

Policy At A Glance:

State Variations in Breast Cancer Screening Policy: Massachusetts vs. Nevada

This brief presents a comparative analysis of breast cancer screening policies in Nevada and Massachusetts, assessing how differences in policy design intersect with social determinants of health (SDOH) and demographic factors to influence screening outcomes.

Introduction

Breast cancer remains the most commonly diagnosed cancer among women in the United States and a leading cause of cancer-related mortality for women, despite the availability of effective early detection strategies.¹ Routine mammography and timely diagnostic follow-up are proven to reduce breast cancer mortality; however, access to screening is uneven across states due to differences in insurance coverage, socioeconomic conditions, and health system capacity.²

Drawing on Breast Cancer Statistics 2024, Massachusetts demonstrates the highest rate of breast cancer screening alongside lower mortality, whereas Nevada's lower screening rates and relatively higher mortality indicate gaps in early detection.¹⁰ These contrasting outcomes provide meaningful context to examine Nevada Chapter 218 (Senator Bill 330) and Massachusetts Chapter 231 (House Bill 4918), two statutes aimed at strengthening breast cancer screening coverage but differing in scope, equity focus, and implementation.^{3,4,5,6} Nevada's law represents a foundational expansion of screening and diagnostic imaging in a state with historically lower uptake and greater reliance on safety-net programs.^{3,4,5} Massachusetts' statute builds upon an already robust screening environment, emphasizing equity and continuity of care by eliminating cost-sharing for medically necessary follow-up imaging.^{6,7}

Relevant Dates

Massachusetts Chapter 231 (HB 4918)^{6,7}

07/25/2024	Introduced to the 193rd legislative session
11/18/2024	Signed by Governor Maura Healey
01/01/2026	Effective

Nevada Chapter 218 (SB 330)^{3,4,5}

03/20/2023	Introduced to the 82nd legislative session
06/06/2023	Signed by Governor Joe Lombardo
01/01/2024	Effective

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Context: Demographic and SDOH Differences

Demographic and social determinants of health (SDOH) differences between Nevada and Massachusetts have important implications for the design and impact of each state's breast cancer screening policy. Massachusetts has a larger and slightly older population, higher median household income, higher educational attainment, and near-universal insurance coverage.⁸ These characteristics are associated with greater health literacy, more consistent use of preventive services, and stronger continuity of care. Within this context, Massachusetts' breast cancer screening policy emphasizes eliminating cost-sharing for supplemental and diagnostic imaging, supporting follow-up after abnormal findings. This approach aligns with the state's higher screening rate and higher reported incidence, as well as a lower mortality rate, which likely reflects earlier detection leading to earlier treatment.¹⁰

In contrast, Nevada's population is more racially and ethnically diverse, with a substantially higher proportion of Hispanic/Latino residents, higher poverty and uninsurance rates, lower educational attainment, and significant rural access challenges.⁹ These SDOH factors contribute to lower screening uptake and a lower reported incidence, suggesting under-detection rather than lower disease burden. Nevada's higher breast cancer mortality rate is consistent with later-stage diagnosis and barriers to timely follow-up care.⁹ Nevada's screening policy, therefore, focuses on establishing baseline access by removing direct cost barriers to screening and diagnostic imaging in state-regulated plans.⁵ However, persistent insurance gaps and structural barriers limit the policy's ability to fully offset SDOH-driven disparities.¹¹

Overall, these differences illustrate that breast cancer screening policies are most effective when aligned with population demographics and SDOH status. States with greater socioeconomic and insurance stability can focus on equity and continuity of care, while states facing broader access barriers require complementary strategies beyond insurance mandates to improve screening utilization and reduce mortality.

Screening Uptake and Breast Cancer Outcomes Massachusetts vs. Nevada

From 2017 to 2022, Massachusetts reported higher breast cancer incidence (136.8 vs. 113)* and screening rates (75% vs. 61%) than Nevada, reflecting more intensive early detection efforts. Despite higher incidence, Massachusetts experienced lower breast cancer mortality (15.2 vs. 17.2),* underscoring the importance of screening access and timely diagnostic follow-up in improving outcomes.¹⁰

* Incidence or mortality rate are per 100,000 population and are age-adjusted to the 2000 U.S. standard population.



