Senate Bill No. 510

CHAPTER 729

An act to add Sections 1342.2 and 1342.3 to the Health and Safety Code, and to add Sections 10110.7 and 10110.75 to the Insurance Code, relating to health care coverage.

[Approved by Governor October 8, 2021. Filed with Secretary of State October 8, 2021.]

LEGISLATIVE COUNSEL'S DIGEST

SB 510, Pan. Health care coverage: COVID-19 cost sharing.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services.

This bill would require a health care service plan contract or a disability insurance policy that provides coverage for hospital, medical, or surgical benefits, excluding a specialized health care service plan contract or health insurance policy, to cover the costs for COVID-19 diagnostic and screening testing and health care services related to the testing for COVID-19, or a future disease when declared a public health emergency by the Governor of the State of California, and would prohibit that contract or policy from imposing cost sharing or prior authorization requirements for that coverage. The bill would also require a contract or policy to cover without cost sharing or prior authorization an item, service, or immunization intended to prevent or mitigate COVID-19, or a future disease when declared a public health emergency by the Governor of the State of California, that is recommended by the United States Preventive Services Task Force or the federal Centers for Disease Control and Prevention, as specified. The bill would only extend the prohibition on cost sharing for COVID-19 diagnostic and screening testing, or an item, service, or immunization intended to prevent or mitigate COVID-19, with respect to an out-of-network provider for the duration of the federal public health emergency. The bill would also apply these provisions retroactively beginning from the Governor's declared State of Emergency related to COVID-19 on March 4, 2020. The bill would make the provisions of the act severable. The bill would also make related findings and declarations. Because a violation of this requirement by a health care service plan would be a crime, the bill 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.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares that a significant public health crisis, including the crisis posed by the COVID-19 pandemic that is the subject of the state of emergency declared by the Governor of the State of California on March 4, 2020, necessitates legislation to ensure that individuals are not discouraged from seeking testing or vaccination due to cost sharing or prior authorization requirements. To ensure that health care service plans and health insurers do not impose cost sharing or prior authorization requirements that might discourage individuals from seeking and receiving testing and vaccinations for a pandemic condition, it is the intent of the Legislature in enacting this act to require coverage for testing costs without cost sharing or prior authorization and to require coverage for prevention recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention. In this regard, the Legislature further finds and declares that this exercise of the police power imposes a reasonable condition that is of a character appropriate to the public purpose of ensuring that as many individuals as possible receive necessary testing and vaccination in response to a pandemic.

SEC. 2. Section 1342.2 is added to the Health and Safety Code, to read:

1342.2. (a) Notwithstanding any other law, a health care service plan contract that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, shall cover the costs for COVID-19 diagnostic and screening testing and health care services related to diagnostic and screening testing approved or granted emergency use authorization by the federal Food and Drug Administration for COVID-19, regardless of whether the services are provided by an in-network or out-of-network provider. Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. Services related to COVID-19 diagnostic and screening testing include, but are not limited to, hospital or health care provider office visits for the purposes of receiving testing, products related to testing, the administration of testing, and items and services furnished to an enrollee as part of testing.

(1) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the health care provider the amount of that lost cost sharing.

(2) A health care service plan contract shall not impose prior authorization or any other utilization management requirements on COVID-19 diagnostic and screening testing.

(3) With respect to an enrollee, a health care service plan shall reimburse the provider of the testing according to either of the following:

(A) If the health plan has a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(B) If the health plan does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider, the plan may negotiate a rate with such provider.

(4) (A) For an out-of-network provider with whom a health care service plan does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing and health care services related to testing, a plan shall reimburse the provider for all testing items or services in an amount that is reasonable, as determined in comparison to prevailing market rates for testing items or services in the geographic region where the item or service is rendered. An out-of-network provider shall accept this payment as payment in full and shall not seek additional remuneration from an enrollee for services related to testing.

(B) The requirement in this subdivision to cover COVID-19 diagnostic and screening testing and health care services related to testing without cost sharing, when delivered by an out-of-network provider, shall not apply with respect to COVID-19 diagnostic and screening testing and services related to testing furnished on, or after, the expiration of the federal public health emergency. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(5) Changes to a contract between a health care service plan and a provider delegating financial risk for diagnostic and screening testing related to a declared public health emergency shall be considered a material change to the parties' contract. A health care service plan shall not delegate the financial risk to a contracted provider for the cost of enrollee services provided under this section unless the parties have negotiated and agreed upon a new provision of the parties' contract pursuant to Section 1375.7.

(b) (1) A health care service plan contract that covers medical, surgical, and hospital benefits shall cover without cost sharing any item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is either of the following with respect to the individual enrollee:

(A) An evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

(B) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, regardless of whether the immunization is recommended for routine use.

