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Plan coverage of COVID-19 testing: Issues remain after June guidance

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Sept. 15, 2020

In this article

The departments of Labor (DOL), Health and Human Services (HHS) and Treasury have issued additional FAQ guidance (Part 43) for health plans required to cover COVID-19 testing without cost sharing for plan participants. The June 2020 FAQs discuss how often tests have to be covered and address reimbursement of out-of-network related items and services, balance billing, circumstances in which the coverage mandate doesn't apply, and other issues related to the coverage mandate — including notice requirements, telehealth expansion, grandfathered plan status, wellness programs and mental health parity requirements. Additional interpretive guidance is welcome, but questions and concerns remain.

Overview of COIVD-19 testing coverage mandate

Section 6001 of the Families First Coronavirus Response Act (FFCRA) (Pub. L. No. 116-127), as amended and expanded by Section 3201 et seq. of the Coronavirus Aid, Relief and Economic Security (CARES) Act (Pub. L. No. 116-136), requires group health plans to cover COVID-19 testing and related services at no cost to plan participants during the public health emergency (currently set to expire on Oct. 23, 2020, absent action by the HHS secretary). Coverage of COVID-19 vaccines, once available, is also required without cost sharing. In April, the departments issued FAQs (Part 42) interpreting health coverage provisions for group health plans and issuers, including:

- Duration of the coverage mandate and the plans to which it applies
- Items and services related to COVID-19 testing that must be covered

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- Coverage of COVID-19 testing and related services in nontraditional settings
- Reimbursement requirements for in- network and out-of-network (OON) providers
- Employee assistance programs (EAPs) and on-site clinics offering COVID-19 diagnosis and testing
- Coordination of broad telehealth and other remote care services during the public health emergency with high-deductible health plans (HDHPs) and health savings accounts (HSAs)
- Notice requirements for midyear plan changes in compliance with coverage mandates and/or expanded telehealth benefits

Details of the statutory COVID-19 coverage requirements and the guidance provided by Part 42 FAQs can be found in an earlier GRIST.

More recent FAQs (Part 43) provide additional clarification about testing coverage and reimbursement requirements but raise new questions and concerns. The new interpretive guidance prompted a letter from Democratic bicameral committee leaders to the agencies criticizing the guidance on COVID-19 testing coverage requirements for group health plans as contrary to the statute. The Part 43 FAQs also touch on subjects beyond the COVID-19 testing coverage and reimbursement, including telehealth, mental health parity and wellness programs, among other topics reviewed below.

June COVID-19 testing coverage requirement guidance

Coverage of COVID-19 testing (including tests to detect SARS-CoV-2) and related items and services is required without cost sharing, prior authorization, or other medical management techniques. Part 43 FAQs provide more detail around when and how often tests must be covered and what must be covered.

When tests must be covered

The Part 43 FAQs confirm the need for an individualized assessment of medical appropriateness before the coverage mandate applies. The agencies note that testing conducted as part of workplace screenings, public health surveillance, or other nonindividualized purposes is not subject to the FFCRA cost-sharing requirements.

In short, current guidance states that testing based on an individualized assessment of medical need in accordance with Centers for Disease Control and Prevention (CDC) guidelines must be covered without cost sharing, even for asymptomatic individuals and in nontraditional settings, but testing conducted without an individualized assessment need not be covered.

This limiting interpretation of the testing coverage mandate immediately drew the ire of some legislators, who described the guidance as "contrary to statute." As noted earlier, in a letter jointly addressed to the secretary of each agency, a group of bicameral Democratic legislators describe the FAQ guidance — which states that the mandate covers only testing "primarily intended for individualized diagnosis or treatment of COVID-19" — as contrary to Congress's primary goal. The legislators asked the agencies to immediately reexamine the guidance and clarify health plans' obligations to cover COVID-19 diagnostic and serologic tests without cost sharing in all circumstances. Nevertheless, no new guidance has been issued to date.

