Group Health Plan Sponsors Receive Welcome Guidance On COVID-19 Testing Coverage Provisions

Insights
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A second round of FAQs recently issued by the Labor Department, the IRS, and the Department of Health and Human Services provides plan sponsors and insurers with additional implementation guidance relating to health coverage provisions under the Families First Coronavirus Response Act (FFCRA), as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The June 23 guidance in FAQs Part 43 is a follow-up to the Departments' April 11 guidance in FAQs Part 42 and provides specific clarifications on testing coverage and provider payments, summary of benefits coverage (SBC) notifications, temporary telehealth relief provisions, and various other compliance matters of significance to group health plans. FAQs Part 43 highlights include the following:

Testing Coverage And Provider Payments
Insured and self-insured plans are subject to FFCRA § 6001 and CARES Act §§ 3201 and 3202(a)& (b). Group health plans and insurers are generally required to cover certain items and services related to FDA-approved COVID-19 diagnostic testing, without cost-sharing, advanced authorization, or other medical management. The CARES Act also requires that test providers be reimbursed at the cash price published on their website, or if lower, a negotiated rate.

Authorized And Non-Authorized Tests

The FDA's website has a list of authorized diagnostic tests and developers. The *in vitro* diagnostic tests that are FDA-approved for the detection of SARS-CoV-2 or the diagnosis of COVID-19, developed under a requested emergency use authorization, or state validated, must be covered, without cost sharing.

If an employee takes a test that is *not* FDA-approved, the plan sponsor may verify that the test developer has requested, or intends to request, emergency use authorization from the FDA. Plan sponsor verification is not a violation of the FFCRA's medical management prohibition. If verification is not provided, coverage must be provided in accordance with plan terms which may include cost-sharing or a denial.

"Attending Health Care Providers"

COVID tests determined as medically appropriate by an "attending health care provider" must be provided without cost-sharing. An "attending health care provider" not only includes the individual's

primary physician but also any attending licensed/authorized provider that makes an individualized clinical assessment. If an attending health care provider orders a diagnostic test designed to be administered at home, it must be covered without cost-sharing. There are no limits on the number of no-cost COVID-19 diagnostic tests plans must provide, if an attending health care provider determines the tests are medically appropriate.

When Cost-Sharing Is Not Permitted

Plans must cover "facility fees" – provider office, telehealth, urgent care, emergency room – and "related items or services" associated with furnishing or determining the need to furnish a COVID-19 diagnostic test *without* cost-sharing. The FAQ includes an example where an individual is treated in an emergency room and the provider, in an effort to determine whether a COVID-19 test is appropriate, orders diagnostic test panels for influenza A and B and respiratory syncytial virus and a chest x-ray, and consequently a COVID-test. In this example, the plan is required to cover the related items and services without cost-sharing, prior authorization, or other medical management requirements, including any physician fees charged to read the x-ray and any facility fees associated in relation to the items and services.

Balance Billing

The CARES Act generally precludes balance billing for mandated diagnostic testing because the plan or issuer reimburses the provider for the full cost of the test with no cost sharing for the individual or other balance due.

When Cost-Sharing Is Permitted

General workplace health and safety screening tests not intended primarily for *individual* COVID-19 diagnosis or treatment are beyond the scope of the FFCRA and CARES Act mandates and are therefore *not* required to be covered without cost-sharing. Please note, however, that while cost-sharing is permitted, for a variety of reasons – including various return-to-work mandates, employee relations, and litigation risk reduction – many employers may be obligated to cover or choose to cover the cost of these screening tests.

Reimbursement

Out-of-network mandated COVID-19 testing must be reimbursed pursuant to the CARES Act (the cash price listed by the provider on the provider's website or a negotiated lower rate), and not at the ACA rate. Plans that do not have negotiated rates with out-of-network providers must either pay the cash price or negotiate lower rates, perhaps using available state reimbursement rate dispute resolution provisions. The HHS may impose civil penalties of up to $300 a day against providers that do not post their cash price for COVID-19 diagnostic testing.

Summary Of Benefits And Coverage Notification

At the end of the COVID-19 emergency period, if plan sponsors reverse COVID-19 diagnosis or treatment coverage enhancements, they will be deemed to have satisfied the Summary of Benefits and Coverage 60-days advance notice obligation for material modifications. In order to achieve this satisfaction, however, plan sponsors need to ensure that participants, beneficiaries, and enrollees: (1) were previously notified of the general duration of the additional benefits coverage or reduced cost-sharing; or (2) were notified of the reversal reasonably in advance of the reversal.

Temporary Relief: Telehealth And Remote-Care

Another provision of the new FAQs provides that large employers may offer solely telehealth and remote-care benefits for employees and dependents *who are not eligible under any employer sponsored plan* for the duration of any plan year beginning before the end of the COVID-19 emergency period. This temporary relief is available for group health plans (and the related insurance).

The offering is exempt from group market reforms such as annual and lifetime limit prohibitions and preventive services mandates. However, the offering remains subject to other mandates such as the prohibition of pre-existing condition exclusions; the prohibition of discrimination based on health status; the prohibition on rescissions; and the applicability of mental health parity requirements.

Compliance: Mental Health Parity, Wellness Standards, And Grandfathered Plans

The new guidance also confirms that no-cost items and services required under FFCRA and CARES Act can be disregarded for purposes of MHPAEA compliance – specifically, the "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations.

Further, plans are permitted to waive an applicable wellness standard (including a reasonable alternative standard) under a health-contingent wellness program if participants or beneficiaries are having difficulty meeting the standards due to COVID-19 circumstances. The waiver must be offered to all similarly situated individuals.

Finally, grandfathered health plans that add benefits or reduce or eliminate cost-sharing pursuant to the safe harbor outlined in FAQs Part 42 (Q9 and Q 14), and then subsequently reverse those benefits after the national COVID-19 emergency period is over, will not lose grandfather status solely because of the reversal.

A Few Important Next Steps

Given this new guidance, group plan sponsors should follow this five-step plan:

- Ensure plan documents are amended to reflect mandatory and permissively adopted changes.
- Ensure participant notices and disclosures are updated to reflect mandatory and permissively adopted changes. Communicate expected duration of COVID-19 related benefit changes.
- Apply health-contingent wellness program standard waivers to all similarly situated individuals.

- Consult TPA and/or insurers to ensure COVID-19 cost sharing has been properly eliminated (including deductibles, co-pays and co-insurance).
- Consult TPA and/or insurers to ensure COVID-19 out-of-network billing complies with CARES Act requirements and balance billing restrictions.

Conclusion

Fisher Phillips will continue to monitor the rapidly developing COVID-19 situation and provide updates as appropriate. Make sure you subscribe to Fisher Phillips' Alert System to get the most up-to-date information. For further information, contact one of the authors, your Fisher Phillips attorney, any attorney in our Employee Benefits Practice Group, or any member of our Post-Pandemic Strategy Group Roster. You can also review our FP BEYOND THE CURVE: Post-Pandemic Back-To-Business FAQs For Employers and our FP Resource Center For Employers.

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