

AMENDED IN ASSEMBLY JUNE 6, 2022

AMENDED IN SENATE MARCH 10, 2022

**SENATE BILL**

**No. 1473**

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**Introduced by Senator Pan**

February 18, 2022

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An act to amend ~~Section~~ *Sections 1342.2, 1342.3, and 1399.848* of the Health and Safety Code, and to amend ~~Section~~ *Sections 10110.7, 10110.75, and 10965.4* of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1473, as amended, Pan. Health care coverage: enrollment periods: coverage.

~~Existing~~

(1) *Existing* federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA.

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 provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to provide a special enrollment period for individual health benefit plans offered through

the Exchange from December 16 of the preceding calendar year to January 31 of the benefit year, inclusive, for policy years beginning on or after January 1, 2020. Under existing law, February 1 of the benefit year is the effective coverage date for individual health benefit plans offered outside and through the Exchange that are selected from December 16 to January 31, inclusive.

This bill would eliminate the above-described special enrollment period for individual health benefit plans offered through the Exchange for policy years on or after January 1, 2023, and would instead create an annual enrollment period from November 1 of the preceding calendar year to January 31 of the benefit year, inclusive. The bill would specify that the effective date of coverage for individual health benefit plans offered outside and through the Exchange would be 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 would be no later than February 1 of the benefit year for plan selection made from January 1 to January 31 of the benefit year, inclusive. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

*(2) Existing law requires 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 of testing and immunization for COVID-19, or a future disease when declared a public health emergency by the Governor, and prohibits the contract or policy from imposing cost sharing or prior authorization requirements for that coverage. Under existing law, the requirement to cover COVID-19 testing and immunizations delivered by an out-of-network provider without cost sharing does not apply to testing and immunizations furnished on or after the expiration of the federal public health emergency. A violation of these provisions by a health care service plan is a crime.*

*This bill would provide that a health care service plan or disability insurer is not required to cover the cost sharing for COVID-19 testing and immunizations delivered by an out-of-network provider beginning 12 months after the federal public health emergency expires. The bill would prohibit a provider from reporting adverse information to a consumer credit reporting agency or commence civil action against an enrollee or insured for payment of COVID-19-related items, services, or immunizations. The bill would extend these and the above-described*

*provisions to therapeutics 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. The bill would require a contract or policy to cover therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for a disease that the Governor has declared a public health emergency. The bill would eliminate a health care service plan’s criminal liability for a violation of COVID-19 testing and immunization coverage requirements that occurred before January 1, 2022.*

~~The~~

(3) *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.*

*Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.*

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

1     SECTION 1. *Section 1342.2 of the Health and Safety Code is*  
2 *amended to read:*  
3     1342.2. (a) *Notwithstanding any other law, a health care*  
4 *service plan contract that covers medical, surgical, and hospital*  
5 *benefits, excluding a specialized health care service plan contract,*  
6 *shall cover the costs for COVID-19 diagnostic and screening*  
7 *testing and health care services related to diagnostic and screening*  
8 *testing approved or granted emergency use authorization by the*  
9 *federal Food and Drug Administration for COVID-19, regardless*  
10 *of whether the services are provided by an in-network or*  
11 *out-of-network provider. Coverage required by this section shall*  
12 *not be subject to copayment, coinsurance, deductible, or any other*  
13 *form of cost sharing. Services related to COVID-19 diagnostic*  
14 *and screening testing include, but are not limited to, hospital or*  
15 *health care provider office visits for the purposes of receiving*  
16 *testing, products related to testing, the administration of testing,*  
17 *and items and services furnished to an enrollee as part of testing.*

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

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

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

11 (A) If the health plan has a specifically negotiated rate for  
12 COVID-19 diagnostic and screening testing with such provider in  
13 effect before the public health emergency declared under Section  
14 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such  
15 negotiated rate shall apply throughout the period of such  
16 declaration.

