



Breast Cancer Reimbursement Rates as a Reflection of National Public Health Trends

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Executive Summary

This analysis of breast cancer reimbursement trends reveals a system that rewards disease burden rather than prevention, resulting in a reactionary system. Using Trek Health's Transparency Platform to evaluate payer and state-level variation across the full care continuum, we found that geography explains nearly half of reimbursement differences, with significant disparities between states and among commercial payers. Screening and incidence rates show no relationship to payment, while mortality and risk burden are strongly associated with higher reimbursement, underscoring that pay structures are reactive, not preventive. For providers, this inequity perpetuates gaps in access and survivorship. But Trek Health enables health systems to turn transparency data into actionable strategies, working with health systems to recover revenue, realign contracts, and advocate for more equitable pay structures, ensuring that equity in reimbursement becomes equity in outcomes.

Table of Contents

Introduction	3
Methodolgy	4
Variation Across States and Payers	5
Medicare as Benchmark	7
Policy Context	10
Epidemiology	11
Conclusion	13
References	15



Introduction

The month of October marks National Breast Cancer Awareness Month (NBCAM), a time devoted to public health efforts centered around prevention, early detection, and survivorship support. Breast cancer remains to be one of the most prevalent malignancies in women across the United States, with approximately 1 in 8 women estimated to develop the disease in their lifetime.¹

While there is no primary prevention currently available, studies do demonstrate that secondary prevention efforts, such as mammogram and ultrasound screenings, do increase survivability.² NBCAM awareness efforts have had measurable impact, with many health systems reporting an uptick in mammography each October; however, access to these services remains uneven.³ State-level resources, both financially and epidemiologically, vary drastically across populations, underscoring the structural inequities in healthcare delivery and insurance coverage. These misalignments extend beyond the point of screening and persist throughout the continuum of care, influencing a patient's stage at diagnosis, their treatment burden, and ultimate prognosis.

Though awareness campaigns have elevated breast cancer as a public health priority, they do little to address the underlying financial drivers of access. Financial coverage and reimbursement largely determines who can consistently obtain preventative and diagnostic care. To understand where gaps persist, we must start by examining how reimbursement actually varies across payers and states.

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Methodology

Using Trek Health's Price Transparency platform capabilities, we uncovered driving factors of payer reimbursement at the state level, analyzing across four major insurers (Aetna, Blue Cross Blue Shield, Cigna, and United Healthcare). We tracked CPT billing codes across the breast cancer prognostic life cycle, from screening initiatives (77066, 76441), diagnoses (19120, 19125), and ultimately mastectomy procedures (19300, 19340). This approach allowed us to capture reimbursement variation not just at a single point of care, but across the continuum of prevention, diagnosis, and treatment. Additionally, this data was supplemented with census and governmental epidemiological data, enabling us to contextualize reimbursement patterns against demographic composition, provider availability, and disease burden to produce more comprehensive findings. The following statistical tests were employed to analyze the findings: ANOVA (analysis of variance), R^2 variance analysis, Pearson correlation, and K-means clustering, with all results evaluated at a significance threshold of $p < 0.05$. An ANOVA was used to determine whether differences in reimbursement across groups were statistically significant rather than due to random variation. The R^2 subanalysis quantified how much of the observed variation could be explained by a given factor within the model. Pearson correlation was applied to measure both the strength and direction of associations between reimbursement and explanatory variables. Finally, K-means clustering was used to group states into data-driven tiers based on reimbursement patterns, highlighting natural breakpoints rather than arbitrary cutoffs.

The p-value in all analyses represents the probability that the observed results occurred by chance. A threshold of $p < 0.05$ indicates that there is less than a 5% likelihood that the differences or associations identified are random, providing confidence that the relationships observed are meaningful.

Variation Across States and Payers

Using an ANOVA statistical test, all assessed codes showed significant variation at the state level. This confirms that where a patient lives plays a major role in determining reimbursement rates for breast cancer services, independent of the service itself. Across codes, an R² analysis of the state of residence explained approximately half of the observed variation, underscoring the magnitude of geography as a determinant of payment. Notable outliers include Alaska as the highest reimbursed state and Arizona as the lowest reimbursed state. These variations demonstrate why reimbursement analysis is central to improving access and negotiating fairness.

