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Departments of Labor, Health and Human Services, and the Treasury Issue FAQ guidance on the FFCRA, the CARES Act, and other health coverage issues related to COVID-19

Article By:

Peter H. Struzzi

On April 11, 2020 the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) issued guidance in the form of frequently asked questions (the "FAQs") regarding the Families First Coronavirus Response Act (the FFCRA), the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), and other health coverage issues related to COVID-19. The guidance states that the FAQs "answer questions from stakeholders to help individuals understand the law and benefit from it, as intended." Certain guidance offered by the FAQs is summarized below; however, these are non-inclusive and stakeholders would be well advised to review the updated FAQs document in full.

Provisions of the FFCRA and CARES Act

Section 6001 of the FFCRA requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19. Section 3201 of the CARES Act amends the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover. According to the FAQs (summarized):

- Q1: The FFCRA, as amended by section 3201 of the CARES Act, applies to group health plans and health insurance issuers offering group or individual health insurance coverage.
- Q2: Plans and issuers are required to comply with section 6001 of the FFCRA as of March 18, 2020. Plans and issuers must provide coverage for the items and services described in section 6001(a) of the FFCRA that were furnished on or after March 18, 2020, and must not impose any cost-sharing requirements, prior authorization, or other medical management requirements with respect to those items and services. Plans and issuers must continue to comply with Section 6001 of the FFCRA for applicable items and services furnished during the public health emergency related to COVID-19.
- Q3: Plans and issuers are required to provide coverage for (1) an in vitro diagnostic test for

the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of the test, and (2) items and services furnished during office visits (including 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 to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of an individual for purposes of determining the individual's need for the product.

- Q4: In vitro diagnostic tests include serological tests for COVID-19 used to detect antibodies against the SARS-CoV-2 virus and intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-CoV-2.

- Q5: Plans and issuers must cover items and services furnished to an individual during visits that result in an order for, or administration of, a COVID-19 diagnostic test to the extent the items or services relate to the furnishing or administration of the test or to the evaluation of the individual for purposes of determining the individual's need for the product. For example, if an individual's attending provider determines that other tests (e.g. influenza tests, blood tests, etc.) should be performed during a visit to determine the individual's need 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 for the related tests.

- Q6: Section 6001(a) of the FFCRA provides that plans and issuers shall not impose any cost sharing requirements (including deductibles, copayments, and coinsurance), prior authorization requirements, or other medical management requirements for these items and services.

- Q7: Section 3202(a) of the CARES Act provides that a plan or issuer providing coverage of items and services described in section 6001(a) of the FFCRA shall reimburse the provider of the diagnostic testing (1) at a negotiated rate if the plan or issuer and provider had a negotiated rate in effect prior to the COVID-19 emergency declaration, or (2) if there is no prior negotiated rate, at the cash price for such service as listed by the provider on a public internet website, or the plan or issuer may negotiate a rate with the provider for less than such cash price. Section 3202(b) of the CARES Act requires providers of diagnostic tests for COVID-19 to make public the cash price of a COVID-19 diagnostic test on the provider's public internet website.

- Q8: The items and services described in section 6001(a) of the FFCRA, as amended by section 3201 of the CARES Act, must be covered when furnished in both traditional and non-traditional care settings, including COVID-19 drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing.

- Q9: The Departments will permit plans and issuers to amend the terms of a plan or coverage to add benefits, or reduce or eliminate cost sharing, for the diagnosis and treatment of COVID-19 prior to satisfying notice of modification requirements and without regard to restrictions on mid-year changes to health insurance coverage in group and individual markets:

    - If a plan or issuer makes a material modification to a plan or coverage that would affect the content of the summary of benefits and coverage (SBC) that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the

modification to enrollees not later than 60 days prior to the date on which the modification will become effective. However, the Departments will not take enforcement action against any plan or issuer that makes such modification to provide greater coverage related to the diagnosis and/or treatment of COVID-19, without providing at least 60 days advance notice. Plans and issuers must provide notice of the changes as soon as reasonably possible.

- HHS will not take enforcement action against any health insurance issuer that changes the benefits or cost-sharing structure of its plans mid-year to provide increased coverage for services related to the diagnosis and/or treatment of COVID-19.

- These non-enforcement policies will apply with respect to changes made during the period the COVID-19 emergency declaration is in effect.

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

- Q10: States may impose additional standards or requirements on health insurance issuers with respect to the diagnosis or treatment of COVID-19.

Excepted Benefits

Some provisions of certain federal laws regulating group health plans do not apply to the provision of benefits known as “excepted benefits.” Excepted benefits include (1) an employee assistance program (EAP) that meets certain requirements, including that it does not provide significant benefits in the nature of medical care, and (2) benefits that are generally not health coverage, including on-site medical clinics. The FAQs clarify that an EAP or on-site medical clinic may provide benefits for diagnosis and testing for COVID-19 without affecting their status as “excepted benefits”:

- Q11: An EAP will not be considered to provide benefits that are significant in the nature of medical care solely because it offers benefits for diagnosis and testing for COVID-19 while the COVID-19 emergency declaration is in effect.

- Q12: An employer may offer benefits for diagnosis and testing for COVID-19 at an on?site medical clinic without changing the clinic’s status as an “excepted benefit.” Coverage of on-site medical clinics is an excepted benefit in all circumstances.

Telehealth and Other Remote Care Services

- Q13: The Departments strongly encourage all plans and issuers to promote the use of telehealth and other remote care services, including by notifying consumers of their availability, by ensuring access to a robust suite of telehealth and other remote care services, including mental health and substance use disorder services, and by covering telehealth and other remote care services without cost sharing or other medical management requirements.

- Q14: The Departments will apply the same non-enforcement policies described in Q8 to situations where a plan or issuer adds benefits, or reduces or eliminates cost sharing, for telehealth and other remote care services. These non-enforcement policies will apply with respect to changes made for the period during which the COVID-19 emergency declaration is in effect. Plans and issuers must provide notice of the changes as soon as reasonably practicable. The Departments would 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 benefits related to the diagnosis and/or treatment of COVID-19.

This post was co-authored by Michael Lisitano, legal intern at Robinson+Cole. Michael is not yet admitted to practice law.

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