

Date of Hearing: April 7, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1570 (Wilson) – As Introduced January 12, 2026

SUBJECT: Health care coverage: diagnostic imaging.

SUMMARY: Requires a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2028, to provide coverage without imposing cost-sharing for screening mammography and medically necessary diagnostic breast imaging. Specifically, **this bill:**

- 1) Requires a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2028, to provide 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 indicated to have a risk factor associated with breast cancer, including family history or known genetic mutation. Specifies that diagnostic breast imaging includes 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 consistent with nationally recognized evidence-based clinical guidelines.
- 2) Applies the provisions of 1) above to “high deductible health plans” (HDHP) as defined in federal law, only after the enrollee’s deductible has been satisfied for the year. With respect to services that are preventive care under federal law, applies the provisions of 1) above to HDHPs regardless of whether the deductible has been satisfied for the year.
- 3) Exempts services provided by a nonparticipating provider from the provisions of this bill, except as provided in paragraph 2) above.
- 4) Clarifies that this bill does not preclude a health plan or insurer that provides coverage for out-of-network benefits from imposing cost-sharing requirements for items or services that are delivered by an out-of-network provider, except as provided in paragraph 2) above or as otherwise required by state law.
- 5) Defines “cost-sharing” as a deductible, coinsurance, or copayment, and any maximum limitation on the application of that deductible, coinsurance, or copayment, or a similar out-of-pocket expense.
- 6) Defines “breast magnetic resonance imaging” as a diagnostic tool that uses a powerful magnetic field, radio waves, and a computer to produce detailed pictures of the structures within the breast.
- 7) Defines “breast ultrasound” as a noninvasive diagnostic tool that uses high-frequency sound.

- 8) Defines “diagnostic breast examination” as a medically necessary and appropriate, in accordance with the National Comprehensive Cancer Network Guidelines, examination of the breast, including an examination using contrast-enhanced mammography, diagnostic mammography, breast magnetic resonance imaging, breast ultrasound, or molecular breast imaging, that is either of the following:
 - a) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or,
 - b) Used to evaluate an abnormality detected by another means of examination.
- 9) Defines “diagnostic mammography” as a diagnostic tool that uses x-ray and is designed to evaluate an abnormality in the breast.
- 10) Defines “supplemental breast examination” as a medically necessary and appropriate, in accordance with the National Comprehensive Cancer Network Guidelines, examination of the breast, including an examination using contrast-enhanced mammography, breast magnetic resonance imaging, breast ultrasound, or molecular breast imaging, that is either of the following:
 - a) Used to screen for breast cancer when an abnormality is not seen or suspected; or,
 - b) Based on personal or family medical history or additional factors that increase the individual’s risk of breast cancer, including heterogeneously or extremely dense breasts.

EXISTING LAW:

- 1) Establishes the Department Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and California Department of Insurance (CDI) to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq.* and Insurance Code (INS) § 106, *et seq.*]
- 2) Establishes California’s Essential Health Benefit (EHB) benchmark under the federal Patient Protection and Affordable Care Act (ACA) as the Kaiser Small Group Health Maintenance Organization contract. Establishes existing California health insurance mandates and the 10 ACA mandated benefits. [HSC § 1367.005 and INS § 10112.27]
- 3) Specifies EHBs in the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care. [HSC § 1367.005 and INS § 10112.27]
- 4) Defines “basic health care services” as all of the following:
 - a) Physician services, including consultation and referral;
 - b) Hospital inpatient services and ambulatory care services;
 - c) Diagnostic laboratory and therapeutic radiologic services;

- d) Home health services;
 - e) Preventive health services;
 - f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,
 - g) Hospice care. [HSC § 1345]
- 5) Requires health plans and insurers, as specified, to provide coverage for mammography screening. [HSC § 1367.65 and INS § 10123.81]
- 6) Requires health plans and insurers, at a minimum, to provide coverage for and prohibits any cost-sharing requirements for the following:
- a) Evidence-based items or services that had in effect on January 1, 2025 a rating of “A” or “B” in the recommendations of the United States Preventive Services Taskforce (USPSTF);
 - b) Immunizations that had a recommendation in effect on January 1, 2025 from the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control; and,
 - c) With respect to infants, children, adolescents, and women, additional preventive care and screenings provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration (HRSA) as of January 1, 2025. [HSC § 1367.002 and INS § 10112.2]
- 7) Permits the State Department of Public Health (DPH) to modify or supplement baseline recommendations by the USPSTF, ACIP and HRSA that were in effect on January 1, 2025. Allows DPH to take into consideration guidance and recommendations from additional medical and scientific organizations, including the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians. [HSC § 120164]
- 8) Establishes the California Health Care Quality and Affordability Act, which creates the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI). Identifies OHCA’s three primary responsibilities: managing spending targets, monitoring system performance, and assessing market consolidation. Requires OHCA to collect, analyze, and publicly report data on total health care expenditures, and enforce spending targets set by a Health Care Affordability Board (Board). [HSC § 127500, *et seq.*]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** The author states that she received her breast cancer diagnosis after a routine mammogram revealed abnormalities that required more diagnostic imaging and testing. The author continues that thankfully, her cancer was detected early, so she was

