The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Fiscal Policy

BILL: SB 1578

INTRODUCER: Senator Davis

SUBJECT: Coverage for Mammograms and Supplemental Breast Cancer Screenings

DATE: April 21, 2025 REVISED: ________ ________ ________ ________

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Moody	Knudson	BI	**Favorable**
2.	Barr	McKnight	AHS	**Favorable**
3.	Moody	Siples	FP	**Favorable**

I. Summary:

SB 1578 modifies required coverage for mammograms and supplemental breast cancer screenings in Florida. The bill requires the Agency for Health Care Administration (ACHA) to provide Medicaid coverage to female recipients who are aged 25 and over for one mammogram and one supplemental breast screening in certain circumstances.

Further, the bill modifies the coverage mandate for mammograms for the following types of insurance coverage:

- An individual accident and health insurance policy ("individual insurance policy"),
- A group, blanket, and franchise health insurance ("group insurance policy"), and
- A health maintenance organization (HMO) contract.

Such policies or contracts are amended to increase mandatory mammogram coverage and to require coverage for supplemental breast cancer screenings in specified circumstances, including coverage for additional risk factors than are covered under current law. The bill defines "supplemental breast cancer screening" to mean a clinically appropriate examination, in addition to a mammogram, deemed medically necessary by a treating physician for breast cancer screening in accordance with applicable American College of Radiology guidelines, which may include but is not limited to magnetic resonance imaging, ultrasound, and molecular breast imaging. The bill's coverage requirement of supplemental breast cancer screenings replaces the mandate that insurance policies and HMO contracts provide coverage for additional mammograms based on a physician's recommendation.

The relevant sections of current law are updated to conform to the revised coverage, and certain terms are defined in the relevant sections to clarify the scope of the coverage.

The bill will have an indeterminate, negative fiscal impact on state expenditures related to state employee insurance. The bill will have an indeterminate negative fiscal impact on private sector individuals and insurers. **See Section V., Fiscal Impact Statement**.

The bill takes effect July 1, 2025.

II. Present Situation:

Background

Rates of breast cancer vary among different groups of people. Rates vary between women and men and among people of different ethnicities and ages. Rates of breast cancer incidence (new cases) and mortality (death) are much lower among men than among women. The American Cancer Society made the following estimates regarding cancer among women in the U.S. during 2024:

- 310,720 new cases of invasive breast cancer (This includes new cases of primary breast cancer, but not breast cancer recurrences);
- 56,500 new cases of ductal carcinoma in situ (DCIS), a non-invasive breast cancer; and
- 42,250 breast cancer deaths.[1]

The estimates for men in the U.S. for 2024 were:

- 2,790 new cases of invasive breast cancer (This includes new cases of primary breast cancers, but not breast cancer recurrences); and
- 530 breast cancer deaths.[2]

Breast cancer is the second most common form of cancer diagnosed in women, and it is estimated that one in eight women will be diagnosed with breast cancer in her lifetime.[3] It accounts for 30 percent of all new female cancers in the United States each year.[4] The median age at which a woman is diagnosed is 62 with a very small percentage of women who are diagnosed under the age of 45.[5]

Risks and Risk Factors

There are no absolute ways to prevent breast cancer as there might be with other forms of cancer; however, there are some risk factors that may increase a woman's chances of receiving a diagnosis. Some risk factors that are out of an individual's control are:

- Being born female;
- Aging beyond 55;
- Inheriting certain gene changes;
- Having a family or personal history of breast cancer;
- Being of certain race or ethnicity;

[1] *Cancer Facts & Figures*, pgs. 10-11, American Cancer Society - Cancer Facts & Figures 2024 (last visited Mar. 20, 2025).
[2] *Id.*
[3] American Cancer Society, *Key Statistics for Breast Cancer,* Breast Cancer Statistics | How Common Is Breast Cancer? | American Cancer Society (last visited Mar. 20, 2025).
[4] *Id.*
[5] *Id.*

- Being taller;
- Having dense breast tissue;
- Having certain benign breast conditions;
- Starting menstrual periods early, usually before age 12;
- Having radiation to the chest; and
- Being exposed to the drug, diethylstilbestrol.[6]

