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Employee Benefits News

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FAQs Part 43: Guidance on Health Coverage Issues Related to COVID-19

The HHS, DOL and IRS have released additional guidance in the form of frequently asked questions (**FAQs**) regarding health coverage issues related to the 2019 novel coronavirus ("COVID-19"),[1] including under the Families First Coronavirus Response Act (Pub. L. 116-127, Mar. 18, 2020 [the "**FFCRA**"]) and the Coronavirus Aid, Relief, and Economic Security Act (Pub. L. 116-136, Mar. 27, 2020 [the "**CARES Act**"]). For more information, see previous alerts on the **FFCRA** and the **CARES Act**.

Section 6001 of the FFCRA, as amended by Section 3201 of the CARES Act, generally requires group health plans and health insurance issuers to provide benefits for certain items and services related to diagnostic testing for COVID-19 during the COVID-19 emergency period. Under the FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing, prior authorization or other medical management requirements. Under Section 3202(a) of the CARES Act, plans and issuers must reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate, if any, or the cash price the provider lists on a public website. These **FAQs** confirm and clarify the following points regarding these requirements:

- **Application of FFCRA to Self-Insured Plans**: Both insured and self-insured group health plans are required to comply with the requirements of section 6001 of the FFCRA.
- **Identifying the Covered COVID-19 Tests**:
  - Approved Tests – Emergency Use Authorization (EUA): Generally, plans and issuers must cover COVID-19 in vitro diagnostic tests that are FDA approved, developed under a requested EUA, or developed and validated in a state that intends to review diagnostic tests. At this time, the FDA has not cleared or approved any COVID-19 diagnostic tests. Clinical laboratories and commercial manufacturers that have provided notification to request an EUA are listed on the FDA's **website**.[2] Plans and issuers must cover diagnostic tests for COVID-19 that are included on this list.
  - "At Home" Tests: If determined to be medically appropriate by an "attending provider," plans and issuers must cover "at home" diagnostic COVID-19 tests. ***Brownstein Comment:*** The FAQs define an "attending provider" as an individual who is licensed (or otherwise authorized) under applicable law, who is acting within the scope of the provider's license (or authorization), and who is responsible for providing care to the patient, but need not be "directly" responsible for providing care to the patient.
  - Testing Not Covered for Surveillance or Employment Purposes: Section 6001 of the FFCRA only requires coverage of COVID-19 items and services for diagnostic purposes without cost-sharing requirements, prior authorization or other medical management requirements. These coverage requirements do not apply to testing for surveillance, immunity screening or employment purposes. ***Brownstein Comment:*** Employers that will recommend or require this testing (e.g., before allowing an employee to return to work) should first confirm how it will be covered or subsidized in order to avoid surprise medical bills for their employees.
  - Multiple Tests: Plans and issuers are required to cover multiple COVID-19 diagnostic tests for an individual so long as each test is determined by an attending provider to be medically appropriate for the individual.

