SENATE COMMITTEE ON HEALTH
Senator Dr. Akilah Weber Pierson, Chair

BILL NO: SB 1309
AUTHOR: Rubio
VERSION: April 14, 2026
HEARING DATE: April 22, 2026
CONSULTANT: Jen Flory

SUBJECT: Health care coverage: lung cancer

SUMMARY: Requires a health plan contract or health insurance policy to provide, without cost-sharing, coverage for follow-up screening or diagnostic services for lung cancer that is recommended by a health care provider acting within the scope of their practice.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Requires a health plan contract and health insurance policy, except for a specialized health plan contract and policy, to be deemed to provide coverage for all generally medically accepted cancer screening tests, subject to all terms and conditions that would otherwise apply. [HSC §1367.665 and INS §10123.20]

3) Requires a group or individual nongrandfathered health plan contract or health insurance policy, at a minimum, to provide coverage for and not impose any cost-sharing requirements for any of the following:
   a) Evidence-based items or services that had in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force (USPSTF) on January 1, 2025 or, as later modified by the California Department of Public Health (CDPH);
   b) Immunizations that had in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention (CDC) on January 1, 2025 or as later modified by CDPH;
   c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines supported by the United States Health Resources and Services Administration (HRSA) as of January 1, 2025 or as later modified by CDPH;
   d) With respect to women, those additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA as of January 1, 2025 or as later modified by CDPH; and,
   e) Indicates the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention as of January 1, 2025, or as later modified by CDPH, is considered the most current other than those issued in or around November 2009. [HSC§ 1367.002 and INS §10112.2]

4) Establishes health savings accounts under federal law, to be used exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written

governing instrument creating the trust meets specified requirements. Establishes high deductible health plans, which are plans with deductibles not less than $1,000 for an individual and $5,000 for a family, as specified. [26 USC §223]

5) Allows an annual tax deduction in an amount equal to the aggregate amount paid in cash by or on behalf of an individual, to a health savings account. [26 USC §223]

6) Prohibits a plan from failing to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care, as specified. [26 USC §223]

This bill:

1) Requires a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027 to provide coverage for follow-up screening or diagnostic services for lung cancer recommended by a health care provider acting within the scope of their practice.

2) Specifies that this coverage is not subject to copayment, coinsurance, deductible or any other form of cost-sharing.

3) Defines "follow-up screening or diagnostic services for lung cancer" as a service provided after an initial abnormal or indeterminate test result, including, but not limited to a diagnostic computed tomography scan, positron emission tomography/computed tomography scan, tissue sampling, biopsy, bronchoscopy, pathology, and surgical consultation.

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

COMMENTS:

1) *Author's statement.* According to the author, lung cancer is the leading cause of cancer-related death in California, yet it is one of the most survivable cancers when caught early. The problem is that too many Californians are skipping life-saving screenings. Not because they do not want to take care of their health, but because they simply cannot afford to be screened. This bill, the Stop Lung Cancer Early Act, directly addresses this barrier by eliminating cost-sharing for lung cancer screenings. There is no reason to delay the care that could save your life. When a screening returns an abnormal or intermediate result, patients need timely follow-up care to determine next steps, yet this is often where the financial burden becomes overwhelming. This bill eliminates cost-sharing for that follow-up care, ensuring patients are not left without answers at the most critical moment in their health journey. The data is clear: when lung cancer is caught at an early stage, survival rates increase dramatically. By removing financial obstacles at every step of the screening and diagnostic process, this bill will encourage more Californians to get screened, more cancers to be caught early, and ultimately, more lives to be saved. No Californian should have to choose between their financial stability and a fighting chance against cancer.

2) *Lung Cancer in California.* Lung cancer is the third most common cancer and the leading cause of cancer deaths in California, according to data from a 2019 UC Davis Comprehensive Cancer Center report. Smoking and secondhand smoke are the leading risk factors, followed by radon exposure and air pollution. The California Tobacco Control Program's estimate of lung and bronchus cancer incidence in California decreased from 41.2 to 33.8 per 100,000 adults between 2016 and 2021, although the COVID-19 pandemic is a notable confounding factor in diagnosis and screening during this period. According to 2025 estimates from the American Lung Association, California has the third lowest rate of new

lung cancer diagnoses in the nation, which may be partially explained by its comparatively low smoking rate, which is also the third lowest in the nation. However, just over 25% of lung cancer cases are caught at an early stage, placing California 43rd among the 50 states in terms of early detection screening. California also has a higher-than-average number of people who do not receive any treatment after being diagnosed with lung cancer, ranking 44th in the nation.

