HOUSE . . . . . No. 4933

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, January 22, 2026.

The committee on Financial Services, to whom was referred the petition (accompanied by bill, House, No. 1076) of James Arciero and others relative to colon cancer screening, reports recommending that the accompanying bill (House, No. 4933) ought to pass.

For the committee,

JAMES M. MURPHY.

FILED ON: 12/16/2025

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The Commonwealth of Massachusetts

In the One Hundred and Ninety-Fourth General Court
(2025-2026)

An Act relative to colon cancer screening.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 32A of the General Laws is hereby amended by adding the following section:-

Section 35. (a) The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage, starting at 30 years of age, for colorectal cancer screening as found medically necessary by the insured's primary care physician, including: (i) Flexible sigmoidoscopy every 5 years; (ii) Flexible sigmoidoscopy every 10 years plus FIT every year; (iii) KRAS, BRAF, PIK3CA Array as frequent as medically necessary; (iv) FIT-DNA every year or every 3 years, as medically necessary; (v) FIT every year; (vi) HSgFOBT every year; (vii) CT colonography every 5 years; and (vii) colonoscopy every 5 or 10 years. For the purposes of this section the term "colonoscopy", shall mean a colorectal cancer screening service procedure that enables a physician to examine visually the inside of a patient's entire colon and includes the concurrent removal of polyps or biopsy, or both.

(b) Colorectal cancer screening services pursuant to subsection (a) performed under contract with the commission shall not be subject to any co-payment, deductible, coinsurance or other cost-sharing requirement. In addition, an insured shall not be subject to any additional charge for any service associated with a procedure or test for colorectal cancer screening, which may include 1 or more of the following: (i) removal of tissue or other matter; (ii) laboratory services; (iii) physician services; (iv) facility use, regardless of whether such facility is a hospital; and (v) anesthesia, provided, however, that cost sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on such for these services.

SECTION 2. Chapter 118E of the General Laws is hereby amended by adding the following section:-

Section 87. The division and it’s contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care plan shall provide coverage, starting at age 30, for colorectal cancer screening as found medically necessary by the insured’s primary care physician, including: (i) Flexible sigmoidoscopy every 5 years; (ii) Flexible sigmoidoscopy every 10 years plus FIT every year; (iii) KRAS, BRAF, PIK3CA Array as frequent as medically necessary; (iv) FIT-DNA every year or every 3 years, as medically necessary; (v) FIT every year; (vi) HSgFOBT every year; (vii) CT colonography every 5 years; and (vii) colonoscopy every 5 or 10 years. For the purposes of this section the term “colonoscopy”, shall mean a colorectal cancer screening service procedure that enables a physician to examine visually the inside of a patient's entire colon and includes the concurrent removal of polyps or biopsy, or both.

(b) Colorectal cancer screening services pursuant to subsection (a) performed under this section shall not be subject to any co-payment, deductible, coinsurance or other cost-sharing requirement. In addition, an insured shall not be subject to any additional charge for any service associated with a procedure or test for colorectal cancer screening, which may include 1 or more of the following: (i) removal of tissue or other matter; (ii) laboratory services; (iii) physician services; (iv) facility use, regardless of whether such facility is a hospital; and (v) anesthesia, provided, however, that cost sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on such for these services.

SECTION 3. Chapter 175 of the General Laws is hereby amended by inserting before section 47CCC the following section:-

Section 47AAA. (a) Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period within which this premium is effective, or any policy of accident or sickness insurance as described in section one hundred and eight which provides hospital expense and surgical expense insurance and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policyholder in the commonwealth, during the period within which this provision is effective, or any employers' health and welfare fund which provides hospital expense and surgical expense benefits and which is issued or renewed to any person or group of persons in the commonwealth, during the period within which this provision is effective, shall provide coverage, starting at 30 years of age, for colorectal cancer screening as found medically necessary by the insured’s primary care physician, including: (i) Flexible

sigmoidoscopy every 5 years; (ii) Flexible sigmoidoscopy every 10 years plus FIT every year; (iii) KRAS, BRAF, PIK3CA Array as frequent as medically necessary; (iv) FIT-DNA every year or every 3 years, as medically necessary; (v) FIT every year; (vi) HSgFOBT every year; (vii) CT colonography every 5 years; and (viii) colonoscopy every 5 or 10 years. For the purposes of this section the term “colonoscopy”, shall mean a procedure that enables a physician to examine visually the inside of a patient's entire colon and includes the concurrent removal of polyps or biopsy, or both.

