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Maryland
INSURANCE ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
1-800-492-6116 TTY: 1-800-735-2258
www.insurance.maryland.gov

BULLETIN 23-7

Date: May 2, 2023

To: All Health Insurers; Nonprofit Health Service Plans; and Health Maintenance Organizations ("Carriers")

Re: COVID-19 – Impact of End of the Federal Public Health Emergency and National Emergency on Private Health Insurance Coverage

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Background

On January 31, 2020, the Secretary of United States Department of Health and Human Services (HHS) declared that a nationwide public health emergency (PHE) had existed since January 27, 2020, as a result of the 2019 novel coronavirus, the virus that causes COVID-19. On March 13, 2020, by Proclamation 9994, the President of the United States declared a National Emergency Concerning the Novel Coronavirus Disease 2019 Pandemic (COVID-19 National Emergency), effective March 1, 2020. Both the COVID-19 National Emergency and the PHE were continually renewed. On February 9, 2023, HHS announced the intent to end the PHE, at the end of the day on May 11, 2023. On April 10, 2023, President Biden signed H.J.Res.7. (Public Law No. 118-3) into law, which terminated the COVID-19 National Emergency immediately. The end of the COVID-19 National Emergency does not impact the announced May 11, 2023 expiration of the PHE.

During the COVID-19 National Emergency and PHE, the federal government imposed numerous requirements related to private health insurance, and many of these requirements were contingent on the existence of the emergency proclamations. **The Maryland Insurance Administration (MIA) is issuing this bulletin to clarify the impact of the expiration of the emergency declarations on the applicable requirements for private health insurance[1] coverage**.

COVID-19 Testing Coverage Requirements

[1] The term 'health insurance' is being used for convenience, and includes other types of health coverage, such as health maintenance organizations, to which the requirements applied.

Section 6001 of the Families First Coronavirus Response Act (FFCRA) and section 3202 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) enacted specific requirements related to insurance coverage of diagnostic testing and services for COVID-19. These requirements were further clarified in federal rules and sub-regulatory guidance. Generally, carriers offering grandfathered or non-grandfathered health benefits plans were required to cover COVID-19 tests, including certain over-the-counter (OTC) tests, and testing-related services without cost sharing, prior authorization, or other medical management requirements, and regardless of whether the testing and services were received from an in-network provider or out-of-network provider.

Under FFCRA and the CARES Act, however, carriers are not required to provide coverage for items and services related to diagnostic testing for COVID-19 that are furnished after the end of the PHE. Federal guidance has clarified that an item or service is considered "furnished" on the date the item or service was rendered to the individual (or for an OTC COVID-19 diagnostic test, the date the test was purchased) and not the date the claim is submitted. When a COVID-19 diagnostic test involves multiple items or services, the entire episode of care is considered to be furnished during the PHE, and therefore subject to the FFCRA and CARES Act requirements, based on the earliest date on which an item or service is furnished within that episode of care.[2] Consequently, for COVID-19 tests and related services furnished on or after May 12, 2023, the following standards are applicable:

- Federal law no longer requires carriers to cover COVID-19 tests and testing-related services, including over-the-counter (OTC) COVID-19 tests. However, the MIA expects carriers to continue to provide coverage for all services in accordance with the terms of their approved health benefit plan contracts. The MIA notes that, with the exception of OTC tests which are customarily excluded under most insurance contracts, medically necessary diagnostic services for COVID-19 would generally be considered a covered service under a health benefit plan approved for issuance in Maryland.

- Federal law no longer requires carriers to cover COVID-19 tests and testing-related services received from an out-of-network provider. Whether or not a carrier is required under Maryland law to cover COVID-19 testing from an out-of-network provider depends on the type of health benefit plan contract, and whether the contract generally provides coverage for services received from out-of-network providers. For example, a preferred provider insurance policy that is subject to § 14-205 of the Insurance Article is required to provide coverage for any service lawfully performed by an out-of-network provider, while an exclusive provider organization contract subject to § 14-205.1 of the Insurance Article or a Health Maintenance Organization contract may not be required to cover most services performed by an out-of-network provider, depending on the terms of the contract.

- Federal law no longer prohibits carriers from applying cost-sharing to covered COVID-19 tests and testing-related services, regardless of whether the services are performed by an

[2] See FAQs about Families First Coronavirus Response Act, Coronavirus Aid, Relief, and Economic Security Act, and Health Insurance Portability and Accountability Act Implementation Part 58 (March 29, 2023)

in-network provider or out-of-network provider. Carriers may apply cost sharing to COVID-19 testing in accordance with the terms of their approved contracts.

- Federal law no longer requires carriers to reimburse a COVID-19 diagnostic test provider the cash price listed on the provider's website if the carrier had not negotiated a rate with the provider prior to the PHE. Carriers may apply their contracted reimbursement rates to in-network providers, and, for out-of-network providers, may calculate of the applicable out-of-network allowed amount based on the terms of their approved contracts.

