Office of Senate Floor Analyses
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THIRD READING

Bill No: SB 257
Author: Portantino (D), et al.
Introduced: 1/30/23
Vote: 21

SENATE HEALTH COMMITTEE: 12-0, 3/29/23
AYES: Eggman, Nguyen, Glazer, Gonzalez, Grove, Hurtado, Limón, Menjivar, Roth, Rubio, Wahab, Wiener

SENATE APPROPRIATIONS COMMITTEE: 6-0, 5/18/23
AYES: Portantino, Jones, Ashby, Bradford, Wahab, Wiener
NO VOTE RECORDED: Seyarto

SUBJECT: Health care coverage: diagnostic imaging

SOURCE: American Colleges of Obstetricians and Gynecologists District IX
Susan G. Koman

DIGEST: This bill requires 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.

ANALYSIS:

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans and the California Department of Insurance (CDI) to regulate health insurance. [HSC §1340, et seq. and INS §106, et seq.]

2) Deems mammography for screening or diagnostic purposes covered if there is a referral by a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician providing care to the patient and operating within the scope of practice provided under existing law. Applies this provision to health plans, individual and group policies of disability insurance, and self-insured employee welfare benefit plans.[HSC §1367.65 and INS §10123.81]

This bill:

1) Prohibits, 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.

2) Requires diagnostic breast imaging to include breast magnetic resonance imaging, breast ultrasound, and other clinically indicated diagnostic testing. Requires 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.

3) Applies 1) and 2) 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.

4) Clarifies 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.

5) Permits 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.

6) Defines "Diagnostic breast examination" as a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, breast magnetic resonance imaging, breast ultrasound, or other clinically indicated diagnostic testing that is either of the following:

   a) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or,

   b) Necessary based on personal or family medical history or additional factors, including known genetic mutations, that may increase the individual's risk of breast cancer.

7) Defines "Supplemental breast examination" as a medically necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging, breast ultrasound, or other clinically indicated diagnostic testing, that is either of the following:

   a) Used to screen for breast cancer when an abnormality is not seen or suspected; or,

   b) Necessary based on personal or family medical history or additional factors, including know genetic mutations that may increase the individual's risk of breast cancer.

Comments

According to the author, breast cancer is the second leading cause of death among women of all races. Although it is rare, men can also get breast cancer. Patients who receive abnormal results on a breast cancer screening or who have a genetic risk factor associated with breast cancer, including family history or known genetic mutation, can be instructed to undergo follow-up testing to ensure that the abnormality is not cancerous. However, health insurance companies in California provide full coverage only for the initial screening mammogram and impose significant cost-sharing for diagnostic imaging if the patients are directed to additional screenings. Such costs cause many to delay or avoid appointments following an abnormal mammography result. This bill provides coverage without imposing cost-sharing for medically necessary diagnostic breast imaging, including diagnostic breast imaging following abnormal mammography, and for an enrollee indicated to have a genetic risk factor associated with breast cancer, including family history or known genetic mutation.

Affordable Care Act (ACA). Under the 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. For women, this includes mammograms, screenings for cervical cancer, prenatal care, and other services as provided for in comprehensive guidelines supported by HRSA. The Women's Preventive Services Initiative (WPSI) and a panel administered by the American College of Obstetricians and Gynecologists (ACOG), under a cooperative agreement, conducts scientifically rigorous reviews to develop recommendations for updated guidelines. Current WPSI guidelines supported by HRSA for Breast Cancer Screening for Average-Risk Women are that average-risk women initiate mammography screening no earlier than age 40 and no later than age 50. Screening mammography should occur at least biennially and as frequent as annually. Screenings should continue through at least age 74 and age alone should not be the basis to discontinue screening. These recommendations are for women at average risk of breast cancer. Women at an increased risk should also under go periodic mammography screening, however, recommendations for additional services are beyond the scope of the recommendation.

Risk assessment. According to the WPSI, 2016 *Recommendations for Preventive Services for Women: Final Report to the U.S. Department of Health and Human Services, Health Resources & Services Administration*, major risk factors for breast cancer include increasing age; family history of breast or ovarian cancer (especially among first-degree relatives and onset before age 50 years); history of atypical hyperplasia or other nonmalignant high-risk breast lesions; previous breast biopsy; and, extremely dense breast tissue. Women considered at high risk for breast cancer (previous breast or ovarian cancer; BRCA1/2 mutation carrier; previous high-dose radiation to the chest) should also undergo periodic mammography screening and may require additional follow-up beyond the scope of this recommendation.

CHBRP analysis. AB 1996 (Thomson, Chapter 795, Statutes of 2002) requested 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, and reviewed SB 974 (Portantino of 2022) and AB 2024 (Friedman of 2022), which are similar to this bill. Key findings include:

Coverage impacts and enrollees covered. 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.

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.

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.

