May 7, 2026

The Honorable Mia Bonta
Chair, Assembly Health Committee
1020 N Street, Room 390
Sacramento, CA 95814

The Honorable Sabrina Cervantes
Chair, Senate Appropriations Committee
State Capitol, 412
Sacramento, CA 95814

The Honorable Akilah Weber Pierson
Chair, Senate Health Committee
1021 O Street, Suite 3310
Sacramento, CA 95814

The Honorable Buffy Wicks
Chair, Assembly Appropriations Committee
1021 O Street, Suite 8220
Sacramento, CA 95814

Re: Requested Letter to the 2025-26 California State Legislature on Assembly Bill 1570: Diagnostic Imaging

Dear Chairs Bonta, Weber Pierson, Cervantes, and Wicks:

On April 30, 2026, Assembly Appropriations Committee staff asked the California Health Benefits Review Program (CHBRP) to analyze the cost impact of proposed amendments to Assembly Bill (AB) 1570 (Wilson) Diagnostic Imaging. CHBRP previously analyzed the bill as introduced on January 12, 2026, and published a full analysis on March 27, 2026. Following that publication, the bill was amended on April 9, 2026; CHBRP's interpretation of those amendments is explained below.

This letter details the updated cost and utilization impacts of the version of AB 1570 provided to CHBRP on May 1, 2026, by Assemblymember Wilson's office. As of May 7, these amendments appear in a Reprint Notice (RN) dated April 29 but have not been formally adopted. CHBRP refers to this version as the "proposed amendments."

Bill Language

As Introduced

As introduced, AB 1570 would require state-regulated health plans and policies to cover certain services related to breast cancer screening and diagnostic imaging services without cost sharing, in accordance with clinical guidelines. The bill cites National Comprehensive Cancer Network (NCCN) guidelines in reference to specific services. The services within scope of AB 1570 as introduced are listed in Table 1, below, as defined in the bill language and mapped to their corresponding clinical guideline terminology. As shown in Table 1, CHBRP determined that biopsy and pathology fall within scope of the bill definition of “diagnostic breast examination,”[1]

[1] The term “diagnostic breast examination” is not included in NCCN. CHBRP used content experts to map this terminology to clinical services.

described in the bill as " examinations…used to evaluate an abnormality seen or suspected from a screening examination for breast cancer [or] used to evaluate an abnormality detected by another means of examination."

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

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

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

CHBRP's full analysis of AB 1570 as introduced on January 12, 2026 can be accessed at www.chbrp.org.

April 9, 2026 Amendments

AB 1570 was amended on April 9, 2026 to remove "tests for screening or diagnostic purposes." CHBRP interprets this change as having minimal impact on the services in scope, but does remove the possibility of broader interpretation.

Proposed Amendments

The proposed amendments provided to CHBRP on April 30 would change the scope of services included in AB 1570. Specifically, the amendments redefine "diagnostic breast examination" as "medically necessary and appropriate, in accordance with [NCCN] Guidelines, *imaging* of the breast" (as opposed to "examination" of the breast). Amendments also remove other broad "examination" language. CHBRP interprets this amendment as removing biopsy and pathology evaluation from the scope of the bill: while the original "examination" language was broad enough to encompass non-imaging services, the revised definition is limited to imaging, and biopsy and pathology are not imaging services.

Existing Benefit Coverage

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[2] plans and policies following the

[2] 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.

United States Preventive Services Task Force (USPSTF) A and B recommendations[3] and the Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for women's preventive services.[4,5] AB 144, which was signed into law in September 2025, requires nongrandfathered state-regulated health plans in California to cover preventive care services recommended by the federal government as of January 1, 2025, or by the California Department of Public Health (CDPH), without cost sharing.[6]

Differences in Baseline Benefit Coverage

While all services relevant to AB 1570 are recommended by the USPSTF or HRSA in some form, not all services are recommended uniformly across all risk levels. Key baseline coverage distinctions include:

- **Women at average risk** of breast cancer have coverage without cost sharing for supplemental screening and additional imaging to complete the screening process or to address findings on an initial screening mammography. The language of this recommendation specifically mentions pathology evaluation (HRSA, 2025).
- **Women at elevated (intermediate or high) risk** of breast cancer do not have coverage without cost sharing for supplemental screening or additional imaging to complete the screening process or address findings on an initial screening mammography.
- **Women at any risk level** lack coverage without cost sharing for diagnostic imaging (e.g., MRI, ultrasound MBI**)** when no prior screening has occurred — referred to here as "diagnostic-first services."