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

20 (4) ~~(A)~~ For an out-of-network provider with whom a health  
21 care service plan does not have a specifically negotiated rate for  
22 COVID-19 diagnostic and screening testing and health care  
23 services related to testing, a plan shall reimburse the provider for  
24 all testing items or services in an amount that is reasonable, as  
25 determined in comparison to prevailing market rates for testing  
26 items or services in the geographic region where the item or service  
27 is rendered. An out-of-network provider shall accept this payment  
28 as payment in ~~full and~~ full, shall not seek additional remuneration  
29 from an enrollee for services related to ~~testing~~. *testing, and shall*  
30 *not report adverse information to a consumer credit reporting*  
31 *agency or commence civil action against the enrollee.*

32 ~~(B) The requirement in this subdivision~~

33 (5) *Beginning 12 months after the federal public health*  
34 *emergency expires, a health care service plan shall no longer be*  
35 *required to cover the cost sharing for COVID-19 diagnostic and*  
36 *screening testing and health care services related to testing* ~~without~~  
37 ~~cost sharing~~, when delivered by an out-of-network provider, ~~shall~~  
38 ~~not apply with respect to COVID-19 diagnostic and screening~~  
39 ~~testing and services related to testing furnished on, or after, the~~  
40 ~~expiration of the federal public health emergency.~~ *except as*

1 *otherwise required by law.* All other requirements of this  
2 subdivision shall remain in effect after the federal public health  
3 emergency expires.

4 ~~(5)~~

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

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

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

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

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

36 (3) (A) A health care service plan subject to this subdivision  
37 shall not impose any cost-sharing requirements, including a  
38 copayment, coinsurance, or deductible, for any item, service, or  
39 immunization described in paragraph (1), regardless of whether

1 such service is delivered by an in-network or out-of-network  
2 provider.

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

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

10 (i) If the health plan has a negotiated rate with such provider in  
11 effect before the public health emergency declared under Section  
12 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such  
13 negotiated rate shall apply throughout the period of such  
14 declaration.

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

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

23 (E) (i) For an out-of-network provider with whom a health care  
24 service plan does not have a negotiated rate for an item, service,  
25 or immunization described in paragraph (1), a health care service  
26 plan shall reimburse the provider for all related items or services,  
27 including any items or services that are necessary for the furnishing  
28 of an item, service, or immunization described in paragraph (1),  
29 in an amount that is reasonable, as determined in comparison to  
30 prevailing market rates for such items or services in the geographic  
31 region in which the item or service is rendered. An out-of-network  
32 provider shall accept this payment as payment in ~~full and full~~, shall  
33 not seek additional remuneration from an ~~insured enrollee~~, and  
34 ~~shall not report adverse information to a consumer credit reporting~~  
35 ~~agency or commence civil action against the enrollee~~ for items,  
36 services, and immunizations described in subdivision (b), including  
37 any items or services that are necessary for the furnishing of an  
38 item, service, or immunization described in paragraph (1).

39 ~~(ii) The requirement in this paragraph~~

1 (ii) *Beginning 12 months after the federal public health*  
2 *emergency expires, a health care service plan shall no longer be*  
3 *required to cover the cost sharing for any item, service, or*  
4 *immunization described in paragraph (1) and to cover items or*  
5 *services that are necessary for the furnishing of the items, services,*  
6 *or immunizations described in ~~subparagraph (D) without cost~~*  
7 *sharing paragraph (1) when delivered by an out-of-network*  
8 *provider will not apply with respect to an item, service, or*  
9 *immunization furnished on or after the expiration of the federal*  
10 *public health emergency. provider, except as otherwise required*  
11 *by law.* All other requirements of this section shall remain in effect  
12 after the federal public health emergency expires.

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

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

27 (c) The director may issue guidance to health care service plans  
28 regarding compliance with this section. This guidance shall not  
29 be subject to the Administrative Procedure Act (Chapter 3.5  
30 (commencing with Section 11340) of Part 1 of Division 3 of Title  
31 2 of the Government Code). The department shall consult with the  
32 Department of Insurance in issuing the guidance specified in this  
33 subdivision.