3) *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 lung cancer screening, the USPSTF recommends an annual screening for lung cancer with low-dose CT scans in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. The screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. This recommendation is a grade B recommendation which means that coverage without a co-pay is required. This recommendation was most recently updated in March 2021. The guidelines are silent on any further testing beyond the annual scan, even if the results are inconclusive or require follow-up.

4) *Internal Revenue Service (IRS) Preventive Services.* Among the requirements to qualify as a health savings account, an individual must be covered under a high deductible health plan with no disqualifying health coverage. A high deductible health plan is a plan that satisfies certain requirements with respect to minimum deductibles and maximum out-of-pocket expenses. Generally, under federal law, a high deductible health plan linked to a health savings account may not provide benefits for any year until the minimum deductible for that year is satisfied. However, the law provides a safe harbor for the absence of a deductible for preventive care. Therefore, a high deductible health plan may provide preventive care benefits without a deductible. To be a preventive care benefit, the benefit must either be described as preventive care under the ACA or for purposes of the Social Security Act or determined to be preventive care in guidance issued by the Department of the Treasury and the IRS. Current IRS guidance does not include follow-up screening or diagnostic services for lung cancer.

5) *California Health Benefits Review Program (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, and reviewed this bill. Key findings include:
   a) *Screening guidelines.* CHBRP found very strong evidence regarding the effectiveness of the initial lung cancer screening currently covered according to the ACA. With regards to the effectiveness of subsequent follow-up services after an abnormal or indeterminate finding, CHBRP did not review the evidence as diagnostic follow-up services have been well documented and thus the analysis assumes that follow-up services significantly improve health outcomes and reduce mortality.

b) *Coverage impacts and enrollees covered.* CHBRP estimates that at baseline 40% of enrollees have coverage compliant with this bill, primarily Medi-Cal enrollees and a small number of CalPERS enrollees without cost-sharing for these services. Post-mandate, all 22.8 million Californians in state-regulated plans would have these services covered without cost-sharing.
c) *Medical effectiveness.* CHBRP found strong evidence that delays in diagnoses and treatment are correlated with worse clinic stage during the diagnostic workup and increased recurrence of lung cancer. CHBRP found some evidence that treatment delays for lung cancer negatively impact mortality. While CHBRP found no direct evidence on the effectiveness of cost-sharing for follow-up services when patients have an abnormal finding during a lung cancer screening, evidence from other cancer research demonstrate how cost affects utilization of health services and outcomes.
d) *Utilization.* CHBRP estimates that an additional 1,000 patients could access follow-up services for lung cancer, including imaging, biopsies, and surgical or other specialist consultations as a result of this bill. Post-mandate, a total of 51,000 Californians would utilize follow-up services without cost-sharing.
e) *Medi-Cal.* CHBRP points out that Medi-Cal enrollees have no cost-sharing and all plans are currently compliant with this bill.
f) *Impact on expenditures.* CHBRP estimates an increase of $27,641,000 in total annual premiums paid by employers and enrollees for covering benefits without cost-sharing. This translates to an additional $.06 to $.31 per member per month premium increase, depending on the type of coverage, with the highest increases being on individually purchased plans. For those needing the services, average annual out-of-pocket expenses would decrease in the commercial/CalPERS market, ranging from $90 (CalPERS) to $840 (individually purchased insurance). For those that do complete the recommended follow-up care, who would not have it without this bill, the average avoided treatment cost is approximately $149,304 per individual who receives an earlier-stage diagnosis. However, the number of individuals in this category is estimated to be very small and not sufficient to change the overall finding that premiums would increase overall.
g) *Public health.* CHBRP projects a modest public health impact at the population level. However, the bill would likely yield health and quality-of-life improvements among a subset of enrollees who would receive diagnostic services and follow-up screenings without cost-sharing at a more frequent or earlier time interval. One study found that of those receiving an initial lung cancer screening, 7.4% had a follow-up procedure within one year. With regards to health disparities, the analysis states that Black, Native American and low-income populations face higher incidence and mortality rates, often driven by late-stage diagnosis and lower screening rates.
h) *Essential health benefits.* If California requires state-regulated health insurance to offer benefits that exceed essential health benefits, the state could be required to defray the cost of additionally mandated benefits under the ACA. In this case, as the additional services are already covered as medically necessary basic health care services, the proposed mandate would not exceed the current definition of essential health benefits in California.

