

Frequently Asked Questions on Health Plan Coverage under the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act

The Department of Labor (DOL), Department of Health and Human Services (HHS), and Department of the Treasury (Treasury) (collectively, the Departments) have released [frequently asked questions](#) (FAQs) regarding group health plan coverage requirements under the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act).

Under the FFCRA, and as amended by the CARES Act, health plans must provide coverage and not impose any cost sharing (including deductibles, copayments, and coinsurance), prior authorization, or medical management requirements for the following services during the public health emergency due to COVID-19:

- An in vitro diagnostic product for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such an in vitro diagnostic product, that 1) has been approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act (FFDCA); 2) the developer has requested, or intends to request, emergency use authorization (EUA) under the FFDCA, unless and until the EUA request has been denied or the developer of such test does not submit a request under the FFDCA within a reasonable timeframe; 3) is developed in and authorized by a state that has notified HHS of its intention to review tests intended to diagnose COVID-19; or 4) is another test that HHS determines to be appropriate.
- Items and services furnished to an individual during healthcare provider visits (in-person 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 that those 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.

Health Plans

The FAQs clarify which health plans are subject to the above requirement. Health plans include group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans). Group health plans include insured and self-insured group health plans, private employer group health 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 (Marketplace), as well as student health insurance coverage.

Health plans do not include short-term, limited-duration insurance, or excepted benefits. Health plans also do not include group health plans that do not cover at least two employees who are current employees (such as plans in which only retirees participate).

Health plans must comply with the coverage requirement noted above beginning March 18, 2020, and continue to comply during the public health emergency related to COVID-19.

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In Vitro Diagnostic Tests

The FAQs provide that in vitro diagnostic tests include serological tests for COVID-19 that are used to detect antibodies against the SARS-CoV-2 virus, and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-CoV-2, the virus which causes COVID-19. Regarding items and services that relate to furnishing or administering of COVID-19 diagnostic testing or that relate to determining the need for such testing, the FAQs instruct that clinicians should use their judgment in determining whether a patient should be tested. Also, clinicians are encouraged to test for other respiratory illnesses to help determine whether COVID-19 diagnostic testing is necessary. If such other testing results in an order for, or administration of COVID-19 diagnostic testing, and the testing is determined medically appropriate by the patient's attending healthcare provider, a health plan must provide coverage for the tests without cost sharing and without imposing prior authorization or other medical management requirements.

Reimbursement of Diagnostic Testing for COVID-19

If a plan or issuer does not have a negotiated rate for diagnostic testing for COVID-19 with a 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 the publicized cash price.

Healthcare Provider Visit

As noted above, the FFCRA requires plans and insurers to cover certain services that are furnished during healthcare provider visits. The FAQs provide that healthcare provider visits include in-person and telehealth visits, as well as visits to urgent care centers and emergency rooms. The term "visit" is interpreted broadly to include traditional and non-traditional care settings, such as drive-through screening and testing sites where licensed health care providers are administering COVID-19 diagnostic testing.

Plan Modifications

Under the Public Health Services Act (PHSA), if a plan makes a material modification, as defined under ERISA, in any of the terms of the plan or coverage that would affect the content of the Summary of Benefits and Coverage (SBC) that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective. However, the FAQs provide that the Departments will not take enforcement action against any plan or issuer that makes a modification to provide greater coverage related to the diagnosis or treatment of COVID-19, without providing at least 60 days advance notice. Modifications to add benefits or reduce cost-sharing for telehealth and other remote care services are included. Plans and issuers must provide notice of

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the changes as soon as reasonably practicable. The FAQs further provide that a health insurance issuer that changes benefits or cost-sharing structure of its plans mid-year to provide increased coverage for services related to the diagnosis or treatment of COVID-19 will not violate the guaranteed renewability of requirements under the PHSA. These non-enforcement policies remain in effect during the public health emergency related to COVID-19.

State Requirements

The FAQs note that nothing in the FFCRA prevents 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.

Excepted Benefits

The FAQs provide that an employee assistance program (EAP) that qualifies as an excepted benefit may offer diagnosis and testing for COVID-19 and remain an excepted benefit during the public health emergency related to COVID-19. On-site medical clinics, which are excepted benefits in all circumstances, may offer diagnosis and testing for COVID-19.

Telehealth and Other Remote Care Services

The FAQs note that the CARES Act allows health savings account (HSA)-eligible high deductible health plans (HDHPs) to cover telehealth and other remote care services without a deductible or with a deductible below the minimum annual deductible for HSA-eligible HDHPs. The CARES Act also removes telehealth and other remote care services as categories of coverage that are disqualifying coverage for HSAs. Therefore, an otherwise eligible individual with coverage under an HDHP may also receive coverage for telehealth and other remote care services outside of the HDHP without being disqualified from contributing to his or her HSA. These provisions are effective as of March 27, 2020, and apply to plan years beginning on or before December 31, 2021.

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