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Frequently Asked Questions on Health Plan Coverage under the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act, Part 2

The Department of Labor (DOL), Department of Health and Human Services (HHS), and the Department of the Treasury (collectively, the Departments), issued frequently asked questions (FAQs) regarding implementation of the Families First Coronavirus Response Act (the FFCRA), the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), and other health coverage issues related to Coronavirus Disease 2019 (COVID-19). These FAQs are in addition to the frequently asked questions the Departments previously released regarding health plan coverage under the FFCRA and CAREs Act. See our Advisor on the prior frequently asked questions.

Below is a summary of the Departments' answers to the FAQs.

Coverage Under the FFCRA, as Amended by the CARES Act

The FAQs confirm that self-insured group health plans are subject to the coverage requirements contained in the FFCRA, as amended by the CARES Act.

Under the FFCRA, plans and issuers must provide coverage for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test that meets one of the following four requirements below.

1. Is approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act (FFDCA).

   As of June 23, 2020, the Food and Drug Administration (FDA) has not cleared or approved an in vitro diagnostic test for COVID-19. However, all in vitro diagnostic tests for COVID-19 that have received an emergency use authorization (EUA) under the FFDCA are listed on the EUA webpage of the FDA website.

2. The developer has requested, or intends to request, EUA under the FFDCA, unless and until the EUA request has been denied or the developer of such test does not submit a request within a reasonable time.

   The FDA website provides a list of clinical laboratories and commercial manufacturers that have notified the FDA that they have validated their own COVID-19 test and are offering the test as outlined in FDA guidance. Plans and issuers must cover in vitro diagnostic tests for COVID-19 that are included on this list. A plan or issuer may take reasonable steps to verify that a test offered by a developer meets the statutory criteria. For example, a plan or issuer may request that a laboratory or commercial manufacturer provide documentation, such as a copy of the EUA request or pre-EUA submitted to the FDA, to demonstrate that it has requested or intends to request an EUA. These requests will not be considered to violate the FFCRA prohibition on medical management requirements as long as they are reasonable and necessary to verify that a COVID-19 test meets the statutory criteria.

3. Is developed in and authorized by a state that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19.

States and territories that have notified the FDA that they choose to use this flexibility are listed on the FDA website.

4. Other tests that the Secretary of HHS determines appropriate in guidance.

Plans and issuers must cover items and services furnished to an individual during visits that result in an order for, or administration of, a COVID-19 diagnostic test, but only to the extent that the items or services relate to the furnishing or administration of the test or to the evaluation of such individual for purposes of determining the need of the individual for the product, as determined by the individual's attending healthcare provider. The Departments clarify that a health care provider need not be "directly" responsible for providing care to the patient to be considered an attending provider, as long as the provider makes an individualized clinical assessment to determine whether the test is medically appropriate for the individual in accordance with current accepted standards of medical practice. A plan, issuer, hospital, or managed care organization is not an attending provider.

COVID-19 tests intended for at-home testing (including tests where the individual performs self-collection of a specimen at home) must be covered, when the test is ordered by an attending health care provider who has determined that the test is medically appropriate for the individual based on current accepted standards of medical practice and the test otherwise meets the criteria under the FFCRA noted in requirements 1 through 4 above.

Testing conducted to screen for general workplace health and safety (such as employee "return to work" programs), for public health surveillance for SARS-CoV-2, or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19 or another health condition is not required to be covered by a health plan under the FFCRA.

Plans and insurers cannot limit the number of diagnostic tests for COVID-19 that will be covered, provided they are medically appropriate for the individual as determined by an attending health care provider in accordance with current accepted standards of medical practice.

If a facility fee is charged for a visit that results in an order for or administration of a COVID-19 diagnostic test, the plan or issuer must cover the facility fee without imposing cost-sharing requirements.

Section 3202 of the CARES Act

Under the CARES Act, a health plan or issuer covering diagnostic testing for COVID-19 must reimburse the provider of the diagnostic testing at the negotiated rate for the service. If the health plan or issuer does not have a negotiated rate with the provider, the reimbursement rate will be the cash price for the service as listed by the provider on a public internet website, or a lower negotiated rate. If a plan or issuer does not have a negotiated rate with a provider and the provider has not made public the price, the plan or issuer may negotiate the price. These requirements only apply to reimbursement for COVID-19 testing. Also, this requirement generally prohibits balance billing for COVID-19 testing. State law governing balance billing will continue to apply to the extent that it does not conflict with these requirements.

If an individual receives a COVID-19 test in an emergency department of a hospital that is out of network, the plan or issuer must reimburse the out-of-network provider of COVID-19 testing an amount that equals the cash price for such service that is listed by the provider on a public website, or the plan or issuer may negotiate a rate that is lower than the cash price.

