California Legislature

SENATE COMMITTEE ON HEALTH

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COVID CARE:
ROLE OF PRIVATE HEALTH INSURANCE
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Senate Chamber

The purpose of this hearing is to examine coverage expectations for state-regulated private health insurance in California with respect to testing, treatment, and vaccines associated with the COVID-19 pandemic. Speakers will discuss current coverage requirements, potential inconsistencies and ambiguities of the requirements, the evolving nature of coverage requirements and guidelines, and their experiences implementing these requirements as California responds to this health care and economic emergency. This hearing is one of several hearings conducted by the California State Senate related to the pandemic, including hearings of the California Senate Special Committee on Pandemic Response on topics related to education, work place health and safety, skilled nursing facilities, and testing and tracing.

On March 11, 2020, the novel Coronavirus (SARS-CoV-2), which causes the infection known as COVID-19, was declared a global pandemic and set in motion public health emergency declarations across the U.S. The COVID-19 outbreak was declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020), and a national emergency on March 13, 2020. On March 4, 2020, Governor Newsom declared a state of emergency to make additional resources available, formalize emergency actions already underway across multiple state agencies, and help the state prepare for broader spread of COVID-19.

California, as well as the rest of the U.S. is experiencing spikes in COVID-19 infections rates and increasing hospitalizations. As of November 19, 2020, California had a total of 1,059,267 positive cases and a total of 18,466 deaths. California's positivity rate is a key indicator of community spread. As of November 19, 2020, the 7-day positivity rate was 5.6% and the 14-day positivity rate was 5.0%. According to the Johns Hopkins Coronavirus Resource Center, the first case of COVID-19 in the U.S. was reported on January 21, 2020. As of November 19, 2020 the country has reported 11,740,229 cases, and 252,838 deaths. Los Angeles County is listed as the county with the most confirmed cases in the country with a total of 353,352 as reported on November 19, 2020 and the second highest deaths of 7,363. According to the California Department of Public Health (CDPH) as of November 19, 2020, there have been

21,552,528 tests conducted in California. These numbers include data from commercial, private and academic labs, including Quest, LabCorp, Kaiser, University of California and Stanford, along with the 25 state and county health labs currently testing.

Policymakers at all levels of government have adopted measures to combat the spread of the virus that causes COVID-19. The federal government enacted the Families First Coronavirus Relief Act (FFCRA), which was approved March 18, 2020, and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which was approved on March 27, 2020, to help Americans respond to the spread of COVID-19 and assist states in their efforts. In order to encourage testing, treatment, and vaccinations (when vaccines become available), federal and state polices have been adopted to mandate private health insurance coverage without cost sharing. Many directives have been issued through regulatory and subregulatory guidance.

California's Department of Managed Health Care (DMHC) issued emergency regulations to health plans covering approximately 13.4 million privately/commercially covered Californians and the California Department of Insurance (CDI) issued a bulletin to its regulated health insurers covering approximately 1.1 million privately/commercially covered Californians related to coverage of COVID-19 testing. Media reports have indicated some people across the country have been surprised by added charges and bills after being tested. In California, testing coverage requirements are not consistent across regulators and in some cases may be unclear.

Testing Coverage Requirements

***Federal*.** FFCRA generally requires group health plans and health insurance issuers offering group or individual coverage to provide benefits for certain items and services related to testing for the detection of COVID-19 when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. Under FFCRA, plans and issuers must provide coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization, or other medical management requirements.

The CARES Act amends FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover without any cost-sharing requirements, prior authorization, or other medical management requirements. Generally, the CARES Act requires plans and issuers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate, or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. The plan or issuer may negotiate a rate with the provider that is lower than the cash price. During the COVID-19 public health emergency, the CARES Act subjects a provider of a COVID-19 diagnostic test that does not list the price on the provider's website to potential enforcement action, including civil monetary penalties. According to "Frequently Asked Questions" or FAQ #42 issued jointly by the federal Department of Labor (DOL), the Department of Health and Human Services (DHHS), and the Department of the Treasury (Treasury) on April 11, 2020, although serological tests should not be the sole basis for COVID-19 diagnosis, under the CARES Act, plans and insurers must cover these tests (among other services) without cost-sharing.

