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COVID-19 and Private Health Insurance Coverage: Frequently Asked Questions

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SUMMARY

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COVID-19 and Private Health Insurance Coverage: Frequently Asked Questions

The Coronavirus Disease 2019 (COVID-19) pandemic is affecting communities around the world and throughout the United States, with case counts growing daily. As private health insurance is the predominant source of health coverage in the United States, there is considerable congressional interest in understanding private health insurance coverage of health benefits related to COVID-19. This report addresses frequently asked questions about private health insurance covered benefits and consumer cost sharing related to COVID-19 testing, treatment, and a potential vaccine. It discusses recent legislation, references existing federal requirements and recent administrative interpretations of them in relation to COVID-19, and notes state and private-sector actions.

Federal and state health insurance requirements may relate to covered benefits and consumer cost sharing, among many other topics. These requirements can vary by coverage type (i.e., individual coverage, fully insured small- and large-group coverage, and self-insured plans). Covered benefits, consumer costs, and other plan features may vary by plan within each type of coverage, subject to applicable federal and state requirements.

The following bullets summarize federal requirements related to coverage and cost sharing (which includes deductibles, coinsurance, and copayments) of COVID-19 testing, treatment, and vaccination. Additional details are addressed in the report, including the applicability of the requirements to different types of plans; whether the coverage requirements apply even when furnished by out-of-network providers; whether plans are allowed to impose prior authorization or other medical management techniques; and the applicable dates of any coverage requirements.

- **COVID-19 Testing.** The Families First Coronavirus Response Act (FFCRA; P.L. 116-127), as amended by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136), requires most private health insurance plans to cover COVID-19 testing, administration of the test, and related items and services, as defined by the acts. This coverage must be provided without consumer cost sharing.
- **COVID-19 Treatment.** There are no federal requirements that specifically require coverage of COVID-19 treatment. However, the existing federal requirement that certain plans cover a set of 10 categories of essential health benefits (EHB) is potentially relevant to coverage of COVID-19 treatment items and services, depending on state and plan variation with regard to implementation of this requirement. Even where treatment items and services are required to be covered as EHB, cost sharing could apply.
- **COVID-19 Vaccine.** As of the date of this report, there is no vaccine against COVID-19 approved by the Food and Drug Administration (FDA) for use in the United States, although several candidates are in development. The CARES Act requires most plans to cover a COVID-19 vaccine, when available, without cost sharing, if it is recommended by the Advisory Committee on Immunization Practices (ACIP). Similarly, most plans must cover, without cost sharing, any other COVID-19 preventive services that are recommended for use by the United States Preventive Services Task Force (USPSTF).

Some states have also announced relevant requirements on the plans they regulate, and some insurers have reported that they will cover certain relevant benefits. Several organizations are tracking these announcements, as noted in this report.

Congressional Research Service (CRS) experts on other topics related to private health insurance and COVID-19, including types of plans and coverage of benefits not addressed in this report, are listed in the **Appendix** for the benefit of congressional clients. For information on other COVID-19 issues, congressional clients can access the CRS Coronavirus Disease resources page at https://www.crs.gov/resources/coronavirus-disease-2019.

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Introduction

The Coronavirus Disease 2019 (COVID-19) pandemic is affecting communities around the world and throughout the United States, with case counts growing daily. As private health insurance is the predominant source of health coverage in the United States,[1] there is considerable congressional interest in understanding private health insurance coverage of health benefits related to COVID-19 diagnosis, treatment, and prevention.

This report addresses frequently asked questions about covered benefits and consumer cost sharing related to COVID-19 testing, treatment, and a potential vaccine. It discusses recent legislation, references relevant existing federal requirements and recent administrative interpretations of them in relation to COVID-19, and notes state and private-sector actions. It begins with background information on types and regulation of private health insurance plans.

The Families First Coronavirus Response Act (FFCRA; P.L. 116-127)[2] requires specified types of private health insurance plans to cover COVID-19 testing, administration of the test, and related items and services, without consumer cost sharing. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136)[3] further addresses private health insurance coverage of COVID-19 testing, and requires coverage of a potential vaccine and other preventive services without cost sharing, if they are recommended by specified federal entities. There are no federal requirements that specifically require coverage of COVID-19 treatment services. However, one or more existing federal requirements are potentially relevant, as discussed in this report. Some states have also announced requirements related to covered benefits and consumer costs, and some insurers have reported that they will voluntarily cover certain relevant benefits.

This report discusses most U.S. private health insurance plans' coverage of health care items and services related to COVID-19, but it generally does not discuss the delivery of those services, insurers' payments to health care providers, or private health insurance coverage of other benefits. The **Appendix** lists Congressional Research Service (CRS) analysts who can discuss with congressional clients other topics of interest related to private health insurance and COVID-19, including types of plans and coverage of benefits not addressed in this report. Also beyond the scope of this report are public health coverage programs (e.g., Medicare); the domestic and international public health responses to COVID-19; and economic, human services, and other nonhealth issues. For further information on these topics, congressional clients can access the CRS Coronavirus Disease 2019 resources page at https://www.crs.gov/resources/coronavirus-disease-2019.

The information in this report is current as of its publication date and may be superseded by subsequent congressional or administrative action. Congressional clients may contact the report author and/or the experts listed in the **Appendix** for questions about further developments. In addition, Centers for Medicare & Medicaid Services (CMS) guidance related to private health insurance and COVID-19 is compiled on its website.[4]

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[1] For more information and coverage estimates, see CRS In Focus IF10830, *U.S. Health Care Coverage and Spending*.