Populations Impacted by AB 1570

Based on the differences in baseline coverage by risk level, CHBRP identified two populations in its initial analysis that would gain new coverage as a result of AB 1570:

- **Women at elevated risk** would gain coverage without cost sharing for supplemental screening and additional diagnostic breast imaging following a screening, as well as biopsy and pathology evaluation. This would close the existing coverage gap between women at elevated risk and women at average risk of breast cancer.
- **Women at any risk level** who proceed directly to diagnostic services without a primary screening would gain coverage without cost sharing for diagnostic-first services within scope of the bill language as identified in NCCN guidelines. Although the bill does not specify risk level for these services, CHBRP assumes that nearly all women who forego a primary screening and receive medically necessary diagnostic-first services presented with symptoms.

The proposed amendments CHBRP was asked to analyze would not change the impacted populations. However, they would remove biopsy and pathology services from scope of the bill for all impacted populations.

For a detailed description of the policy landscape that informs baseline coverage for breast cancer screening and diagnostic imaging services, please see CHBRP's initial analysis of AB 1570 as introduced at www.chbrp.org.

Updated Assumptions and Analytic Approach

Based on CHBRP's interpretation of the proposed amendments, non-imaging services previously considered within the scope of "diagnostic breast examination" — biopsy and pathology evaluation — would no longer be covered by the bill. CHBRP therefore assumes that utilization of these services would not increase from baseline under AB 1570.

[3] 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.
[4] Health and Safety Code (HSC) 1367.002; Insurance Code (INS) 10112.2.
[5] 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*.
[6] HSC 120164.

One of CHBRP's utilization assumptions changed as a result of the proposed amendments. CHBRP's initial analysis assumed that 40% of commercial enrollees and 50% of Medi-Cal beneficiaries receive diagnostic services without a prior screening. Under the proposed amendments, these estimates are reduced to 15% and 20%, respectively. This estimate is based on claims data and is explained in detail in the Appendix.

All other assumptions from CHBRP's initial analysis remain applicable. For further information, see the Appendix and CHBRP's initial analysis of AB 1570 at www.chbrp.org.

Updated Cost and Utilization Impacts

Utilization

CHBRP found that removing biopsy and pathology evaluation from scope for AB 1570 would impact projected utilization in two ways. First, it would remove the impact of the bill on utilization of biopsy and pathology. As stated above, CHBRP assumes that utilization of biopsy and pathology services would not increase from baseline when cost sharing is not prohibited. Second, this change would reduce utilization of other screening and diagnostic imaging services among certain populations.

CHBRP estimates that if coverage without cost sharing for biopsy and pathology was removed, projected utilization of other services would be lower because fewer women would seek diagnostic-first services. This would reduce projected utilization of services more among women at average risk of breast cancer, because this is the only type of new coverage that they would gain as a result of AB 1570. As discussed above, women at average risk of breast cancer have baseline coverage without cost sharing for supplemental screening and follow-up diagnostic services – including biopsy and pathology – when following a screening. However, they do not have such coverage for diagnostic-first services (e.g., MRI, ultrasound, and/or MBI without a prior screening). This means that women at average risk of breast cancer would only gain new coverage from AB 1570 for diagnostic-first services.

Women at elevated risk of breast cancer would gain coverage for diagnostic services through both pathways described above – supplemental screening and diagnostic imaging services as well as diagnostic-first services – as a result of AB 1570. Because of this, their postmandate utilization is driven by both those who do and do not first seek a screening.

Table 2 below highlights the service-level differences in utilization change between AB 1570 as introduced and AB 1570 as proposed to be amended ("as amended" in the table) by risk population.

