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

COVID-19 Testing and Vaccine Coverage Requirements for Group Health Plans and Issuers: New DOL, HHS, and Treasury FAQs

Article By:

Grace H. Ristuccia

Christopher C. Guthrie

On February 26, 2021, the U.S. Department of Labor (DOL), U.S. Department of Health and Human Services (HHS), and the U.S. Department of the Treasury issued guidance entitled "FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 44." The guidance addresses frequently asked questions (FAQs) that stem from the requirements under the FFCRA and CARES Act that group health plans and issuers cover COVID-19 testing (including certain related items and services) and vaccinations without cost sharing during the public health emergency declared by HHS. The declared public health emergency is expected to be in place until at least the end of 2021.

The FAQs also address whether employers can offer benefits for COVID-19 vaccines through and employee assistance plan (EAP) or on-site clinic.

Coverage of COVID-19 Testing

With respect to coverage without cost sharing of COVID-19 testing (and certain related items and services), the guidance provides the following:

- Group health plans and issuers cannot restrict coverage for COVID-19 testing (i.e., they *cannot* deny or impose cost sharing on claims) based on the following reasons:
    - An individual did not have symptoms or a recent known or suspected exposure. In fact, medical screening criteria on coverage of COVID-19 tests are not permitted.
    - An individual did not satisfy the state or local eligibility requirements for COVID-19 testing.
- COVID-19 testing coverage is not required when testing is *not* primarily for individualized diagnosis or treatment—for example, when testing is for general workplace health and safety

or public health surveillance. Such surveillance testing generally applies to asymptomatic individuals or individuals without any known or suspected recent exposures to COVID-19.

    - "[C]ommunications about the circumstances in which testing is covered [should be] clear."

- Coverage must be provided for:

    - COVID-19 diagnostic tests provided through state- or locality-administered testing sites; and

    - point-of-care tests for COVID-19.

The guidance reiterates that items and services associated with COVID-19 diagnostic testing are covered and that plans and issuers "should document any steps" taken to ensure that participants, beneficiaries, and enrollees are protected from "inappropriate cost sharing."

The guidance also states that plan administrators who identify providers that are violating the cash price posting requirements or otherwise operating in bad faith "should report violations to COVID19CashPrice@cms.hhs.gov." A plan and issuer may want to consider providing participants, beneficiaries, and enrollees with information about the providers with which the plan or issuer has a negotiated rate and encouraging reliance on those providers.

Coverage of COVID-19 Vaccines

The guidance clarifies the following with respect to COVID-19 vaccine coverage requirements:

- Group health "[p]lans and issuers must provide coverage without cost sharing) for all [approved] COVID-19 vaccines" (the Pfizer-BioNTech vaccine, as of January 5, 2021, and the Moderna vaccine, as of January 12, 2021, qualify). This coverage includes:

    - administration of vaccines, regardless of how it is billed and even if vaccine dosage is not billed; and

    - vaccines in accordance with vaccine-specific recommendations approved by the director of the Centers for Disease Control and Prevention, regardless of priority.

- Group health plans and issuers cannot deny coverage of an approved COVID-19 vaccine because a patient is not in a category prioritized by states and localities for early vaccination.

    - The guidance also states that group health plans cannot communicate that approved COVID-19 vaccine coverage is limited to those prioritized for early vaccination.

- "[The] decision by an individual's provider (including a provider integrated with a health plan) to decline to give the vaccine to someone because he or she is not within a prioritization category is not an adverse benefit determination" under the Employee Retirement Income Security Act's and the Affordable Care Act's claims and appeals procedures.

Notifying Participants

The guidance notes that under normal rules group health plans must notify participants and beneficiaries of a change in items listed in the summary of benefits and coverage no less than 60 days in advance of the change. However, the guidance states that the DOL, HHS, and Treasury Department will not take enforcement action with respect to this requirement as it applies to coverage of qualifying coronavirus preventive services. The guidance further state that group health plans "must" provide any required notice of the changes as soon as reasonably practicable.

Next Steps

Overall, the guidance's FAQs clarify (and, hopefully, provide reassurance regarding) how group health plans and issuers have been operating with respect to coverage for COVID-19 testing and vaccines for the past year. However, employers that sponsor group health plans (particularly self-funded plans) may want to consider reviewing their processes to ensure compliance. Employers may also want to consider issuing participant communications—both to satisfy the notice requirement and to educate participants and beneficiaries about COVID-19 vaccine coverage details.

National Law Review, Volume XI, Number 82