

**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.)

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Prepared By: The Professional Staff of the Committee on Banking and Insurance

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BILL: SB 1494

INTRODUCER: Senator Davis

SUBJECT: Insurance Coverage for Breast Cancer Screening

DATE: February 3, 2026

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Moody	Knudson	BI	<b>Favorable</b>
2.			AEG	
3.			AP	

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**I. Summary:**

SB 1494 modifies required coverage for mammograms and supplemental breast cancer screenings in Florida 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.

The bill creates a new section that requires the mammogram and supplemental breast cancer screening coverage to apply to small group insurance policies and contracts (“small group policy”).

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 that are not covered under current law. The bill requires one medically necessary supplemental breast cancer screening a year, based upon a physician’s recommendation, for any woman who is at an increased risk of developing breast cancer.

Such policies issued for an insured who has dense breast tissue in the absence of any abnormality or suspicious abnormality are subject to the mandated mammogram and supplemental breast cancer screening coverage in the bill for women who are an increased risk of breast cancer. Further, such policies must offer the mandated coverage in the bill after treatment for any breast cancer, even if the insured is in a remission and surveillance period, if the exam does not meet the definition of a diagnostic breast examination.

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

The bill takes effect July 1, 2026.

## 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.<sup>1</sup>

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.<sup>2</sup>

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.<sup>3</sup> It accounts for 30 percent of all new female cancers in the United States each year.<sup>4</sup> 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.<sup>5</sup>

### 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;

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<sup>1</sup> *Cancer Facts & Figures*, pgs. 10-11, American Cancer Society - [Cancer Facts & Figures 2024](#) (last visited Jan. 31, 2026).

<sup>2</sup> *Id.*

<sup>3</sup> American Cancer Society, *Key Statistics for Breast Cancer*, [Breast Cancer Statistics | How Common Is Breast Cancer? | American Cancer Society](#) (last visited Jan. 31, 2026).

<sup>4</sup> *Id.*

<sup>5</sup> *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.<sup>6</sup>

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.<sup>7</sup>

### **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.<sup>8</sup>

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.<sup>9</sup> The coverage for individual and group policies and contracts is subject to the deductible and coinsurance applicable to other benefits.<sup>10</sup>

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.<sup>11</sup> While screening mammograms are routinely performed to detect breast cancer in women who have no apparent symptoms,

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<sup>6</sup> American Cancer Society, *Breast Cancer Risk Factors You Cannot Change*- [Breast Cancer Risk Factors You Can't Change | American Cancer Society](#) (last visited Jan. 31, 2026).

<sup>7</sup> Centers for Disease Control and Prevention, *Breast Cancer in Men*- [About Breast Cancer in Men | Breast Cancer | CDC](#) (last visited Jan. 31, 2026).

<sup>8</sup> Sections 627.6418(1), 627.6613(2), and 641.31095(1), F.S.

<sup>9</sup> Sections 627.6418(2) and 627.6613(2), F.S.

<sup>10</sup> Sections 627.6418(2), 627.6613(2), and 641.31095(2), F.S.

<sup>11</sup> 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 Jan. 31, 2026).

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.<sup>12</sup>

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.<sup>13</sup> 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.<sup>14</sup> When breast cancer is detected early, the five-year relative survival rate is ninety-nine percent.<sup>15</sup>

### **Regulation of Insurance in Florida**

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida.<sup>16</sup> As part of their regulatory oversight, the OIR may suspend or revoke an insurer's certificate of authority under certain conditions.<sup>17</sup> 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.<sup>18</sup> 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.<sup>19</sup> The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.<sup>20</sup>

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.<sup>21</sup> As part of the certificate process used by the agency, an HMO must provide information to demonstrate that the HMO can provide quality of care consistent with the prevailing standards of care.<sup>22</sup>

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<sup>12</sup> *Id.*

<sup>13</sup> Susan G. Komen Organization, *Breast Cancer Screening & Early Detection*, available at <https://www.komen.org/breast-cancer/screening/> (last visited Jan. 31, 2026).

