ASSEMBLY BILL No. 1645

Introduced by Assembly Member Zbur

February 17, 2023

An act to amend Section 1367.002 of, and to add Section 1367.0021 to, the Health and Safety Code, and to amend Section 10112.2 of, and to add Section 10112.20 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1645, as introduced, Zbur. Health care coverage: cost sharing.

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 group or individual nongrandfathered health care service plan contract or health insurance policy to provide coverage for, and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings.

This bill would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, from imposing a cost-sharing requirement for office visits for the above-described preventive care services and screenings and for items or services that are integral to their provision. The bill would prohibit those contracts and policies from imposing a cost-sharing requirement, utilization review, or other specified limits on a recommended sexually transmitted infections screening, and from imposing a cost-sharing requirement for any items

and services integral to a sexually transmitted infections screening, as specified. The bill would require a plan or insurer to directly reimburse a nonparticipating provider or facility of sexually transmitted infections screening that meets specified criteria its median contracted rate in the general geographic region for screening tests and integral items and services rendered, and would prohibit a nonparticipating provider from billing or collecting a cost-sharing amount for a sexually transmitted infections screening from an enrollee or insured. Because a violation of the bill's requirements 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.

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

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

SECTION 1. Section 1367.002 of the Health and Safety Code is amended to read:

1367.002. (a) A group or individual ~~nongrandfathered~~ health care service plan contract shall, at a minimum, provide coverage ~~for~~ *for,* and shall not impose any cost-sharing requirements ~~for~~ *for,* any of the following:

(1) Evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force, as periodically updated.

(2) Immunizations that have in effect a recommendation, as periodically updated, from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health

Resources and Services Administration for purposes of this paragraph.

(5) For the purposes of this ~~section, the~~ *section:*

(A) The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most ~~current other than~~ *current, not including* those issued in or around November 2009.

(B) A health care service plan contract issued, amended, or renewed on or after January 1, 2024, shall not impose any cost-sharing requirement for office visits that are associated with the provision of an item or service that is required by this subdivision, or for any items or services that are integral to the provision of an item or service that is required by this subdivision, regardless of whether the office visit or integral item or service is billed, or tracked as individual encounter data, separately from an item or service that is required by this subdivision.

(i) "Integral item or service" means an item, service, prescription drug, device, or product, or nonprescription drug, device, or product, that is a current, generally accepted standard of care or clinical practice for the provision of an item or service that is required by this subdivision.

(ii) "Current, generally accepted standard of care or clinical practice" means standards of care and clinical practice that are generally accepted by health care providers practicing in relevant clinical specialties, such as family medicine, pediatrics, preventive medicine, infectious diseases, obstetrics and gynecology, and public health. Valid, evidence-based sources establishing current, generally accepted standards of care and clinical practice include peer-reviewed scientific studies and medical literature, the most recently updated clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, including the American College of Obstetricians and Gynecologists and the federal Centers for Disease Control and Prevention, and product labeling approved by the United States Food and Drug Administration.

(b) This section does not prohibit a health care service plan ~~contract from providing~~ *from doing either of the following:*

(1) Providing coverage for *preventive items or* services in addition to those ~~recommended by the United States Preventive Services Task Force or to deny~~ *required by subdivision (a).*

(2) Denying coverage for services that are not recommended by the United States Preventive Services Task ~~Force.~~ *Force, except as provided by subdivision (d).*

(c) A health care service plan shall provide coverage pursuant to subdivision (a) for plan years that begin on or after the date that is one year after the date ~~the~~ *that a novel* recommendation or guideline is issued. *A health care service plan shall provide coverage for modified or upgraded recommendations or guidelines pursuant to subdivision (a) no later than the first day of the plan year after the modification or upgrade was adopted or 90 days after the date on which the modification or upgrade was adopted, whichever is earlier in the calendar year.*

(1) A health care service plan that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a plan year shall provide coverage through the last day of the plan year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the plan year.

(2) Notwithstanding paragraph (1), if a recommendation or guideline described in paragraph (1) of subdivision (a) that was in effect on the first day of a plan year is downgraded to a "D" rating, or if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a plan year, a health care service plan is not required to cover the item or service through the last day of the plan year.

(d) (1) A health care service plan contract shall cover items and services pursuant to this section in accordance with an applicable requirement of this chapter, including Sections 1342.74 on prophylaxis of HIV infection, 1367.0021 on sexually transmitted infections screening, 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021 on home test kits for sexually transmitted diseases, and 1367.668 on colorectal cancer screening.

