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

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Recent Guidance on COVID-19-Related Group Health Plan Issues

The DOL, IRS, and HHS have issued FAQ guidance (https://www.dol.gov/sites/dol-gov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf) addressing implementation of certain portions of the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that affect group health plans. As background, the FFCRA generally requires group health plans and insurers to cover (without cost-sharing) certain items and services related to diagnostic testing for COVID-19. The CARES Act requires coverage of a broader range of diagnostic items and services and generally requires plans and insurers to reimburse any provider of diagnostic tests the cash price listed by the provider on a public website or a lower negotiated rate. Here are highlights from the agency FAQs:

- **Mandated Coverage of Diagnostic Tests:** Plans and insurers must cover most COVID-19 diagnostic tests (which for these purposes includes both in vitro diagnostic tests and blood or serological tests for antibodies) whether such tests have been approved by the FDA or not.
- **Mandated Coverage of Office Visits and Other Services:** Coverage is also mandated for items and services furnished during health care provider office visits (including in-person, drive-through and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of a diagnostic test, to the extent the items and services relate to the administration of the test or the evaluation of the individual and their need for the test. For example, if the provider administers influenza tests or blood tests to determine if a COVID-19 test is needed and the visit results in administration of a COVID-19 test, the plan must cover the related tests as well. Plans and insurers are required to provide coverage for items and services furnished by in-network as well as out-of-network providers.
- **Coverage of EAP and On-Site Clinic Benefits:** Both EAPs and employer on-site clinics can cover COVID-19 diagnostic tests without losing their status as excepted benefits.
- **Nonenforcement Policy for SBC and Plan Modifications:** It is possible that these additional benefits will not require a plan or SBC (Summary of Benefits and Coverage) amendment. However, agencies will not take enforcement action because any required modifications are made without the minimum 60-day advance notice generally required. Without the advance notice requirement, ERISA plan sponsors are generally required to provide notice of the changes within seven months after the close of the plan year, but by then the mandates will have lapsed.
- **Coverage of Telehealth and Other Remote Care Services:** The temporary safe harbor allowing high-deductible health plans (HDHPs) to cover telehealth and other remote care services without a deductible for plan years beginning on or before December 31, 2021 applies generally to HDHP coverage for telehealth and is not limited to coverage for COVID-19 related services.

The FFCRA's mandates applied immediately to most insurers and group health plans (including insured, self-insured, and grandfathered group health plans, excepted benefits, and retiree plans). The clarifications on diagnostic tests answer a lingering question on the scope of the testing mandate—apparently if the provider doesn't order or administer a COVID-19 diagnostic test, then no part of the visit will be subject to the FFCRA, and the plan's regular cost-sharing rules can apply to the visit.

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.