How often tests must be covered

The mandate places no limit on number of tests that must be covered, as long as an individualized clinical assessment determines a need. Only an individual's attending healthcare provider can determine when a COVID-19 test is medically appropriate and therefore required to be covered without cost sharing. The healthcare provider need not be "directly responsible" for providing care to the individual to qualify as an attending provider. Acknowledging a need to expand the availability of COVID-19 testing, the agencies relaxed the earlier guidance requiring the provider be "directly responsible" for the care. For purposes of the COVID-19 testing coverage mandate, an attending provider is:

- Licensed (or otherwise authorized) under applicable law
- Acting within the scope of the provider's license (or authorization)
- Responsible for the providing care to the patient

No limit applies to the number of diagnostic tests and related items and services that must be covered without cost sharing, as long as an attending provider determines each is medically appropriate after conducting an individualized clinical assessment.

What must be covered

The mandate requires covering (1) tests that have been approved by the FDA, (2) tests that the developer has submitted — or intends to submit — to the FDA for emergency use authorization, (3) tests authorized by a state, and (4) any other tests HHS determines appropriate and specifies in guidance (none yet). The Part 43 FAQs confirm that plans can take reasonable and necessary steps to verify that a SARS-CoV-2 or COVID-19 test meets the statutory criteria without violating the prohibition on medical management techniques.

Testing-related items and services include facility fees. Facility fees assessed in relation to COVID-19 testing must be covered without cost sharing, prior authorization or other medical management requirements. For example, the agencies note that an emergency room visit where the provider orders

diagnostic panels for influenza A and B and respiratory syncytial virus, chest X-rays, and any other related services — including reading of the X-ray and facilities fee associated with the visit —must be covered without cost sharing if a COVID-19 test is ultimately ordered.

At-home testing is covered. Expanding on earlier guidance requiring coverage of COVID-19 testing in nontraditional settings, the agencies confirm that plans must cover tests done at home when ordered by an attending provider.

June reimbursement guidance

The CARES Act amends the FFCRA's COVID-19 testing coverage mandate to impose additional requirements for provider reimbursements. The CARES Act describes the amount a plan must reimburse a provider for testing, but does not address reimbursement for related items and services. The Part 43 FAQs attempt to address questions about the reimbursement required for OON testing providers in the absence of publicly posted rates and concerns about providers balance-billing plan participants.

If testing rates are not posted, negotiate. The CARES Act requires plans to pay testing providers the negotiated rate in effect before the public health emergency began. If no negotiated rate exists, plans must pay the cash price listed by the provider on a public website. If the provider has not publicly listed its cash price, the plan must negotiate a reimbursement in compliance with any applicable state laws. Neither the law nor the FAQs provide guidance for plans reimbursing OON providers that haven't posted a rate and the parties are unable to reach an agreement.

No balance billing for test itself; balance billing for testing-related items and services is discouraged, but not prohibited. The CARES Act doesn't directly address balance billing for COVID-19 testing or related items and services. According to agency FAQs, the statute "generally precludes" balance billing for testing, but not for related items and services.

Balancing billing for related items and services is impeded by the terms and conditions for certain general distributions to Medicare providers who apply to receive funds from the CARES Act's Provider Relief Fund. A general distribution from the fund requires a certification that the recipient will not seek payment from a patient for "all care for a presumptive or actual case of COVID-19" greater than what would have been the patient's out-of-pocket expenses for in-network services. Providers are not required to apply for relief funds, and some may be discouraged from doing so by the certification, leaving plan participants exposed.

State law may limit balance billing of fully insured patients if the COVID-19-related services include emergency care received at an OON facility or nonemergency care from an OON provider working at an in-network facility. State balance-billing laws do not protect self-insured plan participants unless the plan has volunteered to comply with the law, where that's an option.

