# Key Findings

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

Summary to the 2019–2020 California State Legislature, April 6, 2020

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

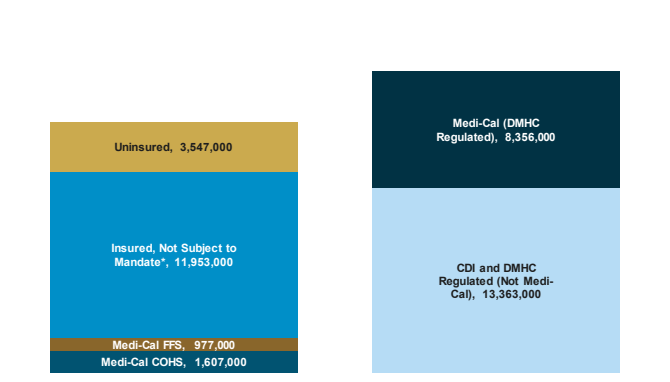
AB 1986 addresses coverage for CRC screening procedures for enrollees in DMHC-regulated plans and CDI-regulated policies. AB 1986 specifically directs a health care service plan contract or a health insurance policy — except as specified — that is issued, amended, or renewed on or after January 1, 2021,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

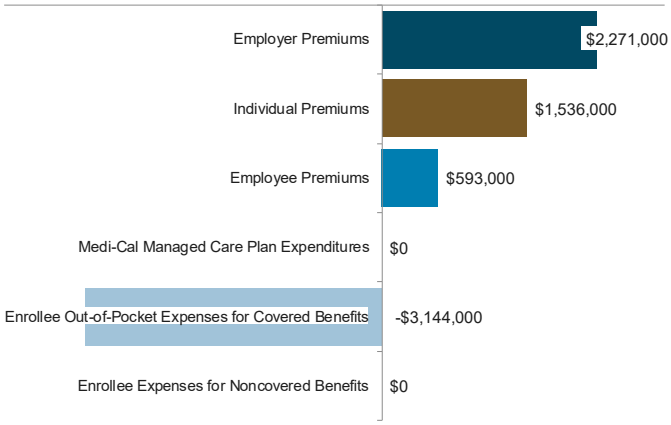
CHBRP estimates that there are 15,373 users of CRC screening examinations and tests who are ages 50–75, with insurance subject to AB 1986, and have cost sharing at baseline. CHBRP estimates these users receive a total of 16,411 screening examinations and tests at baseline. CHBRP estimates that removal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