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Guidance issued on COVID-19 diagnostic testing coverage mandate

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The Departments of Labor, Health & Human Services, and the Treasury recently issued a set of FAQs that provide guidance to group health plan sponsors on various issues related to implementation of the COVID-19 diagnostic testing mandate.

Background

On March 18, 2020, the president signed the Families First Coronavirus Response Act (FFCRA), which includes a requirement for group health plans to cover COVID-19 diagnostic testing — including the cost of office, urgent care, ER and telehealth visits in order to receive testing — without cost-sharing or prior authorization. (See our March 19 *FYI Alert*.) The following week, he signed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which expands the COVID-19 diagnostic testing mandate provisions. (See our March 31 *FYI Alert*.)

Departments' FAQs

The Departments of Labor, Health & Human Services, and the Treasury (the departments) issued a set of FAQs on April 11 that provide guidance to group health plan sponsors on various issues related to the implementation of COVID-19 diagnostic testing requirements. The departments anticipate releasing additional guidance in the future.

The FAQs address the following issues.

Which group health plans are subject to the mandate?

Most group health plans are subject to the mandate. This includes grandfathered plans under the Affordable Care Act, non-federal governmental plans, and church plans. The mandate does not apply to retiree-only plans or to excepted benefits, such as dental, vision, and most EAPs.

When are plans first required to comply and for how long?

Plans are required to cover items and services relating to COVID-19 diagnostic testing that were furnished on and after March 18, 2020, and to continue to do so through the end of the public health emergency. Unless extended or terminated earlier, the public health emergency related to COVID-19 will end on June 16, 2020.

What types of testing must be covered?

The guidance clarifies that in addition to tests that determine whether an individual has the virus based on the presence of COVID-19 virus genetic material in the body, a group health plan must also cover serological testing to detect COVID-19 antibodies. All tests must be either: (1) authorized by the Food and Drug Administration (FDA), (2) under review by the FDA, (3) developed and authorized by a state, or (4) determined appropriate by the Secretary of Health & Human Services.

What items and services must be covered in full during a visit?

Health plans "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." The FAQs clarify that if the attending provider determines that other tests, such as influenza or blood tests, should be performed during a visit to help determine whether COVID-19 diagnostic testing should be conducted, "and the visit results in an order for, or administration of, COVID-19 diagnostic testing," the plan must cover those services in full.

> **Buck comment.** If COVID-19 diagnostic testing is not ordered or administered as a result of the visit, full coverage for these services is not required.

Can a plan impose any cost-sharing, prior authorization, or medical management requirements for COVID-19 testing?

No.

Does the requirement to cover COVID-19 diagnostic testing without cost-sharing apply to out-of-network providers?

Yes. This requirement applies to out-of-network providers, including HMOs that otherwise do not cover non-emergency out-of-network services. Out-of-network providers would be reimbursed based on the cash price listed by the provider on a public website or the amount negotiated by the plan with the provider.

Under what circumstances are services considered to be furnished during a visit?

The FFCRA requires plans to cover COVID-19 diagnostic testing services during office visits including in-person and telehealth visits, as well as urgent care centers and emergency rooms. The guidance defines the term "visit" broadly "to include both traditional and non-traditional care settings in which a COVID-19 diagnostic test … is ordered or administered."

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Buck comment. While the guidance does not require group health plans to include a benefit with a telehealth provider, any services offered by a provider through a telehealth visit or other remote visit for COVID-19 diagnostic testing must be covered in full.

What participant communication requirements apply?

The ACA requires group health plans to provide participants with at least 60 days' advance notice of a material modification to information contained in a Summary of Benefits and Coverage (SBC). The FAQ states that the departments will not enforce this advance notice requirement to the enhanced coverage of items or services related to the diagnosis or treatment of COVID-19. The non-enforcement policy will also apply to the addition or expansion of telehealth and other remote care services. However, plans "must provide notice of the changes as soon as reasonably practical." The guidance notes that the departments would continue to take enforcement action against a plan that attempts to offset the cost of the COVID-19 diagnostic testing requirement by eliminating or limiting benefits or increasing cost-sharing on other services.

The non-enforcement policy applies during the public health emergency period. If the benefit changes are continued beyond the public health emergency period, then plans will be required to update plan documents and terms of coverage.

Buck comment. Employers should communicate the coverage changes to participants as soon as possible. Using updated SBCs for this communication is an option for employers, but not required.

What about SMMs?

Unlike the SBC requirements, unless there is a material reduction in benefits, a group health plan does not have to issue an SMM for a change until 210 days after the close of the plan year in which the change was adopted. Nevertheless, sponsors may want to consider providing notice of the changes in the form of an SMM.

Can an employer offer benefits for COVID-19 diagnostic testing under an EAP or onsite medical clinic that constitute an excepted benefit without impacting its excepted benefit status?

Yes, diagnostic testing coverage can be provided without impacting the excepted benefit status of the EAP or onsite medical clinic.

Buck comment. While the guidance strongly encourages plan sponsors to promote the use of telehealth services, similar relief was not provided for telehealth benefits. Some employers are considering offering a standalone telehealth benefit to employees who are not eligible for medical coverage, or who have waived coverage. However, a standalone telehealth benefit would not satisfy the ACA market reform requirements unless it qualifies as an excepted benefit. (See our February 27, 2019 *FYI In-Depth*.) Use of onsite medical clinics to provide testing could be part of an employer's return-to-work program.

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In closing

The FAQs provide important guidance for employers on implementation of the diagnostic testing requirements and include actions employers need to take to communicate these provisions to employees.

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