INFORMATION FOR INSURERS

Congress has passed several laws that include requirements for insurance coverage of diagnostic testing for COVID-19, vaccines, and other services.

VACCINE COVERAGE

The Food and Drug Administration (FDA) issued emergency use authorizations for vaccines to prevent COVID-19, and more are under development. These vaccines have been found to be safe and effective, but their availability is limited at this time. The vaccines are free for all individuals.

Private Insurance

For most private insurance plans, the *CARES Act* requires coverage for COVID-19 vaccines without cost-sharing. Specifically, this coverage is required to begin fifteen days after a favorable rating or recommendation from the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices. In addition, private health insurance plans are required to cover all the costs of a COVID-19 vaccine even if an out-of-network provider administers it.

Typically, the *Affordable Care Act* requires that preventive services and vaccines be covered by private insurance starting on the first day of the plan year beginning after a favorable rating or recommendation, so the *CARES Act* requires this coverage to begin sooner.

Medicare

The *CARES Act* requires a vaccine that the FDA has authorized or approved and its administration to be free to beneficiaries with Medicare Part B and those with Medicare Advantage who receive the vaccine from an in-network provider.

Medicaid

Medicaid and CHIP must cover recommended vaccines for children without cost-sharing. For adults in Hawaii, Medicaid must cover vaccinations without cost sharing. Please contact Med-QUEST for more information on vaccine coverage.

TESTING FOR COVID-19

The *Families First Coronavirus Response Act* requires health insurers to cover the COVID-19 diagnostic test at no cost to individuals. This includes private health plans,[1] Medicare, Medicare Advantage, Medicaid, CHIP, TRICARE, veterans' plans, federal workers' health plans, and the Indian Health Service.

- Plans may not use tools like prior authorization to limit access to the test.
- Insurers must also cover the cost, without cost-sharing, of a patient's visit to a provider, urgent care center, or emergency room to receive this testing.
- **This means that individuals are not responsible for deductibles, coinsurance, or co-pays for a medically necessary COVID-19 test or the visit associated with receiving that test.**

Pricing of Diagnostic Testing

For COVID-19 testing, the *CARES Act* requires insurers to pay either the rate specified in a contract between the provider and the insurer, or, if there is no contract, a cash price posted by the provider. Insurers may negotiate a lower price than cash price.

Prescription Drug Coverage for Medicare Beneficiaries

[1] This does not include certain types of private health plans that are not in compliance with requirements of the Affordable Care Act, such as short-term limited duration plans.

During the COVID-19 public health emergency, Medicare Part D plans may permit seniors on Medicare to receive up to 90 days of a prescription if that is what their doctor prescribed, as long as there are no safety concerns. Medicare drug plans may also allow beneficiaries to fill prescription early for refills up to 90 days, depending on the prescription.

Over-the-Counter Medical Products
The *CARES Act* allows patients to use funds in Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs), and Health Reimbursement Arrangement (HRAs) for the purchase of over-the-counter medical products, such as non-prescription pain relievers and cold/flu medications, without a prescription from a physician. In addition, menstrual care products have been added to the list of qualified health care expenses under FSAs, HSAs, and HRAs.

Telehealth
The *CARES Act* provides new options to use telehealth, and more information on telehealth is available on Senator Schatz's coronavirus webpage. The *CARES Act* allows for high-deductible health plans with a health savings account to cover telehealth services prior to a patient reaching their deductible.

Catastrophic Plans
HHS will not take enforcement action against any health insurance issuer that amends its catastrophic plans to provide pre-deductible coverage for services associated with the diagnosis and/or treatment of COVID-19.

CMS Guidance
CMS has posted several guidance documents and other information at this link. Of particular note are the following:

- FAQs on diagnostic testing.
- Medicaid and CHIP - Coverage and Benefits Related to COVID-19
- Individual and Small Group Market—
    - Individual and Small Group Market Insurance Coverage – Information Related to COVID-19
    - Payment and Grace Period Flexibilities Associated with the COVID-19 National Emergency
    - FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019
    - FAQs on Prescription Drugs and the Coronavirus Disease 2019 for Issuers Offering Health Insurance Coverage in the Individual and Small Group Markets
- FAQs on Catastrophic Plan Coverage and the Coronavirus Disease 2019
- FAQs on Essential Health Benefit Coverage and the Coronavirus
- Information for Medicare Advantage Organizations, Part D Sponsors, and Medicare-Medicaid Plans

Additional Information
Please visit Senator Schatz's coronavirus webpage to see information on related topics, including financial assistance for health care providers, regulatory relief for health care providers, and health resources.