6) *Related legislation.* SB 950 (Weber Pierson) requires health plans and insurers to cover all medically necessary treatments or medications, as determined by a health care provider, that are approved by the federal Food and Drug Administration for the treatment of Alzheimer's disease or other related dementia. *SB 950 passed this committee by a vote of 9-0 when it was heard in this committee on April 15, 2026.*

SB 1124 (Archuleta) requires CDPH to develop signage for lung cancer screening by July 1, 2027, and mandates that retailers prominently display this signage in retail locations beginning January 1, 2028. Creates a $1,000 penalty for failure to display the signage, enforceable by the California Department of Tax and Fee Administration. *SB 1124 is set for hearing in the Senate Revenue & Taxation Committee on April 22, 2026.*

AB 1570 (Wilson) requires health plans and insurers to cover an annual cervical cancer screening home test kit without cost-sharing. *AB 1570 is set for hearing in the Assembly Appropriations Committee on April 22, 2026.*

AB 1906 (Aguiar-Curry) requires health plans, health insurance, and Medi-Cal to cover screening mammography and medically necessary diagnostic breast imaging, including imaging following an abnormal mammography for an enrollee or insured with a breast cancer risk factor without cost-sharing. *AB 1906 is set for hearing in the Assembly Health Committee on April 21, 2026.*

7) *Support.* Supporters, including co-sponsors the American Cancer Society, the Cancer Action Network and the American Lung Association, write that many patients face substantial out-of-pocket costs for medically necessary follow-up diagnostics procedures after an abnormal screening result. These costs, which for some can be thousands of dollars, can discourage patients from completing essential follow-up testing, thereby delaying or preventing timely, potentially life-saving treatment. For individuals with limited financial resources, even modest co-pays can create substantial barriers. These burdens disproportionately impact low-income Californians, communities of color, and rural populations already experiencing higher lung cancer mortality rates.

8) *Opposition.* The California Association of Health Plans and the Association of California Life and Health Insurance Companies write in opposition stating that this bill goes well beyond preventive services by eliminating cost-sharing for follow-up screening and diagnostic services. Moreover, 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. 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. The California Small Business Association writes in opposition to a number of health care mandate bills, including this one, pointing out that these bills increase the costs to employer-sponsored health coverage.

9) *Policy comment.* While the argument that the high cost of follow-up care deters people from getting the additional diagnostic tests they need after an abnormal or inconclusive initial lung cancer screening test is compelling, the same argument can be made for the cost of lung cancer treatment itself, or indeed, any health care service. Earlier diagnosis and care is always better and cost always deters access to services. California's high rate of persons who receive no treatment after being diagnosed with lung cancer is testament to this fact.

10) *Amendments.* As currently drafted, the requirements of this bill could be interpreted to apply to specialty health plans, such as dental plans, that would not normally cover these services. This is not an issue for health insurance policies given how they are already defined in the Insurance Code. As such, the following technical amendment will be made to the Health and Safety section that regulates health plans:

Section 1 1367.58. (a) A health care service plan contract, ***excluding a specialized health care service plan contract,*** issued, amended, or renewed on or after January 1, 2027, shall provide coverage for follow-up screening or diagnostic services for lung cancer recommended by a health care provider acting within the scope of their practice.

As noted above, health savings account eligible high deductible health plans must meet federal requirements and can only exclude services from cost-sharing as authorized by the IRS. Thus, the following amendment to the section on health plans requires these plans to exclude the additional services from cost-sharing only when authorized federally:

(d) If a health care service plan contract is a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, the contract shall not impose a deductible, coinsurance, or any other cost-sharing on the services described in this section unless doing so would conflict with the current federal requirements for high deductible health plans, including those requirements defining exempt preventive care.

SUPPORT AND OPPOSITION:

Support: American Cancer Society Cancer Action Network (co-sponsor)
American Lung Association (co-sponsor)
Alliance for Patient Access
American Lung Cancer Screening Initiative
AstraZeneca
Biocom
Biomarker Collaborative
Breathe California
California Academy of Family Physicians
California Black Health Network
California Chronic Care Coalition
California Life Sciences
California Society for Respiratory Care
Cedars-Sinai Health Systems
Go2 for Lung Cancer
Health Access California
International Cancer Advocacy Network

Oppose: Association of California Life & Health Insurance Companies
California Association of Health Plans
California Small Business Association

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