CARES Act Impacts Employer-Provided Group Health Plans

By Gena Gibson and Eric Robertson
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On March 27, 2020, President Trump signed the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"). The CARES Act contains new requirements for employer-provided group health plans and expands on requirements contained in the Families First Coronavirus Response Act (FFCRA). (Retirement plan changes made by the CARES Act are discussed in a separate article.)

COVID-19 DIAGNOSTIC TESTING COVERAGE

The FFCRA requires insured and self-insured group health plans to provide coverage for SARS-CoV-2 and COVID-19 diagnostic testing without any cost-sharing (e.g., deductibles, copayments, or coinsurance), prior authorization, or other medical management requirements imposed on plan participants and dependents. Also, items and services related to providing such testing or evaluating the individual's need for it, which are provided during a visit with a health care provider (such as an office, telehealth, urgent care, or emergency room visit) that results in an order for or administration of the test, must be covered without cost-sharing. The coverage requirement is effective from March 18, 2020, which was FFCRA's enactment date, throughout the duration of the declared COVID-19 public health emergency. The CARES Act expands the FFCRA coverage requirement by adding categories of diagnostic testing beyond what has been FDA-approved, such as certain state-authorized testing.

The CARES Act also requires group health plans to reimburse health care providers for COVID-19 diagnostic testing at either: (1) the negotiated rate in effect before the COVID-19 public health emergency was declared, or (2) if no negotiated rate is in place with that provider, the cash price of the service, as listed by the provider on a public website (although plans are permitted to negotiate a lower rate than the publicly-listed cash price).

Note that prior to the FFCRA's enactment, the IRS issued guidance permitting high deductible health plans (HDHPs) to not apply a deductible (or to apply a deductible below the minimum deductible for an HDHP) with respect to medical care services and items related to testing for and treatment of COVID-19. Such a change does not jeopardize the plan's status as an HDHP and allows HDHP participants to remain eligible to make or receive tax-favored contributions to a health savings account (HSA). This is especially helpful guidance in light of the mandatory FFCRA and CARES Act provisions described above.

Summary plan descriptions likely will require revision for FFCRA and CARES Act changes, and plan documents also should be reviewed to determine if an amendment is needed.

COVID-19 PREVENTIVE SERVICES AND VACCINE COVERAGE

The CARES Act requires non-grandfathered group health plans to provide coverage, without cost-sharing, for any qualifying COVID-19 preventive service, including vaccines, within 15 business days after recommendation by the U.S. Preventive Services Task Force or the CDC's Advisory Committee on Immunization Practices. This significantly accelerates the deadline that normally applies under the Affordable Care Act for non-grandfathered plans to cover a newly recommended preventive service. There is no end date specified for this CARES Act requirement, unlike for COVID-19 diagnostic testing coverage.

HDHPS AND TELEHEALTH AND REMOTE CARE SERVICES

The CARES Act permits HDHPs to waive deductibles for telehealth and other remote care services without jeopardizing their HDHP status or participants' ability to make or receive HSA contributions. This exemption is only available for plan years beginning on or before December 31, 2021, and is effective beginning March 27, 2020 (the CARES Act's enactment date). Note that this exemption is not limited to COVID-19-related services.

HSA, HEALTH FSA, HRA, AND ARCHER MSA REIMBURSEMENT OF OVER-THE-COUNTER DRUGS AND CERTAIN MENSTRUAL CARE PRODUCTS

Prior to the CARES Act, account-based plans such as health FSAs, HRAs, and HSAs could only reimburse the costs of an over-the-counter drug if the drug was prescribed. The CARES Act removes the prescription requirement for over-the-counter drugs. The CARES Act also adds menstrual care products as a new category of reimbursable expenses. These changes apply to expenses incurred after December 31, 2019. Plan sponsors should review their plan documents and summary plan descriptions, as revision will likely be necessary to include these categories of reimbursable expenses. Administrative procedures should reflect any changes made to the plan.

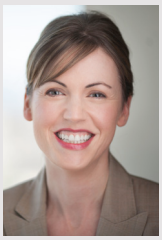
DELAY OF CERTAIN DEADLINES

The IRS has delayed certain deadlines because of the coronavirus. For example, it extended the April 15 deadline for making 2019 contributions to HSAs and Archer MSAs. Contributions for the 2019 year can now be made at any time up to July 15, 2020. The CARES Act also expands the DOL's authority to postpone certain ERISA deadlines.

Please contact a member of the Employee Benefits Team if you have questions about how the CARES Act or other COVID-19-related legislation may impact your benefit plans.

For more information about ongoing developments related to COVID-19, visit Miller Nash Graham & Dunn's resource library.

Disclaimer: This article is not legal advice. It is provided solely for informational and educational purposes and does not fully address the complexity of the issues or steps business must take under applicable laws.



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