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DEPARTMENTS RELEASE FAQ TO ADDRESS HEALTH PLAN OBLIGATIONS UNDER FFCRA AND CARES ACT

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Last month Congress passed landmark legislation aimed at helping individuals and businesses cope with certain medical costs and employment-related financial fallout of the COVID-19 crisis. Specifically the Families First Coronavirus Response Act (FFCRA), which became law on March 18, 2020, and the Coronavirus Aid, Relief, and Economic Security Act (CARES), enacted on March 27, 2020, both contained provisions addressing COVID-19 testing (and eventual vaccination) costs as well as expanding telehealth service availability.

Since both laws passed, the U.S. Department of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments) have released multiple sets of FAQ and other guidance to explain how they will interpret and enforce the various employer and group health plan sponsor obligations in the two laws. New FAQs released April 11, 2020, specifically address several questions plan sponsors have raised regarding covering coronavirus testing costs and increasing telehealth access.

COVID-19 Testing

FFCRA generally requires group health plans to provide benefits for certain items and services related to diagnostic testing to detect SARS-CoV-2 or diagnose COVID-19. Plans must cover these costs with no cost sharing (including deductibles, copayments and coinsurance), prior authorization or any other medical management requirement, when furnished on or after March 18, 2020 (FFCRA's effective date), and until the current national emergency period ends.

There has been some confusion as to whether self-funded group health plans had to comply with these testing-related rules. The FAQs explicitly confirm that FFCRA's health plan provisions apply to self-insured group health plans which include private employment-based group health plans (plans governed by the Employee Retirement Income Security Act of 1974 (ERISA), non-federal governmental plans (such as plans sponsored by states and local governments), and church plans. Plans that do not cover at least two current employees, such as retiree-only plans, are not required to comply.

The FAQs clarify that items and services furnished during a healthcare provider visit must be covered if they result in an order for or administration of an approved in vitro diagnostic product. Thus, the costs of a provider visit that does not result in ordering or administering a COVID-19 test would not be covered on a no-cost

sharing basis. Further, the FAQ expands "in vitro diagnostic tests" to include serological tests used to detect antibodies and to diagnose the disease or the condition of having current or past infection with SARS-CoV-2.

The Departments note that the Centers for Disease Control and Prevention (CDC) has strongly encouraged clinicians to test for other causes of respiratory illness in addition to COVID-19. Thus, the Departments state that other testing costs (e.g., influenza tests, blood tests, etc.) must also be covered with no cost sharing if performed during a visit that results in administering or ordering a COVID-19 diagnostic test. A visit will include non-traditional care settings such as drive-through screening and testing sites where licensed healthcare providers administer COVID-19 tests.

The Departments also explain that they will allow plans and insurance issuers to amend their plans and policies midyear without providing any otherwise applicable advance notice. The FAQs provide that to help facilitate responding to the COVID-19 outbreak, the Departments will not take enforcement action against any entity that modifies its plan to provide greater coverage related to COVID-19 without 60 days' advance notice. Plans and issuers must provide notice of these changes as soon as reasonably practical.

The FAQs instruct that states may impose additional standards or requirements on health insurance issuers regarding diagnosing and treating COVID-19 as long as they do not prevent applying the federal requirements under FFCRA or the CARES Act. Thus, fully insured plans eventually could face additional requirements.

Finally, the Departments warn sponsors and issuers that they should not attempt to limit or eliminate other benefits, or to increase cost sharing, to offset the more generous coronavirus-related benefits.

Excepted Benefits

Some specific types of healthcare-related benefits are exempt from the more burdensome compliance requirements imposed by ERISA. For example, certain on-site medical clinics, stand-alone dental and vision plans, long-term care benefits, nursing home care, home health care, community-based care and employee assistance programs (EAP) do not need to comply with ERISA documentation and disclosure requirements. These types of programs typically take great care to ensure that they remain excepted.

In light of expanded COVID-19 testing, the FAQs specify that an EAP will not risk its status as an excepted benefit simply because it offers diagnosis and testing for COVID-19 while the current federal public health emergency exists. Likewise, an onsite clinic may provide benefits for diagnosing and testing for COVID-19 and still remain an excepted benefit.

Telehealth Services

Many practitioners and plan sponsors have questioned the extent to which the FFCRA and CARES Act permit group health plans to offer telemedicine and telehealth services. As noted above, the laws specifically including telehealth visits as office visits during which COVID-19 diagnostic and testing costs must be covered with no cost sharing. Additionally, the FAQs emphasize that widespread availability and use of telehealth and other remote care services are vital to combat the current public health emergency. Thus, the Departments strongly encourage all plans and issuers to promote telehealth and other remote care services, including notifying consumers about availability, ensuring access to a robust suite of services (including mental health and substance use disorder services), and covering these services without cost sharing.

The FAQs further clarify that, effective March 27, 2020, a high-deductible health plan (HDHP) can provide telehealth and other remote care services for any health care expenses (not just COVID-19 testing) with no deductible. Moreover, providing broad telehealth and other remote care services with no cost sharing will not count as other health plan coverage that would prevent an individual from being able to contribute to a health savings account (HSA). This expanded telehealth safe harbor will apply to plan years beginning on or before December 31, 2021.

As with expanded COVID-19 testing coverage, the Departments have stated that they will allow plans and insurance issuers to amend their plans and policies midyear without providing any otherwise applicable advance notice. The Departments will not take enforcement action against any entity that modifies its plan to provide greater telehealth and other remote care benefits without 60 days' advance notice. Plans and issuers must provide notice of these changes as soon as reasonably practical.

Conclusion

The Departments reiterate that collectively they will continue to implement and enforce the new laws by emphasizing assistance rather that punishment. They explain that they will focus on working with group health plans, health insurance issuers and others who are working diligently and in good faith to comply, and will deemphasize fines and penalties.

These are extraordinary times, and the ramifications of COVID-19 will continue to evolve in the coming weeks. We will continue to monitor developments, including further departmental and agency guidance (which the Departments anticipate issuing) as we receive it and will provide the latest updates as they become available.

COMPLIANCE ALERT

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We express to all of our clients and friends our deep appreciation for our ongoing relationships, and we look forward to strengthening those ties as we work through this shared adversity. Stay safe and be well.

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