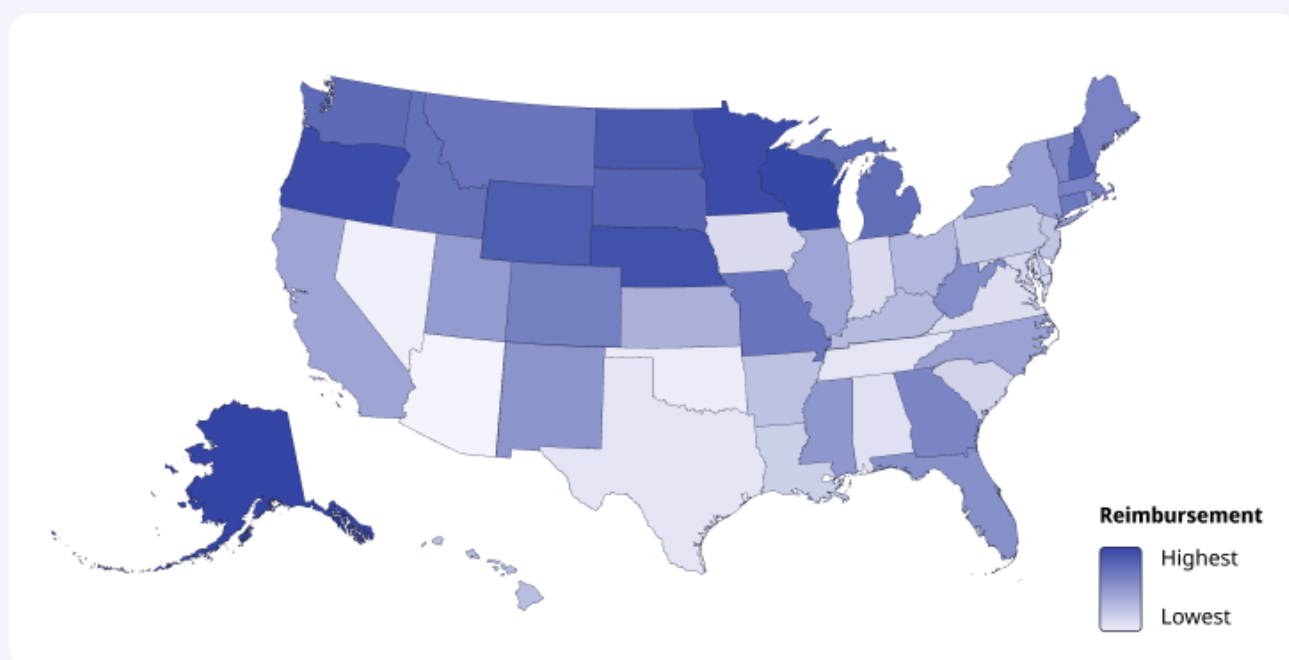


Figure 1: Heatmap of States Ranking in Commercial Reimbursement

However, this was not true across all CPT codes at the payer level: only codes 19120, 19340, and 77066 reached significance, with 19125 and 19300 approaching significance, in this analysis. This dispersion suggests that reimbursement variability is more heavily driven by geography than by payer strategy, and that distinctions between diagnostic versus treatment-related codes do not explain the observed differences.

Interestingly, Aetna demonstrated the largest variation of reimbursements, while consistently awarding below average reimbursements; Cigna showed the smallest variation, but consistently reimbursed above average payments.

