

~~(b)~~

(2) This ~~section~~ *subdivision* does not prevent application of copayment or deductible provisions in a plan, nor shall this ~~section~~ *subdivision* be construed to require that a plan be extended to cover any other procedures under an individual or a group health care service plan contract. ~~This section does not authorize a plan enrollee to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, unless the plan enrollee is referred to that provider by a participating physician, nurse practitioner, or certified nurse-midwife providing care.~~

(b) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2028, excluding a specialized health care service plan contract, shall provide coverage without imposing cost sharing for screening mammography, medically necessary diagnostic or supplemental breast examinations, 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. Diagnostic breast imaging includes breast magnetic resonance imaging, breast ultrasound, and other clinically indicated diagnostic testing. Diagnostic breast imaging, diagnostic mammography, and diagnostic and supplemental breast examinations, or other clinically indicated diagnostic testing are covered under this subdivision to the extent it is consistent with nationally recognized evidence-based clinical guidelines.

(2) (A) Paragraph (1) applies to a health care service plan contract that meets the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code only after an enrollee's deductible has been satisfied for the year.

(B) Notwithstanding subparagraph (A), paragraph (1) applies to a health care service plan contract that meets the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code with respect to items or services that are preventative care pursuant to Section 223(c)(2)(C) of Title 26 of the United States Code regardless of whether an enrollee's deductible has been satisfied for the year.

(c) (1) This section does not authorize an enrollee to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, except as specified in paragraph (2).

(2) A plan shall arrange for the provision of services required by this section from providers outside the plan's network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Section 1367.03.

(d) Subdivision (b) does not preclude a health care service plan that provides coverage for out-of-network benefits from imposing cost-sharing requirements for the items or services described in this section that are delivered by an out-of-network provider, except in the situation described in paragraph (2) of subdivision (c) and as otherwise required by law.

(e) For the purposes of this section:

(1) "Breast magnetic resonance imaging" means a diagnostic tool that uses a powerful magnetic field, radio waves, and a computer to produce detailed pictures of the structures within the breast.

(2) "Breast ultrasound" means a noninvasive diagnostic tool that uses high-frequency sound.

(3) "Cost sharing" means 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.

(4) "Diagnostic breast examination" means a medically necessary and appropriate, in accordance with the National Comprehensive Cancer Network 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 either of the following:

(A) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer.

(B) Used to evaluate an abnormality detected by another means of examination.

(5) "Diagnostic mammography" means a diagnostic tool that uses x-ray and is designed to evaluate an abnormality in the breast.

(6) "Supplemental breast examination" means a medically necessary and appropriate, in accordance with the National Comprehensive Cancer Network Guidelines, examination of the breast, including an examination using contrast-enhanced mammography, breast magnetic resonance imaging, breast ultrasound, or molecular breast imaging, that is either of the following:

(A) Used to screen for breast cancer when an abnormality is not seen or suspected.

(B) 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.

SEC. 2.

Section 10123.81 of the Insurance Code is amended to read:

10123.81.

(a) ~~An individual or group policy of~~ *(1) A* disability insurance *policy* or self-insured employee welfare benefit plan shall be deemed to provide coverage for mammography for screening or diagnostic purposes upon the referral of 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.

~~(b)~~

(2) This ~~section~~ *subdivision* does not prevent the application of copayment or deductible provisions in a policy, nor does this section require that a policy be extended to cover any other procedures under an individual or a group policy. ~~This section does not authorize a policyholder to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, unless the policyholder is referred to that provider by a participating physician, nurse practitioner, or certified nurse-midwife providing care.~~

(b) (1) A health insurance policy that provides hospital, medical, or surgical coverage or a self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1, 2028, shall provide coverage without imposing cost sharing for screening mammography, medically necessary diagnostic or supplemental breast examinations, 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 insured indicated to have a risk factor associated with breast cancer, including family history or known genetic mutation. Diagnostic breast imaging includes breast magnetic resonance imaging, breast ultrasound, and other clinically indicated diagnostic testing. Diagnostic breast imaging, diagnostic mammography, and diagnostic and supplemental breast examinations, or other clinically indicated diagnostic testing are covered under this subdivision to the extent it is consistent with nationally recognized evidence-based clinical guidelines.

(2) (A) Paragraph (1) applies to a health insurance policy that meets the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code only after an insured's deductible has been satisfied for the year.

(B) Notwithstanding subparagraph (A), paragraph (1) applies to a health insurance policy that meets the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code with respect to items or services that are preventative care pursuant to Section 223(c)(2)(C) of Title 26 of the United States Code regardless of whether an insured's deductible has been satisfied for the year.

(c) (1) This section does not authorize an insured to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, except as specified in paragraph (2).

(2) An insurer shall arrange for the provision of services required by this section from providers outside the insurer's contracted network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Sections 10133 and 10133.54.

~~(c)~~

(d) This section ~~shall~~ *does* not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

(e) Subdivision (b) does not preclude a disability insurer that provides coverage for out-of-network benefits from imposing cost-sharing requirements for the items or services described in this section that are delivered by an out-of-network provider, except in the situation described in paragraph (2) of subdivision (c) and as otherwise required by law.

(f) For the purposes of this section:

(1) "Breast magnetic resonance imaging" means a diagnostic tool that uses a powerful magnetic field, radio waves, and a computer to produce detailed pictures of the structures within the breast.

(2) "Breast ultrasound" means a noninvasive diagnostic tool that uses high-frequency sound.

(3) "Cost sharing" means 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.

(4) "Diagnostic breast examination" means a medically necessary and appropriate, in accordance with the National Comprehensive Cancer Network 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 either of the following:

(A) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer.

(B) Used to evaluate an abnormality detected by another means of examination.

(5) "Diagnostic mammography" means a diagnostic tool that uses x-ray and is designed to evaluate an abnormality in the breast.

(6) "Supplemental breast examination" means a medically necessary and appropriate, in accordance with the National Comprehensive Cancer Network Guidelines, examination of the breast, including an examination using contrast-enhanced mammography, breast magnetic resonance imaging, breast ultrasound, or molecular breast imaging, that is either of the following:

(A) Used to screen for breast cancer when an abnormality is not seen or suspected.

(B) 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.

SEC. 3.

No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Policy Framework

This technical brief provides additional material to support the findings and recommendations presented in CHBRP's Analysis of Assembly Bill 1570 Diagnostic Imaging.[5] The following sections contain details on the California and federal landscape. Although this information is essential to the completeness of the analysis, it has been placed in this separate brief to maintain the flow of the main report. Readers are encouraged to consult this material for deeper insights into existing laws and technical details that informed the analysis and conclusions of the main report.

California Policy Landscape

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[6] plans and policies following these four sets of Federal recommendations:[7,8]

- The United States Preventive Services Task Force (USPSTF) A and B recommendations[9];
- The Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for women's preventive services;
- The HRSA-supported comprehensive guidelines for infants, children, and adolescents, which include:
    - The Bright Futures Recommendations for Pediatric Preventive Health Care; and
    - The recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
- The Advisory Committee on Immunization Practices (ACIP) recommendations that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC).

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 CDPH, without cost sharing.[10]

Previous California Legislation

AB 2024 Breast Imaging and SB 974 Breast Imaging, which were proposed in 2022, would have mandated coverage for the same services as AB 1570. AB 2024 was held in the Senate Appropriations Committee, and SB 974 was vetoed by the Governor.[11]

A substantially similar bill was introduced in 2023 as SB 257 Health Care Coverage: Diagnostic Imaging. This bill was vetoed by the Governor.

[5] California Health Benefits Review Program (CHBRP). (2026). *Analysis of California Assembly Bill 1570 Health Care Coverage: Diagnostic Imaging.* Berkeley, CA.
[6] 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.
[7] HSC 1367.002; INS 10112.2.
[8] 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*.
[9] 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.
[10] HSC 120164.
[11] CHBRP completed analyses of AB 2024 Breast Imaging and SB 974 Breast Imaging in 2022.

Other Relevant California Programs

Every Woman Counts (EWC) is a state program that provides free breast and cervical cancer screening and diagnostic services to California's underserved populations. The mission of EWC is to mitigate the medical, emotional, and financial effects of breast and cervical cancer, and eliminate health disparities for medically underserved, low-income people. Eligibility rules require that participants: be a woman 40 years or older or exhibit certain symptoms; meet certain income criteria; have no or limited insurance; be unable to receive services through Medi-Cal or a government-sponsored program; and live in California (DHCS, 2026a).

Federal Policy Landscape

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 1570 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[12,13]

Essential health benefits

In California, nongrandfathered[14] individual and small-group health insurance is generally required to cover essential health benefits (EHBs).[15] In 2027, approximately 11.5% of all Californians will be enrolled in a plan or policy that must cover EHBs.[16]

States may require state-regulated health insurance to offer benefits that exceed EHBs.[17,18,19, 20] Should California do so, the state could be required to defray the cost of additionally mandated benefits for enrollees in health plans or policies purchased through Covered California, the state's health insurance marketplace. However, state benefit mandates specifying provider types, cost sharing, or other details of existing benefit coverage would not meet the definition of state benefit mandates that could exceed EHBs.[21,22] It should be noted that federal guidance establishes the "State" as the entity that would identify when a state benefit mandate exceed EHBs;[23] thus, DMHC and CDI would determine whether the benefit would require defrayal of costs.

AB 1570 Diagnostic Imaging does not exceed EHBs.

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[12] The ACA requires nongrandfathered small-group and individual market health insurance — including but not limited to qualified health plans sold in Covered California — to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website.
[13] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.
[14] A grandfathered health plan is "a group health plan that was created — or an individual health insurance policy that was purchased — on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers."
[15] For more detail, see CHBRP's issue brief, *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*.
[16] See CHBRP's resource, *Sources of Health Insurance in California*.
[17] ACA Section 1311(d)(3).
[18] State benefit mandates enacted on or before December 31, 2011, may be included in a state's EHBs, according to the U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013.
[19] However, as laid out in the Final Rule on EHBs U.S. Department of Health and Human Services (HHS) released in February 2013, state benefit mandates enacted on or before December 31, 2011, would be included in the state's EHBs, and there would be no requirement that the state defray the costs of those state-mandated benefits. For state benefit mandates enacted after December 31, 2011, that are identified as exceeding EHBs, the state would be required to defray the cost.
[20] In February 2026, HHS released a proposed rule that would alter what benefits would be determined to exceed EHBs. Depending on how these regulations are finalized, the below conclusions about whether benefits included in AB 1570 exceed EHBs would be altered. U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program. Proposed Rule. Federal Register, Vol. 91, No. 28. February 11, 2026.
[21] Essential Health Benefits. Final Rule. A state's health insurance marketplace would be responsible for determining when a state benefit mandate exceeds EHBs, and qualified health plan issuers would be responsible for calculating the cost that must be defrayed. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013.
[22] As of 2024, Maine, Massachusetts, Minnesota, Montana, Utah, and Virginia mandate benefits that exceed EHBs (GAO, 2024). For more information about defrayal, refer to CHBRP's issue brief *Essential Health Benefits: Exceeding EHBs and the Defrayal Requirement*.
[23] Essential Health Benefits Final Rule. Federal Register, Vol. 87. No. 27. February 25, 2013.

Other Federal or State Programs

All U.S. states, the District of Columbia, five territories, and 12 tribal organizations provide free or low-cost breast cancer services for low-income, uninsured, or underinsured women through the Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Available services include mammography, screening MRI, clinical breast exam, and diagnostic services funded by NBCCEDP (CDC, 2025a).