For many of the factors above, it is unclear why these characteristics make an individual more susceptible to a cancer diagnosis other than perhaps being female. However, men can and do receive breast cancer diagnoses, just in very small numbers. About one in every 100 breast cancers diagnosed in the United States is found in a man.[7]

Breast Cancer Screening

In Florida, an individual insurance policy, a group insurance policy, or a health maintenance contract issued, amended, delivered, or renewed in this state must provide coverage for at least the following:

- A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
- A mammogram every two years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendation.
- A mammogram every year for any woman who is 50 years of age or older.
- One or more mammograms a year, based upon a physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, having a history of biopsy-proven benign breast disease, having a mother, sister, or daughter who has or has had breast cancer, or a woman has not given birth before the age of 30.[8]

With respect to an individual insurance policy or a group insurance policy only, except for mammograms conducted more frequently than every 2 years for women between the ages of 40 to 50 years old, the coverage for mammograms described above only applies if the insured obtains a mammogram in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health.[9] The coverage for individual and group policies and contracts is subject to the deductible and coinsurance applicable to other benefits.[10]

However, mammography is only the initial step in early detection and, by itself, unable to diagnose cancer. A mammogram is an x-ray of the breast.[11] While screening mammograms are routinely performed to detect breast cancer in women who have no apparent symptoms,

[6] American Cancer Society, *Breast Cancer Risk Factors You Cannot Change*- Breast Cancer Risk Factors You Can't Change | American Cancer Society (last visited Mar. 20, 2025).
[7] Centers for Disease Control and Prevention, *Breast Cancer in Men*- About Breast Cancer in Men | Breast Cancer | CDC (last visited Mar. 21, 2025).
[8] Sections 627.6418(1), 627.6613(2), and 641.31095(1), F.S.
[9] Sections 627.6418(2) and 627.6613(2), F.S.
[10] Sections 627.6418(2), 627.6613(2), and 641.31095(2), F.S.
[11] National Breast Cancer Foundation, *What Is The Difference Between A Diagnostic Mammogram And A Screening Mammogram?*, available at https://www.nationalbreastcancer.org/diagnostic-mammogram (last visited Mar. 21, 2025).

diagnostic mammograms are used after suspicious results on a screening mammogram or after some signs of breast cancer alert the physician to check the tissue.[12]

If a mammogram shows something abnormal, early detection of breast cancer requires diagnostic follow-up or additional supplemental imaging required to rule out breast cancer or confirm the need for a biopsy.[13] An estimated 12-16 percent of women screened with modern digital mammography require follow-up imaging.[14] Out-of-pocket costs are particularly burdensome on those who have previously been diagnosed with breast cancer, as diagnostic tests are recommended rather than traditional screening.[15] When breast cancer is detected early, the five-year relative survival rate is ninety-nine percent.[16]

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida.[17] As part of their regulatory oversight, the OIR may suspend or revoke an insurer's certificate of authority under certain conditions.[18] The OIR is responsible for examining the affairs, transactions, accounts, records, and assets of each insurer that holds a certificate of authority to transact insurance business in Florida.[19] As part of the examination process, all persons being examined must make available to the OIR the accounts, records, documents, files, information, assets, and matters in their possession or control that relate to the subject of the examination.[20] The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.[21]

The Agency for Health Care Administration (AHCA) regulates the quality of care by health maintenance organizations (HMO) under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[22] As part of the certificate process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[23]

[12] *Id.*
[13] Susan G. Komen Organization, *Breast Cancer Screening & Early Detection*, available at https://www.komen.org/breast-cancer/screening/ (last visited Mar. 21, 2025).
[14] *Id.*
[15] *Id.*
[16] National Breast Cancer Foundation, *3 Steps to Early Detection Guide*, available at 3 Steps to Early Detection - Breast Cancer Detection Guide (last visited Mar. 21, 2025).
[17] Section 20.121(3)(a), F.S. The Financial Services Commission, composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serves as agency head of the Office of Insurance Regulation for purposes of rulemaking. Further, the Financial Services Commission appoints the commissioner of the Office of Insurance Regulation.
[18] Section 624.418, F.S.
[19] Section 624.316(1)(a), F.S.
[20] Section 624.318(2), F.S.
[21] Section 624.3161, F.S.
[22] Section 641.21(1), F.S.
[23] Section 641.495, F.S.