- Federal law no longer prohibits a carrier that provides coverage for COVID-19 tests and testing-related services from imposing prior authorization or other medical management requirements for such items and services. Under Maryland law, any medical management requirements that are imposed on these services must be consistent with the terms of the carrier's approved contracts and the carrier's utilization review criteria that are on file with the MIA.

Notwithstanding the general standards described above, carriers are reminded that they are contractually bound to provide all the benefits described in their approved policy forms, in the exact manner that those benefits are explained in the contracts. Therefore, even if an applicable federal or state requirement expires at the end of the PHE, a carrier will be obligated to continue to provide the benefits and cost-sharing described in the contract until such time as the contract may be amended, if otherwise permitted, upon renewal. **For example, if the approved contract states that cost-sharing is waived for COVID-19 tests, or that coverage is provided for OTC COVID-19 tests, the carrier must continue to provide that coverage following the end of the PHE for the remainder of the term of the contract.**

Additionally, to reduce confusion and minimize other adverse impacts on consumers related to unexpected mid-year benefit changes, the MIA encourages carriers to take the following steps:

- Timely notify all covered persons of key information regarding changes in coverage of COVID-19 diagnosis and treatment, including the date when the benefit changes will become effective. Examples of changes include imposition of cost-sharing or medical management requirements.

- Attempt to negotiate with out-of-network providers on costs for covered COVID-19 services to avoid unexpected balance billing of covered persons.

- To the extent practical, continue to treat state-run COVID-19 testing sites and local health departments as in-network providers when determining whether benefits are payable and applicable cost-sharing.

COVID-19 Preventive Services and Vaccination Coverage Requirements

Section 3203 of the CARES Act generally requires non-grandfathered group and individual health benefit plans to cover, without cost-sharing requirements, any item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is: 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 (USPSTF); or an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. During the PHE, federal agencies adopted interim final rules to implement the requirements related to COVID-19 preventive services, which included a provision that coverage must be provided without cost-sharing, regardless of whether the COVID-19 preventive service is provided by an in-network or out-of-network provider. While section 3203 of the CARES Act is not limited to the duration of the PHE, the additional requirements under the interim final rules related to coverage of services performed by out-of-network providers do not apply to COVID-19 preventive services furnished after the end of the PHE.

Therefore, federal law no longer requires carriers to cover COVID-19 preventive services from an out-of-network provider, including vaccination, furnished on or after May 12, 2023, and, if coverage is provided, carriers may impose applicable out-of-network cost-sharing. Whether or not a carrier is required under Maryland law to cover COVID-19 preventive services received from an out-of-network provider depends on the type of health benefit plan contract, and whether the contract generally provides coverage for services received from out-of-network providers.

Conversely, under section 3203 of the CARES Act, carriers offering non-grandfathered group or individual health benefit plans must continue to cover, without cost sharing, required COVID-19 preventive services furnished by an in-network provider after the end of the PHE. This includes, consistent with the applicable ACIP recommendation, all COVID-19 vaccines within the scope of the Emergency Use Authorization (EUA) or Biologics License Application (BLA) for the particular vaccine and their administration, pursuant to section 2713(a) of the Public Health Service Act and its implementing regulations.

Extension of Election and Notice Deadlines for COBRA and Certain Other Group Health Plan Provisions:

On May 4, 2020, in response to the COVID-19 National Emergency, the federal Department of Labor, Department of Treasury, and the Internal Revenue Service issued the Joint Notification of Extensions of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak (Joint Notice). The Joint Notice and subsequent federal guidance extended certain due dates related to elections and other actions for HIPAA special enrollment, COBRA continuation coverage, and internal claims and appeals and external review, by disregarding the period of time lasting for the duration of the COVID-19 National Emergency and 60 days thereafter (the "Outbreak Period"). The disregarded period, however, is limited to one year after the date an individual would have otherwise been permitted or required to take the action. These extended time periods are applicable to the following circumstances under group health plans:

- The 60-day election period for COBRA continuation coverage;
- The date for making COBRA premium payments;
- The date for employers to provide a COBRA election notice;

- The deadline for individuals to notify the plan of a COBRA qualifying event or determination of disability;
- The 30-day period (or, in certain circumstances, 60-day period) to request special enrollment in a group health plan;
- The deadline for individuals to file a claim for benefits under the plan's claims procedures;
- The deadlines for filing internal and external appeals of adverse benefit determinations; and
- The deadline for filing information to perfect a request for external review upon a finding that the request was not complete.

Following the end of the Outbreak Period, which is now confirmed to be June 9, 2023, the calculations for the otherwise applicable time periods and deadlines will resume, with June 10, 2023 being counted as day "one." The MIA encourages carriers to review the examples provided in FAQ 5 of FAQs about Families First Coronavirus Response Act, Coronavirus Aid, Relief, and Economic Security Act, and Health Insurance Portability and Accountability Act Implementation Part 58 (March 29, 2023) to ensure proper calculation of the applicable timeframes under various scenarios.

Questions about this Bulletin may be directed to the Life & Health Division of the Maryland Insurance Administration at 410-468-2170.

KATHLEEN A. BIRRANE
Commissioner

By: **Signature on Original**

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David Cooney
Associate Commissioner
Life and Health