(2) The item, service, or immunization covered pursuant to paragraph (1) shall be covered no later than 15 business days after the date on which the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention makes a recommendation relating to the item, service, or immunization. A recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention is considered in effect after it has been adopted, or granted emergency use authorization, by the Director of the Centers for Disease Control and Prevention.

(3) (A) A health care service plan subject to this subdivision shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for any item, service, or immunization described in paragraph (1), regardless of whether such service is delivered by an in-network or out-of-network provider.

(B) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the health care provider the amount of that lost cost sharing.

(C) With respect to an enrollee, a health care service plan shall reimburse the provider of the immunization according to either of the following:

(i) If the health plan has a negotiated rate with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(ii) If the health plan does not have a negotiated rate with such provider, the plan may negotiate a rate with such provider.

(D) A health care service plan shall not impose cost sharing for any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), including, but not limited to, provider office visits and vaccine administration, regardless of whether the service is delivered by an in-network or out-of-network provider.

(E) (i) For an out-of-network provider with whom a health care service plan does not have a negotiated rate for an item, service, or immunization described in paragraph (1), a health care service plan shall reimburse the provider for all related items or services, including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), in an amount that is reasonable, as determined in comparison to prevailing market rates for such items or services in the geographic region in which the item or service is rendered. An out-of-network provider shall accept this payment as payment in full and shall not seek additional remuneration from an insured for items, services, and immunizations described in subdivision (b), including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1).

(ii) The requirement in this paragraph to cover any item, service, or immunization described in paragraph (1) and to cover items or services that are necessary for the furnishing of the items, services, or immunizations

described in subparagraph (D) without cost sharing when delivered by an out-of-network provider will not apply with respect to an item, service, or immunization furnished on or after the expiration of the federal public health emergency. All other requirements of this section shall remain in effect after the federal public health emergency expires.

(4) A health care service plan subject to this subdivision shall not impose prior authorization or any other utilization management requirements on any item, service, or immunization described in paragraph (1) or to items or services that are necessary for the furnishing of the items, services, or immunizations described in subparagraph (D) of paragraph (3).

(5) Changes to a contract between a health care service plan and a provider delegating financial risk for immunization related to a declared public health emergency, shall be considered a material change to the parties' contract. A health plan shall not delegate the financial risk to a contracted provider for the cost of enrollee services provided under this section unless the parties have negotiated and agreed upon a new provision of the parties' contract pursuant to Section 1375.7.

(c) The director may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The department shall consult with the Department of Insurance in issuing the guidance specified in this subdivision.

(d) This section shall apply retroactively beginning from the Governor's declared State of Emergency related to the SARS-CoV-2 (COVID-19) pandemic on March 4, 2020.

(e) For purposes of this section:

(1) "Diagnostic testing" means 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.

(2) "Screening testing" means 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.

(f) This section does not relieve a health care service plan from continuing to cover testing as required by federal law and guidance.

SEC. 3. Section 1342.3 is added to the Health and Safety Code, to read:

1342.3. (a) A health care service plan contract that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, shall cover, without cost sharing and without prior authorization or other utilization management, the costs of the following health care services to prevent or mitigate a disease when the Governor of the State of California has declared a public health emergency due to that disease:

(1) An evidence-based item, service, or immunization that is intended to prevent or mitigate a disease as recommended by the United States Preventive Services Task Force that has in effect a rating of "A" or "B" or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention.

(2) A health care service or product related to diagnostic and screening testing for the disease that is approved or granted emergency use authorization by the federal Food and Drug Administration, or is recommended by the State Department of Public Health or the federal Centers for Disease Control and Prevention.

(b) The item, service, or immunization covered pursuant to paragraph (1) of subdivision (a) shall be covered no later than 15 business days after the date on which the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention makes a recommendation relating to the item, service, or immunization.

SEC. 4. Section 10110.7 is added to the Insurance Code, to read:

10110.7. (a) This section applies to a disability insurance policy that provides coverage for hospital, medical, or surgical benefits, excluding a specialized health insurance policy and a policy that provides excepted benefits as described in Sections 2722 (42 U.S.C. Sec. 300gg-21) and 2791 (42 U.S.C. Sec. 300gg-91) of the federal Public Health Service Act, subject to Section 10198.61.

(b) Notwithstanding any other law, a disability insurance policy shall cover the costs for COVID-19 diagnostic and screening testing and health care services related to the diagnostic and screening testing approved or granted emergency use authorization by the federal Food and Drug Administration for COVID-19, regardless of whether the services are provided by an in-network or out-of-network provider. Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. Services related to COVID-19 diagnostic and screening testing include, but are not limited to, hospital or health care provider office visits for the purposes of receiving testing, products related

to testing, the administration of testing, and items and services furnished to an insured as part of testing.

(1) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the insurer shall reimburse the health care provider the amount of that lost cost sharing.

(2) A disability insurance policy shall not impose prior authorization or any other utilization management requirements on COVID-19 diagnostic and screening testing.

