CAHP IMPLEMENTATION GUIDELINE

SB 510 (Pan)
Chapter 729, Statutes of 2021

As a service to our members, the California Association of Health Plans produces guidelines designed to assist in the interpretation and implementation of new laws, and to promote full compliance with those laws. This document, however, is not intended to be authoritative. Any questions about official interpretations of the law should be directed to the appropriate state regulatory agency such as the Department of Managed Health Care or the Department of Health Care Services, as well as your legal counsel.

HEALTH CARE COVERAGE: COVID-19 COST SHARING

BACKGROUND

Senate Bill 510 was introduced by Senator Richard Pan (D-Sacramento) and was sponsored by the California Medical Association. SB 510 requires health plans to retroactively cover COVID-19 testing and vaccinations without cost sharing or prior authorization requirements provided both in-network and out-of-network back to March 4, 2020.

CAHP had numerous concerns with this bill. SB 510 exceeds the federal mandate for COVID-19 testing by requiring health plans to cover screening testing, which would include the costs of testing for employment purposes. Furthermore, SB 510 provides no oversight on out-of-network providers, many of whom are charging exorbitant prices for tests. The lack of oversight would legitimize fraud and artificially high testing costs. Lastly, SB 510 would apply retroactively back to March 4, 2020, which may violate both the federal and state constitutions by shifting costs for testing to health plans, even when a preexisting contract requires the provider to cover that cost.

SB 510 passed out of the Legislature on a mostly party-line vote, although many Democratic member of the Assembly withheld their vote from the bill. An earlier version of the bill contained an urgency clause, which would have allowed the provisions of the bill to go into effect immediately upon signature of the bill. However, legislation containing an urgency clause require a 2/3 vote from the legislature. The author could not get the required 2/3 votes to pass the bill of the Assembly floor, so he amended the bill in the last week of session to strip the urgency clause from the bill, thereby rendering it as a simple majority vote. Unfortunately, with the vote threshold lowered, this bill was able to secure enough votes to pass it off the Assembly floor. The California Department of Finance (DOF) was opposed to this bill, citing that its passage would result in potentially significant cost impacts not accounted for in the 2021 Budget Act. DOF also noted that the costs incurred by this bill would likely be spread across state health programs and result in premium increases. The Governor signed SB 510 on October 8, 2021.

REQUIREMENTS

Specifically, SB 510 does the following:

1) Requires health plans and disability insurers that cover medical, surgical, and hospital benefits to cover the costs for COVID-19 diagnostic and screening testing and health care services related to testing approved or granted emergency use authorization by the FDA for COVID-19.

2) Prohibits health plans and disability insurers from imposing a copayment, coinsurance, deductible, or any other form of cost sharing. Requires COVID-19 diagnostic and screening testing and services coverage to include, but not be limited to, hospital or health care provider office visits for the purpose of testing, products related to testing, administering testing, and items and services furnished to an enrollee or insured as part of testing.

3) Prohibits health plans and disability insurers from imposing prior authorization or any other utilization management requirements on COVID-19 diagnostic and screening testing or any item, service, or immunization intended to mitigate or prevent COVID-19.

4) Requires health plans and insurers to reimburse the provider of COVID-19 diagnostic and screening testing and immunizations at the specifically negotiated rate during the public health emergency, or if there is no specifically negotiated rate, allows plans and insurers to negotiate a rate with providers. This bill requires health plans and insurers to reimburse out-of-network providers, which do not have a negotiated rate, for all testing items or services at a reasonable rate as determined in comparison to prevailing market rates for items or services in the geographic region.

5) Requires a change to a contract between a health plan and a health care provider that delegates financial risk for testing or immunizations, related to a public health emergency, to be a material change to the parties' contract, and prohibits a health plan from delegating the financial risk to a contracted health care provider unless the parties have specifically negotiated and agreed upon a new contract provision, as specified.

6) Requires health plans and insurers to cover, without cost sharing, any item, service, or immunization intended to prevent or mitigate COVID-19, regardless of the service being delivered by an in-network or out-of-network provider, that meets either of the criteria with respect to the individual enrollee:

    a) Evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the USPSTF; or,
    b) An immunization that has in effect a recommendation from the ACIP of the CDC, regardless of whether the immunization is recommended for routine use.

7) Requires health plans and insurers to cover the item, service, or immunization that is intended to prevent or mitigate COVID-19 no later than 15 business days after the date that USPSTF or ACIP make a recommendation relating to the item, service, or immunization.

