CHA | California Hospital Association

FAQs

Dec. 20, 2021

Senate Bill (SB) 510: Reimbursement for COVID-19 Testing and Vaccination

Overview

SB 510 (*Statutes of 2021, Ch. 729)* was signed by Gov. Newsom on October 8, 2021, and takes effect on January 1, 2022. The bill requires health plans regulated by the Department of Managed Health Care and health insurers regulated by the Department of Insurance to reimburse both in-network and out-of-network providers for COVID-19 testing and related services without any cost-sharing, prior authorization, or other utilization management requirements. The bill also addresses COVID-19 vaccines. CHA supported this bill.

Q: Which tests must be covered?

A: Diagnostic and screening tests approved or granted emergency use authorization by the federal Food and Drug Administration for COVID-19 must be covered.

- **"Diagnostic testing"** means all the following:
  - 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
  - Testing a person with symptoms consistent with COVID-19
  - Testing a person as a result of contact tracing efforts
  - Testing a person who indicates that they were exposed to someone with a confirmed or suspected case of COVID-19
  - Testing a person after an individualized clinical assessment by a licensed health care provider
- **"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 the following:
  - Workers in a workplace setting
  - Students, faculty, and staff in a school setting
  - A person before or after travel
  - 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
- Health care services related to diagnostic and screening testing. These services 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 a patient as part of testing.

Q: Are patients required to get tested by an in-network provider?

A: No. The health plan or insurance company must pay the provider, regardless of whether the services are provided by an in-network or out-of-network provider. The patient is not responsible for any copay, coinsurance, deductible, or other form of cost sharing. The plan or insurer must reimburse the provider for any cost-sharing amount that would have been required in the absence of this law. However, the requirement to pay for testing without cost sharing for an out-of-network provider ends when the federal public health emergency expires.

Q: How much must the plan/insurer pay?

A: If the plan or insurer had a specifically negotiated rate for COVID-19 testing with a provider in effect before the federal public health emergency was declared on Jan. 31, 2020, then that rate applies until that emergency declaration ends. It is unlikely that specific rates for COVID testing were negotiated at that time. If there was no negotiated rate, the provider and plan may negotiate a rate.

For out-of-network providers with no specifically negotiated rate, plans must reimburse the provider 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 must accept this payment as payment in full and may not seek additional payment from the patient. The governor has directed the Department of Managed Health Care to issue regulations regarding what is reasonable.

Q: Are plans/insurers required to pay for testing provided before January 1, 2022?

A: SB 510 includes a provision for plans and insurers to pay for COVID-19 testing retroactive to March 4, 2020 – the date Gov. Newsom declared a state of emergency due to the pandemic. However, the California Association of Health Plans (CAHP) has filed a lawsuit to invalidate this provision. Hopefully the court will deny CAHP's request, and hospitals will be allowed to seek reimbursement for testing of employees as required or recommended by the California Department of Public Health. CHA will monitor the lawsuit and keep hospitals informed of developments.

Q: Are there similar requirements for COVID-19 vaccines?

A: Yes. Health plans and insurers must cover without cost sharing, prior authorization, or other utilization management, any item, service, or immunization that is intended to prevent or mitigate COVID-19 regardless of whether it is delivered by an in-network or out-of-network provider, if it is either of the following:

(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.

A plan or insurer must reimburse the provider of the immunization in accordance with the methodology that applies to COVID-19 testing, described above. All items or services that are necessary for the furnishing of an item, service, or immunization intended to prevent or mitigate COVID-19 must be covered, including, but not limited to, provider office visits and vaccine administration.

The plan or insurer must reimburse the provider for any cost-sharing amount that would have been required in the absence of this law. However, the requirement to pay for immunizations and other prevention services without cost sharing for an out-of-network provider ends when the federal public health emergency expires.

Q: Can a payer unilaterally include testing and vaccination in our risk contract?

A: No. Changes to a contract between a plan/insurer and a provider delegating financial risk for diagnostic and screening testing, or immunization, related to a declared public health emergency is considered a material change to the parties' contract. A payer may not delegate the financial risk to a contracted provider for the cost of these services unless the parties have negotiated and agreed to a new contract provision.

Q: Does SB 510 include any requirements related to future pandemics?

Yes. Plans and insurers must cover, without cost sharing and without prior authorization or other utilization management, the following services related to a disease that triggers a future public health emergency declared by the governor:

- An evidence-based item, service, or immunization that is intended to prevent or mitigate the 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.
- 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.