ASSEMBLY BILL No. 56

Introduced by Assembly Member Portantino

December 5, 2008

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

AB 56, as introduced, Portantino. Health care coverage: mammographies.

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. Under existing law, a health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, is deemed to provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse-midwife, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law. Under existing law, an individual or group policy of disability insurance or self-insured employee welfare benefit plan that is issued, amended, delivered, or renewed on or after January 1, 2000, is deemed to provide specified coverage based upon age for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse-midwife, or participating physician, providing care to

the patient and operating within the scope of practice provided under existing law. Existing law also requires such plan contracts and policies to cover screenings and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon referral of an enrollee's participating physician.

This bill would require these plans and insurers to send female enrollees or policyholders a written notice, as specified, regarding eligibility for tests for screening or diagnosis of breast cancer. The bill would provide that individual or group policies of health insurance or self-insured employee welfare benefit plans issued, amended, delivered, or renewed on and after July 1, 2010, shall be deemed to provide coverage for mammographies for screening or diagnostic purposes upon referral of a participating nurse practitioner, participating certified nurse-midwife, or participating physician, as specified.

Because this bill would specify an additional requirement for a health care service plan, the willful violation of which would be a crime, it 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. The Legislature hereby finds and declares the following:

(a) It is the intent of the Legislature to ensure that all women have access to medically appropriate breast cancer screening and diagnostic tests, especially those women who possess risk factors that place them at high risk of developing breast cancer during their lives.

(b) In order to protect the health of California citizens, breast cancer screening and diagnostic testing methods must be provided. These diagnostic treatment tools, when used in accordance with nationally accepted guidelines, offer the best chance for the detection and timely, cost-effective treatment of breast cancer.

SEC. 2. Section 1367.65 of the Health and Safety Code is amended to read:

1367.65. (a) On or after January 1, 2000, every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed shall be deemed to provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified ~~nurse midwife~~ *nurse-midwife*, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.

(b) Nothing in this section shall be construed to prevent application of copayment or deductible provisions in a plan, nor shall this section 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. Nothing in this section shall be construed to authorize a plan enrollee to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, unless the plan enrollee is referred to that provider by a participating physician, nurse practitioner, or certified ~~nurse midwife~~ *nurse-midwife* providing care.

(c) A health care service plan subject to this section or Section 1367.6 shall send a female enrollee a written notice, during the calendar year in which national guidelines indicate she should start undergoing tests for screening or diagnosis of breast cancer, notifying her that she is eligible for testing.

SEC. 3. Section 10123.81 of the Insurance Code is amended to read:

10123.81. *(a)* On or after January 1, 2000, every individual or group policy of disability insurance or self-insured employee welfare benefit plan that is issued, amended, or renewed, shall be deemed to provide coverage for at least the following, upon the referral of a nurse practitioner, certified ~~nurse midwife~~ *nurse-midwife*, or physician, providing care to the patient and operating within the scope of practice provided under existing law for breast cancer screening or diagnostic purposes:

~~(a)~~

(1) A baseline mammogram for women age 35 to 39, inclusive.

~~(b)~~

(2) A mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women's physician's recommendation.

~~(c)~~

(3) A mammogram every year for women age 50 and over.

(b) On or after July 1, 2010, every individual or group policy of health insurance or self-insured employee welfare benefit plan that is issued, amended, delivered, or renewed shall be deemed to provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse-midwife, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.

~~Nothing~~

(c) Nothing in this section shall be construed to require an individual or group policy to cover the surgical procedure known as mastectomy or to prevent application of deductible or copayment provisions contained in the policy or plan, nor shall this section be construed to require that coverage under an individual or group policy be extended to any other procedures.

~~Nothing~~

(d) Nothing in this section shall be construed to authorize an insured or plan member to receive the coverage required by this section if that coverage is furnished by a nonparticipating provider, unless the insured or plan member is referred to that provider by a participating physician, nurse practitioner, or certified ~~nurse midwife~~ *nurse-midwife* providing care.

(e) A disability insurer or self-insured employee welfare benefit plan subject to this section or Section 10123.8 shall send a female policyholder a written notice, during the calendar year in which national guidelines indicate she should start undergoing tests for screening or diagnosis of breast cancer, notifying her that she is eligible for testing.

(f) This section shall not apply to Medicare supplement, vision-only, dental-only, or CHAMPUS supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance that does not pay benefits on a fixed-benefit, cash-payment-only basis.

SEC. 4. 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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