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Client Alert Applies To: **Self-Funded, Fully-Funded, Small Group, and Large Group**

April 2nd, 2020

Coronavirus Aid, Relief, and Economic Security Act (CARES Act) Impact on Group Health Plans

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was enacted. The CARES Act is 880 pages long and contains many different provisions. This alert focuses on the provisions specifically related to group health plans.

COVID-19 Testing

Under the Family First Coronavirus Relief Act (FFCRA), FDA-approved COVID-19 testing and related in-network provider and/or facility visits related to obtaining the COVID-19 test must be covered 100 percent by the health plan regardless of the plan's current deductible, co-payments, or coinsurance cost sharing provisions. The CARES Act expands this first-dollar coverage requirement in two ways.

- **COVID-19 Tests:** First-dollar coverage must also include other forms of non-FDA approved COVID-19 tests that the Secretary of the Department of Health and Human Services determines in future guidance.
- **Contracted and Non-Contracted Providers:** Group health plans must reimburse contracted providers and/or facilities for COVID-19 related visits and tests at the rate negotiated prior to the declaration of a health emergency [1]. If the group health plan does not have a negotiated rate with the provider or facility, the plan is required to reimburse the provider/facility at the provider's cash price or may negotiate a lower price. Out-of-network member cost sharing plan provisions will not apply to COVID-19 related provider/facility diagnosis and testing. The CARES Act requires health care providers offering COVID-19 testing to post their cash prices online.

Preventive Services

This provision accelerates the deadline that would otherwise apply under the Affordable Care Act's preventive care mandates.

- If preventive services or vaccines for COVID-19 are recommended by the US Preventive Services Task Force (as an "A" or "B" recommendation) or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, these preventive services or vaccines must be made available at no out-of-pocket cost to participants beginning 15 business days after the recommendation is issued.

Telehealth Services – Health Savings Account Eligibility

In order for a plan participant to be eligible to make or receive contributions to a health savings account (HSA), the participant must be covered by a qualified high deductible health plan (QHDHP) and meet all other HSA eligibility provisions, including no other first-dollar coverage(s). A QHDHP permits only preventive services on a first-dollar basis; all other services under a QHDHP are subject to the plan's deductible.

In Notice 2020-15 [2], the IRS granted a special exception to this rule, allowing first-dollar coverage of the COVID-19 diagnostic testing and the related provider or facility visit as required under FFCRA.

In addition, the CARES Act permits the plan sponsor (for a self-insured plan) or the insurer (for a fully-insured plan) to provide first-dollar coverage for all telehealth or remote care services for plan years beginning on or before December 31, 2021 [3]. Calendar year QHDHPs can allow waiver or reduction of the deductible for telehealth services for the 2020 and/or 2021 plan year without participants losing HSA eligibility status.

Qualified Medical Expenses (OTC)

Under the Affordable Care Act, flexible spending accounts (FSAs), health reimbursement accounts (HRAs), Archer Medical Savings Accounts (Archer MSAs) and health savings accounts (HSAs) could reimburse only prescribed drugs or products. The cost for over the counter (OTC) medical products and drugs (other than insulin) could not be reimbursed by the above accounts. The CARES Act amends the definition of "qualified medical expense" to include OTC medications and products, and expenses for these products incurred on or after January 1, 2020 can now be reimbursed by the above accounts. [4]

In addition, menstrual care products are now deemed qualified medical expenses that can be reimbursed by FSA, HRA, or HSA accounts. Menstrual care products are defined as a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation.

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[1] The Secretary of Health and Human Services (HHS) declared a public health emergency on January 31, 2020, under section 319 of the Public Health Service Act (42 U.S.C. 247d), in response to COVID-19

[2] https://www.irs.gov/pub/irs-drop/n-20-15.pdf

[3] Review and approval may be required by stop loss reinsurance carrier along with a plan document amendment

[4] Although permissible, FSA and HRA plans my require employer adoption and a plan document amendment may be required

Please visit www.moreton.com/news-events/ for more information and to view other client alerts. This Client Alert was written by Carolyn Cox, Moreton & Company's in-house corporate counsel who provides our clients with compliance services. For additional questions, please contact Carolyn at 801-715-7110 or ccox@moreton.com.