34 (d) ~~This section~~ *section, excluding subdivision (h), shall apply*  
35 *retroactively beginning from the Governor's declared State of*  
36 *Emergency related to the SARS-CoV-2 (COVID-19) pandemic*  
37 *on March 4, 2020. Notwithstanding Section 1390, this subdivision*  
38 *does not create criminal liability for transactions that occurred*  
39 *before January 1, 2022.*

40 (e) For purposes of this section:

- 1 (1) “Diagnostic testing” means all of the following:
- 2 (A) Testing intended to identify current or past infection and  
3 performed when a person has signs or symptoms consistent with  
4 COVID-19, or when a person is asymptomatic but has recent  
5 known or suspected exposure to SARS-CoV-2.
- 6 (B) Testing a person with symptoms consistent with COVID-19.
- 7 (C) Testing a person as a result of contact tracing efforts.
- 8 (D) Testing a person who indicates that they were exposed to  
9 someone with a confirmed or suspected case of COVID-19.
- 10 (E) Testing a person after an individualized clinical assessment  
11 by a licensed health care provider.
- 12 (2) “Screening testing” means tests that are intended to identify  
13 people with COVID-19 who are asymptomatic and do not have  
14 known, suspected, or reported exposure to SARS-CoV-2. Screening  
15 testing helps to identify unknown cases so that measures can be  
16 taken to prevent further transmission. Screening testing includes  
17 all of the following:
- 18 (A) Workers in a workplace setting.
- 19 (B) Students, faculty, and staff in a school setting.
- 20 (C) A person before or after travel.
- 21 (D) At home for someone who does not have symptoms  
22 associated with COVID-19 and does not have a known exposure  
23 to someone with COVID-19.
- 24 (f) This section does not relieve a health care service plan from  
25 continuing to cover testing as required by federal law and guidance.
- 26 (g) *The department shall hold health care service plans*  
27 *accountable for timely access to services required under this*  
28 *section and coverage requirements established under federal law,*  
29 *regulations, or guidelines.*
- 30 (h) (1) *A health care service plan contract issued, amended,*  
31 *or renewed on or after the operative date of this subdivision that*  
32 *covers medical, surgical, and hospital benefits, excluding a*  
33 *specialized health care service plan contract, shall cover*  
34 *therapeutics approved or granted emergency use authorization by*  
35 *the federal Food and Drug Administration for COVID-19 when*  
36 *prescribed or furnished by a licensed health care provider acting*  
37 *within their scope of practice and the standard of care.*
- 38 (2) *A health care service plan shall reimburse a provider for*  
39 *the therapeutics described in paragraph (1) at the specifically*  
40 *negotiated rate for those therapeutics, if the plan and provider*

1 *have negotiated a rate. If the plan does not have a negotiated rate*  
2 *with a provider, the plan may negotiate a rate with the provider.*

3 *(3) For an out-of-network provider with whom a health care*  
4 *service plan does not have a negotiated rate for the therapeutics*  
5 *described in paragraph (1), a health care service plan shall*  
6 *reimburse the provider for the therapeutics in an amount that is*  
7 *reasonable, as determined in comparison to prevailing market*  
8 *rates for the therapeutics in the geographic region in which the*  
9 *therapeutic was delivered. An out-of-network provider shall accept*  
10 *this payment as payment in full, shall not seek additional*  
11 *remuneration from an enrollee, and shall not report adverse*  
12 *information to a consumer credit reporting agency or commence*  
13 *civil action against the enrollee for therapeutics described in this*  
14 *subdivision.*

15 *(4) A health care service plan shall cover COVID-19*  
16 *therapeutics without cost sharing, regardless of whether the*  
17 *therapeutics are provided by an in-network or out-of-network*  
18 *provider, and without utilization management. If a provider would*  
19 *have been entitled to receive cost sharing but for this section, the*  
20 *health care service plan shall reimburse the provider for the*  
21 *amount of that lost cost sharing. A provider shall accept this*  
22 *payment as payment in full, shall not seek additional remuneration*  
23 *from an enrollee, and shall not report adverse information to a*  
24 *consumer credit reporting agency or commence civil action against*  
25 *the enrollee for therapeutics pursuant to this subdivision.*

