Health Care Coverage Changes Due to COVID-19

Below is an outline of changes in health care coverage being implemented as a result of the Covid-19 pandemic. In summary, it states that effective for dates of service March 18, 2020 and after, testing for COVID-19 is not subject to any deductible, co-insurance or co-pay. This will include telehealth visits. **Please note this is for TESTING only**, refer to this e-mail if you receive a call from a provider.

Also, effective April 1, 2020, the Plan B out of pocket limit will be reduced from $4,100 to $3,900 for individual, and from $8,200 to $7,800 for family.

1. Group Health Plan Coverage

The Act requires group health plans (and insurers) to cover specific services related to testing for the virus that causes COVID-19. The new requirements would apply to all group health plans, including self-insured plans and grandfathered plans under the Affordable Care Act. These requirements take effect upon enactment (March 18, 2020) and would apply during the currently declared national emergency.

Group health plans and **insurers must provide coverage for, and not charge any cost sharing for**, the following services:

a) **Diagnostic tests to detect the virus that are approved or authorized by the FDA, including the administration of such tests**; and

b) **Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the test described above,** but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

The prohibition on cost sharing means that these services cannot be subject to a deductible or to copayments or coinsurance. Plans and insurers are also prohibited from imposing prior authorization or other medical management requirements for these services.

The Act would appear to **require coverage and payment for these services whether provided by an in-network or out-of-network health care provider**. There are no special provisions discussing plans that generally do not provide out-of-network coverage or for High Deductible Health Plans (HDHPs) paired with

Health Savings Accounts or about balance billing. Under recent guidance issued by the Treasury Department, we know that HDHPs are permitted to cover testing (and treatment) for COVID-19 before the deductible is met, so this new requirement does not conflict with current rules applicable to HDHPs during this emergency. The Departments of Health and Human Services, Labor and Treasury may issue sub-regulatory or other guidance to implement the new requirements.

Similar requirements would apply to Medicare (including Medicare Advantage plans), the Federal Employees Health Benefits Program, TRICARE and other federal health programs.