Published on *The National Law Review* https://natlawreview.com

New Guidance on Health Coverage Issues Relating to COVID-19

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On June 23, 2020, the Department of Labor, Department of Health and Human Services (HHS), and Department of the Treasury (the Departments) issued new frequently asked questions (FAQs) regarding coverage for COVID-19 testing under the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The FFCRA and the CARES Act generally require employer health plans to provide coverage for COVID-19 testing without imposing any cost sharing (including deductibles, copayments and coinsurance), prior authorization or certain other medical management requirements. Prior FAQs were issued on April 11, 2020 (FAQs Part 42).

The June 23, 2020, FAQs provide additional guidance on health coverage issues for sponsors of group health plans during the COVID-19 pandemic, and are particularly relevant for employers considering return-to-work policies.

The issues addressed by the FAQs include:

- **Coverage for Insured and Self-Insured Group Health Plans.** The FAQs confirm that the requirements for coverage for COVID-19 testing under the FFCRA apply to both insured and self-insured group health plans.

- **Which COVID-19 Tests Are Covered.** Plans and health insurance issuers must provide coverage for COVID-19 diagnostic tests:

- That are approved by the Food and Drug Administration (FDA)

- For which the developer has requested (or intends to request) emergency use authorization from the FDA, unless and until such emergency use authorization request has been denied or the developer does not submit such request within a reasonable time frame

- Developed in and authorized by a state or territory that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID-19

- That are other tests the Secretary of HHS determines appropriate in applicable guidance (the FAQs note that none had been specified as of publication of the FAQs).

- **Who Is an Attending Health Care Provider.** FAQs Part 42 provided that coverage for the applicable services must be provided "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." The June 23, 2020, FAQs clarify that an attending provider does not need to be directly responsible for providing care to the patient, so long as the provider makes an individualized clinical assessment to determine whether the test is medically appropriate for the individual in accordance with current accepted standards of medical practice. An attending provider must be an individual who is (1) licensed or otherwise authorized under applicable law, (2) acting within the scope of such license or authorization and (3) responsible for providing care to the patient. A plan, issuer, hospital or managed care organization is not an attending provider.

- **At-Home Testing Covered.** COVID-19 tests intended for at-home testing must be covered when ordered by an attending provider (as described above) who determined that the test is medically appropriate for the patient based on current accepted standards of medical practice, and the test otherwise meets the FFCRA requirements.

- **No Coverage Is Required for Testing for Employment or Surveillance Purposes.** Testing conducted as prescribed by an individual's attending provider (as described above) must be covered, and may include individuals with symptoms compatible with COVID-19 or individuals who are asymptomatic with known or suspected exposure to COVID-19. However, for testing conducted as screening for general workplace health and safety (including for employee return-to-work programs), for public health surveillance or any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19 – coverage is not required.

Related to return-to-work screenings, the U.S. Equal Employment Opportunity Commission (EEOC) has published separate guidance clarifying that employers may administer COVID-19 tests to employees before they enter the workplace to determine if they have the virus, and mandatory COVID-19 viral tests would not violate the Americans with Disabilities Act (ADA) because an individual with COVID-19 would pose a direct health threat to others in the workplace. However, employers cannot require antibody testing before permitting employees to reenter the workplace, and antibody test results should not be used to make decisions about returning individuals to the workplace. An antibody test constitutes a medical examination under the ADA, and it does not meet the ADA's "job related and consistent with business necessity" standard for medical examinations.

- **Multiple COVID-19 Tests Covered.** There is no limit under the FFCRA for the number of diagnostic tests for each individual, provided the tests are diagnostic and medically appropriate.

- **No Reimbursement Required for Services Other Than for COVID-19 Testing.** The CARES Act only requires reimbursement for diagnostic testing for COVID-19, and does not address reimbursement rates for other items or services.