A June 23, 2020 FAQ #43 revises FAQ #42 to indicate that a health care provider need not be "directly" responsible for providing care to the patient to be considered an attending provider, as long as an individualized clinical assessment determines that the test is medically appropriate.

This includes at-home testing that must be provided without cost-sharing, prior authorization, or other medical management requirements. According to the FAQ, a plan, issuer, hospital, or managed care organization is not an attending provider. The FAQ states that testing conducted to screen for general workplace health and safety (such as employee "return to work" programs), public health surveillance for SARS-CoV-2, or any other purpose not primarily intended for diagnosis or treatment of COVID-19 or another health condition is beyond the scope of FFCRA. The FAQ requires plans or issuers to cover facility fees, including fees associated with diagnostic test panels for influenza A and B and chest x-rays, assessed in relation to items or services required to be covered under FFCRA, without cost-sharing requirements, prior authorization, or other medical management requirements. The FAQ indicates that no-cost sharing includes no balance billing, however this does not restrict balance billing for items and services not subject to the CARES Act, unless otherwise prohibited under a state law or applicable contract. The FAQ also indicates that nothing in the FFCRA or the CARES Act prevents a state from imposing additional standards or requirements on health insurance issuers or providers with respect to the diagnosis or treatment of COVID-19, to the extent those standards or requirements do not prevent the application of a federal requirement.

State. The Legislature and Newsom Administration have taken many actions to support Californians, and especially essential workers, in response to the COVID-19 pandemic. In September, Governor Newsom signed SB 1159 (Hill, Chapter 85, Statutes of 2020) and AB 685 (Gómez Reyes, Chapter 84, Statutes of 2020) as part of a worker protection package. These bills expand access to workers' compensation making it easier for first responders, health care workers, and people who test positive due to an outbreak at work to get the support they need, including necessary medical care and wage replacement benefits. These laws also ensure timely notification to employees and local and state public health officials of COVID-19 cases at workplaces. In addition, according to a July 24, 2020 press release issued by the Governor's office, the state will provide employers with information to share with their workers regarding health insurers' COVID-19 testing coverage and eligibility requirements. The press release indicates that the state has also expanded testing and health plan reimbursement for the essential workforce, in addition to requiring health plans to reimburse all COVID-19 testing for high-risk essential workers.

California Department of Insurance. On March 5, 2020, CDI issued a bulletin to all insurers providing commercial health insurance in California that requires immediate reduction of cost-sharing to zero for all medically necessary screening and testing for COVID-19, including hospital, emergency department, urgent care, and provider office visits where the purpose of the visit is to be screened and/or tested for COVID-19. CDI strongly encourages insurers to waive prior authorization requests for services related to COVID-19, or at a minimum, respond to such requests more quickly than the time frames required by law and ensure insureds are not liable for unlawful balance bills from providers, including balance bills related to testing of COVID-19. On October 2, 2020, CDI issued an FAQ follow-up to the March 5th bulletin in response to complaints received and because of the enactment of FFCRA and the CARES Act. In the FAQ,

CDI indicates that coverage of COVID-19 testing and related diagnostic items and services must be provided without imposing any cost sharing or prior authorization requirements regardless of network status with the following caveats:

- An attending provider must make an individualized assessment to determine whether the test is medically appropriate. The federal government broadly defines "attending provider."
- The related items and services must be furnished during a visit that results in an order for, or administration of, a COVID-19 diagnostic test.
- FFCRA requires specified items and services, including but not limited to influenza tests and blood tests, to be covered if furnished in-person or during a telehealth visit as well as in a broad range of settings including health care provider offices, urgent care centers, and emergency rooms. DHHS specified that this includes "nontraditional" settings such as drive-through testing sites.
- Federal law prohibits "balance billing" for the COVID-19 diagnostic test, but not for related items and services, if the related items and services are provided out-of-network, an insured may be subject to balance billing.