Many states have additional programs similar to California's EWC program, including the Colorado Women's Wellness Connection (WWC), the Arkansas BreastCare Program, the Georgia Breast and Cervical Cancer Program, and the New York State Cancer Services Program, among others. Additional program details for these and other states can be found at cervivor.org.

Background on Breast Cancer and Related Screening and Diagnostic Imaging

AB 1570 would mandate that health plans and policies cover the following services without cost sharing: screening mammography, medically necessary supplemental and diagnostic breast exams, diagnostic mammography, tests for screening or diagnostic purposes, and medically necessary diagnostic breast imaging consistent with evidence-based guidelines. Imaging includes 2D mammography, digital breast tomosynthesis (DBT), contrast enhanced mammography (CEM), breast ultrasound, magnetic resonance imaging (MRI), and molecular breast imaging (MBI). The bill applies to people at any risk of breast cancer; however, because 99% of breast cancer occurs in women and NCCN guidelines do not recommend the services relevant to AB 1570 for men, CHBRP's analysis focuses on women.

This section presents contextual information about the incidence of disease and related mortality, risk factors for breast cancer, descriptions of screening and diagnostic imaging, an overview of clinical guidelines for screening and diagnostic services, and disparities in access to and uptake of imaging.

Breast Cancer in California

Breast Cancer Incidence and Mortality Rates

Incidence rate

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. The annual breast cancer incidence rate in California is 124/100,000 or about 34,000 new cases diagnosed annually (ACS, 2024). Fewer than 1% of breast cancer occurs in males (ACS, 2026c) (about 170 cases diagnosed and 40 deaths occurring annually in California [ACS, 2017]).

Mortality rate

The American Cancer Society estimates an average breast cancer death rate of 19/100,000 or about 4,600 breast cancer deaths annually in California (ACS, 2026). Although the state-level, 5-year breast cancer incidence rate appears to be increasing (NCI, 2026), California's breast cancer mortality rate has remained stable over a 12-year span, hovering between 19 and 20 deaths/100,000 women (2010-2022) (NCI, 2026c).

Rate differences by race and ethnicity

Differences in breast cancer incidence and mortality by race and ethnicity persist. According to the most recent data (2022), age-adjusted incidence of breast cancer in California women under age 65 years remains highest among White, women (140/100,000), followed by Black women (125/100,000), Asian/pacific Islander (14/100,000) and Hispanic women (97/100,000); however, age-adjusted mortality rates remain highest among Black Californian women who have a breast cancer mortality rate of 13/100,000, followed by White women (8/100,000), and Hispanic and Asian and Pacific Islander women (7/100,000) (NCI, 2026a).

Breast Cancer Statistics

Incidence: 124/100,00 California women (34,000 new cases annually).

Incidence differences among these women include:

- White 140/100,000
- Black: 125/100,000
- Asian/Pacific Islander: 113/100,000
- Hispanic: 97/100,000

Mortality: 19/100,000 California women (4,600 deaths annually).

Mortality differences among these women include:

- Black: 29/100,000
- White: 21/100,000
- Asian/Pacific Islander: 14/100,000
- Hispanic: 13/100,000

67% of California women aged 40 years and older had a mammography screening within the last 2 years.

71% of breast cancer is diagnosed in the early stages of localized disease, which carries a 99% 5-year survival rate.

Screening and treatment impact on mortality rates

Numerous evidence-based screening guidelines encourage screening mammography to identify cancers in their earliest stage, which results in higher survival rates. (See below for more information on clinical guidelines and differences among racial/ethnic groups.) Since 1989, improvements in technology leading to earlier detection and improved cancer treatments have contributed to decreasing overall mortality rates (ACS, 2024). Data from 2022 show that 67% of California women aged 40 years and older had a mammography screening within the last 2 years (NCI, 2026a). In California, 71% of breast cancer is diagnosed in the early stages of localized disease, which carries a 99% 5-year survival rate (ACS, 2017).

Breast Cancer Risk

Assessing risk

The lifetime average risk of breast cancer is about 13%, or 1 in 8 females, with risk increasing with age (NCI, 2020a). Males have roughly a 0.13% lifetime risk, or 1 in 800 (NCI, 2020a).

There are several validated risk assessment tools available online that clinicians can use to assess a woman's risk including the modified Gail model, Breast Cancer Surveillance Consortium, BRCAPRO, International Breast Cancer Intervention Studies (also known as Tyrer–Cuzick), and the Claus model (Amir et al., 2010; BCSC, 2026; Niell, 2021). These tools can help practitioners and patients determine appropriate screening, including supplemental screening, schedules. The WISDOM study is developing and testing a new tool that integrates the patient's genetic test results and family and medical history to assess personal risk for breast cancer and recommend personalized screening intervals (Esserman et al., 2025).

These tools include different risk factors and weigh them differently, resulting in a different risk prediction for the same woman among the tools; her individual risk level will change over time as well, due to aging. At the population level, these tools provide different estimates of the proportion of women at average risk, intermediate risk, and high risk. Examples of factors that may be included in these risk factor calculators include (CDC, 2025b; NCI, 2026a):

- Age
- Race/ethnicity
- Ever had a biopsy (how many, atypical hyperplasia)
- Age at onset of menarche
- Age at first live birth
- Family history of breast cancer in a first degree relative
- Gene mutations (*BRAC1*/*BRACA2*)

Other factors such as lifestyle factors (i.e., alcohol consumption, physical activity, obesity) also affect risk (American Society of Clinical Oncology, 2020; CDC, 2025b). Practitioners can use specialized risk calculators (not Gail model) for women who have a breast-cancer-associated mutation in BRCA1 or BRCA2 genes or previous history of invasive or in situ breast cancer (NCI, 2026b).

Levels of risk

Most women are at average risk for breast cancer (<15% lifetime risk). Women with 15% to 20% lifetime risk of breast cancer are considered to be "intermediate risk". Factors contributing to that level of risk include personal history of breast cancer, lobular neoplasia, atypical ductal hyperplasia (Yeh et al., 2025). CHBRP estimates that 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).[24]

[24] Adjustments provided by Diana Miglioretti, PhD, University of California, Davis.

Women with >20% lifetime risk are considered "high risk." Those with one or more of the following factors are classified as high risk by the National Comprehensive Cancer Network (NCCN, 2025) (and similarly by the American Cancer Society [ACS, 2023]):

- Genetic (*BRCA1* or *BRCA2* gene mutation; Li-Fraumeni syndrome plus first-degree relatives; Cowden and Bannayan-Riley-Ruvalcaba syndromes plus first-degree relatives). These genetic mutations and syndromes are relatively rare. According to the CDC, about 1 in 500 women in the United States has a BRCA1 or BRCA2 gene mutation. About 50 of 100 women with a *BRCA1* or *BRCA2* gene mutation will get breast cancer by the time they turn 70 years old, compared to only 7 of 100 women in the general U.S. population (CDC, 2024).
- First-degree relative of BRCA carrier (untested).
- Clinical history – chest irradiation treatment between age 10 and 30 years (e.g., Hodgkin's disease treatment).
- A history of atypical ductal hyperplasia, lobular carcinoma in situ, and/or atypical lobular hyperplasia.

Additionally, radiographically dense breast tissue is also considered an independent risk factor for breast cancer. Dense breast tissue can obscure breast cancers on mammography, thus reducing detection of cancer by mammography (CDC, 2021). Women with dense breast tissue experience higher rates of interval cancers occurring between mammography screenings (Ezratty et al., 2020). However, dense breast tissue alone does not put a person into a high-risk category for breast cancer (ACS, 2021). Those with dense breast tissue are not more likely to die from breast cancer than those with non-dense breast tissue (CDC, 2021).

About 50% of females have low or average density, with tissue that is predominantly fatty, and the other 50% have heterogeneously dense or extremely dense tissue throughout the breast. Breast density, on average, decreases with age (NCI, 2020b).

Defining Breast Cancer Screening and Diagnostic Services

Asymptomatic women:

- **Primary screening** exams are conducted for women at risk for breast cancer, but who have no symptoms (asymptomatic). Digital 2D mammography is used most often for primary screening.
- **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.

Symptomatic women:

- **Diagnostic imaging** exams are conducted for people with symptoms of disease or abnormal results on clinical exams or screening tests. *Note*: 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 the biopsy.
- **Biopsy** is part of the diagnostic process where a sample of suspect tissue is removed using fine-needled aspiration or core needle that is guided by ultrasound or MRI imaging to remove the sample. Tissue may also be removed surgically.
- **Pathology evaluation** is part of the diagnostic process that examines tissue samples under a microscope to determine if it is cancerous. Once cancer is confirmed, other diagnostic tests can identify the receptor status to inform the most effective treatment option for that type of cancer.

Primary Screening, Supplemental Screening, and Diagnostic Breast Imaging

AB 1570 would mandate that health plans and policies cover the following services without cost sharing: screening mammography, medically necessary supplemental and diagnostic breast exams, diagnostic mammography, tests for screening or diagnostic purposes, and medically necessary diagnostic breast imaging consistent with evidence-based guidelines (see guideline discussion below).

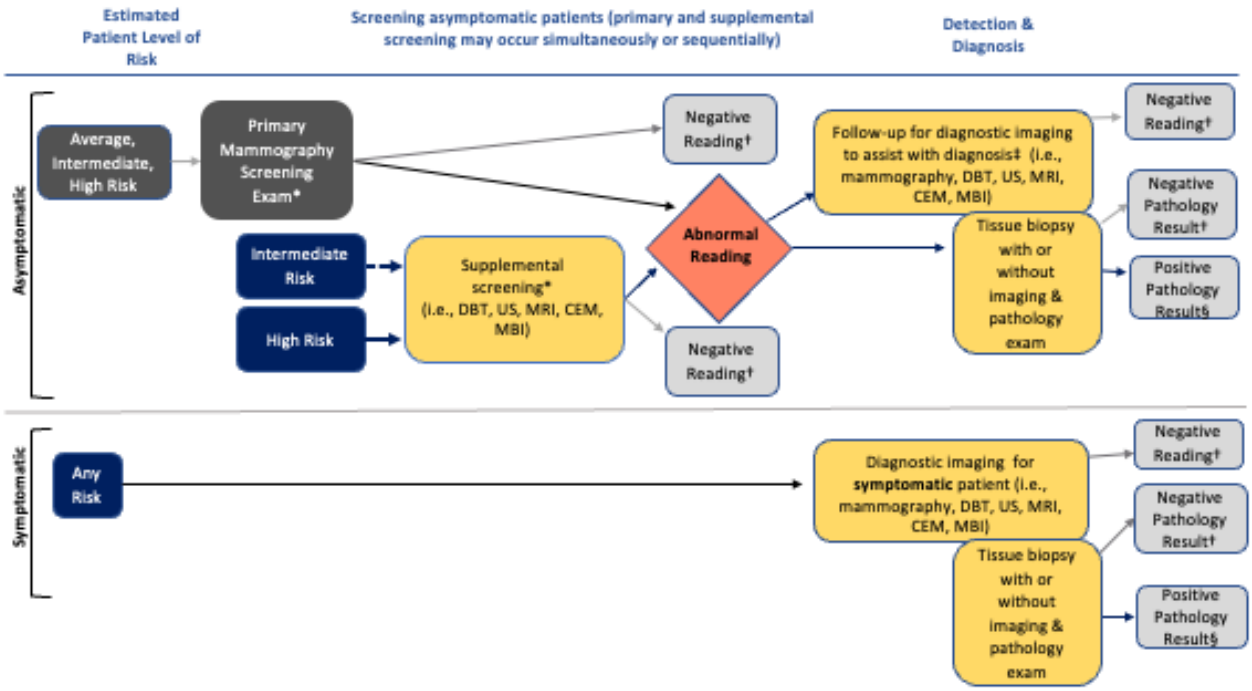
Primary screening mammography (2D mammography or DBT) is a first step in the detection of breast cancers for women at any risk level. Patients who are considered intermediate or high risk for cancer may be recommended for additional screening, known as supplemental screening. This occurs concurrently with primary screening or in the interval between annual or biennial primary mammography screenings. Supplemental screening uses other types of imaging such as breast MRI, breast ultrasound, or less commonly, molecular breast imaging, which is a newer technology. This imaging complements the 2D

radiographic mammography images for women with dense breast tissue or at elevated breast cancer risk with different pictures that may find abnormalities not revealed through mammography; however, these modalities are not recommended as a substitute for primary mammography (ACS, 2023).

