ASSEMBLY THIRD READING
AB 2024 (Friedman)
As Amended April 28, 2022
Majority vote

SUMMARY

Requires a health care service plan (health plan) contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, to provide coverage for screening mammography, medically necessary diagnostic or supplemental breast examinations, or testing for screening or diagnostic purposes upon referral by specified professionals. Prohibits a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, from imposing cost sharing for screening mammography, medically necessary or supplemental breast examinations, or testing. Applies to health plan contracts that meet the federal definition of high deductible health plan after an enrollee's satisfaction of the deductible.

COMMENTS

According to the California Health Benefits Review Program (CHBRP) breast cancer occurs predominantly in females. The annual breast cancer incidence rate in California is 122/100,000 or about 32,000 new cases diagnosed annually. The American Cancer Society estimates an average breast cancer death rate of 19/100,000 or about 4,700 breast cancer deaths annually in California.

This bill requires coverage, without cost sharing, of medically necessary supplemental screening and diagnostic imaging. Primary screening mammography is a first step in the detection of breast cancers for women at any risk level. Patients who are considered above average or high risk for cancer may undergo additional imaging, known as supplemental screening, with other types of imaging such as breast magnetic resonance imaging (MRI), breast ultrasound, or digital breast tomosynthesis (DBT). Patients with abnormalities upon screening mammography and/or clinical exam may undergo additional imaging for diagnosis and/or they may directly undergo a biopsy of the suspicious area(s) to confirm whether there is a malignancy in the breast tissue. It should be noted that although clinical terminology refers to imaging exams as "diagnostic," breast cancer is diagnosed based on examination of breast tissue by a pathologist (usually from biopsy). By enabling the detection of certain forms of invasive cancer at an earlier stage of disease, breast imaging exams have the potential to reduce breast cancer morbidity and mortality. However, according to CHBRP, screening imaging can result in some overdiagnoses (false-positive results or benign cancers) leading, in those cases, to unnecessary interventions (further imaging, biopsies, treatment), as well as potential psychosocial consequences. For those with positive screening and diagnostic results, treatment and prognosis of invasive breast cancers are guided by multiple factors, including biological characteristics of the cancer and the stage of disease, which is determined after excision of a tissue sample or surgery to remove the lump or whole breast. CHBRP notes that increases in supplemental screening may identify additional lesions that may or may not be cancerous. Some results will identify cancers that would become invasive, thus resulting in better outcomes due to early diagnosis. Other results may identify cysts or noncancerous lesions leading to interventions that do not result in a cancer diagnosis. According to most practice guidelines, supplemental screening, usually with breast MRI, is recommended for those women with a high lifetime risk of breast cancer as achieving appropriate care is the goal.

1) *CHBRP.* AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on essential health benefits, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP states in its analysis of this bill the following:

   a) *Impact on expenditures.* This bill would increase total net annual expenditures by $43,742,000, or 0.0293%, for commercial/California Public Employees' Retirement System (CalPERS) enrollees in Department of Managed Health Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies. This is due to an $117,550,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a decrease of $73,808,000 in enrollee expenses for covered and/or noncovered benefits, which includes a $1,018,000 increase in cost sharing for the additional biopsies that will be performed. Changes in premiums as a result of this bill would vary by market segment. Among DMHC-regulated plans, CHBRP estimates that postmandate, premiums will increase by $0.5343 per member per month (PMPM) for large-group plans. Among small-group and individual DMHC plans, premiums will increase by an estimated $0.6719 PMPM and $1.0437 PMPM, respectively. Among CDI-regulated policies, CHBRP estimates that postmandate, premiums will increase by $0.6114 PMPM for large-group policies. Among small-group and individual CDI policies, premiums will increase by an estimated $0.9243 PMPM and $0.9364 PMPM, respectively. Among enrollees in publicly funded DMHC-regulated plans, impacts would vary. For CalPERS enrollees in DMHC-regulated plans, the elimination of cost sharing for breast imaging, postmandate, will increase utilization, and so premiums are expected to increase by $0.2236 PMPM.