[2] H.R. 6201 was signed into law as the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) on March 18, 2020. See CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127*, for more information about the health provisions in the act.

[3] H.R. 748 was signed into law as the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136) on March 27, 2020. See CRS Report R46334, *Selected Health Provisions in Title III of the CARES Act (P.L. 116-136)* for more information about the health provisions in the act.

[4] See Centers for Medicare & Medicaid Services (CMS), The Center for Consumer Information and Insurance

Background on Private Health Insurance

The private health insurance market includes both the *group market* (largely made up of employer-sponsored insurance) and the *individual market* (which includes plans directly purchased from an insurer). The group market is divided into small- and large-group market segments; a *small group* is typically defined as a group of up to 50 individuals (e.g., employees), and a *large group* is typically defined as one with 51 or more individuals.[5] Employers and other group health plan sponsors may purchase coverage from an insurer in the small- and large-group markets (i.e., they may *fully insure*). Sponsors may instead finance coverage themselves (i.e., they may *self-insure*).[6] The individual and small-group markets include plans sold on and off the individual and small-group health insurance exchanges, respectively.[7]

Covered benefits, consumer costs, and other plan features may vary by plan, subject to applicable federal and state requirements. The federal government may regulate all the coverage types noted above (i.e., individual coverage, fully insured small- and large-group coverage, and self-insured group plans), and states may regulate all but self-insured group plans. Federal and state requirements may vary by coverage type.[8]

This report focuses on private-sector plans explained above.[9] There are some variations of these coverage types, and there are other types of private health coverage arrangements, which may or may not be subject to the requirements discussed in this report, or for which there may be other policy questions related to COVID-19. These other coverage types are out of the scope of this report, but a number of them are identified in the **Appendix**, along with resources for further information.

One coverage variation, *grandfathered plans*, is included in this report because it is explicitly referenced in legislation relevant to COVID-19 and private health insurance coverage. Grandfathered plans are individual or group plans in which at least one individual was enrolled as of enactment of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), and which continue to meet certain criteria.[10] Plans that maintain their grandfathered status are exempt from some, but not all, federal requirements.

Oversight (CCIIO), "Coronavirus Disease 2019 (COVID-19) Guidance," accessed April 28, 2020, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs#COVID-19.

[5] In general, for purposes of health insurance requirements, small groups are those with 50 or fewer individuals (e.g., employees). States can also define them as having 100 or fewer individuals. The definition of large group is 51 or more individuals, or 101 or more individuals, depending on the definition of small group.

[6] Employers and other plan sponsors may purchase coverage from state-licensed insurers and offer it to their employees or other group members. Employers and other plan sponsors that obtain health insurance plans in this way are referred to as being *fully insured*. Employers or other plan sponsors that *self-insure* set aside funds to pay for health benefits directly, and they bear the risk of covering medical expenses generated by the individuals covered under the self-insured plan.

[7] The health insurance exchanges are virtual marketplaces in which consumers and small businesses can shop for and purchase private health insurance coverage. For more information, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

[8] For more information about types of plans and regulation of them, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[9] In terms of group coverage, this report focuses on group plans sponsored by private-sector employers and other sponsors. Some information in this report may also apply to federal, state, and local government employee group plans. See the **Appendix** for resources on federal employee and other types of government plans.

[10] The ACA was enacted on March 23, 2010. For more information about grandfathered plans, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

Another type of coverage, *short-term, limited duration insurance* (STLDI or STLD plans), is also included in this report, because it is explicitly excluded from a coverage definition cited by relevant legislation. STLDI is coverage, generally sold in the individual market, which meets certain definitional criteria. The statutory definition of "individual health insurance coverage" excludes STLDI; thus, STLDI is exempt from complying with all federal health insurance requirements applicable to individual health insurance plans.[11]

FAQ: COVID-19 Covered Benefits and Cost Sharing

The remainder of this report addresses private health insurance coverage of COVID-19 testing, treatment, and vaccination, when a vaccine becomes available. Where there are federal requirements related to such coverage, it is useful to understand the following:

- Is the service or item required to be covered? If so, is cost sharing allowed? In general, private health insurance cost sharing includes deductibles, coinsurance, and copayments.[12]
- Are plans allowed to impose prior authorization or other medical management requirements? For example, some insurers require that they (the insurer) provide prior authorization for routine hospital inpatient care, and/or require that primary care physicians provide approval or referrals for specialty care, as a condition for covering the care.[13]
- Does the coverage requirement depend on how or where the service or item is furnished (e.g., by an *in-network* versus *out-of-network* provider)? Under private insurance, benefit coverage and consumer cost sharing is often contingent upon whether the service or item is furnished by a provider that the insurer has contracted with (i.e., whether that provider is in network for a given plan). In instances where a contract between an insurer and provider does not exist, the provider is considered out of network.[14]
- When does the coverage requirement go into effect?
- What types of plans are subject to the coverage requirement?

To the extent that information is available, these issues are addressed with regard to private health insurance coverage of COVID-19 testing, treatment, and vaccination. **Table 1** summarizes key information.

[11] See 42 U.S.C. §300gg-91(b)(5). For more information about STLDI, see the report cited in footnote 10.

