Are Insurance Plans Still Waiving Cost-Sharing?

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A common question that I receive is whether COVID-19 testing is still being covered by insurance plans. The Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES) require insurance plans to cover diagnostic testing without cost-sharing (cost-sharing being the amount assigned to patient responsibility; it includes deductibles, copays, and co-insurance).

The word "diagnostic" is significant. COVID-19 testing falls into two categories:

- *Diagnostic* – used for treatment. Patients are symptomatic or asymptomatic but exposed.
- *Screening* – used for administrative purposes. Patients are asymptomatic and have not been exposed.

Insurance plans must cover diagnostic testing. They do not have to cover screenings. They also do not have to cover antibody testing, which is used to determine whether the patient has a history of COVID-19 rather than the active virus.

This requirement applies to group health plans and health insurance issuers offering group or individual health insurance coverage, including grandfathered health plans. Grandfathered health plans are individual health insurance policies purchased on or before March 23, 2010. This may not include self-funded plans.

These required plans must pay the negotiated rate for diagnostic COVID-19 testing, including the portion that would be assigned to the patient. In the case of out-of-network (OON) plans, the payment amount is the cash price for testing that is listed by the practice on their public website. The patient cannot be balance billed. Balance billing is when a patient is billed for the difference between the provider's charge and the allowed amount.

Clinics are required to publish cash prices for COVID-19 testing to their website homepage during the Public Health Emergency (PHE). The Centers for Medicare & Medicaid Services will take the following action for noncompliance:

1. Provide a written warning
2. Request a corrective action plan
3. Impose a penalty not to exceed $300 per day

Cash price is the charge that applies to a patient who pays cash (or cash equivalent) for a COVID-19 diagnostic test. This is the same as the "walk-in" rate to self-pay individuals and is the maximum charge allowed. Providers can discount this rate. There is an expectation that this would be less than what is billed to insurance due to the lower overhead (eg, no billing functions).

The following terms are required on this posting: provider's name, price, cost, test, COVID, and coronavirus. In addition, standardized information should be included so the patient can understand the relationship between the posted cash price and the diagnostic test offered. At a minimum, this includes:

- Plain language description of each test
- Corresponding cash price
- Billing code(s)
- Any differences in price by location

How long payers will have to waive cost-sharing for diagnostic COVID-19 testing depends on the duration of the PHE. A PHE lasts 90 days but can be renewed, which usually occurs within days of the existing expiration date. This causes confusion, as insurance plans will post a notification that the waiving of cost-sharing is expiring on a specific date and then remove the posting when the PHE is extended.

Cost-sharing is also impacted by state laws. California SB 510 requires plans to cover both diagnostic and screening testing and "health care services related to testing" without cost-sharing. This is tied to California's declaring a PHE.

For OON payers, payment is an amount that is "reasonable," as determined in comparison to prevailing market rates in the region where the item or service is rendered.

California SB 510 was signed on October 8, 2021. Practices may have seen denials for screenings prior to this date. However, it is retroactive to March 4, 2020, when the governor declared a State of Emergency. ■

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