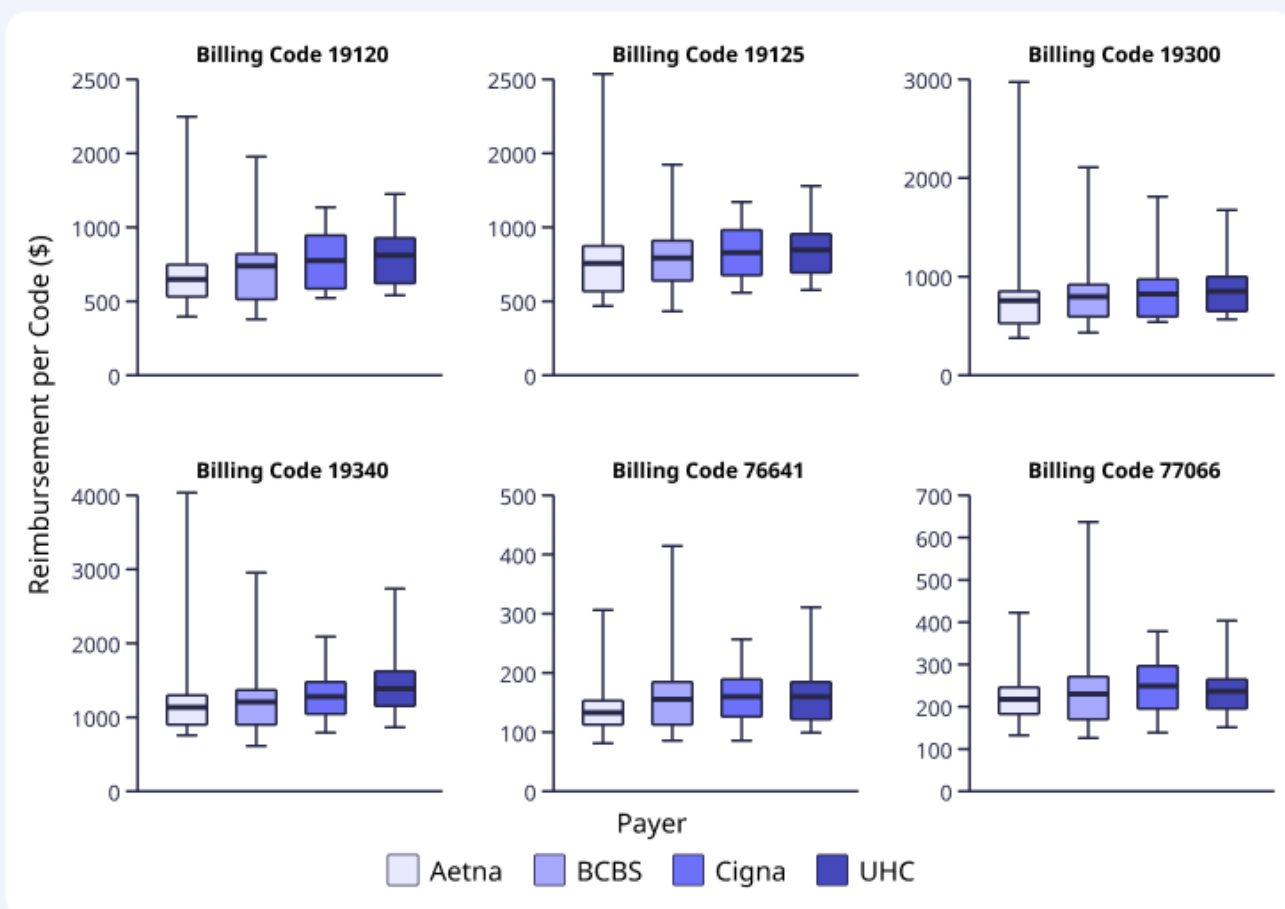


Figure 2: Pay Distribution by Commercial Payer for Individual Breast Cancer Billing Codes

These payer and state-level differences do not exist in isolation; they reflect the underlying structure of how providers are distributed, how concentrated markets are, and how payments are adjusted geographically. Market forces shape payment levels, but Medicare provides the baseline against which commercial payers often negotiate. Examining how commercial rates align, or diverge from Medicare benchmarks reveals the influence of public versus private policy.

