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CARES Act Prompts Changes to Employer-Sponsored Health Plans

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The Coronavirus Aid, Relief, and Economic Security (CARES) Act, which was signed into law on March 27, 2020, contains several provisions—some mandatory and some optional—that affect employer-sponsored group health plans.

COVID-19 Testing

First, the CARES Act expanded certain provisions of the Families First Coronavirus Response Act (FFCRA), which was enacted and became effective on March 18, 2020. The FFCRA requires group health plans to cover products and services used in the testing and diagnosis of COVID-19 on a first-dollar basis, without any cost-sharing or medical management requirements, such as preauthorization. Retiree-only plans, plans providing only excepted benefits (e.g., limited-scope dental and vision plans), and certain other plans are exempt from the FFCRA's COVID-testing mandate.

Building on the FFCRA requirements, the CARES Act expanded the types of COVID-19 tests that must be covered to include:

- products approved by the U.S. Food and Drug Administration (FDA);
- products for which the developer has requested or intends to request an emergency use authorization by the FDA;
- products developed in and authorized by a state that has notified the U.S. Department of Health and Human Services (HHS) of its intention to review COVID-19 tests; and
- products that HHS approves through published guidance.

The CARES Act also governs the amount that plans must cover for COVID-19 testing. First, healthcare providers are required to publish their "cash price" for COVID-19 tests on a public website. Plans may reimburse in-network providers for COVID-19 tests at previously negotiated rates. For out-of-network providers, plans must either reimburse the published "cash price" for the test, or negotiate a lower price.

These CARES Act provisions immediately modify the FFCRA COVID-19-testing provisions, which took effect March 18, 2020.

Note also that the Internal Revenue Service (IRS) recently, in Notice 2020-15, permitted high-deductible health plans (HDHPs) to cover both COVID-19 testing and treatment on a first-dollar basis without making participants ineligible to make health savings account (HSA) contributions.

Preventive Health Services

The CARES Act makes preventive care related to COVID-19 part of the Affordable Care Act (ACA) preventive care coverage mandate. Group health plans must cover COVID-19 preventive care (such as vaccines) on a first-dollar basis

without any cost sharing. Although there currently is no preventive care related to COVID-19, this requirement will become effective within 15 business days after a service receives an "A" or "B" rating by the U.S. Preventive Services Task Force or a recommendation by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention. Under the general ACA preventive care rules, all other preventive services have a lead-time of one year between approval and requirements to cover.

This requirement does not apply to retiree-only or excepted benefit plans.

Over-the-Counter Medicines and Menstrual Care Products

The CARES Act removed a restriction put in place by the ACA on account-based plans, including health flexible spending accounts (FSAs), HSAs, and health reimbursement arrangements (HRAs), reimbursing the costs of over-the-counter (OTC) medicines without a prescription. While this CARES Act provision is effective for amounts reimbursed or expenses incurred after December 31, 2019, most FSAs and HRAs will need to be amended to allow for reimbursement of OTC medicines before this coverage may be offered.

The CARES Act also added menstrual care products to the Internal Revenue Code definition of "medical care" that applies to account-based plans, meaning that HSAs, FSAs, and HRAs can reimburse participants for these costs. This change applies to expenses incurred after December 31, 2019.

HDHP Pre-Deductible Coverage of Telehealth

The CARES Act permits, but does not require, HDHPs to waive cost-sharing or provide coverage prior to satisfaction of the deductible for general telehealth services without affecting participants' eligibility to make or receive HSA contributions. This provision became effective on March 27, 2020, and applies to plan years beginning on or before December 31, 2021.

This provision is a temporary safe harbor, intended to allow individuals to receive medical care without going to crowded hospitals, clinics, or medical practices during the COVID-19 pandemic.
