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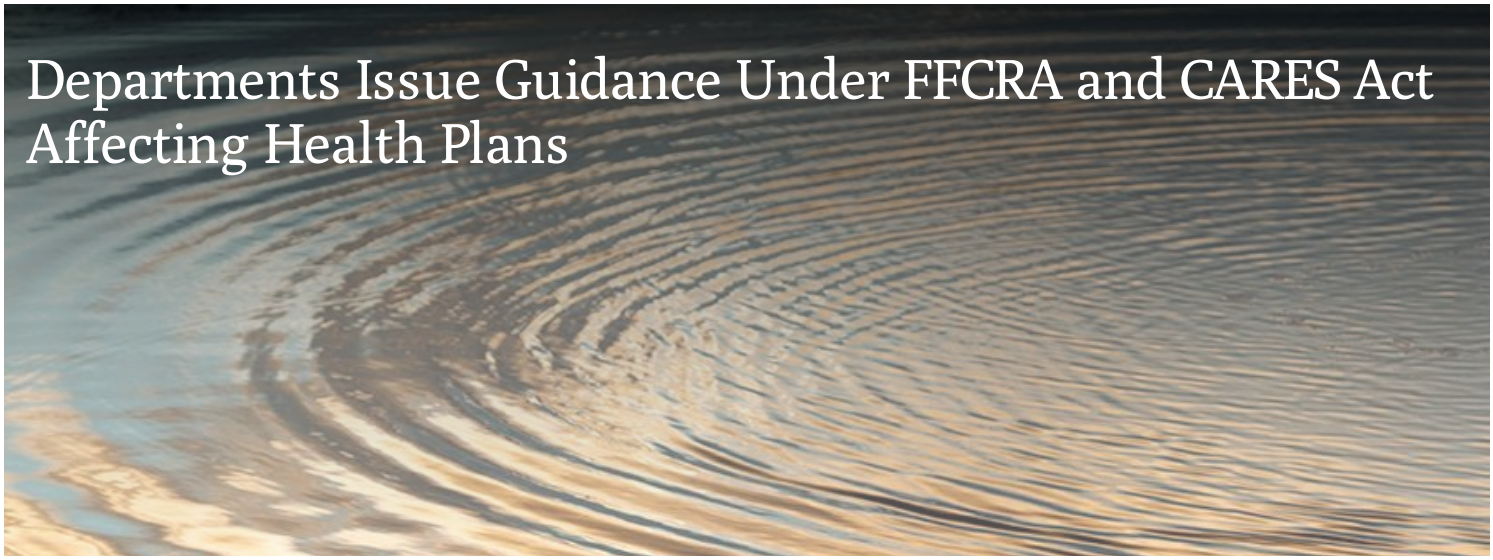

Departments Issue Guidance Under FFCRA and CARES Act Affecting Health Plans

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The Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, the Departments) recently issued FAQ guidance (the FAQs) regarding implementation of the health coverage provisions under the Families First Coronavirus Response Act (the FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act). These FAQs shed light on a number of outstanding issues for employers, health insurance issuers, and other stakeholders.

Background

The FFCRA, as amended by the CARES Act, generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection or diagnosis of COVID-19 without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization, or other medical management requirements (COVID-19 Coverage Requirements).

Specifically, the FFCRA, as amended by the CARES Act, requires plans and issuers to provide coverage for the following items and services:

- in vitro diagnostic testing (meeting certain criteria) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such testing; and
- items and services furnished to an individual during health care provider office visits (including in-person 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 related 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.

Group health plans and health insurance issuers are required to reimburse a provider of COVID-19 diagnostic testing in an amount that equals the negotiated rate with that provider or, if the plan or issuer does not have a

negotiated rate with the provider (*i.e.*, an out-of-network provider), the cash price for such service listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the listed cash price).

Plans and issuers may not impose any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization requirements, or other medical management requirements for these items and services, and they must be covered without cost-sharing when medically appropriate for the individual, as determined by the individual's attending health care provider in accordance with accepted standards of current medical practice.

The FAQs Clarify the Following with Respect to COVID-19 Coverage Requirements:

- The COVID-19 Coverage Requirements apply to fully insured and self-insured group health plans subject to ERISA, grandfathered plans, non-federal governmental plans (such as plans sponsored by states and local governments), church plans, individual health insurance coverage, and student health insurance coverage. They do not apply to short-term limited duration insurance, excepted benefits under the Affordable Care Act (ACA), or group health plans that do not cover at least two employees (such as retiree-only plans).
- In vitro diagnostic tests include serological tests for COVID-19, which are used to detect antibodies against the SARS-CoV-2 virus, for use in the diagnosis of the disease or condition of having current or past infection with SARS-CoV-2, the virus which causes COVID-19. This means that serological tests must also be covered with no cost-sharing, prior authorization, or other medical management requirements at the same reimbursement rates required for in vitro diagnostic testing.
- If an individual's attending provider determines that other tests (such as influenza tests and blood tests) should be performed during a health care provider visit to determine the individual's need for COVID-19 diagnostic testing, and the visit results in an order for, or administration of, COVID-19 diagnostic testing, the plan or issuer must provide coverage for the related tests without cost-sharing when medically appropriate for the individual, as determined by the individual's attending health care provider in accordance with accepted standards of current medical practice. This coverage must also be provided without imposing prior authorization or other medical management requirements.
- For purpose of the COVID-19 Coverage Requirements, an individual's attending provider means an individual who is licensed under applicable state law, who is acting within the scope of the provider's license, and who is directly responsible for providing care to a patient. The FAQs clarify that a group health plan, health insurance issuer, hospital, or managed care organization is not an attending provider for purposes of the COVID-19 Coverage Requirements.
- The term "visit" is construed broadly to include both traditional and non-traditional care settings in which a COVID-19 diagnostic test is ordered or administered, including drive-through screening and testing sites where licensed health care providers are administering COVID-19 diagnostic testing.
- Group health plans and health insurance issuers are required to comply with the COVID-19 Coverage Requirements for services furnished on or after March 18, 2020, and during the public health emergency related to COVID-19 (which ends the earlier of the date the Secretary of HHS declares that the public health emergency no longer exists, or April 25, 2020; such date may be extended by the Secretary of HHS (Public Emergency Declaration Period)).