CDI's FAQ also indicates that these requirements apply to coverage offered in the individual market through or outside of Covered California, as well as student health insurance coverage, and both grandfathered (in place prior to the Affordable Care Act or ACA) and nongrandfathered coverage. The FAQ also indicates that FFCRA/CARES Act requires insurers to reimburse the negotiated rate for in-network providers, or the provider's online cash price for providers with whom the insurer does not have a negotiated rate. Therefore, insurers must pay providers without deducting patient cost sharing, in order to comply with federal law. The FAQ further indicates that health insurers have a legal obligation to promptly pay claims, advises providers about coding for telehealth appointments, encourages health insurers to extend the expiration date of prior authorizations for procedures that had to be rescheduled because of "stay at home orders," and reiterates that the CARES Act requires insurers to cover COVID-19 diagnostic testing regardless of network status.

Department of Managed Health Care. Emergency regulations regarding COVID-19 diagnostic testing issued by DMHC took effect on July 17, 2020. The regulations indicate that during the COVID-19 state of emergency declared by Governor Newsom, diagnostic testing for COVID-19 is a medically necessary basic health care service for enrollees who are essential workers, regardless of whether the enrollee has symptoms of COVID-19 infection or is asymptomatic, or whether the enrollee has a known or suspected exposure to a person with COVID-19. Basic health care services are defined in law and regulation, and are mandated services for DMHC regulated health plans and CDI regulated policies that are required to cover Essential Health Benefits under the ACA. Under the COVID-19 emergency regulations, health plans are prohibited from imposing utilization management requirements on COVID-19 diagnostic tests for essential workers. A health plan is permitted to inquire if an enrollee is an essential worker, but is prohibited from requiring evidence or verification of the enrollee's essential worker status. The regulations define essential workers as:

- A person working in the health care or emergency services sectors who has frequent interactions with the public or with people who may have COVID-19 or have suspected exposure to SARS-CoV-2;
- A person who provides care to an elderly person or a person with a disability;
- A person working in a congregate care facility or homeless shelter;
- A person working in retail, manufacturing, or agriculture who has frequent interactions with the public or who works in an environment where it is not practical to social distance;
- A person working in food services, including restaurants and grocery stores, and public transportation, who has frequent interactions with the public;
- A person working in a correctional facility; and,
- A person working in the education sector with frequent interactions with students or the public, including child care.

The emergency regulations indicate that other enrollees who are not essential workers may be subject to ordinary utilization management procedures allowed under law when determining whether a COVID-19 test is medically necessary for an enrollee, unless otherwise specified by state or federal law. Health plans may subject enrollees to applicable cost-sharing amounts, unless otherwise specified by state or federal law. However, a testing provider, at its discretion, may waive any applicable co-payment or co-insurance amounts. Health plans may deny coverage if the enrollee failed to attempt to access a COVID-19 test from an in-network provider or failed to contact the health plan to locate an in-network testing provider first, unless otherwise specified by state or federal law. The regulations indicate that medically necessary COVID-19 testing is "urgent care" and plans are prohibited from extending the applicable wait time for a COVID-19 testing appointment. If urgent care time and distance standards cannot be met, the enrollee may obtain a COVID-19 diagnostic test from any available testing provider, regardless of if the provider has a contract with the plan. In this situation, the health plan must reimburse the provider at the contracted rate, or if there is no contract, the provider's cash price when required by federal law, or reasonable and customary value.

The emergency regulations also indicate that changes to a contract between a health plan and a provider delegating financial risk for COVID-19 diagnostic testing, including related items and services, is a material change to the parties' contract. Therefore, a plan shall not delegate the financial risk to a contracted provider unless the parties have negotiated and agreed upon a new provision of the contract. On November 13, 2020, the California Association of Health Plans (CAHP) filed a complaint in Los Angeles Superior Court challenging this provision as it relates to existing Delegation of Financial Responsibility agreements. According to CAHP, this complaint does not challenge the regulation in its entirety and the complaint is narrow in scope.