8) Requires 1) - 7) above to remain in effect after the expiration of the federal public health emergency. Requires health plans and insurers to cover COVID-19 diagnostic and screening testing and items or services necessary for furnishing items, service or immunizations without cost-sharing when delivered by an out-of-network provider except following the expiration of the federal public health emergency.

9) Applies 1) – 7) retroactively beginning from the Governor's declared State of Emergency related to the SARS-CoV-2 (COVID-19) pandemic on March 4, 2020.

10) Requires health plan and insurers that cover medical, surgical, and hospital benefits to cover health care services to prevent or mitigate a disease when the Governor of California has declared a public health emergency due to that disease. The item, service, or immunization must be covered no later than 15 business days after the date on which USPSTF or the ACIP makes a recommendation relating to the item, service, or immunization. Requires the following to be covered without cost sharing or prior authorization or other utilization management:

    a) Item, or service, or immunization recommended by USPSTF or ACIP; and,
    b) Health care service or product related to testing for the pandemic disease that is approved or granted emergency use authorization by the FDA, or is recommended by CDPH or the CDC.

11) Defines "Diagnostic testing" as all of the following:

    a) Testing intended to identify current or past infection and performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic but has recent known or suspected exposure to SARS-CoV-2.
    b) Testing a person with symptoms consistent with COVID-19.
    c) Testing a person as a result of contact tracing efforts.
    d) Testing a person who indicates that they were exposed to someone with a confirmed or suspected case of COVID-19.
    e) Testing a person after an individualized clinical assessment by a licensed health care provider.

12) Defines "Screening testing" as tests that are intended to identify people with COVID-19 who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening testing helps to identify unknown cases so that measures can be taken to prevent further transmission. Screening testing includes all of the following:

    a) Workers in a workplace setting.
    b) Students, faculty, and staff in a school setting.
    c) A person before or after travel.
    d) At home for someone who does not have symptoms associated with COVID-19 and does not have a known exposure to someone with COVID-19.

13) Permits DMHC and CDI to adopt regulations to implement this bill.

14) Includes a severability provision in the event any of this bill's provisions is held invalid.

<u>COMPLIANCE DATES</u>
Plans will be required to implement the provisions of this bill retroactively back to March 4, 2020, beginning on January 1, 2022.

IMPLEMENTATION ISSUES

Applicability:
This bill applies to all health care service plans and health insurers that provide coverage for hospital, medical, or surgical benefits, excluding a specialized health care service plan contract or health insurance policy. This bill also applies to COVID-19 testing and treatment covered under Medi-Cal managed care plan (MCP) contracts, but because immunization costs are carved out of MCP contracts, it is difficult to determine plan responsibility for services currently paid by the federal government, now or in the future.

Implementation Issues:
H.S.C. section 1342.2 requires plans to cover, without cost sharing, COVID-19 diagnostic and screening testing and services related to diagnostic and screening testing approved or granted emergency use authorization by the FDA, regardless of whether the services are provided by in-network or out-of-network providers. Plans should review provider contracts and member handbooks/Evidence of Coverage (EOC) to ensure that they comply with this section.

If a health plan does not have a specifically negotiated rate for COVID-19 services with an in-network provider, SB 510 permits plans to negotiate such a rate. Provider contracts should be adjusted accordingly. Plans should also review provider contracts to ensure that no material changes are being made in relation to delegation of financial risk (DOFR), unless the parties have negotiated and agreed upon a new contract provision pursuant to H.S.C. section 1375.7

Plans may need to review their existing Policies and Procedures (P&P), especially those related to utilization management (UM) practices, to ensure that COVID-19 diagnostic and screening testing is not subject to prior authorization or any other UM requirements.

H.S.C. section 1342.2(b)(2) requires plans to cover items, services, or immunizations that are intended to prevent or mitigate COVID-19 no later than 15 business days after the date on which the U.S. Preventive Services Task Force (USPSTF) or Advisory Committee on Immunization Practices (ACIP) makes a recommendation relating to the item, services, or immunization.

H.S.C. section 1342.3 expands the above requirements to prevention and mitigation of any future diseases when the Governor declares a public health emergency.

The Governor's signing message directs the DMHC to issue guidance regarding the prevailing market rate. Plans may need to be prepared to review and potentially implement such guidance.

If you have any questions regarding this document, please email Jedd Hampton at jhampton@calhealthplans.org.