- **Reimbursement Rates for Providers of COVID-19 Testing.** The CARES Act in section 3202(a) requires plans and issuers to reimburse the provider the cash price of a COVID-19 test, but this requirement is contingent upon the provider meeting the CARES Act requirement

at section 3202(b) to make the cash price public. If the plan or issuer does not have a negotiated rate with the provider, they may seek to negotiate a rate with the provider for the test. If the provider has not made the cash price for the test public and the plan or issuer and the provider cannot agree upon a rate, the CARES Act is silent on the reimbursement amount in that situation. The FAQs note that HHS may impose monetary penalties on providers who do not publicly post the cash price for COVID-19 tests and who have not completed a corrective action plan.

- **Notice Requirements After Emergency Period Expires.** Prior guidance permits plans and issuers to make changes to coverage to increase benefits, to reduce or eliminate cost-sharing for diagnosis and treatment of COVID-19 or for telehealth and other remote services without meeting the 60-day notice requirement for material modification to a plan's summary of benefits and coverage (SBC) and without meeting certain notice requirements related to mid-year changes to insured benefits, as the Departments will not enforce these notice requirements during the public health emergency or national emergency declaration period related to COVID-19. Once the COVID-19 public health emergency or national emergency declaration is no longer in effect, if the plan or issuer reverses these changes, the Departments will consider the plan or issuer to have met the advance notice requirements if the plan or issuer (1) previously provided notice of the general duration of the coverage or reduced cost-sharing (i.e., that such changes apply only during the COVID-19 public health emergency), or (2) provides notice of the general duration of the coverage or reduced cost-sharing within a reasonable time frame in advance of the reversal of the changes.

- **Relief for Telehealth and Remote Care Services.** Generally, programs that solely provide telehealth or remote care coverage are considered group health plans, and are therefore subject to certain federal requirements (including Affordable Care Act requirements). To promote public health access and to minimize exposure and community spread of COVID-19, the Departments are providing relief from federal requirements for telehealth and remote care programs that (1) solely provide benefits for telehealth or other remote care services, (2) are sponsored by large employers (generally, employers with an average of at least 50 employees) and (3) are offered only to employees (or their dependents) who are not eligible for coverage under any other group health plan offered by that employer. However, these programs still will be subject to applicable federal nondiscrimination standards (e.g., prohibition on preexisting condition exclusions, prohibition on discrimination based on health status, no rescissions, mental health parity).

- **Grandfathered Health Plans Will Not Lose Grandfathered Status upon Reversing COVID-19 Changes.** If a grandfathered plan or issuer properly added benefits or reduced or eliminated cost-sharing limited to the period in which a public health emergency or national emergency related to COVID-19 is in effect, the grandfathered plan or issuer will not lose its grandfathered status upon reversing the COVID-19-related changes at the end of the emergency period and restoring the terms of coverage to the terms that were in effect prior to the emergency period.

- **Required COVID-19 Coverage Changes Will Not Be Taken into Account for MHPAEA Parity Analyses.** The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that financial requirements and quantitative treatment limits for mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the financial requirements and treatment limits for medical/surgical benefits. The analysis to determine whether parity exists between medical/surgical benefits and MH/SUD benefits is complicated

and requires a plan or issuer to determine whether a particular financial requirement or quantitative treatment limitation applies to “substantially all” medical/surgical benefits within a specified classification of benefits. Recognizing that mandated COVID-19 coverage changes under section 6001 of the FFCRA (e.g., coverage of COVID-19 testing without cost sharing) could skew the results of a plan’s or issuer’s MHPAEA parity analysis, the Departments will not take enforcement action with respect to plans and issuers that disregard benefits for such items and services when performing the MHPAEA parity analyses for financial requirements and quantitative treatment limits.

- **Waivers for Wellness Programs Due to COVID-19.** Health-contingent wellness programs require individuals to satisfy one or more standards related to a health factor in order to obtain a reward. A health-contingent wellness program must offer a reasonable alternative standard (or waiver of such standard) to individuals for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the applicable standard. The FAQs provide that a plan or issuer may waive a standard for obtaining an award under a health-contingent wellness program due to circumstances related to COVID-19, provided the waiver is offered to all similarly situated individuals as required.

National Law Review, Volume X, Number 190