Date of Hearing: July 1, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 297 (Hurtado) – As Amended April 10, 2025

**SENATE VOTE**: 37-0

**SUBJECT**: Valley fever Screening and Prevention Act of 2025.

**SUMMARY:** Requires the California Department of Public Health (DPH) to annually analyze and identify regions with high rates of Valley fever and to publish a list of high-incidence regions. Requires Local Health Departments (LHDs) in high-incidence regions to ensure compliance with screening protocols for Valley fever. Requires LHDs to conduct outreach to health care providers and the general public to raise awareness of Valley fever risks, symptoms, and prevention strategies. Requires an adult patient receiving primary care services in a high incidence region to be offered a Valley fever screening test. Requires health plans, insurers, and Medi-Cal to cover Valley fever screening tests in high-incidence regions. Specifically, **this bill**:

1) Requires DPH to annually analyze and identify regions with high rates of Valley fever using public health surveillance data.

2) Require DPH to publish its first list of high-incidence regions for Valley fever on or before March 1, 2027.

3) Requires DPH to provide LHDs in high-incidence regions with detailed infection data and standardized screening protocols for Valley fever.

4) Required DPH to develop and distribute evidence-based training materials on Valley fever detection, diagnosis, and treatment for healthcare providers.

5) Require DPH, on or before January 1, 2030, and every 2 years thereafter, to evaluate the effectiveness of the Valley fever screening and prevention program and report its findings to the Legislature in compliance with 10) of existing law below.

6) Requires LHDs in high-incidence areas to conduct outreach to health care providers and the general public to raise awareness of Valley fever risks, symptoms, and prevention strategies.

7) Requires LHDs to annually report the number of confirmed cases of Valley fever.

8) Requires an adult patient receiving primary care services in a facility, clinic, unlicensed clinic, center, office, or other setting, and in a high-incidence region for Valley fever, to be offered a Valley fever screening test, to the extent these services are covered under the patient's health insurance, based on the latest screening indications recommended by the latest national clinical practice guidelines, unless the health care provider reasonably believes that one of the following conditions applies:

    a) The patient is being treated for a life-threatening emergency.

b) The patient has previously been offered or has been the subject of a Valley fever screening test, unless the health care provider determines that the screening test should be offered again.

c) The patient lacks capacity to consent to a Valley fever screening test.

d) The patient is being treated in the emergency department of a general acute care hospital.

e) Requires, if a patient accepts the offer of a Valley fever screening test and the test result is positive, a health care provider to offer the patient followup health care or refer the patient to a health care provider who can provide followup health care.

9) Requires follow-up health care to include diagnostic testing and care based on the latest national clinical practice guidelines recommended for Valley fever management.

10) Requires the offering of a Valley fever screening test under this section shall be culturally and linguistically appropriate.

11) Prohibits this bill from affecting the scope of practice of any health care provider or diminish any authority or legal or professional obligation of any health care provider to offer a Valley fever screening test, or to provide services or care for the patient of a Valley fever screening test.

12) Prohibits a health care provider who fails to comply with these provisions from being subject to any disciplinary action related to their licensure or certification, or to any civil or criminal liability for that failure.

13) Requires a health care service plan contract or health insurance policy, except for a specialized health insurance policy, that is issued, amended, delivered, or renewed on or after June 1, 2027, to cover a Valley fever screening test in high-incidence regions for Valley fever, as identified by DPH.

14) Prohibits a health insurance policy from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to 10) above.

15) Prohibits, notwithstanding 11), if a health insurance policy is a high deductible health plan, as defined in federal law the policy from imposing cost-sharing on a Valley fever screening test, unless not applying the cost sharing would conflict with federal requirements for high deductible health plans.

16) Requires, commencing June 1, 2027, Valley fever screening tests in high-incidence regions for Valley fever, as identified by DPH, to be a Medi-Cal covered benefit, subject to any necessary federal approvals and federal financial participation.

17) Defines, for purposes of this bill, the following:

a) "Followup health care" to include providing medical management for Valley fever according to the latest national clinical practice guidelines.

b) "Valley fever screening test" to include any laboratory test or tests that detect the presence of Coccidioides infection and provides confirmation of whether the patient has been infected.

18) Makes the following findings and declarations:

a) Valley fever is a significant public health concern in California, disproportionately impacting residents of arid regions.

b) Early detection and intervention are essential to reduce the medical and economic burdens associated with severe cases of Valley fever.

c) Valley fever screening and prevention is necessary to protect the health and well-being of Californians residing in high-risk areas.