Florida's Medicaid Program[24]

Administration of the Program

The Agency for Health Care Administration (AHCA) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act (SSA). This authority includes establishing and maintaining a Medicaid state plan approved by the federal Centers for Medicare and Medicaid Services and maintaining any Medicaid waivers needed to operate the Florida Medicaid program as directed by the Florida Legislature.

A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid programs; it establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements. State Medicaid programs may request a formal waiver of the requirements codified in the SSA. Federal waivers give states flexibility not afforded through their Medicaid state plan.

In Florida, most Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and Dental. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S.

Mandatory Medicaid Coverage

Section 409.905, F.S., relating to mandatory Medicaid services, provides that the AHCA may make payments for delineated services, which are required of the state by Title XIX of the SSA. Currently, the Florida Medicaid program covers mammograms and other breast screening services under s. 409.905, F.S., and Rule 59G-4.240 of the Florida Administrative Code, which incorporates the Radiology and Nuclear Medicine Services Coverage Policy by reference. An eligible recipient must:

- Be enrolled in the Florida Medicaid program on the date of service,
- Meet the criteria of the policy, and
- Require medically necessary services.[25]

Mandatory services must not be duplicative.[26] Mammography screenings are covered at a frequency of one per year, per recipient.[27] No age limit or requirement is specified.[28] Any additional screening services are covered as listed on the associated Radiology Fee Schedule,

[24] Agency for Health Care Administration, *Senate Bill 1578 Bill Analysis*, (Mar. 20, 2025) (on file with the Senate Committee on Banking and Insurance)

[25] Agency for Health Care Administration, *Florida Medicaid: Radiology and Nuclear Medicine Services Coverage Policy*, p. 2-3, May 2019, available at 59G-4.240_Radiology_and_Nuclear_Medicine_Coverage_Policy_2019.pdf (last visited Mar. 21, 2025).

[26] Agency for Health Care Administration, *Florida Medicaid: Radiology and Nuclear Medicine Services Coverage Policy*, p. 2-3, May 2019, available at 59G-4.240_Radiology_and_Nuclear_Medicine_Coverage_Policy_2019.pdf (last visited Mar. 21, 2025).

[27] *Id.*

[28] *Id.*

which currently includes magnetic resonance imaging (MRI) of breast, molecular breast imaging of breast, ultrasound of breast, and digital breast tomosynthesis mammogram.[29] SMMC plans have the flexibility to cover service above and beyond the ACHA's coverage policies, but they may not be more restrictive than ACHA's policy, meaning they must cover these services as described in this section at a minimum.[30]

Patient Protection and Affordable Care Act

Essential Benefits

Under the Patient Protection and Affordable Care Act (PPACA),[31] all non-grandfathered health plans in the non-group and small-group private health insurance markets must offer a core package of health care services known as the essential health benefits (EHBs). While the PPACA does not specify the benefits within the EHB, it provides 10 categories of benefits and services that must be covered and it requires the Secretary of Health and Human Services to further define the EHB.[32]

The 10 EHB categories are:
- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitation and habilitation services.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.

The PPACA requires each state to select its own reference benchmark plan as its EHB benchmark plan that all other health plans in the state use as a model. Beginning in 2020, states could choose a new EHB plan using one of three options, including: selecting another's state benchmark plan; replacing one or more categories of EHB benefits; or selecting a set of benefits that would become the State's EHB benchmark plan.[33] Florida selected its EHB plan before 2012 and has not modified that selection.[34]

[29] Agency for Health Care Administration, *Senate Bill 1578 Bill Analysis*, (Mar. 20, 2025) (on file with the Senate Committee on Banking and Insurance)
[30] *Id.*
[31] Patient Protection and Affordable Care Act of 2010. Pub. L. No. 111-141, as amended.
[32] 45 CFR 156.100. et seq.
[33] Centers for Medicare and Medicare Services, *Marketplace – Essential Health Benefits,* available at https://www.cms.gov/marketplace/resources/data/essential-health-benefits (last reviewed Mar. 21, 2025).
[34] Centers for Medicare and Medicaid Services, *Information on Essential Health Benefits (EHB) Benchmark Plans,* Florida State Required Benefits, available at https://downloads.cms.gov/ (last viewed on Mar. 21, 2025).