[12] A *deductible* is the amount an insured consumer pays for covered health care services before coverage begins (with exceptions). *Coinsurance* is the share of costs, figured in percentage form, an insured consumer pays for a health service. A *copayment* is the fixed dollar amount an insured consumer pays for a health service.

[13] For more information, see the appendix of CRS Report RL32237, *Health Insurance: A Primer*.

[14] For more information, see the background section of CRS Report R46116, *Surprise Billing in Private Health Insurance: Overview and Federal Policy Considerations*.

Table 1. Applicability of Federal COVID-19 Coverage Requirements to Private Health Insurance Plans

Authority	Coverage and Cost-Sharing Requirements	Medical Management Approaches Allowed?[a]	Also Applies Out-of-Network?[b]	Time Frame	Group Market[c]			Individual Market[d]
					Fully Insured[e]		Self-Insured[f]	
					Large Group[g]	Small Group[g]		
Testing								
FFCRA §6001 (as amended by CARES Act §3201)	COVID-19 testing, administration of the test, and related items and services, as defined, must be covered without cost sharing.	Prohibited	Yes	FFCRA enactment (March 18, 2020) through declared COVID-19 PHE.[h]	√ (+GF)[i]	√ (+GF)[i]	√ (+GF)[i]	√ (+GF)[i]
Treatment								
42 U.S.C. §18022; CMS March 5, 2020, and March 12, 2020, guidance[j]	EHB requirements *may* apply to coverage of COVID-19 treatment services, *subject to* state and plan variation. Cost sharing is possible and may vary by plan.	Allowed; may vary by plan	No	Permanent; existed prior to COVID-19 pandemic.	N.A.	√	N.A.	√
42 U.S.C. §18022	Where EHB requirements are applicable, certain other requirements are also applicable, such as the limit on annual out-of-pocket spending on EHB benefits.	N.A.	No	Permanent; existed prior to COVID-19 pandemic.	√[k]	√	√[k]	√
Vaccination								
CARES Act §3203	COVID-19 vaccination items and services must be covered without cost sharing if recommended by ACIP. Other COVID-19 preventive items and services must be covered without cost sharing if recommended by the USPSTF.[l]	Allowed; may vary by plan	No	15 business days after ACIP or USPSTF recommendation; not limited to declared COVID-19 PHE.	√	√	√	√

Source: CRS analysis of relevant legislation, statute, regulation, and guidance.

Notes: *Checkmark* (√) indicates that the requirement is applicable to that type of health plan. The variation *(√ +GF)* indicates that the requirement is also applicable to grandfathered plans; see table note (i). *N.A.* indicates that the requirement is not applicable to that type of health plan. None of these requirements applies to short-term, limited duration insurance (STLDI); see table note (d). "FFCRA" is the Families First Coronavirus Response Act (P.L. 116-127). "CARES Act" is the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136). "PHE" is the public health emergency for COVID-19 declared pursuant to Section 319 of the Public Health Service Act; see table note (h). "USPSTF" is the United States Preventive Services Task Force. "EHB" is essential health benefits. "ACIP" is the Advisory Council on Immunization Practices.

The requirements listed in the table do not comprise a comprehensive list of all federal requirements and standards that apply to all health plans.

a. An example of a medical management technique that insurers may use, as allowed, is requiring that they (the insurer) provide prior authorization for coverage of certain services. For more information, see the appendix of CRS Report RL32237, *Health Insurance: A Primer*.

b. All requirements apply to services or items furnished in network. Under private insurance, benefit coverage and consumer cost sharing are often contingent upon whether a service or item is furnished by a provider that the insurer has contracted with (i.e., whether that provider is *in network* for a given plan). In instances where a contract between an insurer and provider does not exist, the provider is considered *out of network.* For more information, see the background section of CRS Report R46116, *Surprise Billing in Private Health Insurance: Overview and Federal Policy Considerations*.

c. Health insurance may be provided to a group of people who are drawn together by an employer or other organization, such as a trade union. Such groups generally are formed for purposes other than obtaining insurance, such as employment. When insurance is provided to a group, it is referred to as group coverage or group insurance. In the group market, the entity that purchases health insurance on behalf of a group is referred to as the plan sponsor.

d. Consumers who are not associated with a group can obtain health coverage by purchasing it directly from an insurer in the individual (or nongroup) health insurance market. Although STLDI is a type of coverage generally sold in the individual market, the statutory definition of individual health insurance coverage excludes STLDI. Thus, no federal health insurance requirements on individual health insurance plans apply to STLDI.

e. A *fully insured* health plan is one in which the plan sponsor purchases health coverage from a state-licensed insurer; the insurer assumes the risk of paying the medical claims for benefits covered under the health plan of the sponsor's enrolled members.

f. *Self-insured plans* refer to health coverage that is provided directly by the organization sponsoring coverage for its members (e.g., a firm providing health benefits to its employees). Such organizations set aside funds and pay for health benefits directly. Under self-insurance, the organization bears the risk for covering medical claims. In general, the size of a self-insured employer does not affect the applicability of federal requirements.

g. In general, for purposes of health insurance requirements, small groups are those with 50 or fewer individuals (e.g., employees). States can also define them as having 100 or fewer individuals. The definition of large group is 51 or more individuals, or 101 or more individuals, depending on the definition of small group.

