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INFORMATION MEMO
EMPLOYEE BENEFITS LAW

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Federal Agencies Clarify Coronavirus Testing Coverage Mandate

In an earlier information memo we described the coverage mandate for coronavirus testing and related items and services imposed on health plans under the Families First Coronavirus Response Act (FFCRA). Congress subsequently expanded the FFCRA mandates in the Coronavirus Aid, Relief and Economic Stimulus Act (CARES Act). The two laws require group health plans to cover COVID-19 testing items and services without any participant cost-sharing.

Recently, the three federal agencies that administer the mandate laws (the Departments of Labor, Health and Human Services and the Treasury) issued guidance that explains and clarifies several aspects of the new health plan coverage mandate.

What Must Be Covered

A plan must cover all "in vitro diagnostic tests" for COVID-19 or the coronavirus that are approved by the FDA or for which the manufacturer is seeking or intending to seek emergency FDA approval. Serological tests are specifically included in the coverage mandate.

In addition, items and services furnished to an individual during an office visit (whether in-person or via telehealth) to a health care provider, urgent care center or emergency room that results in an order for a COVID-19 test also must be covered, to the extent they relate to the furnishing or administration of the test or to the evaluation of the individual and their need for testing.

The new guidance includes the following example of items and services that have the required relation to the furnishing or administration of the COVID-19 test:

> If the individual's attending provider determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed during a visit to determine whether there is a need for a COVID-19 diagnostic test for the individual, and the visit results in an order for, or administration of, a COVID-19 test, the plan must provide coverage for the related tests as well.

Plans Subject to the New Requirements

All group health plans, whether insured or self-insured, whether sponsored by private, governmental or church employers, and whether grandfathered or not under the Affordable Care Act (ACA), are subject to the COVID-19 coverage mandate.

However, plans that are considered "excepted benefits" for ACA purposes, such as health flexible spending arrangements (health FSAs) are exempted, as are retiree-only plans.

When the Mandate is in Effect

The coronavirus coverage mandate was first effective on March 18, 2020, the date of enactment of the FFCRA. It will remain in effect until the end of the COVID-19 public emergency period. Unless extended (or terminated earlier), the public health emergency related to COVID-19 will end on June 16, 2020.

Cost-Sharing, Prior Authorization and Medical Management Requirements

The FFCRA states that no cost-sharing can be imposed, and no prior authorization or medical management requirements can apply with respect to any items and services covered by the mandate. The new guidance confirms that no cost-sharing, prior authorization or medical management requirements can apply to covered items or services if the patient's attending physician or provider determines that they are medically necessary. The plan cannot substitute its judgment for that of the attending physician.

Out-of-Network Providers

The new guidance confirms that plans must cover tests performed by out-of-network providers. The guidance states that the plan or insurer must reimburse a provider:

- at the negotiated rate in effect before the public emergency began, if the plan has a negotiated rate with the provider; or
- in an amount not more than the cash price for such service listed by the provider on a public website, if the plan does not have a negotiated rate with the provider.

Under the CARES Act, providers must disclose the cash price of COVID-19 diagnostic tests on the provider's public website.

Note that the new guidance does not state an exception to the "no cost-sharing" rule for out-of-network providers.

Plan Amendments

The new guidance states that a health plan can be amended to add covered benefits or to eliminate cost-sharing without regard to otherwise applicable restrictions on mid-year changes to the plan. In particular, a plan may be so amended without providing 60 days' advance notice to participants, which would otherwise be required by the rules that govern "Summaries of Benefits and Coverage" under the ACA.

Telehealth Visits

Coronavirus tests and related items and services are covered by the mandate whether provided during an in-person provider visit or a telehealth session. In the new guidance, the three federal agencies strongly encourage health plans to adopt or expand telehealth services, but do not require plans to that don't currently cover telehealth services to begin doing so.

Bond continues to monitor the impact of COVID-19 and will be providing weekly updates regarding the latest federal and state guidance impacting employers and businesses. You can register for the complimentary webinar here.

If you have any questions about this Information Memo, please contact any attorney in our Employee Benefits and Executive Compensation Practice Group, or the attorney at the firm with whom you are regularly in contact.

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