A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Bill Analysis Report: California Senate Bill 1309 Lung Cancer

APRIL 17, 2026

California Health Benefits Review Program (CHBRP)
University of California, Berkeley

chbrp.org

KEY FINDINGS

Analysis of California Senate Bill 1309: Lung Cancer

Summary to the 2025-2026 California State Legislature, April 17, 2026

California Senate Bill (SB) 1309, Health Care Coverage: Lung Cancer, as analyzed by the California Health Benefits Review Program (CHBRP), would require state-regulated health plans and policies to provide coverage without cost sharing for follow-up screenings and diagnostic services for lung cancer, as recommended after an abnormal or indeterminate test result.

In 2027, 22.8 million Californians would have state-regulated health insurance subject to SB 1309.

Background

Lung cancer is the leading cause of cancer-related death in California, accounting for about 10,500 deaths annually. Early detection is challenging because early-stage disease is often asymptomatic, contributing to a high proportion of late-stage diagnoses where the risk of mortality is much higher. Screening uptake remains low. In California, only 16.8% of the eligible population reported getting screened for lung cancer in 2022.

State and federal law require coverage of initial lung cancer screenings without enrollee cost sharing for eligible populations; however, enrollees may face cost sharing for follow-up services after an abnormal or indeterminate result. Delays or gaps in follow-up may contribute to later-stage diagnoses and poorer outcomes. Evidence shows that many patients do not follow up with care as recommended or pursue less intensive care than recommended. Black, Hispanic, and Indigenous populations experience poorer access to timely care. Barriers to follow-up care include cost, socioeconomic, geographic, and system-level factors.

Benefit Coverage

SB 1309 prohibits cost sharing for follow-up screenings and diagnostic services, which state-regulated plans are already required to cover, including:

- Follow-up screening low-dose computed tomography (LDCT) scans and diagnostic CT scans;
- Positron emission tomography/CT (PET/CT) scans;
- Tissue sampling such as biopsies; and
- Specialist and surgical consultation.

SB 1309 applies to any individual with an abnormal or indeterminate test result, regardless of U.S. Preventive Services Task Force (USPSTF) eligibility, including those identified incidentally outside of routine lung cancer screening.

Medical Effectiveness

There is *strong evidence* that delays in diagnosis and treatment are correlated with worse clinical stage during the diagnostic workup and increased recurrence of lung cancer. There is *some evidence* that treatment delays for lung cancer negatively impact mortality. While CHBRP found no direct evidence on the effectiveness of cost sharing for follow-up services when patients have an abnormal finding during a lung cancer screening, evidence from other cancer research demonstrate how cost affects utilization of health services and outcomes.

Cost Impacts

CHBRP estimates that SB 1309 would result in an additional 1,000 patients accessing follow-up services for lung cancer, including imaging, biopsies, and surgical or other specialist consults. Postmandate, a total of 51,000 Californians would utilize follow-up services without cost sharing. CHBRP estimates an increase of $27,641,000 in total annual premiums paid by employers and enrollees for covering benefits without cost sharing. Average annual out-of-pocket expenses would decrease in the commercial/CalPERS market, ranging from $90 (CalPERS) to $840 (individually purchased insurance).

Public Health Impacts

Due to the small changes in utilization or delays in utilization, CHBRP projects a modest public health impact at the population level. However, SB 1309 would likely yield health and quality-of-life improvements among a subset of enrollees who would receive diagnostic services and follow-up screenings without cost sharing at a more frequent or earlier time interval. CHBRP estimates that postmandate, an unknown number of enrollees would receive an earlier-stage diagnosis than they would have at baseline, with an average cost savings of $149,304 per case.

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Acronyms and Terminology

Acronyms

ACA – Affordable Care Act

ACR – American College of Radiology

CA – California

CalPERS – California Public Employees' Retirement System

CDC – Centers for Disease Control and Prevention

CDI – California Department of Insurance

CHBRP – California Health Benefits Review Program

COHS – County Organized Health System

CT – computed tomography

DHCS – Department of Health Care Services

DMHC – Department of Managed Health Care

EHB – essential health benefits

LDCT – low-dose computed tomography

Lung-RADS – Lung CT Screening Reporting and Data System

PET/CT – positron emission tomography/computed tomography

SB – Senate Bill

USPSTF – U.S. Preventive Services Task Force

Terminology

CHBRP uses the following terminology for this analysis:

Coverage-related

Cost sharing: Payment for use of covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium expenses[1]).

High deductible health plans (HDHPs): HDHPs are a type of health plan with requirements set by federal regulation.[2] As the name implies, these plans include a deductible, but they are not allowed to have separate medical and pharmacy deductibles. For the 2026 plan year, the Internal Revenue Service (IRS) defines an HDHP as any plan with a deductible of at least $1,700 for an individual and $3,400 for a family.[3]

Health Savings Account–qualified HDHPs: To be eligible to establish a Health Savings Account (HSA) for taxable years beginning after December 31, 2003[4] (and so to be eligible to make tax-favored contributions to an HSA), a person must be enrolled in an HSA-qualified HDHP. In order for an HDHP to be HSA qualified, it must follow specified rules regarding cost sharing and deductibles, as set by the IRS.

Lung cancer–related and/or bill specific

Low-dose computed tomography (LDCT): LDCT is an imaging modality that uses reduced radiation to create detailed images of the lungs and is the recommended method for lung cancer screening among eligible high-risk populations.

[1] Premiums are paid by most enrollees, regardless of their use of any tests, treatments, or services. Some enrollees may not pay premiums for different reasons. For example, their employers cover the full premium, or they receive benefits through Medi-Cal.
[2] HealthCare.gov, Glossary: High Deductible Health Plan (HDHP). Accessed March 5, 2021.
[3] IRS Revenue Procedure 2025-19, 2025-18 IRB 1430.
[4] Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code.

Positron emission tomography/computed tomography (PET/CT): PET/CT is an imaging modality that combines metabolic and anatomical imaging to evaluate suspicious findings and support cancer diagnosis and staging.

Lung CT Screening Reporting and Data System (Lung-RADS): Lung-RADS is a quality assurance tool created by the American College of Radiology (ACR) to standardize reporting and management of LDCT lung cancer screenings. It categorizes findings to reduce overdiagnosis and false positives, providing specific management recommendations based on nodule size and risk.

Initial (baseline) screening: Initial (baseline) screening refers to the first LDCT scan performed for lung cancer screening in an eligible, asymptomatic individual. The population of people receiving an initial scan without cost sharing are usually those identified by the U.S. Preventive Services Task Force (USPSTF). This scan establishes a reference point for future comparisons.

Follow-up screening: Follow-up screening refers to subsequent LDCT scans performed after the initial screening to monitor findings or continue routine annual screening in accordance with clinical guidelines (e.g., Lung-RADS).

Follow-up diagnostic services: Follow-up diagnostic services refer to additional clinical evaluations performed after an abnormal or indeterminate screening result to determine the presence or absence of lung cancer. These services may include diagnostic imaging (e.g., diagnostic CT, PET/CT) and invasive procedures (e.g., biopsy, surgery).

Tissue sampling: Tissue sampling procedures are used to collect cells or tissue from a suspected lung lesion to determine whether cancer is present.

Biopsy: A biopsy is a type of tissue sampling in which a sample of tissue is removed (e.g., via needle or bronchoscopy) for pathological examination to confirm or rule out lung cancer.

Upstaging: Upstaging refers to a change to a more advanced cancer stage based on additional diagnostic information, indicating greater disease extent than initially assessed.

Pulmonary nodule: A pulmonary nodule is a small round or irregular growth in the lung detected on imaging, which may be benign or malignant and may require follow-up evaluation.

Overview: SB 1309 and Lung Cancer

On February 20, 2026, the California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP)[5] conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 1309, Health Care Coverage: Lung Cancer as introduced on February 20, 2026.