h. Some coverage requirements in FFCRA and the CARES Act refer to the "emergency period" or a similar construction. This refers to the public health emergency declared with respect to the COVID-19 outbreak by Secretary of Health and Human Services (HHS) Alex Azar on January 31, 2020, effective as of January 27, pursuant to Section 319 of the Public Health Service Act. Hence, the emergency period began on January 27, 2020, and remains in effect as long as the declaration, or any renewal of it, is in effect. See "Duration of Emergency Period" in CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127*.

i. *Grandfathered plans* are individual or group plans in which at least one individual was enrolled as of enactment of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), and which continue to meet certain criteria. Plans that maintain their grandfathered status are exempt from some federal requirements. However, FFCRA specifies that its COVID-19 testing coverage requirements *do* apply to grandfathered plans.

j. Centers for Medicare & Medicaid Services (CMS), "FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19)," March 12, 2020. CMS, "Information Related to COVID–19 Individual and Small Group Market Insurance Coverage," March 5, 2020.

k. Certain types of plans—self-insured plans and plans offered in the large-group market—must comply with this requirement even though they are not required to cover the EHB. HHS has indicated that such plans must use a permissible definition of EHB (including any state-selected EHB benchmark plans) to determine whether they comply with the requirement.

l. Cost sharing for office visits associated with applicable vaccinations and other preventive services may or may not be allowed. In general, this depends on whether the preventive service or item was the primary purpose of the visit, and whether the service or item was billed or tracked separately from the office visit. See 45 C.F.R. §147.130(a)(2).

Are Plans Required to Cover COVID-19 Testing?

FFCRA and CARES Act

Prior to the enactment of the FFCRA (P.L. 116-127), there were no federal requirements specifically mandating private health insurance coverage of items or services related to COVID-19 testing.

Section 6001 of the FFCRA requires most private health insurance plans to cover COVID-19 testing, administration of the test, and related items and services, as defined in the act. Per FFCRA, the coverage must be provided without consumer cost sharing, including deductibles, copayments, or coinsurance. Prior authorization or other medical management requirements are prohibited.[15]

The definition of testing that must be covered was expanded by Section 3201 of the CARES Act (P.L. 116-136). In addition, the Department of Labor (DOL), Department of Health and Human Services (HHS), and the Treasury issued an FAQ document on April 11, 2020 (hereinafter, "Tri-Agency April 11 FAQ"), on the private health insurance coverage requirements in FFCRA and the CARES Act.[16] Together, the acts and guidance require coverage of certain tests and services, as summarized below.

- Specified COVID-19 diagnostic tests, including both molecular (e.g., polymerase chain reaction, or PCR, tests) and serological tests (i.e., antibody tests), and the administration of such tests are covered.[17]
- "Items and services furnished to an individual during [visits, as specified below] that result in an order for or administration of [an applicable COVID-19 test], but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product."[18] This

[15] See the introduction to this section regarding cost sharing and prior authorization requirements.

[16] Department of Labor (DOL), Department of Health and Human Services (HHS), and the Treasury, "FAQS ABOUT FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT IMPLEMENTATION PART 42," April 11, 2020, at https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf. Hereinafter referred to as "Tri-Agency April 11 FAQ."

[17] FFCRA §6001(a)(1), as amended by CARES Act §3201, describes the types of tests that must be covered. This includes those tests that are authorized or approved by the Food and Drug Administration (FDA); those that are authorized by states to be carried out only by laboratories in the state without an Emergency Use Authorization (EUA); and those for which the manufacturer or clinical laboratory has notified FDA of its intent to submit EUA materials within 15 days. See CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127*, and CRS Report R46334, *Selected Health Provisions in Title III of the CARES Act (P.L. 116-136)*, for further details. The Tri-Agency April 11 FAQ (question four) clarifies that the coverage requirements include serological testing. The guidance notes that serology testing for COVID-19 is covered as long as it "otherwise meets the requirements of FFCRA Sec. 6001(a)(1), as amended by Sec. 3201 of the CARES Act." To date, FDA has authorized for marketing roughly 10 serology tests, although more than 150 serology tests were made available without EUA pursuant to March 16, 2020, FDA guidance. On May 4, 2020, FDA updated its guidance to require certain of these serology tests—those that were commercially manufactured and distributed without an EUA—to submit EUA materials within 10 days of either the guidance update or notification to the agency of validation, whichever is later. However, certain laboratory-developed serology tests may still be used clinically without an EUA. It is unclear whether serology tests in clinical use without an EUA would be covered under the Tri-Agency April 11 FAQ. Congressional clients may contact CRS Specialist in Health Policy Amanda Sarata with questions about types of tests that must be covered.

[18] FFCRA §6001(a)(2). See the Tri-Agency April 11 FAQ for more information, including questions five, six, and

definition could encompass additional diagnostic testing associated with the visit. However, it would not encompass treatment for COVID-19-associated illnesses.