Winston Takeaway: The FAQs greatly expand the types of items and services related to the diagnosis and testing for COVID-19 that must be covered with no cost-sharing, prior authorization, or medical management criteria, and rely on the health care clinician's medical judgment to determine whether COVID-19 testing is appropriate. However, the FAQs repeat the requirement (in the text of the FFCRA, as amended by the CARES Act) that services relating to COVID-19 diagnostic testing be covered on a first-dollar basis only if the visit results in a test or an order for a test; therefore, it appears that influenza tests, blood tests, and other

diagnostic procedures which may be performed to rule out other potential diagnoses can still be subject to regular plan cost-sharing and administration rules if the attending health care provider ultimately determines that a COVID-19 test is not necessary.

If a COVID-19 test is ordered by the attending health care provider, it appears that related services must be covered with no cost-sharing even if the patient does not actually get tested. Thus, a patient is not disadvantaged if he or she is unable to get a test due to unavailability or because he or she does not qualify for a test under CDC or state guidelines. Note that employers may, but are not required to, provide coverage for treatment of COVID-19 with no cost-sharing, and such coverage will not otherwise disqualify an individual covered under a qualifying high-deductible health plan from making or receiving pre-tax contributions to their health savings account.

DOL Non-Enforcement Relief

The DOL also announced limited enforcement relief from the Summary of Benefits and Coverage (SBC) requirements under ERISA. Generally, under the SBC rules, if a group health plan or health insurance issuer makes a material modification (as defined under section 102 of ERISA) to any of the terms of the plan or coverage that would affect the content of the SBC, other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees no later than 60 days prior to the date on which the modification will become effective. Given the retroactive effective date of the COVID-19 Coverage Requirements and other provisions of the CARES Act applicable to telehealth services, the FAQs clarify that during the Public Emergency Declaration Period, the Departments will not take enforcement action against group health plans or health insurance issuers that fail to provide at least 60 days' advance notice of changes to plan designs that provide greater coverage related to the diagnosis and/or treatment of COVID-19, or add benefits, or reduce or eliminate cost-sharing, for telehealth and other remote care services. However, notice of these changes must be provided as soon as reasonably practicable.

Similarly, the FAQs provide that HHS will not take enforcement action against health insurance issuers that change the benefits or cost-sharing structure of plans mid-year to provide increased coverage for services related to the diagnosis and/or treatment of COVID-19. The Departments will continue to take enforcement action against plans or issuers that limit or eliminate other benefits, or increase cost-sharing, to offset the costs of increasing benefits related to the diagnosis and/or treatment of COVID-19.

Winston Takeaway: The FAQs confirm that group health plan sponsors will not be penalized by federal regulators for failing to provide prior notice of telehealth coverage changes made in response to the COVID-19 outbreak, even if the change was not required by the FFCRA or the CARES Act. The FAQs specifically apply the above SBC relief to plan changes to provide telehealth services unrelated to COVID-19 treatment or testing at reduced or no cost-sharing during the Public Emergency Declaration Period. Plan sponsors should coordinate with third-party administrators and insurance carriers to communicate COVID-19-related benefits enhancements to plan participants as soon as practicable.

Excepted Benefits

The FAQs clarify that employers may offer coverage for diagnosis and testing of COVID-19 at an on-site clinic or through an employee assistance program ("EAP") as an excepted benefit. While excepted benefits that provide medical care may be considered group health plans for ERISA purposes, they are exempt from many of the ACA coverage mandates, such as the requirement to provide first-dollar coverage for preventive care benefits and the prohibition against lifetime and annual limits. The FAQs clarify that an employer may offer benefits for diagnosis and testing for COVID-19 at an on-site medical clinic without jeopardizing the excepted benefit status of the on-site clinic. In addition, the FAQs clarify that an EAP will not be considered to provide benefits that are significant in the nature of medical care solely because it offers benefits for diagnosis and testing for COVID-19 while the Public Health Emergency Declaration related to COVID-19 is in effect.

Under current ACA rules, an EAP is an excepted benefit if four requirements are met:

- the EAP does not provide significant benefits in the nature of medical care;
- the benefits under the EAP are not coordinated with benefits under another group health plan, meaning that participants in the other group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a gatekeeper) before an individual is eligible for benefits under the other group health plan, and participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan;
- no employee premiums or contributions are required as a condition of participation in the EAP; and
- there is no cost-sharing under the EAP.

Winston Takeaway: The FAQs leave open the question of whether coverage of COVID-19 diagnosis and testing under an EAP after the Public Emergency Declaration Period has ended would otherwise disqualify an EAP from excepted benefit status. More guidance on this issue will be important as movement restrictions begin to ease and the focus on combatting the spread of the COVID-19 virus shifts to mass testing and contact tracing. In addition, employers should ensure that any benefits for diagnosis and testing for COVID-19 that are offered universally to all employees comply with other federal laws, such as ERISA, HIPAA, COBRA, and the ACA.

Please contact a member of the Winston & Strawn Employee Benefits and Executive Compensation Practice Group for further information.

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