Bill Language of SB 1309

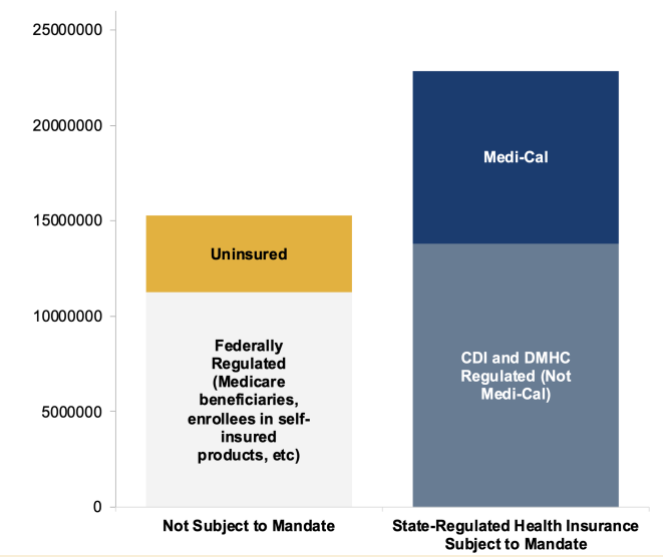
SB 1309 would require coverage of follow-up screening and diagnostic services for lung cancer, as recommended by a health care provider. The bill would require coverage without cost sharing, including copayment, coinsurance, deductibles, or other forms of cost sharing.

Under SB 1309, follow-up screenings and diagnostic services for lung cancer are defined as services provided after an abnormal or indeterminate test result. These follow-up services include:

- Follow-up screening low-dose computed tomography (LDCT) scans;
- Diagnostic computed tomography (CT) scans;
- Positron emission tomography/computed tomography (PET/CT) scans;
- Tissue sampling such as biopsies; and
- Bronchoscopies, pathology review, and surgical consultation.

If enacted, SB 1309 would apply to the health insurance of approximately 22.8 million enrollees (60% of all Californians) (see **Error! Not a valid bookmark self-reference.**).

Figure 1. Health Insurance in CA and SB 1309



Source: California Health Benefits Review Program, 2026.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.[1]
Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

- **Includes:** Enrollees in commercial or CalPERS health insurance regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), and Medi-Cal beneficiaries enrolled in DMHC-regulated plans and county organized health plans (COHS).
- For enrollees in high deductible health plans (HDHPs) that are eligible for a health savings account (HSA), these services would be covered without cost sharing only after the enrollee has met their deductible for the year.

It should be noted that DMHC regulates the plans and policies of approximately 74% of enrollees associated with CalPERS, and 80% of Medi-Cal beneficiaries, in addition to commercial enrollees.[6]

[5] See CHBRP's authorizing statute.
[6] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

CHBRP provides an overview of common cost-sharing practices that are addressed by SB 1309 in its explainer *What Is Cost Sharing*?

See the full text of SB 1309 in CHBRP's Technical Brief on SB 1309, available on www.chbrp.org.

What Is Lung Cancer and How Is it Detected and Diagnosed?

Lung cancer is the uncontrolled growth of abnormal cells in the lungs, often caused by inhaled toxins. Symptoms usually do not appear until later stages where the cancer has spread and the chance of cure or long-term survival is reduced, which makes early detection critical. The top three causes of lung cancer are tobacco smoking, radon gas exposure, and secondhand smoke (Lorenzo-Gonzalez et al., 2019; Possenti et al., 2024). The preponderance (80% to 90%) of lung cancer is caused by inhaled tobacco smoke, but between 10% to 20% percent of lung cancer patients have no smoking history (Forder et al., 2023).[7]

In the United States, there were an estimated 238,240 new cases and 127,070 deaths from lung cancer in 2023, making it the second most diagnosed cancer in both men and women and the leading cause of cancer death. Lung cancer accounted for about 20% of all cancer deaths in the United States in 2023. Lung cancer causes nearly as many as projected deaths as those due to colon, breast, and prostate cancers combined.

California has among the lowest lung cancer incidence rates in the United States, at approximately 36.5 per 100,000 people, well below the national rate of 52.8 per 100,000 people (ALA, 2025). This may be partially attributed to low overall smoking rates in California compared to other states as well as aggressive anti-tobacco policies. In 2024, approximately 16,803 new cases were diagnosed in the state. Yet, concerns persist that a relatively high share of cases are diagnosed at a later stage, which are associated with lower survival rates. A smaller proportion of cases are diagnosed at an early stage in California (25.9%) compared to the national average (28.1%) (ALA, 2025). Later-stage lung cancer diagnosis is associated with lower survival rate.

Uptake of screening of lung cancer – which is often the initial step for lung cancer diagnosis – remains low compared to other cancer screenings. California ranks 32 out of 51 in the nation for lung cancer screening, at 16.8% of the eligible population getting screened (ALA, 2025). The USPSTF recommends that people aged between 50 and 80 years who have a history of smoking get screened annually with an LDCT scan.

Lung Cancer Screening to Treatment Pathway

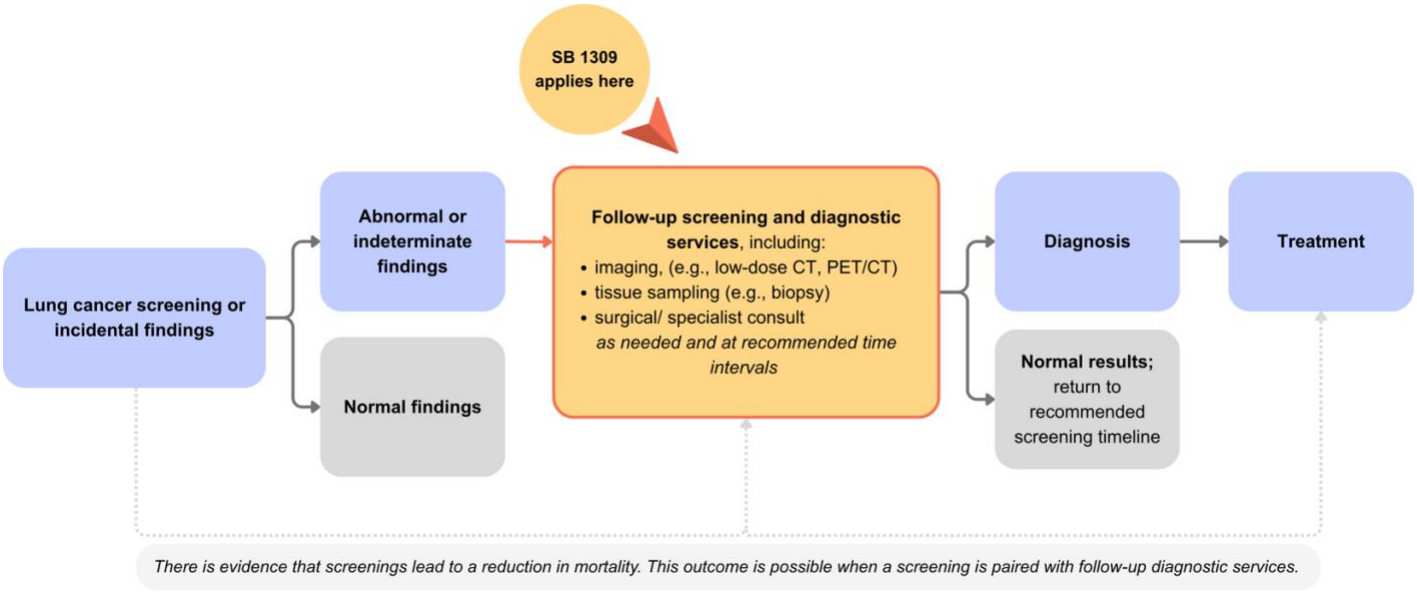
As shown in Figure 2 below, SB 1309 would apply to services occurring between initial lung cancer screening (or incidental detection) and diagnosis. In this report, lung cancer screening is discussed as a key entry point to services addressed by SB 1309. LDCT, which is used for initial screening as recommended by the USPSTF, is also commonly used for follow-up screening after an abnormal or indeterminate result. Additional follow-up services may include diagnostic imaging, tissue sampling (e.g., biopsy), and surgical consultation. Services provided after a diagnosis of lung cancer are not required to be covered without cost sharing under SB 1309.

Detecting, monitoring, and diagnosing lung cancer follows a standardized, evidence-based process. Depending on the outcome of the initial screening LDCT, any nodules (i.e., abnormal growths or spots) on the lung are monitored via follow-up services including, most commonly, follow-up screening LDCTs and diagnostic CTs, as well as other imaging, biopsies, and/or consultation with other medical specialists. Follow-up care is generally determined by standardized clinical guidelines under the Lung-RADS (Lung CT Screening Reporting and Data System) assessment categories or Fleischner Criteria, which specify the recommended type and timing of additional imaging or diagnostic evaluation based

[7] Personal communication with content expert Jonathan Riess, MD.

on initial findings. SB 1309 would require these follow-up services to be covered without cost sharing, when recommended by a health care provider *following* an initial abnormal or indeterminate lung cancer screening result.

