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COVID-19 Testing Requirement – Not as Straightforward as it First Appears

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The requirement for health plans to cover the cost of COVID-19 testing may seem straightforward at first glance, but implementing this requirement is becoming increasingly complex.

As brief background, Section 6001 of the Families First Coronavirus Response Act (FFCRA) requires health plans to cover, with no cost sharing, pre-authorization or other medical management requirements, certain items and services relating to COVID-19 testing beginning March 18, 2020. Section 3201 of the Coronavirus Aid, Relief and Economic Security Act (CARES Act) amended FFCRA Section 6001 to broaden the range of items and services that must be covered, and Section 3202(a) of the CARES Act specifies the required reimbursement amount for the provider of the testing.

After this legislation passed, there were a number of questions regarding implementation of the COVID-19 testing requirements. On April 11, the Departments of Labor, Health and Human Services and Treasury (the "Departments") answered the call for guidance and issued a set of FAQs (Part 42) (the "April FAQs") in which they addressed a number of issues relating to this new coverage requirement. On June 23, the Departments issued a second set of FAQs (Part 43) (the "June FAQs") which address additional issues of importance for health plans.

Some of the highlights of the June FAQs include the following –

- At-home COVID-19 tests must be covered, if the test is ordered by an attending health care provider who has determined that the test is medically appropriate.

- In the April FAQs, the Departments clarified that coverage of items or services related to COVID-19 testing is

required when the items or services are “medically appropriate for the individual, as determined by the individual’s attending health care provider” and provided a definition of attending provider. In the June FAQs, the Departments broaden the definition of “attending provider” to mean an individual who is licensed (or otherwise authorized) under applicable law, who is acting within the scope if such license (or authorization), and who is responsible for providing care to the patient. The June FAQs drop the requirement that the provider be “directly responsible” for providing care to the patient as 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. A plan, hospital, or managed care organization is not an attending provider.

- Health plans are not required to cover testing for general employment, “return to work” purposes, public health surveillance or for other reasons not intended for individual diagnosis or treatment. This should not, however, be confused with the requirement that testing must be covered if it is determined to be medically appropriate for someone with a recent suspected exposure, even if the individual is asymptomatic.

- There is no frequency limit on the number of COVID-19 tests an individual is entitled to receive, but the test must be diagnostic and medically appropriate for the individual, as determined by the attending provider in accordance with current accepted standards.

- Section 3202(a) of the CARES Act establishes that the provider of the COVID-19 test must be reimbursed either the negotiated rate or the cash price listed for the test on the provider’s public website. The June FAQs confirm that participants cannot be balance billed by the provider of the diagnostic testing because the reimbursement rate is established by law. However, this reimbursement rate does not apply to the related items and services (other than the diagnostic testing) which are provided to the individual. These items and services will be subject to the health plan’s rules regarding the amount of the charge that is covered. As a result, if the participant visits an out-of-network provider, he or she may be balance billed for any items or services which are provided other than the diagnostic testing itself. State laws for insured plans which restrict a provider’s ability to balance bill may apply.

- Facility fees must also be covered without cost-sharing if it relates to furnishing the COVID-19 test or evaluation for the need of such a test. As an example, the FAQs state that if an individual goes to the emergency room and has several tests to determine if a COVID-19 test is appropriate, such as a chest x-ray, and a COVID-19 test is ordered, the plan must cover the related items and services without cost-sharing, including the physician fee to read the x-ray and the facility fee.

- In the April FAQs, the Departments announced temporary enforcement relief which allows health plans to increase benefits, or reduce or eliminate cost-sharing requirements, for the diagnosis and/or treatment of COVID-19 and telehealth or other remote care services during the emergency period without providing 60 days' advance notice of the change as required by the Summary of Benefits and Coverage (SBC) rules. Just as the 60-day advance notice for these changes was waived, the Departments confirm in the June FAQs that if the health plan revokes these changes upon expiration of the COVID-19 emergency, the health plan may do so without providing advance notice of the cessation. To qualify for this relief, the plan must have previously notified participants of the general duration of the enhanced coverage (such as, that it applies during the COVID-19 public health emergency) or must notify the participant of the general duration within a reasonable period of time in advance of the reversal of the changes. Plans that have not yet provided notice to participants, or whose notice did not include a general description of the timeframe of the increased benefits, may want to provide the notice soon so that the increased benefits can be terminated when the COVID-19 emergency ends.

- Grandfathered health plans that have elected to provide enhanced benefits in connection with the COVID-19 emergency do not lose their grandfathered status by ending these benefits when the COVID-19 emergency ends if the terms of the plan, as in effect prior to the emergency, are restored. This special rule applies only during the emergency period.