State Employee Health Plan

For state employees who participate in the state employee benefit program, the Department of Management Services through the Division of State Group Insurance (DSGI) administers the state group health insurance program (Program).[35] The Program is a cafeteria plan managed consistent with section 125 of the Internal Revenue Service Code.[36] To administer the program, DSGI contracts with third party administrators for self-insured plans, a fully insured HMO, and a pharmacy benefits manager for the state employees' self-insured prescription drug program, pursuant to s.110.12315, F.S. For the 2025 Plan Year, which began January 1, 2025, the HMO plans under contract with DSGI are Aetna, Capital Health Plan, and United Healthcare, and the preferred provider organization (PPO) plan is Florida Blue.[37]

Breast Cancer Screening Coverage

Currently, the Program covers 100 percent of the costs of screening, preventive mammograms, (consistent with federal requirements related to essential health benefits coverage). Out of pocket costs, such as copayments, may vary for supplemental and diagnostic imaging based on the enrollee's plan and the provider selected.

Legislative Proposals for Mandated Health Benefit Coverage

Any person or organization proposing legislation which would mandate health coverage or the offering of health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, must submit to the AHCA and the legislative committees having jurisdiction a report which assesses the social and financial impacts of the proposed coverage.[38] Guidelines for assessing the impact of a proposed mandated or mandatorily offered health coverage, to the extent that information is available, include:

- To what extent is the treatment or service generally used by a significant portion of the population?
- To what extent is the insurance coverage generally available?
- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment?
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship?
- The level of public demand for the treatment or service.
- The level of public demand for insurance coverage of the treatment or service.
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- To what extent will the coverage increase or decrease the cost of the treatment or service?

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[35] Section 110.123, F.S.

[36] A section 125 cafeteria plan is a type of employer offered, flexible health insurance plan that provides employees a menu of pre-tax and taxable qualified benefits to choose from, but employees must be offered at least one taxable benefit such as cash, and one qualified benefit, such as a Health Savings Account.

[37] Department of Management Services, Division of State Group Insurance, *2024 Open Enrollment Brochure for Active State Employee Participants,* available at https://www.mybenefits.myflorida.com/beta_-_open_enrollment (last visited Mar. 21, 2025).

[38] Section 624.215(2), F.S.

- To what extent will the coverage increase the appropriate uses of the treatment or service?
- To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service?
- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders?
- The impact of this coverage on the total cost of health care.[39]

To date, such a report has not been received by the Senate Committee on Banking and Insurance.

III. Effect of Proposed Changes:

The bill amends certain minimum insurance coverage for mammograms and supplemental breast cancer screenings to apply to younger women and modifies risk factors.

Section 1 requires, subject to availability, limitations or directions of funds, the Agency for Health Care Administration (AHCA) to provide the following specified annual coverage to a woman who is aged 25 years or older and enrolled in the Florida Medicaid Program:

- One mammogram to detect the presence of breast cancer.
- One supplemental breast cancer screening to detect breast cancer if:
  - The woman's mammogram demonstrates that the woman has dense breast based on specified imaging standards.
  - The woman is at increased risk of breast cancer due to a personal or family history of breast cancer, a personal history of biopsy-proven benign breast disease, ancestry, genetic predisposition, not having given birth before the age of 30, and other reasons as determined by the woman's health care provider.

The AHCA must seek any required federal approval to implement these provisions.