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Medicare as Benchmark

Medicare pricing is comparatively standardized across states and consistently lower than commercial reimbursement, reflecting its role as a national benchmark rather than a market-driven negotiator.⁴ However, with recent legislation, there may be new financial caps on state-directed payments (SDPs), which could alter future governmental payment schedules.⁵ At present, Wisconsin proves to have the largest discrepancy from Medicare pricing, whereas Texas has the slimmest gap, due to its abnormally high Medicare as well as its low commercial reimbursement rates.

Rank	State	Average Margin
1	Wisconsin	\$966.83
2	Alaska	\$794.00
3	Minnesota	\$691.50
4	Oregon	\$652.50
5	South Dakota	\$511.00
46	Nevada	\$83.67
47	New Jersey	\$82.50
48	Kentucky	\$77.67
49	Oklahoma	\$77.17
50	Texas	\$67.13

Figure 3: Commercial Discrepancy from Medicare Pricing

Using a k-means cluster analysis, we revealed tiering systems of Medicare reimbursement at the state level.

Highest	Middle	Lowest
Alaska	Alabama	Arkansas
California	Arizona	DC
Connecticut	Colorado	Florida
Delaware	Hawaii	Idaho
Georgia	Illinois	Kentucky
Maine	Indiana	Louisiana
Missouri	Iowa	Maryland
New Jersey	Kansas	Massachusetts
New Mexico	Michigan	Mississippi
North Carolina	Minnesota	Nevada
Pennsylvania	Montana	New Hampshire
Rhode Island	Nebraska	Oklahoma
South Carolina	New York	Oregon
Texas	North Dakota	South Dakota
	Ohio	Tennessee
	Vermont	Utah
	West Virginia	Virginia
		Washington
		Wisconsin

Figure 4: State Tiering of Medicare Reimbursements

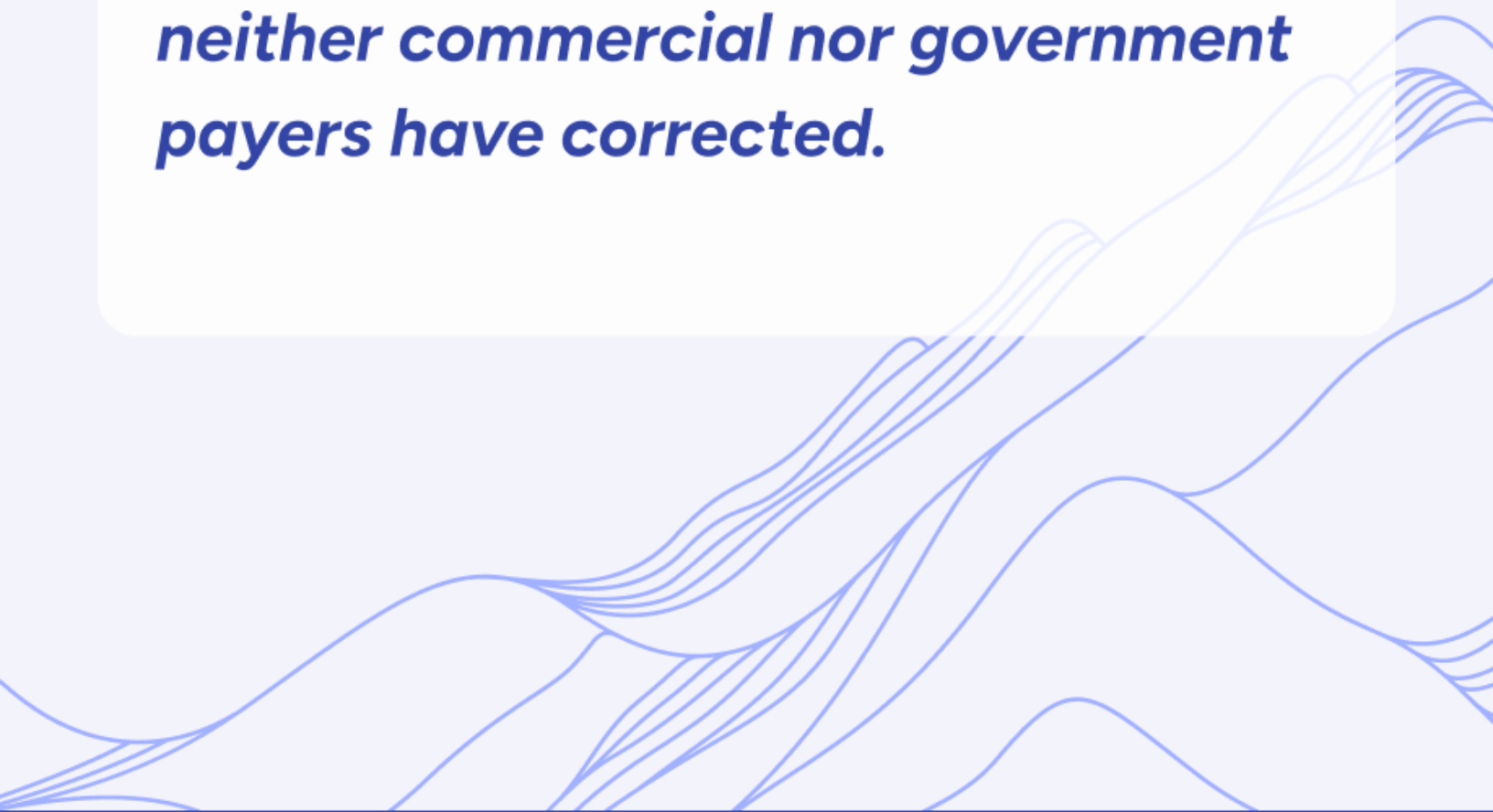
These clusters demonstrate that Medicare does not simply create a uniform payment floor, but rather sorts states into predictable categories of relative generosity that commercial payers may then follow or resist.

