California Health Benefits Review Program

Analysis of California Assembly Bill 1986 Health Care Coverage: Colorectal Cancer: Screening and Testing

A Report to the 2019–2020 California State Legislature

April 6, 2020

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Key Findings

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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Assembly Bill 1986 analyzed by CHBRP would require Department of Managed Health Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies to provide coverage without any cost sharing for a colorectal cancer (CRC) screening examination and laboratory test assigned either a grade of A or B by the United States Preventive Services Task Force (USPSTF) for individuals at average risk, and prohibit cost sharing on colonoscopies, including the removal of polyps, for enrollees aged 50–75 years.

1. CHBRP estimates that, in 2021, of the 21.7 million Californians enrolled in state-regulated health insurance subject to benefit mandates, 3.8 million enrollees aged 50–75 years will have coverage subject to AB 1986.
2. **Benefit coverage**. CHBRP estimates 100% of enrollees aged 50–75 years with health insurance that would be subject to AB 1986 currently have coverage for CRC screening examinations and tests at baseline, with 7% of enrollees having cost sharing for these exams and tests. AB 1986 appears not to exceed the definition of essential health benefits (EHBs) in California.
3. **Utilization**. CHBRP estimates that there are 15,373 users of CRC screening exams and tests among the enrollees aged 50–75 years with coverage subject to AB 1986 and who have cost sharing at baseline. CHBRP estimates these users receive a total of 16,411 screening exams and tests per year. CHBRP estimates that removal of cost sharing would increase utilization of CRC screening services by 1.5% postmandate.
4. **Expenditures**. CHBRP estimates that AB 1986 would increase total net annual expenditures by $1,256,000, or 0.001%, for enrollees covered by DMHC-regulated plans and CDI-regulated policies. CHBRP estimates that enrollee out-of-pocket expenses would decrease by $3,144,000.
5. **Long-term impacts**. CHBRP is unable to estimate changes in overall utilization after the initial 12 months from the enactment of AB 1986.

CONTEXT

Colorectal cancer (CRC) is cancer that occurs in either the colon or rectum. Most colorectal cancers arise from abnormal growth (adenomatous polyps) in the linings of the large bowel that take 10 to 15 years on average to progress to cancerous tissues.[1] In California, colorectal cancer is the third leading cause of cancer death for women and men. For women, the first and second leading causes are lung and breast cancers, respectively; for men, the top two are lung and prostate cancer.

The United States Preventive Services Task Force (USPSTF) makes certain recommendations for screenings for CRC among persons at average risk for the disease. The USPSTF recommends routine screening for all asymptomatic adults between the ages of 50 and 75 years who have an average risk of colorectal cancer based on their genetic and medical history. Several screening methods are available with different suggested screening intervals. The benefits and risks vary among these screening strategies. As such, the USPSTF does not explicitly recommend any specific screening strategy for colorectal cancer; instead, it provides information regarding efficacy, suggested screening intervals, and other considerations.

Insurance coverage and cost-sharing requirements for screenings may influence their use. The Affordable Care Act (ACA) requires coverage of screening examinations and tests, but not all CRC exams and tests are covered without cost sharing for all individuals. Some health plans and insurers may impose cost sharing for colonoscopies following a positive stool or other CRC screening test, while others may impose cost sharing for polyp removal during a colonoscopy. Federal guidance also prohibits enrollee cost sharing for the removal of a polyp during a screening colonoscopy. However, variation in health plan and insurer guidance to providers, as well as inconsistency in how CRC screenings are defined, coded (screening/ preventive vs. diagnostic or therapeutic), and paid, may contribute to the ongoing existence of and variation in enrollee cost sharing.

[1] Refer to CHBRP's full report for full citations and references.

BILL SUMMARY

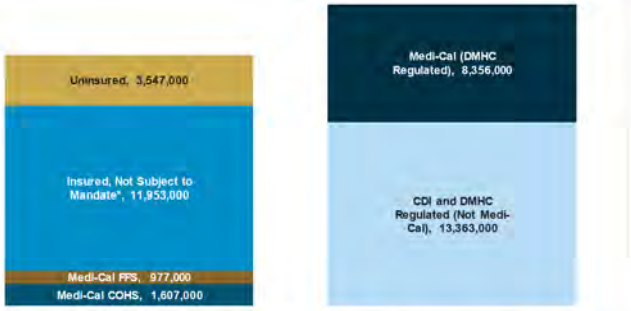
AB 1986 addresses coverage for CRC screening procedures for enrollees in DMHC-regulated plans and CDI-regulated policies. AB 1986 specifically directs a health care service plan contract or a health insurance policy — except as specified — that is issued, amended, or renewed on or after January 1, 2021, to:

- Provide coverage without any cost sharing for a colorectal cancer screening examination and laboratory test assigned either a grade of A or B by the USPSTF for individuals at **average** risk.
- Prohibit cost sharing on colonoscopies, including the removal of polyps, for enrollees aged 50–75 years when either of the following applies:
  - The colonoscopy is a screening procedure not occasioned by a recent positive test or procedure.
  - The colonoscopy has been scheduled because of a positive result on a test or procedure, other than a colonoscopy, assigned either a grade of A or B by the USPSTF.

AB 1986 further specifies that the provisions need not apply to colorectal cancer screening examinations or tests that are delivered by out-of-network providers. The bill does not address enrollees at **high** risk.

Figure A shows the number of Californians who have health insurance subject to state mandates. Of note, AB 1986 does not apply to Medi-Cal (Managed Care, Fee for Service, and County Organized Health Systems/COHS) or Medicare. Enrollees ages 65–75 years with health insurance subject to AB 1986 are assumed to not have Medicare coverage.

Figure A. Health Insurance in California



Source: California Health Benefits Review Program, 2020.
Note: * Medicare beneficiaries, enrollees in self-insured products, etc.

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

CHBRP estimates that 3.8 million enrollees with health insurance that would be subject to AB 1986 are ages 50–75 years and that 100% currently have coverage for CRC screening examinations and tests at baseline. CHBRP estimates that among these, 7% have cost sharing at baseline and that postmandate, 0% would have cost sharing.

Utilization

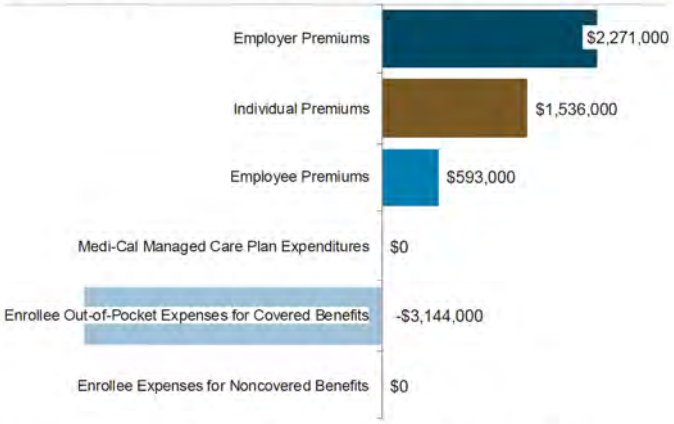
CHBRP estimates that there are 15,373 users of CRC screening examinations and tests who are ages 50–75, with insurance subject to AB 1986, and have cost sharing at baseline. CHBRP estimates these users receive a total of 16,411 screening examinations and tests at baseline. CHBRP estimates that removal of cost sharing would increase total utilization of CRC screening services by 1.5% postmandate.

It is important to note that the total number of users affected by this bill is greater than the 15,373 users at baseline. Guidelines vary by CRC screening procedure, and screening exams or tests may be performed as infrequently as once every 10 years. This analysis examines the first year of implementation postmandate and reflects typical annual CRC screening rates. CHBRP expects similar numbers of procedures and users in subsequent years, but the users receiving services would not be the same people.

Expenditures

CHBRP estimates that AB 1986 would increase total net annual expenditures by $1,256,000, or 0.001%. This is due to an increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a decrease in enrollee expenses for covered benefits. CHBRP also estimates that enrollee out-of-pocket expenses would decrease by $3,144,000 (Figure B).

Figure B. Expenditure Impacts of AB 1986



Source: California Health Benefits Review Program, 2020.

Medi-Cal

CHBRP estimates no impact for DMHC-regulated enrollees associated with Medi-Cal Managed Care, because these plans are not subject to AB 1986.

CalPERS

CHBRP estimates that no CalPERS HMO enrollees have cost sharing with CRC screening examinations and tests at baseline; therefore, AB 1986 would have no impact on benefit coverage or enrollee expenditures.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP estimates AB 1986 would have no measurable impact on the number of uninsured persons.

Long-Term Impacts

CHBRP is unable to estimate changes in overall utilization after the initial 12 months from the enactment of AB 1986. CHBRP notes that receipt of a colonoscopy with negative screening results precludes the need for additional testing for 10 years; thus, long-term increases in colonoscopy may be offset by long-term decreases in receipt of other procedures. However, CHBRP found no literature to quantify these impacts.

Research has shown that CRC screening examinations and tests in general are cost saving, primarily due to the rising cost of cancer care at the end of life. However, the magnitude of cost-saving estimates is dependent on the testing modality. USPSTF guidelines do not specify the use of any testing modalities over others; therefore, CHBRP is unable to project specific long-term cost impacts of AB 1986 by test type.

Essential Health Benefits and the Affordable Care Act

AB 1986 requires coverage for preventive screening tests for colorectal cancer with a grade of A or B by the USPSTF and eliminates cost sharing for persons aged 50–75 years. Therefore, AB 1986 appears not to exceed the definition of EHBs in California.

At the time of this CHBRP analysis, there is substantial uncertainty regarding the impact of the COVID-19 pandemic on premium rates and health plan enrollment, including how the pandemic will impact healthcare costs in 2021. Because the variance of potential outcomes is significant, CHBRP does not take these effects into account as any projections at this point would be speculative, subject to federal and state decisions and guidance currently being developed and released. In addition, insurers', providers', and consumers' responses are uncertain and rapidly evolving to the public health emergency and market dynamics.

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The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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Table 1. AB 1986 Impacts on Benefit Coverage, Utilization, and Cost, 2021

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Benefit coverage				
Total enrollees with health insurance subject to state benefit mandates (a)	21,719,000	21,719,000	0	0.0%
Total enrollees with health insurance subject to AB 1986	13,363,000	13,363,000	0	0.0%
Total enrollees aged 50–75 years with health insurance subject to AB 1986	3,755,867	3,755,867	0	0.0%
Number with coverage not in full compliance with AB 1986	255,511	0	-255,511	-100.0%
Percentage with coverage not in full compliance with AB 1986	7%	0%	-7%	-100.0%
Utilization and unit cost for procedures *with cost sharing*				
Total number of colorectal cancer screening examinations and tests	16,411	0	-16,411	-100.0%
Average cost per examination/test (b)	$1,887	$1,887	$0.00	0.0%
Average cost share per examination/test	$191.60	$0.00	-$191.60	-100.0%
Expenditures				
Premiums (expenditures) by payer				
Private employers for group insurance	$54,037,059,000	$54,039,330,000	$2,271,000	0.00%
CalPERS HMO employer expenditures (c)	$3,264,098,000	$3,264,098,000	$0	0.00%
Medi-Cal Managed Care Plan expenditures	$29,218,820,000	$29,218,820,000	$0	0.00%
Enrollee premiums (expenditures)				
Enrollees with individually purchased insurance	$15,689,758,000	$15,691,294,000	$1,536,000	0.01%
Individually purchased – outside exchange	$4,412,875,000	$4,414,286,000	$1,411,000	0.03%
Individually purchased – Covered California	$11,276,883,000	$11,277,008,000	$125,000	0.00%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (d)	$15,867,227,000	$15,867,820,000	$593,000	0.00%
Enrollee out-of-pocket expenses				
For covered benefits (deductibles, copayments, etc.)	$12,776,801,000	$12,773,657,000	-$3,144,000	-0.02%
For noncovered benefits (e) (f)	--	--	--	--
Total expenditures	$130,853,763,000	$130,855,019,000	$1,256,000	0.001%

Source: California Health Benefits Review Program, 2020.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.[2]

(b) Average costs and cost sharing are estimated across all CRC screening examinations and tests, of which individual tests vary from relatively lower cost (e.g., fecal occult blood test or FOBT) to higher cost (e.g., colonoscopy).