      i) Medi-Cal. No impact would be expected on the premiums paid to enroll Medi-Cal beneficiaries in DMHC-regulated plans, as their coverage generally includes no cost sharing.

      ii) CalPERS. Aggregate premiums for CalPERS would increase by $5,386,000 (0.09%).

      iii) Covered California. Aggregate premiums for all persons purchasing individual market plans and policies through Covered California would increase by $25,687,000 (0.14%).

      iv) Number of Uninsured in California. Since the change in average premiums does not exceed 1% for any market segment, CHBRP expects no measurable change in the number of uninsured persons because of this bill.

   b) *Medical effectiveness*. Although primary screening is not the focus of this analysis, CHBRP notes that the medical effectiveness of mammography for primary screening has been widely recognized in the United States and abroad for more than 25 years. There is a preponderance of evidence that DBT and breast MRI are effective for increased detection of breast cancer when used in a supplemental role. There is limited evidence that ultrasound is effective for the increased detection of breast cancer when used in a supplemental role. There is clear and convincing evidence that DBT and MRI are

effective (sensitivity and specificity) for the diagnosis of breast cancer. The evidence is inconclusive regarding the risks and harms associated with supplementary screening imaging for breast cancer.

c) *Benefit coverage.* At baseline, 35% of enrollees with health insurance that would be subject to this bill have benefit coverage for breast imaging that does not include cost sharing for any breast imaging, including imaging for diagnostic and supplemental screening purposes. These are the Medi-Cal beneficiaries enrolled in DMHC-regulated plans, who generally have no applicable cost sharing – including no applicable deductibles. Postmandate, 100% of enrollees in DMHC-regulated plans or CDI-regulated policies would have $0 cost share for medically necessary breast imaging.

d) *Utilization.* At baseline, 942,908 enrollees have breast imaging annually. Utilization is unevenly distributed by age and gender, with services mostly utilized among women aged 50-74 years. A significant number of breast imaging services, however, are performed for enrollees who are younger or older than the clinical guidelines would indicate for population-based screening. Postmandate, utilization of breast imaging is estimated to increase by an average of 4.05% for all types of breast imaging, ranging from 0.81% to 7.01% depending on the type.

e) *Public health.* According to CHBRP, the short- and long-term public health impact of this bill on breast cancer morbidity or mortality is unknown. Ultimately, the differences in outcomes of breast cancers diagnosed earlier than what would have been discovered at regularly scheduled primary mammography screening are unknown. Postmandate, following the removal of cost sharing requirements, CHBRP estimates an additional 38,226 enrollees (4% increase) would obtain an additional 91,161 supplemental and/or diagnostic breast images. These are the enrollees for whom CHBRP assumes cost-sharing is a barrier to care, and would change their behavior to seek supplemental and diagnostic breast imaging once cost sharing was eliminated. Most of the 38,226 new imaging users would have negative readings from supplemental screenings. Those with positive readings indicating suspicious anomalies could progress to diagnostic imaging, which would further divide the group into 2 subgroups: a false-positive group (benign findings) or a group diagnosed with breast cancer. CHBRP estimates about 5,477 extra biopsies would occur from those new supplemental screenings or diagnostic images. Based on national data, between 70% and 80% of breast biopsies would result in negative findings. If this assumption is true, this could result in approximately 1,370 breast cancer cases being diagnosed earlier due to the removal of breast imaging cost sharing. However, the morbidity and mortality outcomes of these earlier diagnoses as compared with later diagnoses are unknown.

f) *Long-term impacts.* In the first postmandate year, CHBRP does not anticipate long-term population-level measurable change in the annual number of cancer treatments because the additional imaging results in earlier, but not additional, diagnoses. On the person level, some persons might receive less intensive cancer treatments because cancers were identified at an earlier stage than otherwise would have occurred. However, others might experience adverse impacts due to unnecessary treatment related to false-positive imaging results.

