CAHP IMPLEMENTATION GUIDELINE

SB 1473 (Pan)
Chapter 545, Statutes of 2022

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

BACKGROUND

Senate Bill 1473 was authored by Senator Richard Pan (D-Sacramento). The original version of the bill modified the laws relating to open enrollment periods for products sold at Covered California. In this form it cleared the Senate and moved to the Assembly where it was amended substantially. The amendments added language to expand SB 510 (Pan) of 2021 which established several coverage requirements related to COVID-19 testing and treatment, including out-of-network (OON) coverage.

In its new form SB 1473 required plans to cover OON COVID-19 testing, treatment and therapeutics for entire year after the expiration of the federal Public Health Emergency (PHE). The amended bill continued the retroactive application of COVID-19 coverage established by SB 510 but stated that there is no criminal liability for transactions that occurred prior to January 1, 2022. SB 1473 was an urgency measure meaning that a 2/3rds vote of both houses of the Legislature was required for it to pass and go into effect immediately upon signature by the Governor. Democrats hold 2/3rds super majorities in both houses.

CAHP was Opposed Unless Amended to this urgency measure because of the high OON costs plans continue to experience. Among other important amendments, CAHP asked that SB 1473 be amended to remove the requirements that health plans cover COVID-19 testing, services, and therapeutics at no share of cost for 12-months post-PHE. The proposed plan amendments instead terminate those obligations with the PHE expiration.

Leveraging the relatively high 2/3rds vote requirement, CAHP and its allies were able to pin this bill on the Assembly floor as we sought substantial amendments. The health plans ultimately removed opposition to SB 1473 once a different set of author drafted amendments were taken to change all the OON coverage requirements to 6 months after PHE instead or 12 months. The amendments also stated that plans are not required to pay bonus payments for the use of specialized equipment or expedited processing with respect to COVID testing. These author amendments fell short of our desired changes, but political dynamics forced the plans to accept the changes or end up with a worst-case scenario version of the bill.

Once the bill was amended on the Assembly floor it obtained the necessary votes primarily, with some exceptions, on a partisan basis with Democrats in support and Republicans in opposition.

REQUIREMENTS

SB 1473 amends Sections 1342.2, 1342.3, and 1399.848 of the Health and Safety Code, and amends Sections 10110.7, 10110.75, and 10965.4 of the Insurance Code, relating to health care coverage.

Specifically, SB 1473 does the following:

1) Requires coverage for therapeutics for COVID-19 approved or granted emergency use authorization by the federal Food and Drug Administration for COVID-19 when prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care. Requires coverage without cost-sharing or utilization management.

2) Requires a plan or insurer to reimburse a provider at the specifically negotiated rate for those therapeutics, if the plan and provider have negotiated a rate, and if not, permits the plan or insurer to negotiate a rate with the provider.

3) Requires for an out-of-network provider, the health plan or insurer to reimburse an amount that is reasonable, as determined in comparison to prevailing market rates for the therapeutics in the geographic in which the therapeutic was delivered. Requires the provider to accept this payment as payment in full, not seek remuneration from an enrollee or insured and not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee or insured.

4) Prohibits health care providers from reporting adverse information to a consumer reporting agency or commencing civil action against a health plan enrollee or insured who receives a COVID-19 test, vaccine, or therapeutic when assessed a charge by a provider.

5) Indicates that retroactivity requirements on plans and insurers to the beginning of the COVID-19 pandemic do not create criminal liability for transactions that occurred before January 1, 2022.

6) Requires CDI and DMHC to hold plans accountable for timely access to services and coverage requirements established under federal law, regulations, or guidelines.

7) Indicates services related to COVID-19 diagnostic and screening testing do not include bonus payments for the use of specialized equipment or expedited processing.

8) Indicates beginning six months after the federal public health emergency expires, a health plan or insurer shall no longer be required to cover the costsharing for COVID-19 testing, vaccinations, or therapeutics when delivered by an out-of-network provider, except as otherwise required by law.

9) Requires an individual health benefit plan offered through Covered California for policy years beginning on or after January 1, 2023, to provide an annual enrollment period of November 1 of the preceding calendar year to January 31 of the benefit year, inclusive.

10) Makes the effective dates of coverage for plans purchased through and outside of Covered California to be as follows:

    a) No later than January 1 of the benefit year for plan selection made from November 1 to December 31 of the preceding calendar year, inclusive; and,

    b) No later than February 1 of the benefit year for plan selection made from January 1 to January 31 of the benefit year, inclusive.

COMPLIANCE DATES

The urgency clause makes this law effective immediately.

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 Medi-Cal managed care plans.

Implementation Issues:

This bill eliminates the current special enrollment period offered through the Covered California health benefit exchange (12/16 of the preceding year to 1/31 of the benefit year) and replaces it with an annual enrollment period from November 1 of the preceding year to January 31 of the benefit year. Qualified health plans (QHPs) offering products through Covered California will need to operationalize these changes for the policy year starting January 1, 2023, and all years thereafter.

SB 1473 also builds upon the existing requirements of SB 510 (2021) and requires plans to cover, without cost sharing or utilization management (UM), therapeutics for COVID-19 approved or granted emergency use authorization by the federal FDA when prescribed or furnished by a licensed provider acting within their scope of practice and the standard of care. 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 therapeutics are not subject to prior authorization or any other UM requirements. Plans should also review provider contracts and member handbooks/Evidence of Coverage (EOC) to ensure that they comply with this requirement.

If a health plan does not have a specifically negotiated rate for COVID-19 therapeutics with an in-network provider, SB 1473 permits plans to negotiate such a rate.

Plans will need to ensure that administrative processes are in place to reimburse out-of-network providers for the lost cost sharing of any COVID-19 testing, services, and therapeutics delivered by those providers for at least six months following the expiration of the federal PHE. The law requires OON reimbursements to be “an amount that is reasonable,” which is still to be determined. Once the six months are up, plans are no longer obligated to cover cost sharing for COVID-19 testing, services, and therapeutics delivered by OON providers.

The DMHC anticipates issuing further SB 1473 guidance in the form of an All Plan Letter (APL) before the end of the 2022 calendar year.

Because CDI and the DMHC can hold plans accountable to timely access standards for these mandated services, plans should continue to ensure ongoing compliance with timely access and network adequacy standards.