Figure 2. Screening to Treatment Pathway



Source: California Health Benefits Review Program, 2026.
Key: CT = computed tomography; PET/CT = positron emission tomography/computed tomography; SB = Senate Bill.

Barriers to Accessing Lung Cancer Screenings and Disparities in Follow-Up for Lung Cancer

Lung cancer screening is relatively recent compared to other cancer screening modalities and remains underutilized among eligible populations (Bilenduke et al., 2023). Barriers to screening include limited access to care, lack of awareness of screening options, stigma and implicit bias related to smoking and race, perceptions of lung cancer as a fatal condition, challenges with shared decision-making, and underestimation of individual risk. Racial and ethnic disparities in initial lung cancer screening in California show significant gaps in screening eligibility and uptake. Despite 2021 USPSTF guideline expansions, Black, Latino, and Asian American persons in California often have lower screening uptake than White counterparts. Notably, Latino (37.3%), African American (38.4%), and Japanese American (40.0%) patients show the lowest screening eligibility, while Native Hawaiian (56.7%) and White (49.6%) cases show the highest (Aredo et al., 2022).

Evidence also indicates limited adherence to recommended follow-up after abnormal screening results (Keerthy et al., 2022; Pinsky et al., 2026). Some studies report differences in follow-up by population group, with lower rates observed among Black individuals compared to White individuals, men, and individuals who currently smoke compared to those who have quit (Yang et al., 2025).

Cost Barriers. Individuals with an abnormal initial screening test result often incur out-of-pocket costs for the follow-up services and screenings that occur after the initial screening; these out-of-pocket costs have increased over time (Tailor et al., 2022). There is evidence demonstrating that cost sharing can create barriers to completing screening and diagnostic processes, limiting the clinical, equity, and financial benefits of evidence-based preventive and follow-up care (Pegues et al., 2024). Patients with abnormal findings on a screening LDCT scan typically have downstream evaluations to determine if a malignancy exists, varying from diagnostic imaging to invasive procedures. A recent analysis studied 6,268 employer-insured adults undergoing lung screening with LDCT and found that, after the initial screening, 7.4% of patients had

downstream procedure within 1 year. The average out-of-pocket cost incurred in this study was $424, ranging from $0 to $7,500, depending on services delivered (Tailor et al., 2022).

For an in-depth look at clinical guidance, existing disparities, and barriers to access to care for screening and follow-up services for lung cancer, please see the *Background* section in CHBRP's Technical Brief on SB 1309.

How Effective Are Follow-Up Diagnostic Services for Lung Cancer?

There is a substantial, high-quality body of evidence supporting the effectiveness of LDCT for lung cancer screening in high-risk individuals.

Delays in diagnosis and treatment can have significant negative consequences for patients with lung cancer, particularly in terms of tumor progression and recurrence rates. There is *strong evidence* that delays in diagnosis and treatment are correlated with clinical upstaging and increased recurrence rates. Clinical upstaging means that cancer is found to be more advanced than initially thought.[8] For example, tests or procedures may reveal that the tumor has grown larger, spread to nearby tissues, or reached other parts of the body. This can make it harder to treat and may lead to worse outcomes for the patient. Delays in diagnosis and treatment, particularly in small nodules, were correlated with upstaging, as tumor upstaging can negatively impact patient outcomes. Surgical delays for non–small cell lung cancer were significantly linked to worse outcomes including a significant increase in recurrence risk.

There is *some evidence* that treatment delays negatively impact survival and mortality in lung cancer, but this varies depending on the duration of delay and stage or type of lung cancer.[9] Some studies reported no clear harm from short delays and others reported that longer intervals from abnormal finding or diagnosis to treatment were associated with higher mortality or lower survival. One study showed higher mortality for stage I lung cancer with longer time to treatment, while stage II showed high mortality and no statistically significant differences after longer delays in treatment.

There is *some evidence*, based on one large study, that harms are associated with common invasive diagnostic procedures after an abnormal finding from LDCT screening for lung cancer. Potential harms including complications from the procedure, for example, major events such as acute respiratory failure, intermediate events such as blood loss requiring transfusion, or minor events such as allergic reactions.

CHBRP found no direct evidence on the impact of cost sharing for follow-up services after an abnormal/indeterminate result. While not specific to lung cancer, there is evidence from studies on breast cancer that shows increased cost sharing generally contributes to lower utilization of services.

Policy Context

Existing State and Federal Laws and Regulations

Preventive services

Under the California Preventive Services Mandate and the Federal Preventive Services Mandate, nongrandfathered plans and policies must provide coverage without cost sharing for USPSTF A and B recommendations.[10,11,12] Additionally, in September 2025, Governor Newsom signed Assembly Bill 144, which requires nongrandfathered state-regulated health

[8] *Strong evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.
[9] *Some evidence* indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.
[10] Health and Safety Code (HSC) 1367.002; Insurance Code (INS) 10112.2.
[11] More information about the state and federal requirements to cover specified preventive services is included in CHBRP's resource *Federal Recommendations and the California and Federal Preventive Services Benefit Mandates*.
[12] 42 U.S.C. Section 300gg-13(a)(1) and 45 C.F.R. Section 147.130

plans in California to cover preventive care services recommended by the federal government as of January 1, 2025, or recommended by the California Department of Public Health (CDPH), without cost sharing.[13]

Lung cancer screenings as recommended by the USPSTF must be covered without cost sharing for the applicable population when provided by an in-network provider. In 2021, the USPSTF designated a Grade B recommendation for an annual lung cancer screening with LDCT in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. The recommendation specifies that screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative surgery. This recommendation expanded the population from the original 2013 USPSTF recommendation by lowering the age from 55 to 50 and the pack-year history from 30 to 20.

The U.S. Centers for Medicare & Medicaid Services (CMS) Medicare coverage requirements for Medicare regarding lung cancer screenings with LDCT are same as that of USPSTF with regard to a patient's smoking history, with the exception that it applies to enrollees aged 50 to 77 years who are asymptomatic (CMS, n.d.).

Diagnostic and treatment services

There are state and federal requirements on coverage of diagnostic services, and they interact to affect coverage mandates in California. California law requires DMHC-regulated plans to cover basic health care services, under which cancer diagnostic services and treatments fall. CDI-regulated plans must meet minimum levels of coverage. At the federal level, the essential health benefits (EHBs) under the Affordable Care Act (ACA) requires nongrandfathered[14] plans and policies in the individual and small-group market to cover 10 core categories of health care services, which include medically necessary cancer diagnostic services. [15,16,17] In 2027, approximately 11.5% of all Californians will be enrolled in a plan or policy that must cover EHBs.[18]

The follow-up diagnostic services under SB 1309 — which include CT scans, tissue sampling, specialist consults and more — would be considered basic health care services and fall under EHB categories under state and federal law. For more details, see the *Additional Policy Context* section in CHBRP's Technical Brief on SB 1309.

Similar Legislation in Other States

Two states require coverage of follow-up diagnostic services for lung cancer without cost sharing. Similar to SB 1309, New York's law requires state-regulated health insurers to cover follow-up screenings and diagnostic services for lung cancer without cost sharing, starting in 2027. Meanwhile, Maryland requires state-regulated insurers to cover screenings and follow-up diagnostic imaging for lung cancer without cost sharing.

While legislation addressing affordability of services for lung cancer is relatively nascent, advocacy and legislative reform around screening, diagnostics, and treatment for breast cancer has been more robust. Several states require follow-up diagnostic imaging and/or exams related to breast cancer to be covered without cost sharing.

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[13] HSC 120164.
[14] A grandfathered health plan is "a group health plan that was created — or an individual health insurance policy that was purchased — on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers."
[15] The ACA requires nongrandfathered small-group and individual market health insurance — including but not limited to qualified health plans sold in Covered California — to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website.
[16] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.
[17] For more detail, see CHBRP's issue brief *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*.
[18] See CHBRP's resource *Sources of Health Insurance in California*.

Analytic Approach and Assumptions

CHBRP analyzes bills in the current environment given current law and regulations at both the state and federal levels. All estimates are based on current data and do not take into consideration any future or potential changes to factors that may influence the impacts of SB 1309 unless otherwise specifically mentioned.