Table 2. Impacts of AB 1570 on Utilization and Unit Cost, as Introduced and as Amended, 2028

	As Introduced: Increase/Decrease	As Introduced: Percent Change	As Amended: Increase/Decrease	As Amended: Percentage Change
Number of enrollees using mandated benefit – Average Risk Population				
2D mammogram	6,743	5.96%	2,522	2.23%
DBT, or 3D mammography	4,114	5.96%	1,543	2.23%
CEM (a)	0	0.00%	0	0.00%
Breast MRI	1,452	5.96%	544	2.23%
Breast US	7,653	5.96%	2,869	2.23%
MBI	9	5.96%	3	2.23%

	As Introduced: Increase/Decrease	As Introduced: Percent Change	As Amended: Increase/Decrease	As Amended: Percentage Change
Number of enrollees using mandated benefit – Elevated Risk Population				
2D mammogram	6,852	14.89%	6,834	14.89%
DBT, or 3D mammography	4,180	14.89%	4,180	14.89%
CEM (a)	0	0.00%	0	0.00%
Breast MRI	1,475	14.89%	1,475	14.89%
Breast US	7,777	14.89%	7,774	14.89%
MBI	9	14.89%	9	14.89%
Total utilization – Average Risk Population				
2D mammogram	7,009	4.09%	2,682	1.57%
DBT, or 3D mammography	7,059	4.79%	2,711	1.84%
CEM (a)	0	0.00%	0	0.00%
Breast MRI	1,538	4.85%	580	1.83%
Breast US	8,358	4.49%	3,225	1.73%
MBI	6	3.10%	3	1.25%
Total utilization – Elevated Risk Population				
2D mammogram	7,003	10.04%	6,956	10.00%
DBT, or 3D mammography	7,049	11.77%	7,024	11.73%
CEM (a)	0	0.00%	0	0.00%
Breast MRI	1,558	12.08%	1,557	12.07%
Breast US	8,314	10.99%	8,272	10.94%
MBI	6	7.33%	6	7.24%

Source: California Health Benefits Review Program, 2026.
Notes: Although clinical guidelines recommend supplemental screenings for various risk levels, CHBRP found that the services outlined in Table 5 are rarely billed as supplemental screenings. It is common in clinical practice for services used as supplemental screening tools to be coded as diagnostic tools.[7]
(a) CHBRP estimates that CEM utilization and unit cost would increase as a result of AB 1570; however, given low baseline utilization and unit cost, the percent change for both estimates is a fraction of a percent that rounds to zero.
Key: 2D = two-dimensional; CEM = contrast-enhanced mammography; DBT = digital breast tomosynthesis; MRI = magnetic resonance imaging; US = ultrasound.

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

Cost

CHBRP estimates that removing coverage without cost sharing for biopsy and pathology evaluation from AB 1570 would reduce annual premium impacts to $44,722,000. This is a reduction of $49,235,000, or 52% (initial annual premium impacts were estimated at $93,957,000). This reduction is attributable to the corresponding reduction in projected service utilization. Updated estimates of annual premium impacts and per member per month (PMPM) impacts by market segment are shown below in Tables 3 and 4, respectively.

Table 3. Impacts of AB 1570 on Premiums, as Amended, 2028

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Non-enrollee premiums				
Employer-sponsored (a)	$75,730,916,000	$75,757,421,000	$26,505,000	0.03%
CalPERS employer (b)	$8,611,855,000	$8,614,536,000	$2,681,000	0.03%
Medi-Cal	$42,982,384,000	$42,982,520,000	$136,000	0.00%
Enrollee premiums				
Enrollees, individually purchased insurance	$25,775,325,000	$25,783,173,000	$7,848,000	0.03%
Outside Covered California	$9,551,761,000	$9,554,717,000	$2,956,000	0.03%
Through Covered California	$16,223,564,000	$16,228,456,000	$4,892,000	0.03%
Enrollees, group insurance (c)	$21,828,135,000	$21,835,687,000	$7,552,000	0.03%
Total premiums	**$174,928,615,000**	**$174,973,337,000**	**$44,722,000**	0.03%

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

Table 4. Premium Impact Ranges of AB 1570 by Market Segment, as Introduced and as Amended, 2028

Market Segment	As Introduced: Premium Impact Range (PMPM)	As Amended: Premium Impact Range (PMPM)
Commercial plans/policies	$0.56 – $0.59	$0.27 – $0.28
Covered California – individually purchased	$0.55 – $0.64	$0.26 – $0.30
CalPERS	$0.60	$0.29
Medi-Cal	$0.0027	$0.0012

Source: California Health Benefits Review Program, 2026.

