

**From:** DMHC Licensing eFiling

**Subject:** APL 21-011 – New Federal Guidance Regarding COVID-19 Testing

**Date:** Wednesday March 10, 2021 11:07 AM

**Attachments:** APL 21-011 – New Federal Guidance Regarding COVID-19 Testing (3.10.2021).pdf

Dear Health Plan Representative,

Please find attached All Plan Letter (APL) 21-011, concerning new federal guidance regarding health plan coverage of COVID-19 testing.

Thank you.

## ALL PLAN LETTER

**DATE:** March 10, 2021

**TO:** All Health Care Service Plans

**FROM:** Sarah Ream  
Chief Counsel

**SUBJECT:** APL 21-011 – New Federal Guidance Regarding COVID-19 Testing

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On February 26, 2021, the federal Centers for Medicare & Medicaid Services (CMS), in conjunction with the Department of Labor and the Department of the Treasury, issued new guidance making it easier for enrollees to obtain diagnostic COVID-19 testing and clarifying when health plans<sup>1</sup> must cover such testing for their enrollees. Please follow the link to obtain a [copy of the federal guidance](#).

This All Plan Letter (APL) provides an overview of the new federal guidance. The APL also explains how the federal guidance and the DMHC’s emergency regulation regarding COVID-19 testing<sup>2</sup> (the “emergency regulation”) work together to ensure enrollees have ready access to COVID-19 testing at no cost to the enrollee.

### I. Overview of the New Federal Guidance

The new guidance clarifies that health plans *must cover* COVID-19 diagnostic tests for asymptomatic enrollees who have no known or suspected exposure to COVID-19 when a licensed or authorized health care provider administers or has referred the enrollee for such a test.<sup>3</sup> Health plans must cover such testing without cost-sharing, prior authorization, medical screening criteria, or other medical management requirements imposed by the plan.

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<sup>1</sup> The federal guidance does not apply to “non-grandfathered” products. If you have questions regarding COVID-19 testing for enrollees in a non-grandfathered product, please contact your plan’s assigned licensing counsel.

<sup>2</sup> The emergency regulation is codified in section 1300.67.01 of title 28 of the California Code of Regulations.

<sup>3</sup> Previous federal guidance limited required coverage for COVID-19 testing to enrollees with symptoms of COVID-19 or recent known or suspected exposure to COVID-19.

The guidance further states:

When an individual seeks and receives a COVID-19 diagnostic test from a licensed or authorized health care provider, or when a licensed or authorized health care provider refers an individual for a COVID-19 diagnostic test, plans and issuers generally must assume that the receipt of the test reflects an “individualized clinical assessment” and the test should be covered without cost sharing, prior authorization, or other medical management requirements.”

Accordingly, health plans must cover an enrollee’s COVID-19 testing regardless of whether the enrollee receives the test from an in-network or out-of-network provider.

## **II. Impact of New Federal Guidance on the DMHC’s Emergency Regulation Regarding COVID-19 Testing**

The new federal guidance expands coverage for COVID-19 testing beyond what was required of plans as a matter of state law per the DMHC’s emergency regulation. The DMHC’s emergency regulation imposes independent obligations upon health plans as a matter of state law, in addition to plans’ obligations under federal law; nothing in the emergency regulation purports to restrict or diminish plans’ obligations under federal law. Accordingly, there is no conflict between the DMHC’s emergency regulation and the federal guidance, and health plans must continue to comply with both state law and federal law (including the expanded coverage requirements as set forth in the federal guidance).

In particular, in light of the new federal guidance, health plans are required to cover COVID-19 testing as follows:

- All enrollees, including asymptomatic enrollees with no known or suspected recent exposure to COVID-19, can get tested without prior authorization, utilization management, or cost-sharing.
- The new federal guidance does not distinguish between enrollees who are “essential workers” and enrollees who are not “essential workers.” Accordingly, all enrollees, regardless of “essential worker” status, can get COVID-19 testing without prior authorization or utilization management and with no cost-sharing.
- Plans must cover testing regardless of whether the enrollee obtained the test from an in- or out-of-network provider. Per the new federal guidance, enrollees do not need to first try to obtain a test from an in-network provider before obtaining a test from a provider who is not in the health plan’s network.
- There is no limit regarding the number of times an enrollee may seek COVID-19 testing.

### **III. Testing for Workplace “Health and Safety” or Public Health Surveillance Purposes.**

The new federal guidance states that health plans “are not required to provide coverage of testing such as for public health surveillance or employment purposes.” However, the guidance also provides that,

“When an individual seeks and receives a COVID-19 diagnostic test from a licensed or authorized health care provider, or when a licensed or authorized health care provider refers an individual for a COVID-19 diagnostic test, plans and issuers generally must assume that the receipt of the test reflects an “individualized clinical assessment” and the test should be covered without cost sharing, prior authorization, or other medical management requirements.

In light of this language in the new federal guidance, if a plan denies coverage of COVID-19 testing because the plan believes the testing was done for “public health surveillance or employment purposes,” the plan must have a specific reason for believing the testing was done for public health surveillance or employment purposes rather than as an “individualized clinical assessment.” The mere fact that testing was performed at a school or employment location will likely not be sufficient to overcome the assumption that the testing was an “individualized clinical assessment.”

### **IV. The DMHC’s Emergency Regulation, Including Subdivisions (d) and (e), Remain in Effect.**

As stated above, the DMHC’s emergency regulation implements state-law protections independent of (and in addition to) the requirements of federal law. Health plans must therefore continue to comply with the DMHC’s emergency regulation, in addition to federal law.

In particular, although the new federal guidance does not address health plan delegation of financial risk for testing, plans must continue to comply with subdivision (d) of the DMHC’s emergency regulation, which concerns delegation of financial risk for testing. Plans must also continue to comply with subdivision (e), which concerns timeframes for submission and payment of claims for diagnostic testing and related items and services.

If you have questions regarding this APL, please contact your health plans assigned reviewer in the DMHC’s Office of Plan Licensing.