Cost-Related Analytical Approach and Assumptions

This analysis reports the estimated incremental impact of full-scale implementation of SB 1309 on benefit coverage, utilization, and cost for a single year.[19] Full-scale implementation typically requires a "ramp up" period, which may include educating enrollees, providers, and insurance carriers on the new benefits or coverage; updating procedures and policies; and increasing provider capacity for marginal utilization resulting from SB 1309. The incremental impact estimates below assume there is no "ramp up" period and represent ongoing annual costs at full-scale implementation of SB 1309. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.[20] For a discussion of long-term impacts of SB 1309, see the *Long-Term Impacts* section.

Coverage and Utilization

- Because no-cost coverage already applies to the initial LDCT screening, but diagnostic follow-up (e.g., follow-up screening LDCT, diagnostic CT, PET/CT, bronchoscopy, transthoracic needle biopsy) often carries cost sharing under most health care plans, this report examines those follow-up services.
- For the purposes of this analysis, CHBRP groups relevant postscreening services for lung cancer into the following categories: follow-up imaging, biopsy or tissue sampling (including related pathology services), and specialist consultation (including surgical and other specialist) categories. See the *Cost Impact Analysis* section of CHBRP's Technical Brief on SB 1309 for more details on the specific services and medical billing codes.
- Medi-Cal beneficiaries generally do not face cost sharing for covered services. As a result, SB 1309 would not be expected to materially affect cost sharing for Medi-Cal enrollees in 2027. To the extent that cost sharing is introduced in Medi-Cal in future years as a result of H.R.1, it is unclear whether SB 1309 would eliminate such cost sharing for applicable follow-up lung cancer services, which could affect the magnitude of impacts for this population over time.[21] Uncertainty persists at this point on whether copayments and cost sharing may be imposed on portions of the Medi-Cal expansion population, and if so, whether federal law might supersede, or the provisions of SB 1309 would apply to that population.

Postmandate Coverage and Utilization

- CHBRP assumes that utilization of follow-up services for lung cancer would increase postmandate among enrollees who would receive coverage for these services without cost sharing as a result of SB 1309. CHBRP assumes that the increase in utilization would be different across the following categories of follow-up services:
  - Follow-up imaging: 3%
  - Tissue sampling, including biopsies: 2%

[19] For some analyses, impacts as a result of changes to health insurance benefits may occur over multiple years (e.g., impacts in pregnancy and childbirth rates resulting from changes to utilization of fertility services, staggered implementation, or long-term changes in utilization). CHBRP's estimates represent the full impact of the mandate in 1 year even if changes in coverage, utilization offsets, and costs may be realized in more than 1 year.

[20] CHBRP's Cost and Coverage Model also assumes enrollees maintain one form of health insurance for the entire calendar year. Examples of state and industry policies and behavior include medications that may be developed or approved in the future, health insurance market changes beyond what is known at the time of publication of this analysis, and statutory changes resulting from other health benefit mandates.

[21] H.R.1 includes provisions that, beginning in fiscal year 2029 (effective October 1, 2028), would require states to impose cost sharing on certain Medicaid expansion adults with family income above the federal poverty line, subject to exceptions and caps. Those provisions would not apply to all Medi-Cal beneficiaries or all services, but they could increase the relevance of SB 1309 for some Medi-Cal enrollees in future years.

- Specialist and surgical consultation: 1%
  - These differences reflect variation in the role of cost sharing as a barrier to care. Evidence indicates that increased cost sharing is associated with reductions in diagnostic imaging utilization, particularly through decreased likelihood of initiating care (Zheng et al., 2016). Imaging services are more likely to be sensitive to cost-sharing barriers, whereas biopsy and surgical consultation are more strongly driven by clinical necessity, provider referral patterns, and patient readiness. Studies show that adherence to recommended follow-up care for lung cancer is higher for tissue sampling and surgical consults compared to screening LDCTs (Pinsky et al., 2026; Rivera et al., 2022).
  - The expected increase in utilization reflects both improved uptake of recommended follow-up care among enrollees who might otherwise forgo services due to cost-sharing barriers, and reductions in delays among those who would eventually receive care. CHBRP did not separately model these mechanisms but assumes that both would contribute to the overall increase in completed follow-up care.

- For enrollees in HSA–qualified HDHPs, SB 1309 would not eliminate upfront deductible exposure for follow-up lung cancer services; instead, coverage without cost sharing would apply only after the deductible has been satisfied for the plan year. As a result, the financial impact of SB 1309 may be smaller for enrollees in HSA-qualified HDHPs than for other enrollees, because the bill preserves deductible-first cost sharing for that subgroup.
- CHBRP assumes that provider recommendation practices would not change postmandate. That is, providers would not recommend additional or more intensive care for patients due to the elimination of cost sharing as a barrier. CHBRP's assumptions on coverage and utilization maintain current management guidelines for screen-detected and incidental pulmonary nodules.
- CHBRP assumes that SB 1309 would not materially affect unit cost because the bill impacts coverage and enrollee cost sharing but does not alter reimbursement rates or the services themselves. Additionally, CHBRP does not assume material supply constraints or a major shift in the mix of follow-up modalities.

Cost offsets

CHBRP uses the term "cost offset" to describe the amount of medical care costs that may not occur as a result of the use of another covered benefit.

- For this analysis, CHBRP separately models potential downstream reductions in health care costs associated with earlier diagnosis and treatment among the subset of enrollees who would newly access recommended follow-up services due to the elimination of cost sharing in SB 1309; these are not part of the utilization assumption itself or the total fiscal estimates included below. This assumption is informed by evidence that delays in follow-up, diagnosis, and treatment are associated with upstaging and worse outcomes (Ahmed et al., 2023; Mullin et al., 2026; Pirzadeh et al., 2024), and by evidence that treatment costs are substantially higher for lung cancer diagnosed at later stages than at earlier stages (McGarvey et al., 2022). For more information on the impact of delays in treatment on the stage at which cancer is diagnosed, see the *Medical Effectiveness* section in CHBRP's Technical Brief on SB 1309.
- CHBRP estimates a conservative stage-shift assumption of 0.25% of incremental follow-up users. CHBRP assumes that, for affected enrollees, earlier diagnosis would result in cancer being identified one or more stages earlier than it otherwise would have been.
- For commercial coverage, CHBRP estimated an average avoided treatment cost of approximately $149,304 per shifted case, based on weighted stage-specific differences in first-year treatment costs.
- The offset calculation is a partial offset calculation. CHBRP does not model all clinical scenarios or all potentially offsetting downstream effects, including the possibility that earlier diagnosis may increase spending in some cases through additional diagnostic workup, treatment initiation, surgery, or longer survival. As a result, the modeled offset should be interpreted as conservative.

For further details on the underlying data sources, methods, and assumptions used in this analysis please see the CHBRP's Technical Brief on SB 1309, available at www.chbrp.org.

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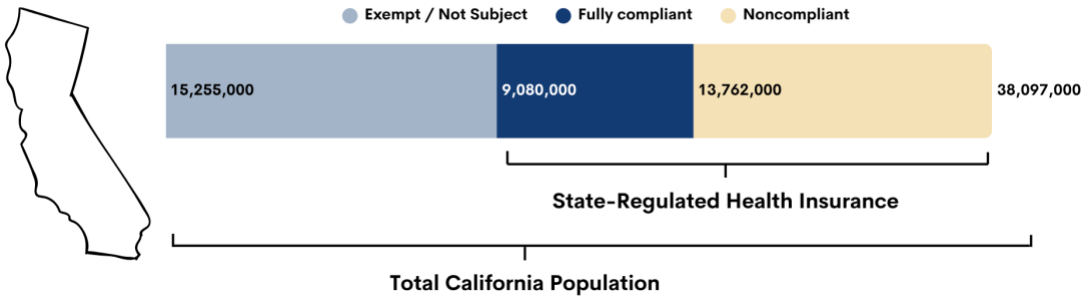
SB 1309 Impacts: Benefit Coverage and Cost

Benefit Coverage

CHBRP estimates that, at baseline, 9,080,000 enrollees (40% of enrollees in state-regulated plans and policies subject to SB 1309) have coverage compliant with SB 1309. This baseline-compliant population consists primarily of Medi-Cal enrollees, who generally do not face cost sharing for covered services, and a small number of CalPERS enrollees with coverage without cost sharing for all follow-up services affected by the bill (Figure 3. California Health Insurance and Baseline Compliance with SB 1309

Figure 4. California Health Insurance and Baseline Compliance with SB 1309



Source: California Health Benefits Review Program, 2026.