(c) Approximately 57.36% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents.

(d) Enrollee premium expenditures include contributions by employees to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care.

(e) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(f) Although enrollees with newly compliant coverage may have paid for some colorectal cancer screening services before AB 1986, CHBRP cannot estimate the frequency with which such situations may have occurred and therefore cannot estimate the related expense. Postmandate, enrollees with newly compliant coverage might pay for some colorectal cancer screening tests for which coverage is denied, or coverage is allowed but cost sharing is imposed (e.g., for exams or tests not recommended by the USPSTF, multiple tests when only one test or one test plus a colonoscopy are covered), as some enrollees who always had compliant coverage may have done and may continue to do.

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HMO = Health Maintenance Organization.

[2] For more detail, see *Estimates of Sources of Health Insurance in California for 2021*, available at http://chbrp.org/other_publications/index.php.

POLICY CONTEXT

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)[3] conduct an evidence-based assessment of the impacts of AB 1986, Colorectal Cancer: Screening and Testing. CHBRP conducted a cost-only analysis for AB 1986, since the medical effectiveness and public health impacts of colorectal cancer screening and testing are known and were included in CHBRP's 2016 analysis of AB 1763 that addressed this topic.

Bill-Specific Analysis of AB 1986, Colorectal Cancer: Screening and Testing

AB 1986 addresses insurance coverage for examinations and laboratory tests intended to detect colorectal cancer (CRC). The United States Preventive Services Task Force (USPSTF) makes certain recommendations for screenings for CRC among persons at **average** risk for the disease (Bibbins-Domingo et al., 2016). The USPSTF recommends that all adults aged 50–75 years receive CRC screening. Recommended screening methods include stool-based tests such as the fecal occult blood test (FOBT), fecal immunochemical test (FIT), and multi-targeted stool DNA testing (FIT-DNA), as well as direct visualization tests such as flexible sigmoidoscopy and colonoscopy.

Some people are designated as **high** risk for CRC based on factors such as personal or family history of CRC or certain polyps, or other specific health conditions; AB 1986 addresses only those who are **average** risk.

CRC screening is used to find and remove pre-cancerous polyps, which prevents them from subsequently transforming to colorectal cancer. As described in detail in the *Background* section, about 30% of Californians do not receive recommended CRC screenings despite their effectiveness and coverage by the Affordable Care Act (ACA). Complexities regarding the definition of "screening colonoscopy" and variation in enrollee cost sharing may contribute to this, as described below.

The exams and tests used to detect polyps or colorectal cancer can be used for screening or diagnosis. Screening colonoscopies, for example, which evaluate asymptomatic people for previously undiagnosed polyps and colon cancer, differ from diagnostic or therapeutic colonoscopies, which are used to evaluate or treat specific symptoms such as abdominal pain, intestinal bleeding, or known colon polyps.[4] While the ACA requires full coverage of preventive CRC screenings, health plans/insurers are authorized to impose cost sharing on diagnostic examinations. Under AB 1986, if a polyp was found during a screening via flexible sigmoidoscopy for an enrollee aged 50–75 years and its removal deferred until a colonoscopy could be scheduled, the colonoscopy would be covered without cost sharing due to the two-step nature of the screening process. In this case, although the colonoscopy is 'therapeutic', it is still part of the overall screening process.

Insurance coverage and cost-sharing requirements for screenings may influence their use. The ACA requires coverage for screening examinations and tests, but not all CRC exams and tests are covered without cost sharing for all individuals. Some health plans and insurers may impose cost sharing for colonoscopies following a positive stool or other CRC screening test, while others may impose cost sharing for polyp removal during a colonoscopy (AMA, 2018; Mehta et al., 2015; Pollitz et al, 2012). If enrollees have cost-sharing requirements for a colonoscopy that follows a FIT test, for example, they may choose a colonoscopy first, in order to possible avoid cost sharing from a colonoscopy ordered as a result of a positive non-invasive test. Federal guidance prohibits enrollee cost sharing for the removal of a polyp during a screening colonoscopy; however, variation in health plan and insurer guidance to providers, as well as inconsistency in how CRC screenings are defined, coded (screening/preventive vs. diagnostic or therapeutic), and paid, may contribute to the ongoing existence of and variation in enrollee cost sharing (AMA, 2018; Pollitz et al, 2012).

[3] CHBRP's authorizing statute is available at www.chbrp.org/docs/authorizing_statute.pdf.
[4] Personal communication, Jed Weissberg, MD, March 2020.

Bill Language

AB 1986 addresses coverage for CRC screening procedures for enrollees in plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI). AB 1986 specifically directs a health care service plan contract or a health insurance policy — except as specified — that is issued, amended, or renewed on or after January 1, 2021, to:

- Provide coverage without any cost sharing for a colorectal cancer screening examination and laboratory test assigned either a grade of A or B by the USPSTF for individuals at **average** risk.[5]
- Prohibit cost sharing on colonoscopies, including the removal of polyps, for enrollees aged 50–75 years when either of the following applies:
    - The colonoscopy is a screening procedure not occasioned by a recent positive test or procedure.
    - The colonoscopy has been scheduled because of a positive result on a test or procedure, other than a colonoscopy, assigned either a grade of A or B by the USPSTF.

The Bill Author's office indicated to CHBRP that the bill would be amended, and the Assembly Health Committee requested that CHBRP review the language with the proposed amendments. The full text of AB 1986 as introduced, as well as with the proposed amendments, can be found in Appendix A.

Relevant Populations

If enacted, AB 1986 would apply to the health insurance of approximately 3.8 million enrollees (9.4% of all Californians) ages 50–75 years. This represents 17% of the 21.7 million Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law — in DMHC-regulated plans and CDI-regulated policies.

AB 1986 does not apply to Medi-Cal enrollees in managed care plans. Also, enrollees ages 65–75 with health insurance subject to AB 1986 are assumed to not have Medicare coverage.

As described in the *Background* section, the USPSTF recommends routine screening for all asymptomatic adults between the ages of 50 and 75 who have an average risk of colorectal cancer based on their genetic and medical history. Several screening methods are available with different suggested screening intervals. The benefits and risks vary between these screening strategies. As such, the USPSTF does not explicitly recommend any specific screening strategy for colorectal cancer, and instead provides information regarding efficacy, suggested screening intervals, and other considerations.

Interaction With Existing Requirements

Proposed legislation can interact with state and federal requirements. When possible, CHBRP indicates possible overlaps or interactions.

Health benefit mandates may interact and align with the following state and federal mandates or provisions.

[5] The USPSTF recommends services with grades of A or B. More information on USPSTF grades is available at https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions.

California Policy Landscape

California law and regulations

California law requires DMHC-regulated plans and CDI-regulated[6] policies to cover medically accepted cancer screening tests. Although this benefit mandate requires coverage for CRC screening, it does not address cost-sharing requirements. AB 1986: 1) eliminates cost sharing for a colorectal cancer screening examination and laboratory test assigned either a grade of A or B by the USPSTF for persons aged 50–75 years who are at average risk, and 2) prohibits cost sharing for colonoscopies, including the removal of polyps, when an enrollee aged 50–75 years uses in-network providers, either when it is a screening procedure not following a positive test or procedure OR it has been scheduled because of a positive result on a test or procedure, other than a colonoscopy, that is assigned either a grade of A or B by the USPSTF.

Similar requirements in other states

CHBRP is aware of only one other state that addresses two components similar to those of AB 1986: (1) coverage for CRC screening examinations and laboratory tests, and (2) a prohibition on cost sharing for fecal tests and colonoscopies, including the removal of polyps, for enrollees aged 50 years and over. Per Revised Statue 743A.124 of 2017, Oregon health benefit plans are required to cover all CRC screening examinations and laboratory tests rated an A or B by the USPSTF. In addition, insurers may not impose cost sharing on coverage for fecal tests and colonoscopies, including the removal of polyps, for enrollees aged 50 years and over. Oregon's legislation also defines individuals at high risk for CRC and states that they are entitled to coverage of CRC screening examinations and laboratory tests as recommended by the treating physician.

Federal Policy Landscape

Affordable Care Act

The ACA has impacted health insurance in California, expanding the Medi-Cal program (Medicaid in California)[7] and making subsidized and nonsubsidized health insurance available through Covered California, the state's health insurance marketplace.[8]

A number of ACA provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 1986 may interact with requirements of the ACA, including the requirement for certain health insurance to cover essential health benefits (EHBs).[9]

Under the ACA, health insurance plans and policies issued or renewed after September 23, 2010, must cover preventive screenings with an A or B rating from the USPSTF, including those for colorectal cancer. The Centers for Medicare & Medicaid Services (CMS) provides further guidance clarifying coverage for screening colonoscopies.[10] Among the CMS clarifications on ACA coverage is the prohibition of cost

[6] California Health & Safety Code (1367.665) and California Insurance Code (10123.20).
[7] The Medi-Cal expansion is to 133% of the federal poverty level (FPL) — 138% with a 5% income disregard.
[8] The ACA requires the establishment of health insurance exchanges in every state, now referred to as health insurance marketplaces.
[9] The ACA requires nongrandfathered small-group and individual market health insurance — including, but not limited to, Qualified Health Plans (QHPs) sold in Covered California — to cover 10 specified categories of EHBs. Resources on EHBs and other ACA impacts are available on the CHBRP website: http://www.chbrp.org/other_publications/index.php.
[10] Centers for Medicare & Medicaid Services, 2020. Available at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html#Affordable%20Care%20Act.

sharing imposed on enrollees of nongrandfathered group health plans and health insurance coverage offered in the individual or group market for the removal of a polyp during a screening colonoscopy.[11]

Essential Health Benefits

Nongrandfathered plans and policies sold in the individual and small-group markets are required to meet a minimum standard of benefits as defined by the ACA as essential health benefits (EHBs). In California, EHBs are related to the benefit coverage available in the Kaiser Foundation Health Plan Small Group Health Maintenance Organization (HMO) 30 plan, the state's benchmark plan for federal EHBs.[12,13] CHBRP estimates that approximately 4 million Californians (10%) have insurance coverage subject to EHBs in 2021.[14]

AB 1986 requires coverage for preventive screening tests for colorectal cancer with a grade of A or B by the USPSTF and eliminates cost sharing for persons aged 50–75 years. AB 1986 appears not to exceed the definition of EHBs in California because the state's benchmark plan provides coverage for colorectal cancer screening and AB 1986 only addresses cost sharing for screening examinations and tests.