The coverage requirements apply to the specified items and services when furnished at visits including to health care provider offices, urgent care centers, emergency rooms, and "nontraditional" settings, including drive-through testing sites. The requirements apply to both in-person and telehealth visits.[19]

FFCRA does not specify whether its coverage requirements apply when the test is furnished by an out-of-network provider. However Section 3202 of the CARES Act addresses insurer payments to in-network and out-of-network providers.[20] In addition, the Tri-Agency April 11 FAQ clarifies that the FFCRA coverage requirements apply both in network and out of network.[21]

The coverage requirements in FFCRA apply only to the specified items and services that are furnished during the COVID-19 public health emergency period described in that act, as of the date the FFCRA was enacted (March 18, 2020).[22]

These requirements apply to individual health insurance coverage and to small- and large-group plans, whether fully insured or self-insured. This includes grandfathered individual or group plans, which are exempt from certain other federal private health insurance requirements. Per the definition of individual health insurance coverage cited in the act, the requirements do not apply to STLDI.[23]

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eight. Although the law and subsequent guidance seemingly intend to prevent all consumer cost sharing related to COVID-19 testing, there may be specific situations in which cost sharing is possible. This could include an office visit or other charges if the consumer receives services not related to COVID-19 testing during the same visit in which they receive services related to COVID-19 testing. The law could also be read to allow cost sharing for items and services related to evaluating someone for the need for a COVID-19 test, if they don't ultimately receive the COVID-19 test.

[19] The Tri-Agency April 11 FAQ clarifies that the FFCRA coverage requirements apply to applicable items and services furnished at "both traditional and non-traditional care settings," including "COVID-19 drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing." It also includes more information about telehealth visits. See questions 8 and 13.

[20] CARES Act §3202 establishes a methodology for determining the amount that a health plan must reimburse in-network and out-of-network providers for the COVID-19 testing, and testing-related services and items, that are required to be covered under FFCRA §6001. This CRS report focuses on consumers' covered benefits and cost sharing, not on provider payments; see CRS Report R46334, *Selected Health Provisions in Title III of the CARES Act (P.L. 116-136)* for discussion of §3202.

[21] Tri-Agency April 11 FAQ, question seven. Furthermore, on April 22, 2020, HHS announced guidelines for health care providers seeking relief funding made available by the CARES Act and/or other recent legislation. The guidelines appear to prohibit a provider receiving these funds from "surprise billing" enrollees of private health insurance plans for which the provider is not in network: "[F]or all care for a presumptive or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient." See HHS, "Acceptance of Terms and Conditions," at https://www.hhs.gov/sites/default/files/relief-fund-payment-terms-and-conditions.pdf. For background on surprise billing, see the CRS report cited at footnote 14. Congressional clients may also contact the CRS experts listed in the **Appendix**.

[22] Some coverage requirements in FFCRA and the CARES Act refer to the "emergency period" or similar construction. This refers to the public health emergency declared with respect to the COVID-19 outbreak by HHS Secretary Alex Azar on January 31, 2020, effective as of January 27, pursuant to §319 of the Public Health Service Act (PHSA). Hence, the emergency period began on January 27, 2020, and remains in effect as long as the declaration, or any renewal of it, is in effect. See "Duration of Emergency Period" in CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127*, for more information.

[23] See "Background on Private Health Insurance" regarding these types of plans, including grandfathered plans and STLDI.

State and Private-Sector Actions

In recent weeks, some states have announced coverage requirements, and some insurers have clarified or expanded their policies, regarding coverage of COVID-19 testing, among other services.[24] However, states cannot regulate self-insured plans, and insurer announcements do not necessarily apply to those plans either. FFCRA does apply to self-insured group plans in addition to the other plan types discussed above.

To the extent that state requirements about or plans' voluntary coverage of COVID-19 testing did not extend as far as FFCRA and CARES Act requirements, the federal laws supersede them. However, state requirements and plans' voluntary coverage may exceed applicable federal requirements, as long as they do not prevent the implementation of any federal requirements.[25]

Even though federal law now requires most plans to cover specified COVID-19 testing services without cost sharing, it may be useful for consumers to contact their insurers or plan sponsors to understand their coverage. Subject to applicable federal and state requirements, coverage of the COVID-19 test and related services and items may vary by plan.

Are Plans Required to Cover COVID-19 Treatment?

Essential Health Benefits Guidance on COVID-19 Coverage

Although FFCRA requires certain plans to cover specified COVID-19 *testing* services without cost sharing, neither FFCRA nor the CARES Act mandates coverage of COVID-19 *treatment* services. There is no federal requirement specifically mandating private health insurance coverage of items or services related to COVID-19 treatment. However, one or more existing federal requirements are potentially relevant, subject to state implementation and plan variation.

There is a federal statutory requirement that certain plans cover a core set of 10 categories of *essential health benefits* (EHB).[26] However, states, rather than the federal government, generally specify the benefit coverage requirements within those categories. Current regulation allows each state to select an EHB-benchmark plan. The benchmark plan serves as a reference plan on which plans subject to EHB requirements must substantially base their benefits packages. Because states select their own EHB-benchmark plans, there is considerable variation in EHB coverage from state to state.[27]

On March 5, 2020, and March 12, 2020, CMS issued guidance addressing the potential relevance of EHB requirements to coverage of COVID-19 treatment, among other benefits, subject to

[24] Several organizations are tracking these announcements by states and/or insurers. See, for example, the National Association of Insurance Commissioners (NAIC) at https://content.naic.org/naic_coronavirus_info.htm, and the Association of Health Insurance Plans (AHIP) at https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/.

[25] See, for example, the introduction of the Tri-Agency April 11 FAQ.

