FEHB Program Carrier Letter
All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

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Fee-for-service [7] Experience-rated HMO [7] Community-rated HMO [8]

Subject: COVID-19 Public Health Emergency Transition

On January 30, the Biden-Harris Administration announced that the Department of Health and Human Services (HHS) intends to end the public health emergency (PHE) for coronavirus disease-2019 (COVID-19) on May 11, 2023.[1] FEHB Carriers must continue to cover benefits for the diagnosis, prevention, and treatment for COVID-19 even after the expiration of the PHE. As explained further in this Carrier Letter, after the expiration of the PHE, Carriers:

- Must continue to cover laboratory and over-the-counter (OTC) COVID-19 diagnostic tests including associated items and services for furnishing those tests. Carriers may impose, but are **encouraged** to waive, cost-sharing (including deductibles, copayments, and coinsurance) and medical management (including prior authorization) for COVID-19 diagnostic tests and associated items and services furnished after the end of the PHE.
- Are encouraged to provide notice to covered individuals about changes to key information about their COVID-19 benefits (*e.g.*, date when the Carrier would begin to impose cost-sharing requirements).
- Must continue to cover, without cost-sharing, COVID-19 vaccines (including their administration), and any other qualifying coronavirus preventive services intended to prevent or mitigate COVID-19 on an in-network basis.

[1] See Executive Office of the President, Office of Management and Budget, Statement of Administration Policy: H.R. 382 and H.J. Res. 7 (Jan. 30, 2023). See also HHS Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap (Feb. 9, 2023), clarifying that the COVID-19 PHE is anticipated to end at the end of the day on May 11, 2023.

OPM's guidance leverages the Frequently Asked Questions (FAQs) Part 58 issued on March 29, 2023 by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments).

This Carrier Letter updates OPM's previous guidance in Carrier Letters 2020-02, 2020-08, 2020-19, 2022-01, 2022-08, 2022-21, and it supersedes any guidance that was previously issued to the extent it is inconsistent with this guidance.

COVID-19 Diagnostic Testing

Even after the PHE ends, Carriers must continue to cover laboratory and OTC COVID-19 diagnostic tests including associated items and services for furnishing those tests. For the duration of the PHE, Carriers have been required to waive cost-sharing (including deductibles, copayments, and coinsurance) and medical management (including prior authorization) for COVID-19 diagnostic tests and associated items and services.[2] Once the PHE expires, Carriers may impose, but are **encouraged** to waive, cost-sharing and medical management requirements for COVID-19 diagnostic tests and associated items and services furnished after the end of the PHE.

As noted in Question 1 of the Departments' FAQs Part 58, an item or service is furnished on the date the item or service was rendered to the individual (or for an OTC COVID-19 test, the date the test was purchased) and not the date the claim is submitted. Consistent with Question 1, Carriers should look to the earliest date on which an item or service is furnished within an episode of care to determine the date a COVID-19 test is rendered, when the test involves multiple items or services. For example, if a health care provider collects a specimen to perform a COVID-19 test on the last day of the PHE but the laboratory analysis occurs on a later date, then a Carrier should treat both the specimen collection and laboratory analysis as if they

[2] See Carrier Letters 2020-08 and 2022-01, which implemented the requirements of sections 6001 and 6006(c) of the Families First Coronavirus Response Act (FFCRA). Unless otherwise specified, references in this document to section 6001 of the FFCRA include the amendments made by section 3201 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Section 6006(c) of the FFCRA applies section 6001 to FEHB covered individuals.

were furnished during the PHE. Therefore, the Carrier should cover both the specimen collection and laboratory analysis without cost-sharing or medical management.

Notification to FEHB Covered Individuals

OPM encourages Carriers to notify covered individuals of key information regarding coverage of COVID-19 diagnosis and treatment, including testing. This includes the date when the Carriers will begin to impose cost-sharing requirements, prior authorization, or other medical management requirements on COVID-19 tests, to the extent applicable under the plan or coverage. Carriers may provide such notice through means such as email or Internet posting.