Key: CalPERS = California Public Employees' Retirement System.

Average enrollee expenses by market segment would change minimally under the proposed amendments compared to CHBRP's initial analysis. Table 5 below compares average annual enrollee expenses between these two versions of the bill.

Table 5. Average Annual Enrollee Expenses for Users, AB 1570 as Introduced and as Amended, 2028

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
As Introduced: Average annual enrollee expenses impact for users	-$84.11	-$82.29	-$84.47	-$89.92	-$1.04
As Amended: Average annual enrollee expenses impact for users	-$87.05	-$85.17	-$87.42	-$92.96	-$1.05

Source: California Health Benefits Review Program, 2026.
Notes: Average enrollee expenses include enrollee premium (employee portion only), cost sharing (e.g. deductibles, copays, etc.) for covered benefits and out-of-pocket expenses for noncovered benefits.
Key: CalPERS = California Public Employees' Retirement System.

For more information on CHBRP's cost and utilization methods, see the Appendix.

Public Health Impacts

Although CHBRP was not formally asked to analyze the public health impacts of the proposed amendments to AB 1570, removing biopsy and pathology services from scope could possibly reduce the early detection gains identified in CHBRP's initial analysis.

CHBRP's faculty and staff appreciate the opportunity to provide this analysis, and we will be happy to respond to any of your questions.

Sincerely,

Garen L. Corbett, MS
Director
California Health Benefits Review Program

Appendix

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.[8] 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.[9]

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

Analysis-Specific Data Sources

Current coverage of breast cancer diagnostic services for commercial enrollees was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represented 67% of commercial enrollees with health insurance that can be subject to state benefit mandates. In addition, CalPERS and DHCS were queried regarding related benefit coverage.

For this analysis, CHBRP relied on CPT codes to identify services related to AB 1570. CPT copyright 2026 American Medical Association. 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 American Medical Association.

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.

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

- 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.
- 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 three 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 Database (CHSD). The data was limited to California commercial and Medicaid enrollees.
- Claims for each service category were identified using procedure codes (CPT and HCPCS).[1] 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, higher than average 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.

Methodology and Assumptions for Baseline Cost

- CHBRP calculated the average cost per service using Milliman's proprietary 2023 CHSD database. The data was limited to California commercial and Medi-Cal enrollees.
- 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 which 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 was calculated using the 2023 CHSD database. The data was limited to California commercial and Medi-Cal enrollees.
- The average cost sharing per service for Medi-Cal enrollees 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.

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, higher than average risk enrollees, and members using services out of network) would increase 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.
- While 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 postmandate.

Methodology and Assumptions related to Breast Cancer Screening

- CHBRP assumed 28.9% of utilizers of breast cancer screening and diagnostic services are at intermediate or high risk of breast cancer. The rest – 71.2% - are at average risk of breast cancer (Sprague et al., 2017).
- CHBRP assumed 15% of commercial enrollees and 20% of Medi-Cal beneficiaries receive diagnostic services without a prior screening service based on claims data in the 2023 CHSD. These factors are applied at 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.

Other Methodology and Assumptions

The following tables show the assumed average unit cost and utilization rate per 1,000 members by service category in the baseline and the list of procedure codes by service category used for this analysis.

Service Category	Average Per Unit Cost	Baseline Utilization per 1,000
2D Mammogram	$263.43	10.54
DBT	$197.53	9.07
Contrast-Enhanced Mammogram	$6.42	0.31
MRI of Breast	$1,309.99	1.95
Ultrasound of Breast	$183.01	11.46
Molecular Imaging	$162.98	0.01

List of Procedure Codes by Service Category

CPT / HCPCS[10]	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

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96374	Diagnostic	Contrast-enhanced mammogram	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
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

References

Health Resources & Services Administration (HRSA). Women's Preventive Services Guidelines. December 2025. Available at: https://www.hrsa.gov/womens-guidelines. Accessed January 26, 2026.

Sprague BL, Arao RF, Miglioretti DL, et al. National performance benchmarks for modern diagnostic digital mammography: update from the Breast Cancer Surveillance Consortium. *Radiology.* 2017;283(1):59-69. doi:10.1148/radiol.2017161519.