(2) Notwithstanding paragraph (1), Section 1367.25 shall exclusively govern the coverage of contraceptive drugs, devices, and products pursuant to this chapter.

~~(d)~~

(e) This section does not apply to a *health care service plan contract that is a grandfathered health plan, or to a* specialized health care service plan that does not cover an essential health benefit, as defined in Section 1367.005. ~~This~~ *The cost-sharing requirements of this* section shall only apply to a health savings account-eligible health care service plan to the extent it does not fail to be treated as a high deductible health plan under Section 223 of Title 26 of the United States Code.

~~(e)~~

(f) The department shall coordinate with the Department of Insurance if it adopts regulations to implement this section.

SEC. 2. Section 1367.0021 is added to the Health and Safety Code, to read:

1367.0021. (a) In addition to the items and services that are required by Section 1367.002, a group or individual health care service plan contract issued, amended, or renewed on or after January 1, 2024, shall not impose a cost-sharing requirement on a sexually transmitted infections screening that is recommended by the federal Centers for Disease Control and Prevention (CDC) in the most recently updated version of its Sexually Transmitted Infections Treatment Guidelines, as subsequently modified by any published updates in the Morbidity and Mortality Weekly Report or similar method of official public communication. If a screening recommendation of the United States Preventive Services Task Force conflicts with that of the CDC, or omits a CDC screening recommendation, a health care service plan contract shall not require any cost sharing for a sexually transmitted infections screening, or for any items and services that are integral to a screening, that is performed by an essential community provider or participating provider, facility, or processing laboratory consistent with the CDC's recommendation.

(b) Notwithstanding Section 2713 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg), a health care service plan contract issued, amended, or renewed on or after January 1, 2024, shall not require or impose any of the following for coverage of sexually transmitted infections screening, or of any items and services that are integral to a screening, that is performed by an essential community provider or participating provider, facility, or processing laboratory:

(1) Prior authorization or other utilization review requirements.

(2) Limits on frequency, method, treatment, or setting.

(3) Limits on confirmatory or post-treatment retesting of an asymptomatic patient.

(4) Limits that are based on risk of infection, sexual behavior, sexual orientation, gender, or anatomical sites of screening.

(5) Any other limits on the coverage or provision of sexually transmitted infections screening as a preventive item or service under this section, Section 1367.002, or Section 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021, as a preventive basic health care service, or that constitutes a discriminatory benefit design or marketing practice as prohibited by this chapter.

(c) A health care service plan contract issued, amended, or renewed on or after January 1, 2024, shall not impose a cost-sharing requirement for sexually transmitted infections screening, or for any items and services that are integral to a screening, under this section, Section 1367.002, or Section 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021, regardless of any of the following:

(1) The location or method of sample collection or processing, including at locations that are both clinical and nonclinical in nature, regardless of whether a location constitutes a health care setting.

(2) The screening test, testing method or algorithm, or method of sample collection or processing.

(3) The identity or qualifications of the individual who collected or processed a sample.

(4) The clinical circumstances of screening, including whether or not a screening was based on risk of infection, or there was an emergent or urgent need for immediate or prompt screening or the results of screening.

(d) A health care service plan shall directly reimburse a nonparticipating provider or facility of sexually transmitted infections screening its median contracted rate in the general geographic region for screening tests and integral items and services rendered, if the provider or facility was an essential community provider when the screening tests and integral items and services were rendered. If a nonparticipating essential community provider does not generate the results of screening, the provider shall submit the samples to a participating processing

laboratory. A nonparticipating essential community provider shall not bill or collect any cost-sharing amounts from an enrollee for a sexually transmitted infections screening, or for integral items and services, under this section, Section 1367.002, or Section 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021.

(e) For purposes of this section:

(1) "Essential community provider" means a provider or facility that is eligible for listing, and is listed, on the California Health Benefit Exchange's Essential Community Provider List.

(2) "General geographic region" has the same meaning as provided by Section 1371.31 and the regulations promulgated thereunder.

(3) "Gender" means sex, including gender identity and gender expression.

(4) "Gender expression" means gender-related appearance and behavior, whether or not stereotypically associated with assigned sex at birth.

(5) "Utilization review" has the same meaning as defined by Section 1374.721 and any regulations promulgated thereunder.

