ASSEMBLY BILL No. 2234

Introduced by Assembly Members Portantino and Wolk
(Principal coauthor: Senator Negrete McLeod)
(Coauthors: Assembly Members Berg and Dymally)

February 20, 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 2234, as introduced, Portantino. Health care coverage: breast
conditions.
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.

This bill would provide that such plans or policies issued, amended,
delivered, or renewed on and after January 1, 2009, shall be deemed to
provide coverage for tests necessary for screening or diagnoses, as
specified, of breast conditions upon referral of 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 and in accordance with national
guidelines. The bill would also 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 conditions.

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.

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,
including any of the following:

(1) A woman who has had a personal history of breast cancer,
including ductal carcinoma in situ (DCIS).

(2) A woman who has been identified as having the BRCA1 or
BRCA2 gene mutation or is a first degree relative of someone
identified as having the BRCA1 or BRCA2 gene mutation.

(3) A woman who has two or more first degree relatives with
breast cancer diagnosed before 50 years of age.
(4) A woman who has been diagnosed with Li-Fraumeni syndrome (LFS), Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome (BRRS), or who has a first degree relative who has been diagnosed with one of those syndromes.

(5) A woman identified with a lifetime risk of breast cancer of 20 percent or greater, as defined by the BRCAPRO model or other models that are largely dependent upon family history.

(6) A woman who has experienced radiation to her chest between 10 to 30 years of age, inclusive.

(7) A woman who has been diagnosed with lobular carcinoma in situ (LCIS) or atypical lobular hyperplasia (ALH).

(8) A woman who has been diagnosed with atypical ductal hyperplasia (ADH).

(9) A woman with heterogeneously or extremely dense breast tissue on mammography.

(b) In order to protect the health of California citizens, breast cancer diagnostic methods such as mammography, magnetic resonance imaging (MRI), and ultrasound must be provided. These diagnostic treatment tools, when used together 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, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.

(b) On or after January 1, 2009, every health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, delivered, or renewed shall be deemed to provide coverage for tests necessary for screening or diagnoses of breast conditions, upon referral. Necessary tests shall encompass those tests consistent with national guidelines and shall include, but not be limited to, mammography, magnetic resonance imaging, ultrasound, and computer-aided detection. Referral shall be made 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 and in accordance with national guidelines.

(c) 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 providing care.

(d) A health care service plan subject to this section 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 conditions, 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, 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:

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

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

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

(b) On or after January 1, 2009, 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 tests necessary for screening or diagnoses
of breast conditions, upon referral. Necessary tests shall encompass
those tests consistent with national guidelines and shall include,
but not be limited to, mammography, magnetic resonance imaging,
ultrasound, and computer-aided detection. Referral shall be made
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 and in accordance with national guidelines.

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 providing care.

(e) A disability insurer or self-insured employee welfare benefit
plan subject to this section 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 conditions, 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.