HHS July 7, 2020

COVID-19 Testing – Group Health Plan and Health Insurance Coverage, Non-Emergent Care

	In-Network	Out-of-Network (OON)
Coverage	Section 6001 of the Families First Coronavirus Response Act (FFCRA, as amended by section 3201 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) requires group health plan and issuers of health insurance to cover certain diagnostic tests for COVID-19. Questions 1-4 in FAQS About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42 provide more details on the specific coverage requirement.	
Types of Testing Covered	Question 4 in FAQS About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42 specifies 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. In question 5 of FAQS About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43, the Departments of Health and Human Services, Labor, and the Treasury (the Departments) clarified that section 6001 of FFCRA, as amended by section 3201 of the CARES Act requires coverage of items and services only for diagnostic purposes. Testing conducted to screen for workplace safety (such as employee "return to work" programs), public health surveillance, or any efforts not primarily associated with individualized diagnosis or treatment of COVID-19 or another health condition is outside the scope of the requirements.	
Out-of-Pocket Liability	Plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization, or other medical management requirements.	
Provider Balance Billing	The Departments interpret the CARES Act to generally preclude balance billing for COVID-19 testing, but not for related items and services described under section 6001 of FFCRA. A statutory change is required to prohibit balance billing for related items or services.	The CARES Act is silent on what an issuer or plan must reimburse if the OON provider fails to post a cash price and does not negotiate a rate. It is unclear whether balance billing would be allowed in this circumstance.
Pricing	Payer-negotiated rate.	Plans and issuers must pay an amount that equals the cash price for such service as listed by the provider on a public internet website, or may seek to negotiate a rate with the provider for less than such cash price.

COVID-19 –- Group Health Plan and Health Insurance Coverage, Emergency Care

	In-Network	Out-of-Network (OON)
Coverage	Coverage is provided according to the parameters of the health insurance benefit. For non-grandfathered individual and small group market health insurance, plans must cover emergency services as a category of essential health benefits.	
Types of Testing Covered	The Departments have stated that section 6001 of FFCRA requires coverage of items and services only for diagnostic purposes. Testing conducted to screen for workplace safety (such as employee "return to work" programs), public health surveillance, or any efforts not primarily associated with individualized diagnosis or treatment of COVID-19 or another health condition is outside the scope of the requirements.	
Out-of-Pocket Liability	Normal cost sharing requirements apply.	Non-grandfathered group health plans and health insurance issuers cannot impose cost sharing on out-of-network emergency services in a greater amount than what is imposed for in-network emergency services.
Provider Balance Billing	The Departments interpret the CARES Act to generally preclude balance billing for COVID-19 testing, but not for related items and services described under section 6001 of FFCRA. A statutory change is required to prohibit balance billing for related items or services.	The CARES Act is silent on what an issuer or plan must reimburse if the OON provider fails to post a cash price and does not negotiate a rate. It is unclear whether balance billing would be allowed in this circumstance.
Pricing	Payer-negotiated rate	Out-of-network emergency services must be reimbursed in an amount at least equal to the greatest of the following three amounts (adjusted for in-network cost-sharing requirements): (1) the median amount negotiated with in-network providers for the emergency service; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); or (3) the amount that would be paid under Medicare for the emergency service.

Uninsured – Testing and Treatment

Coverage	Providers that have conducted COVID-19 testing of uninsured individuals or provided treatment to uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020, can request claims reimbursement.
Types of Testing and Treatment Covered	For dates of service or admittance on or after February 4, 2020, the program provides reimbursement to health care entities for qualifying testing for COVID-19 and treatment services with a primary COVID-19 diagnosis as determined by HRSA (subject to adjustment as may be necessary), including the following: • Specimen collection, diagnostic and antibody testing. • Testing-related visits including in the following settings: office, urgent care or emergency room or telehealth. • Treatment, including office visit (including telehealth), emergency room, inpatient, outpatient/observation, skilled nursing facility, long-term acute care (LTAC), acute inpatient rehab, home health, DME (e.g., oxygen, ventilator), emergency ambulance transportation, non-emergent patient transfers via ambulance, and FDA-approved drugs as they become available for COVID-19 treatment and administered as part of an inpatient stay. □ FDA-approved vaccine, when available. For testing and treatment claims to be eligible for reimbursement, they must include the diagnosis codes specified by the program (see https://coviduninsuredclaim.linkhealth.com/billing-codes.html).
Out-of-Pocket Liability	The provider must agree not to charge any type of cost sharing. If an uninsured individual paid the provider for any portion of the care reimbursed under the program for uninsured individuals, the provider must return the payment.
Provider Balance Billing	In order to receive program reimbursement, eligible health care entities must sign the program Terms and Conditions, which set forth the following prohibitions on balance billing: • Treatment Terms and Conditions: The Recipient certifies that it will not engage in "balance billing" or charge any type of cost sharing for any items or services provided to Uninsured Individuals receiving care or treatment for a positive diagnosis of COVID-19 for which the Recipient receives a Payment from the Relief Fund. • Testing Terms and Conditions: The Recipient certifies that it will not engage in "balance billing" or charge any type of cost sharing for any COVID-19 Testing and/or Testing-Related Items and Services provided to FFCRA Uninsured Individuals for which the Recipient receives a Payment from the FFCRA Relief Fund. Both sets of Terms and Conditions also state that if providers, prior to signing the Terms and Conditions, charged any uninsured individual a fee for COVID-19 related testing or treatment which they subsequently received a payment from the program, they must notify the uninsured individual that no money is owed and must timely return any payment received from the individual.
Pricing	Providers will be reimbursed generally at Medicare rates.