According to the Author
Early access to breast cancer diagnosis and treatment can save lives. In California alone, 31,720 women will be diagnosed with breast cancer this year and 4,690 women will die from the disease in 2022. Thanks to the [Affordable Care Act (ACA)], millions of women have access to preventative screening mammography. An estimated 16% of women screened with modern digital mammography require follow-up imaging. Unfortunately, if the results of a screening mammogram require a follow-up exam to determine if the patient has breast cancer, the patient will likely be facing significant out-of-pocket (OOP) costs, even with health insurance, all before they even begin treatment. A recent Susan G. Komen-commissioned study found the OOP costs for diagnostic breast imaging to be high in California, ranging from $265 for a diagnostic mammogram to more than $3,000 for a breast MRI. When patients are unable to afford their share of the cost for diagnostic imaging, many delay care or forego follow-up tests until the cancer has spread to other parts of her body, making it much deadlier and much more costly to treat. No one should have to choose between a necessary medical exam and paying for groceries. The author concludes that reducing OOP costs for diagnostic imaging improves access to care and will lead to more patients receiving early detection services and critical follow-up care.

Arguments in Support
Susan G. Komen, sponsor of this bill, writes that widespread access to preventive screening mammography is available to millions of women as a result of ACA. Unfortunately, if the results of that screening mammogram require a follow-up diagnostic exam (such as an MRI, ultrasound, or diagnostic mammogram) to rule out breast cancer or confirm the need for a biopsy, the patient will likely face hundreds to thousands of dollars in OOP costs, all before they even begin treatment. Aside from follow-up testing, diagnostic imaging is also often recommended as primary breast imaging for breast cancer survivors, women at high-risk for breast cancer and those who have undergone a lumpectomy followed by radiation therapy. This bill will ensure fair and equitable access to these services by eliminating the OOP costs for medically necessary diagnostic imaging tests.

Arguments in Opposition
The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans contend that in the face of continued uncertainty and efforts to fragment the market and promote less comprehensive coverage, California needs to protect the coverage gains we've made and stay focused on the stability and long-term affordability of our health care system.

FISCAL COMMENTS

According to the Assembly Appropriations Committee:

1) CHBRP estimates aggregate premiums for commercial and California Public Employees' Retirement System (CalPERS) health plans and insurance policies would increase by $5,386,000 annually, and total net annual expenditures by $43,742,000, or 0.0293%, for commercial enrollees in plans regulated by the DMHC and policies regulated by the CDI.

2) CHBRP estimates aggregate premiums for all persons purchasing individual market plans and policies through Covered California would increase by $25,687,000.

3) CHBRP states no effect would be expected on the premiums paid to enroll Medi-Cal beneficiaries in DMHC-regulated plans, because their coverage generally includes no cost sharing.

4) Estimated costs to CDI in the thousands to low tens of thousands of dollars per year in fiscal years (FY) 2022-23 and 2023-24 (Insurance Fund).

5) Estimated costs to DMHC in the hundreds of thousands of dollars per year in FYs 2022-23 and 2023-24 (Managed Care Fund).

VOTES

ASM HEALTH: 12-1-2
YES: Wood, Waldron, Aguiar-Curry, Arambula, Carrillo, Maienschein, Mayes, McCarty, Nazarian, Rodriguez, Santiago, Cristina Garcia
NO: Bigelow
ABS, ABST OR NV: Flora, Luz Rivas

ASM APPROPRIATIONS: 13-3-0
YES: Holden, Bryan, Calderon, Carrillo, Mike Fong, Fong, Gabriel, Eduardo Garcia, Levine, Quirk, Robert Rivas, Akilah Weber, Wilson
NO: Bigelow, Megan Dahle, Davies

UPDATED

VERSION: April 28, 2022

CONSULTANT: Kristene Mapile / HEALTH / (916) 319-2097 FN: 0002684