COMPLIANCE ALERT

Alliant EMPLOYEE BENEFITS

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Updated FFCRA and CARES Act Guidance: COVID-19 Testing, Telehealth, and More

Introduction

On March 18, 2020, the President signed the Families First Coronavirus Response Act (FFCRA) (See Alert 2020-05). The FFCRA was quickly followed by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). These laws contain numerous measures intended to stabilize the economy in the midst of the COVID-19 crisis, including requirements for group health plans to cover certain COVID-19 related tests and services without cost sharing, expanded unemployment insurance, aid to small businesses, cash payments to households, and new paid sick and family leave provisions. The Departments of Treasury, Labor, and Health and Human Services (the Departments) previously issued a series of Frequently Asked Questions (FAQs) on health plan obligations under the FFCRA and CARES Act, and on June 22, 2020, issued FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation, Part 43. This latest guidance clarifies several key items for employer/plan sponsors on what testing is required, the number of tests plans must cover, and return to work testing. It also includes significant temporary relief allowing employers to expand telehealth offerings during the COVID-19 public health emergency. These issues, as well the effect of COVID-19 coverage on certain other laws, are addressed below.

COVID-19 Testing

The FFCRA generally requires group health plans and health insurance carriers to cover certain items and services related to COVID-19 testing when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. Under the FFCRA, plans and carriers must provide this coverage without any cost-sharing requirements (deductibles, copayments, and coinsurance), prior authorization, or other medical management requirements. The CARES Act then amended the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover subject to these same terms. In addition, the CARES Act generally requires plans and issuers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. The plan or issuer may also negotiate a rate with the provider that is lower than the cash price.

Self-funded Plans. The FAQs clarify that self-insured group health plans are required to cover COVID-19 testing and related items and services without cost sharing as required under the FFCRA and CARES Act. Although this was already clear, the Departments emphasized that they will enforce these provisions and provided toll free numbers for participants in both private sector and public sector plans to call if they have concerns.

Types of Tests that must be Covered. The FAQs clarify the scope of the COVID-19 testing mandate. Specifically, the coverage mandate is for in vitro diagnostic tests for detection or diagnosis and the administration of such a test (prior FAQ guidance indicated that stereological tests are covered but the criteria below must also be satisfied). Tests must meet the following requirements: (a) be approved cleared

or authorized under the Federal Food, Drug, and Cosmetics Act; (b) a developer has requested or been approved for emergency use authorization; (c) is developed in and authorized by a state that has notified HHS of its intention to review tests; or (d) is otherwise approved by HHS in formal guidance (none to date). Significantly, the scope of covered tests should be determined exclusively by carriers and TPAs.

Next, and most importantly, the FAQs confirm that COVID-19 testing is only covered by plans without cost sharing when "medically appropriate for the individual, as determined by the individual's attending healthcare provider." This means that plans will largely not be required to cover testing for asymptomatic individuals unless deemed medically necessary and appropriate by a healthcare provider. For testing to be covered a provider must make a clinical assessment that the test is medically appropriate in accordance with current accepted standards of medical practice.

At-home Testing. The guidance provides that plans must cover certain at-home COVID-19 testing options without cost sharing when ordered by an attending health care provider who has determined that the test is medically appropriate.

Return to Work Testing. The Departments incontrovertibly confirm that COVID-19 testing for general workplace health and safety as part of an employer's return to work plans is not covered by the FFCRA and CARES Act COVID-19 testing mandate. Thus, plans and carriers are not required to provide general return to work testing or cover such testing without cost sharing.

Coverage for Multiple Tests. The FAQs provide that the requirement to provide COVID-19 without cost sharing is not limited to any particular number of tests for an individual, provided that the tests are medically appropriate. While plans may not impose prior authorization or other medical management requirements to deny coverage for individuals who are tested multiple times, the guidance urges providers to consult CDC guidelines, as well as state and local health departments etc., in determining whether testing is appropriate.