- **Facility Fees**: Plans and issuers must cover without cost-sharing any facility fee to the extent it relates to the furnishing or administration of a COVID-19 test or to an evaluation to determine the individual's need for testing.
- **Balance Billing**: The CARES Act and the FFCRA protect participants from balance billing for a COVID-19 diagnostic test, but do not preclude balance billing for other items and services that might be received at the time of the testing; however, applicable state law or provider contract provisions may preclude balance billing for these other items and services. ***Brownstein Comment:*** Plan sponsors should communicate with participants regarding in-network provider and facility options to avoid potential balance billing.
- **Payment to an Out-of-Network Provider**: If an individual receives a COVID-19 test from an out-of-network provider (such as in an emergency room), the plan or issuer must reimburse the out-of-network provider for the COVID-19 testing in an amount that equals the provider's published cash price for such service, or negotiate a lower rate. For all other out-of-network services, the minimum payment standards under the Affordable Care Act (found at section 2719A of the Public Health Service Act) would apply.[3] That is, the CARES Act supersedes the Affordable Care Act only with respect to the COVID-19 diagnostic testing. ***Brownstein Comment:*** Where possible, in order to minimize balance billing, plan sponsors should work with out-of-network providers to transfer patients to in-network providers and facilities for any in-patient care once patients are stabilized.
- **Notice of Material Changes in Benefits**: The Affordable Care Act requires a plan or insurer to provide advance notice of material changes in health benefits at least 60 days prior to the effective date of the change. **FAQ 42** (Apr. 11, 2020) announced temporary enforcement relief of this advance notice requirement with respect to changes made to increase benefits, or reduce or eliminate cost-sharing requirements, for the diagnosis and/or treatment of COVID-19 and telehealth or other remote care services during the public health emergency or national emergency declaration period related to COVID-19. Now, **FAQ 43** advises that, if a plan or insurer wishes to reimpose cost sharing or reduce benefits to pre-COVID-19 levels after the end of the COVID-19 public health emergency or national emergency declaration period, this advance notice requirement will be considered met if the notice of these changes is provided within a reasonable period of time in advance of the reversal of the changes. ***Brownstein Comment:*** We recommend that plan sponsors review the current participant notices and disclosures and, if it already has not done so, send notices now about the benefits being provided during the COVID-19 emergency, including expectations about the general duration of any COVID-19-related benefit changes.
- **Telehealth**: A large employer may offer coverage only for telehealth and other remote care services to employees who are not eligible for any other group health plan offered by the employer. However, these arrangements must continue to satisfy certain nondiscrimination rules and other requirements under the Affordable Care Act.
- **Grandfathered Plans**: If, upon the expiration of the COVID-19 emergency period, a grandfathered group health plan or issuer of grandfathered group or individual health insurance coverage restores the plan or coverage by reversing any benefits or cost-sharing changes it made for COVID-19 diagnosis or treatment or telehealth service, the plan or coverage will not lose its grandfather status.
- **Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)**: Plans are permitted to disregard benefits for items and services that must be covered without cost sharing under the FFCRA when performing certain tests for financial requirements and quantitative treatment limitations under MHPAEA regulations. ***Brownstein Comment:*** As a result of this guidance, the temporary requirement to provide 100% coverage for COVID-19 testing and related services should not have any impact on mental health parity considerations in benefit plan design.

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- **Wellness Programs**: A plan or issuer may waive a standard for obtaining a reward under a health-contingent wellness program if participants 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 ("HRA")**: An employer offering individual coverage HRAs is required to provide employees with a notice, generally at least 90 days before the start of the plan year, that includes, among other information, important information about the requirements for individual coverage HRAs, the terms of the HRA, and certain consequences of accepting or not accepting the individual coverage HRA. Under **EBSA Disaster Relief Notice 2020-01** (**EBSA Notice 2020-01**, Apr. 28, 2020), the U.S. Department of Labor extended the time by which plans and insurers had to distribute certain notices, provided they made a good faith effort to do so as soon as administratively practicable under the circumstances. This relief applied to individual coverage HRAs. Now, in **FAQ 43**, it encourages employers to consider whether they can provide the individual coverage HRA notice at least early enough in advance of the first day on which the individual coverage HRA may take effect so that eligible employees have sufficient time to read and understand the notice, make an informed decision whether or not to enroll in the individual coverage HRA, and exercise their special enrollment right to individual health insurance coverage so that the coverage would start no later than the first day of the individual coverage HRA plan year. For more information about the guidance on benefit plan extended deadlines, see "**For Whom the Timing Tolls: The COVID-19 Outbreak Period Extends Benefit Plan Deadlines**."

How We Can Help

Please contact one of us or your regular Brownstein attorney for answers to your questions about this new guidance or if we can help you navigate and communicate its application to your employee benefit plans.

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[1] FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43 (June 23, 2020).

[2] FDA will post the names of entities that provide such notification on FDA's website at https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-cov-2#offeringtests. States and territories that have authorized laboratories within that state or territory to develop and perform a test for COVID-19 are also listed on the FDA's website.

[3] Under section 2719A of the Public Health Service Act, plans and issuers cannot impose cost sharing on out-of-network emergency services in an amount greater than what is imposed for in-network emergency services and must pay for the emergency services in an amount at least equal to the greatest of the following three amounts (adjusted for in-network cost-sharing requirements): (1) the median amount negotiated with in-network providers for the emergency service; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); or (3) the amount that would be paid under Medicare for the emergency service.