Patients with screening abnormalities (i.e., lesion found on primary screening mammography) undergo further imaging for or directly undergo a biopsy of the suspicious area(s) to confirm whether there is a malignancy in the breast tissue. Patients presenting with symptoms start at this diagnostic step. Although clinical terminology refers to imaging exams as "diagnostic," breast cancer is diagnosed based on examination of breast tissue by a pathologist (usually from biopsy). By detecting certain forms of invasive cancer at an earlier stage of disease, breast imaging exams have the potential to reduce breast cancer morbidity and mortality.

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 1 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 patients are not recommended for supplementary screening. Intermediate risk patients may be recommended for supplemental screening (denoted by dotted arrow in Figure 1), such as some women with dense breast tissue. High risk patients are commonly recommended for supplemental screening (denoted by solid arrow in Figure 1). The blue boxes in Figure 1 (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 1. 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).

Breast Cancer Screening and Diagnosis Guidelines

There are several nationally recognized, evidence-based clinical guidelines regarding breast cancer screening and diagnosis (and treatment, which is not addressed by AB 1570). This analysis focuses on National Comprehensive Cancer Network (NCCN) guidelines, per bill language. The NCCN is a national consortium of 33 cancer research and treatment centers and develops evidence-based clinical practice guidelines to treat more than 70 types of cancer (NCCN, 2025). NCCN is one of the more comprehensive guidelines on this topic. This section also includes recommendations from other major national guideline organizations, which are mostly consistent among the issuing organizations, including NCCN.

Screening Guidelines (Asymptomatic Women)

Primary[25] and supplemental breast cancer screening guidelines are generally organized according to lifetime risk of breast cancer. The NCCN recommends that women undergo a risk assessment by age 25 years to identify those who may be at higher risk of breast cancer and are recommended for earlier primary screening than women at average risk (NCCN, 2025). (*Note*: NCCN guidelines focus on people assigned female at birth with residual native breast tissue. The NCCN defers to the consensus-based guidelines for transgender individuals, such as the ACR Appropriateness Criteria and encourages transgender individuals to consult with their clinician(s) to determine when/whether screening would be appropriate (NCCN, 2025).

Average risk of breast cancer (<15% lifetime risk)

NCCN recommends ongoing breast cancer risk assessment, risk counseling, and clinical breast exams (CBE) for women aged 25 to 39 years who have less than a 15% lifetime risk for breast cancer. For women aged 40 years and older (no upper age determined; clinician recommendation based on comorbidities and 10-year mortality expectation), NCCN recommends continued risk assessment, CBE, and annual screening mammography with DBT (NCCN, 2025). Most other national organizations' guidelines, such as USPSTF, the American Cancer Society (ACS), and the American College of Obstetricians and Gynecologists (ACOG), comport with starting primary screening at age 40 years, but some differ in their recommended modality or frequency (i.e., digital mammography with/without tomosynthesis, annual vs biennial, etc.). NCCN also states that they agree with other national organizations (i.e., ACS) that recommend these screenings be covered without enrollee cost sharing (NCCN, 2025).

The Women's Preventive Services Initiative (WPSI) recommends "initiating annual or biennial mammography screening for women at average risk of breast cancer no earlier than age 40 years and no later than age 50 years and, if indicated, providing additional imaging and pathology evaluation to complete the screening process. Screening should continue through at least age 74 years, and age alone should not be the basis for discontinuing screening. Supporting documentation from WPSI recommend that these services be covered with enrollee cost sharing (Nelson et al., 2024). These WPSI recommendations were used to establish the HRSA-supported health plan coverage guidelines for women's preventive services. More information about these policy recommendations can be found in the *Policy Context* section.

Intermediate risk of breast cancer (15% to 20% lifetime risk)

Several national guideline organizations suggest early start of mammography screening with or without shorter (supplemental) screening intervals for women with above-average risk of breast cancer. However, none of the guidelines recommend a specific age to begin screening. For those with intermediate risk of breast cancer, NCCN recommends supplemental screening on an individual basis depending on clinical risk factors (NCCN, 2025). These guidelines do not recommend for or against supplemental screening with breast ultrasound for this risk category. The ACS recommends that, for those with above-average lifetime risk, a mutual decision should be made between a patient and the clinician regarding annual adjuvant breast MRI. The American College of Radiology (ACR) finds DBT supplemental screening "usually appropriate"; breast ultrasound and MRI "may be appropriate" for those with dense breast tissue in this risk category (Freer and Slanetz, 2026).

[25] Although the primary screening mammography step is not the focus of AB 1570, it is included here because it is the beginning of the breast imaging pathway.

High risk of breast cancer (>20% lifetime risk)

National guidelines for women with a greater than 20% lifetime risk of breast cancer agree on recommendations for earlier and more frequent screening including supplemental screening. The NCCN recommends a clinical encounter every 6 to 12 months beginning at the age when increased risk was identified. In addition to the screening mammography, breast MRI (supplemental screening) should occur in intervals or in conjunction with screening mammography. NCCN and ACR recommend breast ultrasound for those for whom breast MRI is contraindicated. ACR also finds DBT supplemental screening "usually appropriate" for this risk category (ACR, 2024; NCCN, 2025). The WPSI notes that women at high risk (e.g., previous diagnosis of breast or ovarian cancer, known *BRCA1* or *BRCA2* gene mutation, previous high-dose radiation to the chest) may require additional testing and closer follow-up; however, it does not specify frequency of type of imaging (Nelson et al., 2024).

Dense breast tissue

The NCCN recommends shared decision-making between a patient with dense breast tissue and her provider regarding supplemental imaging. The USPSTF, ACS, ACOG, and American Academy of Family Physicians do not recommend supplemental breast ultrasonography, MRI, DBT, or other types imaging for people with dense breast tissue, no other risk factors, and negative mammogram results; however, if other key risk factors are present, clinicians should inform patients to decide best course of action (Freer and Slanetz, 2026; NCCN, 2025).

Diagnostic Evaluation and Imaging Guidelines (Symptomatic Women)

Diagnostic evaluation occurs when a woman is either asked to return for further imaging due to an abnormal or inconclusive result from a primary screening mammogram or supplemental screen, or when a woman presents to the clinician with symptoms such as pain, swelling, nipple discharge, lump, or skin dimpling or change in breast shape (CDC, 2025c). In the case of physical symptoms, depending on the findings and her history of primary screening, the patient may skip the screening mammogram step (Figure 2**)** and proceed directly to diagnostic mammography, additional imaging, and perhaps tissue biopsy (i.e., fine-needle aspiration, core needle) for examination by a pathologist. The NCCN recommends additional diagnostic imaging based on the BI-RADS finding from mammography, which might include DBT, breast ultrasound, CEM, and/or MRI. Subsequent follow-up for benign results may be recommended at 6, 12, and 24 months depending on patient risk (NCCN, 2025).

Disparities[26] and Social Drivers of Health[27] in Breast Cancer and Screening and Diagnostic Testing

Disparities are noticeable and preventable differences between groups of people. Social drivers of health (SDOH) include factors outside of the traditional medical care system that influence health status and health outcomes (e.g., income, education, geography, etc.). Where intersections between health insurance benefit mandates and social determinants or systemic factors exist, CHBRP describes relevant literature.

Disparities in Breast Cancer Incidence and Mortality

Differences in breast cancer incidence and mortality rates by race and ethnicity are influenced by age at diagnosis as well as by a 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).

Some research consensus appears to be building around identifying the largest contributing factor to racial and ethnic cancer outcome disparities. Molecular tumor types differ in progression, treatment response, and survival outcome

[26] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population (Wyatt et al., 2016).
[27] For more information about SDOH, see CHBRP's Public Health Impact Analysis and Research Approach.

present with different frequencies in different race and ethnicity groups. As compared with White women, Black and Hispanic women are more likely 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 guideline recommendations as compared with 16% of White women (Oppong et al., 2021).

Some of the 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 higher 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 in Screening and Diagnostic Imaging for Breast Cancer

Several studies reported more breast imaging studies ordered for White women than women of other races, and for women with higher educational attainment than those with a high school education or less (Ezratty et al., 2020; Killelea et al., 2013; Lee et al., 2021). Edmonds et al. (2025) report that Black women are less likely to have supplemental screening referrals than White women after controlling for age, insurance, and breast density. Black women also experienced greater diagnostic delays as compared with White women. However, other studies, including those related to patient notification laws about breast-tissue density or analyzing lifetime risk factor cohorts, found a convergence in supplemental screening rates between White and Black women (Killelea et al., 2013; Lee et al., 2021). Other studies have noted that Black women report being up-to-date with mammography screening at rates similar to or higher than White women (NCI, 2021).

Barriers to Care

Financial burden

There are a multitude of factors influencing why women delay or do not obtain (primary and/or supplemental) screening for breast cancer including financial, patient and clinician barriers. Most of the literature reviewed focused on financial barriers; Conley et al. (2025) report that 97% of survey respondents reported concern about costs related to supplemental screening and subsequent diagnostic or treatment costs with some specifically mentioning that they declined breast MRIs due to their high OOP costs (especially women enrolled in HDHPs). A single-institution retrospective study of 13,000 women found greater uptake of digital breast tomosynthesis (DBT) upon removal of the OOP fee with greater response from populations that were non-White, lower income, or non-English-speaking (Capiro 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. Hughes et al. (2023) reports that women in the service industry have a lower frequency of breast cancer screening (56%) than health care professionals (75%). Miles et al. (2022) reported that, of 7,500 women, those who reported worrying about medical bills were less likely to report having a screening mammogram within the last two years as compared with those who reported no financial worries (note that the ACA removed cost sharing for primary mammography for average risk women in 2010). Findings from Ngo et al. (2023) and American Cancer Society also note that delayed or skipped supplemental breast cancer screening or diagnostic imaging are associated with higher OOP costs, especially among people with lower incomes and/or HDHPs (ACS CAN, 2025). In California, an American Cancer Society report estimated that OOP costs for supplemental imaging and diagnostic imaging and tests accounted for 24% of total cost of that bundle of care (ACS CAN, 2025). Another study considering the role of income found that among Medicaid beneficiaries in states with and without copayment requirements; states without copayments had higher screening rates than states with copayments (Sabik et al., 2020). As noted earlier, delays in diagnosis may lead to delays in treatment, which might affect health outcomes adversely.

