AMENDED IN ASSEMBLY JUNE 6, 2022

AMENDED IN SENATE MARCH 10, 2022

SENATE BILL No. 1473

Introduced by Senator Pan

February 18, 2022

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:

SECTION 1. Section 1342.2 of the Health and Safety Code is amended 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~~ *full,* shall not seek additional remuneration from an enrollee for services related to ~~testing.~~ *testing, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee.*

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

(5) Beginning 12 months after the federal public health emergency expires, a health care service plan shall no longer be required to cover *the cost sharing for* 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.~~ *except as*

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

~~(5)~~

(6) 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~~ *full*, shall not seek additional remuneration from an ~~insured~~ *enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee* 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~~

(ii) Beginning 12 months after the federal public health emergency expires, a health care service plan shall no longer be required to cover *the cost sharing for* 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~~ *paragraph (1)* 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.~~ *provider, except as otherwise required by law.* 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~~ *section, excluding subdivision (h),* 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. *Notwithstanding Section 1390, this subdivision does not create criminal liability for transactions that occurred before January 1, 2022.*

(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.

(g) The department shall hold health care service plans accountable for timely access to services required under this section and coverage requirements established under federal law, regulations, or guidelines.

(h) (1) A health care service plan contract issued, amended, or renewed on or after the operative date of this subdivision that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, shall cover 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.

(2) A health care service plan shall reimburse a provider for the therapeutics described in paragraph (1) at the specifically negotiated rate for those therapeutics, if the plan and provider

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

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

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

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

SEC. 2. Section 1342.3 of the Health and Safety Code is amended 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.

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

(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.

~~SECTION 1.~~

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

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

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

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

(1) 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.

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

SEC. 4. Section 10110.7 of the Insurance Code is amended 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~~ *full,* shall not seek additional remuneration from an insured for services related to ~~testing.~~ *testing, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured.*

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

(5) Beginning 12 months after the federal public health emergency expires, an insurer shall no longer be required to cover *the cost sharing for* 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.~~ *provider, except as otherwise required by law.* 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~~ *full*, shall not seek additional remuneration from an ~~insured~~ *insured, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the 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~~ *Beginning 12 months after the federal public health emergency expires, an insurer shall no longer be required* to cover *the cost sharing for* 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~~ *paragraph (1)* 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.~~ *provider, except as otherwise required by law.* 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~~ *section, excluding subdivision (i),* 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.

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

(i) (1) A disability insurance policy issued, amended, or renewed on or after the operative date of this subdivision that covers medical, surgical, and hospital benefits, excluding a specialized disability insurance policy, shall cover 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.

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

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

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

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

SEC. 5. Section 10110.75 of the Insurance Code is amended 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.

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

(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. 2.~~

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

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

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

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

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

(1) 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.

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

~~SEC. 3.~~

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.

O