Emergency services reimbursement rate. The CARES Act's reimbursement requirement for COVID-19 testing at an OON provider supersedes emergency services reimbursement requirements in the Affordable Care Act (ACA), according to the FAQs. The ACA requires nongrandfathered group health plans to impose cost sharing for OON emergency services no greater than what is imposed for in-network emergency services using one of three minimum payment standards: (1) the median in-network negotiated rate, (2) the amount calculated using the plan's normal method for determining payment for OON services or (3) the Medicare rate. These standards continue to apply for OON emergency items and services related to the COVID-19 testing, but the plan must reimburse the publicly posted cash price for the COVID-19 diagnostic test itself.

Other related issues

Notice requirement for benefit reductions. Earlier agency guidance provides that plans can make COVID-19-related benefit changes (e.g., increase coverage, decrease cost sharing or expand telehealth) without providing the normally required 60-day advance notice, as long as notice is provided as soon as reasonably practicable. The new guidance addresses notice requirements for plans that make these benefit changes on a temporary basis — for example, for the duration of the public health emergency or the separate national emergency.

Plans that intend to reverse the benefit changes upon expiration of the COVID-19 public health emergency or the national emergency declaration must provide notice "within a reasonable timeframe in advance of the reversal." This can be accomplished with a notice providing the general duration of the benefit enhancements. For example, a notice indicating that reduced cost sharing or expanded coverage will be in effect for the duration of the public health emergency is sufficient. This is likely the best method for plans intending to make the benefit changes temporary, since the public health emergency end-date can be extended or cut short by the HHS secretary. Under existing law, the national emergency declaration automatically terminates on the anniversary date (March 1, 2021) but can be extended by the president or terminated early by congressional or presidential action (see 50 USC § 1622(d)).

Telehealth for employees not eligible for the group health plan. Recent FAQ guidance continues to temporarily expand access to telehealth services. FAQ 43 provides limited compliance relief for stand-alone telehealth plans offered by large employers to employees (and their dependents) who are not eligible for any other group health plan offered by the same employer. Such a stand-alone telehealth plan does not have to comply with certain ACA market reforms (e.g., preventive care coverage requirement, maximum out-of-pocket limits, and prohibition on annual and lifetime limits) for the duration of the plan year, as long as it begins before the public health emergency ends.

The compliance relief does not extend to the ACA's nondiscrimination requirements (the bans on preexisting condition exclusions and discrimination based on a health factor), rescission prohibition, or mental health parity requirements. In addition, the plan would still be subject to ERISA (except for church

and government employer-sponsored plans), COBRA continuation coverage requirements (except for church plans), and the Health Insurance Portability and Accountability Act (HIPAA). Finally, the arrangement might be considered minimum essential coverage, requiring ACA reporting and interfering with an individual's eligibility for premium tax credits for exchange coverage. Clarification from the agencies on this point would be welcome.

Grandfathered health plans and coverage changes. Earlier guidance confirmed that the COVID-19 testing coverage requirement extends to grandfathered health plans. Grandfathered group health plans have to cover COVID-19 testing and related services without imposing cost sharing, prior authorization or medical management techniques to the same extent as nongrandfathered plans. For grandfathered plans, concerns arose around a plan's ability to revert to the coverage and terms that existed prior to the public health emergency, without losing grandfathered status. Under the ACA rules, grandfathered status ordinarily ends if a plan eliminates all or substantially all benefits to diagnose or treat a certain condition or increases cost sharing above certain thresholds relative to the plan terms in effect on March 23, 2010. The recent FAQs confirm that a plan will not lose grandfathered status if it reverses the required COVID-19 testing coverage enhancements — or other benefit enhancements related to COVID-19 diagnosis or treatment or telehealth expansion — when the emergency period ends. Plans continuing the COVID-19 related benefit enhancements beyond the public emergency period should also be able to reverse course later without losing grandfathered status — if the reversal doesn't affect the benefits and cost sharing in place in 2010.