26 *(5) Beginning 12 months after the federal public health*  
27 *emergency expires, a health care service plan shall no longer be*  
28 *required to cover the cost sharing for COVID-19 therapeutics*  
29 *delivered by an out-of-network provider, unless otherwise required*  
30 *by law. All other requirements of this subdivision shall remain in*  
31 *effect after the federal public health emergency expires.*

32 *SEC. 2. Section 1342.3 of the Health and Safety Code is*  
33 *amended to read:*

34 1342.3. (a) A health care service plan contract that covers  
35 medical, surgical, and hospital benefits, excluding a specialized  
36 health care service plan contract, shall cover, without cost sharing  
37 and without prior authorization or other utilization management,  
38 the costs of the following health care services to prevent or mitigate  
39 a disease when the Governor of the State of California has declared  
40 a public health emergency due to that disease:

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

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

12 (3) *Therapeutics approved or granted emergency use*  
13 *authorization by the federal Food and Drug Administration for*  
14 *the disease.*

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

22 **SECTION 4.**

23 *SEC. 3.* Section 1399.848 of the Health and Safety Code is  
24 amended to read:

25 1399.848. (a) Notwithstanding paragraph (1) of subdivision  
26 (c) of Section 1399.849, with respect to individual health benefit  
27 plans offered outside of the Exchange, a plan shall provide an  
28 annual enrollment period for policy years beginning on or after  
29 January 1, 2020, from November 1 of the preceding calendar year,  
30 to January 31 of the benefit year, inclusive.

31 (b) Notwithstanding paragraphs (2) and (3) of subdivision (c)  
32 of Section 1399.849, with respect to individual health benefit plans  
33 offered through the Exchange, for policy years beginning on or  
34 after January 1, 2023, a plan shall provide an annual enrollment  
35 period from November 1 of the preceding calendar year to January  
36 31 of the benefit year, inclusive.

37 (c) Notwithstanding paragraph (3) of subdivision (c) of Section  
38 1399.849, with respect to individual health benefit plans offered  
39 outside and through the Exchange, the effective date of coverage  
40 shall be as follows:

1 (1) No later than January 1 of the benefit year for plan selection  
2 made from November 1 to December 31 of the preceding calendar  
3 year, inclusive.

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

6 *SEC. 4. Section 10110.7 of the Insurance Code is amended to*  
7 *read:*

8 10110.7. (a) This section applies to a disability insurance  
9 policy that provides coverage for hospital, medical, or surgical  
10 benefits, excluding a specialized health insurance policy and a  
11 policy that provides excepted benefits as described in Sections  
12 2722 (42 U.S.C. Sec. 300gg-21) and 2791 (42 U.S.C. Sec.  
13 300gg-91) of the federal Public Health Service Act, subject to  
14 Section 10198.61.

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

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

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

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

37 (A) If the health insurer has a specifically negotiated rate for  
38 COVID-19 diagnostic and screening testing with such provider in  
39 effect before the public health emergency declared under Section  
40 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such

1 negotiated rate shall apply throughout the period of such  
2 declaration.

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

6 (4) (A) For an out-of-network provider with whom an insurer  
7 does not have a specifically negotiated rate for COVID-19  
8 diagnostic and screening testing and health care services related  
9 to testing, an insurer shall reimburse the provider for all testing  
10 items or services in an amount that is reasonable, as determined  
11 in comparison to prevailing market rates for testing items or  
12 services in the geographic region where the item or service is  
13 rendered. An out-of-network provider shall accept this payment  
14 as payment in ~~full and full~~, shall not seek additional remuneration  
15 from an insured for services related to ~~testing~~. *testing, and shall*  
16 *not report adverse information to a consumer credit reporting*  
17 *agency or commence civil action against the insured.*

18 ~~(B) The requirement in this subdivision~~

19 (5) *Beginning 12 months after the federal public health*  
20 *emergency expires, an insurer shall no longer be required to cover*  
21 *the cost sharing for COVID-19 diagnostic and screening testing*  
22 *and health care services related to testing without cost sharing*  
23 *when delivered by an out-of-network provider will not apply with*  
24 *respect to COVID-19 diagnostic and screening testing and health*  
25 *care services related to testing furnished on or after the expiration*  
26 *of the federal public health emergency. provider, except as*  
27 *otherwise required by law.* All other requirements of this  
28 subdivision shall remain in effect after the federal public health  
29 emergency expires.

