FAQs address group health plan coverage under FFCRA and CARES Act

The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (Departments) have issued a set of frequently asked questions (FAQs) regarding implementation of the Families First Coronavirus Response Act (the FFCRA), the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), and other health coverage issues related to COVID-19.

Group health plan coverage. Section 6001 of the FFCRA, as amended by section 3201 of the CARES Act, generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period.

The FAQs explain this requirement applies to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans as defined in section 1251(e) of 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 states and local governments), and church plans.

Section 6001 does not apply to short-term, limited-duration insurance or to a plan or coverage in relation to its provision of excepted benefits. It also does not apply to group health plans that do not cover at least two employees who are current employees (such as plans in which only retirees participate).

Items and services. Plans and issuers must provide coverage for an in vitro diagnostic test (as defined in 21 C.F.R. 809.3) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that:

(a) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act;

(b) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

(c) is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or
(d) other tests that the Secretary of HHS determines appropriate in guidance.

Plans and issuers also must cover Items and services furnished to an individual during health care provider office visits (which includes in-person visits 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 the 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.

The FAQs indicate that "in vitro diagnostic tests" described in section 6001(a)(1) of the FFCRA, as amended by section 3201 of the CARES Act, include serological tests for COVID-19. Serological tests for COVID-19 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. The Food and Drug Administration (FDA) currently believes such tests should not be used as the sole basis for diagnosis. The FDA has advised the Departments that serological tests for COVID-19 meet the definition of an in vitro diagnostic product for the detection of SARS-CoV-2 or the diagnosis of COVID-19. Therefore, plans and issuers must provide coverage for a serological test for COVID-19 that otherwise meets the requirements of section 6001(a)(1) of the FFCRA, as amended by section 3201 of the CARES Act.

No cost-sharing, prior authorization. Section 6001(a) of the FFCRA provides that plans and issuers must 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 attending health care provider in accordance with accepted standards of current medical practice.

Plan amendments. Section 2715(d)(4) of the PHS Act and final rules issued by the Departments regarding the Summary of Benefits and Coverage (SBC) provide that if a plan or issuer makes a material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the 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, to help facilitate the nation's response to COVID-19, the Departments will not take enforcement action against any plan or issuer that makes such modification to provide greater coverage related to the diagnosis and/or treatment of COVID-19, without providing at least 60 days advance notice. Plans and issuers must provide notice of the changes as soon as reasonably practicable. HHS encourages states to take a similar approach and will not consider a state to have failed to substantially enforce PHSA Sec. 2715(d)(4) if it takes such an approach.

Additionally, issuers generally are not permitted to modify the health insurance coverage for a product mid-year subject to certain exceptions. However, 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. HHS encourages states to take a similar approach, and will not consider a state to have failed to substantially enforce PHSA Sec. 2703 if it takes such an approach.

Excepted benefits. The FAQs indicate that an employer may offer benefits for diagnosis and testing for COVID-19 under an EAP that constitute an excepted benefit. The Departments' final regulations provide that for the purpose of determining whether an EAP provides benefits that are significant in the nature of medical care, the amount, scope, and duration of covered services are taken into account. An EAP will not be considered to provide benefits that are significant in the nature of medical care solely because it offers benefits for diagnosis and testing for COVID-19 while a public health emergency declaration under

section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies Act, related to COVID-19 is in effect.

Coverage of on-site medical clinics is an excepted benefit in all circumstances, according to the FAQs.

SOURCE: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf