Date of Hearing: June 16, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1309 (Rubio) – As Amended April 27, 2026

SENATE VOTE: 38-0

SUBJECT: Health care coverage: lung cancer.

SUMMARY: Requires health plans and health insurers to provide coverage for follow-up screening or diagnostic services for lung cancer without cost-sharing. Specifically, **this bill**:

1) Requires a health plan and health insurer to provide coverage for follow-up screening or diagnostic services for lung cancer recommended by a health care provider acting within their scope of practice.

2) Prohibits coverage in 1) above from being subject to copayment, coinsurance, deductible, or any other form of cost-sharing.

3) Prohibits, if the health plan is a high deductible health plan, the imposition of a deductible, coinsurance, or any other cost-sharing on the coverage required pursuant to this bill unless not imposing the deductible, coinsurance, or cost-sharing would conflict with the federal requirements for high deductible health plans, including those requirements defining exempt preventive care.

4) Exempts specialized health plans from the provisions of this bill.

5) 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.

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) and the California Department of Insurance (CDI) to regulate health and other insurance. [Health & Safety Code (HSC) § 1340, *et seq*. and Insurance Code (INS) § 106, *et seq*.]

2) Establishes California's essential health benefits (EHBs) benchmark under the Patient Protection and Affordable Care Act (ACA) as the Kaiser Small Group Health Maintenance Organization, establishes existing California health insurance mandates, and the 10 ACA mandated benefits, including prescription drug coverage. [HSC § 1367.005 and INS § 10112.27]

3) 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]

4) 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]

5) 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]

6) 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. [HSC § 127500, *et seq*.]

FISCAL EFFECT: According to the Senate Appropriations Committee, DMHC anticipates minor and absorbable costs for state administration, CDI estimates costs of $3,000 in 2026-27 and $16,000 in 2027-28 for state administration (Insurance Fund). Unknown General Fund costs, potentially hundreds of thousands, due to increased California Public Employees' Retirement System (CalPERS) plan premiums.

COMMENTS:

1) **PURPOSE OF THIS BILL**. 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 don't want to take care of their health, but because they simply cannot afford to be screened. SB 1309, 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. SB 1309 also 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. The author states she is proud to author this bill and urges her colleagues to support this commonsense measure. No Californian should have to choose between their financial stability and a fighting chance against cancer.

2) **BACKGROUND.** Lung cancer is the uncontrolled growth of abnormal cells in the lungs, often caused by inhaled toxins. Symptoms usually do not appear until later stages when the cancer has spread and the chance of cure or long-term survival is reduced, which makes early detection critical. The top three causes of lung cancer are tobacco smoking, radon gas exposure, and secondhand smoke. Eighty percent to 90% of lung cancer is caused by inhaled tobacco smoke, but between 10% to 20% of lung cancer patients have no smoking history. California has among the lowest lung cancer incidence rates in the United States, at approximately 36.5 per 100,000 people, well below the national rate of 52.8 per 100,000 people. This may be partially attributed to low overall smoking rates in California compared to other states as well as aggressive anti-tobacco policies. In 2024, approximately 16,803 new cases were diagnosed in the state. Yet, concerns persist that a relatively high share of cases are diagnosed at a later stage, which are associated with lower survival rates.

   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) **Increased premiums, reduced out-of-pocket expenses.** CHBRP estimates that SB 1309 would result in an additional 1,000 patients accessing follow-up screenings or services for lung cancer, including imaging, biopsies, and surgical or other specialist consults. A total of 51,000 Californians would utilize these follow-up services without cost-sharing. CHBRP estimates that these utilization changes would lead to an increase of $27,641,000 in total annual premiums paid by employers and enrollees for covering benefits without cost-sharing. Average annual out-of-pocket expenses would decrease for those accessing follow-up screenings and services in the commercial and CalPERS market, ranging from $90 (CalPERS) to $840 (individually purchased insurance).

      ii) **Medical effectiveness.** CHBRP found that there is strong evidence that delays in diagnosis and treatment are correlated with worse clinical stage during the diagnostic workup and increased recurrence of lung cancer. There is some evidence that treatment delays for lung cancer negatively impact mortality. CHBRP notes that individuals with an abnormal initial screening test result often incur out-of-pocket costs for the follow-up services and screenings that occur after the initial screening, and these out-of-pocket costs have increased over time. CHBRP found no direct evidence on the impact of cost-sharing for follow-up services after an

abnormal/indeterminate results for lung cancer. While not specific to lung cancer, there is evidence from studies on breast cancer that shows increased cost-sharing generally contributes to lower utilization of services.

iii) **Public health & long-term impacts.** Due to the small changes in utilization or delays in utilization, CHBRP projects a modest public health impact. CHBRP estimates that an unknown number of enrollees would receive an earlier-stage diagnosis than they would have at baseline, with an average cost savings of $149,304 per case.

b) **California lags in lung cancer screening.** CHBRP's analysis notes that a smaller proportion of lung cancer cases are diagnosed at an early stage in California (25.9%) compared to the national average (28.1%). Uptake of screening of lung cancer – which is often the initial step for lung cancer diagnosis – remains low compared to other cancer screenings. California ranks 32 out of 51 in the nation for lung cancer screening, with only 16.8% of the eligible population getting screened. Lung cancer screening is relatively recent compared to other cancer screening modalities and remains underutilized among eligible populations. Barriers to screening include limited access to care, lack of awareness of screening options, stigma and implicit bias related to smoking and race, perceptions of lung cancer as a fatal condition, challenges with shared decision-making, and underestimation of individual risk. Racial and ethnic disparities in initial lung cancer screening in California show significant gaps in screening eligibility and uptake. Despite 2021 USPSTF guideline expansions, Black, Latino, and Asian American populations in California often have lower screening uptake than white counterparts. Notably, Latino (37.3%), African American (38.4%), and Japanese American (40.0%) patients show the lowest screening eligibility, while Native Hawaiian (56.7%) and white (49.6%) cases show the highest.

