Date of Hearing: July 1, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 1309 (Rubio) – As Amended June 18, 2026

Policy Committee: Health Vote: 15 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill requires health plans and health insurance policies provide coverage without cost sharing for follow-up screenings and diagnostic services for lung cancer after an abnormal or indeterminate screening result.

Specifically, this bill:

1) Requires health care service plans and health insurers (collectively, health plans), except specialized health plans, 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 item 1, above, from being subject to copayment, coinsurance, deductible, or any other form of cost sharing.

3) For a high deductible health plan, prohibits 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) 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:

1) The California Health Benefits Review Program (CHBRP) estimates premium costs to the California Public Employees Retirement System (CalPERS): CHBRP estimates that premium costs for CalPERS would increase by $544,000, of which approximately $250,000 would be General Fund (GF) costs for premiums for health plans regulated by the Department of Managed Health Care (DMHC). The state would incur additional costs of an unknown amount, likely less than $250,000 GF, for CalPERS insurance policies regulated by the California Department of Insurance (CDI).

2) DMHC and CDI estimate minor and absorbable costs.

3) CHBRP estimates this bill will increase total premiums for all employers and enrollees by approximately $27.6 million (0.016%) statewide, while decreasing cost sharing by $20.7 million statewide for those enrollees who use the newly mandated benefits. Although most of these costs are not borne by the state, premium increases inflate overall health care costs for employers and enrollees, especially those in the small group and individual insurance markets.

COMMENTS:

1) **Purpose.** This bill is sponsored by the American Cancer Society Cancer Action Network and American Lung Association. 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…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.

2) **Background.** ***Lung Cancer.*** Lung cancer is the leading cause of cancer death in the U.S. The top three causes of lung cancer are tobacco smoking, radon gas exposure, and secondhand smoke. While 80% to 90% of lung cancer is caused by inhaled tobacco smoke, 10% to 20% of lung cancer patients have no smoking history. Lung cancer symptoms usually do not appear until later stages, when the cancer has spread and the chance of cure or long-term survival is reduced. In 2024, approximately 16,803 new cases were diagnosed in the state. CHBRP notes that California has among the lowest lung cancer incidence rates in the nation, at 36.5 per 100,000 people, versus the national rate of 52.8 per 100,000. However, a smaller proportion (25.9%) of lung cancer cases are diagnosed at an early stage in California compared to the national average (28.1%). CHBRP states uptake of screening of lung cancer – which is often the initial step for lung cancer diagnosis – is low in California, with only 16.8% of the eligible population getting screened.

Initial and Follow-up Screening. The U.S. Preventive Services Taskforce (USPSTF) recommends people between 50 and 80 years who have a history of smoking get screened annually with a low-dose computed tomography (LDCT) scan. CHBRP defines initial (or baseline) screening as the first LDCT scan performed for lung cancer screening in an eligible, asymptomatic individual. This initial LDCT scan establishes a reference point for future comparisons. CHBRP defines follow-up screening as subsequent LDCT scans performed after the initial screening to monitor findings or continue routine annual screening in accordance with clinical guidelines.

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, as noted above, uptake of these initial screenings in California is low.

3) **Opposition**. The California Association of Health Plans (CAPH) and Association of California Life and Health Insurance Companies (ACLHIC) oppose this bill, arguing that this bill does not address the primary barriers to screening uptake and risks increasing costs without meaningfully improving outcomes. CAPH and ACLHIC suggest that cost may not be the primary barrier to screening uptake, that the barriers to lung cancer screening are more likely to occur earlier in the care continuum, rather than at the stage of follow-up diagnostic services, and 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.

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