Health care costs comprise an increasing proportion of household income, and medical debt is reported by many California households. 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). Latino and Asian Californians skipped care more often than Black or White Californians. 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). Of those, 65% with incomes ≥200% FPL reported cost sharing as the major reason for skipping care compared with 78% of respondents earning less than 200% FPL. Forty percent of 2,552 adult survey respondents reported household medical debt (55% with income ≤200% of FPL and 37% with income ≥200% FPL). Among those with medical debt, 49% reported that diagnostic tests such as MRI contributed to their debt. Finally, 74% said that debt contributed to feelings of stress and anxiety (Joynt, 2026).

On the whole, CHBRP found more literature documenting an inverse association between screening rates and financial stability (i.e., income, insurance coverage) but there is also evidence of little to no association. For example, a literature review reported mixed results of the effect of eliminating enrollee cost-sharing for various preventive screenings (including breast cancer). Of the 18 articles focused on breast cancer screening; 8 reported increased screening utilization; 5 reported no significant utilization change; and 4 reported decreased screening rates. The review also reported 14 studies about colorectal cancer screening; 6 studies showed no change in utilization after removing cost sharing; 5 showed increased screening rates; and 2 reported decreased rates (Norris et al., 2022). Reasons for little-to-no impact on elimination of cost sharing for screening include patient 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.

Other patient barriers

Beyond financial considerations, other patient-identified barriers to supplemental screening include: understanding what intermediate or high risk means and how to manage the risk; perceived severity of breast cancer and benefits of screening; logistical challenges (childcare, transportation, time constraints); navigating health care (identifying proper imaging providers, making appointments) and insurance systems (referrals and prior authorization); and low confidence or weak clinician-patient relationship (Conley et al., 2025; Lawson et al., 2025).

Of note, although not specified in AB 1570, the HRSA-endorsed WPSI guidelines also recommend no-cost sharing coverage of patient navigation services to support women with differential access or who need support for coordinating follow-up screening and diagnosis (HRSA, 2025). The intent is to help patients experiencing systemic barriers to breast imaging services achieve recommended screening schedules assuming health care providers offer such services. This recommendation is based on evidence from studies identifying disparities in imaging access and use (Breslau et al., 2019; Elmohr et al., 2024) and evidence supporting the use of patient navigators to increase rates of breast cancer screening among low-income women (CPSTF, 2025).

Clinician barriers

There are also clinician-related barriers to women obtaining screening, such as: 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; concerns about overstepping scope of practice (i.e., radiologists vs. primary care/gynecology); and concerns about unnecessary follow-up and biopsy (Amornsiripanitch et al., 2021; Conley et al., 2024; Reichman et al., 2025).

Medical Effectiveness Review

AB 1570 would mandate that health plans and policies cover the following services without cost sharing: screening mammography, medically necessary supplemental and diagnostic breast exams, diagnostic mammography, tests for screening or diagnostic purposes, and medically necessary diagnostic breast imaging consistent with evidence-based guidelines. Imaging includes 2D mammography, digital breast tomosynthesis (DBT), contrast enhanced mammography (CEM), breast ultrasound, magnetic resonance imaging (MRI), and molecular breast imaging (MBI). The bill applies to people at any risk of breast cancer; however, because 99%of breast cancer occurs in women and NCCN guidelines do not recommend the services relevant to AB 1570 for men, CHBRP's analysis focuses on women.

As primary screening mammography is already covered without cost sharing by existing federal and state mandates, this section does not address the medical effectiveness of primary screening mammography. Additionally, women at average risk are covered without cost sharing for medically indicated diagnostic imaging following a screening based on federal regulations. For more information on existing law, see the *Policy Context* section.

Research Approach and Methods

Additional information on modalities for breast cancer imaging is included in the *Background* section. The medical effectiveness review summarizes findings from evidence[28] 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 risk) or diagnostic imaging (to evaluate an abnormality or suspicious lesion). These breast imaging modalities include:

1. Contrast enhanced mammography (CEM)
2. Breast magnetic resonance imaging (MRI)
3. Breast ultrasound (US)
4. Molecular breast imaging (MBI)
5. Digital breast tomosynthesis (DBT, or 3D mammography)[29]

Key Questions

1. Are modalities for supplemental breast imaging effective when used to screen for breast cancer in women with dense breasts without evidence or suspicion of abnormality?
2. Are modalities for supplemental breast imaging exams effective when used to screen for breast cancer in patients at increased risk (based on personal or family medical history, breast density, or additional factors that increase the individual's risk of breast cancer)?
3. Are modalities for diagnostic breast imaging exams effective when used to evaluate suspected or identified abnormalities?

[28] 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.

[29] Although not explicitly addressed in the definitions for diagnostic or supplemental breast examinations, NCCN guidelines recommend annual screening mammograms with DBT for patients at average and increased risk.

4. What are the risks involved with modalities used for supplemental or diagnostic breast imaging exams?

The search related to contrast enhanced mammography, digital breast tomosynthesis, breast MRI, and breast ultrasound was limited to studies published from 2022 to the present because CHBRP had previously conducted thorough literature searches on these topics in 2022 for its analyses of AB 2024 and SB 974. The search related to MBI and CEM was limited to studies published from 2016 to present.[30]

A total of 34 studies were included in the medical effectiveness review for this report. The other articles were eliminated because they did not focus on a specific population of interest (i.e., primary breast screening in asymptomatic women only), were of poor quality,[31] or did not report findings from clinical research studies. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in CHBRP's Medical Effectiveness Analysis and Research Approach document.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.[32] Unpublished studies are not reviewed because the results of such studies are not peer-reviewed, and if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Outcomes Assessed

CHBRP did not identify any studies assessing the long-term health outcomes (e.g., mortality or cancer-related morbidity) of these breast cancer imaging modalities. The primary outcome assessed was test performance of each respective modality when used to screen for breast cancer without evidence or suspicion of abnormality (supplemental exam) or to evaluate suspected or identified abnormalities (diagnostic exam). The specific outcomes include cancer detection rates, diagnostic accuracy (sensitivity and specificity), and recall rates. Studies evaluating these outcomes for supplemental screening help to define test performance, but do not confirm whether their use changes health outcomes, including stage at diagnosis or breast cancer mortality, compared to standard screening.

It is important to note that better test performance metrics do not always correspond to improved long-term health outcomes (lower morbidity or mortality). Screening tests are designed to be applied to a large population of asymptomatic women, and test performance characteristics do not confirm that supplemental screening tests will improve health outcomes. In addition, studies of supplemental screening have generally been conducted only in women defined as high risk or as having dense breasts; how they perform in women without these characteristics may be different.

Terminology

- **Cancer Detection Rate (CDR)**: the number of true-positive results divided by the total number of screenings or diagnostic exams.
- **Sensitivity**: the proportion of breast cancers detected when breast cancer is present, or the true positive rate. Research suggests a desirable sensitivity threshold for breast cancer screening at 85% (Feig, 2007)
- **Specificity**: the proportion of negative test results when cancer is absent. If the test specificity is low, the test would have a high false-positive rate that could result in unnecessary interventions. Research suggests a desirable specificity threshold for breast cancer screening at 90% (Feig, 2007).
- **Recall Rate**: the number of patients recalled for further testing due to inconclusive or suspicious test results. After further testing (which may include biopsy) some recalled patients have positive findings, and some have negative

[30] Studies of the effects of mammography, contrast enhanced mammography, digital breast tomosynthesis, breast MRI, breast ultrasound and molecular breast imaging were identified through searches of PubMed, Cochrane Library, Web of Science, and Embase. The search was limited to abstracts of studies published in English.
[31] For a detailed explanation of how CHBRP defines high-quality research, see the "Selecting Studies for Inclusion in the Literature Review" section of CHBRP's Medical Effectiveness Analysis and Research Approach document.
[32] Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. See CHBRP's website for more information.

findings, meaning their recall was unnecessary. Research suggests a desirable recall rate for screening mammography at <10% (Feig, 2007).

Methodological Considerations

This Medical Effectiveness review is limited to women undergoing supplemental screening (due to breast density or increase lifetime risk, after a normal mammogram) or women receiving diagnostic breast imaging (after an abnormal mammogram or due to symptoms). CHBRP excluded studies that were limited to primary screening for breast cancer and studies that included a mix of primary screening, supplemental screening and/or diagnostic populations where results were not stratified by these indications. CHBRP also excluded studies that compared radiologist or reader performance using different imaging modalities.

Imaging and Procedures Not Covered in This Review

Primary screening

Although the effectiveness of imaging for primary screening is not the focus of this analysis, any narrative would be incomplete without providing a brief summary of the effectiveness of imaging for this purpose. The medical effectiveness of mammography for primary screening has been widely recognized in the United States and abroad for more than 25 years. National guidelines, customary practices of care, and current health care coverage, as mandated by existing California statute, all accept mammography as the standard for the screening of breast cancer. The National Cancer Institute (NCI) reports the sensitivity for mammography screening is approximately 79%, but ranges between 54% and 58% in women aged 40 to 49 years and 81% to 94% in women aged 65+ years (NCI, 2025). In 2024, the U.S. Preventive Services Task Force published updated recommendations that women aged 40 to 74 years receive biennial mammography screening (Nicholson et al., 2024). The accompanying “practice considerations” note that DBT is also considered an effective mammographic screening modality, but must be accompanied by traditional digital mammography or synthetic digital mammography (2D image constructed from DBT data) (Nicholson et al., 2024).

Biopsy

As with primary screening, the medical effectiveness of breast biopsies and other pathology evaluations are not fully reviewed here for analysis as both surgical and core-needle biopsies have been shown to be effective for finding breast cancer, and biopsy with pathology is the final gold standard for diagnosis of breast cancer.

Study Findings

This following section summarizes CHBRP’s findings regarding the strength of evidence for the use of the breast imaging modalities addressed by AB 1570, stratified by indication (i.e., modalities used for supplemental screening versus modalities used for diagnostic imaging). Each section is accompanied by a corresponding figure. The title of the figure indicates the breast imaging modality for which evidence is summarized. The statement in the box above the figure presents CHBRP’s conclusion regarding the strength of evidence about the effect of a particular breast imaging modality based on a specific relevant outcome and the number of studies on which CHBRP’s conclusion is based. Definitions of CHBRP’s grading scale terms are included in the box below.

The following terms are used to characterize the body of evidence regarding an outcome:

Very strong evidence (formerly called *clear and convincing evidence*) indicates that there are multiple studies of a test or treatment and the large majority of studies are of high quality and consistently find that the intervention is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.

Strong evidence (formerly called *preponderance of evidence*) indicates that the majority of the studies reviewed are consistent in their findings that intervention is either effective or not effective. Conclusions could be altered with additional strong evidence.

Some evidence (formerly called *limited 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.

Conflicting evidence (formerly called *inconclusive evidence*) indicates that of the studies of equal quality, the number suggesting the intervention is effective is similar to the number of those suggesting the treatment is not effective.

Not enough research (formerly called *insufficient evidence*) indicates that (1) there are no studies of the intervention **or** (2) the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a the intervention is effective. *Not enough research* does not indicate that a treatment is not effective.