The bill also defines the following terms in the Florida Medicaid laws:

- "Mammogram" means "an image of a radiologic examination used to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the X-ray picture of the breast captured using equipment dedicated specifically for mammography, including, but not limited to, the X-ray tube, filter, compression device, screens, film, and cassettes. The radiologic examination must include two views of each breast. The term also includes images from digital breast tomosynthesis and the professional interpretation of images from any mammography equipment but does not include any diagnostic mammography image."
- "Supplemental breast cancer screening" means "a clinically appropriate examination, in addition to a mammogram, deemed medically necessary by a treating health care provider for breast cancer screening in accordance with applicable American College of Radiology guidelines, which examination includes, but is not limited to, magnetic resonance imaging, ultrasound, and molecular breast imaging."

Sections 2, 3, and 4 modifies ss. 627.6418, 627.6613, and 641.31095, F.S., relating to an individual insurance policy; a group insurance policy; and a health maintenance organization contract, respectively, to revise the state's coverage mandates for mammograms. For any woman aged 25 or older, the policy or contract must provide coverage for one mammogram and must

[39] Section 624.215(2)(a)-(l), F.S.

also cover one supplemental breast cancer screening per year, based upon a physician's recommendation if the woman is a risk for breast cancer because of dense breast tissue, a personal or family history of breast cancer, a personal history of biopsy-proven benign breast disease, ancestry, genetic predisposition, the woman has not given birth before age 30, or because of other reasons determined by the woman's physician.

The bill makes the following changes to current law:

- Lowers the minimum age for any mandatory coverage by ten years (i.e. from 35 years old to 25 years old).
- Increases coverage for any woman who is between 35 and 40 years old to cover mammograms, rather than a single baseline mammogram.
- Clarifies that a mammogram for any woman covered under the provision includes a digital breast tomosynthesis mammogram.
- Increases the frequency of coverage for any woman who is between the ages of 40 and 50 years old to one mammogram per year, rather than one every two years or more frequently based on the patient's physician's recommendation.
- Based upon a physician's recommendation, requires such policies to cover one supplemental breast cancer screening per year, rather than one or more mammograms a year provided under current law, based on certain risk factors which are modified in the bill to include the following additional risk factors:
  - Dense breast tissue, as evidenced by the woman's mammogram and standards prescribed by the American College of Radiology.
  - A personal or family history of breast cancer.
  - A personal history of biopsy-proven benign breast disease.
  - Ancestry.
  - Genetic predisposition.
  - Other reasons as determined by the woman's physician.

Further, the risk factor of having a mother, sister, or daughter who has or has had breast cancer is removed because it overlaps with the new broader factor of having a personal or family history of breast cancer. The risk factor of having a history of biopsy-proven benign breast disease is clarified to specify that the history must be a "personal" one.

The bill defines "supplemental breast cancer screening" for purposes of the section to mean "a clinically appropriate examination, in addition to a mammogram, deemed medically necessary by a treating health care provider for breast cancer screening in accordance with applicable American College of Radiology guidelines, which examination includes, but is not limited to, magnetic resonance imaging, ultrasound, and molecular breast imaging."

With respect to **sections 2 and 3 only** (relating to an individual insurance policy and a group insurance policy), the bill also modifies current law to require coverage of all mammograms and applicable supplement breast cancer screenings obtained in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health, rather than only certain specified mammograms, and such coverage is subject to deductibles and coinsurance provisions applicable to outpatient visits.

Section 5 provides that the bill is effective July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The fiscal impact on the private sector is indeterminate. Based on the additional coverage provided under the bill, a negative fiscal may impact the private sector if premiums are raised; however, the private sector may get earlier access to diagnosis and treatment.

Insurers may incur indeterminate administrative costs for implementing provisions of the bill. Any increased costs which the insurers may incur due to the enhanced coverage requirement within the bill would likely be passed on to insureds. However, if the bill increases early detection of breast cancer, it may lead to more successful health outcomes for women.