**EXISTING LAW**:

1) Establishes DPH, directed by a state Public Health Officer (PHO), to be vested with all the duties, powers, purposes, functions, responsibilities, and jurisdictions as they relate to public health and licensing of health facilities, as specified. [Health and Safety Code (HSC) § 131050]

2) Requires each county board of supervisors to appoint a local health officer (LHO). [HSC § 101000]

3) Requires LHOs to enforce and observe orders and ordinances of the board of supervisors, pertaining to the public health and sanitary matters, orders, including quarantine and other regulations prescribed by DPH, and statutes relating to public health. [HSC § 101030]

4) Requires DPH to establish a list of diseases and conditions to be reported to DPH by LHOs, clinical laboratories, and health care providers, including Valley fever. [HSC § 120130 and 17 California Code of Regulations (CCR) § 2500, *et seq.*]

5) Requires DPH to specify the timeliness requirements related to the reporting of each disease and condition, and the mechanisms required for, and the content to be included in, these reports. [HSC § 120130]

6) Places reporting requirements on DPH related to Valley fever surveillance, including: attributing late-reported data to the year of diagnosis in future data reporting; collecting cases by April 15 of each year; reporting to LHOs about any removal of discrepant data; and, including an explanation for likely data changes between initial and final publication of data and an explanation for discrepancies. [HSC §§ 120161-120163]

7) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975. [HSC § 1340, *et seq.*]

8) Establishes the California Department of Insurance (CDI) to regulate health insurers. [INS § 106, *et seq.*]

9) Establishes the Medi-Cal program, which is administered by the Department of Health Care Services (DHCS), and under which qualified low-income individuals receive health care services. [WIC § 14000, *et seq.*]

10) Requires any report required or requested by law, or identified in the Legislative Analyst's Supplemental Report of the Budget Act, to be submitted by a state or local agency to a committee of the Legislature or the Members of either house of the Legislature generally, to instead be submitted as a printed copy to the Secretary of the Senate, as an electronic copy to the Chief Clerk of the Assembly, and as an electronic or printed copy to the Legislative Counsel. Each report shall include a summary of its contents, not to exceed one page in length. Requires, if the report is submitted by a state agency, that agency to also provide an electronic copy of the summary directly to each member of the appropriate house or houses of the Legislature. Requires notice of receipt of the report to also be recorded in the journal of the appropriate house or houses of the Legislature by the secretary or clerk of that house. [Government Code § 9795]

11) Defines "high deductible health plan" to means a health plan— (i) which has an annual deductible which is not less than— (I) $1,000 for self-only coverage, and (II) twice the dollar amount in subclause (I) for family coverage, and (ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed— (I) $5,000 for self-only coverage, and (II) twice the dollar amount in subclause (I) for family coverage, as specified. [26 United States Code § 223(c)(2)]

**FISCAL EFFECT**: According to the Senate Appropriations Committee, unknown ongoing General Fund (GF) costs, likely hundreds of thousands, for DPH for state administration. The DMHC estimates minor and absorbable costs for state operations. CDI estimates costs of $6,000 in 2025-26 for state operations (Insurance Fund). Unknown, potential costs in the Medi-Cal program to the extent that additional outreach and test offerings result in increased utilization of Valley fever screening tests (GF and federal funds). Unknown, potential GF costs to reimburse county health departments for outreach activities. Cost to counties would be potentially reimbursable by the state, subject to a determination by the Commission on State Mandates.

**COMMENTS**:

**1) PURPOSE OF THIS BILL**. According to the author, Valley fever is a growing public health crisis, yet too many cases go undiagnosed for too long. The author states that this bill ensures that Californians in high-incidence regions receive the early detection and care they deserve. The author notes that by 2027, DPH will identify the hardest-hit areas, giving communities the data they need to act. County health departments will standardize screening protocols and work with LHOs to educate providers and the public. The author contends that for too many, a simple test could mean the difference between a quick recovery and years of misdiagnosis. That's why, starting in 2028, primary care providers in high-risk regions must offer Valley fever screenings to adults. No one should have to choose between affordability and their health—so beginning in 2027, insurance plans, including Medi-Cal (pending federal approval), will cover these tests without cost-sharing. The author states that public health should be proactive, not reactive. The author continues that this bill strengthens California's response by requiring ongoing program assessments and legislative reports to ensure effectiveness. By equipping communities with better data, removing cost barriers, and

prioritizing early detection, this bill takes a critical step toward reducing the devastating impact of Valley fever. The author concludes that Californians deserve a healthcare system that catches Valley fever early—before it catches them.

