From: DMHC Licensing eFiling

Subject: APL 23-017 - Impact of the end of federal Public Health Emergency on health plan coverage of COVID-19 tests, immunizations, and therapeutics

Date: Friday, July 21, 2023 11:00AM

Attachments: APL 23-017 - Impact of the end of federal Public Health Emergency on health plan coverage of COVID-19 tests, immunizations, and therapeutics.pdf

Dear Health Plan Representative:

The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 23-017, which addresses the impact of the end of the COVID-19 public health emergency (PHE) on health plan coverage of COVID-19 tests, immunizations, and therapeutics.

Thank you.

Gavin Newsom, Governor
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ALL PLAN LETTER

DATE: July 21, 2023

TO: All Full-Service Health Care Service Plans[1]

FROM: Sarah Ream
Chief Counsel

SUBJECT: APL 23-017: Impact of the end of federal Public Health Emergency on health plan coverage of COVID-19 tests, immunizations, and therapeutics

On January 31, 2020, the U.S. Department of Health and Human Services (HHS) declared a public health emergency (PHE) due to COVID-19. That declaration was renewed several times but ended on May 11, 2023. This All Plan Letter (APL) addresses the impact of the end of the PHE on health plan coverage of COVID-19 tests, immunizations, and therapeutics.

I. Background

Shortly after HHS declared the federal PHE, Congress enacted the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Families First Coronavirus Response Act (FFCRA). These laws required health plans to cover COVID-19 "diagnostic" testing and immunizations without cost-sharing, prior authorization, or in-network requirements. The end of the PHE impacts the federal requirements outlined in the CARES Act and the FFCRA. However, the end of the PHE does not impact (except as discussed below), state laws requiring plans to continue to cover COVID-19 testing, immunizations, and therapeutics without cost-sharing, prior authorization, or in-network requirements.

Specifically, on January 1, 2022, Senate Bill (SB) 510 took effect.[2] That bill requires health plans to cover the costs associated with COVID-19 diagnostic and screening testing and immunizations against COVID-19 without cost-sharing, prior authorization, or in-network requirements. SB 510 applies retroactively to March 4, 2020, which was

[1] This APL does not apply to Medicare Advantage or specialized health care service plan products. It does apply to limited or restricted full-service health plans.
[2] SB 510 is codified at Health and Safety Code section 1342.2.

the beginning of the Governor's declared State of Emergency related to COVID-19.[3] Additionally, on September 25, 2022, SB 1473 took effect and requires health plans to cover COVID-19 therapeutics without cost-sharing, prior authorization, or in-network requirements.[4]

II. Continued coverage of COVID-19 testing, immunizations, and therapeutics

The requirements of SB 510 and SB 1473 are not impacted by the end of the PHE, with the exception that beginning six months after the PHE ends, health plans are no longer required to cover the cost-sharing for COVID-19 testing, immunizations, and therapeutics if an enrollee receives the service from an out-of-network provider (unless otherwise required by law). Accordingly, beginning November 11, 2023, health plans will still be required to cover COVID-19 testing, immunizations, and therapeutics. However, if an enrollee receives these services out-of-network, the enrollee (including an enrollee in an HMO product) can be charged cost-sharing. If an enrollee receives the services from an in-network provider, the enrollee cannot be charged cost-sharing for these services.

If a plan intends to impose cost-sharing for out-of-network COVID-19 testing, immunizations, and/or therapeutics on or after November 11, 2023, the plan must file an amendment with the DMHC regarding the cost-sharing amounts and describing how the plan will communicate the cost-sharing amounts to enrollees.

III. Continued coverage of over-the-counter (OTC) COVID-19 tests

A. Plans must continue to cover eight OTC COVID-19 tests per enrollee per month.

On January 10, 2022, the federal government issued guidance (available at this link) requiring commercial full-service plans to cover at least eight OTC COVID-19 tests authorized by the U.S. Food and Drug Administration per enrollee per month through the end of the federal PHE. On April 25, 2022, the DMHC issued guidance interpreting SB 510 as requiring commercial health plans to cover at least eight OTC COVID-19 tests per enrollee per month.[5] The DMHC's guidance can be found in APL 22-014, which is available at this link.

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[3] Following the enactment of SB 510, the California Association of Health Plans (CAHP) sued the DMHC to enjoin enforcement of SB 510 to the extent it prevents a plan from delegating the financial risk for COVID-19 testing to contracted providers without the providers and plan first negotiating and agreeing to a new contract provision. The DMHC will issue a separate APL regarding the outcome of that litigation.

[4] SB 1473 amended Health and Safety Code section 1342.2 and 1342.3.

[5] The state and federal requirements for plans to cover OTC COVID-19 tests were not additive, meaning plans were *not* required to cover at least 16 OTC tests per month. Rather, they were (and are) required to cover at least 8 OTC tests per month.

The federal requirement to cover at least eight OTC COVID-19 tests expired on May 11, 2023, with the end of the federal PHE. However, SB 510 continues to require plans to cover at least eight OTC COVID-19 tests per month with no prior authorization, cost-sharing, or in-network requirements. On November 11, 2023, and thereafter, the only change that will occur is that an enrollee may be charged cost-sharing for OTC COVID-19 tests if the enrollee received the tests from an out-of-network provider.

B. Reimbursement amount for OTC COVID-19 tests

The January 10, 2022 federal guidance allowed plans to elect to provide direct coverage of OTC COVID-19 tests, in which case enrollees would pay nothing out-of-pocket if they obtained their tests from an in-network provider. If a plan had an adequate network of providers to deliver OTC COVID-19 tests, enrollees could still purchase and seek reimbursement for tests obtained out-of-network. However, in that case, the plan would only need to reimburse the enrollee at the lesser of: (1) the amount the enrollee paid for the test; or (2) $12 per test. If a plan did not have an adequate network of providers, the federal guidance required the plan to reimburse enrollees for the actual amount they paid for OTC COVID-19 tests (up to the maximum of 8 tests/month)—the plan could not limit reimbursement to $12/test.

The DMHC's APL 22-014 adopted the federal approach to reimbursement for OTC COVID-19 tests. However, beginning November 11, 2023, health plans may limit reimbursement to $12/test for OTC COVID-19 tests an enrollee purchases from an out-of-network provider. The DMHC continues to strongly encourage plans to contract with providers to deliver OTC COVID-19 tests to enrollees with no out-of-pocket costs to enrollees.

IV. Cost sharing for out-of-network COVID-19 tests, immunizations, and therapeutics imposed on or after November 11, 2023, will not be considered "mid-year cost-sharing design" changes.

Health and Safety Code section 1374.255 generally prohibits plans from changing cost-sharing amounts for their individual and small group products during a plan year, unless the change is required by state or federal law. Because the legislature expressly allows plans to impose out-of-network cost-sharing for COVID-19 testing, immunizations, and therapeutics beginning six months after the end of the federal PHE (i.e., beginning November 11, 2023), the DMHC will not consider the imposition of cost-sharing in this instance to be an impermissible mid-year change.

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