Effectiveness of Supplemental Breast Imaging Modalities

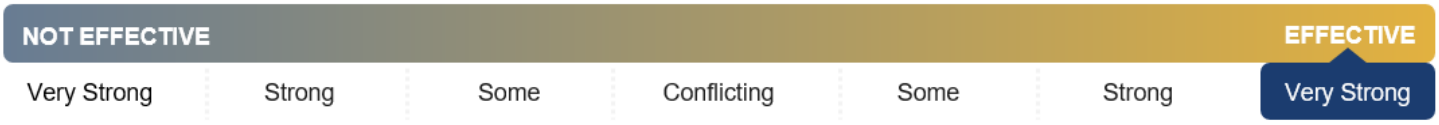
Although mammography is most often utilized in a primary screening role and is considered to be the single most effective screening tool, credited with sharply reducing cancer-related mortality (Nicholson et al., 2024; Siu, 2016), it has been criticized for its moderate sensitivity and specificity (75%) and also due to its limited ability to distinguish between lesions and overlapping tissue (Chen et al., 2021; Hooshmand et al., 2021). Other supplemental imaging modalities, such as DBT, breast ultrasound, and breast MRI (and, more recently, CEM and MBI), are often used in addition to mammography, attempting to improve identification of breast cancer, particularly in women with certain risk factors (such as a personal or family medical history of breast cancer) or heterogeneously or very dense breasts.

Findings for Digital Breast Tomosynthesis

Digital breast tomosynthesis (DBT) (also referred to as 3D mammography) is often used in conjunction with digital or other 2D mammography for both primary and supplemental breast screening in women with dense breasts (Henderson et al., 2024). DBT has been shown to be more effective than traditional 2D mammography with regard to tissue visualization, resulting in greater confidence in interpretation for the characterization of suspicious findings from initial screening (Houssami and Skaane, 2013). A 2018 meta-analysis of studies comparing 2D mammography and DBT for supplemental screening reviewed 17 studies involving over 1 million patients (approximately 39% to 43% of whom had dense breasts). They found that DBT improves detection rates (incremental CDR of 1.6 per 1,000 screens) and reduces recall (decrease of 2.2%) (Marinovich et al., 2018). A 2026 meta-analysis including 13 studies compared the use of supplemental DBT versus 2D mammography in women with dense breasts and found that DBT resulted in an additional 1.69 cancers detected per 1,000 exams and reduced recalls (Duggan et al., 2026). A 2023 meta-analysis including 8 studies compared the use of supplemental DBT in patients with dense breasts (and a previous negative mammogram) and found that DBT resulted in an additional 4.8 cancers detected per 1,000 exams. The authors also reported an additional 1 case of ductal carcinoma in situ (DCIS) detected per 1,000 screened and an invasive CDR of 3.2 cancers per 1,000 screened with DBT (3 studies) (Hussein et al., 2023). Overall, the primary evidence evaluating DBT included in the meta-analyses was the most extensive of all the supplemental screening modalities.

Summary of findings regarding DBT for supplemental breast screening: Based on three meta-analyses, there is very strong evidence that DBT can increase the detection of breast cancer when used in a supplemental role to mammography for women with dense breasts and it may reduce recall rates compared with mammography alone..

Figure 2. Level of Evidence of DBT for Supplemental Breast Screening

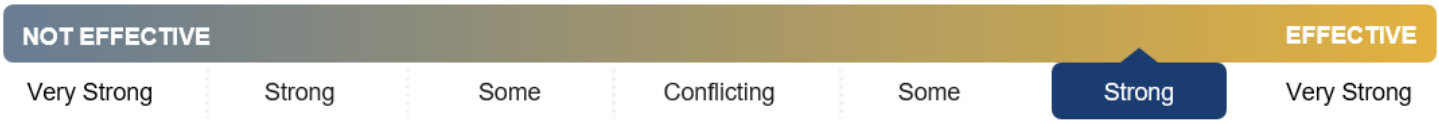


Findings for Breast Ultrasound

A systematic review by Zeng et al. (2022) evaluated the use of supplemental screening with breast ultrasound. Among the three studies limited to high-risk women (defined as young age, high genetic risk, and/or dense breasts),the authors found that supplemental imaging using breast ultrasound identified an additional 0 to 4.4 cancers per 1,000 screens and increased recalls compared to 2D mammography alone (Zeng et al., 2022). A 2026 meta-analysis of supplemental screening for women with dense breasts found that automated and handheld breast ultrasound detected additional cancers compared to 2D mammography alone (4.5 and 2.7 cancers per 1,000 screens, respectively) but increased recall rates (Duggan et al., 2026). Another meta-analysis assessed the use of supplemental automated (4 studies) or handheld ultrasound (10 studies) in patients with dense breasts (and a previous negative mammogram). The authors found that both automated and handheld ultrasound resulted in an incremental detection rate of 4.3 per 1,000 exams compared to 2D mammography alone. Handheld ultrasound identified slightly more invasive cancers and DCIS (4.5 and 0.5 cancers per 1,000 exams, respectively) compared to automated breast ultrasound (4.1 and 0.1 cancers per 1,000 exams, respectively) (Hussein et al., 2023).

Summary of findings regarding breast ultrasound for supplemental breast screening: Based on 2 meta-analyses and 1 systematic review, there is strong evidence that breast ultrasound can increase the detection of breast cancer when used for supplemental screening in women with dense breasts or other risk factors, but may increase recall rates

Figure 3. Level of Evidence of Ultrasound for Supplemental Breast Screening



Findings for Breast Magnetic Resonance Imaging

A 2022 systematic review by Zeng and colleagues evaluated the use of supplemental screening with breast magnetic resonance imaging (MRI) after an initial negative mammogram. Among the two studies limited to high-risk women (defined as young age, high genetic risk, and/or dense breasts),the authors found that supplemental imaging using breast MRI identified an additional 14.2 to 16.5 cancers per 1,000 screens compared to 2D mammography alone (Zeng et al., 2022). The addition of breast MRI resulted in increased recall rates (ranging from 94.9 to 159.7 recalls per 1,000 screens). A 2026 meta-analysis including six studies compared the use of supplemental MRI versus standard mammography in women with dense breasts found that MRI resulted in an additional 18.9 cancers detected per 1,000 exams (after a negative mammogram) but increased recalls (Duggan et al., 2026). Another meta-analysis including four studies assessed the use of supplemental MRI in patients with dense breasts (and a previous negative mammogram) and found that MRI resulted in an additional 25.7 cancers detected per 1,000 exams. The authors also reported an additional 4.4 DCIS detected per 1,000 screened and an invasive CDR of 19.9 cancers per 1,000 screened with MRI (three studies) (Hussein et al., 2023).

A retrospective study by Kerlikowske et al. (2024) including 52,237 women examined the differences in cancer detection between mammography with or without supplemental MRI for women with dense versus non-dense breasts. In women with dense breasts, MRI plus mammography had an incremental cancer detection rate of 4.0 per 1,000 screening exams compared to mammography alone. MRI plus mammography also identified an additional 5.3 cases of DCIS per 1,000 screening compared to mammography alone (Kerlikowske et al., 2024).

Summary of findings regarding MRI for supplemental breast screening: Based on 2 meta-analyses, 1 systematic reviews and 1 retrospective study, there is strong evidence that breast MRI can increase the detection of breast cancer when used in a supplemental role in women with dense breasts or other risk factors, but may increase recall rates

Figure 4. Level of Evidence of MRI for Supplemental Breast Screening

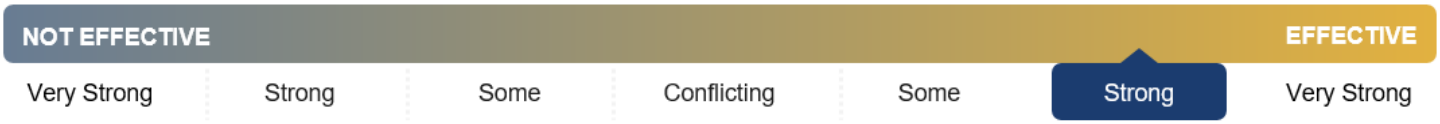


Table 1. Cancer Detection and Recall Rates for DBT, MRI, and US for Supplemental Screening Based on Published Systematic Reviews

	Population	DBT	MRI	US
Cancer Detection Rate				
Duggan, 2026	Dense breasts	1.69 additional cancers per 1,000 exams (13 studies)	18.92 additional cancers per 1,000 exams (6 studies)	ABUS: 2.3 additional cancers per 1,000 exams (6 studies) HHUS: 2.57 additional cancers per 1,000 exams (8 studies)
Hussein, 2023	Dense breasts	4.8 additional cancers per 1,000 exams (8 studies)	25.7 additional cancers per 1,000 exams (4 studies)	ABUS: 4.3 additional cancers per 1,000 exams (10 studies) HHUS: 4.3 additional cancers per 1,000 exams (4 studies)
Zeng, 2022	High-risk women (defined as young age, high genetic risk, and/or dense breasts)	NR	14.2 – 16.5 additional cancers per 1,000 exams (2 studies)	0–4.4 additional cancers per 1,000 exams (3 studies)
Marinovich, 2018	Asymptomatic women (39%-43% with dense breasts)	1.6 additional cancers per 1,000 exams (17 studies)	NR	NR
Recall Rate				
Duggan, 2026	Dense breasts	Difference in recall rate vs. mammography alone: −2.19% (11 studies)	Difference in recall rate vs. mammography alone: 7.98% (3 studies)	ABUS: Difference in recall rate vs. mammography alone: 5.49% (5 studies) HHUS: Difference in recall rate vs. mammography alone: 6.65% (5 studies)
Hussein, 2023	Dense breasts	NR	NR	NR

	Population	DBT	MRI	US
Zeng, 2022	High-risk women (defined as young age, high genetic risk, and/or dense breasts)	NR	Difference in recall rate vs. mammography alone: 9.5% (2 studies)	Difference in recall rate vs. mammography alone: 7.7% (1 study)
Marinovich, 2018	Asymptomatic women (39%-43% with dense breasts)	Difference in recall rate vs. mammography alone: −2.2% (17 studies)	NR	NR

Sources: **Duggan et al. (2026); Hussein et al. (2023); Marinovich et al. (2018).**
Key: ABUS = automated breast ultrasound; DBT = digital breast tomosynthesis; HHUS = hand-held ultrasound; MRI = magnetic resonance imaging; NR = not reported; US = ultrasound.

Findings for Contrast-Enhanced Mammography

One randomized controlled trial by Gilbert et al. enrolled women with a negative screening mammogram and dense breasts to receive supplemental screening with CEM, MRI or ultrasound. Among the 2,035 women randomized to receive supplemental screening with CEM, the cancer detection rate was 17.4 cancers per 1,000 screened, which was similar to the detection rate for MRI (16.0 per 1,000 screened) and higher than that of ultrasound (4.0 per 1,000 screened). The recall rate of CEM was similar to MRI (9.7% in both arms) and higher than ultrasound (4.0%) (Gilbert et al., 2025). One prospective study enrolled asymptomatic women ages 35 years and older at elevated risk (defined as lifetime breast cancer risk of 15% or greater or with a personal history of breast cancer) who had a negative breast cancer screening exam (with 2D or DBT) within the past 6 months days to receive supplemental imaging with CEM. Among the 460 enrolled women (88% of whom had dense breasts), the overall incremental supplemental cancer detection rate for CEM was 23.9 cancers per 1,000 patients (Patel et al., 2024).