DMHC issued an FAQ on July 17, 2020, clarifying that someone experiencing symptoms or who thinks they were exposed to someone with COVID-19 can obtain a test anywhere and cannot be charged a co-pay for testing under federal law, but in all other circumstances, except for essential workers, a copay may be charged as it would when getting any other health care services. DMHC's FAQ indicates that an essential worker must be offered a testing appointment no more than 48 hours after contacting the plan, at a site that is within 15 miles or 30 minutes of residence or workplace. If that does not occur, an essential worker can go to any available testing site and

the plan must pay. For others without symptoms or suspected exposure, if their health care provider determines a test is medically necessary, a plan must offer a testing appointment more than 96 hours after contacting the plan, at a site within 15 miles or 30 minutes of residence or workplace. If that does not occur, an enrollee can go to any available testing site. The FAQ points out that self-insured plans must cover testing for a covered person with symptoms or who was exposed to someone known or suspected of having COVID-19 under federal law, but that those plans are regulated by the federal government.

A July 23, 2020, All Plan Letter (APL) issued by DMHC clarifies that enrollees with symptoms of COVID-19 or known or suspected exposure to someone with COVID-19 cannot be charged cost-sharing under the FFCRA/CARES Act for testing and health plans may not impose utilization management or prior authorization requirements on testing for these enrollees.

On September 18, 2020 DMHC issued an APL to respond to many stakeholder questions regarding the emergency regulations. The APL clarifies that although the DMHC's regulation and CDPH guidance both address COVID-19 testing, and should generally be construed consistently, those two documents are directed at different audiences and address different questions. The emergency regulation applies to full-service commercial health care service plans, including restricted health plans, and specifies when a health plan must cover testing for COVID19. In contrast, CDPH's guidance is directed to public health officials and providers, such as hospitals, health care providers, and laboratories, and addresses how they should prioritize testing.

The APL also indicates that the regulation requires plans to cover "diagnostic testing" as that term is defined in the regulation. The regulation's definition of "diagnostic testing" mirrors the definitions used in the CARES Act. Those definitions look to whether the U.S. Food and Drug Administration (FDA) has approved, authorized or cleared a test. To date, while the FDA has authorized two COVID-19 serology tests, the FDA cautions against using serology tests to diagnose an active COVID-19 infection. Accordingly, health plans currently do not have to cover serological tests for COVID-19 antibodies because such testing is not diagnostic.

Posted on DMHC's website is an August 7, 2020 statement from the Department of Health Care Services (DHCS), which administeres Medi-Cal, California's Medicaid program. DHCS indicates that DHCS covers both COVID-19 viral and serologic (antibody) tests, at no cost to Medi-Cal beneficiaries, and recommends providers follow the testing guidance of CDPH, CDC, and other governmental and professional organizations with expertise on COVID-19 testing. CDPH testing guidance for health care providers states: "Serologic tests should generally not be used to diagnose acute cases of COVID-19 or to infer immunity." In addition, the American Medical Association has developed recommendations for the consideration and use of serologic tests to help guide providers and individuals considering using them. Based on this guidance, DHCS is issuing the following clarifications and policy on the use and coverage of serologic testing in Medi-Cal. Providers should pay close attention to the regulatory status of any test offered. FDA maintains a listing of all serologic tests authorized for use for COVID-19. Providers should be aware of the performance characteristics of any test used and how those align with the FDA recommended performance standards. Providers should note that there has been reported fraudulent marketing of some tests and should verify the regulatory status of these claims before incorporating them in to practice.

With respect to testing for surveillance or employment purposes, DHCS states COVID-19 testing is a covered Medi-Cal benefit and can be provided to enrolled beneficiaries, based on medical necessity, as ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within their scope of practice as defined by state law or ordered by a physician but provided by a referral laboratory. Tests for the detection of SARS-CoV-2 or the diagnosis of COVID-19 are mandatory Medicaid laboratory services as described in the federal Social Security Act, and federal regulations. Health plans have indicated they prefer this DHCS policy compared to the policy of DMHC.

