SENATE THIRD READING
SB 257 (Portantino)
As Introduced January 30, 2023
Majority vote

SUMMARY

Requires a health plan contract, a disability insurance policy that provides hospital, medical, or surgical coverage, or a self-insured employee welfare benefit plan to provide coverage without cost-sharing for screening mammography 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, except as specified.

COMMENTS

According to the California Health Benefits Review Program (CHBRP), breast cancer in California 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. Breast cancer does occur in males, but at a much lower rate with about 170 cases diagnosed and 40 deaths annually in California. Rate Differences in breast cancer incidence and mortality by race and ethnicity persist. Although the most recent data (2012-2016) for age-adjusted incidence of breast cancer remains highest among California's non-Hispanic white (NHW) women (140/100,000), followed by non-Hispanic Black (NHB) women (129/100,000), non-Hispanic Asian and Pacific Islander (NHA/PI) women (102/100,000), and Hispanic women (91/100,000), mortality rates remain highest among NHB women. NHB have a breast cancer mortality rate of 31/100,000, followed by NHW women (21/100,000), and Hispanic women (16/100,000). NHA/PI have the lowest breast cancer mortality rate of 13/100,000.

1) *California's Preventive Services.* California codified the Patient Protection and Affordable Care Act (ACA's) mandate that most plans must cover a set of preventive services at no cost-sharing in SB 406 (Pan), Chapter 302, Statutes of 2020. For women age 40 to 74, the federal Preventive Services mandate, through reference to the recommendations of the United States Health Resources and Services Administration, already prohibits cost-sharing for primary screening mammography. This bill amends existing law as follows:

    a) For women aged 40-74 years, this bill prohibits cost-sharing for all medically necessary breast imaging when used for any of the following purposes: i) diagnostic; ii) primary screening for those not known to be at higher risk; or, iii) supplemental screening for those at high risk for breast cancer. This bill expands an existing prohibition on cost-sharing for primary screening mammography to also prohibit cost-sharing for supplemental screening and diagnostic breast imaging;

    b) For others, women and men, at high risk for breast cancer, this bill creates a new cost-sharing prohibition for all medically necessary breast imaging when used for either of the following purposes: (1) diagnostic; or, (2) supplemental screening for those at high risk for breast cancer.

c) For others, women and men, not known to be at higher risk, this bill creates a new cost-sharing prohibition for all medically necessary breast imaging when used for diagnostic purposes.

2) *CHBRP analysis.* 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 reviewed SB 974 (Portantino) of 2022 and AB 2024 (Friedman) of 2022, which is similar to this bill and stated the following in its analysis:

a) *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 the Department of Managed Health Care (DMHC)-regulated plans, who generally have no applicable cost-sharing, including no applicable deductibles. Postmandate, 100% of enrollees in DMHC-regulated plans or California Department of Insurance (CDI)-regulated policies would have $0 cost share for medically necessary breast imaging. 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, breast imaging utilization 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.

b) *Impact on expenditures.* CHBRP estimates 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 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.

i) At baseline, for three of the types of breast imaging used for supplemental/ diagnostic purposes (mammography, breast magnetic resonance imaging, and breast ultrasound), cost-sharing is present for less than half of the services, 42%, 46% and 47%, respectively. For digital breast tomosynthesis, 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. As a group, these enrollees would see the $74 million reduction in cost-sharing. The average per supplemental/diagnostic breast imaging service cost-sharing that this bill would prohibit (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 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;

ii) 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;

iii) CalPERS - Aggregate premiums for CalPERS would increase by $5,386,000 (0.09%);

iv) Covered California – Premiums for all persons purchasing individual market plans and policies through Covered California would increase by $25,687,000 (0.14%); and,

v) 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 due to this bill.

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, the author states that 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. The author concludes that 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.

Arguments in Support
The American Cancer Society Cancer Action Network (ACS CAN) write that individuals facing high out-of-pocket costs associated with screening and diagnostic imaging are less likely to have their recommended follow-up imaging. This can mean the person will delay diagnosis and care until the cancer has spread to other parts of the body, making it much deadlier and more costly to treat. Thanks to the ACA, widespread access to preventive screening mammography is available to millions of people at no cost. However, an estimated 16% of screening mammograms require a follow-up diagnostic exam to completely rule out breast cancer or confirm the need for a biopsy if an abnormality is detected. Diagnostic imaging is also often recommended as the 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. Unfortunately, these patients often face exorbitant costs ranging from hundreds to thousands of dollars for follow-up diagnostic imaging. ACS CAN concludes that patients who incur high expenses prior to even starting treatment run a much higher risk of financial hardship and often put off needed care.