In addition, to the extent applicable, Carriers must follow Question 2 of the Departments' FAQs Part 58 relative to a material modification that would affect the content of the Summary of Benefits and Coverage (SBC).

Provider Reimbursement for COVID-19 Diagnostic Tests

As previously noted in Carrier Letter 2020-08, Carriers providing coverage for COVID-19 diagnostic tests must reimburse any COVID-19 diagnostic test provider the cash price listed on the provider's website if a negotiated rate was not in effect before the PHE, or the Carrier may negotiate a rate with such provider for less than such cash price. Under section 3202(a) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), this applies only to COVID-19 diagnostic tests furnished during the PHE, beginning on or after March 27, 2020. OPM's guidance is consistent with Question 3 of the Departments' FAQs Part 58.

Similarly, section 3202(b) of the CARES Act, which requires COVID-19 diagnostic test providers to make public the cash price of a COVID-19 diagnostic test on the provider's public internet website, applies only during the PHE, beginning on or after March 27, 2020. However, as noted in Question 3 of FAQs Part 58, the Departments have encouraged providers of diagnostic tests for COVID-19 to continue to make the cash price of a COVID-19 diagnostic test available on the provider's public internet website

for a sufficient time (*e.g.*, at least 90 days) after the end of the PHE. This will help Carriers process claims for tests furnished prior to the end of the PHE in accordance with the cash price reimbursement requirements.

COVID-19 Vaccines and Other Qualifying Coronavirus Preventive Services

Even after the PHE ends, Carriers must continue to provide in-network coverage, without cost-sharing, for qualifying coronavirus preventive services,[3] including, consistent with recommendations of the Advisory Committee on Immunization Practices (ACIP), all COVID-19 vaccines (and their administration) within the scope of an Emergency Use Authorization (EUA) or Biologics License Application (BLA). OPM's guidance is consistent with Question 4 of the Departments' FAQs Part 58.

Carriers must cover COVID-19 vaccines, and any other qualifying coronavirus preventive service, within 15 business days after a recommendation with an "A" or "B" rating by the United States Preventive Services Task Force (USPSTF),[4] or a recommendation by ACIP. Given the widespread availability of COVID-19 vaccines, after the end of the PHE, OPM is no longer requiring coverage "as soon as possible" after the U.S. Food and

[3] Pursuant to section 3203(b)(1) of the CARES Act, the term "qualifying coronavirus preventive service" means an 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.

[4] The recent opinion in *Braidwood Management, Inc. v. Becerra,* --- F. Supp. 3d ---, 2023 WL 2703229 (N.D. Tex.), pertains to the preventive services requirement under the Affordable Care Act; it does not impact the preventive services requirements for FEHB Carriers. Under 5 U.S.C § 8902, OPM has broad authority to negotiate for benefit plans for Federal employees. OPM "may contract with qualified carriers" and "each contract … shall contain a detailed statement of benefits offered … *as [OPM] considers necessary or desirable*." 5 U.S.C § 8902(a), (d) (emphasis added). OPM has required inclusion of preventive services based on quality industry standards prior to the Affordable Care Act, as described in FEHB Carrier Letters pre-dating the ACA. Accordingly, as set forth in Carrier Letter 2019-01, OPM will continue to require coverage, without cost sharing, of all evidence-based items and services that have in effect a rating of "A" or "B" in the current recommendations of the USPSTF, including those recommended on or after March 23, 2010.

Drug Administration's (FDA) authorization or approval, as previously noted in Carrier Letters 2020-08 and 2020-19.

With respect to coverage of COVID-19 vaccines and other qualifying coronavirus preventive services, Carrier Letter 2020-19 directed Carriers to follow the Departments' interim final rule published on November 16, 2020. But the interim final rule has a sunset provision under which certain regulations will not apply to qualifying coronavirus preventive services furnished after the end of the PHE.[5] As a result of the sunset provision, Carriers will no longer be required to provide out-of-network coverage for COVID-19 vaccines (and their administration) or any other qualifying coronavirus preventive service furnished after the end of the PHE. However, OPM expects that Carriers that continue to offer out-of-network coverage will do so with out-of-network cost sharing.

