akerman

Practice Update

The CARES Act Impacts to Employer-Sponsored Health and Welfare Benefit Plans

March 30, 2020
By Beth Alcalde

Health and welfare benefit plans and insurers are affected by various provisions of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) passed on March 27, 2020. In addition to provisions impacting tax-qualified retirement plans and executive compensation (summarized here), the CARES Act affects coverage of diagnostic testing, preventive services, telehealth services, and drug reimbursement. Here are the highlights:

Section 3201 – Coverage of Diagnostic Testing for COVID-19

FFCRA Baseline. First we should recall what the Families First Coronavirus Response Act (FFCRA), enacted March 18, 2020, already addressed. The FFCRA had already required that group health plans and health insurers offering group and individual health insurance coverage (including grandfathered health plans), provide coverage for items related to COVID-19 testing. This "testing" concept was extended to FDA-approved diagnostic products, items, and services furnished during a provider visit (whether in person or in a telehealth setting), an emergency room visit, or an urgent care visit that results in a diagnostic test.

Related People

Beth Alcalde

Related Work

Employee Benefits and Executive Compensation
Healthcare
Labor and Employment

Related Offices

West Palm Beach

HR Defense Blog

Akerman Perspectives on the Latest Developments in Labor and Employment Law

Visit this Akerman blog

Coronavirus Resource Center

No Cost Sharing. The FFCRA prohibited group health plans and insurers from imposing any cost sharing requirements (including deductibles, copayments, and coinsurance), prior authorizations, or other medical management requirements for the aforementioned testing products and services.

Expansion by CARES Act. **The CARES Act expands upon the types of testing covered with no cost sharing as provided under the FFCRA**. In addition to FDA-approved diagnostic testing, **coverage is now extended to diagnostic tests where a developer "has requested, or intends to request" FDA emergency use authorization and to diagnostic tests authorized by an individual State** (provided that the State has notified HHS).

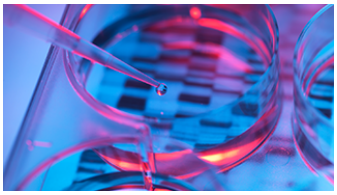
Tests Not Yet Developed. Scientists around the world are racing to develop new testing and treatment protocols in response to COVID-19. And so the CARES Act leaves the door open for coverage of "other tests that the Secretary determines appropriate in guidance."

Section 3202 – Pricing of Diagnostic Testing

Amount of Reimbursement. Pricing mandates also accompany the CARES Act's broader COVID-19 testing coverage requirement. The CARES Act requires that group health plans and insurers providing the mandated COVID-19 testing coverage **must reimburse the providers of such testing at the same rates negotiated prior to the declaration of the coronavirus public health emergency**. If no such rates were negotiated, reimbursements must be paid at an amount equal to (or less than) the cash price for the testing services as listed on the provider's website.

Pricing Transparency. The CARES Act mandates that all providers of COVID-19 diagnostic tests publish the price of the testing services online. Providers who fail to comply with the publishing requirement are subject to a fine of up to $300 per day.

Visit the Resource Center



Section 3203 – Rapid Coverage of Preventive Services and Vaccines for Coronavirus

Preventive Service Definition. The CARES Act requires group health plans and health insurers to cover any "qualifying coronavirus preventive service" without any cost sharing requirements. A qualifying preventive service is defined as an "item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019," that has received either an "A" or "B" in the recommendation of the United States Preventive Services Task Force or a recommendation by the CDC. This coverage requirement is effective "15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service."

Section 3701 – Exemption for Telehealth Services

Impact to High Deductible Health Plans and HSAs. As noted in our March 13, 2020 Blog Post, the IRS issued Notice 2020-15, confirming that a health plan will not fail to satisfy the high deductible health plan (HDHP) requirements, and a participant will not be disqualified from contributing to a health savings account (HSA), simply because the health plan provides health benefits associated with testing for and treatment of COVID-19 without a deductible, or with a deductible below the minimum statutory deductible required for an HDHP.

Limited Duration Safe Harbor. On a related note, the CARES Act creates a safe harbor for HDHPs that do not charge deductibles for telehealth. For plan years beginning on or before December 31, 2021, a plan will not fail to be a high deductible health plan (and a participant will not be disqualified from contributing to an HSA) by reason of failing to charge a deductible for "telehealth and other remote care services."

Section 3702 – Inclusion of Certain Over-the-Counter Medical Productions as Qualified Medical Expenses

OTC Drug Reimbursement Expansion. Since the 2010 enactment of the Affordable Care Act, individuals have been prohibited from using HSAs, flexible spending accounts, health reimbursement accounts, and Archer medical savings accounts to purchase most over-the-counter medicines. Under the CARES act, over-the-counter medications and menstrual products are deemed "qualified medical expenses." As such, individuals may use pre-tax dollars in the aforementioned accounts to purchase over-the-counter medicines and menstrual products. This provision applies to expenses incurred after December 31, 2019.
