Highlights from Three-Agency FAQs about the FFCRA and the CARES Act Relating to Group Health Plans

On April 11, 2020, the Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, "the Departments") issued a set of FAQs intended to assist stakeholders grappling with the provisions of the Families First Coronavirus Response Act ("FFCRA") and the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") governing group health plans, health insurance issuers, and others. Our previous post discussed the various provisions of the CARES Act that affect welfare benefit plans. This post reports on the highlights from the Departments' FAQs.

1. *Which Plans and Products Are Covered (and Which Are Not)*?

The FFCRA and CARES Act provisions relating to COVID-19 apply to group health plans and health insurance issuers offering group or individual health insurance coverage in the group and individual markets, including grandfathered health plans under the Affordable Care Act. It includes private employment-based group health plans (ERISA plans), non-federal governmental plans (such as plans sponsored by states and local governments), and church plans. Individual market health insurance coverage is also subject to the new rules, whether marketed through or outside of a health insurance exchange. Student health insurance coverage is also included. Not included are short-term, limited-duration insurance, excepted benefits, and group health plans that do not cover at least two employees who are current employees (e.g., retiree-only plans).

2. *What COVID-19 Items and Services Must Be Covered*?

Generally, plans and issuers must provide coverage for in vitro diagnostic testing products and services:

- That are approved, authorized, or cleared by the FDA
- With respect to which a developer has requested, or intends to request, emergency use authorization from the FDA
- That are developed in and authorized by a State, with prior notice to HHS
- That HHS determines appropriate

The coverage requirement includes items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of

an in vitro diagnostic product, but "only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product."

The FAQs clarify that in vitro diagnostic tests include "serological tests for COVID-19," i.e., tests that measure antibodies or proteins present in the blood when the body is responding to a specific infection, like COVID-19, despite the FDA's statement that "such tests should not be used as the sole basis for diagnosis."

3. *Cost Sharing*

A plan or issuer may not impose any cost-sharing requirements, prior authorization requirements, or medical management requirements for COVID-19 testing and related services:

- If the plan or issuer has a negotiated, in-network rate with a provider in effect before the public health emergency was declared (for COVID-19, as of March 13, 2020), that rate applies throughout the period of such declaration.
- For out-of-network coverage, a plan or issuer must reimburse the provider in the amount of the cash price for such service "as listed by the provider on a public internet website, or the plan or issuer may negotiate a rate with the provider for less than such cash price." Providers of diagnostic tests for COVID-19 are required to make public the cash price of a COVID-19 diagnostic test on the provider's public internet website.

The term "visit" for this purpose is defined broadly to include 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.

4. *Timing of Plan Amendments/Waiver of SBC Notice Requirements*

Under current law, Summaries of Benefits and Coverage ("SBCs") generally require 60 days' advance notice of a material modification in any of the terms of the plan or coverage that would materially affect the content of the SBC. The FAQs announce a non-enforcement policy effective during the COVID-19 pandemic. Plans and issuers may amend the terms of a plan or policy to add benefits, or reduce or eliminate cost sharing, for the diagnosis and treatment of COVID-19 without having to satisfy any applicable notice of modification requirements. Instead, notice must be provided as reasonably practicable.

5. *Excepted Benefits/EAPs and On-Site Clinics*

The FAQs clarify that an employer may offer benefits for diagnosis and testing for COVID-19 under an EAP or through an on-site clinic without risking the loss of the EAP's or on-site clinic's status as an excepted benefit.

6. *Temporary Telehealth Rule*

For plan years beginning on or before December 31, 2021 (2020 for calendar year plans), the CARES Act modifies the rules governing high deductible health plans ("HDHPs") and Health Savings Accounts ("HSAs") by providing a temporary safe harbor for telehealth and other remote care services. Under the change, HSA-eligible HDHPs can cover telehealth and other remote care services without a deductible or with a deductible below the applicable minimum annual deductible. Thus, an otherwise eligible individual with coverage under an HDHP may also receive coverage for telehealth and other remote care services outside the HDHP, and before satisfying the deductible of the HDHP, and still contribute to an HSA. These changes apply to telehealth coverage generally. They are not limited to coverage for COVID-19-related telehealth and other remote care services.

The FAQs also allow plan amendments to add benefits, or reduce or eliminate cost sharing, for telehealth and other remote care services prior to satisfying any applicable above-described notice of modification requirements and without regard to restrictions on mid-year changes to provide coverage for telehealth services.