[26] The 10 categories of essential health benefits (EHB) are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

[27] For information about the process for defining the EHB in each state that is in place for plan years beginning before 2020, see CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*. On April 17, 2018, HHS issued a final rule that modifies the process for defining the EHB for plan years beginning in 2020. For more information, see Department of Health and Human Services, "HHS Notice of Benefit and Payment Parameters for 2019," 83 *Federal Register* 16930, April 17, 2018.

variation in states' EHB-benchmark plan designations.[28] According to the March 12 document, "all 51 EHB-benchmark plans currently provide coverage for the diagnosis and *treatment* of COVID-19" (emphasis added), but coverage of specific benefits within the 10 categories of EHB (e.g., hospitalization, laboratory services) may vary by state and by plan.

The March 12 document suggests that coverage of medically necessary hospitalizations would include coverage of medically necessary isolation and quarantine during the hospital admission, subject to state and plan variation. Quarantine in other settings, such as at home, is not a medical benefit. The document notes, "however, other medical benefits that occur in the home that are required by and under the supervision of a medical provider, such as home health care or telemedicine, may be covered as EHB," subject to state and plan variation.

The March 12 document confirms that "exact coverage details and cost-sharing amounts for individual services may vary by plan, and some plans may require prior authorization before these services are covered." In other words, even where certain treatment items and services are required to be covered as EHB in a state, cost-sharing and medical management requirements could apply, subject to applicable federal and state requirements. In addition, cost sharing and other coverage details may vary for services furnished by out-of-network providers.[29]

Individual and fully insured small-group plans are subject to EHB requirements. Large-group plans, self-insured plans, grandfathered plans, and STLDI are not.[30]

Whether or not certain treatment services are defined as EHB in a state, other state benefit coverage requirements may be relevant to COVID-19 treatment. Plans may also voluntarily cover benefits. See "State and Private-Sector Actions" below.

Certain Federal Requirements Related to Cost Sharing

Other existing federal requirements are also relevant to consumer cost sharing on COVID-19 treatment services, to the extent that such treatments are covered by the consumer's plan, and largely to the extent that they are defined by a state as EHB.

For example, plans must comply with annual limits on consumers' out-of-pocket spending (i.e., cost sharing, including deductibles, coinsurance, and copayments) on in-network coverage of the EHB.[31] If certain treatment services are defined as EHB in a state, and are furnished by an in-network provider, consumers' out-of-pocket costs for the plan year would be limited as discussed

[28] Centers for Medicare & Medicaid Services, "FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19)," March 12, 2020, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/EHB-Benchmark-Coverage-of-COVID-19.pdf. The March 5, 2020, document has similar content: CMS, "Information Related to COVID–19 Individual and Small Group Market Insurance Coverage," at https://www.cms.gov/files/document/03052020-individual-small-market-covid-19-fact-sheet.pdf. These fact sheets each also addressed policy considerations related to private health insurance coverage of COVID-19 testing and vaccination. The enactment of FFCRA and the CARES Act have likely superseded much of the information in these documents regarding such coverage of testing and vaccination, but as of the date of this report, the documents are still relevant with regard to coverage of COVID-19 treatment.

[29] See the introduction to this section, "FAQ: COVID-19 Covered Benefits and Cost Sharing," for information on cost sharing, prior authorization requirements, and provider networks. Also see footnote 21 regarding a provider's ability to bill the consumer for these services.

[30] See "Background on Private Health Insurance" regarding these types of plans, including grandfathered plans and STLDI.

[31] 42 U.S.C. §18022. For more information on this requirement, and on other federal cost-sharing requirements that may similarly be relevant (prohibition on lifetime limits and annual limits; minimum actuarial value requirements), see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

below. If certain treatment services are not defined as EHB in a state, and/or are furnished by out-of-network providers, this out-of-pocket maximum would not necessarily apply.

In 2020, the out-of-pocket limits cannot exceed $8,150 for self-only coverage and $16,300 for coverage other than self-only. This means that once a consumer has spent up to that amount in cost sharing on applicable in-network benefits, the plan would cover 100% of remaining applicable costs for the plan year.

The out-of-pocket maximum applies to individual health insurance coverage and to small- and large-group plans, whether fully insured or self-insured.[32] The requirement does not apply to grandfathered plans or STLDI.

State and Private-Sector Actions

As stated above, in recent weeks, some states have announced coverage requirements related to COVID-19 testing services and items, and some insurers have clarified or expanded their policies to include relevant coverage.[33] Some of these state and insurer statements also address coverage of treatment services. However, as discussed above, states cannot regulate self-insured plans, and insurer announcements do not necessarily apply to those plans either.

Coverage, cost sharing, and the application of medical management techniques (e.g., prior authorization) can vary by plan, subject to applicable federal and state requirements. It may be useful for consumers to contact their insurers or plan sponsors to understand their coverage of services and items related to COVID-19 treatment.

Will Plans Be Required to Cover a COVID-19 Vaccine?

CARES Act and Existing Preventive Services Coverage Requirements

As of the date of this report, there is no vaccine against COVID-19 approved by the Food and Drug Administration (FDA) for use in the United States, although several candidates are in development. Prior to the enactment of the CARES Act, there were no federal requirements specifically mandating private health insurance coverage of items or services related to a COVID-19 vaccine.