**2) BACKGROUND**.

**a) What is Valley fever?** Valley fever (also called coccidioidomycosis or "cocci") is a disease caused by the Coccidioides fungus that grows in the soil and dirt in some areas of California and the southwestern United States. This fungus can infect the lungs and cause respiratory symptoms, including cough, difficulty breathing, fever, and tiredness or fatigue. In rare cases, the Valley fever fungus can spread to other parts of the body and cause severe disease – this type of Valley fever is less common and is called disseminated Valley fever. Valley fever can be serious and even fatal. People can get Valley fever by breathing in dust from outdoor air that contains spores of the Coccidioides fungus that grows in the soil. Like seeds from a plant, a fungus grows and spreads from tiny spores that are too small to see. When soil or dirt is stirred up by strong winds or while digging, dust containing these fungus spores can get into the air. Anyone who lives, works, or travels in an area where the Valley fever fungus grows can breathe in these fungus spores from outdoor dust without knowing it and become infected. Valley fever is not contagious, meaning it cannot spread from one person or animal to another.

**b) Prevalence of Valley fever**. In California, the number of reported Valley fever cases has greatly increased in recent years. Since 2000, the number of cases has increased from less than 1,000 cases to more than 9,000 cases in 2019. According to DPH, most cases of Valley fever in California are reported from the Central Valley and Central Coast regions of the state, but the number of cases has also been increasing nearby in the northern Central Valley and southern coastal areas of California. From 2000-2018, the California Southern San Joaquin Central Valley region had the highest rates of Valley fever. Counties in this region include: Fresno; Kern; Kings; Madera; and Tulare. The California Central Coast and Northern San Joaquin Central Valley regions had increasing rates of Valley fever. Counties in these regions include: Monterey; San Luis Obispo; Santa Barbara; Ventura; Merced; San Benito; San Joaquin; Stanislaus. People are more likely to get Valley fever if they live, work, or travel in these areas or travel to other places where Valley fever has been reported, including nearby southwestern states, Mexico, and Central and South America.

**c) Reporting of Valley fever**. Under state law, Valley fever is a reportable condition. Health care providers report suspected and confirmed cases to LHDs. LHDs are then mandated to report all cases of Valley fever to DPH. DPH uses data on Valley fever cases to track trends and better understand who is affected by Valley fever. DPH currently provides two types of surveillance updates on reported Valley fever cases in California: (1) provisional monthly updates and (2) final year-end updates. Data is provided in dashboard and report formats. DPH also periodically publishes more focused Valley fever reports in journals, including surveillance summaries, analyses of hospital and death data, and reports summarizing Valley fever outbreaks. AB 1790 (Salas and Grayson), Chapter 338, Statutes of 2018, provided resources for DPH to create a Valley fever awareness campaign to communicate with local health jurisdictions, healthcare providers, and the public about Valley fever, which it carried out from 2019 to 2020. This bill requires DPH to annually analyze and identify regions with high rates of Valley fever

using public health surveillance data, publish its first list of high-incidence regions for Valley fever on or before March 1, 2027, provide LHDs in high-incidence regions with detailed infection data and standardized screening protocols for Valley fever.

**d) Valley fever and healthcare providers**. DPH's webpage titled "*Information for Health Professionals*" includes information about Valley fever, including but not limited to a DPH-issued health advisory warning healthcare providers about an increased number of reported cases of Valley fever and a recommendation that providers consider testing patients who present with compatible symptoms and risk factors, and other recommendations and guidance related to clinical testing and treatment. DPH's website includes information about the federal Centers for Disease Control and Prevention (CDC)'s clinical testing algorithm for Valley fever. The CDC recommends the consideration of testing on an initial presentation of community-acquired pneumonia or erythema nodosum (an inflammatory disorder characterized by tender bumps under the skin) following recent respiratory symptoms for patients who: have a link to a known outbreak; or, live in or recently traveled to the highly endemic regions (like desert regions of South-Central Arizona and the San Joaquin Valley of California). The CDC also recommends testing in patients with community-acquired pneumonia who live in or recently traveled to an endemic area and have symptoms that did not improve following antibiotics. This bill includes a provision to develop and distribute evidence-based training materials on Valley fever detection, diagnosis, and treatment for health care providers. The author notes that the intent of this provision is to codify DPH's existing practice. As it relates to providers, this bill requires adult patients receiving primary care services in a high incidence region for Valley fever to be offered testing to the extent the services are covered under the patient's health insurance and based on the latest screening indications recommended by the latest national clinical practice guidelines. This bill prohibits a provider who fails to comply with the requirements of this bill from being subject to disciplinary actions related to their license or certification or any civil or criminal liability because of their failure to comply.