Additionally, two systematic reviews examined the test performance of supplemental CEM among women with dense breasts. Neither of these systematic reviews reported differences in cancer detection rates with the use of CEM for supplemental breast imaging. A systematic review by Cozzi et al. (2022) included 9 studies conducted in patients with dense breasts, representing 1,364 CEM examinations in 1,249 patients. Among patients with dense breasts, CEM had a 95% pooled sensitivity rate and a 78% pooled specificity rate (Cozzi et al., 2022). A systematic review by Gelardi et al. (2022) including 3 studies of CEM among women with dense breasts estimated a pooled sensitivity of 99% (Gelardi et al., 2022).

Summary of findings regarding CEM for supplemental breast screening: Based on one randomized controlled trial and one prospective study, there is some evidence that CEM can increase the detection of breast cancer when used in a supplemental role to mammography for women with dense breasts or other risk factors. Additionally, based on two systematic reviews, there is some evidence that CEM can accurately identify breasts cancer during supplemental screening.

Figure 5. Level of Evidence of CEM for Supplemental Breast Screening

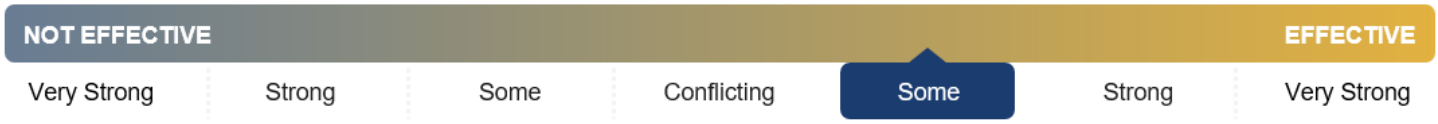
Findings for Molecular Breast Imaging

A recent systematic review (Dibble et al., 2025) was summarized in consensus guidelines developed by an expert working group convened to create appropriate use criteria for molecular breast imaging (MBI) as applied to various clinical scenarios. The expert working group included representatives from the Society of Nuclear Medicine and Molecular Imaging, the American College of Radiology, the American College of Nuclear Medicine, the Society of Breast Imaging, the American Society of Breast Surgeons, the American Society of Clinical Oncology, and the European Association of Nuclear Medicine. Their summary of the systematic review concluded that MBI is appropriate for supplemental screening after mammography in women with dense breasts at average or intermediate, as well as high, risk of breast cancer. For women with dense breasts at average or intermediate risk, supporting evidence from two prospective trials found that the addition of MBI increased the overall CDR from 3.2 per 1,000 screened with mammography alone to 10.7 to 12.0 per 1,000 screened with mammography plus MBI; additionally, one retrospective study found that the addition of MBI resulted in an incremental cancer detection rate of 7.7 cancers per 1,000 screened. For women with dense breasts at high risk, supporting evidence from one retrospective study found that the addition of MBI resulted in an incremental cancer detection rate of 20.1 cancers per 1,000 screened; two other supporting studies (one prospective and one retrospective) found that MBI demonstrated high sensitivity for the detection of breast cancer (Dibble et al., 2025). The summary of the systematic review noted that no studies were identified examining the use of MBI for supplemental screening after mammography in women with non-dense breasts at average or intermediate risk of breast cancer (Dibble et al., 2025).

Density MATTERS is a recent prospective multicenter trial evaluating the performance of MBI as a supplement to DBT as compared to DBT alone in women with dense breasts. (Hruska et al., 2025) This study found that MBI identified an additional 6.7 cancers per 1,000 screenings in year 1 (prevalence screen) and an additional 3.5 cancers per 1,000 screenings in year 2 (incidence screen). Of the incremental cancers only detected with MBI, 70% were invasive, 90% were node-negative and 20% were advanced cancer (twice as many invasive and four times as many advanced cancers as DBT). Recall and biopsy rates were higher with the addition of MBI compared to the use of DBT alone (9.4% higher and 2.9% higher, respectively).

Summary of findings regarding molecular breast imaging for supplemental breast screening: Based on one systematic review summarized in consensus guidelines (reflecting two prospective studies and two retrospective) and one prospective trial, there is some evidence that MBI can increase the detection of breast cancer when used in a supplemental role in women with dense breasts.

Figure 6. Level of Evidence of MBI for Supplemental Breast Screening



Effectiveness of Diagnostic Breast Imaging Modalities

Diagnostic breast imaging is used after suspicious lesions are identified on a screening exam (either primary or supplemental screening exam) or due to suspicious symptoms (e.g., new lumps or masses, breast or nipple pain, nipple discharge) (NBCF, 2026). Diagnostic breast imaging usually involves taking a more detailed image of the breast from different angles to assess the suspicious area more closely (NCI, 2026b). Diagnostic mammography is the established standard to which newer imaging modalities are compared. We did not review the effectiveness of diagnostic mammography.

Findings for Digital Breast Tomosynthesis

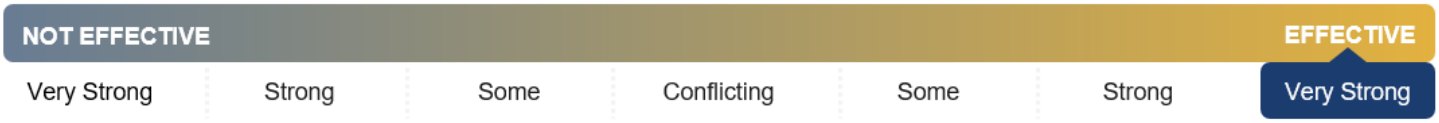
A systematic review and meta-analysis by Ko and colleagues examined the accuracy of digital breast tomosynthesis (DBT) in the diagnostic setting. The authors pooled data from 20 studies (N = 44,513) and reported sensitivity and

specificity of 90% (for both), as compared with 76% and 83% for 2D diagnostic mammography alone (Ko et al., 2021). An earlier meta-analysis of studies comparing DBT with 2D diagnostic mammography found similar results. They pooled seven studies involving over 2,000 patients and found DBT had a sensitivity and specificity of 90% and 79%, as compared with 89% and 72%, respectively, for diagnostic mammography (Lei et al., 2014).

In a prospective study comparing the diagnostic efficacy of DBT with 2D diagnostic mammography in 90 patients, researchers reported a sensitivity of 100% and specificity of 98% as compared to a sensitivity of 64% and specificity of 78% for diagnostic mammography. They concluded that DBT offers better characterization of anomalies, including for women with dense breasts (Naeim et al., 2021). A retrospective study examining the diagnostic properties of DBT versus diagnostic mammography in 217 breast anomalies (e.g., distortions, masses, asymmetries) found significantly fewer false positives and more accurate classifications without a reduction in specificity with use of DBT as compared with diagnostic mammography (Zuley et al., 2013). Another prospective study comparing the diagnostic performance of DBT versus diagnostic mammography in women with clinically suspicious lesions revealed similar results, namely that DBT had significantly better diagnostic efficacy for detecting malignant breast lesions (You et al., 2020). In another retrospective study examining the diagnostic performance of DBT for women with abnormal screening results, it was reported that the addition of DBT to diagnostic mammography following an abnormal screening mammogram proved more effective as compared to diagnostic mammography alone (Ohashi et al., 2018).

Summary of findings regarding DBT for diagnostic breast imaging: Based on two systematic reviews and four studies, there is very strong evidence that DBT is more accurate than diagnostic mammography in accurately identifying breast cancer when used for diagnostic breast imaging.

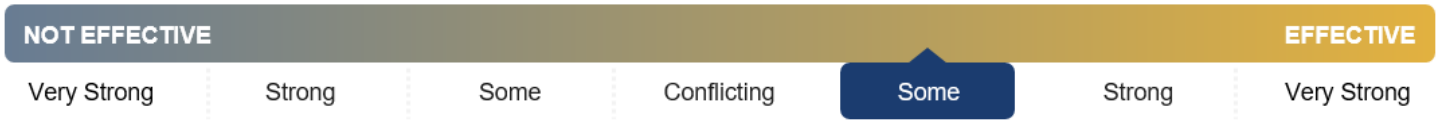
Figure 7. Level of Evidence of DBT for Diagnostic Breast Imaging



Findings for Breast Ultrasound

A systematic review by Tadesse et al. (2023) evaluated the performance of diagnostic mammography and ultrasound for diagnostic breast imaging. In the 12 studies evaluating the use of ultrasound, the pooled sensitivity per patient was 74% and the pooled specificity per patient was 89% (compared to 82% and 91% for diagnostic mammography). The authors also pooled sensitivity and specificity on a per-lesion basis. Sensitivity was higher for ultrasound (94% sensitivity and 85% specificity) compared to diagnostic mammography (78% and 90%, respectively). Based on the per-lesion sensitivity findings, the authors conclude that compared to diagnostic mammography, “ultrasound is more effective for detecting and ruling out clinically relevant breast cancer” (Tadesse et al., 2023).

Summary of findings regarding ultrasound for diagnostic breast imaging: Based on one systematic review, there is some evidence that breast ultrasound is more accurate than diagnostic mammography in accurately identifying breast cancer when used for diagnostic breast imaging.



Findings for Breast Magnetic Resonance Imaging

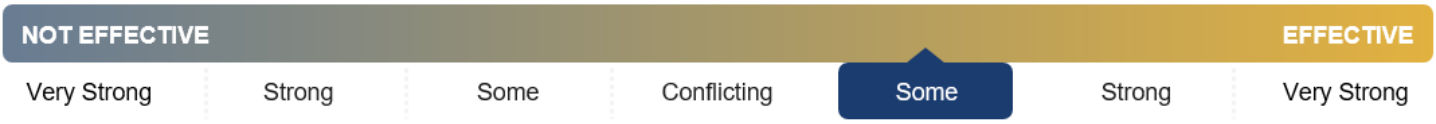
Breast magnetic resonance imaging (MRI) is another commonly used imaging technique for the characterization and diagnosis of breast cancer. The systematic review by Gelardi et al. (2022) evaluated the use of contrast-enhanced MRI for

diagnostic breast imaging. For differentiating suspicious lesions identified at screening, the authors report a pooled sensitivity of 95% and pooled specificity of 55%. For use in pre-operative staging, the authors report a pooled sensitivity of 97% and a pooled specificity of 8% (Gelardi et al., 2022). A systematic review by Li et al. (2025) including 17 studies compared the test performance of MRI versus 2D mammography and DBT for detecting DCIS. The pooled results indicate that supplemental MRI (in addition to mammography) has the highest sensitivity (99%) compared to mammography alone (36%) or MRI alone (85%) (Li et al., 2025).

One study retrospectively examined records from 216 patients who had a previous mammogram and were referred to a follow-up MRI and DM. They reported a sensitivity of 96% for MRI compared to 75% for DM. However, although it is very sensitive in the diagnostic role, its specificity, often moderate, often lags behind the specificity of other techniques (Radhakrishna et al., 2018). Another study comparing breast MRI to digital mammography, as well as ultrasound, concluded that breast MRI had the highest performance with regard to sensitivity and specificity for the diagnosis and characterization of suspected breast cancer (Sun et al., 2018). Another study reported similar findings regarding the use of breast MRI to characterize breast lesions. The authors concluded that breast MRI in combination with digital mammography provided the best diagnostic performance as compared to DBT and DM, or DM alone (Tang et al., 2017).