Figure 3). Enrollees in commercial and most CalPERS plans and policies otherwise have cost sharing for at least some follow-up services at baseline.[22] Postmandate, CHBRP estimates that all 22,842,000 Californians in state-regulated plans and policies subject to SB 1309 would have coverage compliant with SB 1309. Please note that CHBRP's approach is to assume full compliance postmandate on the part of all health insurance subject to the proposed mandate. For additional details on impacts to benefit coverage, see Table 7 and Table 8 in the Appendix.

Utilization and Unit Cost

At baseline, utilization of the services affected by SB 1309 is driven by the number of enrollees in state-regulated insurance who access follow-up services after receiving an abnormal or indeterminate test result from an LDCT. The abnormal or indeterminate findings can come from LDCTs performed as part of routine lung cancer screenings or may be incidental pulmonary nodules found from LDCTs as part of other care unrelated to initial lung cancer screenings. CHBRP estimates that at baseline, the majority of enrollees who receive an initial lung cancer screening do not receive follow-up care, either because they do not need it, or because some enrollees do not access recommended follow-up. Some enrollees may not proceed with follow-up care or may delay obtaining follow-up care due to cost sharing. As a result, baseline utilization reflects both existing use of follow-up services and incomplete adherence to recommended workups.

Postmandate, CHBRP estimates a modest increase in utilization of covered follow-up services of 3% for imaging, 2% for biopsy or tissue sampling, and 1% for specialist or surgical consultations within the commercial and CalPERS market segments. This increase reflects improved take-up of recommended follow-up services and not an expansion of the eligible population or changes in clinical indications, guidelines, or provider practice patterns. CHBRP does not expect an impact on utilization within the Medi-Cal population in 2027, since Medi-Cal beneficiaries generally do not face cost sharing for medically necessary services at baseline.

[22] Baseline cost sharing for commercial and CalPERS enrollees is not uniform across all categories of follow-up services. CHBRP's carrier survey indicated that some enrollees, particularly in certain large-group products, may already have coverage without cost sharing for one or more follow-up service categories at baseline.

Table 1 provides estimates of the impacts of SB 1309 on utilization and unit cost of follow-up imaging, biopsy or tissue sampling, and specialist consultation services within the commercial and CalPERS market.

Table 1. Impacts of SB 1309 on Utilization and Unit Cost in the Commercial and CalPERS Market, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Enrollees with lung cancer screening or diagnostics				
Number of enrollees with initial screening or diagnostic test	132,000	132,000	0	0.00%
Number of enrollees with follow-up diagnostic tests or procedures	50,000	51,000	1,000	2.00%
Total utilization				
Follow-up biopsy or tissue sampling	61,000	62,000	1,000	1.64%
Follow-up specialist/surgical consultation	48,500	49,000	500	1.03%
Follow-up imaging	67,000	69,000	2,000	2.99%
Average unit cost				
Follow-up biopsy or tissue sampling (a)	$970.00	$970.00	$0.00	0.00%
Follow-up specialist/surgical consultation (b)	$215.00	$215.00	$0.00	0.00%
Follow-up imaging (c)	$1,470.00	$1,470.00	$0.00	0.00%
Average enrollee cost sharing per unit				
Follow-up biopsy or tissue sampling	$185.00	$0.00	-$185.00	-100.00%
Follow-up specialist/surgical consultation	$45.00	$0.00	-$45.00	-100.00%
Follow-up imaging	$110.00	$0.00	-$110.00	-100.00%

Source: California Health Benefits Review Program, 2026.
Notes: Table 1 reflects impacts for commercial and CalPERS enrollees and does not include Medi-Cal beneficiaries, who do not face cost sharing for covered services during the analysis year. Average unit cost estimates represent the average allowed amount per service. At baseline, this allowed amount is financed through a combination of plan or insurer payments and enrollee cost sharing.
(a) Follow-up biopsy or tissue sampling includes image-guided biopsy, bronchoscopy with biopsy, and associated pathology services.
(b) Follow-up specialist/surgical consultation includes visits with specialists such as pulmonologists, thoracic surgeons, or other providers involved in evaluation and management of abnormal findings.

(c) Follow-up imaging includes diagnostic CT, PET/CT, and other imaging modalities used in the evaluation of abnormal or indeterminate lung cancer screening results.
Key: CalPERS = California Public Employees' Retirement System; CT = computer tomography; PET/CT = positron emission tomography/computed tomography.

Expenditures and Premium Impacts

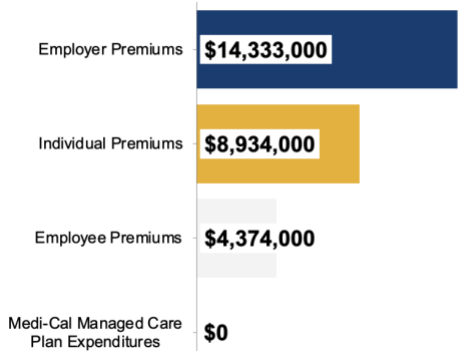
Policies affecting health insurance benefits, such as benefit coverage mandates, impact stakeholders in distinct ways. In terms of direct costs, these stakeholders can generally be grouped into two categories: (1) enrollees who utilize the benefit,[23] and (2) those who pay for the benefit but do not utilize it. All enrollees within a risk pool share in these costs through the benefit's impact on plan premiums. As shown in Table 7 and Table 8, changes in total expenditures reflect the combined effects of increased premiums and decreased enrollee cost sharing, with no measurable change in expenditures for noncovered benefits. Because the follow-up services affected by SB 1309 are already covered at baseline, the main financial effect of the bill is a shift in payment responsibility from enrollees to plans and insurers.

Expenditure Impacts on Employers and All Enrollees

As shown in Figure 4. Expenditure Impacts of SB 1309 on Employers and Enrollees

Figure 4, for DMHC-regulated plans and CDI-regulated policies, SB 1309 would increase total premiums paid by employers and enrollees by approximately $27,641,000 (0.016%). For more details, see Table 8 in the Appendix. This increase is driven primarily by the shift in financial responsibility from enrollee cost sharing to plans and insurers for follow-up services already being used at baseline, as well as the cost of additional utilization postmandate by an estimated 1,000 additional enrollees.

Figure 7. Expenditure Impacts of SB 1309 on Employers and Enrollees



Enrollee premium estimates include premiums paid by all enrollees in affected markets, including enrollees who already have baseline coverage for follow-up services but may face cost sharing for one or more service categories, as well as enrollees whose coverage would become fully compliant postmandate. Premium impact estimates include all enrollees in the affected markets, regardless of whether they use services addressed under SB 1309.

Changes in premiums as a result of SB 1309 would vary by market segment (Table 2; see also Table 7 and Table 8 in Appendix).

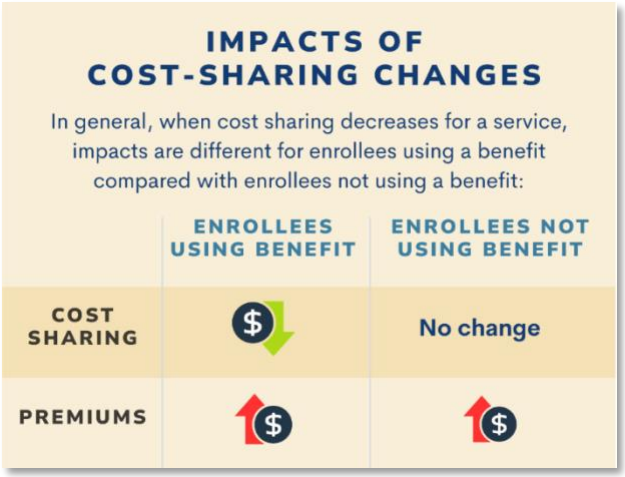
Source: California Health Benefits Review Program, 2026.

[23] Depending on their health insurance and the benefit in question, enrollees may or may not also pay for the benefit. For example, most Medi-Cal beneficiaries do not have cost sharing and do not pay health insurance premiums, whereas enrollees with health insurance a plan in the individual market may pay both insurance premiums and cost sharing or other out-of-pocket expenses.