**e) Insurance coverage**. This bill requires a health care service plan contract or health insurance policy, except as specified, that is issued, amended, delivered, or renewed on or after June 1, 2027, to cover, without cost sharing, Valley fever screening test, as specified, in high-incidence regions for Valley fever, as identified by DPH. According to information provided by DMHC, in general, medically necessary screenings are already covered benefits. Under DMHC regulations, "preventive health services" (including services for the detection of asymptomatic disease) include reasonable health appraisal examinations on a periodic basis. According to DMHC, Valley fever screenings are covered as medically necessary, subject to applicable cost sharing. State statute requires health plans to cover screenings recommended by the United States Preventive Services Task Force (USPSTF) without cost sharing. Currently, the USPSTF does not recommend Valley fever screenings. Thus, current law does not require these screenings without cost sharing. The author's intent is to ensure Valley fever screenings for patients in high incidence areas are covered without cost sharing.

**f) Medi-Cal**. According to information provided by DHCS, under existing Medi-Cal coverage, skin test screenings for Valley fever are available to Medi-Cal members as part of an office visit for any Medi-Cal member experiencing symptoms. In addition, Medi-Cal covers diagnostic blood tests. The screening skin test is covered as part of an office

visit. The diagnostic blood test is covered as a lab service. Valley fever screenings skin tests are not separately reimbursed and are billed as part of an office visit. The fee-for-service (FFS) reimbursement rate for the diagnostic blood test is $11.62. Both the skin test and the blood test are available to Medi-Cal members statewide whenever a provider believes it's medically necessary.

3) **SUPPORT**. Altura Centers for Health (ACH) supports this bill and states despite the growing prevalence of Valley fever, awareness remains low. Misdiagnosis is common, leading to delay in treatment and unnecessary suffering for patients. ACH continues that public health agencies face significant challenges in tracking cases due to inconsistent testing and reporting practices. ACH continues that in the Central Valley, thousands of cases go unreported each year, leaving public health officials with an incomplete picture of the disease's true impact. ACH contends that as Valley fever becomes more widespread, the need for improved surveillance, education, and research into its management requires the upmost urgency. ACH notes that the threat of Valley fever isn't merely a problem for today, but it's a looming problem for the future. Proactive measures like this bill aim to tackle this issue by requiring DPH to identify and share data on regions with high Valley fever rates, mandating screening in high-incidence areas when medically necessary, and ensuring health insurance providers, including Medi-Cal, cover screenings at no additional cost to patients.

4) **OPPOSITION**. The California Medical Association (CMA) opposes a mandate requiring physicians to offer Valley fever testing to all primary care patients in high-incidence regions. CMA continues that the mandate overrides a physician's clinical judgment in determining whether testing is appropriate for a given patient. For context, Valley fever is typically a mild infection for most individuals, with 90% to 95% of those infected experiencing mild symptoms that resolve without testing or treatment. CMA continues that mandating physicians to offer this testing would result in unnecessary screenings for asymptomatic individuals or those with mild symptoms, even when offering the test goes against clinical judgment. CMA contends that this could contribute to longer wait times for all patients awaiting laboratory results – a serious concern, particularly for those with severe Valley fever symptoms or for those experiencing other health issues where timely testing is essential to their recovery. CMA argues that unlike other conditions such as Tuberculosis, Valley fever currently lacks a risk assessment tool, making clinical discretion even more crucial. CMA concludes that it's critical that we not remove a physician's clinical judgement to offer Valley fever testing to patients in high-incidence regions, as appropriate.

