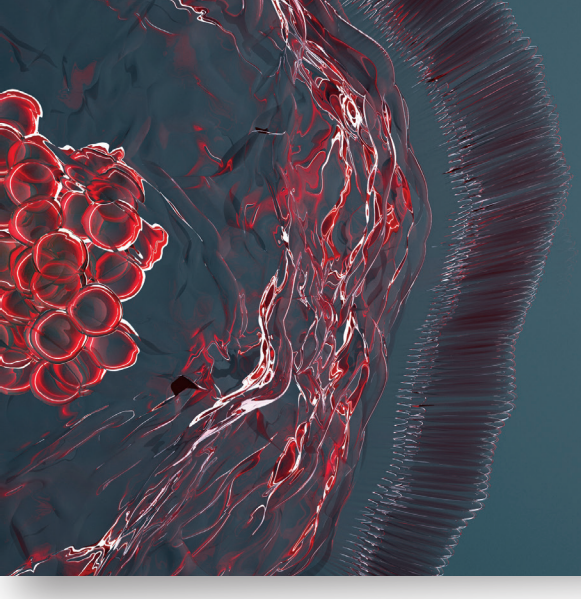

CONNER STRONG & BUCKELEW

IMPORTANT COVID-19 UPDATE

COVID-19 TESTING REQUIREMENTS FOR GROUP HEALTH PLANS

The U.S. Department of Labor (DOL), Department of Health and Human Services (HHS), and the Department of the Treasury have released FAQs to assist group health plans in understanding and complying with the COVID-19 testing requirements under the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The FAQs help plan sponsors understand which types of group health plans are subject to the new laws, what services must be covered, the requirements for out-of-network providers, and more. As we have publicized in other updates, the CARES Act amended the FFCRA to include a broader range of diagnostic items and services that plans must cover without cost-sharing requirements or prior authorization. Additionally, the CARES Act requires plans providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or if the plan does not have a negotiated rate with the provider, the cash price for the service as listed on the provider's public website.

KEY ITEMS FROM THE Q&A INCLUDE:

Which types of group health plans and health insurance coverage are subject to the requirements of the FFCRA and the CARES Act?

The requirements apply to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans as defined by the Patient Protection and Affordable Care Act). The term group health plan includes both insured and self-insured group health plans. It includes private employment-based group health plans (ERISA plans), non-federal governmental plans (such as plans sponsored by state and local governments) and church plans. Individual health insurance coverage includes coverage offered in the individual market through or outside of an Exchange, as well as student health insurance coverage. The requirement does not apply to short-term, limited-duration insurance. It also does not apply to group health plans that do not cover at least two employees who are current employees. Compliance will not cause a plan or coverage to cease to be a grandfathered health plan, provided that no other changes are made that would cause a loss of grandfather status.

What items and services must plans provide benefits for?

Plans must provide coverage for the following items and services.

1. An in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of COVID-19 and the administration of such a test
2. Items and services furnished to an individual during health care provider office visits (which include in-person visits and telehealth visits), urgent care center visits and emergency room visits that result in an order for an in vitro diagnostic product

May a plan impose any cost-sharing requirements, prior authorization requirements or medical management requirements for benefits?

No. Plans may not impose any cost-sharing requirements (including deductibles, copayments and coinsurance), prior authorization requirements or other medical management requirements for these items and services. These items and services must be covered without cost sharing when medically appropriate for the individual, as determined by the individual's health care provider.

Are plans required to provide coverage for items and services that are furnished by providers that have not agreed to accept a negotiated rate as payment in full (i.e., out-of-network providers)?

Yes. A plan providing coverage of items and services shall reimburse the provider of the diagnostic testing as follows:

1. If the plan has a negotiated rate with a provider in effect before the public health emergency was declared, the negotiated rate will apply.
2. If the plan does not have a negotiated rate with a provider, the plan shall reimburse the provider an amount that equals the cash price for the service as listed by the provider on a public website, or the plan or issuer may negotiate a rate with the provider for less than the cash price.

The CARES Act requires providers of diagnostic tests for COVID-19 to make public the cash price of the test on the provider's public website. Additionally, it grants the Secretary of HHS authority to impose penalties on any provider that does not comply with this requirement.

In light of COVID-19, will the Departments permit changes to the terms of a plan to add benefits, or reduce or eliminate cost sharing, for the diagnosis and treatment of COVID-19 without providing 60-days advance notice?

Yes. To help facilitate the nation's response to COVID-19, the Departments will not take enforcement action against any plan that makes modifications to provide greater coverage related to the diagnosis and/or treatment of COVID-19, without providing at least 60-days advance notice. Plans must provide notice of the changes as soon as reasonably practicable. Additionally, HHS will not take enforcement action against any health insurance issuer that changes the benefits or cost-sharing structure of its plans mid-year to provide increased coverage for services related to the diagnosis and/or treatment of COVID-19. These non-enforcement policies will apply during the period in which a public health emergency declaration related to COVID-19 is in effect. For any changes beyond the emergency period, plans must comply with all other applicable requirements to update plan documents or terms of coverage.

Click here to review the full Q&A from the regulator's site.

Please visit our COVID-19 Resource Center for more information.

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