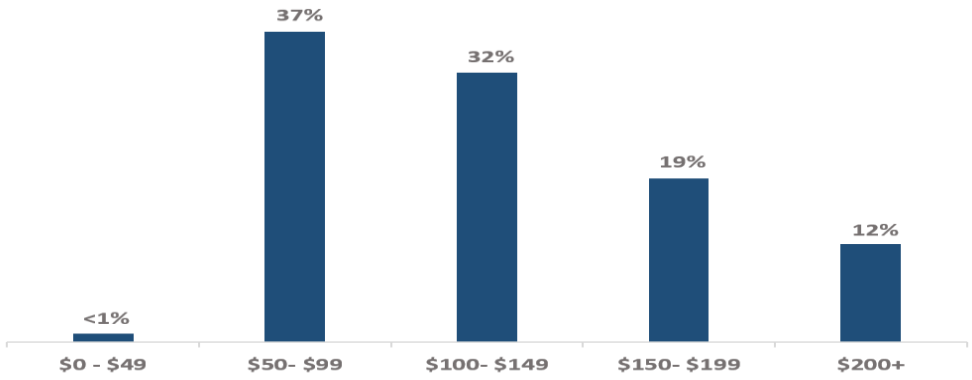
Testing Costs

CDPH has contracted with PerkinElmer to build out new laboratory capabilities within the state to expand testing capacity by up to 150,000 diagnostic tests per day with a contractual turnaround time of 24-48 hours. This new testing capacity will be additive to the capacity currently available in the network of laboratories, and is not intended to replace existing capacity. Under the contract, the cost per test will be $37.78 at 100,000 tests per day and decreasing for every additional 10,000 tests to $30.78 at 150,000 tests per day. Additional costs to recover facility and logistics costs will be added to this per test charge. For context, Medicare and Medicaid both reimburse at roughly $100 per test, while the average reimbursement by other payers ranges from $150 to $200.

Health plans have indicated that out-of-network labs and/or providers are billing at significantly higher rates for testing than contracting providers with one outlier as high as $14,265 but most plans reported maximum billed charges at around $5,900 for diagnostic testing and $390 for antibody testing.

In order to get a sense of the variation in hospital testing costs across the state, the Committee requested the Senate Office of Research (SOR) analyze hospital chargemasters. The complete SOR analysis is attached to this background paper. SOR found the prices for a single COVID–19 test averaged to approximately $130. However, the price of a single COVID–19 test widely varies throughout California. In the hospital-listed prices, COVID–19 testing ranged between $41 and $995. Although 37% of the hospitals fall within the $50 to $99 range for COVID–19 diagnostic tests, a substantial number of hospitals far exceed the average price (Figure 1). Approximately one in three hospitals on average charged at or above $150 for a single COVID–19 test.

Figure 1: Hospital Prices for COVID-19 Diagnostic Testing



This wide range of COVID–19 diagnostic testing prices is found throughout most regions in California. Two of the widest ranges of pricing are found in the greater Bay Area with a range of $28 to $958 and Los Angeles County at $51 to $995. The Northern and Sierra region and the Inland Empire both have hospitals that charge nearly 285% more than the average price found in California.

In addition to COVID–19 diagnostic testing, hospitals also bill for specimen collection and telehealth fees. Approximately 30 hospitals reviewed had listed their prices for COVID–19 specimen collection, ranging from $16 to $261. It is unclear whether the remaining hospitals reviewed charge for specimen collection for COVID–19 testing potentially through separate codes unrelated to COVID–19. CMS has set the current reimbursement rate for specimen collection in hospital outpatient departments at $23. One hospital reviewed listed a fee for sending out COVID–19 specimens at $100 and another separate fee for handling priced at $40. There is no federal law on how much hospitals may charge for specimen collection or related fees.

Vaccines and Treatment

Vaccines. Currently, there are no COVID-19 vaccines that have been authorized or approved by the FDA and recommended by the Centers for Disease Control and Prevention (CDC's) Advisory Committee on Immunization Practices (ACIP). In recent weeks, two pharmaceutical companies have announced promising vaccine trials which may mean vaccinations to prevent COVID-19 will be available soon.

The ACA requires health plans and issuers to cover certain preventive services without cost-sharing (deductible, co-payment, or coinsurance), including vaccines recommended by ACIP at minimum intervals established by DHHS of not less than one year between the date of the recommendation or guideline is issued and the plan year in which coverage and no cost sharing is required. These include immunizations for "routine use" in children and adults that have been recommended by ACIP; vaccines are only considered to be for routine use if they are listed on the immunization schedules of the CDC. Coverage for recommended vaccines is provided without cost-sharing even for enrollees or insureds who have not reached their deductible. California law codifies these ACA preventive services provisions. The ACA requirement does not apply to grandfathered plans or out-of-network providers. The CARES Act addresses the timing of vaccine coverage with a provision requiring insurers and employer plans to cover COVID-19 vaccines within 15 days after a recommendation from ACIP.