Federally Selected Preventive Services

The ACA requires that nongrandfathered group and individual health insurance plans and policies cover certain preventive services without cost sharing when delivered by in-network providers as soon as 12 months after a recommendation appears in any of the following:[15]

- The United States Preventive Services Task Force (USPSTF) A and B recommendations;
- The Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for women's preventive services;
- The HRSA-supported comprehensive guidelines for infants, children, and adolescents, which include:
  - The Bright Futures Recommendations for Pediatric Preventive Health Care; and
  - The recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
- The Advisory Committee on Immunization Practices (ACIP) recommendations that have been adopted by the director of the Centers for Disease Control and Prevention (CDC).

AB 1986 is consistent with the ACA's requirement for coverage of preventive services and specifically directs a health care service plan contract or a health insurance policy — except as specified — that is issued, amended, or renewed on or after January 1, 2021, to provide coverage for a CRC screening exam and laboratory test assigned a grade of A or B by the USPSTF for persons who are at average risk.

Analytic Approach and Key Assumptions

For this analysis, CHBRP assumes that the bill:

- Applies to average-risk enrollees aged 50–75 years only;

[11] Centers for Medicare & Medicaid Services, 2013. Available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.
[12] CCIIO, Information on Essential Health Benefits (EHB) Benchmark Plans. Available at: https://www.cms.gov/cciio/resources/data-resources/ehb.html.
[13] H&SC Section 1367.005; IC Section 10112.27.
[14] CHBRP, Estimates of Sources of Health Insurance in California in 2021. Available at: www.chbrp.org/other_publications/index.php.
[15] A resource on this ACA requirement is available on the CHBRP website: www.chbrp.org/other_publications/index.php.

- Eliminates cost sharing for enrollees who use in-network providers for a colonoscopy, including the removal of polyps, either when it is a screening procedure not following a positive test or procedure OR it has been scheduled because of a positive result on a test or procedure, other than a colonoscopy that is assigned either a grade of A or B by the USPSTF;
- Does not apply to Medi-Cal managed care plans.

CHBRP assumes that AB 1986 does not apply to CRC screening examinations and tests performed out of network; therefore, all estimates reflect utilization and costs of in-network examinations and tests.

Cost Sharing Considerations

Enrollees may still experience cost sharing for CRC screenings despite the ACA mandate requiring coverage without cost sharing for certain preventive services, due to the following aspects of the mandate:

1. It only applies to nongrandfathered group health plans and health insurers offering nongrandfathered group or individual health insurance coverage, thereby leaving some populations with coverage requiring cost sharing.

2. It only applies to services provided in-network (Federal Register, 2015).

3. It is only relevant to screening examinations and tests given a grade of A or B under the current USPSTF recommendations. Some screening exams or test may not be included in the recommendations. In these circumstances, the examination either may not be covered by certain health plans/insurers, or may be covered but still require cost sharing by the health plan/insurer (Dorn and Fendrick, 2012).

At the time of this CHBRP analysis, there is substantial uncertainty regarding the impact of the COVID-19 pandemic on premium rates and health plan enrollment, including how the pandemic will impact healthcare costs in 2021. Because the variance of potential outcomes is significant, CHBRP does not take these effects into account as any projections at this point would be speculative, subject to federal and state decisions and guidance currently being developed and released. In addition, insurers', providers', and consumers' responses are uncertain and rapidly evolving to the public health emergency and market dynamics.

BACKGROUND ON COLORECTAL CANCER SCREENING

This *Background* section provides context for CHBRP's analysis of AB 1986 by discussing the incidence of colorectal cancer, relevant risk factors, screening guidelines, and patterns of use, as well as the social determinants of health that may influence screening behaviors in California. It also provides a brief overview of cost sharing. Note that the following discussion broadly applies to the general population and includes persons with insurance subject to AB 1986, as well as the uninsured and those with health insurance not subject to state-regulated mandates, unless otherwise stated.

Colorectal Cancer

Colorectal cancer (CRC) is cancer that occurs in either the colon or rectum. Most colorectal cancers arise from abnormal growth (adenomatous polyps) in the linings of the large bowel that take 10 to 15 years on average to progress to cancerous tissues (Doubeni, 2016). In California, colorectal cancer is the third leading cause of cancer death for women and men. For women, the first and second leading causes are lung and breast cancers, respectively; for men, the top two are lung and prostate cancer (USCSWG, 2019).

Nationally, the lifetime incidence of CRC is about 4.2%, with incidence being 25% greater among men than women and about 20% higher in African Americans than whites (NCI, 2019). Patients with predisposing heritable conditions also demonstrate higher CRC incidence (Macrae, 2016). Between 1988 and 2016, CRC incidence rates in California declined steadily for the general population and among all major racial/ethnic groups, with the greatest decreases (46.2%) observed for African Americans (CDPH, 2019).

CRC is known as a "silent killer" since individuals with the disease tend to remain asymptomatic during early stages (i.e., before the cancer has spread beyond the intestinal wall), resulting in a larger proportion of late-stage diagnoses; survival declines to 71% and 14% for patients diagnosed with regional and distant metastases, respectively (ACS, 2020). CRC screening may reduce CRC-specific mortality by detecting it at earlier stages and may decrease CRC incidence by detecting premalignant polyps that can be surgically removed (Bevan and Rutter, 2018). With early detection, the 5-year probability of survival from CRC is 89.9% (NCI, 2019). In some cases, CRC may be prevented entirely with removal of precancerous polyps during a screening (Doubeni, 2016). Analyses of past trends of colorectal cancer screenings across the nation indicate that more than half of the decline in CRC mortality in recent years is a result of increased acceptance and use of CRC screening (Zauber, 2015).

Risk Factors and Screening Recommendations

The risk of developing colorectal cancer is most strongly associated with aging. Although CRC is sometimes observed in younger adults, an individual's risk for large bowel cancers increases rapidly after age 50 years (Macrae, 2016). In the United States, colorectal cancer is infrequent before the age of 40 years, with approximately 90% of CRC occurring among individuals aged 50 years and older (Doubeni, 2016). Most CRCs are diagnosed after 60 years of age (Bevan and Rutter, 2018). The age at which the balance of benefits and harms of colorectal cancer screening becomes less favorable varies based on a patient's life expectancy, health status, comorbid conditions, and prior screening status. The USPSTF found little evidence for increased benefit of screenings above the age of 75 years. Accordingly, USPSTF recommends routine screening for all asymptomatic adults between the ages of 50 and 75 years who have an average risk of colorectal cancer based on their genetic and medical history. Several screening methods are available with different suggested screening intervals. The benefits and risks vary among these screening strategies. Furthermore, the quality of the evidence demonstrating the effectiveness of each test in reducing CRC mortality also varies. There are only two CRC screening strategies (FOBT and flexible sigmoidoscopy) that have been shown in randomized controlled trials to reduce CRC mortality (Bibbins-Domingo et al., 2016). As such, the USPSTF does not explicitly recommend any specific

screening strategy for colorectal cancer, and instead provides information regarding efficacy, suggested screening intervals, and other considerations (Table 2).

Table 2. Colorectal Cancer Screening Modalities by Screening Interval for Average-Risk Individuals

Screening Tests	USPSTF Interval	CMS Guidelines
Stool-based tests		
Fecal occult blood test (FOBT)	Every year	Every year
Fecal immunochemical test (FIT)	Every year	N/A
Multitargeted stool DNA test (FIT-DNA)	Every 1–3 years (a)	Every 3 years
Direct visualization tests		
Flexible sigmoidoscopy (b)	Every 5 years	Every 4 years, 10 years after previous screening colonoscopy
Computed tomography (CT) colonography	Every 5 years	N/A
Colonoscopy	Every 10 years	Every 10 years or 4 years after previous flexible sigmoidoscopy
Flexible sigmoidoscopy with FIT	Every 10 years for flexible sigmoidoscopy and every year for FIT	N/A

Source: United States Preventive Services Task Force (Bibbins-Domingo et al., 2016; CMS, 2014).

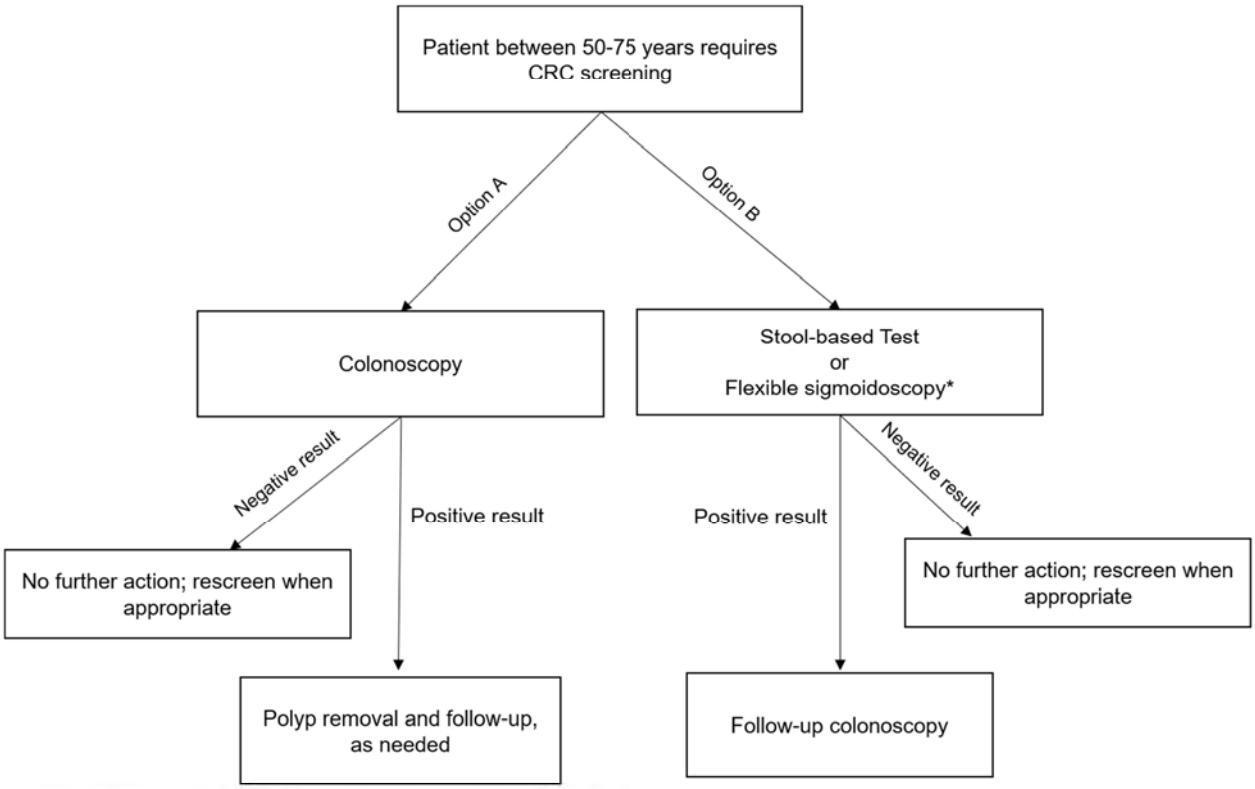
Notes: (a) Recommended by the manufacturer.