COVID-19 testing coverage mandate need not be included in parity analysis. The Mental Health Parity and Addiction Equity Act (MHPAEA) generally requires group health plans that provide benefits for mental health conditions and substance use disorders to do so at the same level as medical and surgical benefits. Plans should be tested and evaluated for compliance with MHPAEA any time a change in plan design, cost sharing or utilization would affect a financial requirement or treatment limitation. The COVID-19 testing coverage mandate raises some concerns about a plan's requirement to conduct a parity analysis in light of enhanced COVID-19 benefits, and whether a plan would have to enhance other benefits as a result to remain compliant with parity requirements.

In FAQ 43, the agencies announce that plans will not face enforcement action if they disregard benefits for FFCRA-required items and services covered without cost sharing when conducting a parity analysis of financial requirements and quantitative treatment limitations. However, COVID-19-related coverage enhancements beyond the FFCRA requirements — for example, no-cost or lower-cost COVID-19 treatment or expanded telehealth made optional by agency pandemic relief — apparently would have to factor into a parity analysis. Plans would similarly need to include FFCRA-required benefits in the parity analysis if those benefits are maintained beyond the public health emergency period.

Wellness program flexibility reminder. Group health plans are prohibited from discriminating in eligibility, benefits or premiums because of a plan participant's or beneficiary's health factor. An

exception applies for group health plans that have wellness programs meeting the HIPAA nondiscrimination rules. Those rules address two types of wellness programs — participatory and health-contingent. Health-contingent programs require participants to meet a health-related standard (outcome based) or health-related activity (activity only) to obtain a reward. Programs ordinarily can waive the health contingency (and reasonable alternative standard) if satisfying the requirement is unreasonably difficult due to a medical condition or is medically inadvisable.

The FAQs confirm that this waiver concept extends to participants or beneficiaries for whom circumstances related to COVID-19 make meeting the health contingency difficult. Any waiver that is "a result of the COVID-19 public health emergency" must be offered to all similarly situated individuals. For example, a wellness program may waive certain biometric screening standards if the pandemic has made on-site, physician or lab screenings impossible. Or an employer may want to waive the requirements of an activity-only health-contingent program if state or local government COVID-19-related orders prevent participants and beneficiaries from accessing gyms or pools where such activity normally takes place. In sum, individual waivers are permitted, but if the waiver's justification generally relates to circumstances surrounding the pandemic, the waiver option should be made available to all program participants.

Notice requirements for individual-coverage HRAs. Employers can offer individual-coverage health reimbursement arrangements (HRAs) to employees who are not eligible for a traditional employer-sponsored group health plan but are enrolled in an individual health policy or Medicare. Employer sponsoring these HRAs must provide employees with a notice, generally due 90 days before the start of the plan year, that includes information about plan terms, individual coverage requirements and the impact on premium tax credit eligibility. Despite earlier pandemic-related relief (EBSA Notice 2020-01) granting leniency for the timing of certain notices — including the individual coverage HRA notice during the outbreak period — FAQ 43 states that employers should nevertheless ensure that notices are provided with sufficient time to allow individuals to read and understand them, make an informed decision after weighing the coverage options, and enroll in individual coverage by the deadline.

COVID-19 testing coverage mandate and nonfederal government plans. A June 5 letter from the Centers for Medicare & Medicaid Services (CMS) provides guidance on COVID-19 testing coverage requirements for nonfederal government employer plans (group health plans for state and local government employees) and encourages expansive telehealth and other remote care services similar to the FAQs. CMS confirms that nonfederal governmental plans, whether grandfathered or nongrandfathered, are group health plans subject to the FFCRA and CARES Act requirements.