Notice Requirements

Under the Public Health Services Act (PHSA), if a plan makes a material modification, as defined under the Employee Retirement Income Security Act (ERISA), in any of the terms of the plan or coverage that would affect the content of the Summary of Benefits and Coverage (SBC) that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective. However, the FAQs provide that the Departments will not take enforcement action against any plan or issuer that makes a modification to increase benefits, or reduce or eliminate cost-sharing requirements, for the diagnosis or treatment of COVID-19 and telehealth or other remote care services, without providing at least 60 days advance notice during the public health emergency or national emergency declaration period related to COVID-19. A plan or issuer may reverse these changes once the COVID-19 public health emergency or national emergency declaration is no longer in effect, without violating the advance notice requirement noted above, if the plan or issuer had previously notified the participant, beneficiary, or enrollee of the general duration of the additional benefits coverage or reduced cost sharing or notifies the participant, beneficiary, or enrollee of the general duration of the additional benefits coverage or reduced cost sharing within a reasonable timeframe in advance of the reversal of the changes.

Telehealth and Other Remote Care Services

A large employer (employer with an average of at least 51 employees on business days during the preceding calendar year) may offer a plan beginning before the end of the public health emergency related to COVID-19 that solely provides benefits for telehealth or other remote care services that is not required to comply with the group market reforms under Part 7 of ERISA, Title XXVII of the PHS Act, and Chapter 100 of the Internal Revenue Code (the Code), except as specified below. See the DOL Compliance Assistance Guide for an overview of these group market reforms. This relief is limited to telehealth and other remote care service arrangements that are sponsored by a large employer and that are offered only to employees (or their dependents) who are not eligible for coverage under any other group health plan offered by that employer.

Under this temporary relief, the Departments will continue to apply otherwise applicable federal non-discrimination standards. The specified market reforms that these arrangements must continue to satisfy are the following provisions of the PHS Act (and corresponding provisions of ERISA and the Code):

- Section 2704 (relating to prohibition of pre-existing condition exclusions or other discrimination based on health status)
- Section 2705 (relating to prohibition of discrimination against individual participants and beneficiaries based on health status)

- Section 2712 (relating to prohibition of rescissions)
- Section 2726 (relating to parity in mental health or substance use disorder benefits)

Grandfathered Health Plans

If a grandfathered group health plan or issuer of grandfathered group or individual health insurance coverage adds benefits, or reduces or eliminates cost-sharing requirements, for the diagnosis and treatment of COVID-19 or for telehealth and other remote care services during the public health or national emergency period related to COVID-19, the plan will not lose its grandfather status solely because it later reverses these changes upon the expiration of the COVID-19 emergency period.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

For a group health plan or health insurance issuer offering group or individual health insurance coverage that provides both medical/surgical benefits and mental health or substance use disorder (MH/SUD) benefits, the MHPAEA requires that the financial requirements (such as coinsurance and copays) and quantitative treatment limits (such as visit limits) imposed on MH/SUD benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a particular benefit classification.

When performing the "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations under the MHPAEA regulations, the Departments will not take enforcement actions against plans and issuers that disregard benefits for items and services required to be covered without cost sharing under the FFCRA.

Wellness Programs

Under the wellness program regulations, a health-contingent wellness program is any "program that requires an individual to satisfy a standard related to a health factor to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward)." Among other requirements, a health-contingent wellness program must provide a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining any reward to individuals for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the otherwise applicable standard.

A plan or issuer may waive a standard for obtaining a reward (including any reasonable alternative standard) under a health-contingent wellness program if participants or beneficiaries are facing difficulty in meeting the standard as a result of circumstances related to COVID-19. The waiver must be offered to all similarly situated individuals.

Individual Coverage Health Reimbursement Arrangements (ICHRAs)

An ICHRA is required to provide employees with a notice, generally at least 90 days before the start of the plan year, that includes important information about requirements for ICHRAs, the terms of the ICHRA, and certain consequences of accepting or not accepting the ICHRA, among other information. DOL provides a model notice.

The DOL released EBSA Disaster Relief Notice 2020-01 (EBSA Notice 2020-01), which extends the time for plan fiduciaries and plan sponsors impacted by the COVID-19 outbreak to furnish certain notices and disclosures required by Title 1 of ERISA so long as they make a good faith effort to furnish the documents as soon as administratively practicable under the circumstances. See our Advisor for more information on EBSA Notice 2020-01. The relief provided under EBSA Notice 2020-01 can be applied to the ICHRA notice described above. However, the FAQs provide potential issues employers should consider before delaying the ICHRA notice to the extent permitted by EBSA Notice 2020-01:

- Individuals must be enrolled in individual health insurance coverage (or Medicare Parts A and B, or Part C) for each month during which they are covered by an ICHRA. The ICHRA provides individuals with information about how to enroll in individual health insurance coverage through an open enrollment or special enrollment period. Employers should ensure that the ICHRA notice is provided with enough time to allow individuals to weigh their coverage options and enroll in individual health insurance coverage.
- The offer or acceptance of an ICHRA may have consequences regarding an individual's eligibility for premium tax credits when purchasing insurance through the Health Insurance Marketplaces (also referred to as Exchanges). The ICHRA notice provides information on those consequences and includes information individuals need to present to the Health Insurance Marketplace when applying for advance payments of the premium tax credits, or to verify eligibility for a special enrollment period. The Department encourages employers affected by the COVID-19 pandemic to consider whether they can provide the ICHRA notice early enough in advance of the first day on which the ICHRA will take effect.

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