Breast Cancer Screening Policy Comparison

Nevada and Massachusetts have enacted significant legislation to reduce financial barriers to breast cancer screening and diagnostic care, though their approaches differ in timing, scope, and equity focus. Nevada's Breast Cancer Act (SB 330) requires most state-regulated health insurance plans to cover annual screening mammograms for individuals aged 40 and older, as well as medically necessary supplemental and diagnostic breast imaging, without deductibles, copayments, or coinsurance.⁵ Massachusetts' Chapter 231 similarly mandates coverage for screening and diagnostic breast cancer services including mammography, digital breast tomosynthesis, breast MRI, and ultrasound without adding any out-of-pocket costs for patients, building on an already robust screening framework.⁶

Prior to Chapter 218, Nevada lacked a state-level mandate for comprehensive breast cancer screening, with coverage largely following Affordable Care Act (ACA) preventive service requirements and cost sharing for diagnostic follow-up, creating access and equity gaps.⁵ In contrast, Massachusetts had existing screening mammography mandates. Chapter 231 builds on this stronger foundation by eliminating cost sharing for medically necessary diagnostic and supplemental imaging, improving continuity of care statewide.⁶

A central difference between the two laws lies in their treatment of public employee plans, which has significant public health equity implications. Massachusetts explicitly applies its requirements to state employee health plans and MassHealth (the state Medicaid program), ensuring that individuals enrolled in public insurance receive the same protections as those with private insurance.⁶ Nevada, by contrast, excludes the Public Employees' Benefits Program and local government self-insured plans from mandatory compliance, instead allowing these entities to opt in voluntarily.⁵ This policy choice may lead to uneven access to diagnostic breast imaging among public sector workers and their dependents, potentially reinforcing disparities based on employer and plan type rather than medical need.

Both states emphasize a provider-driven medical necessity framework, allowing clinicians to determine when additional screening or diagnostic imaging is appropriate based on abnormal results, symptoms, or personal or family history of breast cancer.^{5,6} This approach supports individualized care, reduces administrative barriers, and aligns with evidence-based screening practices that recognize differential risk across populations. Each law also incorporates a similar health savings account (HSA)-qualified plan exception, allowing limited cost sharing when necessary to maintain federal HSA eligibility, while preserving no-cost coverage for preventive services as defined under federal law.^{5,6}

From a public health equity perspective, both laws address a long-standing gap in breast cancer care: the out-of-pocket costs associated with follow-up and diagnostic imaging after an abnormal screening. These costs disproportionately burden lower-income patients and communities of color and can delay diagnosis and treatment. Massachusetts' broader application across Medicaid and public employee plans strengthens its equity impact, while Nevada's earlier effective date positions it as an early model for evaluating changes in screening uptake, diagnostic follow-through, and early detection outcomes.^{5,6}

Conclusion

The comparison of breast cancer screening policies in Nevada and Massachusetts illustrates how policy design interacts with social determinants of health and health system capacity to shape prevention outcomes. Massachusetts' comprehensive approach eliminating cost sharing across the full screening-to-diagnosis continuum within a highly insured and resource-dense environment aims to close any remaining gaps in its high screening rates, increased early detection, and lower breast cancer mortality. In contrast, Nevada's recent reforms to address its low screening rate represent meaningful progress in reducing financial barriers to screening but remain constrained by insurance exemptions, rural access challenges, and persistent socioeconomic disparities.

As such, insurance coverage alone is insufficient to reduce disparities in breast cancer outcomes. Effective prevention requires policies that align with population needs, ensure seamless access to diagnostic follow-up, and are supported by robust safety-net programs. States seeking to improve equity and survival outcomes should adopt comprehensive, equity-centered screening policies that translate access into timely diagnosis and effective treatment.

References

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Did you know?

Comparison of Socioeconomic Indicators (2024-2025)^{7,8}

Uninsured rate for age 65 and under:

- Massachusetts: 3.30%
- Nevada: 13.50%

Bachelor's degree or higher:

- Massachusetts: 47.30%
- Nevada: 27.90%



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