On Oct 19, 2020, Governor Newsom announced the creation of a COVID-19 Scientific Review Workgroup of California physician scientists with expertise in immunization and public health that will independently review the safety and efficacy of any vaccine that receives FDA approval for distribution. These experts will be guided by the principles of safety, equity and transparency and will review any vaccine that receives federal approval and verify its safety, before California makes a COVID-19 vaccine available to those most at risk. Additionally, a Drafting Guidelines Workgroup comprised of immunization, public health, ethicists, health care and academic experts will develop California-specific guidance for the prioritization and allocation of vaccines when supplies are limited. A Community Advisory Vaccine Committee will provide input and feedback to the planning efforts and solve barriers of equitable vaccine implementation and decision-making.

On October 28, 2020, an interim final rule (IFR) issued by DOL, DHHS, and Treasury requires health plans and insurers to cover and waive cost-sharing for COVID-19 vaccines that have been recommended by ACIP, regardless of whether CDC has placed them on the immunization schedules for routine use. This includes the administration of the vaccine if the purpose of the encounter was delivery of the COVID-19 vaccine, and if delivered out-of-network. Plans and insurers must reimburse out-of-network providers at a "reasonable" rate, as determined in comparison to prevailing market rates. Providers who participate in the CDC COVID-19 Vaccination Program contractually agree to administer a COVID-19 vaccine regardless of an individual's ability to pay and are barred from balance billing a vaccine recipient. The IFR goes into effect immediately and lasts for the duration of the public health emergency. The federal agencies are seeking public comment on these and other provisions of the rule within 60 days.

On November 12, 2020, federal DHHS announced partnerships with large chain pharmacies, networks of independent pharmacies and regional chains to increase access to vaccines once they become available.

Treatment. Both DMHC and CDI have issued a series of directives to their regulated plans and insurers during the COVID-19 state of the emergency to ensure continued access to treatment. These include extending special COVID-19 enrollment periods to ensure Californians can gain insurance coverage outside of the regular open and special enrollment periods if necessary.

Included in the March 5th bulletin, CDI encourages insurers to work with contracted providers to use telehealth services when medically appropriate to limit exposure and increase capacity of contracted providers and facilities; and, in the event of a prescription drug shortage, encourage insurers to waive prior authorization and/or step therapy requirements if a prescribing provider recommends a different drug to treat the condition.

On March 18, 2020, CDI directed health insurance companies to submit emergency plans detailing how they will ensure continued access to medically necessary health care services for the duration of the declared COVID-19 state of emergency. These include allowing for 90-day prescription drug refills, suspending refill waiting periods for all drug tiers, including specialty drugs, and maximizing telehealth to help health insurance policyholders who are sheltered in place. Health insurers were required to file their plans no later than March 20, 2020. On March 30, 2020, another directive was issued by CDI encouraging the use of telehealth during the COVID-19 state of emergency.

An April 13, 2020, Health Affairs Blog indicates there are gaps in protections for people receiving treatment for COVID-19. Since different plans have different cost-sharing configurations and actuarial values, these costs could be extensive for consumers who need treatment. As part of the CARES Act Provider Relief Fund payments, DHHS indicates that a prohibition on balance billing applies to "all care for a presumptive or actual case of COVID-19." A presumptive case of COVID-19 is a case where a patient's medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record. Dental providers who are not caring for patients with presumptive or actual cases of COVID-19 would not be subject to this provision.

The CARES Act includes a safe harbor for high-deductible health plans (HDHPs) paired with a health savings account that begin on or before December 31, 2021 thru 2022 to provide pre-deductible coverage for telehealth and other remote care services. Thus, telehealth and other remote care services could be covered pre-deductible without violating federal rules for HDHPs. These are not limited to COVID-19-related services.