C. Government Sector Impact:

The bill would have minimal operational impact on the Agency for Health Care Administration and the Florida Medicaid program. Required updates of rules to conform with the provisions of the bill can be covered within existing staff and resources. The bill would not have any fiscal impact on the agency to the extent that mammograms and

supplemental breast cancer screenings required in the bill are already covered by Florida Medicaid.[40]

The Division of State Group Insurance may incur an indeterminate negative fiscal impact to cover state employees for the additional coverage required in the bill.

VI. Technical Deficiencies:

Regarding the Florida Medicaid program coverage:

- The scope of coverage in the bill may have unintended consequences such as reducing coverage in some circumstances because the bill:
  - Narrowly defines “mammogram” which means, in part, an exam to detect “unsuspected” breast cancer and in an “asymptomatic” woman (lines 34-35).
  - Fails to specify that a mammogram must be medically necessary as required under federal law.
  - Limits the coverage to one mammogram and one supplemental breast cancer screening per year if certain conditions are met (lines 50-71), whereas current Medicaid recipients receive any medically necessary mammograms or supplemental breast cancer screenings.
  - Limits the age for which Medicaid recipients can receive coverage (line 53), whereas there is no age limit for current Medicaid recipients, which will expand coverage of regular screenings in most instances for women that are at least 25 years old but less than 40 years old, but could prevent women younger than 25 years of age from accessing coverage.
  - Limits the bases for which supplemental breast cancer screenings may be covered more than the medically necessary requirement provided under current federal and state law (lines 58-71).
  - The coverage does not specify in the bill that it is the minimum coverage provided under the Medicaid provisions.
- The basis for a supplemental breast cancer screening that provides on lines 70-71 “other reasons as determined by the woman’s health care provider” should specify that the other reason must be a “medically necessary” reason.

The coverage provided in the bill for recipients 25 years of age or older (lines 53-54, 88-89, 147-148, and 203-204) is not consistent with the American College of Radiology (ACR) guidelines which provide:

a. For patients at average risk for breast cancer, annual screening mammography starting at age 40 is recommended.[41]
b. For patients at high risk for breast cancer, annual screening mammography may commence at age 30 (except as specified in limited cases, such as a history of chest radiation received between the ages of 10 and 30, who should begin screening 8 years after radiation therapy but not before age 25).[42]

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[40] Agency for Health Care Administration, *Senate Bill 1578 Bill Analysis*, (Mar. 20, 2025) (on file with the Senate Committee on Banking and Insurance)
[41] American College of Radiology (ACR), *ACR Practice Parameter for the Performance of Screening and Diagnostic Mammogramy*, available at: Full Document Preview (last visited April 17, 2025).
[42] *Id.*

Further, the 25 year old minimum age limit is not consistent with the Affordable Care Act (ACA) guidelines which recommends examination every 1 to 2 years for women 40 and older.[43] The list of increased risks of breast cancer (lines 62-71) or women at risk of breast cancer (100-110, 159-169, and 215-225) for which a supplemental breast cancer screening are covered are not consistent with the ACR guidelines high risk factors for which an annual screening is recommended to be commence at a younger age.[44]

With respect to a woman at risk of breast cancer, it is unclear how the risk basis of “family history of breast cancer” (line 104, 163, and 219) is different from the risk basis of “ancestry” (line 106, 165, and 221).

VII. Related Issues:

Federal authority is not required to implement the requirements of the bill because Florida Medicaid already covers the services prescribed in the bill.[45]

Rule 59G-4.240, F.A.C., Radiology and Nuclear Medicine Services Coverage Policy, would need to be amended to conform to the provisions of the bill.[46]

The effective date of July 1, 2025, in sections 2, 3, 4, and 5 does not coincide with the typical January 1 start of the plan year for commercial and state group plans.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.6418, 627.6613, and 641.31095.

The bill creates section 409.904 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill’s introducer or the Florida Senate.

[43] HealthCare.gov, *Preventive Care Benefits for Women*, available at: [Preventive care benefits for women | HealthCare.gov] (last visited April 17, 2025).
[44] American College of Radiology (ACR), *ACR Practice Parameter for the Performance of Screening and Diagnostic Mammogramy*, available at: [Full Document Preview] (last visited April 17, 2025).
[45] *Id.*
[46] *Id.*