Summary of findings regarding MRI for diagnostic breast imaging: Based on one systematic review and three studies, there is some evidence that MRI is more accurate than diagnostic mammography in accurately identifying breast cancer when used for diagnostic breast imaging.

Figure 8. Level of Evidence of MRI for Diagnostic Breast Imaging



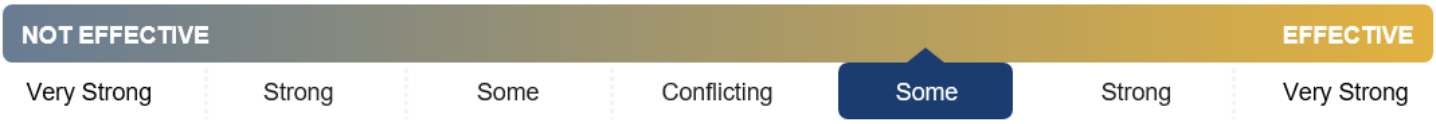
Findings for Contrast-Enhanced Mammography

Three systematic reviews examined the performance of CEM in differentiating suspicious lesions identified on screening mammography. None of these systematic reviews reported differences in cancer detection rates with the use of CEM for diagnostic breast imaging.

A systematic review by Liu et al. (2024) evaluated the performance of CEM in 12 studies conducted in patients presenting with suspicious lesions identified on screening mammography. Meta-analyses estimated a pooled sensitivity of 97% and a pooled specificity of 76% (Liu et al., 2024). The systematic review by Cozzi et al. (2022) included 10 studies conducted in patients with suspicious findings on digital mammography, representing 953 CEM examinations in 720 patients. Among patients with suspicious findings, CEM had a 92% pooled sensitivity rate and an 84% pooled specificity rate (Cozzi et al., 2022). The systematic review by Gelardi et al. (2022) included 7 studies evaluating the use of CEM for diagnostic imaging. The meta-analysis estimated that CEM has a pooled sensitivity of 98% for differentiating suspicious lesions identified at screening (Gelardi et al., 2022).

Summary of findings regarding contrast-enhanced mammography for diagnostic breast imaging: Based on three systematic reviews, there is some evidence that CEM is more accurate than diagnostic mammography in accurately identifying breast cancer when used for diagnostic breast imaging.

Figure 9. Level of Evidence of CEM for Diagnostic Breast Imaging

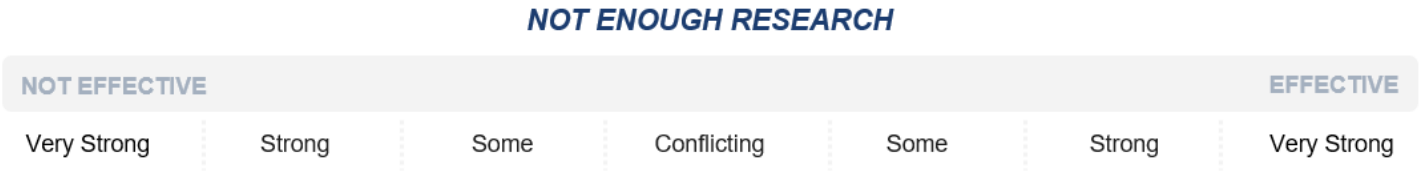


Findings for molecular breast imaging

This medical effectiveness review did not identify any studies evaluating the use of MBI for diagnostic breast imaging, which is a relatively new imaging technique. Please note that the absence of evidence is not "evidence of no effect," and it is possible that use of MBI during diagnostic breast imaging could identify additional cancers, but current evidence is insufficient to inform an estimate.

Summary of findings regarding molecular breast imaging for diagnostic breast imaging: There is not enough research regarding the use of molecular breast imaging when used for diagnostic breast imaging.

Figure 10. Level of Evidence of MBI for Diagnostic Breast Imaging

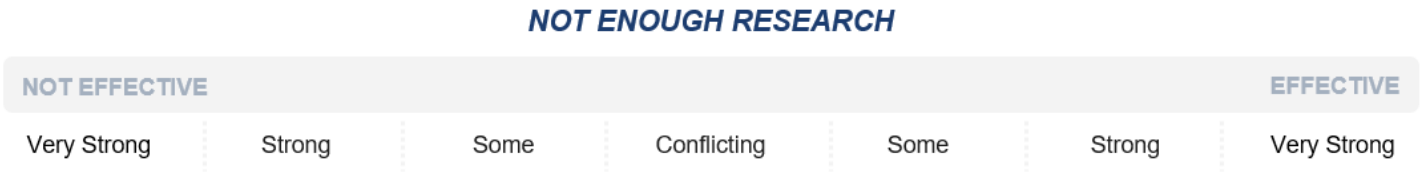


Risks Associated With Breast Imaging Modalities

There is a large body of evidence arguing that the risks involved with primary screening using digital mammography are small compared to the potential decrease in mortality rates (Hooshmand et al., 2022). The current (2024) USPSTF recommendation notes that *"Potential harms of screening mammography include false-positive results, which may lead to psychological harms, additional testing, and invasive follow-up procedures; overdiagnosis and overtreatment of lesions that would not have led to health problems in the absence of detection by screening; and radiation exposure"* (Nicholson et al., 2024).

Regarding supplemental screening, the current (2024) USPSTF recommendation states that: *"The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of supplemental screening for breast cancer using breast ultrasonography or magnetic resonance imaging (MRI) in women identified to have dense breasts on an otherwise negative screening mammogram."* (Nicholson et al., 2024). The systematic review accompanying the 2024 USPSTF recommendation noted several harms associated with supplemental screening, including allergic reactions to contrast agents or leaking of contrast agents (for MRI) and downstream consequences due to additional imaging, including increased false positive rates and physical pain associated with imaging or biopsy; however, the USPSTF review concluded that the strength of this evidence was low (Henderson et al., 2024).

Summary of findings regarding risks of supplemental breast cancer screening: There is not enough research regarding the risks and harms associated with supplemental screening for breast cancer.



Summary of Findings

Table 2 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*[33] 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*[34] 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*[35] 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*[36] to evaluate its use in diagnostic breast imaging.

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.

Table 2. 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	Very strong evidence (a)	Very strong evidence
Breast US	Strong evidence (a, b)	Some evidence
Breast MRI	Strong evidence (a, b)	Some evidence
CEM	Some evidence (a, b)	Some evidence
MBI	Some evidence (a)	Not enough research

Source: California Health Benefits Review Program, 2026.
(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; MRI = magnetic resonance imaging; US = ultrasound.

[33] *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.
[34] *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.
[35] *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.
[36] *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.

Cost Impact Analysis: Data Sources, Caveats, and Assumptions

Analytical Assumptions

In addition to the assumptions described in the *Analytical Approach and Assumptions* section of CHBRP's Analysis of California Assembly Bill 1570, CHBRP made the following assumptions:

Additional Assumptions

- Postmandate, CHBRP assumes full compliance by DMHC-regulated health plans and CDI-regulated health insurance policies, including Medi-Cal managed care and county organized health systems, with AB 1570's requirement to cover the specified supplemental screening and diagnostic imaging services without cost sharing when medically necessary and consistent with nationally recognized evidence-based clinical guidelines. As mentioned above, CHBRP refers to NCCN guidelines to inform its analysis to remain consistent with the bill language.
- CHBRP assumes a 1:1 ratio of biopsy to pathology evaluation for women who receive a biopsy for breast cancer diagnostics.
- CHBRP assumes a uniform distribution of women at elevated risk of breast cancer in commercial insurance markets.
- CHBRP is aware that grandfathered health plans are not required to comply with the Federal Preventive Services Mandate. Some portion of this population – which makes up 4% of enrollees in state-regulated health plans and policies in California – would newly gain coverage without cost sharing from AB 1570. CHBRP did not quantify the impact of this population, given its share of the market.
- Starting October 1, 2028, Medi-Cal will be required to implement cost sharing 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 California will impose a $5 copayment for Medi-Cal services as a result of H.R. 1. California's Medi-Cal program first imposed nominal copayments effective May 15, 1982, codified in California Welfare and Institutions Code §14134 and continued by Chapter 1260, Statutes of 1984 (SB 2242), which set the copayment at $1 per outpatient visit.[37] The national CPI-U Medical Care index[38] stood at approximately 575 as of early 2025 (U.S. Bureau of Labor Statistics via FRED, 2025). A straightforward inflation adjustment of the historical $1 copay yields $1 × (575 ÷ 100) = $5.75 in current dollars. A $5 copay is therefore a conservative figure and is consistent with DHCS's stated intent to establish nominal copayment amounts (DHCS, 2026b) well under the $35 per-service ceiling established by H.R. 1.
- CHBRP is aware that individuals covered by Medi-Cal who receive services at Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are exempt from the future cost-sharing requirement imposed by H.R.1. CHBRP assumes that the individuals covered by Medi-Cal who receive services impacted by AB 1570 at FQHCs or RHCs is small enough that its impact on the cost of this bill would be marginal; as such, CHBRP did not quantify these exemptions.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

[37] California Department of Health Care Services [DHCS], 1985; Cal. Welf. & Inst. Code § 14134
[38] BLS series CUUR0000SAM, 1982–84=100

Postmandate Administrative and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

It is possible that, postmandate, some enrollees would incur expenses related to supplemental breast screening and associated diagnostics for which coverage was denied. CHBRP cannot estimate the frequency with which such situations occur and so cannot offer a calculation of impacted enrollees.

State Health Care Spending Target

In 2024, in an effort to slow health care spending growth and improve health care affordability for California families, California's Office of Health Care Affordability (OHCA) under the Department of Health Care Access and Information approved a statewide target for maximum annual growth in health care spending for certain health care entities. The targets apply to per capita spending to specific entities, including health plans and insurers, provider organizations with at least 25 physicians, and hospitals (HCAI, 2022). The state is implementing this target with a phased-in approach, with a spending target of 3.5% for 2026, lowered to 3.2% in 2027 and 2028, and will be at 3% for 2029 and beyond (HCAI, 2025). Since health insurance benefit mandates may increase health care spending, such as increases to insurance premiums, administrative costs, and OOP costs, OHCA spending targets may be relevant considerations in benefit mandate policy decisions.

Postmandate Changes in the Number of Uninsured Persons

CHBRP assumes that if premiums increase by more than 1.7% in the small- or large-group market segments or 0.6% in the individual market, some enrollees will lapse their coverage. Because the change in average premiums do not exceed either of these thresholds (see Table 5, Table 11, and Table 12 of the Analysis of California Assembly Bill 1570), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 1570.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 1570.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask plans and insurers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

Cost Impact Analysis: Data Sources, Methodology, Assumptions and Caveats

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc., the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[39] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses, are available on CHBRP's website.[40]

This section describes analysis-specific data sources, estimation methodology, assumptions and caveats used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Baseline coverage of supplemental screening, diagnostic imaging, biopsy, and pathology evaluation for commercial enrollees was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represent 67% of commercial enrollees with health insurance that can be subject to state benefit mandates. In addition, CalPERS, DHCS, and the four largest (by enrollment) DMHC-regulated plans enrolling Medi-Cal beneficiaries were queried regarding related benefit coverage. As necessary, CHBRP extrapolated from responses of similarly situated plans/policies.

For this analysis, CHBRP relied on Current Procedural Terminology (CPT®) codes to identify relevant services: CPT copyright 2026 American Medical Association (AMA). All rights reserved. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the AMA.

