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compliance ALERT

Agencies Issue Guidance on COVID-19 Testing and Vaccines

March 2, 2021

On February 26, 2021, the Centers for Medicare & Medicaid Services, together with the Department of Labor and Treasury (collectively, the "Agencies"), issued new FAQ guidance (the "Guidance") clarifying the rules applicable to how group health plans must offer COVID-19 diagnostic testing and vaccinations under the FFCRA and CARES Act, including applicable cost sharing requirements. The new Guidance applies to all group health plans (including self-insured plans), health plan issuers offering group or individual health insurance coverage, and providers of COVID-19 related services to the uninsured.

How Does the New Guidance Change the Law? How does the Guidance Apply to COVID-19 Testing?

While the new Guidance does not change the law, it does help to clarify how the FFCRA and CARES Act apply in several circumstances applicable to COVID-19 testing and vaccines, and it answers important questions that remained unanswered in the Agencies' previously issued rules and guidance.

Specifically, and with regard to COVID-19 testing, the Guidance clarifies that private group health plans and health plan issuers generally cannot use medical screening criteria to deny coverage for COVID-19 diagnostic tests for individuals with health coverage who are asymptomatic, and who have no known or suspected exposure to COVID-19. Such testing must be covered without cost sharing requirements (including deductibles, copays and coinsurance), prior authorization or other medical management requirements imposed by the plan or insurer.

Notably, the Guidance goes further than the Agencies' prior regulations and guidance to eliminate cost-related roadblocks to getting tested. For example, the Guidance provides that "[w]hen an individual seeks and receives a COVID-19 diagnostic test from a licensed or authorized health care provider, or when a licensed or authorized health care provider refers an individual for a COVID-19 diagnostic test, plans and issuers generally must assume that the receipt of the test reflects an 'individualized clinical assessment' and the test should be covered without cost sharing, prior authorization, or other medical management requirements."

The Guidance also clarifies that plans and issuers must cover COVID-19 diagnostic

SYNOPSIS

- The new Guidance clarifies how group health plans must offer COVID-19 diagnostic testing and vaccinations under the FFCRA and CARES Act, including applicable cost sharing requirements.
- The Guidance goes further than prior regulations and guidance to eliminate cost-related roadblocks to getting tested.
- The Guidance provides that plans and issuers must cover qualifying coronavirus preventive services without cost sharing starting no later than 15 business days after an official federal recommendation.
- Employers and plan sponsors should make sure that their SBCs are, or will soon be, updated to reflect the new rules clarified in the Guidance.

[1] The Guidance also includes information for medical providers on how to get reimbursed for providing COVID-19 diagnostic testing or for administering the COVID-19 vaccine to those who are uninsured.

testing without cost sharing when provided through state- or locality-administered testing (including "drive-through" sites), as well as when provided at point-of-care.

What Has to be Covered under the new Guidance?

The Guidance provides that:

- Plans and issuers must cover all COVID-19 vaccines without cost sharing (and all other vaccines that have received a recommendation from the Advisory Committee on Immunization Practices (ACIP)). Plans and issuers are not permitted to exclude coverage for (or impose cost sharing on) any qualifying coronavirus preventive services.
- Plans and issuers must cover the vaccine administration fee without cost sharing for an immunization, regardless of how the administration is billed, and regardless of whether a COVID-19 vaccine or any other immunization requires the administration of multiple doses in order to be considered a complete vaccination. This includes covering, without cost sharing, the administration of a required preventive immunization in instances where a third party, such as the federal government, pays for the preventive immunization.
- A plan or issuer may not deny coverage of recommended COVID-19 vaccines because a participant, beneficiary or enrollee is not in a category recommended for early vaccination

When Must the Required Coverage Begin under the new Guidance?

The Guidance provides that plans and issuers must cover qualifying coronavirus preventive services without cost sharing starting no later than 15 business days (not including weekends or holidays) after the date the United States Preventive Services Task Force (USPSTF) or ACIP makes an applicable recommendation regarding a qualifying coronavirus preventive service. The requirement to cover the Pfizer BioNTech COVID-19 vaccine became effective on January 5, 2021, and the requirement to cover the Moderna COVID-19 vaccine became effective on January 12, 2021.

COVID-19 diagnostic testing has been required to be provided by group health plans without cost sharing since January 27, 2020, which marked the beginning of the ongoing COVID-19 public health emergency.

Does the Guidance Require Employers to Pay for "Return to Work" or Employment-based COVID-19 Testing?

No. Q&A #2 of the Guidance makes it clear that the requirement to provide COVID-19 testing without cost sharing only applies to COVID-19 testing provided by group health plans and health plan issuers for diagnostic purposes, and that these rules do not apply to COVID-19 testing for "general workplace health and safety," testing for "other employment purposes," or testing for "public health surveillance."

What Should Employers and Plan Sponsors do Next?

While it's unlikely that any medical provider has charged plan participants for administering COVID-19 vaccine (since it is primarily being administered through federal and state programs), employers across the country have already received numerous complaints by employees and plan participants that they were improperly charged cost sharing for COVID-19 diagnostic testing by their health plan or insurer. Given how common this problem is, employers and plan sponsors should check to ensure that all of the group health plans that they sponsor (whether fully-insured or self-insured) are offering COVID-19 diagnostic testing without cost sharing.

Additionally, while the Guidance provides that the Agencies will not take enforcement action against plans and issuers that haven't modified their summary of benefits and coverage (SBC) notice to indicate that the plan covers qualifying coronavirus preventive services, the Guidance does state that plan and issuers must provide any required notice of these plan changes "as soon as reasonably practicable." Accordingly, employers and plan sponsors should also make sure that their SBCs are, or will soon be, updated to reflect the new rules clarified in the Guidance.

If you have any additional questions, please call your Corporate Synergies Account Manager or 866.CSG.1719.

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