   This bill aims to expand access to follow-up screenings for lung cancer by eliminating cost-sharing for those screenings. Initial lung cancer screenings are already covered without cost-sharing for consumers, yet evidence shows that uptake of these screenings in California is still incredibly low. This raises the question whether removing cost-sharing for follow-up screenings will increase early detection, or if there are alternative solutions to pursue to increase lung cancer screening rates across California.

c) **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**. A coalition of patient, provider, and stakeholder advocates support this bill, including the American Lung Association and American Cancer Society Cancer Action Network. The supporters note that when detected early, lung cancer has a five-year survival rate of approximately 65%, compared to roughly 10% when diagnosed at a later stage. The supporters argue that this bill builds on California's commitment to preventive care by ensuring that the full screening-to-diagnosis pathway is accessible and effective. The supporters continue that low-dose computed tomography lung cancer screening is generally provided without cost-sharing in California's individual and group insurance markets, including Medi-Cal managed care, many patients nonetheless face substantial out-of-pocket costs in certain situations for medically necessary follow-up diagnostic procedures after an abnormal screening result. The supporters state that these costs—often in the form of copayments, coinsurance, or deductibles—can range from hundreds to thousands of dollars. The supporters argue that financial barriers frequently discourage or delay patients from completing essential follow-up testing, undermining the life-saving potential of lung cancer screening. The supporters continue that these burdens disproportionately affect low-income Californians, communities of color, and rural populations—groups that already experience higher lung cancer mortality rates. The supporters argue that this bill addresses this critical gap by eliminating cost-sharing for follow-up diagnostic procedures that are clinically indicated after a lung cancer screening. The supporters conclude that by removing financial barriers to timely diagnostic care, this bill will help ensure that more patients complete recommended testing, promote earlier diagnosis, reduce disparities in access to care, improve survival outcomes, and may reduce long-term system costs by avoiding late-state treatment and preventable emergency care.

4) **OPPOSITION**. The California Association of Health Plans and Association of California Life and Health Insurance Companies oppose this bill. The opposition states that they share the author's goal of improving early detection of lung cancer but argue that this bill does not address the primary barriers to screening uptake and risks increasing costs without meaningfully improving outcomes. The opposition cites that initial lung cancer screening rates in California remain low, at approximately 16.8%, despite these screenings already being covered without cost-sharing. The opposition notes this is significantly lower than screening rates for other cancers, and share the example that breast cancer screening rates are closer to 65%. The opposition suggests that cost may not be the primary barrier to screening uptake. The opposition additionally cites research that indicates that the barriers to lung cancer screening are more likely to occur earlier in the care continuum, rather than at the follow-up diagnostic services. These include: provider challenges, such as evolving eligibility criteria and difficulty identifying eligible patients; low patient awareness, including limited understanding of screening availability and benefits; stigma associated with smoking history; and geographic and demographic access disparities. The opposition argues that taken together, these factors suggest that improving early detection may depend more on increasing awareness, clarifying eligibility, and strengthening provider engagement than on

eliminating cost-sharing for follow-up diagnostic services. The opposition continues that this bill focuses on eliminating cost-sharing for downstream follow-up services — a later point in the care continuum — while evidence indicates that initial lung cancer screening rates remain far below where they need to be. The opposition concludes that this bill risks increasing costs without meaningfully improving those rates or early detection outcomes.

5) RELATED LEGISLATION.

a) AB 1570 (Wilson) would have required health plans and insurers to cover an annual cervical cancer screening home test kit without cost-sharing. AB 1570 was held on the Assembly Appropriations suspense file.

b) AB 1906 (Aguiar-Curry) would require 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 currently pending in the Senate Health Committee.

c) SB 950 (Weber Pierson) would require 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 is currently pending in the Assembly Health Committee.

d) SB 1124 (Archuleta) would require DPH 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. Would create a $1,000 penalty for failure to display the signage, enforceable by the California Department of Tax and Fee Administration. SB 1124 is currently pending in the Assembly Health Committee.

6) TECHNICAL AMENDMENTS. CDI has requested and the author has agreed to amendments to apply exemptions for specialized health care service plans and high deductible health plans in the HSC sections of this bill to the INS code sections, as follows:

INS 10123.78. (a) A health insurance policy 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.

(b) ***(1)*** Coverage required pursuant to this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost-sharing.

(2) Notwithstanding paragraph (1), if a health insurance policy is a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, the policy shall not impose a deductible, coinsurance, or any other cost-sharing on the coverage required pursuant to this section unless not imposing the deductible, coinsurance, or cost-sharing would conflict with the federal requirements for high deductible health plans, including those requirements defining exempt preventive care.

(c) For purposes of this section, "follow-up screening or diagnostic services for lung cancer" means 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.

(d) This section does not apply to a specialized health insurance policy that covers only dental, mental health, or vision benefits.

REGISTERED SUPPORT / OPPOSITION:

Support

American Cancer Society Cancer Action Network (sponsor)
American Lung Association (sponsor)
Alliance for Patient Access
AstraZeneca
Biocom
Breathe California of the Bay Area, Golden Gate and Central Coast
Breathe California Sacramento Region
Breathe Southern California
California Academy of Family Physicians
California Black Health Network
California Chronic Care Coalition
California Life Sciences
California Medical Association (CMA)
California Professional Firefighters
California Society for Respiratory Care
Go2 for Lung Cancer
Health Access California
ICAN, International Cancer Advocacy Network

Opposition

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

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