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HFMA Summary of HHS/DOL/IRS FAQ on Cost Sharing for COVID-19 Testing and Related Services

On April 11, 2020, the Departments of Health and Human Services, Labor, and Internal Revenue Service (hereafter the "Tri-Agencies") issued an FAQ to clarify the implementation of provisions in the Families First Coronavirus Response Act (the FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act) requiring health plans to cover COVID-19 testing and related services.

The FAQ states that the Tri-Agencies' approach to implementation is characterized by an emphasis 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.

Below is a summary of key questions related to cost sharing for COVID-19 testing and related services.

1) **Which types of group health plans and health insurance coverage are subject to the requirement to cover COVID-19 testing and related services?**

- The term "group health plan" includes both insured and self-insured group health plans. It includes private employment-based group health plans (ERISA plans), non-federal governmental plans (such as plans sponsored by states and local governments), and church plans. "Individual health insurance coverage" includes coverage offered in the individual market through or outside of an Exchange, as well as student health insurance coverage.

- The requirement does not apply to short-term, limited-duration insurance, or to a plan or coverage in relation to its provision of excepted benefits. It also does not apply to group health plans that do not cover at least two current employees (such as plans in which only retirees participate).

2) **When are plans and issuers required to cover COVID-19 testing and related services and for how long?**

- The requirement begins on March 18, 2020, and will last the duration of the national health emergency.

3) **What items and services must health plans and issuers provide benefits for free of cost sharing?**

- Health plans and insurers must cover diagnostic tests to detect COVID-19. These are tests that are either:
    - Approved by the FDA,
    - The developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (unless the request has been denied),
    - Developed in and authorized by a state that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19, or

  - Other tests that the Secretary of HHS determines appropriate in guidance.
- Items and services furnished to an individual include those provided during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described above, but 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. Please see FAQ 5 for additional details about what is considered a "related" item or service.

4) Are serological tests for COVID-19 required to be provided without cost sharing under the CARES Act?

- Yes, serological tests are to be provided free of cost sharing under the CARES Act.

5) What types of items and services "relate to the furnishing or administration" of COVID-19 diagnostic testing, or relate "to the evaluation of such individual for purposes of determining the need" and therefore, must be covered without cost sharing?

- 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 relate 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 product, as determined by the individual's attending healthcare provider.

- The Centers for Disease Control and Prevention (CDC) advises that clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested.

- In addition, the CDC strongly encourages clinicians to test for other causes of respiratory illness. Therefore, for 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 healthcare 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.

6) May a plan or issuer impose any cost-sharing requirements, prior authorization requirements, or medical management requirements for COVID-19 testing and related services?

- No. Plans and issuers shall not impose any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization requirements, or other medical management

requirements for these items and services. These items and services must be covered without cost sharing when medically appropriate for the individual, as determined by the individual's attending healthcare provider in accordance with accepted standards of current medical practice.

7) Are plans and issuers 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)?

- Yes. A plan or issuer providing coverage of items and services for COVID-19 testing and related services shall reimburse the provider of the diagnostic testing as follows:
    - If the plan or issuer has a negotiated rate with such provider in effect before the public health emergency, the negotiated rate shall apply throughout the period of such declaration.
    - If the plan or issuer does not have a negotiated rate with such provider, the plan or issuer shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website, or the plan or issuer may negotiate a rate with the provider for less than such cash price.
- Providers of diagnostic tests for COVID-19 are required to make public the cash price of a COVID-19 diagnostic test on their websites. HHS may impose civil monetary penalties on any provider that does not comply with this requirement, and has not completed a corrective action plan, in an amount not to exceed $300 per day that the violation is ongoing.

8) Under what circumstances are items or services considered to be furnished during a visit?

- The term "visit" is broadly interpreted to include both traditional and non-traditional care settings in which a COVID-19 diagnostic test and related services are ordered or administered. This includes COVID-19 drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing. Therefore, COVID-19 tests and related items and services must be covered when furnished in non-traditional settings, as well as traditional settings.

9) May states impose additional requirements on health insurance issuers to respond to the COVID-19 public health emergency?

- Yes, nothing in the CARES Act precludes states from imposing additional standards or requirements on health insurance issuers with respect to the diagnosis or treatment of COVID-19, to the extent that such standards or requirements do not prevent the application of a federal requirement.