SB-974 Health care coverage: diagnostic imaging. (2021-2022)

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CALIFORNIA LEGISLATURE— 2021–2022 REGULAR SESSION

SENATE BILL NO. 974

Introduced by Senator Portantino
(Principal coauthors: Assembly Members Cristina Garcia and Friedman)
(Coauthors: Senators Archuleta, Borgeas, Hueso, and Nielsen)
(Coauthors: Assembly Members Cooley and Luz Rivas)

February 10, 2022

An act to amend Section 1367.65 of the Health and Safety Code, and to amend Section 10123.81 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 974, Portantino. Health care coverage: diagnostic imaging.

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 provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract issued, amended, delivered, or renewed on or after January 1, 2000, or an individual or group policy of disability insurance or self-insured employee welfare benefit plan to provide coverage for mammography for screening or diagnostic purposes upon referral by specified professionals. Under existing law, mammography performed pursuant to those requirements or that meets the current recommendations of the United States Preventive Services Task Force is provided to an enrollee or an insured without cost sharing.

This bill would require a health care service plan contract, a policy of disability insurance that provides hospital, medical, or surgical coverage, or a self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1, 2024, to provide coverage without imposing cost sharing for, among other things, screening mammography and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer, except as specified.

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 Local Program: yes

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

SECTION 1. Section 1367.65 of the Health and Safety Code is amended to read:

1367.65. (a) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2000, excluding a specialized health care service plan contract, shall provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.

(2) This subdivision does not prevent application of copayment or deductible provisions in a plan, nor shall this subdivision be construed to require that a plan be extended to cover any other procedures under an individual or a group health care service plan contract.

(b) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2024, excluding a specialized health care service plan contract, shall provide coverage without imposing cost sharing for screening mammography, medically necessary diagnostic or supplemental breast examinations, diagnostic mammography, tests for screening or diagnostic purposes, and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee indicated to have a risk factor associated with breast cancer, including family history or known genetic mutation. Diagnostic breast imaging includes breast magnetic resonance imaging, breast ultrasound, and other clinically indicated diagnostic testing. Diagnostic breast imaging, diagnostic mammography, and diagnostic and supplemental breast examinations, or other clinically indicated diagnostic testing are covered under this subdivision to the extent it is consistent with nationally recognized evidence-based clinical guidelines.

(2) Paragraph (1) shall apply to a health care service plan contract that meets the definition of a “high deductible health plan” set forth in Section 223(c)(2) of Title 26 of the United States Code only after an enrollee’s deductible has been satisfied for the year.

(c) (1) This section does not authorize an enrollee to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, except as specified in paragraph (2).

(2) A plan shall arrange for the provision of services required by this section from providers outside the plan’s network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Section 1367.03.

(d) Subdivision (b) does not preclude a health care service plan that provides coverage for out-of-network benefits from imposing cost-sharing requirements for the items or services described in this section that are delivered by an out-of-network provider, except in the situation described in paragraph (2) of subdivision (c) and as otherwise required by law.

(e) For the purposes of this section:

(1) “Breast magnetic resonance imaging” means a diagnostic tool that uses a powerful magnetic field, radio waves, and a computer to produce detailed pictures of the structures within the breast.

(2) “Breast ultrasound” means a noninvasive diagnostic tool that uses high-frequency sound.

(3) “Cost sharing” means a deductible, coinsurance, or copayment, and any maximum limitation on the application of that deductible, coinsurance, or copayment, or a similar out-of-pocket expense.

(4) “Diagnostic breast examination” means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, breast magnetic resonance imaging, breast ultrasound, or other clinically indicated diagnostic testing that is either of the following:

(A) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer.

(B) Necessary based on personal or family medical history or additional factors, including known genetic mutations, that may increase the individual's risk of breast cancer.

(5) "Diagnostic mammography" means a diagnostic tool that uses x-ray and is designed to evaluate an abnormality in the breast.

(6) "Supplemental breast examination" means a medically necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging, breast ultrasound, or other clinically indicated diagnostic testing, that is either of the following:

(A) Used to screen for breast cancer when an abnormality is not seen or suspected.

(B) Necessary based on personal or family medical history or additional factors, including known genetic mutations, that may increase the individual's risk of breast cancer.

SEC. 2. Section 10123.81 of the Insurance Code is amended to read:

10123.81. (a) (1) A disability insurance policy or self-insured employee welfare benefit plan shall be deemed to provide coverage for mammography for screening or diagnostic purposes upon the referral of a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.

(2) This subdivision does not prevent the application of copayment or deductible provisions in a policy, nor does this section require that a policy be extended to cover any other procedures under an individual or a group policy.

(b) (1) A disability insurance policy that provides hospital, medical, or surgical coverage or a self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1, 2024, shall provide coverage without imposing cost sharing for screening mammography, medically necessary diagnostic or supplemental breast examinations, diagnostic mammography, tests for screening or diagnostic purposes, and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an insured indicated to have a risk factor associated with breast cancer, including family history or known genetic mutation. Diagnostic breast imaging includes breast magnetic resonance imaging, breast ultrasound, and other clinically indicated diagnostic testing. Diagnostic breast imaging, diagnostic mammography, and diagnostic and supplemental breast examinations, or other clinically indicated diagnostic testing are covered under this subdivision to the extent it is consistent with nationally recognized evidence-based clinical guidelines.

(2) Paragraph (1) shall apply to a health insurance policy that meets the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code only after an enrollee's deductible has been satisfied for the year.

(c) (1) This section does not authorize an insured to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, except as specified in paragraph (2).

(2) An insurer shall arrange for the provision of services required by this section from providers outside the insurer's contracted network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Sections 10133 and 10133.54.

(d) This section does not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

(e) Subdivision (b) does not preclude a disability insurer that provides coverage for out-of-network benefits from imposing cost-sharing requirements for the items or services described in this section that are delivered by an out-of-network provider, except in the situation described in paragraph (2) of subdivision (c) and as otherwise required by law.

(f) For the purposes of this section:

(1) "Breast magnetic resonance imaging" means a diagnostic tool that uses a powerful magnetic field, radio waves, and a computer to produce detailed pictures of the structures within the breast.

(2) "Breast ultrasound" means a noninvasive diagnostic tool that uses high-frequency sound.

(3) "Cost sharing" means a deductible, coinsurance, or copayment, and any maximum limitation on the application of that deductible, coinsurance, or copayment, or a similar out-of-pocket expense.

(4) "Diagnostic breast examination" means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, breast magnetic resonance imaging, breast ultrasound, or other clinically

indicated diagnostic testing that is either of the following:

(A) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer.

(B) Necessary based on personal or family medical history or additional factors, including known genetic mutations, that may increase the individual's risk of breast cancer.

(5) "Diagnostic mammography" means a diagnostic tool that uses x-ray and is designed to evaluate an abnormality in the breast.

(6) "Supplemental breast examination" means a medically necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging, breast ultrasound, or other clinically indicated diagnostic testing that is either of the following:

(A) Used to screen for breast cancer when an abnormality is not seen or suspected.

(B) Necessary based on personal or family medical history or additional factors, including known genetic mutations, that may increase the individual's risk of breast cancer.

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.