States with high clinical burdens or structural disadvantages, such as rurality or provider shortage, don't necessarily get higher reimbursement. Commercial payers often follow these same lines, magnifying regional inequity. Because Medicare is a federal standard, state-level coverage requirements and insurance environments become especially visible when commercial rates diverge from those benchmarks. Insurance landscapes, funding priorities, and benefit requirements create very different conditions across the country, which can amplify or blunt reimbursement disparities.

The contrast between Texas and Wisconsin illustrates how Medicare benchmarks interact with commercial markets in unexpected ways. In Wisconsin, commercial breast cancer reimbursement exceeds Medicare by nearly \$1,000 per service on average, the largest gap in the country. In Texas, the opposite is true: the difference is barely \$67. This reflects the state's unusually high Medicare baseline, combined with one of the lowest commercial reimbursement rates.

For providers, this means that the same service generates dramatically different margins depending on geography, with Wisconsin providers seeing substantially greater returns relative to Medicare, while Texas providers operate on the narrowest margins in the nation. These extremes underscore how geography, layered on top of federal benchmarks, creates inequities that neither commercial nor government payers have corrected.

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Policy Context

While many states have advocated for more comprehensive coverage of breast cancer screenings to expand access to care, these efforts do not translate into differences in how payers reimburse providers.⁶ This analysis revealed no statistically significant relationship between the tiering of state mandates and commercial payer reimbursement. Further, when assessing access through a different lens, the distribution of providers per state, reimbursement variation remained insignificant. Together, these findings suggest that even well-intentioned structural levers, such as mandates or provider supply, may not meaningfully influence how reimbursement is determined. Lastly, public health spending told a similar story, with higher state dollars allocated per capita showing no relationship to reimbursement levels.⁷ These findings indicate that system-level investments, while important for infrastructure and outreach, are not the drivers shaping how payers set prices for breast cancer services.

By contrast, reimbursement trends look markedly different when viewed through the lens of population burden. States with a higher percentage of uninsured residents demonstrated significantly higher reimbursement ($p = 0.0097$), suggesting that payers may raise rates in riskier markets as a hedge against uncompensated care. However, these higher reimbursement levels did not correspond with improved screening or outcomes, highlighting a persistent misalignment between pricing signals and patient benefit. Similarly, states with higher average HCC risk scores, reflecting greater clinical disease burden, also aligned with significantly higher reimbursement ($p = 0.0085$). Together, these results underscore a consistent theme: reimbursement follows burden, not prevention.