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

Impact on expenditures. This bill would increase total net annual expenditures by $43,742,000, or 0.0293%, for commercial/CalPERS enrollees in DMHC-regulated plans and 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. Cost-sharing: At baseline, for three of the types of breast imaging used for supplemental/diagnostic purposes (mammography, breast MRI, and breast ultrasound) cost-sharing is present for less than half of the services, 42%, 46% and 47%, respectively. For the fourth (DBT), cost-sharing is present for 7% of services. Postmandate, all supplemental/diagnostic breast

imaging would be provided without cost-sharing. This bill would result in an additional 38,226 enrollees to become new users of or to make additional use of supplemental/diagnostic breast imaging. The average per supplemental/diagnostic breast imaging service cost-sharing that this bill prohibits (for enrollees for whom cost-sharing had been applicable) would be between $104.40 (for an enrollee in a large-group market plan or policy) and $212.70 (for an enrollee in an individual market plan or policy). For enrollees in plans and polices with applicable deductibles, especially those enrolled in high deductible plans and polices, the reduction in total out-of-pocket spending could be greater. Depending on what the enrollee's spend towards the deductible in that plan/policy year, the enrollee could have been, at baseline, responsible for the full unit cost of the breast imaging test.

Public health. This bill produces an unknown impact on breast cancer morbidity and mortality. An additional 38,226 enrollees would obtain an additional 91,161 breast imaging tests. Results would vary. Many would yield negative results (no cancer detected). Some would yield false-positive results that would require unnecessary recall treatment (biopsy) and costs. A smaller number would yield earlier cancer detection. The marginal impact of the earlier cancer detection is unknown, as is the marginal impact of the additional adverse events stemming from false-positives (i.e., physical pain, anxiety, added biopsy expense, and overtreatment). Measurable impacts at the population level are unlikely, though some persons could experience improved outcomes and some could experience more adverse events.

EHBs. CHBRP believes this bill would not exceed EHBs.

Related/Prior Legislation

SB 974 of 2022 was substantially similar to this bill. SB 974 was vetoed by the Governor, who stated:

> Breast cancer screenings save lives, which is why health plans must provide coverage for mammograms. However, this bill proposes to implement a standard that is not included by the USPSTF and HRSA. The USPSTF is currently in the process of updating their recommendations on breast cancer screening; until those recommendations are released, this bill is premature.
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> 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 CHBRP, 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.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

- The DMHC estimates minor, absorbable costs.
- The 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.

SUPPORT: (Verified 5/17/23)

American Colleges of Obstetricians and Gynecologists District IX (co-source)
Susan G. Koman (co-source)
American Association of University Women, California
American Association of University Women, San Jose
American Cancer Society Cancer Action Network
Biocom
California Academy of Family Physicians
California Chronic Care Coalition
California Life Sciences
California Medical Association
California Professional Firefighters
California Radiological Society
California Society of Plastic Surgeons
City of Hope National Medical Center
Medical Imaging and Technology Alliance
National Association of Social Workers, California Chapter
National Health Law Program
Western Center on Law and Poverty

OPPOSITION: (Verified 5/17/23)

America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce

ARGUMENTS IN SUPPORT: Susan G. Koman, one of the cosponsors of this bill, writes this bill will eliminate out-of-pocket costs for medically necessary diagnostic and supplemental breast imaging. Eliminating this financial barrier will ensure Californians have access to no-cost diagnostic services that allow them to identify breast cancer cases earlier and begin treatment sooner and will greatly increase patients' chances of survival. Individuals at a higher risk of breast cancer or those requiring follow-up imaging due to an abnormal mammogram result face hundreds to thousands of dollars in patient cost sharing. This bill would ensure fair and equitable access to these services by eliminating the out-of-pocket costs for medically necessary imaging tests. According to the American Colleges of Obstetricians and Gynecologists District IX, the other cosponsor of this bill, regular breast screening can help find cancer at an early and more curable stage. A woman may be at high risk of breast cancer if she has certain risk factors including a family history of breast cancer, ovarian cancer, or other inherited types of cancer; BRCA1 and BRCA2 mutations; chest radiation treatments at a young age; and a history of high-risk breast biopsy results. Screening also can find problems in the breasts that are not cancer. Using x-ray technology, mammography is currently the primary tool used to screen for breast cancer and other problems, but other diagnostic breast imaging may be utilized as well. Despite these advantages of increased cancer detection, not all private insurer and health plans cover this diagnostic testing and many still require patients to pay out-of-pocket. The ability to pay for breast cancer screening – whether it be for lack of coverage or high-cost sharing – should not be an impediment for patients to receive this care.This bill eliminates this problem by removing the financial barriers of co-pays and deductibles for these life-saving screening 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 write in opposition to this along with 22 other health insurance mandate bills. These bills include mandates for health plans and insurers to cover specific services, as well as bills that eliminate cost sharing and limit utilization management, which have similar cost impacts as coverage mandates. Moreover, they will increase costs, reduce choice and competition, and further incent some employers and individuals to avoid state regulation by seeking alternative coverage options. State mandates increase costs of coverage – especially for families who buy coverage without subsidies, small business owners who cannot or do not wish to self-insure, and California taxpayers who foot the bill for the state's share of those mandates. Benefit mandates that do not promote evidence-based medicine can lead to lower quality care, over- or misutilization of services, and higher costs for treatments that may be ineffective, less safe, or higher cost than other, new or trusted services. California is rightly focused on

achieving both universal coverage and cost containment at a time when the national conversation has shifted toward lower costs through less comprehensive options. The California Chamber of Commerce writes employer-based health care coverage is usually one of the largest expenses a business experiences and, while this bill is well-intentioned, it will unintentionally exacerbate health care affordability issues.

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