5) **OPPOSE UNLESS AMENDED**. The County Health Executives Association of California (CHEAC) opposes this bill unless it is amended and states, LHDs are already required to report all positive Valley fever cases to DPH, and several jurisdictions with higher case counts coordinate outreach to providers and the public on the conditions, symptoms, and causes of Valley fever, to the extent resources allow. However, there is currently no dedicated funding for these activities, and this bill does not provide funding to carry out this new mandate. CHEAC appreciates the author's willingness to limit the new mandate for outreach and education to "high incidence area" as defined in the bill, but respectfully requests the insertion of "upon appropriation" or "to the extent that resources are available". CHEAC notes that LHDs are facing the elimination of vital federal funding and deep cuts to core public health programs. Considering this context, policymakers have a duty to ensure that new mandates are paired with adequate funding. LHDs share the author's desire to ensure awareness and timely treatment for those with Valley fever infections, many of whom

live in underserved areas. However, the new mandate on LHDs to conduct Valley fever outreach and education without funding for these activities requires CHEAC to oppose this bill unless amended to address this concern.

**6) PREVIOUS LEGISLATION**.

**a)** SB 1231 (Caballero) of 2022 would have required DPH to create a California Standard Diagnostic for Valley fever and to conduct an awareness campaign to communicate with LHDs, providers, and the public about the Diagnostic for Valley fever. SB 1231 was held on the Assembly Appropriations Committee suspense file.

**b)** AB 789 (Low), Chapter 470, Statutes of 2021 requires an adult patient who receives primary care services to be offered a hepatitis B and C screening test according to the latest recommendations from the USPSTF, and to the extent these services are covered under the patient's health insurance, unless the patient lacks capacity to consent to the test, or is being treated in the emergency department of a general acute care hospital.

**c)** AB 1787 (Salas and Fong), Chapter 229, Statutes of 2018 places reporting requirements on DPH related to Valley fever surveillance, including: attributing late-reported data to the year of diagnosis in future data reporting; collecting cases by April 15 of each year; reporting to LHOs about any removal of discrepant data; and including an explanation for likely data changes between initial and final publication of data, and an explanation for discrepancies between data reported by an LHO and data reported by DPH.

**d)** AB 1788 (Salas and Grayson), Chapter 230, Statutes of 2018 permits DPH, for the purpose of Valley fever case reports, to use a laboratory criteria for diagnosis, with or without clinical criteria.

**e)** AB 1789 (Salas and Fong) of 2018 would have required the Occupational Safety and Health Standards Board to adopt Valley fever standards for state public works projects, as specified. AB 1789 was held on the Assembly Committee of Appropriations suspense file.

**f)** AB 1790 (Salas and Grayson), Chapter 338, Statutes of 2018, enacted the Valley fever Education, Early Diagnosis, and Treatment Act, and required DPH to conduct an awareness campaign to LHDs, providers, and the public. AB 1790 became inoperative on January 1, 2021.

**g)** AB 1279 (Salas) of 2017 would have required DPH to develop and implement public outreach programs to educate the public about Valley fever. AB 1279 was vetoed by Governor Brown, who stated: “DPH already provides fact sheets, brochures, posters and other educational materials to raise awareness of this disease. Expanding this program would necessitate additional resources which should be considered along with other funding requests as part of the budget process.”

**7) AMENDMENTS (TO BE TAKEN IN A SUBSEQUENT COMMITTEE)**. In consultation with the committee, the author has committed to address stakeholder concerns regarding maintaining a physician’s clinical judgment to offer Valley fever testing to patients in high-incidence regions, as appropriate, by amending this bill to require culturally and linguistically appropriate screening for valley fever. Given that Valley fever screenings and

tests are already covered under Medi-Cal, the author has also committed to striking the current Medi-Cal provisions and including a finding and declaration to the effect that Valley fever screenings and tests are covered. Given that that Valley fever testing is covered subject to applicable cost sharing, the author has committed to amending this bill to clarify that this bill requires health plans to cover Valley fever screening tests without cost sharing for any covered individual who lives, works, goes to school, or has recently visited a region with a high incidence of Valley fever. The author has also committed to an amendment requiring DPH to annually analyze and identify regions with high rates of Valley fever to the extent feasible using available data and resources based on public health surveillance data in consultation with subject matter experts. The amendments would additionally authorize DPH to revise its identification criteria over time in response to shifting patterns of disease incidence. Because this bill is double referred, and due to timing issues, amendments will be taken in a subsequent committee.

8) **DOUBLE REFERRAL**. This bill is double referred. Should the bill pass out of this committee, it will be referred to the Assembly Committee on Judiciary.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

Altura Centers for Health
Aria Community Health Center
California Health Collaborative
City of Avenal
Kern Medical
Mycare Foundation
Saint Agnes Medical Center
One individual

**Opposition**

California Medical Association (CMA)

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