(b) Colonoscopy should be performed if test results are positive.

Key: CMS = Centers for Medicare & Medicaid Services; N/A = not applicable; USPSTF = United States Preventive Services Task Force.

Beyond the USPSTF guidelines for average risk individuals, AB 1986 would mandate coverage for colonoscopies, including the removal of polyps, when either: (1) the colonoscopy is a screening procedure not occasioned by a recent positive test or procedure; or (2) the colonoscopy has been scheduled because of a positive result on a test or procedure, other than a colonoscopy, assigned a grade A or B by the USPSTF. Colonoscopies are typically conducted as a follow-up procedure after a positive result on a previous noncolonoscopy CRC screening (Figure 1). Most polyps and some cancers can be removed during this type of procedure (CDC, 2020). Refer to the *Benefit Coverage, Utilization, and Cost Impacts* section for more information regarding current utilization rates.

Figure 1. Colorectal Cancer Screening Options



Source: California Health Benefits Review Program, 2020.

* Polyp removal may occur during a flexible sigmoidoscopy

Colorectal Cancer Screening Prevalence in California

The CDC considers adults to be up to date with screening guidelines for colorectal cancer if they are screened starting at 50 years of age and then continue regular screenings until the age of 75. By that definition, per the Behavioral Risk Factor Surveillance System (BRFSS), an estimated 28.4% of Californians aged 50–75 years in 2018 had not fully met the USPSTF recommendation (CDC, 2018).The rates observed in California fell short of the national target for CRC, adopted by the California Dialogue on Cancer,[16] which promoted 80% adherence to screening guidelines by 2018 (CDPH, 2017).

Patterns of Screening

In California, the prevalence of screening for CRC differs among demographic groups. In the most recent year for which data are available, older adults, women, and African Americans were more likely to be in compliance with USPSTF screening recommendations (Table 3). Specifically, women screen at higher rates than men (73.3% vs. 69.7%), and screening rates observed by age group show that 57.3% of adults aged 50 to 59 years report compliance to guidelines as compared with 88% among adults aged 70 to 75 years (CDC, 2018). The likelihood of adherence to guidelines is highest among non-Hispanic Whites

[16] The California Dialogue on Cancer is a cancer coalition that is administered by the California Department of Public Health's Comprehensive Cancer Control Program. It was created to implement California's Comprehensive Cancer Control Plan (the state cancer plan) to reduce the burden of cancer on the state.

(79.0%) and African Americans (76.0%). By contrast, Hispanics are estimated to have the lowest screening participation with only 56.3% reporting compliance with guidelines (CDC, 2018). As shown in Table 3Table 3, CRC screening is inversely correlated with income and educational attainment, with persons making less than $25,000 and those who have not graduated high school reporting adherence to guidelines below 60%.

Although CHBRP found limited literature regarding differential screening rates among risk groups, results from a New Jersey study of more than 700 patients in primary care settings suggest that screening prevalence differs by known level of risk for developing CRC (Felsen et al., 2011). When surveyed, patients who identified as high risk (on the basis of family medical history and diagnosis with inflammatory bowel disease (IBD) demonstrated the highest rates of screening guideline adherence (63%) as compared with 41% of average-risk patients. Additionally, high-risk patients were three times more likely to be up to date with guidelines and seven times more likely to adhere to a physician recommendation for CRC screening than those at average risk (Felsen et al., 2011).

Social Determinants of Health[17] and Disparities[18] in Colorectal Cancer Screening

Per statute, CHBRP now includes discussion of disparities under the broader umbrella of social determinants of health (SDoH). SDoH include factors outside of the traditional medical care system that influence health status and health outcomes. CHBRP will consider the full range of SDoH and related disparities (e.g., income, education, and social construct around age, race/ethnicity, gender, and gender identity/sexual orientation) that are relevant to this bill and where evidence is available. In the case of AB 1986, evidence shows that colorectal cancer-related mortality occurs disproportionately among older adults, African Americans, and men (Ellis et al., 2018). A review of the literature also indicates that educational attainment and socioeconomic status are inversely correlated with death from CRC (Jemal et al., 2015; Singh and Jemal, 2017). There are also disparities in CRC screenings between rural and urban residents. Rural residents with disabilities are at greater risk for late-stage diagnosis and mortality relative to people with disabilities in urban areas, and there is a much lower participation rate in CRC screenings for rural residents (Horner-Johnson et al., 2014; Ojinnaka et al., 2015; Ward et al., 2011).

Although CRC mortality rates are highest among adults aged 70 to 75 years (38.0 per 100,000 persons) and African Americans (14.0 per 100,000 persons), these populations have some of the most robust screening rates (88% and 76%, respectively) compared with all other groups (Table 3). This pattern may be reflective of the magnitude of increased risk that these groups experience, particularly among older adults; however, the literature is inconclusive on the reasons that African Americans experience high CRC mortality. Researchers evaluating the geographic distribution of gastroenterologists relative to populations of insured individuals found that African Americans are more likely to live near a gastrointestinal specialist (Stimpson et al., 2012).

The California Cancer Registry does not collect incidence and mortality by income or educational attainment; however, researchers comparing vital statistics and demographics at the state level observed that CRC mortality was inversely related to educational attainment (used in this study as a proxy for income). In California, non-Hispanic blacks with less than 12 years of schooling were found to have the

[17] CHBRP defines social determinants of health as conditions in which people are born, grow, live, work, learn, and age. These social determinants of health (economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources and impacted by policy (adapted from Healthy People 2020 (Office of Disease Prevention and Health Promotion, 2019). CHBRP's white paper on SDoH is available at: http://www.chbrp.org/analysis_methodology/docs/Incorporating%20Relevant%20Social%20%20Determinants%20of%20Health%20in%20CHBRP%20Analyses%20Final%20to%20WEBSITE%20033016.pdf.

[18] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: "Health disparities are potentially avoidable differences in health (or health risks that policy can influence) between groups of people who are more or less advantaged socially; these differences systematically place socially disadvantaged groups" at risk for worse health outcomes (Braveman, 2006).

highest mortality rates (18.3 per 100,000 persons) and highly-educated (greater than 16 years of schooling) Hispanics had the lowest mortality rates (3.9 per 100,000 persons) (Jemal et al., 2015).

Table 3. Percent Distribution of Colorectal Cancer Screening Use and CRC Incidence Among Californians Aged 50–75, By Age, Gender, Race/Ethnicity, Income, and Educational Attainment, California, 2018

Demographic	Meets USPSTF Colorectal Cancer Screening Recommendations (a)	California CRC mortality Rate, per 100,000 Persons, per Year, 2016 (b)
All	**71.6%**	**9.7**
Age group		
50–59 years	57.3%	11.5
60–69 years	81.3%	22.8
70–75 years	88.0%	38.0
Gender		
Male	69.7%	11.0
Female	73.3%	8.7
Race/ethnicity		
Non-Hispanic white	79.0%	9.8
African American	76.0%	14.0
Hispanic	56.3%	9.1
Asian/Pacific Islander	71.9%	8.3
Multiracial	60.6%	—
Income		
Less than $15,000	55.9%	—
$15,000–$24,999	56.7%	—
$25,000–$34,999	66.2%	—
$35,000–$49,999	66.1%	—
$50,000+	80.8%	—
Educational attainment		
Less than high school	49.4%	—
High school diploma or GED	68.9%	—
Some college or vocational school	75.2%	—
Bachelor's degree or higher	81.2%	—

Source: (CDC, 2018; CDPH, 2019).

Notes: (a) Numbers collected from the 2018 Behavioral Risk Factor Surveillance System survey in California.

(b) Mortality data collected from the California Cancer Registry. 2016 is the most recent year for which incidence and mortality data are available.

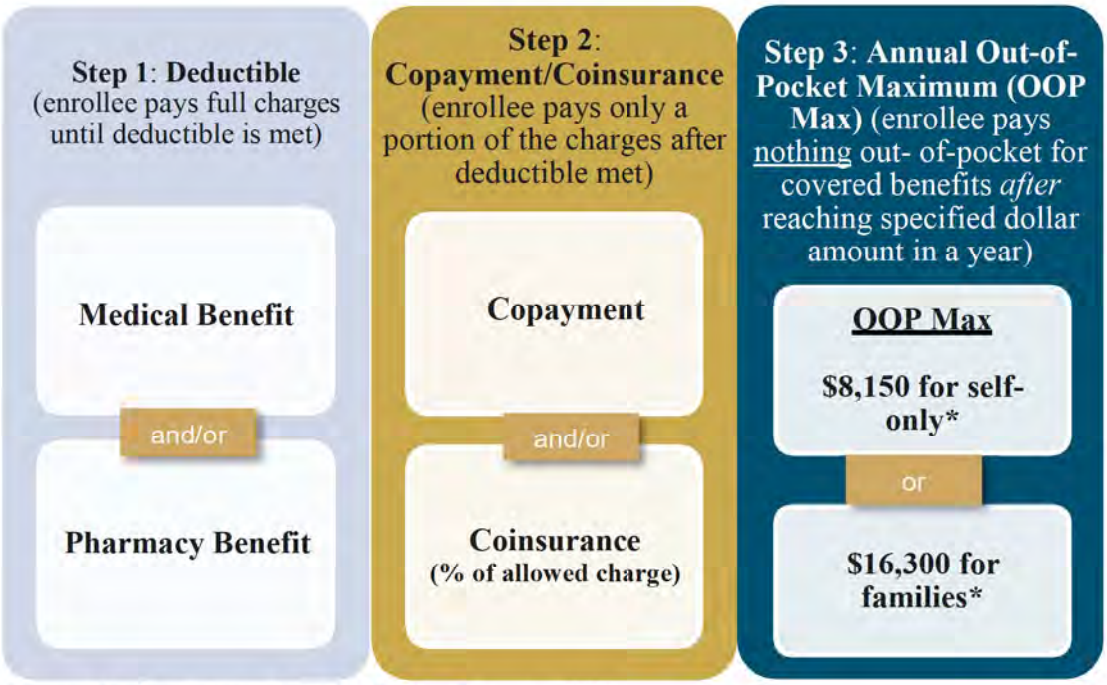
Key: — = California mortality data not available; CRC = colorectal cancer; GED = Graduate Equivalency Diploma; USPSTF = United States Preventive Services Task Force.

Cost Sharing

Payment for covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Specifically, the patient cost-share is the portion that enrollees are responsible for paying out of pocket directly to the provider for the health care service or treatment (including prescription drugs) covered by the plan or policy. Noncovered services or treatments are always paid in full by the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles but do not include premium payments. CHBRP refers to these as enrollee out-of-pocket expenses.[19] Annual out-of-pocket maximums are limits on the enrollee's total cost-sharing obligations (including any copayments, coinsurance, and deductibles) in a one-year period. After the amount an enrollee has paid for copayments, coinsurance, and deductibles reaches this limit, insurance pays 100% of the cost of covered care. Health care services that are not covered by the health plan or insurer would not be included in the maximum; enrollees are responsible for the full charges associated with noncovered services.

