Illinois Health and Hospital Association

April 13, 2020

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

SUBJECT: Federal Guidance on Commercial Payer Coverage of COVID-19

On April 11, 2020, the Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) issued guidance for commercial payers on implementation of the new COVID-19-related benefit requirements under the Families First Coronavirus Response (FFCRA) Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act (the Acts). This memo highlights key pieces of this guidance, including covered group health plans and health insurance issuers, in- and out-of-network provider reimbursement requirements, covered items and services, and cost-sharing and utilization management prohibitions. Health plans and issuers must comply with these requirements for dates of service on or after March 18, 2020 through the end of the public health emergency (PHE).

Covered Health Plans and Issuers
The Acts apply to group health plans and health insurance issuers offering group or individual coverage, including grandfathered health plans under the Affordable Care Act, as outlined in the table below. The Acts do not apply to short-term, limited duration insurance, excepted benefit plans, and group health plans that do not cover at least two current employees (e.g., retiree plans are excluded).

Group Health Plans	Individual Health Insurance Coverage
Insured group health plans	Individual coverage offered on an exchange
Self-insured group health plans	Individual coverage offered off an exchange
Private employment-based group health plans (ERISA plans)	Student health insurance coverage
Non-federal governmental plans, such as state and local government plans	
Church plans	

Covered Benefits
Plans and issuers are only required to provide benefits for the following COVID-19-related services:

- Specific in vitro diagnostic tests for the detection of SARS-CoV-2 or the diagnosis of COVID-19, including serological tests for COVID-19.
- Items and services provided during office visits (in-person and telehealth visits), urgent care center visits, and emergency room visits that relate to (1) the furnishing or administration of a test; and (2) the evaluation of a patient for purposes of determining the need for testing, as determined by the patient's attending provider. *(NOTE: if the attending physician determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed during the visit to determine the need for COVID-19 diagnostic testing **and** the visit results in an order for, or the administration of, COVID-19 testing, the plan or issuer must cover the related tests.)*

  Items and services furnished during an office visit must be covered when provided in traditional settings or in non-traditional settings, such as drive-through screening and testing sites.

Provider Reimbursement

The CARES Act requires plans and issuers to reimburse both in- and out-of-network providers for covered items and services. Specifically:

- In-network: the negotiated rate in effect prior to the PHE.
- Out-of-network: if the plan and provider do not have a negotiated rate, the cash price for the service, unless the plan/issuer negotiates an amount that is less than the cash price. **The cash price for the item or service must be posted by the provider on a public website.**

The CARES Act also requires **providers of diagnostic tests for COVID-19 to make the cash price of the test publically available on their websites.**

Cost Sharing, Prior Authorization, and Utilization Management

For the specific COVID-19-related benefits outlined above, the FFCRA prohibits plans and issuers from imposing any cost sharing, including deductibles, copayments, and coinsurance; requiring prior authorization; or implementing any other medical management requirements.

Enforcement

Covered plans and issuers may provide more generous benefits as long as the federal requirements are met. The Departments will, however, take enforcement action against any health plan or issuer that tries to limit or eliminate other benefits or increase cost-sharing to offset the costs of meeting the COVID-19 benefit requirements mandated under the Acts. The Departments also clarify that states may impose additional standards or requirements on health insurance issuers with respect to COVID-19 diagnosis and treatment.