Table 2. Premium Impact Ranges of SB 1309 by Market Segment

Market Segment	Premium Impact Range (PMPM)
Commercial plans/policies	$0.109–$0.285
Covered California – individually purchased	$0.299–$.313
CalPERS	$0.058
Medi-Cal	$0.0

Source: California Health Benefits Review Program, 2026.
Key: CalPERS = California Public Employees' Retirement System; PMPM = per member per month.



Below, Table 3 provides estimates of the aggregate impacts of SB 1309 on premiums.

Table 3. Impacts of SB 1309 on Premiums, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Non-enrollee premiums				
Employer-sponsored (a)	$75,730,916,000	$75,744,705,000	$13,789,000	0.018%
CalPERS employer (b)	$8,611,855,000	$8,612,399,000	$544,000	0.006%
Medi-Cal (c)	$42,982,384,000	$42,982,384,000	$0	0.000%
Enrollee premiums				
Enrollees, individually purchased insurance	$25,775,325,000	$25,784,259,000	$8,934,000	0.035%
Outside Covered California	$9,551,761,000	$9,555,437,000	$3,676,000	0.038%
Through Covered California	$16,223,564,000	$16,228,822,000	$5,258,000	0.032%
Enrollees, group insurance (d)	$21,828,135,000	$21,832,509,000	$4,374,000	0.020%
Total premiums	$174,928,615,000	$174,956,256,000	$27,641,000	0.016%

Source: California Health Benefits Review Program, 2026.
Notes: Numbers might not align with those in Tables 7 and 8 due to rounding. (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 49.0% are state retirees, state employees, or their dependents.
(c) Includes Medi-Cal beneficiaries enrolled in DMHC-regulated plans and COHS managed care.
(d) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

Enrollee Expenses for Benefit Users

SB 1309 would reduce enrollee cost sharing by a total of $20,700,000 across all users in the commercial/CalPERS market who receive and utilize follow-up services for lung cancer without cost sharing from the bill (Table 8). This reduction reflects elimination of cost sharing for the larger baseline population already receiving covered follow-up services at baseline.[24] CHBRP estimates that approximately 0.36% of enrollees in each affected commercial and CalPERS market segment would have an enrollee expense impact related to follow-up services covered by SB 1309 (see Table 4). Among those enrollees, average annual enrollee expenses would decrease by approximately $250 in the large-group market, $690 in the small-group market, $840 in the individual market, and $90 in CalPERS, and with no impact for Medi-Cal enrollees, since they already have coverage without cost sharing. The larger reductions projected for the small-group and individual markets likely reflect higher baseline enrollee cost-sharing exposure in those markets, including a greater concentration of enrollees in plans with high deductibles.

For enrollees in HSA-qualified HDHPs, SB 1309 would eliminate cost sharing only after the deductible has been satisfied for the plan year, so reductions in out-of-pocket expenses may be smaller or delayed for that subgroup than for other enrollees. Table 4 presents average enrollee expense impacts for users, while Table 5 presents impacts for non-users. Additional detail on baseline and postmandate expenditures by market segment is provided in Table 7 and Table 8.

It is possible that some enrollees incurred expenses related to follow-up imaging, biopsy or tissue sampling, and specialist consultation services for which coverage was denied, but CHBRP cannot estimate the frequency with which such situations occur and so cannot offer a calculation of impact.

Cost Offsets

$149,304
Average avoided treatment cost in the first year of diagnosis for individuals receiving an earlier-stage diagnosis

It is possible there is a cost offset among a small subset of enrollees who newly complete recommended follow-up care or utilize care earlier, resulting in an earlier-stage diagnosis. For commercial/CalPERS coverage, CHBRP estimated an average avoided treatment cost of approximately $149,304 per shifted individual who receives an earlier-stage diagnosis, based on weighted stage-specific differences in first-year treatment costs. The number of individuals who receive an earlier-stage diagnosis as a result of SB 1309 may vary depending on a number of factors, though it stands to reason it may be small. Therefore, this offset is not large enough to materially change the overall finding that premiums increase postmandate. For more details on the calculations for the average avoided treatment cost per individual who is diagnosed at an earlier-stage, see CHBRP's Technical Brief on SB 1309.

[24] Some enrollees may receive more than one category of follow-up service during the diagnostic workup, and some may undergo repeated imaging or additional diagnostic evaluation before a diagnosis is confirmed, which increases aggregate baseline cost-sharing exposure.

See more information in the *Cost Impact Analysis* section of CHBRP's Technical Brief on SB 1309, including what else policymakers should consider such as state spending targets, impacts to the number of uninsured in California, how lack of benefit coverage shifts costs to other payers, changes in public program enrollment, and administrative and other expenses.

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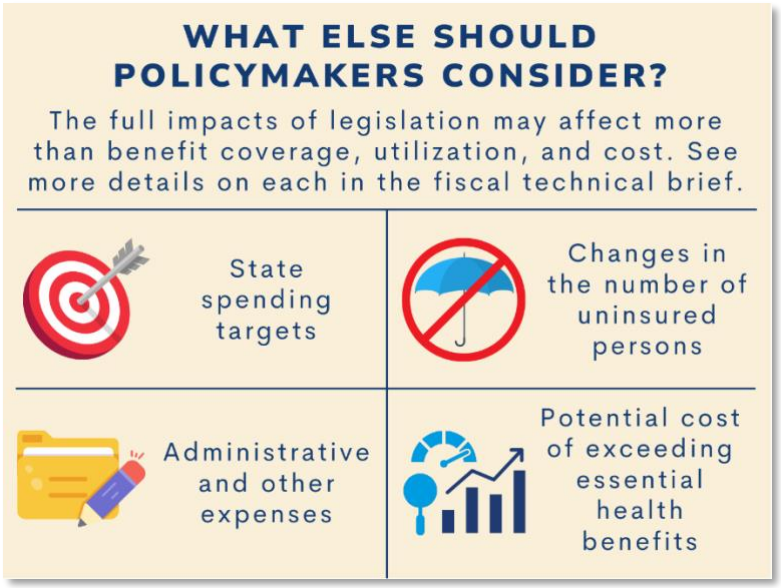

Table 4. Impact of SB 1309 on Average User Enrollee Expenses

	Large Group	Small Group	Individual	CalPERS	Medi-Cal (a)
% of population with enrollee expenses impact due to SB 1309	0.36%	0.36%	0.36%	0.36%	0.00%
Average annual enrollee expenses impact for users	-$250	-$690	-$840	-$90	$0.00

Source: California Health Benefits Review Program, 2026.
Notes: Average enrollee expenses includes cost sharing (deductibles, copays, etc.) for covered benefits and out-of-pocket expenses for noncovered benefits. Average annual enrollee premium impact includes the employee portion of the premium only.
(a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

Table 5. Impact of SB 1309 on Average Non-User Enrollee Expenses

	Large Group	Small Group	Individual	CalPERS	Medi-Cal (a)
% of population without enrollee expenses impact due to SB 1309	99.64%	99.64%	99.64%	99.64%	100.00%
Average annual enrollee premium impact for non-users	$0.09	$0.10	$0.39	$0.00	$0.00

Source: California Health Benefits Review Program, 2026.
Notes: Average enrollee expenses includes cost sharing (deductibles, copays, etc.) for covered benefits and out-of-pocket expenses for noncovered benefits. Average annual enrollee premium impact includes the employee portion of the premium only.
(a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

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SB 1309 Impacts: Public Health

The public health impact analysis includes estimated impacts in the short term (within 12 months of full implementation) and in the long term (beyond the first 12 months following full implementation). This section estimates the short-term impact[25] of SB 1309 on potential higher follow-up lung cancer screening rates, less delay for further lung cancer diagnostic screening and related diagnostic services and reduced financial burden. See *Long-Term Impacts* for discussion of potential long-term impacts on mortality and quality of life.

Estimated Public Health Outcomes

CHBRP found not enough research on the impact of cost sharing on uptake of follow-up services for lung cancer. However, as presented in the *Overview* section, CHBRP found *strong evidence* that delays in diagnosis and treatment are correlated with upstaging and increased recurrence rates. Delays of surgery for non–small cell lung cancer were also significantly linked to worse outcomes, including a significant increase in recurrence risk.