There are a variety of cost-sharing mechanisms employed by health plans and insurers to manage the cost of health care and ensure medically necessary care is provided (Figure 2). A full discussion of the literature on the effects of removal of cost sharing on utilization of CRC screening examinations and tests can be found in the *Benefit Coverage, Utilization, and Cost Impacts* section. AB 1986 would require health plans and insurers to cover a colorectal cancer screening examination and laboratory test assigned a grade A or B by USPSTF without cost sharing.

Figure 2. Overview of the Intersection of Cost-Sharing Methods Used in Health Insurance



Source: California Health Benefits Review Program, 2020.

[19] CHBRP's Glossary of Key Terms is available at: www.chbrp.org/analysis_methodology/glossary_key_terms.php.

Note: Steps 1 and 2 are not mutually exclusive. Under certain circumstances (e.g., preventive screenings or therapies), enrollees may pay coinsurance or copayments prior to their deductible being met; also copayments and coinsurance may be applied against the deductible in some circumstances. The figure assumes that the enrollee is in a plan with a deductible. If there is no deductible, then the enrollee pays a coinsurance and/or a copayment beginning with the first dollar spent (Step 2).

*The annual out-of-pocket amounts in this figure are the HHS-proposed maximum amounts allowed in 2020 (HHS, 2019); some plans and policies may have lower annual out-of-pocket maximums.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, AB 1986 would require DMHC-regulated health plans and CDI-regulated policies to provide coverage **without cost sharing** for a colorectal cancer screening examination and laboratory test assigned either a grade of A or B by the USPSTF for individuals at average risk. AB 1986 also prohibits cost sharing on colonoscopies, including the removal of polyps, for enrollees between 50 and 75 years of age when either of the following applies:

- The colonoscopy is a screening procedure not occasioned by a recent positive test or procedure.
- The colonoscopy has been scheduled because of a positive result on a test or procedure, other than a colonoscopy, assigned either a grade of A or B by the USPSTF.

AB 1986 allows health plans and insurers to impose cost sharing when services are provided by an out-of-network provider.

This section reports the potential incremental impacts of AB 1986 on estimated baseline benefit coverage, utilization, and overall cost.

Assumptions on Utilization and Cost

Types of insurance plans subject to AB 1986

CHBRP assumes AB 1986 applies to DMHC-regulated health plans and CDI-regulated policies, including DMHC-regulated CalPERS HMOs. CHBRP assumes Medi-Cal Managed Care Plans are not subject to AB 1986. Enrollees ages 65–75 with health insurance subject to AB 1986 are assumed to not have Medicare coverage.

Relevant examinations and lab tests under AB 1986

AB 1986 describes eligible CRC screening examinations and lab tests as those assigned either grade A or B by the USPSTF. As noted in the *Background* section, current USPSTF guidelines do not assign specific colorectal cancer screening exams and lab tests as grade A or grade B; instead, the USPSTF recommends general colorectal cancer screening, with a number of stool-based and visualization-based tests (Table 2). Thus, CHBRP assumes AB 1986 applies to all tests listed in Table 2.

CHBRP's analysis only included examinations and lab tests that were identified as: (1) performed in-network; and (2) screening, based on procedure, modifier, and diagnosis codes (see Appendix C).

Relevant populations with coverage subject to AB 1986

CHBRP examined individuals ages 50–75 years in the relevant market segments covered by health plans/insurers as shown in Table 1. For further details on the underlying data sources and methods used in this analysis, see Appendix C.

Baseline and Postmandate Benefit Coverage

Currently, CHBRP estimates 100% of enrollees aged 50–75 years with health insurance that would be subject to AB 1986 have coverage for CRC screening examinations and tests meeting USPSTF recommendations at baseline. CHBRP estimates 7% of enrollees have cost sharing[20] with USPSTF-

[20] Cost-sharing amounts for enrollees can vary by benefit design (e.g., some enrollees in a high-deductible health plan may have to pay the full cost of a CRC screening exam or test, while other enrollees in this type of plan may

recommended CRC screening examinations and tests at baseline (Table 4) and are not in full compliance with AB 1986. CHBRP estimates 0% of CalPERS HMO enrollees have cost sharing with CRC screening examinations and tests at baseline.

Current coverage of CRC screening without cost sharing was determined by surveys of the largest (by enrollment) providers of health insurance in California and CalPERS. Responses to this survey represent 59% of enrollees with DMHC-regulated policies and 12% of enrollees with CDI-regulated policies that can be subject to state mandates. To supplement survey data on the CDI insurance market, CHBRP derived additional estimates of coverage based on survey responses conducted in a prior analysis on CRC screening coverage (see Appendix C for details).

CHBRP assumes compliance with the proposed mandate on the part of all subject health plans/insurers. CHBRP assumes out-of-network screening examinations and tests are not subject to AB 1986. All estimates presented reflect in-network CRC examinations and tests. CHBRP estimates that 7.5% of total allowed charges for CRC screening examinations and tests are for services performed out-of-network at baseline (see Appendix C for details).

Table 4. Impact of AB 1986 on Utilization of Colorectal Cancer Screenings That Require Enrollee Cost Sharing, 2021

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total number of CRC screening examinations and tests performed requiring enrollee cost sharing	16,411	0	-16,411	-100%
(1) With Polyp Removal				
a. Colonoscopies not preceded by another test or procedure	3,798	0	-3,798	-100%
b. Colonoscopies performed following other CRC examinations and tests	298	0	-298	-100%
(2) Without Polyp Removal				
a. CRC screening examinations and tests not preceded by another test or procedure	11,873	0	-11,873	-100%
b. Colonoscopies performed following other CRC examinations and tests	440	0	-440	-100%

Baseline and Postmandate Utilization

Baseline utilization

CHBRP estimates that enrollees with health insurance subject to AB 1986 and who have cost sharing receive a total of 16,411 screening examinations and tests at baseline (Table 1 and Table 4).

Estimates of utilization of CRC screening examinations and tests that require enrollee cost sharing are shown in Table 4, with estimates for specific provisions as outlined in AB 1986. First, AB 1986 requires coverage without cost sharing for CRC screenings and tests, including the removal of polyps . Frequency of polyp removal was estimated from Milliman's 2017 Consolidated Health Cost Guidelines Sources Database (CHSD) and MarketScan databases. The utilization rates were trended from 2017 to 2021 using a 1.0% trend.

have minimal cost sharing if they have met their annual deductible or out-of-pocket maximum due to other medical expenses).

Second, AB 1986 requires coverage without cost sharing for colonoscopies that are not occasioned by a prior positive test or procedure (Table 4, rows (1) a. and (2) a.). Third, AB 1986 requires coverage without cost sharing for colonoscopies that have been scheduled due to a prior positive (noncolonoscopy) test or procedure (Table 4, rows (1) b. and (2) b.). CHBRP is unable to directly identify positive colorectal cancer screening tests from health plan claims and encounters data. Instead, CHBRP used Milliman's 2017 CHSD and MarketScan data to identify utilization of colorectal cancer screening procedures that were followed by a colonoscopy to estimate utilization of colonoscopies conducted following a positive screen from a noncolonoscopy exam or test. The utilization rates were trended from 2017 to 2021 using a 1.0% trend.

CHBRP estimates that at baseline, among colonoscopies that include removal of polyps and require enrollee cost sharing, 298 follow a prior (noncolonoscopy) exam or test, whereas 3,798 do not (Table 4). CHBRP estimates that at baseline, for CRC screening exams and tests that do not involve the removal of polyps, there are 440 colonoscopies that follow a prior (noncolonoscopy) exam or test, and 11,783 CRC screening exams and tests without a prior CRC screening exam or test.

Intervals for CRC screening examinations and tests vary for enrollees. As such, the baseline estimate of enrollees who have coverage with cost sharing include: (1) those who have had a screening exam or test in the baseline year; (2) those who have had an exam or test in previous year(s); and, (3) those who have never had an exam or test. CHBRP recognizes that utilization in response to cost sharing may differ for each of these groups. However, these sub-populations cannot be identified within the existing data.

Postmandate utilization

Based on a review of the current literature, CHBRP estimates that removal of cost sharing would increase utilization of colorectal cancer screening services by 1.5% (Khatami et al., 2012). A recent systematic review (for which full results have not yet been published) examined literature on the effect of the ACA on colorectal cancer screening. The authors reported a small majority of studies found increased screening; however, the studies included both expansion of health insurance coverage and removal of cost sharing (Xu et al., 2020). Several studies that specifically examined the removal of cost sharing for CRC screening have reported a range of changes in utilization, from a 5% decrease in odds of colonoscopy among high-risk Medicare enrollees (Cooper et al., 2016), to no change (Atallah, 2019; Han et al., 2015; Steenland et al., 2019), to increases of 1.5% to 6%, primarily among men over 65 years of age (Fedewa et al., 2015; Hamman and Kapinos, 2015; Khatami et al., 2012; Whaley, 2018; Zerhouni et al., 2019). However, most studies examined populations with coverage not subject to AB 1986, including newly insured Medicaid enrollees (Zerhouni et al., 2019; Fedewa et al., 2019) and Medicare enrollees (Atallah, 2019), or reported changes in a combined population of both commercially-insured and Medicare enrollees (Hamman and Kapinos, 2015; 2016; Fedewa et al., 2015). One study of a commercially-insured population was limited to Massachusetts (Steenland et al., 2019) and another to Texas (Khatami, 2012). A third examined a national sample (Whaley, 2018), but the findings are preliminary and have not been subjected to peer review. Given the absence of research that directly examines a population similar to that subject to the provisions of AB 1986, and the mixed results in recent literature, CHBRP considered a more conservative estimate of postmandate utilization and drew from the findings of Khatami et al., to estimate a 1.5% increase in utilization postmandate.

Of note, all studies but one examined overall population-level changes in utilization, rather than utilization changes by specific risk or utilization category (e.g., among those with no prior CRC screening, utilization for colonoscopies following a positive noncolonoscopy test, colonoscopy with polyp removal). One study examined impacts of removal of cost sharing on a high-risk Medicare population aged 70 years and above who had been identified as having received no colonoscopy in the previous five years (Cooper et al., 2016). Given the differences between the study sample and the enrollee population with health insurance subject to AB 1986, CHBRP did not use findings from this study to generate sub-population estimates of changes in utilization. Given the lack of evidence, CHBRP postmandate utilization estimates are based on overall changes in CRC screening examinations and tests, rather than postmandate utilization estimates of each sub-category of colonoscopy listed in Table 4.

Baseline and Postmandate Per-Unit Cost

CHBRP estimates baseline per-unit costs on the average of the colorectal cancer screening examinations and tests listed in Table 2 (in the *Background* section) derived from the 2017 Milliman CHSD and MarketScan databases. Outpatient and professional unit costs were trended from 2017 to 2021 using 7.0% and 4.5% annual trends, respectively. CHBRP estimates that the per-unit cost for each type of colorectal cancer screening examination and test will not change in the first 12 months postmandate due to the limited number of enrollees whose utilization will increase. CHBRP's estimates for the per-unit cost and cost share are also summarized in Table 1. Note that estimates reflect the average per-unit cost across all examinations and tests, which can vary by type, e.g., the average cost of FOBT is less than that of colonoscopy.

