

Issue brief: Balance billing for COVID-19 testing and care - federal and state restrictions

There are valid reasons to be concerned about patients receiving out-of-network care during the COVID-19 pandemic and the financial impact of that care on patients and their physicians. As this virus continues to spread, networks may be overwhelmed, out-of-state or retired physicians may be providing care, and patients may be accessing care through treatment locations or methods other than those specified in their coverage and network documents. While some new policies meant to address these issues offer strong patient protections, other actions may be shifting the costs of out-of-network care from insurers onto the two parties that are ill-equipped more than ever to shoulder those costs—patients and physician practices.

Federal Action

On March 27, 2020, President Trump signed the CARES Act into law. Included in the new law is the [Provider Relief Fund](#)—funds to be distributed to physicians, hospitals and other providers to address both the economic harm due to the stoppage of elective procedures and the economic impact on providers incurring additional expenses caring for COVID-19 patients. **Generally, physicians and other providers accepting these funds are prohibited from balance billing patients for COVID-19 testing and care.**

Testing:

Section 3202 of the CARES Act attempts to address a requirement in the second federal response to COVID-19, the Families First Coronavirus Response Act (FFCRA), that commercial health insurers must cover COVID-19 testing without any cost-sharing. The CARES Act language ensures out-of-network lab providers receive fair payment for COVID-19 testing by requiring commercial plans to pay an out-of-network provider “an amount that equals the cash price for such service as listed by the provider on a public internet website” while prohibiting balance billing.

COVID-19 treatment:

A portion of the provider relief fund is allocated for general distribution to facilities and providers. [Guidance](#) released by the Administration to providers accepting Provider Relief Fund payments states that:

“As a condition to receiving these funds, providers must agree not to seek collection of out-of-pocket payments from a presumptive or actual COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.”

In addition, the [terms and conditions](#) documents to be signed by providers accepting relief funds includes a balance billing prohibition for COVID-19 care:

“The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for 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.”

Testing and treatment for the uninsured

Also included in the Provider Relief Fund are funds to be used to support healthcare-related expenses attributable to the treatment of uninsured individuals with COVID-19. Providers who have conducted COVID-19 testing or provided treatment for uninsured individuals with COVID-19 on or after February 4, 2020 can [file claims for reimbursement](#) under the CARES Act.

Regarding the uninsured relief funds, the [guidance](#) states:

“As announced in early April, a portion of the \$100 billion Provider Relief Fund will be used to reimburse healthcare providers, at Medicare rates, for COVID-related treatment of the uninsured... As a condition, providers are obligated to abstain from "balance billing" any patient for COVID-related treatment.”

Similarly, in the terms and conditions document for both the [Uninsured Relief Fund Payments](#), payment is set at 100% of Medicare rates with a ban on balance billing:

“The Secretary will reimburse the Recipient generally at 100 percent of Medicare rates (including any amounts that would have been due to the provider as patient cost sharing) for the items and services that Respondent provided to Uninsured Individuals for which the Recipient submits claims to the Relief Fund. If there is no Medicare standard rate, a calculated average rate will be used. Exclusions from coverage and alternatives to where Medicare rates do not apply are outlined in the program details.

The Recipient certifies that it will not engage in ‘balance billing’ or charge any type of cost sharing for any COVID-19 Testing and/or Testing-Related Items and Services provided to FFCRA Uninsured Individuals for which the Recipient receives a Payment from the FFCRA Relief Fund. The Recipient shall consider Payment received from the FFCRA Relief Fund to be payment in full for such care or treatment.”

Despite some ambiguity in the scope of the federal guidance, the Administration has stated that the intent of the terms and conditions under the CARES ACT is to bar balance billing for actual or presumptive COVID-19 care. As such, **providers accepting Provider Relief Funds should not balance bill a patient for any COVID-19 or suspected COVID-19-related care.** Payment rates will depend on whether the patient is insured or uninsured.

State action

Several states have acted over the last several weeks to address out-of-network care and costs for patients during the COVID-19 pandemic. Of note, state statutes and regulations generally do not apply to self-insured plans that are regulated under the Employee Retirement Income Security Act of 1974 (ERISA) or Medicare fee-for-services and Medicare Advantage plans.

Balance billing:

Many states have surprise billing laws in place that will apply to COVID-19 care. For example, regulators in [New York](#), have issued guidance to clarify that their state laws may apply to COVID-19 care.

Several states have taken more direct action to address out-of-network coverage and balance billing for COVID-19 testing and care. For example, in [Ohio](#), the insurance commissioner designated COVID-19 testing and treatment as emergency care and, while prohibiting balance billing, is requiring payment at the greatest of the amount negotiated with in-network providers, the amount calculated using the same method the plan generally uses to determine payments for out-of-network services, or the amount that would be paid under Medicare.

In [Washington DC](#), plans are required to cover all out-of-network charges related to COVID-19 testing, screening and treatment, including cost-sharing and balance billing, unless a patient was first offered the services in-network without unreasonable delay. Providers are being encouraged to accept the highest in-network rate as payment in full. Similarly in [Utah](#), the insurance department has requested that plans pay the highest in-network reimbursement rate for out-of-network patients to avoid surprise medical bills. Finally, legislation recently enacted in [Wisconsin](#) prevents patients from paying more than in-network costs for out-of-network care by prohibiting balance billing by an out-of-network provider for “any service, treatment, or supply that is related to the diagnosis or treatment for COVID-19” and setting the out-of-network payment rates at 225% of Medicare.

Network adequacy:

Several states are requiring health insurance plans to ensure that provider networks were adequate to handle the expected increase in utilization. For example, in [Louisiana](#), regulators have required plans to verify that networks are adequate to handle increases, including by offering access to out-of-network services where appropriate. Similar directives have been put in place in [Rhode Island](#), [Tennessee](#) and several other states. [Rhode Island](#) is also preventing health plans from removing providers from their networks during this time, except for specific causes.

[Maryland](#) has also required plans to ensure that their networks are adequate and in terms of testing, is requiring health insurers to evaluate a request to use an out-of-network provider to perform diagnostic testing of COVID-19 solely on the basis of whether the use of the out-of-network provider is medically necessary or appropriate.

The [Texas](#) Insurance Commissioner has clarified that the Department expects plans to monitor and verify that their networks are adequate to handle increased demand and when a network provider is not reasonably available, carriers must ensure that the consumer is protected, as contemplated by the CARES Act and by Texas’s law.

Summary

In those states that have acted to prevent balance billing for COVID-19 testing and care, there may be discrepancies between state and federal directives, especially as they relate to payment rates for such out-of-network care. Moreover, despite some initial ambiguity in the scope of the federal guidance, the Administration has stated that the intent of the terms and conditions under the CARES Act is to bar balance billing for actual or presumptive COVID-19 care. As such, **providers accepting Provider Relief Funds should not balance bill a patient for any COVID-19 or suspected COVID-19-related care.** Payment rates will depend on both federal and state guidance.

If you have any questions or for more information, please contact Emily Carroll, JD., Senior Legislative Attorney, AMA Advocacy Resource Center, at emily.carroll@ama-assn.org.