Measurable health outcomes relevant to SB 1309 include reduced upstaging and a potential for reduced mortality in certain cases. It is difficult to estimate exactly how many enrollees may receive earlier-stage diagnoses, since the impact of delays in follow-up care and treatment depends on a variety of factors, including an individual's stage at diagnosis, the length of the delay, and progression of the disease. However, removing out-of-pocket costs for follow-up care is expected to result in more cancers being caught at an earlier stage as enrollees receive more care and/or earlier care postmandate.

Due to the modest changes in utilization or delays in utilization, CHBRP projects a modest public health impact at the population level. However, SB 1309 would likely yield health and quality-of-life improvements among enrollees who would experience reductions in upstaging, mortality, and lung cancer recurrence rates as a result of receiving more timely care under SB 1309. This subset of enrollees could come from two groups: one, among the estimated 1,000 enrollees newly utilizing additional or more timely follow-up services for lung cancer without cost sharing due to SB 1309; and two, among the existing population of users who, postmandate, would utilize more timely care within the same year as they did at baseline due to the removal of cost sharing.

CHBRP estimates that postmandate, a small number of enrollees would receive an earlier-stage diagnosis than they would have at baseline, with an average cost savings of $149,304 per case.

As discussed in the *Benefit Coverage and Cost Impacts* section, CHBRP estimates that prohibiting cost sharing for follow-up services for lung cancer would result in an estimated annual decrease in enrollee expenses between $90 and $840, depending on the market segment. This decrease in cost sharing may reduce financial burden for enrollees and lead them to seek more or earlier care, though the impact may be less for enrollees in HSA-eligible HDHPs who still have to meet their deductible requirements before coverage without cost sharing under SB 1309 would apply.

Impact on Disparities[26]

Disparities in lung cancer disease in California disproportionately affect Black, Native American, and low-income populations, who face higher incidence and mortality rates, often driven by late-stage diagnosis and lower screening rates. While California has a low incidence rate overall, rural, impoverished areas show higher incidences. In terms of race and ethnicity, the 5-year survival rate is lower for Black Californians (27.3%) compared to White Californians (31.4%).

[25] CHBRP defines short-term impacts as changes occurring within 12 months of full implementation of an enacted law.
[26] For details about CHBRP's methodological approach to analyzing disparities, see the *Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts* document.

More information on disparities in lung cancer can be found in the *Background* section in CHBRP's Technical Brief on SB 1309.

To the extent changes SB 1309 results in changes to utilization, reductions in these disparities may occur; however, the magnitude is unknown.

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SB 1309 Impacts: Long-Term

In this section, CHBRP estimates the long-term impact of SB 1309, which CHBRP defines as impacts occurring beyond the first 12 months after legislation is fully implemented.[27] 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.

Utilization Impacts

CHBRP does not project additional long-term growth in utilization attributable to SB 1309 beyond the modest postmandate increase estimated in the first year of full implementation. The bill affects enrollee cost sharing for services that are already covered at baseline, and CHBRP's cost model assumes that the ongoing annual utilization effect reflects the full effect of removing cost-sharing barriers. As a result, long-term utilization impacts in the commercial and CalPERS market segments are expected to remain relatively stable rather than increase materially in subsequent years, absent changes in clinical practice, screening patterns, or other external factors.

Medi-Cal beneficiaries generally do not face cost sharing for covered services. As a result, SB 1309 is not expected to materially affect utilization for Medi-Cal enrollees in 2027. However, to the extent that cost sharing is introduced in Medi-Cal in future years as a result of H.R.1, it is unclear whether SB 1309 would eliminate such cost sharing for applicable follow-up lung cancer services, which could affect utilization and the magnitude of impacts for this population over time. Uncertainty persists at this point on whether copayments and cost sharing may be imposed on portions of the Medi-Cal expansion population, and if so, whether federal law might supersede, or the provisions of SB 1309 would apply to that population.

Cost Impacts

CHBRP does not project additional long-term growth in premiums or expenditures attributable to SB 1309 beyond the annual postmandate impacts estimated in the first year of full implementation, other than changes that could occur due to factors outside the scope of this analysis, such as medical inflation or broader changes in care patterns. The bill does not affect reimbursement rates, or the types of services provided, so any ongoing cost impacts would continue to be driven by the increase in utilization and shift in financial responsibility from enrollees to plans and insurers reflected in the annual estimates.

As described in the *Overview* section, there is *strong evidence* that delays in diagnosis and treatment are associated with upstaging and increased recurrence rates, and *some evidence* that longer delays may be associated with worse survival outcomes. To the extent that SB 1309 reduces financial barriers and improves timeliness of follow-up care, there is potential for downstream health benefits, including earlier-stage diagnosis and reduced recurrence.

To the extent that H.R.1 impacts utilization in future years, cost to Medi-Cal may also be impacted respectively.

CHBRP did not identify evidence sufficient to quantify long-term cost offsets beyond the estimates presented in the *Benefit Coverage and Cost Impacts* section.

[27] Full-scale implementation typically requires a "ramp up" period, which may include educating enrollees, providers, and insurance carriers on the new benefits or coverage; updating procedures and policies; and increasing provider capacity for marginal utilization resulting from SB 1309. Furthermore, some policies may have staggered implementation or longer-term changes in utilization. The short-term, incremental impact estimated by CHBRP assumes there is no "ramp up" period and represents ongoing annual costs at full-scale implementation of SB 1309, including potential short-term offsets. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.

Long-Term Public Health Impacts

Assuming that current lung cancer screening rates and guidelines remain stable, CHBRP estimates that the use of diagnostic screening and related follow-up services would remain relatively stable beyond the first year postmandate. As in the first postmandate year, CHBRP does not anticipate long-term, population-level measurable change in the annual number of cancer treatments, because the additional imaging would result in earlier, but not additional, diagnoses. Similar to the short-term impacts, on the person-level, some individuals may be diagnosed and treated at earlier stages of lung cancer in the future because cancers were followed up on at an earlier stage due to the elimination of cost sharing.

Depending on how implementation and operationalization of cost sharing for Medi-Cal under H.R.1 impacts utilization of services under SB 1309 for the Medi-Cal population, there may be a public health impact.

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Appendix. Impacts of SB 1309 on Benefit Coverage and Expenditures, 2027

Table 6 through Table 8 present detailed estimates of the impacts of SB 1309 on benefit coverage, premiums, cost sharing, and total expenditures by market segment. Table 6 summarizes changes in benefit coverage, Table 7 presents baseline premiums and expenditures, and Table 8 presents postmandate changes in premiums, enrollee expenses, and total expenditures. Overall, SB 1309 results in a shift in financial responsibility from enrollees to plans and insurers, with modest increases in premiums offset by reductions in enrollee cost sharing.

Table 6. Impacts of SB 1309 on Benefit Coverage, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	22,842,000	22,842,000	0	0.00%
Total enrollees with health insurance subject to SB 1309	22,842,000	22,842,000	0	0.00%
Percentage of enrollees with coverage without cost sharing for mandated benefit	40%	100%	60%	151.57%
Number of enrollees with fully compliant coverage for mandated benefit	9,080,000	22,842,000	13,762,000	151.56%

Source: California Health Benefits Review Program, 2026.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[28]
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

[28] For more detail, see CHBRP's resource Sources of Health Insurance in California.

Table 7. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to SB 1309	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Premium costs										
Average portion of premium paid by employer (e)	$619.33	$539.05	$0.00	$770.84	$367.89	$632.17	$780.34	$573.31	$0.00	$127,325,155,000
Average portion of premium paid by enrollee	$134.02	$263.52	$864.90	$145.41	$0.00	$0.00	$184.88	$242.16	$832.16	$47,603,460,000
Total premium	**$753.35**	**$802.56**	**$864.90**	**$916.25**	**$367.89**	**$632.17**	**$965.22**	**$815.47**	**$832.16**	**$174,928,616,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$56.38	$184.07	$271.63	$70.59	$0.00	$0.00	$126.72	$213.52	$192.93	$19,432,815,000
Expenses for noncovered benefits (f)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures (g)	**$809.72**	**$986.63**	**$1,136.53**	**$986.84**	**$367.89**	**$632.17**	**$1,091.94**	**$1,029.00**	**$1,025.09**	**$194,361,431,000**

Source: California Health Benefits Review Program, 2026.
Notes: Numbers might not align with those in earlier tables due to rounding.
(a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five (20.4%) of these enrollees has a pharmacy benefit not subject to DMHC.[29] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[30]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) 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 covered by insurance at baseline. 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.
(g) Total expenditures represent the sum of premiums, cost sharing for covered benefits, and expenses for noncovered benefits.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

[29] For more detail, see CHBRP's resource Pharmacy Benefit Coverage in State-Regulated Health Insurance.
[30] For more detail, see CHBRP's resource Sources of Health Insurance in California.