Baseline and Postmandate Expenditures

Tables 5 and Table 6 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. These tables present per member per month premiums, enrollee expenses for covered benefits, and total expenditures (premiums as well as enrollee expenses).

AB 1986 would increase total net annual expenditures by $1,256,000, or 0.001%, for enrollees covered by DMHC-regulated plans and CDI-regulated policies. This is due to an increase in total health insurance premiums paid by employers and enrollees for the removal of cost sharing postmandate, adjusted by a decrease in enrollee expenses for covered services.

Premiums

Changes in premiums as a result of AB 1986 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 5, and Table 6) with health insurance that would be subject to AB 1986. CHBRP estimates the following increases in premium expenditures (Table 1):

- Employer premiums: $2,271,000
- Individual premiums: $1,536,000
- Employee premiums: $593,000

CHBRP estimates per-member-per-month premium increases of $0.0629 and $0.0385 for individual market DMHC- and CDI-regulated plans, respectively, as well as increases of $0.0299 and $0.0082 for large-group markets for DMHC- and CDI-regulated plans, respectively (Table 6). CHBRP estimates no change in premiums for the small-group markets.

CHBRP estimates the increase in expenditures is primarily related to the assumed 1.5% increase in utilization of CRC screening examinations and tests among the enrollees aged 50–75 years after the removal of baseline cost sharing. The increase in total annual health insurance premiums paid by employers and enrollees is due to the assumed utilization increase and the shift of cost-sharing amounts previously paid by enrollees into premiums.

Among publicly funded DMHC-regulated health plans, CHBRP estimates no impact for DMHC-regulated enrollees associated with Medi-Cal Managed Care, because these plans are not subject to AB 1986. CHBRP estimates no impact for CalPERS HMO enrollees, as an estimated 100% had coverage compliant with AB 1986 at baseline.

Enrollee Expenses

Out-of-pocket spending for covered expenses

CHBRP estimates enrollee expenses would decrease by $3,144,000 due to the removal of cost sharing for CRC screening examinations and tests. AB 1986–related changes in enrollee out-of-pocket expenses for covered benefits (e.g., deductibles, copays) would vary by market segment. Among enrollees who use CRC screening examinations and tests and have cost sharing, CHBRP estimates baseline average out-of-pocket costs of $191.60 per examination or test (Table 1). CHBRP assumes out-of-pocket costs per examination or test will be eliminated post-mandate.

Note that such changes are related to the number of enrollees (Table 1, Table 5, and Table 6) with health insurance that would be subject to AB 1986, who have cost sharing at baseline, and who are expected to use CRC examinations and tests during the year after enactment. It is possible that some enrollees incur expenses related to colorectal cancer screening for which coverage was denied or coverage granted but cost sharing is still imposed (e.g., CRC examinations or tests not recommended under USPSTF guidelines, use of exams or tests without required prior authorization). However, CHBRP cannot estimate the frequency with which such situations occur and so cannot offer a calculation of impact.

CHBRP estimates per-enrollee expenses, when accounting for both premium increases and reductions in out-of-pocket spending, would result in no change in small-group markets; estimated increases in large-group and individual market segments are <0.01% (Table 6).

Potential Cost Offsets or Savings in the First 12 Months After Enactment

CHBRP does not project any cost offsets or savings in health care that would result from enactment of provisions in the first 12 months following enactment of AB 1986. CHBRP notes that increased CRC screening examinations and tests may be offset by cost savings due to early detection and treatment of colorectal cancer. These issues will be discussed more fully in the *Long-Term Impacts* section.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 1, Table 5, and Table 6), CHBRP estimates AB 1986 would have no measurable impact on the number of uninsured persons.

Changes in Public Program Enrollment

CHBRP estimates that AB 1986 would produce no measurable impact on enrollment in publicly funded insurance programs.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

CHBRP assumes that AB 1986 would not result in a shift in payment or service delivery to public payers. CHBRP assumes that enrollees who did not have full benefit coverage for cost sharing for CRC screening examinations and tests used self-pay and that cost shifting would not occur for public payers as a result of AB 1986.

Table 5. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2021

	DMHC-Regulated						CDI-Regulated			
	Privately Funded Plans (by Market) (a)			Publicly Funded Plans			Privately Funded Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS HMOs (b)*	*MCMC (Under 65) (c)*	*MCMC (65+) (c)*	*Large Group*	*Small Group*	*Individual*	**Total**
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,797,000	2,127,000	1,938,000	522,000	7,481,000	875,000	645,000	174,000	160,000	21,719,000
Total enrollees in plans/policies subject to AB 1986	7,797,000	2,127,000	1,938,000	522,000	0	0	645,000	174,000	160,000	13,363,000
Premiums										
Average portion of premium paid by employer	$421.33	$387.36	$0.00	$521.09	$262.75	$536.28	$493.36	$435.79	$0.00	$86,519,976,000
Average portion of premium paid by employee	$109.79	$140.13	$632.59	$97.10	$0.00	$0.00	$137.09	$167.01	$509.49	$31,556,986,000
Total premium	**$531.12**	**$527.49**	**$632.59**	**$618.19**	**$262.75**	**$536.28**	**$630.44**	**$602.80**	**$509.49**	**$118,076,962,000**
Enrollee expenses										
For covered benefits (deductibles, copays, etc.)	$41.92	$115.98	$170.63	$51.02	$0.00	$0.00	$123.80	$161.70	$161.76	$12,776,801,000
For noncovered benefits (e)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$573.05**	**$643.47**	**$803.22**	**$669.20**	**$262.75**	**$536.28**	**$754.24**	**$764.50**	**$671.25**	**$130,853,763,000**

Source: California Health Benefits Review Program, 2020.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Approximately 57.36% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

Table 6. Postmandate Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2021

	DMHC-Regulated						CDI-Regulated			
	Privately Funded Plans (by Market) (a)			Publicly Funded Plans			Privately Funded Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS HMOs (b)*	*MCMC (Under 65) (c)*	*MCMC (65+) (c)*	*Large Group*	*Small Group*	*Individual*	**Total**
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,797,000	2,127,000	1,938,000	522,000	7,481,000	875,000	645,000	174,000	160,000	21,719,000
Total enrollees in plans/policies subject to AB 1986	7,797,000	2,127,000	1,938,000	522,000	0	0	645,000	174,000	160,000	13,363,000
Premiums										
Average portion of premium paid by employer	$0.0237	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0064	$0.0000	$0.0000	$2,271,000
Average portion of premium paid by employee	$0.0062	$0.0000	$0.0629	$0.0000	$0.0000	$0.0000	$0.0018	$0.0000	$0.0385	$2,129,000
Total premium	$0.0299	$0.0000	$0.0629	$0.0000	$0.0000	$0.0000	$0.0082	$0.0000	$0.0385	**$4,400,000**
Enrollee expenses										
For covered benefits (deductibles, copays, etc.)	-$0.0208	$0.0000	-$0.0468	$0.0000	$0.0000	$0.0000	-$0.0065	$0.0000	-$0.0290	-$3,144,000
For noncovered benefits (e)	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
Total expenditures	$0.0091	$0.0000	$0.0160	$0.0000	$0.0000	$0.0000	$0.0017	$0.0000	$0.0095	**$1,256,000**
Percent change										
Premiums	0.0056%	0.0000%	0.0099%	0.0000%	0.0000%	0.0000%	0.0013%	0.0000%	0.0076%	0.0037%
Total expenditures	0.0016%	0.0000%	0.0020%	0.0000%	0.0000%	0.0000%	0.0002%	0.0000%	0.0014%	0.0010%

Source: California Health Benefits Review Program, 2020.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Approximately 57.36% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Car

LONG-TERM IMPACTS

In this section, CHBRP estimates the long-term impacts of AB 1986, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

CHBRP is unable to estimate long-term changes in overall utilization, given the absence of literature on the long-term effects of cost sharing. An extensive body of literature on CRC screening examinations and tests has identified an array of barriers to screening, including geographic distance, time demands, inconvenience, discomfort, and supply of providers who can perform endoscopies (CHBRP, 2016). CHBRP also notes that receipt of a colonoscopy with negative screening results precludes the need for additional testing for 10 years; thus, long-term increases in colonoscopy may be offset by long-term decreases in receipt of other procedures. However, CHBRP found no literature to quantify these impacts.

Cost Impacts

Microsimulation modeling approaches have found that CRC screening examinations and tests in general are cost saving, mainly because of the rising cost of cancer care at the end of life, but the magnitude of estimates vary depending on the testing modality (Ladabaum and Mannalithara, 2016; Lansdorp-Vogelaar et al., 2018; Lew et al., 2017, 2018; Lucidarme et al., 2012; Patel and Kilgore, 2015; Subramanian et al., 2017; van der Meulen et al., 2018). Because current USPSTF guidelines do not specify the use of any testing modalities over others, CHBRP is unable to project specific long-term cost impacts of AB 1986 by test type.

APPENDIX A TEXT OF BILL ANALYZED

On January 31, 2020, the California Assembly Committee on Health requested that CHBRP analyze AB 1986.

Below is the bill language as it was introduced on January 23, 2020. Immediately following is the bill language with proposed amendments. The Bill Author's office has indicated to CHBRP that the bill will be amended in these ways and CHBRP, per request from the Assembly Health Committee, has analyzed the text with the proposed amendments.

ASSEMBLY BILL NO. 1986

Introduced by Assembly Member Gipson

January 23, 2020

An act to add Section 1367.668 to the Health and Safety Code, and to add Section 10123.2074 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1986, as introduced, Gipson. Health care coverage: colorectal cancer: screening and testing.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires individual and group health care service plan contracts and health insurance policies to provide coverage for all generally medically accepted cancer screening tests and requires those contracts and policies to also provide coverage for the treatment of breast cancer. Existing law requires an individual or small group health care service plan contract or health insurance policy to, at a minimum, include coverage for essential health benefits, which include preventive services, pursuant to the federal Patient Protection and Affordable Care Act.

This bill would require a health care service plan contract or a health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2021, to provide coverage for colorectal cancer screening examinations and laboratory tests, as specified. The bill would require the coverage to include additional colorectal cancer screening examinations as listed by the United States Preventive Services Task Force as a recommended screening strategy and at least at the frequency established pursuant to regulations issued by the federal Centers for Medicare and Medicaid Services for

the Medicare program if the individual is at high risk for colorectal cancer. The bill would prohibit a health care service plan contract or a health insurance policy from imposing cost sharing on an individual who is between 50 and 75 years of age for colonoscopies conducted for specified purposes. The bill would also provide that it does not require a health care service plan or health insurer to provide benefits for items or services delivered by an out-of-network provider and does not preclude a health care service plan or health insurer from imposing cost-sharing requirements for items or services that are delivered by an out-of-network provider. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

DIGEST KEY

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.668 is added to the Health and Safety Code, to read:

1367.668. (a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2021, shall provide coverage without any cost sharing for all colorectal cancer screening examinations and laboratory tests assigned either a grade of A or a grade of B by the United States Preventive Services Task Force for individuals at average risk. If an enrollee is at high risk for colorectal cancer, the coverage required by this subdivision shall include additional colorectal cancer screening examinations as listed by the United States Preventive Services Task Force as a recommended screening strategy and at least at the frequency established pursuant to regulations issued by the federal Centers for Medicare and Medicaid Services for the Medicare program.

