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CARES Act - New Group Health Plan Rules and Relief

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The Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which was signed by the President on March 27, 2020, includes several provisions affecting group health plans, as discussed below.

Health Plan Rules and Relief

Coverage for In-Network and Out-of-Network Coronavirus Testing

As discussed in our previous article addressing the Families First Coronavirus Response Act ("FFCRA"), FFCRA requires group health plans to cover coronavirus testing without any cost-sharing (i.e., deductibles, copayments, or coinsurance) imposed on the plan member during the declared public health emergency. The CARES Act clarifies that this applies to services conducted by both in-network and out-of-network health care providers.

- *Reimbursement Calculation for Out-of-Network Coverage*. Since there is no pre-negotiated rate with out-of-network providers, the CARES Act provides a special calculation for determining the rate paid to out-of-network providers for coronavirus testing. Each provider is required to make public the "cash price" for such testing on a publicly-available website. Health plans are required to reimburse out-of-network providers at this cash price, or negotiate a rate for less than cash price.

Expediting Coronavirus Vaccines (Once Available) as a Permanent Cost-Free Preventive Service

The CARES Act expedites the process by which coronavirus vaccines (once available) will be determined a preventive service that must be covered by non-grandfathered health plans at no cost to the plan member, pursuant to the Affordable Care Act (ACA). Unlike FFCRA's coverage mandate—which is temporary mandate to cover testing with no cost-sharing during the public emergency—this would be a permanent coverage mandate. To be determined a "preventive service," ACA requires the vaccine to achieve a certain recommendation from a specified governmental health-related committee or task force, and then the coverage requirement is triggered upon the first plan year beginning one year from the date of the recommendation. The CARES Act would fast-track this

requirement and require coverage, with no cost-sharing, within 15 days of the date of their recommendation.

Temporary Relief for Telehealth and High Deductible Health Plans

The CARES Act provides a temporary safe harbor to high deductible health plans (HDHPs) compatible with health savings accounts (HSAs). Under the Act, a HDHP will not lose HDHP qualified status if it offers cost-free telehealth services to plan members before the annual deductible is satisfied. In other words, HDHPs can offer plan members access to telehealth services with no cost-sharing to the member, regardless of whether the deductible is met, and such members will remain eligible to make and receive contributions to an HSA. This offers significant relief to plan sponsors who want to offer first-dollar, pre-deductible telehealth coverage while still desiring to preserve HDHP qualified status. This is only temporary relief, and this safe harbor only applies for plan years beginning before January 1, 2022.

Over-the-Counter Drug Reimbursements from HSAs, FSAs, and HRAs

Eliminating an ACA prohibition, HSAs, health flexible spending accounts (“FSAs”), and health reimbursement arrangements (HRAs) can once again reimburse the costs of over-the-counter drugs with no prescription. This provision is effective for expenses incurred and amounts paid after December 31, 2019.

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