(b) Colorectal cancer screening services pursuant to subsection (a) performed under this section shall not be subject to any co-payment, deductible, coinsurance or other cost-sharing requirement. In addition, an insured shall not be subject to any additional charge for any service associated with a procedure or test for colorectal cancer screening, which may include 1 or more of the following: (i) removal of tissue or other matter; (ii) laboratory services; (iii) physician services; (iv) facility use, regardless of whether such facility is a hospital; and (v) anesthesia, provided, however, that cost sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on such for these services.

SECTION 4. Chapter 176A of the General Laws is hereby amended by inserting after section 8DDD the following section:-

Section 8EEE. (a) Any contract between a subscriber and the corporation under an individual or group hospital service plan which is delivered, issued or renewed within the commonwealth shall provide coverage, starting at 30 years of age, for colorectal cancer screening as found medically necessary by the insured’s primary care physician, including: (i)

Flexible sigmoidoscopy every 5 years; (ii) Flexible sigmoidoscopy every 10 years plus FIT every year; (iii) KRAS, BRAF, PIK3CA Array as frequent as medically necessary; (iv) FIT-DNA every year or every 3 years, as medically necessary; (v) FIT every year; (vi) HSgFOBT every year; (vii) CT colonography every 5 years; and (viii) colonoscopy every 5 or 10 years. For the purposes of this section the term “colonoscopy”, shall mean a procedure that enables a physician to examine visually the inside of a patient's entire colon and includes the concurrent removal of polyps or biopsy, or both.

(b) Colorectal cancer screening services pursuant to subsection (a) performed under this section shall not be subject to any co-payment, deductible, coinsurance or other cost-sharing requirement. In addition, an insured shall not be subject to any additional charge for any service associated with a procedure or test for colorectal cancer screening, which may include 1 or more of the following: (i) removal of tissue or other matter; (ii) laboratory services; (iii) physician services; (iv) facility use, regardless of whether such facility is a hospital; and (v) anesthesia, provided, however, that cost sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on such for these services.

SECTION 5. Chapter 176B of the General Laws is hereby amended by inserting after section 4DDD the following section:-

Section 4EEE. (a) Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall provide coverage, starting at 30 years of age, for colorectal cancer screening as found medically necessary by the insured’s primary care physician, including: (i) Flexible sigmoidoscopy every 5

years; (ii) Flexible sigmoidoscopy every 10 years plus FIT every year; (iii) KRAS, BRAF, PIK3CA Array as frequent as medically necessary; (iv) FIT-DNA every year or every 3 years, as medically necessary; (iv) FIT every year; (vi) HSgFOBT every year; (vii) CT colonography every 5 years; and (viii) colonoscopy every 5 or 10 years. For the purposes of this section the term “colonoscopy”, shall mean a procedure that enables a physician to examine visually the inside of a patient's entire colon and includes the concurrent removal of polyps or biopsy, or both.

(b) Colorectal cancer screening services pursuant to subsection (a) performed under this section shall not be subject to any co-payment, deductible, coinsurance or other cost-sharing requirement. In addition, an insured shall not be subject to any additional charge for any service associated with a procedure or test for colorectal cancer screening, which may include 1 or more of the following: (i) removal of tissue or other matter; (ii) laboratory services; (iii) physician services; (iv) facility use, regardless of whether such facility is a hospital; and (v) anesthesia, provided, however, that cost sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on such for these services.

SECTION 6. Chapter 176G of the General Laws is hereby amended by inserting after section 4VV the following section:-

Section 4WW. (a) An individual or group health maintenance contract that is issued or renewed shall provide coverage, starting at 30 years of age, for colorectal cancer screening as found medically necessary by the insured’s primary care physician, including: (i) Flexible sigmoidoscopy every 5 years; (ii) Flexible sigmoidoscopy every 10 years plus FIT every year;

(iii) KRAS, BRAF, PIK3CA Array as frequent as medically necessary; (iv) FIT-DNA every year or every 3 years, as medically necessary; (v) FIT every year; (vi) HSgFOBT every year; (vii) CT colonography every 5 years; and (viii) colonoscopy every 5 or 10 years. For the purposes of this section the term “colonoscopy”, shall mean a procedure that enables a physician to examine visually the inside of a patient's entire colon and includes the concurrent removal of polyps or biopsy, or both.

(b) Colorectal cancer screening services pursuant to subsection (a) performed under this section shall not be subject to any co-payment, deductible, coinsurance or other cost-sharing requirement. In addition, an insured shall not be subject to any additional charge for any service associated with a procedure or test for colorectal cancer screening, which may include 1 or more of the following: (i) removal of tissue or other matter; (ii) laboratory services; (iii) physician services; (iv) facility use, regardless of whether such facility is a hospital; and (v) anesthesia, provided, however, that cost sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on such for these services.