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

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

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

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

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

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

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

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

31 (i) If the health insurer has a negotiated rate with such provider  
32 in effect before the public health emergency declared under Section  
33 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such  
34 negotiated rate shall apply throughout the period of such  
35 declaration.

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

38 (D) For an out-of-network provider with whom a disability  
39 insurer does not have a negotiated rate for an item, service, or  
40 immunization described in paragraph (1), an insurer shall reimburse

1 the provider for all such items or services, including any items or  
 2 services that are necessary for the furnishing of an item, service,  
 3 or immunization described in paragraph (1), in an amount that is  
 4 reasonable, as determined in comparison to prevailing market rates  
 5 for such items or services in the geographic region in which the  
 6 item or service is rendered. An out-of-network provider shall accept  
 7 this payment as payment in ~~full~~ and full, shall not seek additional  
 8 remuneration from an ~~insured~~ insured, and shall not report adverse  
 9 information to a consumer credit reporting agency or commence  
 10 civil action against the insured for items, services, and  
 11 immunizations described in paragraph (1), including any items or  
 12 services that are necessary for the furnishing of an item, service,  
 13 or immunization described in paragraph (1).

14 (E) ~~The requirement in this subdivision~~ *Beginning 12 months*  
 15 *after the federal public health emergency expires, an insurer shall*  
 16 *no longer be required to cover the cost sharing for any item,*  
 17 *service, or immunization described in paragraph (1) and to cover*  
 18 *any items or services that are necessary for the furnishing of the*  
 19 *items, services, or immunizations described in* ~~subparagraph (B);~~  
 20 ~~without cost sharing~~ *paragraph (1)* when delivered by an  
 21 out-of-network provider will not apply with respect to an item,  
 22 service, or immunization furnished on or after the expiration of  
 23 the federal public health emergency. *provider, except as otherwise*  
 24 *required by law.* All other requirements of this section shall remain  
 25 in effect after the federal public health emergency expires.

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

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

39 (e) ~~This section~~ *section, excluding subdivision (i), shall apply*  
 40 *retroactively beginning from the Governor's declared State of*

1 Emergency related to the SARS-CoV-2 (COVID-19) pandemic  
2 on March 4, 2020.

3 (f) For purposes of this section:

4 (1) “Diagnostic testing” means all of the following:

5 (A) Testing intended to identify current or past infection and  
6 performed when a person has signs or symptoms consistent with  
7 COVID-19, or when a person is asymptomatic but has recent  
8 known or suspected exposure to SARS-CoV-2.

9 (B) Testing a person with symptoms consistent with COVID-19.

10 (C) Testing a person as a result of contact tracing efforts.

11 (D) Testing a person who indicates that they were exposed to  
12 someone with a confirmed or suspected case of COVID-19.

13 (E) Testing a person after an individualized clinical assessment  
14 by a licensed health care provider.

15 (2) “Screening testing” means tests that are intended to identify  
16 people with COVID-19 who are asymptomatic and do not have  
17 known, suspected, or reported exposure to SARS-CoV-2. Screening  
18 testing helps to identify unknown cases so that measures can be  
19 taken to prevent further transmission. Screening testing includes  
20 all of the following:

21 (A) Workers in a workplace setting.

22 (B) Students, faculty, and staff in a school setting.

23 (C) A person before or after travel.

24 (D) At home for someone who does not have symptoms  
25 associated with COVID-19 and does not have a known exposure  
26 to someone with COVID-19.

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

29 (h) *The department shall hold insurers accountable for timely*  
30 *access to services required under this section and coverage*  
31 *requirements established under federal law, regulations, or*  
32 *guidelines.*

33 (i) (1) *A disability insurance policy issued, amended, or*  
34 *renewed on or after the operative date of this subdivision that*  
35 *covers medical, surgical, and hospital benefits, excluding a*  
36 *specialized disability insurance policy, shall cover therapeutics*  
37 *approved or granted emergency use authorization by the federal*  
38 *Food and Drug Administration for COVID-19 when prescribed*  
39 *or furnished by a licensed health care provider acting within their*  
40 *scope of practice and the standard of care.*

1 (2) A disability insurer shall reimburse a provider for the  
2 therapeutics described in paragraph (1) at the specifically  
3 negotiated rate for those therapeutics, if the insurer and provider  
4 have negotiated a rate. If the insurer does not have a negotiated  
5 rate with a provider, the insurer may negotiate a rate with the  
6 provider.