On May 20, 2020, DMHC reminded plans that they have an on-going duty to ensure they have adequate networks to provide enrollees with all medically necessary services in a timely and geographically appropriate manner. Providers, including medical and dental clinics and hospitals, report experiencing significant financial difficulties due to COVID-19, as patients have delayed receiving all but emergency and urgent medical services. To address these concerns, plans were asked to submit an informational filing to the DMHC explaining the steps the plan has taken, and/or will take, to ensure continued network adequacy.

On October 18, 2020, CDI requested that all health insurance and specialized health insurance companies provide their policyholders with a partial premium refund no later than December 31, 2020, to provide much-needed financial relief to individual consumers, families, and small businesses during the COVID-19 pandemic.

Appendix

SOR Analysis on California Hospital Pricing for COVID–19 Diagnostic Testing

Background. Among the various components of the federal COVID–19 response legislation are consumer protections and transparency requirements for COVID–19 testing and diagnostics. Through the CARES Act and FFCRA, most group health plans and health insurance issuers are required to cover a broad range of diagnostic testing and services for detecting COVID–19 without any cost-sharing, prior authorization, or other medical management requirements. The no cost-sharing requirement for COVID–19 diagnostic tests is to remain in place for the duration of the public health emergency. Currently, the federal public health emergency is set to expire on January 20, 2021.

COVID–19 diagnostic tests include various testing methods, such as polymerase chain reaction tests, antigen tests, and antibody/serology tests. Under the CARES Act, providers of these COVID–19 diagnostic tests, such as hospitals, are required to publish the cash price of the diagnostic tests on the provider's website. This price transparency requirement went into effect on March 27, 2020, and will continue for the duration of the public health emergency.

Outside of the Medicare program, there is no federal regulation addressing the price of COVID–19 diagnostic tests or other related tests/visits.

This research focuses on the prices for COVID–19 testing charged by California hospitals. As is the case for most health services, hospitals can set their own rates for COVID–19-related services for privately insured and uninsured individuals. Private health insurers negotiate allowed charges with hospitals and providers participating in their network. In the absence of a negotiated rate for out-of-network providers, insurers must pay the provider's cash price, also known as the list price, for COVID–19 testing and related services. The CARES Act requires that insurers reimburse out-of-network providers the list price for COVID–19 testing posted on the provider's website. The CARES Act is silent as to the amount private plans should reimburse out-of-network COVID test providers that do not post their cash price online.

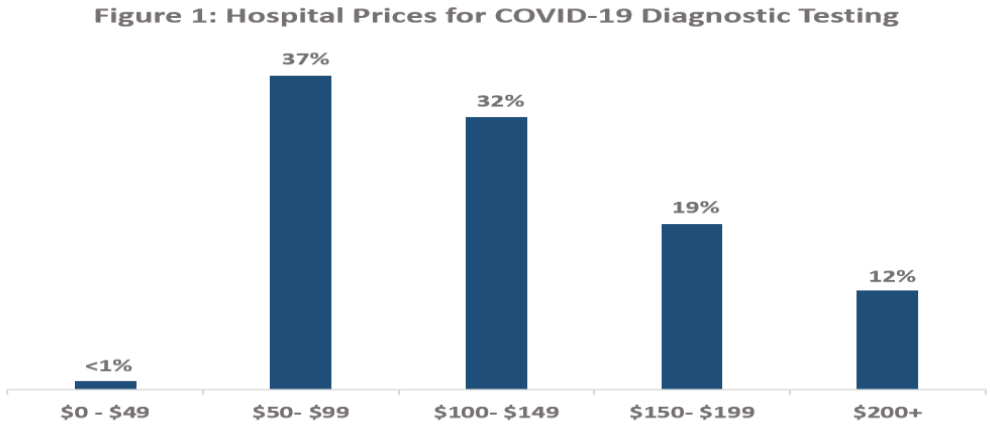
Before the pandemic, numerous studies showed payments to hospitals from private insurers are much higher than Medicare payments to hospitals. Earlier this year,
Kaiser Family Foundation (KFF) published an issue brief reviewing the literature on the increased amounts private insurers pay compared with Medicare. KFF found that private insurers on average paid nearly double Medicare rates for all hospitals services, ranging from 141% to 259%. Currently, the federal Centers for Medicare and Medicaid Services (CMS) has set the reimbursement rates for COVID–19 tests up to $100, depending on the test.

