Multi-Agency Guidance Clarifies Statutory Impact on Employer Health Plans

Labor and Employment Alert **| April 16, 2020**

By: L. Stephen Bowers

On April 11, 2020, the Centers for Medicare and Medicaid Studies (CMS), in conjunction with the Department of Treasury and the United States Department of Labor (DOL), released FAQs detailing certain coverage elements mandated by the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (together, the "COVID Statutes"). The guidance applies broadly to most forms of health coverage, including many types of benefits offered through employer-sponsored group health benefit plans.

The FAQs address the types of plans covered by changes imposed by the COVID Statutes, the types of benefits that the COVID Statutes require, and certain administrative and operational clarifications regarding the application of those changes.

TYPES OF PLANS

The FAQs indicate that the changes implemented by the COVID Statutes will apply broadly to most types of healthcare coverage, including both individual health insurance coverage (including student health coverage) and most group or group-type health insurance plans provided by employer plan sponsors or similar entities (e.g., union coverage). The FAQs are specific that both fully insured and self-insured plans are covered, and also specify that "grandfathered" coverage under the Affordable Care Act (ACA) is still required to comply with the COVID Statutes. However, the FAQs note that the following types of coverage are exempt from the changes:

- Short-term limited duration insurance exempted from ACA requirements;
- Plans which provide solely "excepted benefits," as defined in the Employee Retirement Income Security Act (ERISA): generally, certain on-site medical clinics or limited scope dental or vision-only coverage;
- Employee Assistance Plans (EAPs) which do not provide "substantial benefits" in the nature of medical care, are not otherwise coordinated with employer-sponsored medical coverage, and do not require premium payments or cost sharing from participants; and
- Plans which cover fewer than two employees of an employer (including retiree-only coverage).

These exceptions generally parallel exceptions from other federal requirements, including the ACA and the Health Insurance Portability and Accountability Act (HIPAA).

MANDATED BENEFITS

Other than plans exempted above, health insurance plans are required to provide benefits for certain products and services without cost-sharing requirements. Specifically, such plans must provide coverage for:

- In-vitro COVID-19 tests (including serological testing which tests for prior infection), if the test is approved by the Food and Drug Administration (FDA), the test manufacturer has or will apply for emergency approval by the FDA, or the test is approved by a state which has notified the Department of Health and Human Services of such approval; and
- Items or services provided during any in-person visit with a medical provider (which explicitly includes such a visit provided via telemedicine) that results in the administration of such a test, including evaluation and services required to determine whether the test is advisable.

These products and services must be provided without cost-sharing or required pre-authorization or referrals. If the health plan has a negotiated rate with the provider of the covered service, reimbursement is at the negotiated rate. However, if no negotiated rate exists, the health plan is required to reimburse the provider at the provider's publicly posted cash rate. There are no stated limitations on such rate, but it is required to be made available on a publicly accessible website.

Although exempt from the requirement to provide such services, the FAQs indicate that an EAP will not violate the "no substantial medical benefits" requirement described above by providing coverage for these listed benefits (meaning that it may remain an "excepted benefit" for other legal purposes). The FAQs also note that coverage for such services may be provided at an on-site medical clinic without jeopardizing the clinic's status as an excepted benefit.

OTHER ITEMS

The FAQs also address certain other clarifications implemented by the COVID Statutes. Specifically, the FAQs reiterate that telemedicine coverage that meets certain safe harbor requirements will not negatively impact an individual's ability to utilize a health savings account (HSA), and urges state governments to encourage the use of telemedicine. Additionally, the FAQs note that restrictions on mid-year changes to health plans will not be enforced to the extent such changes are required to comply with the COVID Statutes, but specifically note that plans may not implement changes that reduce other benefits to offset the expenses for benefits mandated by the COVID Statutes.

These changes are all effective as of the effective dates of the COVID Statutes (March 18th and 27th, respectively). Employer plan sponsors should coordinate with counsel and their insurers or third-party administrators as soon as possible to ensure compliance with these requirements.

If you have questions or would like more information, please contact Stephen Bowers (bowers@whiteandwilliams.com; 215.864.6247) or another member of our Labor and Employment Group.

As we continue to monitor the novel coronavirus (COVID-19), White and Williams lawyers are working collaboratively to stay current on developments and counsel clients through the various legal and business issues that may arise across a variety of sectors. Read all of the updates here.

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