7 (3) For an out-of-network provider with whom a disability  
8 insurer does not have a negotiated rate for the therapeutics  
9 described in paragraph (1), a disability insurer shall reimburse  
10 the provider for the therapeutics in an amount that is reasonable,  
11 as determined in comparison to prevailing market rates for the  
12 therapeutics in the geographic region in which the therapeutic  
13 was delivered. An out-of-network provider shall accept this  
14 payment as payment in full, shall not seek additional remuneration  
15 from an insured, and shall not report adverse information to a  
16 consumer credit reporting agency or commence civil action against  
17 the insured for therapeutics described in this subdivision.

18 (4) A disability insurer shall cover COVID-19 therapeutics  
19 without cost sharing, regardless of whether the therapeutics are  
20 provided by an in-network or out-of-network provider, and without  
21 utilization management. If a provider would have been entitled to  
22 receive cost sharing but for this section, the disability insurer shall  
23 reimburse the provider for the amount of that lost cost sharing. A  
24 provider shall accept this payment as payment in full, shall not  
25 seek additional remuneration from an insured, and shall not report  
26 adverse information to a consumer credit reporting agency or  
27 commence civil action against the insured for therapeutics pursuant  
28 to this subdivision.

29 (5) Beginning 12 months after the federal public health  
30 emergency expires, a disability insurer shall no longer be required  
31 to cover the cost sharing for COVID-19 therapeutics delivered by  
32 an out-of-network provider, unless otherwise required by law. All  
33 other requirements of this subdivision shall remain in effect after  
34 the federal public health emergency expires.

35 SEC. 5. Section 10110.75 of the Insurance Code is amended  
36 to read:

37 10110.75. (a) This section applies to a disability insurance  
38 policy that provides coverage for hospital, medical, or surgical  
39 benefits, excluding a specialized health insurance policy.

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

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

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

18 (C) *Therapeutics approved or granted emergency use*  
19 *authorization by the federal Food and Drug Administration for*  
20 *the disease.*

21 (2) The item, service, or immunization covered pursuant to  
22 subparagraph (A) of paragraph (1) shall be covered no later than  
23 15 business days after the date on which the United States  
24 Preventive Services Task Force or the Advisory Committee on  
25 Immunization Practices of the federal Centers for Disease Control  
26 and Prevention makes a recommendation relating to the item,  
27 service, or immunization.

28 ~~SEC. 2.~~

29 *SEC. 6.* Section 10965.4 of the Insurance Code is amended to  
30 read:

31 10965.4. (a) Notwithstanding paragraph (1) of subdivision (c)  
32 of Section 10965.3, with respect to individual health benefit plans  
33 offered outside of the Exchange, a health insurer shall provide an  
34 annual enrollment period for policy years beginning on or after  
35 January 1, 2020, from November 1 of the preceding calendar year,  
36 to January 31 of the benefit year, inclusive.

37 (b) Notwithstanding paragraphs (2) and (3) of subdivision (c)  
38 of Section 10965.3, with respect to individual health benefit plans  
39 offered through the Exchange, for policy years beginning on or  
40 after January 1, 2023, a health insurer shall provide an annual

1 enrollment period from November 1 of the preceding calendar  
2 year to January 31 of the benefit year, inclusive.

3 (c) Notwithstanding paragraph (3) of subdivision (c) of Section  
4 10965.3, with respect to individual health benefit plans offered  
5 outside and through the Exchange, the effective date of coverage  
6 shall be as follows:

7 (1) No later than January 1 of the benefit year for plan selection  
8 made from November 1 to December 31 of the preceding calendar  
9 year, inclusive.

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

12 ~~SEC. 3.~~

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