COVID-19 Update: DOL, HHS and Treasury issue FAQs for group health plans and insurers on COVID-19 testing and provider visits

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On April 11, 2020, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury issued frequently asked questions (FAQs) regarding implementation of the Families First Coronavirus Response Act (FFCRA), the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and other health coverage issues related to COVID-19.

In issuing the FAQs, the departments noted that their emphasis is "on assisting (rather than imposing penalties on) group health plans, health insurance issuers and others that are working diligently and in good faith to understand and come into compliance with the new law."

The FAQs offer helpful guidance to both insurers and health care providers to ensure COVID-19 billing and payment policies adhere to the new laws. They address the following topics: the FFCRA/Cares Act[1], Excepted Benefits, and Telehealth and Other Remote Care Services.

Answers provided by the departments in the FAQs include:

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- Plans and issuers must provide coverage for a serological test for COVID-19. These tests are used to detect antibodies against the SARS-CoV-2 virus and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-CoV-2, the virus that causes COVID-19.
- Plans and issuers must cover items and services furnished to an individual during visits that result in an order for, or administration of, a COVID-19 diagnostic test, but only to the extent that the items or services related to the furnishing or administration of the test or to the evaluation of such individual for purposes of determining the need of the individual for the test, as determined by the individual's attending health care provider.
    - The FAQs give the following example: If the individual's attending provider determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed during a visit (which term here includes in-person visits and telehealth visits) to determine the need of such individual for COVID-19 diagnostic testing, and the visit results in an order for, or administration of, COVID-19 diagnostic testing, the plan or issuer must provide coverage for the related tests.
    - This coverage must be provided without cost-sharing, when medically appropriate for the individual, as determined by the individual's attending health care provider in accordance with accepted standards of current medical practice. This coverage must also be provided without imposing prior authorization or other medical management requirements.
- Plans and issuers are required to provide coverage for items and services that are furnished by providers that have not agreed to accept a negotiated rate as payment in full (i.e., out-of-network providers).
- Covered items and services for health care provider office visits include traditional and non-traditional settings, including in-person and telehealth visits, as well as visits to urgent care centers, emergency rooms, and drive-through COVID-19 screening and testing sites.
- An employer can offer benefits for diagnosis and testing for COVID-19 under an employee assistance program (EAP) that constitute an excepted benefit.
- An employer may offer benefits for diagnosis and testing for COVID-19 at an on-site medical clinic that constitute an excepted benefit.
- Plans and issuers can add benefits, or reduce or eliminate cost-sharing, for telehealth and other remote care services prior to satisfying any applicable notice of modification requirements and without regard to restrictions on mid-year changes to provide coverage for telehealth services.

[1] The FFCRA was enacted on March 18, 2020. Section 6001 of the FFCRA generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 (referred to collectively in this document as COVID-19) when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. Under the FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments and coinsurance) or prior authorization or other medical management requirements.

The CARES Act was enacted on March 27, 2020. Section 3201 of the CARES Act amended section 6001 of the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover without any cost-sharing requirements or prior authorization or other medical management requirements. Additionally, section 3202 of the CARES Act generally requires plans and issuers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the cash price.)

A state may impose additional standards or requirements on health insurance issuers with respect to the diagnosis or treatment of COVID-19, to the extent those standards or requirements do not prevent the application of a federal requirement.