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February 11, 2021

Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Ave., NW
Washington, DC 20500

Norris Cochran
Acting Secretary of Health & Human Services
200 Independence Ave., SW
Washington, DC 20201

Al Stewart
Acting Secretary of Labor
200 Constitution Ave., NW
Washington, DC 20210

Re: Insurance and Health Plan Coverage of COVID-19 Testing, Executive Order 13996

Dear Secretary Yellen and Acting Secretaries Cochran and Stewart:

On behalf of the Individual and Small Group Markets Committee and the Active Benefits Subcommittee of the American Academy of Actuaries,[1] we would like to offer input as the Departments of the Treasury, Labor, and Health & Human Services consider proposing regulations or revising guidance pursuant to President Biden's Executive Order 13996, *Establishing the COVID-19 Pandemic Testing Board and Ensuring a Sustainable Public Health Workforce for COVID-19 and Other Biological Threats*, issued on January 21, 2021. The Executive Order in part directs you to "clarify group health plans' and health insurance issuers' obligations to provide coverage for COVID-19 testing."

COVID-19 testing for diagnostic and surveillance purposes is an important component of controlling the spread of the virus. Public health surveillance and employment-related testing remains a key recommendation from public health experts and can help facilitate a safer re-opening of schools and businesses. There is a question however, of how to fund testing that is performed for public health reasons.

[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Joint guidance from the Departments released in 2020 clarified the responsibility of health insurers and employer health plans with regards to COVID-19 tests—they must cover medically necessary diagnostic COVID-19 testing under the Families First Coronavirus Response Act, but not COVID-19 testing for surveillance or employment purposes.[2] Increasing insurer and group health plan responsibility to include coverage of public health surveillance and employment-related testing could change how insurers and health plans are currently covering testing and increase their costs. Given the importance of expanded testing, including surveillance testing, for reducing the spread of COVID-19, it is important not to create unintended disincentives to testing.

Although Current Procedural Terminology (CPT) medical coding does not directly distinguish between diagnostic, public health surveillance, and employment-based testing,[3] it is our understanding that some insurers are reviewing utilization patterns and sites of care at the member and group level to identify possible surveillance testing situations after claims submission. In contrast, some insurers may be electing to pay for more testing than is truly medically necessary both in the interest of public health and to support providers during this time. Depending on how much surveillance testing an insurer is currently covering, requiring insurers to pay for all testing could increase their costs beyond the amount assumed in 2021 premiums.

The increase in costs is also dependent on the costs of the tests. While issuers may be typically paying close to the Medicare rate ($75–$100)[4] for in-network claims, out-of-network claims can be substantially higher with wide variation, particularly in light of the provisions enacted through the CARES Act[5] that require insurers to pay posted prices for coronavirus testing during the public health emergency. The availability of rapid tests could bring down the cost per test, but could raise issues on how to structure coverage under insurance if the tests are available without prescription and are permissible for surveillance and/or employment-based testing. Widespread availability and permissibility of at-home rapid testing could lead to a large increase in testing.

A broad COVID-19 testing coverage requirement would affect health plans differently depending on the insurance market. Individual market premiums for 2021 cannot be changed mid-year, whereas some states may allow premium changes on a quarterly basis for small group plans. Large group premiums can be reset on their renewal date, which is not required to be based on calendar year. Any impact from increased testing costs incurred before the insurer can update premiums would be absorbed by the insurer. Depending on assumptions regarding the needs for ongoing testing beyond 2021, broader testing requirements could affect 2022 premiums for individuals, small groups, and large groups.

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[2] FAQS About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43

[3] The CDC finalized a new code to specify surveillance testing (i.e., non-diagnostic) in December (Z11.52), but recommended it not be used until the end of the public health emergency. ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, January 1, 2021.

[4] Centers for Medicare and Medicaid Services, CMS Changes Medicare Payment to Support Faster COVID-19 Diagnostic Testing, Press Release, October 15, 2020.

[5] Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136).

At the same time, increased testing costs will not necessarily drive losses for all insurers. For some insurers, an unexpected increase in insurer testing costs could reduce medical loss ratio (MLR) rebates for the 2021 benefit year. 2019 MLR rebates in the individual market exceeded $1.7 billion. Many of these individual market insurers are expected to owe rebates for the 2020 benefit year due to the combined effect of lower 2018 and 2019 loss ratios and the reduction in claims starting in the second quarter of 2020 due to pandemic-related lockdowns (MLR rebates are calculated based on three-year averages). In turn, 2019 and 2020 experience may result in many issuers owing MLR rebates in 2021 as well, even if 2021 costs on their own are above the minimum MLR threshold. For those issuers, additional testing costs incurred in 2021 could, in effect, result in paying a portion of the MLR rebate to members in the form of additional covered testing. However, this dynamic only applies to insurers who would owe 2021 MLR rebates—over half of individual market enrollees did not receive a 2019 MLR rebate—so the additional costs for those insurers would not be offset by reduced MLR rebates.

Many large employers self-insure their medical benefits and insured large group premiums are typically fully or partially based on the group's experience. Thus, the requirement to cover all testing would largely fall to the employer and its employees through higher total medical costs. These costs would be borne disproportionately by certain industries (and employers) with high testing needs, including many employing essential workers.[6]

We appreciate and acknowledge the need for both diagnostic COVID-19 testing as well as surveillance testing done for public health purposes. Insurers and employer health plans are currently required to cover COVID-19 testing costs when done for diagnostic purposes, but not for surveillance purposes. When reassessing these requirements, it is important to consider the potential unintended consequences of expanding testing coverage requirements, including higher premiums in 2022 if testing needs are expected to be ongoing with greater burdens on employer plans covering essential workers and other employees with high testing needs. It may be appropriate for the coverage of testing for public health reasons, rather than for the diagnosis and treatment of an individual, to be supported at least in part by public health funds.

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We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss further, please contact Matthew Williams, senior health policy analyst, at williams@actuary.org.

Sincerely,

Joyce E. Bohl, MAAA, ASA
Chairperson
Individual and Small Group Markets Committee
American Academy of Actuaries

Karin M. Swenson-Moore, MAAA, FSA
Chairperson
Active Benefits Subcommittee
American Academy of Actuaries

CC: Jeffrey D. Zients, Coordinator of the COVID-19 Response

[6] Linda J. Blumberg, Sabrina Corlette, and Michael Simpson, "Imposing the Costs of Workplace Coronavirus Testing on Group Plan Coverage Would Place an Excessive Burden on Essential Workers," *Health Affairs* blog post, July 28, 2020.