(b) For an enrollee who is between 50 and 75 years of age, a health care service plan contract shall not impose cost sharing on colonoscopies, including the removal of polyps, when either of the following applies:

(1) The colonoscopy is a screening procedure not occasioned by a recent positive test or procedure.

(2) The colonoscopy has been scheduled because of a positive result on a test or procedure, other than a colonoscopy, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force.

(c) Nothing in this section requires a health care service plan that has a network of providers to provide benefits for items or services described in this section that are delivered by an out-of-network provider or precludes a health care service plan that has a network of providers from imposing cost-sharing requirements for the items or services described in this section that are delivered by an out-of-network provider.

SEC. 2. Section 10123.207 is added to the Insurance Code, to read:

10123.207. (a) Every health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2021, shall provide coverage without cost sharing for all colorectal cancer screening examinations and laboratory tests assigned either a grade of A or a grade of B by the United States Preventive Services Task Force for individuals at average risk. If an insured is at high risk for colorectal cancer, the coverage required by this subdivision shall include additional colorectal cancer screening examinations as listed by the United States Preventive Services Task Force as a recommended screening strategy and at least at the frequency established pursuant to regulations issued by the federal Centers for Medicare and Medicaid Services for the Medicare program.

(b) For an insured who is between 50 and 75 years of age, a health insurance policy shall not impose cost sharing on colonoscopies, including the removal of polyps, when either of the following applies:

(1) The colonoscopy is a screening procedure not occasioned by a recent positive test or procedure.

(2) The colonoscopy has been scheduled because of a positive result on a test or procedure, other than a colonoscopy, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force.

(c) Nothing in this section requires a health insurer that has a network of providers to provide benefits for items or services described in this section that are delivered by an out-of-network provider or precludes a health insurer that has a network of providers from imposing cost-sharing requirements for the items or services described in this section that are delivered by an out-of-network provider.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

AMENDMENTS TO ASSEMBLY BILL NO. 1986

Amendment 1

In the title, in line 2, strike out "10123.2074" and insert:

10123.207

Amendment 2

On page 2, in line 6, strike out "all" and insert:

a

Amendment 3

On page 2, in line 7, strike out "examinations" and insert:

examination

Amendment 4

On page 2, in line 7, strike out "tests" and insert:

test

Amendment 5

On page 2, in line 9, strike out "If an enrollee is at high risk", strike out lines 10 to 13, inclusive, and on page 3, strike out lines 1 and 2

Amendment 6

On page 3, in line 13, strike out "Nothing in this section requires" and insert:

This section does not require

Amendment 7

On page 3, between lines 19 and 20, insert:

(d) This section does not apply to a Medi-Cal managed care plan or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

Amendment 8
On page 3, in line 25, strike out "all" and insert:

a

Amendment 9
On page 3, in line 25, strike out "examinations" and insert:

examination

Amendment 10
On page 3, in line 26, strike out "tests" and insert:

test

Amendment 11
On page 3, in line 28, strike out "If an insured is at high risk for colorectal cancer, the" and strike out lines 29 to 34, inclusive

Amendment 12
On page 4, in line 5, strike out "Nothing in this section requires" and insert:

This section does not require

Amendment 13
On page 4, between lines 11 and 12, insert:

(d) This section does not apply to a Medi-Cal managed care plan or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

PROPOSED AMENDMENTS TO ASSEMBLY BILL NO. 1986

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL **No. 1986**

Introduced by Assembly Member Gipson

January 23, 2020

Amendment 1

An act to add Section 1367.668 to the Health and Safety Code, and to add Section ~~10123.2074~~ *10123.207* to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1986, as introduced, Gipson. Health care coverage: colorectal cancer: screening and testing.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires individual and group health care service plan contracts and health insurance policies to provide coverage for all generally medically accepted cancer screening tests and requires those contracts and policies to also provide coverage for the treatment of breast cancer. Existing law requires an individual or small group health care service plan contract or health insurance policy to, at a minimum, include coverage for essential health benefits, which include preventive services, pursuant to the federal Patient Protection and Affordable Care Act.

This bill would require a health care service plan contract or a health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2021, to provide coverage for *a* colorectal cancer screening ~~examinations~~ *examination* and laboratory ~~tests,~~ *test,* as

specified. ~~The bill would require the coverage to include additional colorectal cancer screening examinations as listed by the United States Preventive Services Task Force as a recommended screening strategy and at least at the frequency established pursuant to regulations issued by the federal Centers for Medicare and Medicaid Services for the Medicare program if the individual is at high risk for colorectal cancer.~~ The bill would prohibit a health care service plan contract or a health insurance policy from imposing cost sharing on an individual who is between 50 and 75 years of age for colonoscopies conducted for specified purposes. The bill would also provide that it does not require a health care service plan or health insurer to provide benefits for items or services delivered by an out-of-network provider and does not preclude a health care service plan or health insurer from imposing cost-sharing requirements for items or services that are delivered by an out-of-network provider. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

Page 2

SECTION 1. Section 1367.668 is added to the Health and Safety Code, to read:

1367.668. (a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2021, shall provide coverage without any cost sharing for ~~all~~ *a* colorectal cancer screening ~~examinations~~ *examination* and laboratory ~~tests~~ *test* assigned either a grade of A or a grade of B by the United States Preventive Services Task Force for individuals at average risk. ~~If an enrollee is at high risk for colorectal cancer, the coverage required by this subdivision shall include additional colorectal cancer screening examinations as listed by the United States Preventive Services Task Force as a recommended screening~~

Amendment 2
Amendments 3 & 4

Amendment 5

Page 3

~~strategy and at least at the frequency established pursuant to regulations issued by the federal Centers for Medicare and Medicaid Services for the Medicare program.~~

(b) For an enrollee who is between 50 and 75 years of age, a health care service plan contract shall not impose cost sharing on colonoscopies, including the removal of polyps, when either of the following applies:

(1) The colonoscopy is a screening procedure not occasioned by a recent positive test or procedure.

(2) The colonoscopy has been scheduled because of a positive result on a test or procedure, other than a colonoscopy, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force.

(c) ~~Nothing in this section requires~~ *This section does not require* a health care service plan that has a network of providers to provide benefits for items or services described in this section that are delivered by an out-of-network provider or precludes a health care service plan that has a network of providers from imposing cost-sharing requirements for the items or services described in this section that are delivered by an out-of-network provider.

Amendment 6

(d) This section does not apply to a Medi-Cal managed care plan or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

Amendment 7

SEC. 2. Section 10123.207 is added to the Insurance Code, to read:

10123.207. (a) Every health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2021, shall provide coverage without cost sharing for ~~all~~ *a* colorectal cancer screening ~~examinations~~ *examination* and laboratory ~~tests~~ *test* assigned either a grade of A or a grade of B by the United States Preventive Services Task Force for individuals at average risk. ~~If an insured is at high risk for colorectal cancer, the coverage required by this subdivision shall include additional colorectal cancer screening examinations as listed by the United States Preventive Services Task Force as a recommended screening strategy and at least at the frequency~~

Amendments 8 & 9
Amendment 10

Amendment 11

Page 3

~~established pursuant to regulations issued by the federal Centers for Medicare and Medicaid Services for the Medicare program.~~

(b) For an insured who is between 50 and 75 years of age, a health insurance policy shall not impose cost sharing on colonoscopies, including the removal of polyps, when either of the following applies:

(1) The colonoscopy is a screening procedure not occasioned by a recent positive test or procedure.

Page 4

(2) The colonoscopy has been scheduled because of a positive result on a test or procedure, other than a colonoscopy, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force.

(c) ~~Nothing in this section requires~~ *This section does not require* a health insurer that has a network of providers to provide benefits for items or services described in this section that are delivered by an out-of-network provider or precludes a health insurer that has a network of providers from imposing cost-sharing requirements for the items or services described in this section that are delivered by an out-of-network provider.

Amendment 12

+ *(d) This section does not apply to a Medi-Cal managed care plan or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.*

Amendment 13

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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APPENDIX B LITERATURE REVIEW

CHBRP identified ten studies conducted since 2012 on the effects of removal of cost sharing on utilization of CRC screening examinations and tests, as well as one systematic review of the literature.

The study populations and main findings are summarized below (Table 7).

Table 7. Summary of Literature on Utilization Impacts of Change in Insurance Benefits on CRC Screening Examinations and Tests

Author (Year)	Population	Coverage Change	Main Effects on Utilization
Zerhouni et al. (2019)	Medicaid, ages 50–64 years	Expanded Medicaid eligibility	Increased CRC screening by 5.7% among low-income population
Fedewa et al. (2019)	Medicaid, ages 50–64 years	Expanded Medicaid eligibility	Increased 8.8% in very early expansion states, no difference between early/late/non-expansion
Atallah (2019)	Private commercial plans and Medicare, ages 50–75 years	Removal of cost sharing in commercial and Medicare plans	No change in FOBT; increase in colonoscopy 5.1% and decrease in flexible sigmoidoscopy 6.4% — neither change significant
Steenland et al. (2019)	Massachusetts, private commercial plans	Removal of cost sharing	No change in colonoscopy screening
Whaley (2018)	Health Care Cost Institute (Private commercial plans), ages 50–64 years	Reductions in cost sharing for colonoscopy, post-ACA	Increase in utilization of colonoscopies by 1.7%; No change in polypectomy
Cooper et al. (2016)	High risk, Medicare, ages 60–74 years	Removal of cost sharing	5% lower odds of colonoscopy
Han et al. (2015)	Private commercial plans and Medicare, ages 50–75 years	Removal of cost sharing in commercial and Medicare plans	No change in CRC screening except among Medicare population ages 65 years and above
Hamman and Kapinos (2016)	Private commercial plans and Medicare, ages 50–75 years	Removal of cost sharing by state benefit mandates	Increase in utilization of endoscopy (colonoscopy or flexible sigmoidoscopy) by 2.5% among men
Hamman and Kapinos (2015)	Private commercial plans and Medicare, ages 66–75 years	Removal of deductibles and coinsurance for screening colonoscopy	Increased utilization of colonoscopy by 4% among men
Fedewa et al. (2015)	Private commercial plans and Medicare, ages 50–75 years	Removal of cost sharing, post-ACA	Decrease in FOBT utilization by 2.5% among privately insured; increase in colonoscopy among privately insured not significant
Khatami et al. (2012)	University of Texas Health plan enrollees, ages 50–64 years	Removal of cost sharing	Increase in utilization of colonoscopy of 1.5%

Key: ACA = Affordable Care Act; CRC = colorectal cancer; FOBT = fecal occult blood test.

AB 1986 Search Terms (English Only Articles, 2010 to present)

- Anus Neoplasms
- Colon Cancer
- Colonic Neoplasms
- Colorectal Cancer
- Colorectal Neoplasms
- Diagnostic Techniques, Digestive System
- Early Detection of Cancer
- Rectal Cancer
- Rectal Neoplasms
- Sigmoid Neoplasms

Cost Terms

- Business Finance
- Cost Control
- Cost of Illness
- Cost-Benefit Analysis
- Cost Effectiveness
- Cost Savings
- Cost Sharing
- Costs and Cost Analysis
- Deductibles and Coinsurance
- Drug Costs
- Economics
- Elasticity
- Health Care Costs
- Health Care Industry
- Health Expenditures
- Health Insurance
- Insurance Companies
- Medical Economics
- Medical Savings Accounts
- Medically Uninsured Persons
- Medicare
- Medication Adherence
- Medication Compliance
- Rationing
- Reimbursement
- Risk Assessment
- Socioeconomic Factors
- Statistical Sampling
- Substitution
- Underuse

APPENDIX C COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

The cost analysis in this report was prepared by the members of the cost team, which consists of CHBRP task force members and contributors from the University of California, Davis, as well as the contracted actuarial firm, Milliman, Inc.[21]

Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses are available at CHBRP's website.[22]

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Caveats and Assumptions

This subsection discusses the caveats and assumptions relevant to specifically to an analysis of AB 1986.