Arguments in Opposition
The California Chamber of Commerce (Chamber) writes in opposition that when health plans and insurers are required to cover new services or to waive/limit cost-sharing requirements for certain services, premiums for all enrollees and purchasers go up. This is true even though only some enrollees will utilize the mandated product or services, or benefit from the reduction in cost-sharing. CHBRP analyzed the cost impact of a substantially similar bill that was vetoed last year, SB 974, and concluded that if the mandate went into effect, it would increase employer and enrollee health care premiums by $117,550,000 adjusted by a decrease of $73,808,000 in enrollee expenses for covered and/or noncovered benefits. Additionally, while this bill is certainly well intentioned, it approaches health care affordability with a piecemeal approach. This bill favors one disease over other diseases. When looking at the coverage mandate cost increases in isolation they seem tolerable, however, this bill must be considered in context. Premiums for employers and enrollees consistently increase year after year due to a number of issues including benefit mandates. The 2022 Kaiser Family Foundation Employer Health Benefits Survey indicated that the average premium for family coverage has increased 20% over the last five years and 43% over the last 10 years. Additionally, annual premiums for employer-sponsored family health coverage reached $22,463 in 2022, with workers on average paying $6,106 toward the cost of their coverage. The Chamber states that California should not increase health care coverage costs for employers and employees with another mandate.

The Department of Finance writes that this bill will significantly increase health care premiums and create potential ongoing costs and pressures to the General Fund that are not included in the 2023-24 budget plan. This bill would also increase cost pressures to a greater extent for excluding other health conditions from cost sharing.

FISCAL COMMENTS

According to the Assembly Appropriations Committee:

1) Minor and absorbable costs to the DMHC.

2) CDI estimates costs of $37,000 in fiscal year 2024-25 to review insurance policies for compliance with this bill (Insurance Fund).

3) Based on the CHBRP analyses for SB 974 (Portantino), of the 2021-22 Legislative Session, and AB 2024 (Friedman), of the 2021-22 Legislative Session, which were similar to this bill, this bill will increase aggregate premiums for CalPERS by $5.4 million (0.09%). The state pays for approximately 60% of CalPERS enrollees (Public Employees Health Care Fund, special funds).

4) No increases in costs to the Department of Health Care Services, as Medi-Cal already covers breast imaging without cost sharing.

5) Based on the previous CHBRP estimates, this bill will reduce aggregate cost sharing by $73.8 million, but increase overall health expenditures by $43.7 million for enrollees in DMHC-regulated plans and CDI-regulated policies, due to a $117.6 million increase in total health insurance premiums paid by employers and enrollees for newly covered benefits. However, most of these costs are not borne by the state.

VOTES

SENATE FLOOR: 35-0-5
YES: Allen, Archuleta, Ashby, Atkins, Becker, Blakespear, Bradford, Cortese, Dahle, Dodd, Durazo, Eggman, Glazer, Gonzalez, Grove, Hurtado, Jones, Laird, Limón, McGuire, Menjivar, Min, Newman, Nguyen, Niello, Ochoa Bogh, Padilla, Portantino, Roth, Skinner, Smallwood-Cuevas, Umberg, Wahab, Wiener, Wilk
ABS, ABST OR NV: Alvarado-Gil, Caballero, Rubio, Seyarto, Stern

ASM HEALTH: 15-0-0
YES: Wood, Waldron, Aguiar-Curry, Arambula, Boerner, Wendy Carrillo, Flora, Vince Fong, Maienschein, McCarty, Joe Patterson, Rodriguez, Santiago, Villapudua, Weber

ASM APPROPRIATIONS: 15-1-0
YES: Holden, Megan Dahle, Bryan, Calderon, Wendy Carrillo, Mike Fong, Hart, Lowenthal, Mathis, Papan, Pellerin, Sanchez, Soria, Weber, Wilson
NO: Dixon

UPDATED

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