<sup>14</sup> Susan G. Komen Organization, *New Susan G. Komen Study Unveils High Cost of Diagnostic Test for Breast Cancer Serves as a Barrier to Needed Care*, available at: [New Susan G. Komen® Study Unveils High Cost of Diagnostic Tests for Breast Cancer Serves as a Barrier to Needed Care - Susan G. Komen®](#) (last visited Jan. 31, 2026).

<sup>15</sup> National Breast Cancer Foundation, *3 Steps to Early Detection Guide*, Sept. 26, 2024, available at: [3 Steps to Early Detection - Breast Cancer Detection Guide](#) (last visited Jan. 31, 2026).

<sup>16</sup> 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.

<sup>17</sup> Section 624.418, F.S.

<sup>18</sup> Section 624.316(1)(a), F.S.

<sup>19</sup> Section 624.318(2), F.S.

<sup>20</sup> Section 624.3161, F.S.

<sup>21</sup> Section 641.21(1), F.S.

<sup>22</sup> Section 641.495, F.S.

## **Employee Health Care Access Act**

The Employee Health Care Access Act is intended to promote health insurance availability for small employers<sup>23</sup> that employ an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year.<sup>24</sup> To transact business in Florida, every small employer carrier must offer and issue all small employer health benefits plans on a guaranteed-issued basis to every eligible small employer that meets certain conditions.<sup>25</sup> The Financial Services Commission may establish rules to ensure that small employer carrier rates are reasonable and reflect objective differences in plan design.<sup>26</sup>

## **Florida's Medicaid Program<sup>27</sup>**

### ***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:

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<sup>23</sup> Section 627.6699(2), F.S.

<sup>24</sup> Section 627.6699(3)(v), F.S.

<sup>25</sup> Section 627.6699(5)(b), F.S.

<sup>26</sup> Section 627.6699(6)(a), F.S.

<sup>27</sup> Agency for Health Care Administration, *Senate Bill 1578 Bill Analysis*, (Mar. 20, 2025) (on file with the Senate Committee on Banking and Insurance)

- Be enrolled in the Florida Medicaid program on the date of service,
- Meet the criteria of the policy, and
- Require medically necessary services.<sup>28</sup>

Mandatory services must not be duplicative.<sup>29</sup> Mammography screenings are covered at a frequency of one per year, per recipient.<sup>30</sup> No age limit or requirement is specified.<sup>31</sup> Any additional screening services are covered as listed on the associated Radiology Fee Schedule, which currently includes magnetic resonance imaging (MRI) of breast, molecular breast imaging of breast, ultrasound of breast, and digital breast tomosynthesis mammogram.<sup>32</sup>

## **Patient Protection and Affordable Care Act**

### ***Essential Benefits***

Under the Patient Protection and Affordable Care Act (PPACA),<sup>33</sup> 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.<sup>34</sup>

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 and devices.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.<sup>35</sup>

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

<sup>28</sup> 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 Jan. 31, 2026).

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> Agency for Health Care Administration, *Senate Bill 1578 Bill Analysis*, (Mar. 20, 2025) (on file with the Senate Committee on Banking and Insurance)

<sup>33</sup> Patient Protection and Affordable Care Act of 2010. Pub. L. No. 111-141, as amended.

<sup>34</sup> 45 CFR 156.100. et seq.

<sup>35</sup> 45 CFR 156.110

that would become the State's EHB benchmark plan.<sup>36</sup> Florida selected its EHB plan before 2012 and has not modified that selection.<sup>37</sup>

### **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).<sup>38</sup> The Program is a cafeteria plan managed consistent with section 125 of the Internal Revenue Service Code.<sup>39</sup> 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, 2026, 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.<sup>40</sup>

### ***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.<sup>41</sup> 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?

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<sup>36</sup> Centers for Medicare and Medicare Services, *Marketplace – Essential Health Benefits*, available at <https://www.cms.gov/marketplace/resources/data/essential-health-benefits> (last reviewed Jan. 31, 2026).