Assumptions for Baseline Benefit Coverage

CHBRP assumes that the percentage of enrollees without cost sharing for colorectal cancer screening is the same as the percentage of enrollees without cost sharing derived from responses to a mandate-specific survey to California's largest health plans and insurers (representing 95% and 88% of the DMHC- and CDI-regulated markets, respectively). Responses to the survey for AB 1986 represented 59% of the DMHC-regulated market and 12% of the CDI-regulated market. CHBRP thus used plan responses for the AB 1986 survey to derive estimates for the DMHC-regulated market. To supplement information on the CDI-regulated market, CHBRP applied plan responses from the CHBRP analysis for AB 1763, conducted in 2016, which would have required coverage for colorectal cancer screenings and removal of cost sharing for individuals ages 50 years and over (CHBRP, 2016). CHBRP recognizes that health plan/insurer policies and practices may have changed since 2016; however, in the absence of current information on the CDI-regulated market, CHBRP considers prior responses derived from standard CHBRP methodology as the preferred approach. Alternative approaches would have required assumptions with greater uncertainty, e.g., assuming plans in the individual market would have the same policies as plans in the large-group market.

Assumptions for Baseline Utilization

- The utilization rates for colorectal cancer screenings are based on the 2017 MarketScan data and 2017 Consolidated Health Cost Guidelines Sources Database (CHSD). The data were limited to California commercial enrollees between the ages of 50 and 75 years. Colorectal cancer screening utilization rates were trended from 2017 to 2021 using a 1.0% trend.
- Colorectal cancer screenings were identified using a combination of procedure (CPT/HCPCS) codes, modifiers, and diagnostic codes (ICD-10) organized into the following four mutually exclusive categories (Tables 8-11):
    - **Screening without polyp removal.** This category is defined as any noncolonoscopy cancer screening (Table 8) or a colonoscopy without polyp removal (Table 11) and either a

[21] CHBRP's authorizing statute, available at http://chbrp.com/CHBRP_authorizing_statute_2018_FINAL.pdf, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[22] See method documents posted at http://chbrp.com/analysis_methodology/cost_impact_analysis.php; in particular, see *2019 Cost Analyses: Data Sources, Caveats, and Assumptions*.

corresponding preventive colorectal cancer screening modifier (Table 9) or diagnosis (Table 10).

- **Screening with polyp removal.** This category is defined as any colonoscopy with polyp removal (Table 12) with a corresponding preventive colorectal cancer screening modifier (Table 9) or diagnosis (Table 10).
- **Two step without polyp removal.** This category captures the colonoscopies of patients who initially received a less invasive, noncolonoscopy screening test followed by a colonoscopy without polyp removal. The initial screening is defined as a noncolonoscopy screening procedure (Table 8) with either a corresponding preventive colorectal cancer screening modifier (Table 9) or diagnosis (Table 10). The colonoscopy included in this category is defined as a procedure occurring within 3 months of the initial screening. Only the colonoscopy, not the initial screening, is included in this category.
- **Two step with polyp removal.** This category is similar to the two step without polyp removal outlined above, except the colonoscopy with polyp removal (Table 12) is defined as a procedure occurring within 3 months of the initial screening. Only the colonoscopy is included in this category.

- Colonoscopy utilization from the second step of the two-step screenings was given a seasonality adjustment to account for potential colonoscopies for which the first step preventive screening was in the prior year.
- CHBRP assumed colorectal cancer screening utilization for enrollees without cost sharing is 1.5% greater than the utilization for enrollees with cost sharing.
- Milliman's CHSD and MarketScan data do not contain enrollee benefit information. CHBRP therefore assumes that the percentage of enrollees without cost sharing for colorectal cancer screening in the data sources is the same as the percentage of enrollees without cost sharing derived from responses to the AB 1986 mandate-specific survey. In conjunction with the 1.5% utilization differential for enrollees with and without cost sharing, CHBRP was able to determine utilization rates for enrollees with and without cost sharing in the baseline period.
- CHBRP assumes CRC screening examinations and tests performed out of network are not subject to AB 1986; therefore, all estimates reflect utilization and costs of in-network examinations and tests. CHBRP used total allowable charges in 2017 MarketScan and CHSD data to estimate that 7.5% of total charges for CRC screening examinations and tests are for services performed out of network at baseline.

Table 8. Noncolonoscopy Cancer Screening Procedure Codes

CPT/HCPCS Codes	Description
G0106	Colorectal cancer screening; barium enema; as an alternative to G0104, screening sigmoidoscopy
G0120	Colorectal cancer screening; barium enema; as an alternative to G0105, screening colonoscopy
G0122	Colorectal cancer screening; barium enema (noncovered).
G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1–3 simultaneous
45330	Diagnostic sigmoidoscopy
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45334	Sigmoidoscopy, flexible; with control of bleeding, any method
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
45337	Sigmoidoscopy & decompression
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45339	Sigmoidoscopy with ablation of tumors
45340	Sigmoidoscopy with transendoscopic balloon dilation
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45342	Sigmoidoscopy with ultrasound guided biopsy or aspiration
45345	Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)
45346	Sigmoidoscopy w/ablation
G0104	Colorectal cancer screening; flexible sigmoidoscopy
G0464	Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin
0066T	Computed tomographic (CT) colonography (i.e., virtual colonoscopy); screening
G0394	Blood occult test, colorectal
G0107	Fecal blood test
74263	Computed tomographic (CT) colonography, screening, including image postprocessing
81528	Oncology colorectal screening
82270	Occult blood feces screening
82274	Assay test for blood fecal

Table 9. Preventive Colorectal Cancer Screening Modifiers

Modifier	Modifier Description
33	Preventive Service
PT	Colorectal Screening to Diagnose

Table 10. Preventive Colorectal Cancer Screening Diagnoses

ICD 10 Diagnosis Code	Description
Z0000	Encounter for general adult medical exam without abnormal findings
Z0001	Encounter for general adult medical exam with abnormal findings
Z008	Encounter for other general examination
Z1210	Encounter screen for malignant neoplasm of intestinal tract, unspecified
Z1211	Encounter for screening for malignant neoplasm of colon
Z1212	Encounter for screening for malignant neoplasm of rectum
Z125	Encounter for screening for malignant neoplasm of prostate
Z800	Family history of malignant neoplasm of digestive organs
Z8371	Family history of colonic polyps
Z8379	Family history of other diseases of the digestive system
Z8500	Personal history of malignant neoplasm of unspecified digestive organ
Z85038	Personal history of malignant neoplasm of large intestine

Z85048	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus
Z86010	Personal history of colonic polyps

Table 11. Colonoscopy Without Polyp Removal Procedure Codes

CPT/HCPCS Codes	Description
44388	Colonoscopy through stoma including collection of specimen
44389	Colonoscopy through stoma; with biopsy, single or multiple
44391	Colonoscopy through stoma; with control of bleeding, any method
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance
44405	Colonoscopy through stoma; with transendoscopic balloon dilation
44406	Colonoscopy w/ultrasound
45378	Diagnostic colonoscopy
45379	Colonoscopy, flexible; with removal of foreign body(s)
45380	Colonoscopy, flexible; with biopsy, single or multiple
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance
45382	Colonoscopy, flexible; with control of bleeding, any method
45386	Colonoscopy, flexible; with transendoscopic balloon dilation
45391	Colonoscopy with endoscopic ultrasound
45392	Colonoscopy with endoscopic ultrasound or transmural fine needle aspiration/biopsy(s)
45398	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

Table 12. Colonoscopy With Polyp Removal Procedure Codes

CPT/HCPCS Codes	Description
44392	Colonoscopy & polypectomy
44393	Colonoscopy with lesion removal
44394	Colonoscopy with snare
44401	Colonoscopy with ablation
45383	Colonoscopy with lesion removal
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45387	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)
45388	Colonoscopy with ablation
G6019	Colonoscopy with lesion removal
G6024	Colonoscopy with lesion removal

Assumptions for Baseline Cost

The average costs for colorectal cancer screenings are based on the 2017 MarketScan and CHSD data. The data was limited to California commercial enrollees between the ages of 50 and 75 years.

Costs for colonoscopies include all outpatient and professional services on the day of the colonoscopy, including laboratory costs. Costs for noncolonoscopy screenings are only for the screenings themselves. Outpatient and professional unit costs were trended from 2017 to 2021 using 7.0% and 4.5% annual trends, respectively.

Assumptions for Postmandate Utilization and Cost

CHBRP assumed 100% of enrollees would have colorectal cancer screening coverage without cost sharing postmandate. CHBRP assumed the postmandate utilization rate is the same as the utilization rate without cost sharing used in the baseline utilization calculation. CHBRP assumed the postmandate average cost is the same as the baseline average cost.

Determining Public Demand for the Proposed Mandate

This subsection discusses public demand for the benefits AB 1986 would mandate. Considering the criteria specified by CHBRP's authorizing statute, CHBRP reviews public demand for benefits relevant to a proposed mandate in two ways. CHBRP:

- Considers the bargaining history of organized labor; and
- Compares the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

On the basis of conversations with the largest collective bargaining agents in California, CHBRP concluded that unions currently do not include cost-sharing arrangements for specific treatments or services. In general, unions negotiate for broader contract provisions such as coverage for dependents, premiums, deductibles, and broad coinsurance levels.

Among publicly funded self-insured health insurance policies, the PPO plans offered by CalPERS currently have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask health plans/insurers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

Second-Year Impacts on Benefit Coverage, Utilization, and Cost

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of AB 1986 would have a substantially different impact on the utilization of CRC screening examinations and tests, the utilization of any indirectly affected utilization, or both. CHBRP consulted a content expert about the possibility of varied second year impacts and determined the second year's impacts of AB 1986 would be substantially the same as the impacts in the first year (see Table 1). Minor changes to utilization and expenditure projections may occur between the first year postmandate and the second year postmandate.

APPENDIX D INFORMATION SUBMITTED BY OUTSIDE PARTIES

In accordance with the California Health Benefits Review Program (CHBRP) policy to analyze information submitted by outside parties during the first 2 weeks of the CHBRP review, the following parties chose to submit information.

The following information was submitted by Daniel S. Anderson, MD, FACP, President, Board of Directors, California Colorectal Cancer Coalition (C4) in March 2020.

Lansdorp-Vogelaar I, et al. "Effect of rising chemotherapy costs on the cost savings of colorectal cancer screening," *J Natl Cancer Inst.*, Oct 21, 2009; 101(20):1412-22.

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Submitted information is available upon request. For information on the processes for submitting information to CHBRP for review and consideration please visit: www.chbrp.org/requests.html.

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A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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