able to begin treatment right away. The author states that she is here today because of it. The author notes that for most women, a mammogram is just the first step. Follow-up diagnostic imaging is often medically necessary to rule out or confirm cancer. Yet the high out-of-pocket costs for these services place a financial burden on patients, forcing some to delay or forego critical care. The author argues that when patients cannot afford follow-up testing, the chance for early detection and better outcomes is lost. The author concludes that this bill will ensure no Californian is forced to choose between financial hardship and timely, life-saving breast cancer detection.

- 2) **BACKGROUND.** According to DPH, breast cancer is the most common non-skin cancer diagnosis and the second leading cause of cancer deaths for women in California. Ninety-nine percent of breast cancer occurs in women. Women experience different levels of risk of breast cancer based on factors such as age, personal and familial medical history, and genetics. Under federal and state law, all women have coverage without cost sharing for primary screening for breast cancer. While all the services covered under this bill are recommended in some way by state and federal preventive service mandates for coverage without cost-sharing, they are not recommended for women at all risk levels. Women at average risk of breast cancer have coverage without cost-sharing for supplemental screening and diagnostic imaging following screening. This bill would provide coverage without cost-sharing for supplemental screening, diagnostic imaging, biopsy, and pathology evaluation for women at intermediate and high risk of breast cancer. This bill would further provide coverage without cost-sharing for diagnostic imaging for women at any risk level who receive diagnostic imaging without first receiving a primary screening mammography.
- a) **California Health Benefits Review Program (CHBRP).** CHBRP was created in response to AB 1996 (Thomson), Chapter 795, Statutes of 2002, which 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. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost-sharing, premiums, and other health insurance topics to CHBRP's purview. CHBRP reviewed this bill and included the following impact estimates in their analysis:
- i) **Premium increases & enrollee out-of-pocket decreases.** Premiums paid by employers and enrollees would increase upon enactment of this bill by an estimated \$93,957,000 annually. Commercial and individual market enrollees would save an average of \$85.17 in enrollee out-of-pocket expenses per year.
- ii) **Increased utilization of care.** This bill would result in over 66,000 additional screenings, diagnostic images, biopsies, and pathology evaluations without cost-sharing for fewer than 40,263 women if this bill were enacted. CHBRP notes that cost-sharing is reported as a primary, but not exclusive, barrier to obtaining supplemental screening and diagnostic imaging for breast cancer. The removal of this barrier through this bill would lead to this increased utilization.
- iii) **Public health impacts.** CHBRP determined that this bill would produce an unknown impact on breast cancer morbidity and mortality for an approximate 1,840 enrollees who would avoid a delayed breast cancer diagnosis that might otherwise occur with

cost-sharing in place. CHBRP notes that 31 other states have enacted legislation similar to this bill and 12 states are currently considering similar legislation.

- a) **Office of Health Care Affordability (OHCA) cost targets.** OHCA was established in 2022 in response to widespread cost-related access challenges across California. According to the California Health Care Foundation (CHCF), over half of Californians say they skip or delay health care due to costs. OHCA collects, analyzes, and publicly reports data on total health care expenditures and enforces spending targets. OHCA's spending targets are intended to reduce excess spending and slow health care spending growth. In April of 2024, OHCA approved a statewide cost growth target of 3.5% starting in 2025 and phasing down to 3% by 2029. Health care entities, including health plans and insurers, are subject to the statewide spending target and are subject to progressive enforcement if the entity's costs exceed the target. Some entities have raised concerns that new legislative insurance mandates will make it difficult for them to meet the established cost growth target.

