CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT

("*CARES*" ACT)

(enacted March 28, 2020)

The *Coronavirus Aid, Relief, and Economic Security Act* – or CARES Act – became law on March 28, 2020. While the majority of the Act's 335 pages deals with economic relief for American businesses, financial assistance for workers, and bolstering our health care system in light of the COVID-19 pandemic (including Medicare and Medicaid), several provisions affect self-funded group health plans and health insurance policies offering both individual and group health coverage (including grandfathered plans). Most of the Act's health plan-related provisions clarify earlier requirements set forth in the *Families First Coronavirus Response Act* ("FFCRA") and therefore bear the same effective dates. In addition, the CARES Act includes expanded coverage for telehealth, COVID-19 vaccines, and over-the-counter medications.

Expanded Coverage of COVID-19 Testing

The FFCRA mandates health plans to cover COVID-19 testing for FDA-approved tests. The CARES Act expands that mandate to include coverage of *non*-FDA approved tests. Specifically, it expands the coverage mandate to include tests that are:

- approved, cleared, or authorized by the FDA.
- from a developer that has requested or intends to request emergency use authorization under applicable FDA guidance.
- developed in and authorized by a state that has notified the Secretary of Health and Human Services ("HHS") of its intention to review tests intended to diagnose COVID-19; or
- determined by HHS to be appropriate in guidance.

MedBen recommends that all group health plan sponsors amend their plans to include coverage of COVID-19 testing and any related visit charges as described above from March 18, 2020 through December 31, 2020.

Costs of COVID-19 Testing

While the FFCRA described how cost sharing for COVID-19 testing must be waived for individuals covered under a health plan, the CARES Act establishes how health care providers can charge for such COVID-19 diagnostics tests. In cases where the plan had a negotiated rate for such testing and related services prior to the date of the COVID-19 public health emergency, that negotiated rate will apply to COVID-19 tests throughout the current public health emergency.

However, if there was no prior negotiated rate for COVID-19 testing and related services, the plan must pay the amount the health care provider has listed on the provider's publicly available website. The CARES Act also requires that each provider of a diagnostic test for COVID–19 make public the cash price for such test on a public internet website.

MedBen recommends that all group health plan sponsors amend their plans to include coverage of COVID-19 testing and any visit charges for same as described above from March 18, 2020 through December 31, 2020. MedBen will process claims in accordance with the published public price for such tests.

Coverage for COVID-19 Vaccine

The CARES Act includes provisions intended to expedite coverage of a COVID-19 vaccine under health plans when it has been developed. Once available, health plans must cover any qualifying coronavirus preventive service – including a vaccine – without member cost-sharing.

Under the framework requiring coverage for preventive services established in the Affordable Care Act, preventive services include evidence-based services that have a rating of "A" or "B" under current U.S. Preventive Services Task Force (USPSTF) recommendations, as well as vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Health plans usually have one year from the date a preventive service is identified as having an "A" or "B" USPSTF rating or recommendation by the ACIP to cover the preventive service under the plan. However, under the CARES Act, health plans are required to cover any item, service, or immunization to prevent or mitigate COVID-19 that has received an appropriate recommendation within 15 days after such a recommendation from either the USPSTF or ACIP.

MedBen recommends that all group health plan sponsors amend their plans to cover coronavirus vaccines at 100% in-network and as the plan otherwise covers ACA preventive services as soon as such vaccines become available.

High Deductible Health Plans and Telehealth

A qualified high deductible health plan (HDHP) with an associated Health Savings Account (HSA) is only permitted to pay benefits after the plan deductible has been met, with the exception of preventive services, in order for plan participants to still qualify for contributions to their HSAs. In response to the COVID-19 pandemic, the IRS issued Notice 2020-15 to address the payment of COVID-19 testing under qualified High Deductible Health Plans. In the Notice, the IRS confirms that a High Deductible Health Plan with a Health Savings Account will not lose its "qualified" status if it pays for COVID-19 related testing or treatment without a deductible, or with a deductible below the minimum required deductible.

In addition to the IRS Notice, the CARES Act permits HDHPs with plan years beginning on or before December 31, 2021 to provide pre-deductible coverage for telehealth and other remote care services without disqualifying the associated health savings accounts. This is not a coverage mandate for HDHPs, but rather an option for plan sponsors. HDHPs do not have to implement this option and can require some form of cost-sharing – such as telehealth visit copayments – prior the deductible being met.

MedBen recommends that all high deductible health plan sponsors consider amending their plans to allow telehealth services to be covered at same level of coverage (coverage tier) and at the same cost-sharing as other in-person office visits as described in the plan.

Telehealth in General

While not a mandate under the Families First Coronavirus Response Act or the Cares Act, telehealth may be an important benefit for employees during the COVID-19 public health emergency. Given the current 'stay-at-home' and 'social distancing' environment, many patients and their providers are asking to conduct their visits over the telephone or via teleconference, if possible.

Telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by an eligible health care provider. Services can include diagnostic evaluation and the prescribing of medication. Due to the Coronavirus (COVID-19) doctors and other health care providers can use telehealth services to treat COVID-19 (and for other medically reasonable purposes) from offices, hospitals, and places of residence (like homes, nursing homes, and assisted living facilities).

MedBen recommends that all group health plan sponsors consider amending their plans to allow telehealth services to be covered at same level of coverage (coverage tier) and at the same cost-sharing as other in-person office visits until the current public health emergency is over.

Consumer Driven Health Plan Funds for Non-Prescription Purchases

Effective retroactively to January 1, 2020, the CARES Act permanently reinstates coverage of OTC (Over the Counter) drugs and medicines as eligible for reimbursement from flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), health savings accounts (HSAs), and Archer medical savings accounts (MSAs) without the need for a prescription. It further expands the definition of qualified OTC items to include menstrual care products.

MedBen recommends that all sponsors of consumer-driven health plans consider allowing plan reimbursement for over-the-counter drugs and medicines without a prescription if the plan currently reimburses prescription drugs and medicines.