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.

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

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.

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