Table 8. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to SB 1309	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Premium costs (postmandate change)										
Average portion of premium paid by employer (e)	$0.0898	$0.1831	$0.0000	$0.0487	$0.0000	$0.0000	$0.1415	$0.2002	$0.0000	$14,333,000
Average portion of premium paid by enrollee	$0.0194	$0.0895	$0.2993	$0.0092	$0.0000	$0.0000	$0.0335	$0.0846	$0.3134	$13,307,000
Total premium	$0.1092	$0.2726	$0.2993	$0.0578	$0.0000	$0.0000	$0.1750	$0.2847	$0.3134	**$27,639,000**
Enrollee expenses (postmandate change)										
Cost sharing for covered benefits (deductibles, copays, etc.)	-$0.0738	-$0.2088	-$0.2527	-$0.0270	$0.0000	$0.0000	-$0.1284	-$0.2278	-$0.2251	-$20,700,000
Expenses for noncovered benefits (f)	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
Total expenditures (g)	$0.0355	$0.0638	$0.0466	$0.0308	$0.0000	$0.0000	$0.0466	$0.0570	$0.0883	**$6,939,000**
Postmandate percent change										
% change insured premiums	0.0145%	0.0340%	0.0346%	0.0063%	0.0000%	0.0000%	0.0181%	0.0349%	0.0377%	0.0158%
% change total expenditures	0.0044%	0.0065%	0.0041%	0.0031%	0.0000%	0.0000%	0.0043%	0.0055%	0.0086%	0.0036%

Source: California Health Benefits Review Program, 2026.
Notes: Numbers might not align with those in earlier tables due to rounding.
(a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[31] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[32]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) 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 covered by insurance at baseline. 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.

[31] For more detail, see CHBRP's resource Pharmacy Benefit Coverage in State-Regulated Health Insurance.
[32] For more detail, see CHBRP's resource Sources of Health Insurance in California.

(g) Changes in total expenditures reflect increases in premiums and decreases in enrollee cost sharing for covered benefits. No change in expenditures for noncovered benefits is projected, as the services affected by SB 1309 are covered at baseline. Medi-Cal enrollees are included for completeness; no measurable impact is projected due to the absence of cost sharing during the analysis year. Changes in average unit cost reflect rounding and trend assumptions and do not represent a material change in reimbursement rates.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

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CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research. A group of faculty, researchers, and staff complete the analysis that informs 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** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with an independent actuarial firm, **Milliman, Inc.**, 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. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

CHBRP Staff

Garen Corbett, MS, Director
Adara Citron, MPH, Associate Director
An-Chi Tsou, PhD, Principal Policy Analyst
Anna Pickrell, MPH Principal Policy Analyst
Karen Shore, PhD, Contractor*
Nisha Kurani, MPP, Contractor*
*Independent Contractor who supports CHBRP analyses and projects.

Task Force

Faculty Vice Chairs

Janet Coffman, MA, MPP, PhD, *Vice Chair for Medical Effectiveness,* University of California, San Francisco
Elizabeth Magnan, MD, PhD, *Vice Chair for Medical Effectiveness and Public Health*, University of California, Davis
Sara McMenamin, PhD, *Vice Chair for Medical Effectiveness and Public Health*, University of California, San Diego
Nadereh Pourat, PhD, *Vice Chair for Cost*, University of California, Los Angeles

Peer Faculty and Senior Cost Reviewers

Mark Bounthavong, PharmD, PhD, MPH, University of California, San Diego
Kimberly Buss, MD, MS, MPH, University of California, San Francisco
Todd Gilmer, PhD, University of California, San Diego
Sylvia Guendelman, PhD, LCSW, University of California, Berkeley
Grace Lin, MD, MAS, University of California, San Francisco
Jack Needleman, PhD, University of California, Los Angeles
Mark A. Peterson, PhD, University of California, Los Angeles
Alejandro Schuler, PhD, University of California, Berkeley
Marilyn Stebbins, PharmD, University of California, San Francisco
Jonathan Watanabe, PharmD, MS, PhD, University of California, San Francisco

Leads and Analysts

Khadijah Ameen, PhD, MPH, University of California, Berkeley
Bethney Bonilla-Herrera, MA, University of California, Davis
Paul Brown, PhD, University of California, Merced
Timothy T. Brown, PhD, University of California, Berkeley
Danielle Casteel, MA, University of California, San Diego
Margaret Fix, MPH, University of California, San Francisco
Brent Fulton, PhD, MBA, University of California, Berkeley
Carlos Gould, PhD, University of California, San Diego
Alein Haro-Ramos, PhD, MPH, University of California, Irvine
Julia Huerta, BSN, RN, MPH, University of California, Davis
Michelle Keller, PhD, MPH, University of California, Los Angeles, and University of Southern California
Thet Nwe Myo Khin, MPH, University of California, San Diego
Joy Melnikow, MD, MPH, University of California, Davis
Jacqueline Miller, University of California, San Francisco
Marykate Miller, MS, University of California, Davis
Aimee Moulin, MD, University of California, Davis
Katrine Padilla, MPP, University of California, Davis
Jonathan Palisoc, MPP, University of Michigan
Denise Payán, PhD, MPP, University of California, Irvine
Kyoko Peterson, MPH, University of California, San Francisco
Amy Quan, MPH, University of California, San Francisco
Dominique Ritley, MPH, University of California, Davis
Dylan Roby, PhD, University of California, Irvine
Neil Sehgal, PhD, MPH, University of Washington
Mienah Sharif, PhD, MPH, University of California, Berkeley
Riti Shimkhada, PhD, University of California, Los Angeles
Meghan Soulsby Weyrich, MPH, University of California, Davis
Steven Tally, PhD, University of California, San Diego
Dan Zeltzer, PhD, University of California, Berkeley

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Ruchika Talwar, MD, MMHC, Assistant Professor Department of Urology and Medical Director Episodes of Care, Population Health, Vanderbilt University Medical Center
Alan Weil, JD, MPP, Senior Vice President for Public Policy, AARP, Washington, DC

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Aimee Moulin, MD, of the University of California, Davis, and Margaret Fix, MPH, of the University of California, San Francisco, prepared the medical effectiveness analysis. Bruce Abbott, MLS, of the University of California, Davis, conducted the literature search. Garen Corbett, MS, of CHBRP, and Zach Blundell, of the University of California, San Diego, prepared the public health impact analysis. Neil Jay Sehgal, PhD, MPH, and Nadereh Pourat, PhD, MPP, prepared the cost impact analysis. Daniel Perlman, FSA, MAAA, and Norman Yu, ASA, MAAA, of Milliman provided actuarial analysis. Content expert Jonathan Riess, MD, of the University of California, Davis, provided technical assistance and expert input on the analytic approach. Nisha Kurani, MPP, CHBRP contractor, prepared the Overview and Policy Context and synthesized the individual sections into a single report. Abby Choy, project assistant with CHBRP, prepared the infographic. A subcommittee of CHBRP's National Advisory Council (see previous page of this report) and members of the CHBRP Faculty Task Force — Alejandro Schuler, PhD, of the University of California, Berkeley; Nadereh Pourat, PhD, of the University of California, Los Angeles; Janet Coffman, PhD, of the University of California, San Francisco; and Sara McMenamin, PhD, of the University of California, San Diego — reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

Garen Corbett, MS Director

Please direct any questions concerning this document to: California Health Benefits Review Program, MC 3116, Berkeley, CA 94720-3116; info@chbrp.org; or chbrp.org.

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The California Health Benefits Review Program (CHBRP) was established in 2002. CHBRP's mission is to inform and support policymaking in California through the creation of impartial, evidence-based resources. 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. CHBRP is dedicated to providing academic rigor on a Legislature's timeline.

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. An independent actuarial firm 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.

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This analysis is based on existing literature and public sources identified through systematic search methods. This evidence informs the California Legislature about potential impacts of proposed health benefit legislation and does not constitute a policy recommendation from CHBRP.

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