Health cost guidelines

The health cost guidelines (HCGs) are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. It is likely that these organizations use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, we believe the HCG-based values are also good estimates of the premium impact as estimated by the HMOs and insurance companies.

The highlights of the commercial HCGs include:

- Specific major medical, managed care, and prescription drug rating sections and guidance with step-by-step rating instructions.
- Other helpful analysis resources, such as inpatient length of stay distribution tables, Medicare Severity-Adjusted Diagnosis Related Group (MS-DRG) models, and supplementary sections addressing EHBs and mandated benefits, experience rating, and individual and small group rating considerations.
- Presentation of loosely and well-managed nationwide utilization and cost information by Milliman benefit-aligned service categories used throughout the Rating Structures – inpatient hospital services for both loosely and well-managed are also supported by DRG level utilization and cost benchmarks.
- Annual updates address emerging regulatory considerations such as health care reform and mental health parity requirements.
- Annually updated benefit descriptions used in the HCG service categories.
- Annually updated medical trend assumptions and considerations.

[39] CHBRP's authorizing statute requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[40] See CHBRP's Cost Impact Analysis landing page; in particular, see *Cost Impact Analyses: Data Sources, Caveats, and Assumptions*.

- Presentation of two sets of nationwide area factors to facilitate development of area-specific claim costs, including separate utilization and charge level factors by type of benefit, state and Metropolitan Statistical Area for first-dollar coverage, and composite factors by deductible amount.
- Claim Probability Distributions (CPDs) by type of coverage that contain distributions of claim severity patterns for unique combinations of benefits and member types (adult, child, composite member).
- The Prescription Drug Rating Model (RXRM), an automated rating tool that provides a detailed analysis of prescription drug costs and benefits.

Consolidated health cost guidelines sources database

Milliman maintains benchmarking and analytic databases that include health care claims data for nearly 60 million commercial lives and over 3 million lives of Medicaid managed care data. This dataset is routinely used to evaluate program impacts on cost and other outcomes.

Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable.

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act, and Managed Medi-Cal.
- CHBRP surveyed the carriers to determine the percentage of the population with coverage for breast cancer screening and diagnostic services.
- CHBRP assumed that all members of average risk for breast cancer are fully covered in the baseline without cost sharing for screening services and diagnostic services following a screening service.

Methodology and Assumptions for Baseline Utilization

- The average utilization rates for breast cancer screening and diagnostic services are based on the 2023 Consolidated Health Cost Guidelines™ Sources Database (CHSD). The data were limited to California commercial and Medicaid enrollees.
- Claims for each service category were identified using procedure codes (CPT and HCPCS).[41] The procedure codes used to identify and classify services are listed in Exhibit 1. Utilization rates were summarized separately for claims with and without cost sharing.
- Utilization was trended from 2023 to 2028 using 0.0% trend based on trends from the 2025 Milliman Health Cost Guidelines.
- The overall utilization rate was separated into several groups consisting of average-risk members who start with a screening service and who do not start with a screening service, elevated-risk members, and members who seek services out of network.
    - Average-risk members are assumed to be covered without cost sharing only if they begin treatment with a screening service. Members who begin treatment with a diagnostic service directly may be subject to cost sharing requirements depending on their plan's benefit design. CHBRP estimated the share of members who do not receive a screening service using claims data from the 2023 CHSD.

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Methodology and Assumptions for Baseline Cost

- CHBRP calculated the average cost per service using Milliman's proprietary 2023 CHSD database. The data were limited to California commercial and Medi-Cal beneficiaries.
- The average cost per service for Medicaid enrollees was estimated by calculating the total allowed ratio comparing Medicaid to commercial costs to the unit costs for commercial services. This was done to comply with data use restrictions that forbid sharing unit cost information for Medicaid claims in the CHSD.
- The average costs per medical service were trended from 2023 to 2028 using a 3.0% annual trend based on trends from the 2025 Milliman Health Cost Guidelines.

Methodology and Assumptions for Baseline Cost Sharing

- The average cost sharing per service for the Commercial population was calculated using the 2023 CHSD database. The data were limited to California commercial enrollees.
- The average cost sharing per service for Medi-Cal beneficiaries was estimated by calculating the overall average cost sharing ratio between Medi-Cal and Commercial claims. This was done to comply with data use restrictions for the CHSD.

Table 3. Impacts of AB 1570 on Cost Sharing, 2028

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Average per unit cost sharing – Average Risk Population				
2D mammogram	$33.35	$0.00	−$33.35	−100.00%
DBT	$36.56	$0.00	−$36.56	−100.00%
CEM	$1.59	$0.00	−$1.59	−100.00%
Breast MRI	$103.07	$0.00	−$103.07	−100.00%
Breast US	$29.75	$0.00	−$29.75	−100.00%
MBI	$20.44	$0.00	−$20.44	−100.00%
Breast biopsy	$55.36	$0.00	−$55.36	−100.00%
Pathology evaluation	$13.21	$0.00	−$13.21	−100.00%
Average per unit cost sharing – Elevated Risk Population				
2D Mammogram	$88.14	$0.00	−$88.14	−100.00%
DBT	$94.76	$0.00	−$94.76	−100.00%
CEM	$3.98	$0.00	−$3.98	−100.00%
Breast MRI	$260.96	$0.00	−$260.96	−100.00%
Breast US	$78.99	$0.00	−$78.99	−100.00%
MBI	$73.68	$0.00	−$73.68	−100.00%

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Breast biopsy	$151.05	$0.00	−$151.05	−100.00%
Pathology evaluation	$36.27	$0.00	−$36.27	−100.00%

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

Methodology and Assumptions for Postmandate Utilization

- CHBRP assumed the utilization rate for enrollees of average risk who use screening services and therefore do not have cost sharing at baseline have the same postmandate utilization as in the baseline.
- The postmandate utilization for each service for the populations subject to cost sharing in the baseline (average-risk enrollees who do not receive a screening, elevated-risk enrollees, and members using services out of network) will increase utilization based on the amount of cost sharing removed. These induced utilization factors were calculated using utilization factors at various copay levels from the 2025 Milliman Health Cost Guidelines. These utilization factors were derived from the data underlying the Milliman HCGs.

Methodology and Assumptions for Postmandate Cost

- CHBRP assumed the average cost per service by market would not change as a result of AB 1570.
- Although the cost of each specific service is not assumed to change, the statewide mix of services does. Commercial plans have a larger increase in utilization postmandate compared to Medi-Cal due to their higher baseline average cost sharing. Due to commercial unit costs being higher than Medicaid, the overall weighted average cost per unit increases postmandate when calculated across all markets, even though each market does not see an increase in unit cost individually.

Methodology and Assumptions for Postmandate Cost Sharing

- CHBRP assumed the average cost sharing per service is $0 in the postmandate.

Methodology and Assumptions related to Breast Cancer Screening

- CHBRP assumed 28.9% of utilizers of breast cancer screening and diagnostic services are at elevated risk of breast cancer (Sprague et al., 2017).[42]
- CHBRP assumed 40% of commercial enrollees and 50% of Medi-Cal beneficiaries receive diagnostic services without a prior screening service based on claims data in the 2023 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. The proportions were derived by counting the percent share of members with a diagnostic claim in June through December of 2023 who did not receive a screening service from January 2023 through the date of their first diagnostic service. This count of diagnostic-only members is divided by the total count of members using any screening or diagnostic service between June and December 2023.
- CHBRP assumed that every biopsy has a corresponding pathology evaluation service.

Other Methodology and Assumptions

- The following table shows the assumed average unit cost and utilization rate per 1,000 members by service category in the baseline.

[42] 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.

Service Category	Average Per Unit Cost	Baseline Utilization Per 1,000
2D mammogram	$249.28	10.56
DBT, or 3D mammography	$191.40	9.07
CEM	$6.33	0.31
Breast MRI	$1,272.18	1.95
Breast US	$175.71	11.46
MBI	$150.77	0.01
Breast biopsy	$893.26	6.72
Pathology evaluation	$111.35	6.72

Exhibit 1 – List of Procedure Codes by Service Category

CPT / HCPCS[43]	Purpose	Service	Description
77067	Screening	2D mammogram	Screening mammography, bilateral (two-view study of each breast), including computer-aided detection (CAD) when performed
77063	Screening	3D mammogram	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)
3014F	Screening	Review of 2D mammogram	Screening mammography results documented and reviewed positive predictive value (PV)
G9899	Screening	Review of 3D mammogram	Screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammography results documented and reviewed
G9900	Screening	Review of 3D mammogram	Screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammography results were not documented and reviewed, reason not otherwise specified
77065	Diagnostic	2D mammogram	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	Diagnostic	2D mammogram	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77061	Diagnostic	3D mammogram	Diagnostic digital breast tomosynthesis; unilateral
77062	Diagnostic	3D mammogram	Diagnostic digital breast tomosynthesis; bilateral
96374	Diagnostic	Contrast-enhanced mammogram	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug

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Q9967	Diagnostic	Contrast-enhanced mammogram	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml
77048	Diagnostic	MRI of breast	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
77049	Diagnostic	MRI of breast	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral
C8905	Diagnostic	MRI of breast	Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral
C8906	Diagnostic	MRI of breast	Magnetic resonance imaging with contrast, breast; bilateral
C8908	Diagnostic	MRI of breast	Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral
C8937	Diagnostic	MRI of breast	Computer-aided detection, including computer algorithm analysis of breast MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation (list separately in addition to code for primary procedure)
76642	Diagnostic	Ultrasound of breast	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited
76645	Diagnostic	Ultrasound of breast	Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation
76882	Diagnostic	Ultrasound of breast	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (e.g., joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation
78800	Diagnostic	Molecular imaging	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, single area (e.g., head, neck, chest, pelvis), single-day imaging
10021	Diagnostic	Breast biopsy	Fine needle aspiration biopsy, without imaging guidance; first lesion
19081	Diagnostic	Breast biopsy	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance
19083	Diagnostic	Breast biopsy	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance

19085	Diagnostic	Breast biopsy	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance
19100	Diagnostic	Breast biopsy	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)
19101	Diagnostic	Breast biopsy	Biopsy of breast; open, incisional
19120	Diagnostic	Breast biopsy	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions
19125	Diagnostic	Breast biopsy	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion
19126	Diagnostic	Breast biopsy	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (list separately in addition to code for primary procedure)
19281	Diagnostic	Breast biopsy	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance
19282	Diagnostic	Breast biopsy	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)
19283	Diagnostic	Breast biopsy	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance
19286	Diagnostic	Breast biopsy	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)
19287	Diagnostic	Breast biopsy	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance
19288	Diagnostic	Breast biopsy	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)
76098	Diagnostic	Breast biopsy	Radiological examination, surgical specimen
76942	Diagnostic	Breast biopsy	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation
77021	Diagnostic	Breast biopsy	Magnetic resonance imaging guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation

88305	Diagnostic	Pathology evaluation	Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy
88307	Diagnostic	Pathology evaluation	Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse

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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.

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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 developed its Cost and Coverage model in collaboration with Milliman, an independent actuarial firm, to estimate fiscal values. The model projects premium and other financial impacts of proposed health insurance benefits. Milliman verified that model inputs, calculations, and outputs comply with generally accepted actuarial standards and are consistent, reasonable, and appropriate. Public health impacts are estimated using literature review data and fiscal projections.

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.