(f) This section does not apply to a specialized health care service plan contract that does not cover an essential health benefit, as defined by Section 1367.005. If a health care service plan contract is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the contract shall not impose a deductible on sexually transmitted infections screening, or on integral items and services, under this section, Section 1367.002, or Section 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021, unless not applying the deductible would conflict with federal requirements for high deductible health plans.

SEC. 3. Section 10112.2 of the Insurance Code is amended to read:

10112.2. (a) A group or individual ~~nongrandfathered~~ health insurance policy shall, at a minimum, provide coverage ~~for~~ *for,* and shall not impose any cost-sharing requirements ~~for~~ *for,* any of the following:

(1) Evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force, as periodically updated.

(2) Immunizations that have in effect a recommendation, as periodically updated, from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration for purposes of this paragraph.

(5) For the purposes of this ~~section, the~~ *section:*

(A) The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most ~~current other than~~ *current, not including* those issued in or around November 2009.

(B) A health insurance policy issued, amended, or renewed on or after January 1, 2024, shall not impose any cost-sharing requirement for office visits that are associated with the provision of an item or service that is required by this subdivision, or for any items or services that are integral to the provision of an item or service that is required by this subdivision, regardless of whether the office visit or integral item or service is billed, or tracked as individual encounter data, separately from an item or service that is required by this subdivision.

(i) "Integral item or service" means an item, service, prescription drug, device, or product, or nonprescription drug, device, or product, that is a current, generally accepted standard of care or clinical practice for the provision of an item or service that is required by this subdivision.

(ii) "Current, generally accepted standard of care or clinical practice" means standards of care and clinical practice that are generally accepted by health care providers practicing in relevant clinical specialties, such as family medicine, pediatrics, preventive medicine, infectious diseases, obstetrics and gynecology, and public health. Valid, evidence-based sources establishing current, generally accepted standards of care and clinical practice include

peer-reviewed scientific studies and medical literature, the most recently updated clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, including the American College of Obstetricians and Gynecologists and the federal Centers for Disease Control and Prevention, and product labeling approved by the United States Food and Drug Administration.

(b) This section does not prohibit a health ~~insurance policy from providing~~ *insurer from doing either of the following:*

(1) Providing coverage for services in addition to those ~~recommended by the United States Preventive Services Task Force or to deny~~ *required by subdivision (a).*

(2) Denying coverage for services that are not recommended by the United States Preventive Services Task ~~Force.~~ *Force, except as provided by subdivision (d).*

(c) A health insurer shall provide coverage pursuant to subdivision (a) for policy years that begin on or after the date that is one year after the date ~~the~~ *that a novel* recommendation or guideline is issued. *A health insurer shall provide coverage for modified or upgraded recommendations or guidelines pursuant to subdivision (a) no later than the first day of the plan year after the modification or upgrade was adopted or 90 days after the date on which the modification or upgrade was adopted, whichever is earlier in the calendar year.*

(1) A health insurer that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a policy year shall provide coverage through the last day of the policy year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the policy year.

(2) Notwithstanding paragraph (1), if a recommendation or guideline described in paragraph (1) of subdivision (a) that was in effect on the first day of a policy year is downgraded to a "D" rating, or if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a policy year, a health insurer is not required to cover the item or service through the last day of the policy year.

(d) (1) A health insurance policy shall cover items and services pursuant to this section in accordance with an applicable requirement of this part, including Sections 10112.20 on sexually transmitted infections screening, 10123.1933 on prophylaxis of HIV infection, 10123.207 on colorectal cancer screening, and 10123.208 on home test kits for sexually transmitted diseases.

(2) Notwithstanding paragraph (1), Section 10123.196 shall exclusively govern the coverage of contraceptive drugs, devices, and products pursuant to this part.

~~(d)~~

(e) This section does not apply to a *health insurance policy that is a grandfathered health plan, or to a* specialized health insurance policy that does not cover an essential health benefit, as defined in Section 10112.27. ~~This~~ *The cost-sharing requirements of this* section shall only apply to a health savings account-eligible health insurance policy to the extent it does not fail to be treated as a high deductible health ~~insurance policy~~ *plan* under Section 223 of Title 26 of the United States Code.

~~(e)~~

(f) The department shall coordinate with the Department of Managed Health Care if it adopts regulations to implement this section.

