COVID-19: SUMMARY OF RECENT DEVELOPMENTS REGARDING GROUP HEALTH PLAN COVERAGE AND REMOTE/TELEHEALTH SERVICES

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Recent novel coronavirus legislation — the Families First Coronavirus Response Act ("FFCRA") and the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") — include two provisions impacting employer-provided group health benefits: (1) mandatory "first-dollar" coverage of COVID-19 diagnosis and testing, and (2) permissive "first-dollar" coverage by high deductible group health plans of remote (or telehealth) services. On April 11, 2020, federal regulators published guidance in the form of Frequently Asked Questions ("FAQs"). This Alert provides a brief summary of these two legislative provisions and the agency FAQs.

MANDATORY COVERAGE OF COVID-19 TESTING

Starting March 18, 2020 and continuing for the duration of the COVID-19 public health emergency, employer-sponsored group health plans must provide coverage for COVID-19 testing subject to a number of terms and conditions.

Authorized Tests

The coverage mandate applies only to COVID-19 diagnostic tests approved by the U.S. Food and Drug Administration ("FDA") or tests that have not been approved but for which FDA approval has been requested or is intended, and state-authorized tests. (As of April 11, 2020, the only FDA-approved test is the Cellex Inc. Rapid Test.) Testing includes serological or antibody testing designed to test for current or past infection.

Related Items and Services During Visits

The coverage mandate includes coverage for items and services furnished during a visit to a healthcare provider. Visits include an in person or telehealth visit to a healthcare provider's office, a visit to an urgent care or emergency room facility, and visits in nontraditional settings such as drive-through screening and test sites, that result in an order for or administration of an authorized test, but only to the extent they relate to the administration of the test or the evaluation of the individual to determine the need for the test (i.e., diagnosis). This includes items and services related to testing for other conditions (e.g., influenza) if the visit results in covered COVID-19 testing.

FirstDollar Coverage

The covered tests and related items and services must be provided as "first-dollar" coverage with no cost-sharing such as deductibles, copayments, and coinsurance.

Out-of-Network Providers

Coverage must be provided even for out-of-network providers. Test providers are obligated to publish the prices for their testing on their internet web sites and, whether in-network or out-of-network, plans must pay the published rate unless a lower rate is negotiated.

Plan Participant Notification Requirements

Ordinarily, mid-year changes to covered benefits that affect the required content of the annual Summary of Benefits and Coverage can be made only with 60 days advance notice of the change to plan participants. The FAQs waive the 60-day advance notice requirement for the mandated COVID-19 testing coverage, but notice must be provided as soon as is reasonably practicable.

Exceptions

The COVID-19 testing mandate does not apply to arrangements that are not generally subject to the Affordable Care Act's market reform provisions and the privacy and security requirements of the Health Insurance Portability and Accountability Act (“HIPAA”), including on-site medical clinics; limited scope vision or dental benefits; long-term care, nursing home care, home healthcare or community care benefits; and employee assistance plans (“EAPs”) that (among other things) do not provide significant medical benefits. The FAQs make clear that while an otherwise exempt EAP is not required to cover COVID-19 diagnosis and testing, if it does so, it will not be treated as providing significant medical benefits and will be able to retain its exemption from the Affordable Care Act market reform and HIPAA privacy and security provisions.Recent Changes Concerning High Deductible Health Plans

RECENT CHANGES CONCERNING HIGH DEDUCTIBLE HEALTH PLANS

A High Deductible Health Plan (“HDHP”) is a group health plan that sets specified annual deductible thresholds so that, with certain exceptions (such as preventive care benefits), no benefits are provided until the required annual deductible is satisfied. The design enables an employer and/or its employees to make pre-tax contributions to the employees' health savings accounts (“HSAs”). Two recent developments expand the universe of expenses that may be covered by the HDHP before the required annual deductible has been satisfied.

First, the CARES Act creates a new exception that allows an HDHP to cover remote (or telehealth) services before the required annual deductible has been satisfied subject to the following terms and conditions.

Not Limited to COVID-19 Testing

The exception is designed to encourage telehealth services to limit the spread of COVID-19. Accordingly, the exception is not limited to telehealth services for COVID-19 diagnosis and testing. It covers all telehealth medical benefits whether or not related to COVID-19.

Coverage Not Mandatory

The HDHP telehealth services provision of the CARES Act is not mandatory (except in the case of COVID-19 diagnosis and testing as described above).

Effective Dates

The HDHP telehealth services provision is effective March 27, 2020, and applies to plan years beginning on or before December 31, 2021. For HDHPs with calendar-year plan years, this means that the provision is effective through December 31, 2021.

Plan Participant Notification Requirements

As with mandatory coverage of COVID-19 diagnosis and testing, the FAQs waive the 60-day advance notice requirement for HDHPs that are amended to provide pre-deductible coverage of telehealth services, but notice must be provided as soon as is reasonably practicable.

Second, in Notice 2020-15, the Internal Revenue Service had provided that coverage of COVID-19 testing and treatment is treated as preventive care and can, therefore, be covered by the HDHP before satisfaction of the required annual deductible. So, while first-dollar coverage of COVID-19 diagnosis and testing is required by the CARES Act, Notice 2020-15 makes clear that such coverage will not affect the pre-tax treatment of employee and employer HSA contributions. Also, while the CARES Act does not mandate treatment for COVID-19, Notice 2020-15 makes clear that if an HDHP chooses to cover such treatment prior to satisfaction of the annual deductible, it will not affect the pre-tax treatment of employee and employer HSA contributions.

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