SENATE COMMITTEE ON APPROPRIATIONS
Senator Anthony Portantino, Chair
2023 - 2024 Regular Session

SB 257 (Portantino) - Health care coverage: diagnostic imaging

Version: January 30, 2023
Urgency: No
Hearing Date: April 10, 2023

Policy Vote: HEALTH 12 - 0
Mandate: Yes
Consultant: Agnes Lee

Bill Summary: SB 257 would require health care coverage without imposing cost-sharing for screening mammography, medically necessary diagnostic or supplemental breast examinations, diagnostic mammography, tests for screening or diagnostic purposes, and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer, including family history or known genetic mutation.

Fiscal Impact:
- The Department of Managed Health Care (DMHC) estimates minor, absorbable costs.
- The California Department of Insurance (CDI) estimates costs of $37,000 for staffing (Insurance Fund).
- Unknown, ongoing General Fund cost increases related to increased state expenditures for CalPERS health plan benefits.

Background: The DMHC regulates health plans under the Knox-Keene Act and CDI regulates health and other insurance. Existing law requires health plans, health insurers or self-insured employee welfare benefit plans to provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician, providing care to the patient and operating within their scope of practice.

Under the federal Affordable Care Act (ACA), non-grandfathered group and individual health insurance plans and policies must cover certain preventive services without cost-sharing when delivered by in-network providers. The ACA prohibits copayments, coinsurance, and deductibles for preventive services that are determined based on recommendations by specified federally recognized groups and federal agencies, and must be covered without cost-sharing when provided in-network as soon as 12 months after a recommendation appears. Currently, health plans generally cover the initial screening mammograms at no cost to the enrollee, based on the federal guidelines. However, health plans may impose cost-sharing on other medically necessary diagnostic testing and related imaging/exams.

Proposed Law: Specific provisions of the bill would:

- Prohibit, on or after January 1, 2025, health plan and disability insurance coverage or a self-insured employee welfare benefit plan from imposing cost-sharing for screening mammography, medically necessary diagnostic or supplemental breast examinations, diagnostic mammography, tests for screening or diagnostic purposes, and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee indicated to have a risk factor associated with breast cancer, including family history or known genetic mutation.

- Require diagnostic breast imaging to include breast magnetic resonance imaging, breast ultrasound, and other clinically indicated diagnostic testing; and require diagnostic breast imaging, diagnostic mammography, and diagnostic and supplemental breast examinations, or other clinically indicated diagnostic testing, to be covered to the extent consistent with nationally recognized evidence-based clinical guidelines.

- Would apply the provisions above to a plan contract that meets the definition of a "high deductible health plan," as set forth federal law only after an enrollee's or insured's deductible has been satisfied for the year.

- Clarify that this bill does not authorize enrollees or insureds to receive services when those services are provided from providers outside the plan's or insurer's network unless those services are unavailable within the network consistent with timely access standards, as specified in law.

- Permit a health plan or disability insurer that provides coverage for out-of-network benefits to impose cost-sharing requirements for the items or services described in this bill that are delivered by an out-of-network provider, except as otherwise required by law.

Related Legislation: SB 974 (Portantino, 2022) was substantially similar to this bill. SB 974 was vetoed by the Governor. The veto message included, *"Furthermore, the bill prohibits health plans and insurance policies from imposing cost-sharing for these services, which exceed the requirements of the federal Affordable Care Act, and will result in increased health care costs. According to the California Health Benefits Review Program, this bill would increase premiums by $117,550,000, a significant impact that would be felt by many Californians. The State must weigh the potential benefits of all mandates with the comprehensive costs to the entire delivery system."*

Staff Comments: According to the California Health Benefits Review Program (CHBRP) analysis for SB 974 (Portantino, 2022), the bill would have increased total net annual expenditures by $43,742,000 for commercial/CalPERS enrollees in DMHC-regulated plans and CDI-regulated policies. This is due to a $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. This estimate includes an increase of annual state expenditures for CalPERS funded health plans of about $5.4 million.

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