COVID-19 FAQs

April 16, 2020

Guidance Issued on COVID-19 Testing Mandate

The U.S. Departments of Labor, Health and Human Services, and Treasury issued FAQs on April 11, 2020, that provide guidance for group health plans implementing coverage mandates under the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act). Below is a summary of key points from the FAQs, which may be found here.

Testing for COVID-19 Detection and Diagnosis

Group health plans and health insurance issuers must provide coverage for in vitro diagnostic testing and services for detection and diagnosis of the COVID-19 virus without cost sharing or medical management. The mandate applies to group health plans and health insurance companies offering group or individual health insurance coverage, including grandfathered plans. It does not apply to short-term, limited-duration coverage, excepted benefit health plans such as dental and vision, or retiree-only plans.

Plans must cover items and services furnished to an individual during a healthcare provider office visit (including in-person and telehealth visits), urgent care center visits, and emergency visits that result in an order for a COVID-19 test. The FAQs state that the items and services furnished during a visit must be covered "only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product." Plans must also cover serological tests that are used to detect COVID-19 antibodies, and are intended for use in the diagnosis of the disease or condition of having a current or past COVID-19 infection.

Differential Diagnosis Tests Also Included

The Centers for Disease Control and Prevention (CDC) strongly encourages clinicians to test for other causes of respiratory illness. The FAQs clarify that if the attending provider determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed during a visit to determine the need for COVID-19 diagnostic testing, and the visit results in an order for, or administration of, COVID-19 diagnostic testing, the plan must cover those services in full. If a COVID-19 test is not ordered or administered as a result of the visit, full coverage of these services is not required.

No Cost-Sharing, Prior Authorization or Medical Management Allowed

Health plans must cover the cost of all items and services that the individual's attending health provider determines are medically appropriate for the individual, in accordance with accepted standards of medical practice. Health plans may not impose cost-sharing (including deductibles, copayments and coinsurance), prior authorization requirements or other medical management requirements for COVID-19 testing.

In-Network and Out-of-Network Coverage Required

Health plans are required to cover the cost of the COVID-19 testing and related services described above whether provided in-network or out-of-network. Plans reimburse providers with whom the health plan has a negotiated rate at the negotiated rate. For providers with whom a health plan does not have a negotiated rate, the health plan is to reimburse the provider at the cash rate the provider lists on its public internet site or at such lesser amount as the plan negotiates with the provider.

Visit Includes Traditional and Non-Traditional Settings

The FFCRA requires plans to cover COVID-19 diagnostic testing services during office visits, including in-person and via telehealth, urgent care centers and emergency rooms. The FAQs define the term "visit" broadly to include both traditional and non-traditional care settings, including COVID-19 drive-through screening and testing sites where licensed healthcare providers are providing COVID-19 diagnostic testing.

Departments Relax Participant Notice Requirements

The Affordable Care Act requires group health plans to give participants sixty days' advance notice of a material modification to information contained in the summary of benefits and coverage (SBC). To address this, the Departments announced that they will not enforce this rule with respect to plan modifications that provide greater coverage related to the diagnosis and/or treatment of COVID-19. The non-enforcement policy also applies to the addition of or expansion of telehealth and other remote care services. However, the guidance states group health plans and health insurance companies should provide notice of the changes as soon as reasonably practicable.

Excepted Benefits – EAPs and Onsite Medical Clinics

Excepted benefits are exempt from certain provisions of the Public Health Services Act, ERISA, and the Internal Revenue Code, such as special enrollment requirements, the mandate to provide preventive care with no cost-sharing, and rules to provide essential health services with no annual or lifetime limits. To constitute an excepted benefit an employee assistance program must, among other things, not provide significant benefits in the nature of medical care.

The FAQs state that an EAP can offer benefits for diagnosis and testing for COVID-19 during the period of the public health emergency without affecting its excepted benefit status. Additionally, coverage of on-site medical clinics is an excepted benefit in all circumstances. This will help employers provide COVID-19 diagnosis and testing by clarifying that they may offer this coverage through onsite clinics and EAPs– without providing medical care that changes excepted benefit status.

IRS Rule for Telehealth and Remote Care Services Under HSA/HDHP Not Limited to COVID-19 Services

The IRS previously provided guidance that a health plan may cover services related to COVID-19 under an HSA-compatible high deductible health plan (HDHP) before participants meet their deductibles without affecting the participants' HSA eligibility. The Departments' FAQs state that with respect to this guidance, it applies "generally to coverage for healthcare provided through telehealth and other remote care services." Thus, it is not limited to coverage for COVID-19-related telehealth and remote care services. This expansive interpretation is designed to encourage telehealth in order to mitigate the impact of the COVID-19 public health emergency.