Balance Billing Protection. Balance billing occurs when a provider bills a participant for the balance of the cost of a service after the plan has paid the amount due under the terms of the plan. This often occurs when a participant receives care from an out of network provider or where the participant is covered under a referenced based pricing plan. Participants can be billed significant, unanticipated amounts. Balance billing has been the subject of debate on both a federal and state level, with several states enacting laws prohibiting balance billing by insured plans. In the FAQs, the Departments state that they, "read the requirement to provide coverage without cost sharing . . . as intended to protect participants . . . from being balance billed for an applicable COVID-19 test." Specifically, the law requires a provider of COVID-19 testing be reimbursed at either a negotiated rate or an amount that equals the cash price for such service that is listed by the provider on a public website. Regardless, the amount the plan reimburses the provider constitutes payment in full for the test, with no cost sharing to the individual or other balance due. As a result, the statute generally precludes balance billing for COVID-19 testing. Note that state balance billing laws continue to apply.

Telehealth and Remote Care Services

The FAQs contain significant and unexpected relief regarding telehealth services for plan years beginning **"before the end of the public health emergency related to COVID-19**[.]" Specifically, the guidance allows large employers (as opposed to small group market employers) to offer benefits for telehealth or other remote care services to employees (and their dependents) who are not eligible for coverage under any other group health plan offered by that employer. Historically, this would have created significant compliance

concerns because telehealth is a group health plan subject to HIPAA, ERISA, COBRA and market reforms under the ACA, including no lifetime and annual limits and the provision of preventive care without cost sharing. Under this temporary relief, the Departments will not apply ACA market reforms to telehealth offered pursuant to guidance. The Departments will continue to apply other applicable federal non-discrimination standards, and the telehealth and remote care services must continue to satisfy the prohibitions against pre-existing condition exclusions, health status discrimination, rescission of coverage, and also must comply with parity requirements for mental health or substance use disorder benefits. Although not noted, HIPAA (special enrollment rights), ERISA (notice and disclosure requirements including the distribution of SPDs and SARs), and COBRA (election opportunities, included DOL extension of deadlines regarding both election and payment) will also continue to apply. Because of these requirements, as well as the limited and uncertain duration of this relief, employers should only offer this expansion of telehealth after careful consideration.

COVID-19 Issues and Other Laws

Summary of Benefits Coverage. Under the Affordable Care Act (ACA), when a plan makes a mid-year change that would affect the content of the last SBC it distributed it must provide an updated SBC to participants 60 days in advance of the change. In prior FAQs, the Departments announced temporary enforcement relief from this requirement for changes made to increase benefits, or reduce or eliminate cost-sharing requirements, for the diagnosis and/or treatment of COVID-19 and telehealth during the emergency period related to COVID-19. The FAQs clarify that when a plan reverses those changes once the COVID-19 crisis ends a new SBC is not required if participants were informed of the general duration of the additional benefits or reduced cost sharing at the time the change was originally made.

Grandfathered Health Plans. Under the ACA grandfathered health plans are able to avoid compliance with certain ACA market reforms, including coverage of preventive care without cost sharing, limits on cost sharing, and expanded claims and appeals procedures. The FAQs confirm that a grandfathered plan will not lose its grandfathered status if it 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 national emergency period related to COVID-19 as long as these changes are later reversed and the terms of the plan or coverage that were in effect prior to the emergency period are restored.

Mental Health Parity. In general, the Mental Health Parity Addiction Equity Act (MHPAEA) provides that the financial requirements (such as coinsurance and copays) and quantitative treatment limits (such as visit limits) imposed on Mental Health or Substance Use Disorder 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. The FAQs clarify that when evaluating financial requirements and quantitative treatment limitations under the MHPAEA, may plans disregard benefits for items and services required to be covered without cost sharing under the FFCRA while the public health emergency related to COVID-19 is in effect. For more information on MHPAEA compliance see our Alliant Insight, Mental Health Parity It's Time for a Checkup.

Wellness Plans. Wellness plans come in a wide range of designs and depending on their structure can be heavily regulated. HIPAA regulates "health-contingent wellness programs," which are defined as 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). The FAQs

conform that a plan may waive a standard for obtaining a reward (including any requirement to meet a 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. Such a waiver must be offered to all similarly situated individuals. For more information on Wellness Plans see our Alliant Insight, Wellness Plan Compliance Obligations.

Conclusion

This latest guidance includes important clarifications for employers. Since enactment of both the FFCRA and CARES Act carriers and TPAs had struggled with the scope and limits on required COVID-19 testing. We will continue to monitor this very fluid situation and provide the latest information on the COVID-19 pandemic, including emerging legal challenges and practical recommendations. Our full suite of resources is available on Alliant's COVID-19 Resource Page.

Compliance Alert is presented by the Compliance Practice Group of Alliant Employee Benefits

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