However, per an existing federal requirement (§2713 of the Public Health Service Act [PHSA]) and its accompanying regulations, most plans must cover specified preventive health services without cost sharing.[34] This includes any preventive service recommended with an A or B rating by the United States Preventive Services Task Force (USPSTF); or any immunization with a recommendation by the Advisory Committee on Immunization Practices (ACIP), adopted by the Centers for Disease Control and Prevention (CDC), for routine use for a given individual.[35] These

[32] Certain types of plans—self-insured plans and plans offered in the large-group market—must comply with this requirement even though they are not required to cover the EHB. HHS has indicated that such plans must use a permissible definition of EHB (including any state-selected EHB benchmark plans) to determine whether they comply with the requirement.

[33] See footnote 24 regarding organizations that are tracking such activity.

[34] §2713 was added to the PHSA (codified at 42 U.S.C. §300gg-13) and incorporated into the Employee Retirement Income Security Act (ERISA) and Internal Revenue Code (IRC) by the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Regulations are at 45 C.F.R. §147.130; 29 C.F.R. §2590.715-2713; and 26 C.F.R. §54.9815-2713.

[35] For further discussion of this provision, see CRS Report R45146, *Federal Requirements on Private Health Insurance*

coverage requirements apply no sooner than one year after a new or revised recommendation is published.[36]

Requirements of PHSA Section 2713 apply to individual health insurance coverage and to small- and large-group plans, whether fully insured or self-insured. The requirements do not apply to grandfathered plans or to STLDI. By regulation, plans are generally not required to cover preventive services furnished out of network.[37] They are allowed to use "reasonable medical management" techniques, within provided guidelines. Cost sharing for office visits associated with a furnished preventive service may or may not be allowed, as specified in regulation.[38]

Section 3203 of the CARES Act requires specified plans—the same types as those subject to PHSA Section 2713—to cover a COVID-19 vaccine, when available, and potentially other COVID-19 preventive services, if they are recommended by ACIP or USPSTF, respectively.[39] This coverage must be provided without cost sharing. Section 3203 also applies an expedited effective date for the required coverage: 15 business days after an applicable ACIP or USPSTF recommendation is published. Otherwise, requirements of Section 3203 mirror the existing requirements under PHSA Section 2713. The requirement to cover COVID-19 vaccination and other preventive services is not time limited, whereas the FFCRA requirement to cover COVID-19 testing is limited to the duration of a declared COVID-19 public health emergency. See "Are Plans Required to Cover COVID-19 Testing?"

State and Private-Sector Actions

Some of the state and insurer announcements about coverage of COVID-19 benefits, discussed earlier in this report, reference coverage of a potential vaccine.[40] However, pending development and approval of the vaccine, and pending the implementation of the CARES Act requirements related to COVID-19 vaccine coverage, it is premature to discuss potential variations in coverage of the vaccine at the state or plan level. It may still be useful for consumers to contact their insurers or plan sponsors to understand their coverage of services and items related to a potential COVID-19 vaccine.

Plans. For more information about the USPSTF and ACIP, see https://uspreventiveservicestaskforce.org/uspstf/ and https://www.cdc.gov/vaccines/acip/index.html, respectively. For more information about the definition of "routine" use, see Richard Hughes IV, Reed Maxim, and Alessandra Fix, "Vague Vaccine Recommendations May Be Leading To Lack Of Provider Clarity, Confusion Over Coverage," *Health Affairs*, May 7, 2019.

[36] Per 45 C.F.R. §147.130(b), such coverage is required "for plan years (in the individual market, policy years) that begin on or after the date that is one year after the date the recommendation or guideline is issued."

[37] However, see footnote 21 regarding a provider's ability to bill the consumer for these services.

[38] In general, whether cost sharing for office visits is allowed or prohibited depends on whether the preventive service or item was the primary purpose of the visit, and whether the service or item was billed or tracked separately from the office visit. See 45 C.F.R. §147.130(a)(2). Also see 45 C.F.R.§147.130(a)(3) regarding out-of-network coverage and (a)(4) regarding reasonable medical management.

[39] CARES Act §3203 refers to, but does not amend, PHSA §2713.

[40] See footnote 24.

Appendix. Resources for Questions about Private Health Insurance and COVID-19

This report has focused on coverage of COVID-19 testing, treatment, and vaccination by most types of private health insurance plans. CRS analysts are also available to congressional clients to discuss other topics of interest related to private health insurance and COVID-19, including

- coverage of COVID-19 benefits by types of private plans not specifically addressed in this report;
- other issues related to private coverage of COVID-19 benefits;
- private coverage of certain other benefits of concern during this pandemic, or of services furnished via telehealth; and
- issues related to private health insurance enrollment and premium payments.

The following table lists examples of such topics of interest, any relevant legislative or administrative resources, any relevant CRS resources, and names of appropriate CRS experts for the benefit of congressional clients. Besides the CRS reports listed below that provide background on relevant topics, also see CRS reports on health provisions in recent COVID-19 legislation:

- CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127*, and
- CRS Report R46334, *Selected Health Provisions in Title III of the CARES Act (P.L. 116-136)*.

The information in this report is current as of its publication date and may be superseded by subsequent congressional or administrative action. Congressional clients may contact the report author and/or experts listed below for questions about further developments. In addition, CMS guidance related to private health insurance and COVID-19 is compiled on its website.[41]

[41] CMS, CCIIO, "Coronavirus Disease 2019 (COVID-19) Guidance," accessed April 28, 2020, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs#COVID-19.

