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Employee Benefits Update July 8, 2020

COVID-19 and Benefit Plans: Part 8
Additional FFCRA and CARES Act
Health Care Coverage Guidance

Executive Summary

The Families First Coronavirus Response Act (the "FFCRA") and the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), covered in our COVID-19 Employee Benefits Update series, require self-insured and fully-insured group health plans to cover COVID-19 testing and diagnostic items and services without cost-sharing requirements, prior authorization or other medical management requirements while the COVID-19 public health emergency, which began March 13, 2020, remains in effect. The Departments of Labor, Health and Human Services, and Treasury continue to provide guidance in the form of frequently asked questions (FAQs) about the implementation of FFCRA and the CARES Act and other health coverage issues related to COVID-19. This Employee Benefits Update highlights some of the topics addressed in FAQ Part 43 that are most relevant for employers sponsoring group health plans for their employees.

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Medically Appropriate Determinations:

Group health plans must fully cover COVID-19 related testing and diagnostic services if an "attending health care provider" determines the tests or services are medically appropriate. The FAQs clarify that the attending health care provider need not be "directly" responsible for care of the patient, so long as the provider makes an individualized clinical assessment that a test or service is medically appropriate. This means the attending health care provider can be any individual licensed or authorized under applicable law acting within the scope of the provider's license or authorization responsible for providing care to the patient.

Covered Testing and Diagnostic Services:

The FAQs confirm there is no limit to the number of tests and related services that group health plans must fully cover for any individual's diagnosis, provided that the tests and services are medically appropriate. In addition, at-home testing must be fully covered if the test is medically appropriate and ordered by an attending health care provider. Furthermore, the group health plan must cover any facility fees related to the furnishing or administration of a COVID-19 test or diagnosis without imposing cost-sharing requirements.

However, testing conducted to screen for general workplace health and safety purposes (such as "return to work programs") are not required to be provided without cost-sharing under the FFCRA.

Telehealth/Remote Care Services:

For the duration of any plan year beginning before the end of the public health emergency related to COVID-19, the FAQs permit group health plans sponsored by large employers to offer telehealth or other remote care services to employees who are not eligible for any other health coverage offered by that employer without violating the Affordable Care Act ("ACA") market reforms or essential health benefit requirements. However, any telehealth or remote care services offered to those employees who are not otherwise eligible for any other coverage may not impose pre-existing condition limitations, discriminate on the basis of a health condition, or retroactively rescind coverage unless the employee intentionally misrepresents a material fact or acts fraudulently. Such telehealth or remote care services must also satisfy parity requirements for mental health and substance use disorder benefits.

Grandfathered Health Plans:

The FAQs confirm that while the COVID-19 public health emergency is in effect, if a group health plan that has previously maintained "grandfathered" status under the ACA adds benefits, or reduces or eliminates cost-sharing, the plan will not lose its grandfathered status when, after the public health emergency ends, the plan reverses these changes and restores the terms of the plan or coverage in effect before the emergency.

Notice of Coverage Changes:

If, after the COVID-19 public health emergency ends, a group health plan reverses 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, the plan will not have to issue a notice to participants 60 days before the reversal of changes if (i) the group health plan had previously notified participants about the general duration of the additional benefits coverage or reduced cost-sharing (by providing, for example, that the increased coverage applies only during the COVID-19 public health emergency), or (2) the plan provides notice of the general duration of the additional benefits coverage or reduced cost-sharing within a reasonable timeframe before the reversal of the changes.

To discuss any of the information discussed in this Employee Benefits Update, or any additional information covered in FAQ Part 43, please contact any member of our Employee Benefits and Executive Compensation Group below.

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