As noted in Carrier Letter 2020-19, consistent with a provision of the Departments' interim final rule, Carriers must cover a COVID-19 vaccine even if not listed for "routine use" on the Immunization Schedules of the Centers for Disease Control and Prevention. That provision of the Departments' interim final rule will sunset with the end of the PHE. But please note that as of the date of publication of this Carrier Letter, all FDA-authorized or approved COVID-19 vaccines are for routine use, and therefore, the coverage requirement remains effectively unchanged.

Medicaid and Children's Health Insurance Program (CHIP) Coverage

Between March 18, 2020 and March 31, 2023, the Centers for Medicare & Medicaid Services (CMS) temporarily waived certain Medicaid and Children's Health Insurance Program (CHIP) requirements on the condition that individuals were kept continuously enrolled (known as the "continuous enrollment condition"). The easing of these rules helped prevent people with Medicaid and CHIP – in all 50 states, the District of Columbia, and the five

[5] The interim final rules specify that paragraphs (a)(1)(v), (a)(3)(iii), and (b)(3) of 26 CFR 54.9815-2713T, 29 CFR 2590.715-2713, and 45 CFR 147.130 will not apply to a qualifying coronavirus preventive service furnished after the end of the PHE.

U.S. territories – from losing their health coverage during the COVID-19 pandemic. However, states have begun resuming or will soon resume Medicaid and CHIP eligibility reviews following the end of the continuous enrollment condition on March 31, 2023. According to some estimates, when states resume these reviews, up to 15 million people could lose their current Medicaid or CHIP coverage through a process called "unwinding."[6]

In an effort to minimize the number of people that lose access to health coverage as a result of unwinding, the Biden-Harris Administration is working to inform people about renewing their coverage and exploring other available health insurance options if they no longer qualify for Medicaid or CHIP. See, for example, Question 7 of the Departments' FAQs 58.

For purposes of the FEHB Program, pursuant to 5 CFR 892.101, the loss of Medicaid or CHIP coverage would be a qualifying life event (QLE) for employees or eligible family members, and an FEHB enrollment change is permitted within 60 days after loss of coverage. In addition, an employee or eligible family member becoming eligible for premium assistance under Medicaid or CHIP is also a QLE, and an FEHB enrollment change is permitted within 60 days after the date the employee or family member is determined to be eligible for assistance.

High Deductible Health Plans (HDHPs)

In March 2020, the Treasury Department and the Internal Revenue Service (IRS) issued Notice 2020-15,[7] which provides that a health plan that otherwise satisfies the requirements to be a high deductible health plan (HDHP) under section 223(c)(2)(A) of the Internal Revenue Code (Code) will not fail to be an HDHP merely because the health plan provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible. As a result, the individuals covered by such a plan will not fail to be eligible individuals under section 223(c)(1) of the Code who may contribute to a

[6] For more information about unwinding, see www.Medicaid.gov/unwinding.
[7] See Internal Revenue Bulletin 2020-14, page 559.

health savings account (HSA) merely because of the provision of those health benefits for testing and treatment of COVID-19.

Notice 2020-15 was issued due to the PHE. The notice states that the relief provided would continue until further guidance is issued. The notice further states that it does not modify previous guidance with respect to any of the HDHP requirements, other than with respect to the relief for testing for and treatment of COVID-19. The notice also reiterates that vaccinations continue to be considered preventive care under section 223(c)(2)(C) of the Code for purposes of determining whether a health plan is an HDHP.

Accordingly, an individual covered by an HDHP that provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible may continue to contribute to an HSA until further guidance is issued. The Treasury Department and the IRS are reviewing the appropriateness of continuing this relief given the anticipated end of the PHE and anticipate issuing additional guidance in the near future. Any future modifications to the guidance previously provided in Notice 2020-15 will not generally require HDHPs to make changes in the middle of a plan year in order for covered individuals to remain eligible to contribute to an HSA.

For more information, see Question 8 of the Departments' FAQs Part 58.

If you have any questions, please contact your Health Insurance Specialist.

Sincerely,

Laurie Bodenheimer
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Healthcare and Insurance