Hospital Pricing Data. To examine the pricing for COVID–19 diagnostic testing by California hospitals, pricing data was reviewed for a total sample of 116 general acute care hospitals and special hospitals throughout the state.[1] Data was gathered for at least two hospitals (if applicable) and no more than four hospitals, per county. Six counties had no data in the dataset reviewed, and 16 counties had data for only one hospital. COVID–19 diagnostic testing prices were collected from "chargemasters" submitted by each hospital under the Payers' Bill of Rights:

[1] There are more than 300 such hospitals in the state.

AB 1627 (Frommer, Chapter 582, Statutes of 2003) and AB 1045 (Frommer, Chapter 532, Statutes of 2005). The Payers' Bill of Rights requires general acute care hospitals, special hospitals, and psychiatric acute hospitals to submit annually a copy of their chargemaster, a description of all services, goods, and procedures used to generate a patient's bill, to the Office of Statewide Health Planning and Development (OSHPD). According to OSHPD, the purpose of the Payers' Bill of Rights is to provide patients, health plans and healthcare purchasers with more information about charges for hospital care; and to discourage hospitals from establishing charges that adversely affect private payers and patients. Chargemasters used to generate this data were obtained from OSHPD on October 26, 2020. The prices listed in the chargemaster were in effect on June 1, 2020. Six hospitals listed no pricing for COVID–19 testing, and another six hospitals had indistinguishable pricing for COVID–19 diagnostic testing or services. For example, one hospital in the Eastern Sierra region listed "Special Care/COVID–19" with a list price of $7,262.

Of the remaining 104 hospitals in this sample set, the prices for a single COVID–19 test averaged to approximately $130. However, the price of a single COVID–19 test widely varies throughout California. In the hospital-listed prices, COVID–19 testing ranged between $41 and $995. Although 37% of the hospitals fall within the $50 to $99 range for COVID–19 diagnostic tests, a substantial number of hospitals far exceed the average price (Figure 1). Approximately one in three hospitals on average charged at or above $150 for a single COVID–19 test.



Averaged prices for COVID–19 diagnostic tests for a sample of 104 hospitals throughout California.

This wide range of COVID–19 diagnostic testing prices is found throughout most regions in California. To examine hospitals' pricing by region, testing prices from each county (if a hospital was located in the county) were collected and divided into nine regions. Two of the widest ranges of pricing are found in the greater Bay Area with a range of $28 to $958 and Los Angeles County at $51 to $995 (Table 1). The Northern and Sierra region and the Inland Empire both have hospitals that charge nearly 285% more than the average price found in California.

Table 1: Regional COVID–19 Diagnostic Test Pricing

Region	Low Price	High Price	Average Price
Central Coast—Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura	$28	$450	$124
Greater Bay Area—Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma	$28	$958	$151
Inland Empire—Riverside, San Bernardino	$44	$500	$181
Los Angeles County—Los Angeles	$51	$995	$289
Northern and Sierra—Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba	$26	$500	$100
Orange County—Orange	$43	$414	$179
Sacramento Area—El Dorado, Placer, Sacramento, Yolo	$42	$200	$117
San Diego Area—Imperial, San Diego	$42	$525	$132
San Joaquin Valley–Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare	$28	$375	$115

California regions listed with the lowest, highest, and average prices for COVID–19 diagnostic testing for each region.

In addition to COVID–19 diagnostic testing, hospitals also bill for specimen collection and telehealth fees. Approximately 30 hospitals reviewed had listed their prices for COVID–19 specimen collection, ranging from $16 to $261. It is unclear whether the remaining hospitals reviewed charge for specimen collection for COVID–19 testing potentially through separate codes unrelated to COVID–19. CMS has set the current reimbursement rate for specimen collection in hospital outpatient departments at $23. One hospital reviewed listed a fee for sending out COVID–19 specimens at $100 and another separate fee for handling priced at $40.

There is no federal law on how much hospitals may charge for specimen collection or related fees.