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Departments Issue Guidance

Re: FFCRA and CARES Act

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On February 26, 2021, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") issued FAQ 44 addressing health coverage issues related to COVID-19.

Briefly, the new FAQs focus on diagnostic testing and coverage for testing and clarify previous guidance in FAQs.

Background

Section 6001 of the FFCRA requires group health plans (including grandfathered health plans) and health insurance issuers to provide coverage for certain items and services related to testing or the diagnosis of COVID-19 without any cost-sharing requirements, prior authorization or other medical requirements. Section 3201 of the CARES Act amended Section 6001 of the FFCRA to include a broader range of diagnostic items and services that must be covered the same way. Since the FFCRA and CARES Act have been enacted, the Departments have issued several sets of FAQs to help people better understand the laws.

The guidance clarifies that:

- medical screening criteria may not be used to deny (or impose cost sharing on) a claim for COVID-19 diagnostic testing for an asymptomatic person who has no known or suspected exposure to COVID-19. Plans and carries may still distinguish between asymptomatic people and general workplace testing.

- referrals for COVID-19 testing that come from a licensed or authorized health care provider are assumed to reflect an "individualized clinical assessment" and the test should be covered without cost sharing, prior authorization, or other medical management requirements.

- providers may limit eligibility for testing based on clinical risk or management of testing supplies

- plans and issuers are not required to provide coverage for testing for employment purposes (though they may)

- there is no distinction between point-of-care testing (i.e., drive through) and other testing for coverage purposes

- all COVID-19 vaccines recommended by Centers for Disease Control and Prevention ("CDC") must be covered without cost sharing. As of the date of this bulletin, the Pfizer and Moderna vaccines must be covered. The Johnson and Johnson vaccine is expected to require coverage by March 18, 2021.

- COVID-19 vaccines must be covered without cost sharing regardless of how it is billed and regardless of whether the vaccine requires the administration of multiple doses in order to be considered a complete vaccination

- coverage of a recommended COVID-19 vaccine may not be denied because an individual is not in a category recommended for early vaccination – the coverage must be provided regardless of priority set by states and local jurisdictions.

- although on-site medical clinics are always excepted benefits, COVID-19 vaccines may be offered at on-site medical clinics as excepted benefits.

- an Employee Assistance Plan (an "EAP") will not be considered an excepted benefit solely because it offers benefits for COVID-19 vaccines and their administration but there must be no cost-sharing.

- The Departments will not take enforcement action against any plan or issuer that does not provide at least 60 days' advance notice of a change affecting the SBC to reflect the addition of coverage for qualifying coronavirus preventive services, as such services must be covered on an expedited timeframe. However, plans and issuers must provide any required notice of the changes as soon as reasonably practicable.

Employer Action

Plan sponsors should review the Departments' new guidance and confirm with their carriers or TPAs that the plans they sponsor are meeting the requirements contained in the new FAQs.