

Required Health Plan Changes to Address COVID-19 Legislation

The past several weeks have seen several waves of federal COVID-19 legislation and regulatory guidance on numerous issues affecting employers. Several aspects of this legislation and guidance have a direct impact on benefit plans offered by employers (including retirement plans, health plans, flexible benefits plans, etc.). Ice Miller LLP is working with clients to help them navigate the new developments and challenges that each day brings with respect to responding to the Coronavirus, including to ensure they understand the new laws that affect their employee benefit plans.

The recently-enacted federal COVID-19 legislation includes the following provisions that are pertinent to each employer's health plans and health care FSAs under any Flexible Benefits Plan, which will require plan amendments, SPD amendments, communications to employees, discussions with stop-loss carriers, and changes to SBCs:

1. The legislation **requires** most group health plans to provide coverage—**without any cost sharing, prior authorization, or other medical management requirements**—for certain products and services related to testing for COVID-19 when medically appropriate for the covered person as determined by his or her attending health care provider in accordance with accepted standards of current medical practice:
 - a. In vitro diagnostic tests (including serological tests) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such in vitro diagnostic tests: (i) that are FDA-approved or authorized; or (ii) for which the developer has requested, or intends to request, emergency use authorization under the Federal Food, Drug, and Cosmetic Act; or (iii) that are developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID-19; or (iv) that the Secretary of HHS otherwise has approved in guidance; **AND**
 - b. Items and services furnished during a visit to a provider's office (including via telehealth), urgent care, or an emergency room that results in an order for or administration of an in vitro diagnostic product described above, but only to the extent the item or service relates to: (i) the furnishing or administration of the diagnostic product, or (ii) the evaluation of the individual to determine need for the diagnostic product. A "visit" includes both traditional and non-traditional care settings in which a COVID-19 diagnostic test is ordered or administered, including drive-through screening and testing sites where licensed healthcare providers are administering COVID-10 tests. This mandate does **not** require COVID-19 **treatment** without cost-sharing.

The coverage requirement applied beginning March 18, 2020, and encompasses testing products and services that are furnished during any portion of the COVID-19 public health emergency.

2. In addition, the CARES Act directs the federal agencies to **require** group health plans (other than plans providing **excepted benefits or retiree-only plans**) to cover any "qualifying coronavirus preventive service" without cost-sharing (including deductibles, co-payments, coinsurance, and out-of-pocket maximums) from in-network providers. The coverage requirement applies **15 business days after the date on which a preventive coverage recommendation is made**. This is much quicker than is required for preventive care services under the Affordable Care Act.

3. The CARES Act provides a **temporary safe harbor** for high deductible health plans ("HDHPs") to cover "telehealth and other remote care services" without a deductible. The relief extends through plan years that begin on or before December 31, 2021. **Telehealth visits do not have to be connected with COVID-19 to be eligible for this relief.**

4. The CARES Act also expands the types of medical care individuals may purchase with funds from **HSAs and health care FSAs** to include (a) menstrual care products, and (b) over-the-counter medicines and drugs (even if they are not prescribed). The CARES Act does not contain an expiration date for this change, so it appears to be permanent. The CARES Act does not make clear whether an employer can amend its cafeteria plan to allow health care FSAs to reimburse medicines or drugs without a prescription and/or menstrual care products that were incurred between January 1, 2020 and the date of the cafeteria plan amendment. However, under the cafeteria plan rules, amendments generally can only be made prospectively, not retroactively. This creates uncertainty.

Employers need to consider what plan amendments, SPD amendments, revisions to SBCs, notification to stop loss carriers, and employee communications are needed to address the COVID-19 legislation.

For additional information, please contact Melissa Proffitt (melissa.proffitt@icemiller.com or 317-236-2470) or the Ice Miller Employee Benefits attorney with whom you work.

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