In addition, CMS encourages these plans to provide COVID-19 treatment without cost sharing, prior authorization, or other medical management restrictions and to cover or expand general telehealth services. At the same time, CMS encourages state and local authorities not to take enforcement action against any nonfederal government plan that makes midyear changes to provide greater coverage for telehealth or for COVID-19 diagnosis or treatment, or to reduce or eliminate cost-sharing requirements

for these services. CMS will not take enforcement action against any plan that enhances benefits in these ways without providing 60 days' advance notice — as long as notice is provided as soon as possible.

Employer next steps

As employers contemplate group health plan coverage terms for 2021, the COVID-19 pandemic continues. Although currently set to expire near the end of October, the public health emergency — which dictates the duration of COVID-19 coverage requirements for group health plans, as well as various plan-related compliance relief — could be renewed and extended into the new year. Meanwhile, agencies continue to issue guidance interpreting the COVID-19 coverage requirements in the FFCRA and the CARES Act — at times drawing heavy criticism from lawmakers. Lawmakers continue to debate additional pandemic relief legislation that could include more terms related to employer-sponsored group health plans. Against this backdrop, employers should take the following into consideration:

- **Review notice and need for clarification.** A report from the Kaiser Family Foundation and an analysis by the Brookings Institute demonstrate a variety of factors leading to balance billing for COVID-19-related services. Given the confusion over the scope of the COVID-19 testing coverage mandate, communicate clearly to plan participants when diagnostic tests and related services will be covered without cost sharing. Decide whether to include information about free COVID-19 testing in the plan's 2021 summary of benefits and coverage (SBC). While including this information is not necessarily required, the mandate might still be in effect in 2021. Determine whether previous notices to plan participants about pandemic-related benefit enhancements indicate when the enhancements apply and will end or whether a new notice is required.

- **Check vendor claims processing and assist employees.** Unexpected bills from doctor's offices and hospitals remain a concern for many employers and plan participants. Make readily available information regarding in-network testing facilities and treatment facilities. Consider an audit of claims processing (or confirm the third-party administrator has a process to self-audit), particularly earlier in the pandemic, to identify claims for related items and services (for example, chest X-rays, blood work, or testing for other respiratory ailments) that led to or are related to a COVID-19 diagnostic test but were improperly denied due to coding inconsistencies or errors. Implement a process to help plan participants review bills from OON providers for services and concerns related to COVID-19 to ensure the provider is not charging more than the in-network cost-sharing requirement.

- **Steer employees to providers with transparent costs.** The Kaiser Family Foundation reports that the published cost of COVID-19 diagnostic tests vary widely — from $20 to $850 — not including the price of a provider visit, facility fee, specimen collection, or any other item, test, or service that may have been included during the testing visit, with hospitals and health systems generally charging more than doctor's offices. Review Food and Drug Administration (FDA) guidance for what is

considered safe and accurate testing and minimize financial exposure uncertainty by identifying and informing plan participants of trusted testing providers with predictable costs.

- **Return-to-the-workplace considerations.** Review plans and procedures for employees to return to the workplace, as well as for ongoing workplace health and safety while the pandemic continues. Decide how diagnostic testing will factor into the process and how costs will be covered. Current Equal Employment Opportunity Commission (EEOC) guidance permits employers to require COVID-19 diagnostic testing before allowing employees to re-enter the workplace. But relying upon CDC guidelines, the EEOC says employers may not require antibody testing for workplace re-entry. Consider this alongside current agency guidance indicating COVID-19 testing conducted as part of generalized workplace screening is not required to be covered by the group health plan under the FFCRA, but COVID-19 testing — including antibody testing — must be covered without cost sharing if determined medically necessary after individualized assessment. Self-insured plans can choose to cover the cost of workplace screening, but it could be cost prohibited and will not reach employees not covered by the employer plan. Consider a voluntary screening program with at-home testing kits. Keep in mind the state laws (for example, in California and New York) requiring insurers or certain employers to cover the cost of testing as a public health/occupational matter.