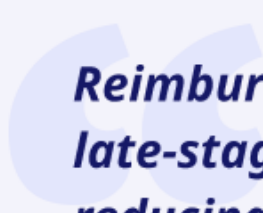
Strong mandates and generous spending do not guarantee better outcomes. To see whether reimbursement and policy truly translate into patient impact, we connect these financial and political factors to epidemiologic trends in screening, incidence, and mortality.

***Reimbursement
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Epidemiology

The epidemiology continuum of breast cancer can be understood as a progression from screening to diagnostic workup, through incidence of disease, and ultimately either mortality or survivorship. Although mammograms are advised every two years for women 40 years of age and older, adherence to these guidelines remains inconsistent across populations and states.⁸ Despite substantial evidence indicating that early detection is highly favorable in breast cancer survivability, this preventive value is not reflected in reimbursement priorities. Statistical analysis confirms this disconnect: screening rates for women ages 40–49 and 50–74 by state were not significantly associated with reimbursement levels, underscoring that payment structures are not aligned with evidence-based preventive care.⁹ Inadequate reimbursement for preventive services further undermines effective screening and early detection, perpetuating inequities in outcomes.

When incidence of new annual breast cancer diagnoses was examined, no significant relationship was found, suggesting that reimbursement does not track with diagnosis rates alone. Higher or lower detection at the state level had no discernible impact on payer trends, reinforcing that preventive uptake is not rewarded within the reimbursement framework. However, mortality, both adjusted to population size and expressed as a percentage of incidence, proved to be a driver of commercial rates. States with higher population-adjusted mortality demonstrated significantly higher reimbursement ($p = 0.0016$), showing that payment rises once the burden of disease becomes unavoidable. A similar trend was observed with case fatality: states with higher proportions of deaths relative to incidence also showed higher reimbursement ($p = 0.0003$). These findings make clear that reimbursement is tied more closely to managing late-stage disease and clinical complexity than to reducing incidence or improving survivability through early detection.



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Taken together, these layers reveal a consistent theme: inequities in reimbursement cascade into inequities in access and outcomes. To create meaningful change, earlier efforts must be prioritized, aligning favorable pay structures with earlier prognostic interventions.¹⁰ States with sicker, riskier populations are seeing higher reimbursement, but this is reactive, not proactive: compensation increases with disease complexity, not with measures that would prevent poor outcomes in the first place.

Conclusion

Trek Health advocates for more favorable and fair pay structures across diverse market contexts. By equipping health systems with data-driven insights into payer behavior, we enable them to negotiate from a position of strength and ultimately drive better patient outcomes. At the heart of this work is a simple truth: equity in reimbursement is a driver of equity in outcomes.

NBCAM awareness campaigns and “pink ribbon” funding, while symbolically powerful, do not always correlate with meaningful improvements in population health. The analysis suggests that reimbursement in U.S. healthcare is largely reactionary, tracking with disease burden rather than preventive efforts. Incidence and screening rates show no relationship with payment levels, while mortality and risk burden are significantly associated with higher reimbursement. This pattern reflects a system that prioritizes compensating for complexity once it emerges, rather than investing in prevention that could reduce both mortality and long-term costs. For insurers, this approach defers immediate spending and aligns payment increases with undeniable burden, but it also highlights the structural misalignment between short-term financial incentives and long-term population health.

This reality reflects a system that rewards managing failure over investing in prevention. For insurers, it defers immediate spending and ties payment increases to unavoidable burden. But for patients and providers, it perpetuates inequities in access, timeliness, and survivorship. The result is a structural misalignment: short-term financial incentives run counter to long-term population health. Trek helps providers not only comply with transparency mandates but use those same datasets to recover revenue, realign contracts, and advocate for preventive care. In doing so, Trek creates a path for health systems to shift from reactive reimbursement toward a proactive model that reduces costs, advances equity, and strengthens trust between patients, providers, and payers.



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