(g) The commissioner and department may exercise the authority provided by this code and the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4.5 (commencing with Section 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code) to implement and enforce this section and all related sections, including those referenced herein. If the commissioner assesses a civil penalty for a violation, any hearing that is requested by the insurer shall be conducted by an administrative law judge of the Administrative Hearing Bureau of the department under the formal procedure of Chapter 5. This subdivision does not impair or restrict the commissioner's authority pursuant to another provision of this code or the Administrative Procedure Act.

SEC. 4. Section 10112.20 is added to the Insurance Code, immediately following Section 10112.2, to read:

10112.20. (a) In addition to the items and services that are required by Section 10112.2, a group or individual health insurance

policy issued, amended, or renewed on or after January 1, 2024, shall not impose a cost-sharing requirement on a sexually transmitted infections screening that is recommended by the federal Centers for Disease Control and Prevention (CDC) in the most recently updated version of its Sexually Transmitted Infections Treatment Guidelines, as subsequently modified by any published updates in the Morbidity and Mortality Weekly Report or similar method of official public communication. If a screening recommendation of the United States Preventive Services Task Force conflicts with that of the CDC, or omits a CDC screening recommendation, a health insurance policy shall not require any cost sharing for a sexually transmitted infections screening, or for any items and services that are integral to a screening, that is performed by an essential community provider or participating provider, facility, or processing laboratory consistent with the CDC's recommendation.

(b) Notwithstanding Section 2713 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg), a health insurance policy issued, amended, or renewed on or after January 1, 2024, shall not require or impose any of the following for coverage of sexually transmitted infections screening, or of any items and services that are integral to a screening, that is performed by an essential community provider or participating provider, facility, or processing laboratory:

(1) Prior authorization or other utilization review requirements.

(2) Limits on frequency, method, treatment, or setting.

(3) Limits on confirmatory or post-treatment retesting of an asymptomatic patient.

(4) Limits that are based on risk of infection, sexual behavior, sexual orientation, gender, or anatomical sites of screening.

(5) Any other limits on the coverage or provision of sexually transmitted infections screening as a preventive item or service under this section, Section 10112.2, or Section 10123.208, as a preventive basic health care service, or that constitutes a discriminatory benefit design or marketing practice as prohibited by this chapter.

(c) A health insurance policy issued, amended, or renewed on or after January 1, 2024, shall not impose a cost-sharing requirement for sexually transmitted infections screening, or for any items and services that are integral to a screening, under this

section, Section 10112.2, or Section 10123.208, regardless of any of the following:

(1) The location or method of sample collection or processing, including at locations that are both clinical and nonclinical in nature, regardless of whether a location constitutes a health care setting.

(2) The screening test, testing method or algorithm, or method of sample collection or processing.

(3) The identity or qualifications of the individual who collected or processed a sample.

(4) The clinical circumstances of screening, including whether or not a screening was based on risk of infection, or there was an emergent or urgent need for immediate or prompt screening or the results of screening.

(d) A health insurer shall directly reimburse a nonparticipating provider or facility of sexually transmitted infections screening its median contracted rate in the general geographic region for screening tests and integral items and services rendered, if the provider or facility was an essential community provider when the screening tests and integral items and services were rendered. If a nonparticipating essential community provider does not generate the results of screening, the provider shall submit the samples to a participating processing laboratory. A nonparticipating essential community provider shall not bill or collect any cost sharing amounts from an insured for a sexually transmitted infections screening, or for integral items and services, under this section, Section 10112.2, or Section 10123.208.

(e) For purposes of this section:

(1) “Essential community provider” means a provider or facility that is eligible for listing, and is listed, on the California Health Benefit Exchange’s Essential Community Provider List.

(2) “General geographic region” has the same meaning as provided by Section 10112.82 and the regulations promulgated thereunder.

(3) “Gender” means sex, including gender identity and gender expression.

(4) “Gender expression” means gender-related appearance and behavior, whether or not stereotypically associated with assigned sex at birth.

(5) "Utilization review" has the same meaning as defined by Section 10144.52 and any regulations promulgated thereunder.

(f) This section does not apply to a specialized health insurance policy that does not cover an essential health benefit, as defined by Section 10112.27. If a health insurance policy is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the policy shall not impose a deductible on sexually transmitted infections screening, or on integral items and services, under this section, Section 10112.2, or Section 10123.208, unless not applying the deductible would conflict with federal requirements for high deductible health plans.

SEC. 5. 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.

O