Current law does not explicitly require OHCA to adjust the cost growth targets based on changes to state policy, such as insurance mandates, that may increase spending. However, it does require OHCA to consider state benefit mandates in its development and enforcement of cost growth targets. Specifically, when establishing cost growth target methodology, OHCA is required to review relevant state policy changes impacting covered benefits, provider reimbursement, and costs, among other factors. In addition, in enforcing cost growth targets, OHCA is required to consider factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target.

- 3) **SUPPORT.** Susan G. Komen, sponsor of this bill, states that they often receive calls and emails from patients who are unable to afford the out-of-pocket costs for their follow-up diagnostic imaging services. Susan G. Komen continues that without some assistance, many of these patients will simply delay or forego their follow-up screenings, leading to later diagnoses. Susan G. Komen notes that this delay can mean that they will not seek care until their cancer has spread making it much deadlier and much more costly to treat. Susan G. Komen continues that breast cancer can be up to five times more expensive to treat when it has spread beyond the breast to other parts of the body. Susan G. Komen notes that delayed or missed breast imaging can result in later stage diagnosis leading to significantly higher health care costs, extended employment absences, higher disability claims, increased staffing costs and greater retention risks, ultimately straining the workforce. Susan G. Komen concludes that by eliminating burdensome financial barriers to comprehensive preventive care, this bill can drive earlier detection, improve outcomes, reduce the overall costs to the health care system and create a healthier more productive workforce.
- 4) **OPPOSITION.** The California Association of Health Plans and Association of California Life and Health Insurance Companies are opposed to this bill, stating that preventive screening mammography is already covered without cost-sharing, ensuring access to early detection services, consistent with USPSTF recommendations. While the opposition shares the author's goal of reducing barriers to care and improving breast cancer outcomes, they argue that this bill goes well beyond preventive services by broadly eliminating cost-sharing for supplemental screening and diagnostic imaging. The opposition cites CHBRP's analysis, which found that this bill would result in substantial new costs, increasing premiums by

nearly \$94 million annually. The opposition states that it remains unclear whether this approach would meaningfully improve health outcomes. The opposition continues that eliminating cost-sharing for one category of diagnostic services while maintaining it for others sets a troubling precedent and raises concerns about consistency and equity across the health care system. The opposition concludes that these added costs ultimately increase premiums and shift financial burdens onto other purchasers and enrollees, at a time when health care affordability remains a pressing concern for Californians.

5) PREVIOUS LEGISLATION.

- a) SB 974 (Portantino) of 2022 was substantially similar to this bill. SB 974 was vetoed by Governor Newsom who indicated: “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 the federal United States 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.

Furthermore, the bill prohibits health plans and insurance policies from imposing cost-sharing for these services, which exceed the requirements of the ACA 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.”

- b) AB 2024 (Friedman) of 2022, would have required coverage screening mammography, medically necessary diagnostic or supplemental breast examinations, or tests for screening or diagnostic purposes upon the referral of a participating providers, as specified, and would have prohibited cost-sharing for screening mammography, medically necessary diagnostic or supplemental breast examinations, or testing. AB 2024 was held on the Senate Appropriations suspense file.
- c) AB 2342 (Burke) of 2018 would have required health plans, health insurers, and DHCS to cover breast and ovarian cancer susceptibility screening as recommended by the USPSTF but was vetoed by Governor Brown who indicated: “Each of these bills require significant, ongoing general fund commitments. As such, I commend these policies to the budget process where they may be prioritized along with other spending proposals and which begins again on January 3rd.”
- d) AB 1860 (Limón), Statutes of 2018, Chapter 427, extends the January 1, 2019 sunset in existing law that requires health plans and health insurers that provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells from requiring an enrollee or insured to pay, notwithstanding any deductible, a total amount of copayments and coinsurance that exceeds \$250 for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication, as specified.
- e) SB 1034 (Mitchell), Chapter 332, Statutes of 2018, extends the January 1, 2019 sunset in existing law that requires a health facility at which a mammography examination is performed to include a prescribed notice on breast density in the summary of the written report that is sent to a patient, if specified circumstances apply.

- 6) AUTHOR AMENDMENTS.** The author has submitted amendments to the committee to delete the terms “tests for screening or diagnostic purposes” and “other clinically indicated diagnostic testing” throughout the bill.

REGISTERED SUPPORT / OPPOSITION:

Support

Susan G. Komen (sponsor)
Biocom California
California Retired Teachers Association
California Society of Plastic Surgeons
Health Access California

Opposition

Association of California Life & Health Insurance Companies
California Association of Health Plans

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