(3) With respect to an insured, a health insurer shall reimburse the provider of the testing according to either of the following:

(A) If the health insurer has a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(B) If the health insurer does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider, the insurer may negotiate a rate with such provider.

(4) (A) For an out-of-network provider with whom an insurer does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing and health care services related to testing, an insurer shall reimburse the provider for all testing items or services in an amount that is reasonable, as determined in comparison to prevailing market rates for testing items or services in the geographic region where the item or service is rendered. An out-of-network provider shall accept this payment as payment in full and shall not seek additional remuneration from an insured for services related to testing.

(B) The requirement in this subdivision to cover COVID-19 diagnostic and screening testing and health care services related to testing without cost sharing when delivered by an out-of-network provider will not apply with respect to COVID-19 diagnostic and screening testing and health care services related to testing furnished on or after the expiration of the federal public health emergency. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(c) (1) A disability insurance policy shall cover without cost sharing any item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is either of the following with respect to the individual insured:

(A) An evidence-based item or service that has in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.

(B) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention regardless of whether the immunization is recommended for routine use.

(2) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the insurer shall reimburse the health care provider the amount of that lost cost sharing.

(3) The item, service, or immunization covered pursuant to paragraph (1) shall be covered no later than 15 business days after the date on which the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention makes a recommendation relating to the item, service, or immunization. A recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention is considered in effect after it has been adopted, or granted emergency use authorization, by the Director of the Centers for Disease Control and Prevention.

(4) (A) A disability insurance policy subject to this subdivision shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for any item, service, or immunization described in paragraph (1), regardless of whether such service is delivered by an in-network or out-of-network provider.

(B) A disability insurance policy shall not impose cost sharing for any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), including, but not limited to, provider office visits and vaccine administration, regardless of whether the service is delivered by an in-network or out-of-network provider.

(C) With respect to an insured, a health insurer shall reimburse the provider of the immunization according to either of the following:

(i) If the health insurer has a negotiated rate with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(ii) If the health insurer does not have a negotiated rate with such provider, the insurer may negotiate a rate with such provider.

(D) For an out-of-network provider with whom a disability insurer does not have a negotiated rate for an item, service, or immunization described in paragraph (1), an insurer shall reimburse the provider for all such items or services, including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), in an amount that is reasonable, as determined in comparison to prevailing market rates for such items or services in the geographic region in which the item or service is rendered. An out-of-network provider shall accept this payment as payment in full and shall not seek additional remuneration from an insured for items, services, and immunizations described in paragraph (1), including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1).

(E) The requirement in this subdivision to cover any item, service, or immunization described in paragraph (1) and to cover any items or services that are necessary for the furnishing of the items, services, or immunizations described in subparagraph (B), without cost sharing when delivered by an

out-of-network provider will not apply with respect to an item, service, or immunization furnished on or after the expiration of the federal public health emergency. All other requirements of this section shall remain in effect after the federal public health emergency expires.

(5) A disability insurer subject to this subdivision shall not impose prior authorization or any other utilization management requirements on any item, service, or immunization described in paragraph (1) or to items or services that are necessary for the furnishing of the items, services, or immunizations described in subparagraph (B) of paragraph (4).

(d) The commissioner may issue guidance to insurers regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The department shall consult with the Department of Managed Health Care in issuing the guidance specified in this subdivision.

(e) This section shall apply retroactively beginning from the Governor's declared State of Emergency related to the SARS-CoV-2 (COVID-19) pandemic on March 4, 2020.

(f) For purposes of this section:

(1) "Diagnostic testing" means 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.

(2) "Screening testing" means 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.

(g) This section does not relieve an insurer from continuing to cover testing as required by federal law and guidance.

SEC. 5. Section 10110.75 is added to the Insurance Code, immediately following Section 10110.7, to read:

10110.75. (a) This section applies to a disability insurance policy that provides coverage for hospital, medical, or surgical benefits, excluding a specialized health insurance policy.

(b) (1) A disability insurance policy shall cover, without cost sharing and without prior authorization or other utilization management requirements, the costs of the following health care services to prevent or mitigate a disease when the Governor of the State of California has declared a public health emergency due to that disease:

(A) An evidence-based item, service, or immunization that is intended to prevent or mitigate a disease as recommended by the United States Preventive Services Task Force that has in effect a rating of "A" or "B" or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention.

(B) A health care service or product related to diagnostic and screening testing for the disease that is approved or granted emergency use authorization by the federal Food and Drug Administration, or is recommended by the State Department of Public Health or the federal Centers for Disease Control and Prevention.

(2) The item, service, or immunization covered pursuant to subparagraph (A) of paragraph (1) shall be covered no later than 15 business days after the date on which the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention makes a recommendation relating to the item, service, or immunization.

SEC. 6. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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