COMPLIANCE ALERT

Joint Agencies Release FAQs Clarifying Health Plan Coverage of COVID-19 Testing and Vaccines

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Quick Facts

- The FFCRA and CARES Acts require health plans to provide coverage for COVID-19 testing and vaccines at no cost-sharing during the public health emergency.
- Recent clarifying guidance provides detail on testing and vaccine coverage for asymptomatic individuals and individuals outside of state and local vaccine requirements.
- Flexibility for changing SBCs to reflect COVID-19 testing and vaccines remains in place.
- The joint Agencies provide clarifying guidance for onsite vaccine clinics.

Background

On February 26, 2021, the Department of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the "Agencies") jointly released Frequently Asked Questions (FAQs) regarding health coverage issues related to COVID-19. The guidance titled, "FAQs FFCRA and CARES Act Part 44," clarified how group health plans (GHPs) – including self-insured and grandfathered plans – must implement the COVID-19 test and vaccine requirements of the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) both signed into law in March 2020. The new Q&A guidance supplements the already existing COVID-19 guidance FAQs Part 42 and FAQs Part 43 that the Agencies released on April 11, 2020, and June 23, 2020.

Coverage for COVID-19 Testing and Vaccines

Generally, the FFCRA, the CARES Act, and the implementing regulations require GHPs and insurers to cover COVID-19 diagnostic testing of plan participants at no cost. The FFCRA requires group health plans to provide benefits for certain items and services related to diagnostic testing for COVID-19 when those services are furnished during the public health emergency (PHE) period beginning on March 18, 2020. The FFCRA requires plan issuers to offer this coverage without any cost-sharing (e.g., deductibles, copayments, or coinsurance), prior authorization, or other administrative plan management requirements. The CARES Act amends and broadens the scope of the FFCRA's provisions relating to COVID-19 testing, requiring plans to cover testing whether it is provided by an in- or out-of-network provider and mandating that servicers list the service cost for testing on a public website. Further, the CARES Act and accompanying agency regulations require GHPs to cover COVID-19 vaccinations and other preventive measures as preventive services without cost-sharing and on an expedited basis.

FAQs Part 44 is the latest guidance that the Agencies released, offering direction to GHPs to cover coronavirus testing and vaccinations. The FAQs consist of 14 questions and answers (Q&As) that provide additional clarification about how coverage operates when a plan participant receives a COVID-19 test or vaccine.

Q&As 1-6

Q&A1 reiterates and confirms that GHPs cannot use medical-screening criteria to deny or impose cost-sharing on claims for COVID-19 testing. It also states that a plan cannot impose as a coverage requirement that a participant exhibits symptoms or has a recent known or suspected exposure to COVID-19.

Q&A2 explains that GHPs are not required to give first-dollar coverage to testing for public health surveillance or employment purposes. This answer encourages plans to clearly communicate the circumstances in which the plan will cover testing.

Q&A3 and Q&A4 detail that GHPs must cover testing provided through state- or locally administered testing sites, including drive-through sites, and that they do not require appointments. Q&A3 and Q&A4 also clarify that point-of-care tests, commonly referred to as rapid testing, must be covered on the same basis as other COVID-19 tests.

Q&A5 reiterates that plans must cover items and services provided during the course of testing and diagnosis of COVID-19, such as physician-prescribed tests for other respiratory diseases in order to rule out COVID-19, without any cost-sharing. Plans must cover in- and out-of-network testing without any cost-sharing during the public health emergency. Plans can negotiate the price they will pay an out-of-network provider for testing cost or pay the posted price of testing and services.

Q&A6 encourages GHPs to report testing providers that violate the requirement to post their cash prices for diagnostic tests or that act contrary to similar regulatory requirements.

Q&As 7-10

Q&A7 reiterates that GHPs must cover all recommended COVID-19 vaccines as a preventive service, including those receiving EUA from the CDC Advisory Committee. Q&A7 builds on the meaning of covering COVID-19 related items and services without cost-sharing and explains that plans must cover these services both in-network and out-of-network. Plans must cover the services at the posted service price or a negotiated rate that will apply throughout the public health emergency (PHE) declaration period.

Q&A8 and Q&A9 remind plans that they must cover recommended COVID-19 vaccines no later than 15 business days after a vaccine receives its applicable recommendation. The answers state that plans must cover the vaccine administration cost regardless of the administrator or whether the federal government or another third party pays for the vaccine itself. Plans must also cover these costs even when the vaccine requires the administration of multiple doses.

Q&A10 explains that a GHP cannot deny vaccine coverage merely because a participant did not meet their state's or locality's current vaccination priority criteria when they received their vaccination.

Q&A10 further states that an individual provider's decision not to administer the vaccine because the individual is not in a priority vaccine category is not an adverse benefit determination subject to the plan's claims and appeals requirements.

Q&A11

Q&A 11 clarifies that the rules require a plan to provide at least 60 days' notice to plan participants prior to making any material modifications to the Summary of Benefits and Coverage (SBC). Q&A11 builds on the suspension of this requirement first addressed in FAQ Part 42. That previous guidance said that GHPs must provide notice of material modifications to the SBC relating to telehealth/teleservices as soon as reasonably practicable. Q&A11 extends the reasonably practicable standard to the addition of coverage for qualifying COVID-19 preventive services.

Q&As 12-13

Q&A12 builds on the previous answers (11 and 12) in FAQs Part 42 about Employee Assistance Programs' (EAPs) and onsite clinics' excepted benefit status. FAQs Part 42 Q&A11 states that an EAP that qualifies as an excepted benefit can maintain its status if it provides coverage for COVID-19 diagnostics and testing during the PHE. FAQs Part 42 Q&A12 explains that an onsite clinic remains an excepted benefit even if it offers COVID-19 testing and diagnosis because an onsite clinic is always an excepted benefit.

Q&A12 and Q&A13 build on that previous guidance by including coverage of COVID-19 vaccines and their administration during the PHE as services that will not disrupt the excepted benefit status of an EAP or onsite medical clinic.

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