



National Compliance Update

USI EMPLOYEE BENEFITS

Updated April 16, 2020

FAQs on COVID-19 and Health Coverage

After publication of our original article, the Departments issued an update to FAQ 42 to correct the expiration date of the public health emergency declaration from June 16, 2020 to April 25, 2020. This article has been revised to reflect this change.

On April 11, 2020, the Departments of Labor, the Treasury, and Health and Human Services (“HHS”) (collectively, “the Departments”) issued FAQ Part 42, which includes implementation guidance on the health coverage aspects of the Families First Coronavirus Response Act (“FFCRA”) and the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”), as well as other health plan issues related to COVID-19.

Briefly, FAQ 42 provides:

- For grandfathered group health plans, extending coverage as required under FFCRA will not affect grandfathered status.
- The coverage requirements related to COVID-19 diagnostic testing:
 - Are effective March 18, 2020 and expire at the end of the emergency period. Currently, the end of the emergency period is April 25, 2020 but may be extended (or shortened) by HHS.
 - Include COVID-19 antibody testing.
 - Extend to out-of-network providers and traditional and non-traditional places of care (e.g., a drive-through COVID-19 testing site).
- Relief from the 60-day advance notice requirement for mid-year plan design changes that affect the Summary of Benefits and Coverage (“SBC”) when related to COVID-19 during the emergency period (including adding or enhancing telehealth benefits).
- An employee assistance program (“EAP”) may offer benefits for COVID-19 diagnosis and testing without jeopardizing excepted benefit status while emergency declarations related to the pandemic are in effect.

Employers should ensure their group health plans comply with the coverage requirements under the FFCRA (as amended by the CARES Act).

Additional details are described below.

BACKGROUND

The FFCRA, enacted on March 18, 2020, requires coverage for certain items and services related to diagnostic testing for COVID-19 without cost-sharing, pre-authorization, or medical management techniques.

The CARES Act, enacted on March 27, 2020:

- Amends the FFCRA and expands the range of diagnostic items and services that a plan must cover without cost-sharing pre-authorization or medical management techniques.
- Requires health plans and insurance carriers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount equal to:
 - the negotiated rate, or
 - if the plan or carrier does not have a negotiated rate with the provider, the cash price as listed on the provider’s public website.
- Provides temporary relief to qualified high deductible health plans (“HDHP”) to provide telehealth or other remote health care services prior to satisfaction of the deductible without jeopardizing an individual’s eligibility for a health savings account (“HSA”).

HEALTH PLANS SUBJECT TO FFCRA COVERAGE REQUIREMENTS

Group health plans sponsored by private employers, non-federal governmental plans and church plans are subject to the FFCRA coverage requirements. This includes fully insured, self-funded, grandfathered and non-grandfathered plans.

Individual plans are also subject to this mandate including policies sold through, or outside of, the Marketplace and student health insurance coverage.

The coverage mandates do not apply to:

- Short-term limited duration insurance;
- Excepted benefits; or
- Group health plans that do not cover at least two current employees (e.g., a retiree-only plan).

Providing the required diagnostic items and services related to COVID-19 will not cause a plan to lose grandfathered status so long as no other changes are made that could otherwise cause a loss of this status.

DURATION OF COVID-19 COVERAGE FOR DIAGNOSTIC TESTING AND SERVICES.

Health plans must comply with the requirements under the FFCRA as of March 18, 2020 and must do so until the public health emergency declaration related to COVID-19 ends.

The FAQ clarifies that a public health emergency declaration lasts until the earlier of a declaration by HHS that the emergency no longer exists or the expiration of the 90-day period measured from the date the emergency was declared.

Unless extended or terminated earlier, the public health emergency related to COVID-19 will end April 25, 2020.

ITEMS AND SERVICES THAT MUST BE COVERED UNDER FFCRA (AS AMENDED BY THE CARES ACT).

Health plans must provide coverage for the following items and services:

- 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:
 - Is approved, cleared or authorized by the Federal Food, Drug and Cosmetic Act (“FDCA);
 - The developer has requested (or intends to request) emergency use authorization under the FDCA, unless and until the emergency use authorization request is denied or if the developer does not submit a request within a reasonable timeframe;
 - Is developed in and authorized by a state that has notified HHS of its intention to review tests intended to diagnose COVID-19; or
 - Is another kind of test that HHS deems appropriate in guidance.
- Items and services furnished to an individual during healthcare provider office visits (which include in-person visits 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 described above, but only to the extent the items and services relate 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.

