

April 14, 2020

Joint Departmental Guidance Implementing Expanded Coverage for Essential COVID-19 Diagnostic Testing and Related Services

The Departments of Health and Human Services (HHS), Labor (DOL) and Treasury jointly issued [guidance](#) April 11 implementing legislative provisions specific to COVID-19 diagnostic testing and services from the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The guidance is in the form of Frequently Asked Questions (FAQs) similar to previously issued COVID-19 related guidance from [DOL](#) and [HHS](#).

The guidance principally implements the requirement for group health plans and group and individual health insurance (health plans) to cover both certain diagnostic testing and certain related items and services provided during a medical visit with no cost sharing. The following is a summary of key provisions.

Cost Sharing. Beginning March 18, 2020, health plans are required to cover COVID-19 related diagnostic testing and related items and services provided during a medical visit with no cost sharing, which includes deductibles, copayments and coinsurance. In addition, plans cannot impose prior authorization or other medical management requirements on such services.

Diagnostic Testing, Items and Services, and Care Sites. Health plans are required to cover approved COVID-19 diagnostic testing. The serological test, used to detect the presence of COVID-19 antibodies, also is considered an approved test. In addition, items and services related to COVID-19 testing and furnished during a health care provider visit, whether in-person or through a telehealth visit, will be covered. Such visits could include traditional sites of care such as provider offices, urgent care centers and emergency departments, as well as non-traditional sites such as drive-through and other testing sites.

Health Plan Reimbursement of Diagnostic Test. Health plans are required to reimburse providers for COVID-19 related diagnostic testing. If the health plan has a negotiated rate with the testing provider in place prior to the COVID-19 national emergency, that negotiated rate would apply during the emergency period. If the health plan does not have a negotiated rate with the test provider (i.e., the provider is out-of-network), the plan can either negotiate a payment rate with the provider or pay the provider an amount that equals the case price for the service listed on the provider's public website (see below).

Posting of Cash Price. Diagnostic testing providers, including both hospital and commercial laboratories, must post the cash prices for their COVID-19 testing services on a public website. For example, a hospital lab providing diagnostic testing would need to post the cash price on the hospital's website. HHS is authorized to fine testing providers that fail to comply and submit a corrective action up to \$300 per day.

Health Plan Terms of Coverage and Benefit. Health plans would be permitted to make changes mid-year to increase benefits or decrease cost-sharing for services related to COVID-19 diagnosis and/or treatment. HHS encourages states to take a similar approach in their oversight of health plans.

Further Questions

If you have questions, please contact the AHA at 800-424-4301.