<sup>37</sup> 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 Jan. 31, 2026).

<sup>38</sup> Section 110.123, F.S.

<sup>39</sup> 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.

<sup>40</sup> 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](https://www.mybenefits.myflorida.com/beta_-_open_enrollment) (last visited Jan. 31, 2026).

<sup>41</sup> Section 624.215(2), F.S.

- 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?
- 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.<sup>42</sup>

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.

**Sections 1, 2, 3, and 4** modify ss. 627.6418, 627.6613, 627.6699, and 641.31095, F.S., relating to an individual insurance policy; a group insurance policy; small employer policy; and a health maintenance organization contract, respectively, to revise the state's coverage mandates for mammograms beginning on or after January 1, 2027. For any woman aged 40 or older, the policy or contract must provide coverage for one screening mammogram every year. "Screening mammogram" is defined as "a radiologic examination using equipment dedicated specifically for mammography, including digital breast tomosynthesis mammography but not including any diagnostic mammography imaging, for the purpose of detecting any potential breast cancer, which examination results in the production of at least two radiographic images of each breast."

The bill also provides that the policy or contract must cover one or more medically necessary screening mammogram based on a licensed physician's recommendation<sup>43</sup> for any woman who is at an increased risk of developing breast cancer. The increased risk factors in current law are replaced with a new definition of "increased risk" that means, in accordance with the National Comprehensive Cancer Network, any one of the following that enhances the likelihood that a woman may develop breast cancer, including:

- Having a known genetic predisposition or a pedigree suggestive of a genetic predisposition for breast cancer.
- Having a lifetime risk of breast cancer equal to or greater than 20 percent as defined by models that include a comprehensive family history, including first-, second-, and, when relevant to the model, third-degree relatives.
- Having previously received thoracic radiation between 10 and 30 years of age.

<sup>42</sup> Section 624.215(2)(a)-(l), F.S.

<sup>43</sup> See ch. 458 and 459, F.S.

- Being 35 years of age or older with a 5-year risk of invasive breast cancer equal to or greater than 1.7 percent.
- Having a lifetime risk equal to or greater than 20 percent based on a history of atypical ductal hyperplasia, lobular carcinoma in situ, or atypical lobular hyperplasia.
- Having heterogeneously or extremely dense breast tissue as defined under the BI-RADS, which is defined as the American College of Radiology Breast Imaging Reporting and Data System, and based on a woman's most recently completed mammogram results.

The bill also covers one supplemental breast cancer screening per year, based upon a physician's recommendation, if the woman is at an increased risk for breast cancer. The bill defines "supplemental breast cancer screening" to mean "an imaging examination of the breast, including, but not limited to, breast magnetic resonance imaging, breast ultrasound, contrast-enhanced mammography, or molecular breast imaging, which is used to screen for breast cancer when there is no abnormality seen or suspected."

The bill provides that the policies or contracts issued for an insured who has dense breast tissue by itself in the absence of any evidence of an abnormality or suspicious abnormality of the breast are subject to the medically necessary screening mammogram and supplemental breast cancer screening coverage. The policies and contracts are subject to the mandated coverage provisions in the bill after treatment for breast cancer is completed, even if the insured is in remission and surveillance period prior to any clinical designation that the insured is in long-term remission or cured, if any examination conducted during this period does not meet the definition of diagnostic breast examination. The bill defines "diagnostic breast examination" as "a medically necessary imaging examination using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, which is used to evaluate an abnormality that is seen or reasonably suspected during a screening examination for breast cancer." The term "reasonably suspected" is defined to mean "the screening examination evidences at least one observable sign of a potential abnormality."

With respect to **sections 1, 2 and 3 only** (relating to an individual insurance policy, small employer 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, 2026.

#### **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 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:**

None.

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill substantially amends the following sections of the Florida Statutes: 627.6418, 627.6613, 627.6699, 641.31095

**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.

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

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