The guidance clarifies:

- Testing for COVID-19 antibodies will meet the definition of an “in vitro diagnostic product” and is covered, assuming it otherwise satisfies the requirements of the FFCRA (as amended by the CARES Act).¹
- The term “visit” is defined broadly to include both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered, including drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing.

The guidance also provides an example of how plans must cover other tests as part of the evaluation of an individual for COVID-19.

Example

If the individual’s attending provider determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed during a visit to determine the need of such individual 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 without cost sharing, when medically appropriate for the individual, as determined by the individual’s attending healthcare 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.

¹ Serological tests for COVID-19 are used to detect antibodies against the SARS-CoV-2 virus (the virus that causes COVID-19) and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-CoV-2. The FDA has advised the Departments that serological tests for COVID-19 meet the definition of an in vitro diagnostic product for the detection of SARS-CoV-2 or the diagnosis of COVID-19. According to the guidance, to date, the FDA has authorized one emergency use authorization for a serological test that is intended for use by clinical laboratories. See U.S. Food and Drug Administration, Letter to Cellex Inc. Regarding qSARS-CoV-2 IgG/IgM Rapid Test (Apr. 1, 2020), available at <https://www.fda.gov/media/136622/download>.

OUT-OF-NETWORK PROVIDERS

Health plans are required to provide coverage for items and services related to a COVID-19 diagnosis without cost-sharing when furnished by out-of-network providers. Where there is no negotiated rate with an out-of-network provider, the plan must reimburse the provider at the cash price for the services as listed by the provider on a website.

One FAQ response clarifies that the plan may negotiate with the out-of-network provider for a lower price than the listed cash price.

SBC RELIEF

Generally, if there is a mid-year material modification in any of the terms of the plan or coverage that would affect the content of the SBC, the plan must provide 60 days advance notice of the change.

One FAQ response announces relief from this requirement, stating that the Departments will not take enforcement action against any plan or carrier that makes a modification to the SBC to provide greater coverage related to the diagnosis and/or treatment of COVID-19 without providing at least 60 days advance notice. This relief extends to plans and carriers that add benefits or reduce/eliminate cost sharing for telehealth or other remote care services mid-year.

Plans and carriers should provide notice of the changes as soon as reasonably practicable, either by issuing an updated SBC or a separate notice describing the material modification.

The Departments will continue to take enforcement action against any health insurance issuer or plan that attempts to limit or eliminate other benefits, or to increase cost-sharing, to offset the costs of increasing the generosity of benefits related to the diagnosis and/or treatment of COVID-19.

EAP AND ONSITE CLINICS – EXCEPTED BENEFITS

An EAP is treated as an excepted benefit when it meets certain requirements, including that the EAP does not provide significant medical benefits.² For this purpose the amount, scope and duration of covered services are considered. EAPs generally must maintain excepted benefit status in order to avoid certain coverage mandates under the Affordable Care Act with which it cannot comply (e.g., providing coverage for certain preventive care items and services without cost-sharing).

One FAQ response states that an EAP will not be considered to provide significant medical benefits solely because it offers benefits for diagnosis and testing for COVID-19 while a public health declaration or national emergency declaration related to COVID-19 is in effect.

² An EAP is an excepted benefit when it meets all of the following requirements:

- The EAP does not provide significant medical benefits. For this purpose, the amount, scope and duration of covered services are taken into account.
- The benefits are not coordinated with benefits under another group health plan:
 - 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.
- There is no cost sharing under the EAP.

Therefore, an EAP that offers benefits for diagnosis of, or testing for, COVID-19 may still qualify as an excepted benefit. This guidance may allow other arrangements offered by employers to qualify as an excepted benefit EAP when providing benefits to diagnose or test for COVID-19.

Another FAQ reiterates that an onsite clinic is an excepted benefit in all circumstances.

RESOURCES

For a copy of FAQ 42, visit <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf>

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