Table A-1. Resources for Questions About Private Health Insurance and COVID-19

	Key Federal Resources	CRS Resources	CRS Experts
Coverage of COVID-19 benefits by types of private plans not addressed in this report			
Federal Employees Health Benefits (FEHB) Program	FFCRA §6006	CRS Report R43922, *Federal Employees Health Benefits (FEHB) Program: An Overview*	**Noah Isserman**
Catastrophic plans	CMS March 18 FAQ[a]	CRS Report R44065, *Overview of Health Insurance Exchanges*	**Vanessa Forsberg**
Certain other health coverage arrangements[b]	Tri-Agency April 11 FAQ[c]	CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*	**Vanessa Forsberg**
Other issues related to private coverage of COVID-19 benefits			
Health savings account (HSA) eligibility and high-deductible health plans (HDHPs)	IRS March 11 Notice[d] CARES Act §3701 and §3702	CRS Report R45277, *Health Savings Accounts (HSAs)*	**Ryan Rosso**
Out-of-network coverage and surprise billing	Tri-Agency April 11 FAQ[c] HHS Provider Relief Funding Terms and Conditions[e] CARES Act §3202	CRS Report R46116, *Surprise Billing in Private Health Insurance: Overview and Federal Policy Considerations*	**Ryan Rosso** **Noah Isserman**
Private coverage of certain benefits not addressed in this report			
Mental health	N/A	N/A	**Noah Isserman** (coverage) **Johnathan Duff** (service provision)
Telehealth	CMS March 24 Telehealth FAQ[f] Tri-Agency April 11 FAQ[c]	CRS Report R46239, *Telehealth and Telemedicine: Frequently Asked Questions*	**Noah Isserman** (coverage) **Victoria Elliott** (service provision)
Prescription drugs	CMS March 24 Prescription Drug FAQ[g]	Consumer out-of-pocket drug costs section of CRS Report R44832, *Frequently Asked Questions About Prescription Drug Pricing and Policy*	**Noah Isserman**
Private health insurance enrollment and premiums			
Health insurance exchanges	Healthcare.gov COVID-19 page[h]	CRS Report R44065, *Overview of Health Insurance Exchanges*	**Vanessa Forsberg**
Premium payments; premium tax credits and cost-sharing subsidies	CMS March 24 Premium Payment FAQ[i]	CRS Report R44425, *Health Insurance Premium Tax Credits and Cost-Sharing Subsidies* CRS Report R44392, *The Health Coverage Tax Credit (HCTC): In Brief*	**Bernadette Fernandez**

	Key Federal Resources	CRS Resources	CRS Experts
Employment-based coverage and COBRA	N/A	CRS In Focus IF11523, *Health Insurance Options Following Loss of Employment* CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*	**Ryan Rosso**

Source: Created by CRS.

Notes: This table is not meant to represent a comprehensive list of topics related to private health insurance coverage and COVID-19. "FFCRA" is the Families First Coronavirus Response Act. "CARES Act" is the Coronavirus Aid, Relief, and Economic Security Act. "CMS" is the Centers for Medicare & Medicaid Services. "IRS" is the Internal Revenue Service. "Tri-Agency" refers to the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury.

a. CMS, "FAQs on Catastrophic Plan Coverage and the Coronavirus Disease 2019 (COVID-19)," March 18, 2020, at https://www.cms.gov/CCIIO/Resources/Files/Catastrophic-Coverage-of-COVID-19.pdf.

b. The Tri-Agency April 11 FAQ notes the applicability of FFCRA requirements to certain types of plans not addressed in this report, including nonfederal governmental plans, church plans, student plans, group health plans covering fewer than two current employees (including "retiree plans"), and plans in their provision of excepted benefits. It also addresses short-term, limited-duration insurance (STLDI). Background on some of these coverage arrangements is provided in the CRS report noted above.

c. DOL, HHS, and the Treasury, "FAQS ABOUT FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT IMPLEMENTATION PART 42," April 11, 2020, at https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf.

d. IRS, "HIGH DEDUCTIBLE HEALTH PLANS AND EXPENSES RELATED TO COVID-19," March 11, 2020, at https://www.irs.gov/pub/irs-drop/n-20-15.pdf.

e. HHS, "Acceptance of Terms and Conditions," accessed April 22, 2020, at https://www.hhs.gov/sites/default/files/relief-fund-payment-terms-and-conditions.pdf.

f. CMS, "FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019," March 24, 2020, at https://www.cms.gov/files/document/faqs-telehealth-covid-19.pdf.

g. CMS, "FAQs on Prescription Drugs and the Coronavirus Disease 2019 (COVID-19) for Issuers Offering Health Insurance Coverage in the Individual and Small Group Markets," March 24, 2020, at https://www.cms.gov/files/document/faqs-rx-covid-19.pdf.

h. Healthcare.gov, "Marketplace Coverage & Coronavirus," accessed April 21, 2020, at https://www.healthcare.gov/coronavirus/. In addition, some organizations are tracking state-based exchanges' decisions to open special enrollment periods. For example, see National Association of Insurance Commissioners (NAIC), "State Bulletins and Alerts," "Life and Health Chart," accessed April 21, 2020, at https://content.naic.org/naic_coronavirus_info.htm.

i. CMS, "Payment and Grace Period Flexibilities Associated with the COVID-19 National Emergency," March 24, 2020, at https://www.cms.gov/files/document/faqs-payment-and-grace-period-covid-19.pdf.

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