- **Evolving guidance across agencies presents ongoing challenges.** Further complicating matters is the likelihood that guidance from the EEOC and the CDC will evolve as the science related to COVID-19 improves. The EEOC guidance has been updated multiple times, most recently on Sept. 8. In addition, agency guidance interpreting the COVID-19 testing mandate for group health plans could also evolve, and coverage requirements could change in future pandemic relief legislation.

- **Review compliance requirements for stand-alone telehealth.** Be cautious of providing stand-alone telehealth to employees not eligible for any other group health plan offered by the same employer. Although FAQ 43 provides this type of arrangement relief from some group health plan requirements, many other federal compliance obligations remain. In addition, the uncertainty around ACA reporting obligations and the impact on premium tax credits for exchange coverage warrant consultation with legal counsel before implementation.

- **Grandfathered plan considerations.** Grandfathered health plans should consider whether or not required COVID-19 testing coverage and any other pandemic-related benefit enhancements will continue beyond the emergency period. Recent guidance provides that a plan will not lose grandfathered status if benefit enhancements are later reversed.

- **Non-ERISA plans should comply with the mandate.** The federal testing mandate applies equally to self-insured nonfederal (state and local) government plans and church plans. These employers should also review state law for any additional COVID-19 related coverage requirements that might apply.

- **Mental health parity considerations.** Conduct a mental health parity analysis if expanding benefits during the pandemic beyond what's required by the FFCRA or if continuing coverage of COVID-19 testing and related items and services without cost sharing beyond the public health emergency. If changes are made midyear and not continued into the next plan year, a parity analysis may not be required.

Related resources

Non-Mercer resources

- What you should know about COVID-19 and the ADA, the Rehabilitation Act, and other EEO laws (EEOC, Sept. 8, 2020)
- State action related to COVID-19 coverage of critical services by private insurers (The Commonwealth Fund, Aug. 28, 2020)
- Renewal of determination that a public health emergency exists (HHS, July 23, 2020)
- State balance-billing protections (The Commonwealth Fund, July 20, 2020)
- COVID-19 test prices and payment policy (Kaiser Family Foundation, July 15, 2020)
- The laws governing COVID-19 test payment and how to improve them (The Brookings Institute, July 13, 2020)
- Democrat bicameral committee leaders' letter to agencies regarding FAQ 43 (July 7, 2020)
- ACA FAQs, Part 43 (DOL/HHS/Treasury, June 23, 2020)
- Letter to sponsors of nonfederal government plans (CMS, June 5, 2020)
- ACA FAQs, Part 42 (DOL/HHS/Treasury, April 11, 2020)
- Press release on expanded coverage for essential COVID-19 diagnostic services (HHS, April 11, 2020)
- Pub. L. No. 116-136, the CARES Act (Congress, March 27, 2020)
- Pub. L. No. 116-127, the FFCRA (Congress, March 18, 2020)

Mercer Law & Policy resources

- California expands COVID-19 test coverage for managed care plans (Aug. 11, 2020)

- Top 10 compliance issues for health and leave benefits in 2021 (July 20, 2020)
- IRS, DOL ease deadlines for health, other benefit plans and participants (May 27, 2020)
- Employer health plans have to meet new COVID-19 coverage mandate (April 21, 2020)
- CARES Act boosts telehealth, makes other health, paid leave changes (March 27, 2020)
- Virus aid legislation includes cost-sharing curbs, new leave rights (March 18, 2020)
- COVID-19 spurs IRS relief for HDHPs, state insurance guidance (March 18, 2020)
- Mental Health Parity FAQs address nonquantitative limits, disclosures (Dec. 17, 2019)
- Final rules ease restrictions on health reimbursement arrangements (June 14, 2019)

Other Mercer resources

- Stay informed on the coronavirus (regularly updated)
- Contact tracing at work, works — and it's not that complicated (July 30, 2020)
- Worksite employee COVID-19 testing covered by insurance? — Not so fast! (July 16, 2020)

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