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GRIST

Employer health plans have to meet new COVID-19 coverage mandate

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COVID-19 relief legislation requires employer-sponsored group health plans to cover certain testing and related items without cost sharing. Agency guidance has elaborated on these requirements and created new flexibilities to encourage COVID-19 diagnosis and treatment. Plans can expand access to healthcare through telehealth and other remote mechanisms that minimize opportunities for virus transmission. This GRIST discusses these federal health coverage requirements and flexibilities, implementation issues, and open questions. Additional guidance is expected as the pandemic continues to fundamentally affect the US healthcare system and economy.

New COVID-19 health coverage mandates

The COVID-19 pandemic has ushered in temporary but unprecedented regulatory changes that impact health coverage nationwide. The Families First Coronavirus Response Act (FFCRA) (Pub. L. No. 116-127) requires coverage of COVID testing across all parts of the health system, including employer-sponsored plans. The Coronavirus Aid, Relief and Economic Security (CARES) Act (Pub. L. No. 116-136) expands the FFCRA's COVID-19 diagnostic coverage requirements to add reimbursement standards and mandate coverage of preventive care like vaccines, once available. The departments of Labor (DOL), Health and Human Services (HHS), and Treasury have issued FAQs (Part 42) to implement these health coverage provisions for group health plans and issuers.

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No cost sharing for COVID-19 testing and related services

Effective March 18, all group health plans — whether self-insured, fully insured, grandfathered or nongrandfathered — must cover COVID-19 testing and related services without cost sharing. This coverage mandate applies for the duration of the public health emergency, currently slated to last through July 24, unless ended earlier or extended by the HHS secretary.

The mandate includes state and local government plans and church plans. It also applies to individual coverage purchased on or off the public health insurance exchanges; student health insurance; and "grandmothered" health plans — transitional plans that have until 2021 to meet certain Affordable Care Act (ACA) standards — in the individual and small-group markets. However, the mandate does not apply to excepted benefits; retiree-only plans; or short-term, limited-duration coverage.

Plans and issuers subject to the law must provide coverage meeting the following standards:

- COVID-19 testing with no cost sharing. Plans must cover not only in vitro diagnostic tests approved by the Food and Drug Administration (FDA) to detect SARS-CoV-2 or diagnose COVID-19, but also other COVID-19 tests awaiting FDA emergency use authorization, developed in and authorized by a state that has notified HHS, or determined appropriate under HHS guidance. The mandate includes "serological tests" to detect antibodies against the virus. The cost-sharing ban means that plans can't charge a deductible, copayment or coinsurance for these tests. The ban does not prohibit balance billing for the test and related items or services or cost sharing for nontesting-related items and services.

- COVID-19 testing-related items and services with no cost sharing. The FFRCA also bans cost sharing for items and services provided during a visit that results in an order for or administration of a COVID-19 test. For the cost-sharing ban to apply, the item or service must relate to the "furnishing or administration" of the test or the "evaluation" of an individual's need for the test. While this statutory language leaves some room for interpretation, the FAQs indicate that an individual's attending provider (not the plan) should determine the need for COVID-19 testing. The guidance also says that if an attending provider orders other tests (such as a blood test or an influenza test) to determine the need for COVID-19 testing, the plan must cover these additional tests free of cost sharing if a COVID-19 test is ultimately ordered.

- Visit in any settings. The FFRCA requires coverage of COVID-19 testing-related items and services provided during any type of provider visit, whether in a doctor's office, a telehealth session, an urgent care center or an emergency room. The FAQs add that required coverage includes visits in traditional settings or nontraditional settings, such as drive-thru screening and testing sites.

- No prior authorization or medical management. Plans cannot impose prior-authorization or medical-management requirements for COVID-19 testing or related services. Plans must cover related services

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when medically appropriate, as determined by an individual's attending provider following accepted standards of current medical practice. The FAQs define the attending provider as an individual who is licensed under applicable state law, acting within the scope of the provider's license and directly responsible for providing care to the patient.

- Both in- and out-of-network coverage. The FFCRA's COVID-19 testing mandate is not limited to in-network coverage. The FAQs confirm that plans must provide no-cost coverage for testing-related items and services from out-of-network providers.

Reimbursement requirements for covered benefits

The FAQs discuss reimbursement for the diagnostic test provider, but do not distinguish between the provider of the test and the provider of related items and services. If a plan had a negotiated rate with a diagnostic test provider in effect before the public health emergency, the provider must receive that rate throughout the emergency. If a plan has no prenegotiated rate with the test provider (referred to as an out-of-network provider in the FAQs), the plan must reimburse the "cash price for such service" listed on the provider's public website or negotiate a lesser price. The CARES Act requires all testing providers to post the cash price for a COVID-19 diagnostic test or risk a civil penalty of up to $300 per day. No similar provision requires posting the cash price for related items and services.

Coverage of COVID-19 treatment not federally mandated

Federal law does not mandate that large employer-sponsored plans cover COVID-19 treatment. While the virus does not have a specific treatment, the current care regimens are considered essential health benefits (EHBs) that individual and small-group insurance plans must cover under ACA rules. Recent FAQs from the Centers for Medicare & Medicaid Services (CMS) confirm that EHBs include coverage for COVID-19 diagnosis and treatment, although coverage details and cost sharing may vary by plan.

The EHB rules don't apply to large group health plans, although most plans do cover the types of care — like hospitalization — that COVID-19 patients receive. Some states have issued their own directives for insured group health plans that extend the federal cost-sharing ban for COVID-19 testing to include coverage of treatment without cost sharing. In addition, many insurers are voluntarily offering to cover COVID-19 care without cost sharing under their plans for insured and self-insured employers. While these changes automatically apply to insured group health plans, self-insured plan sponsors will need to decide whether to adopt no-cost COVID treatment provisions.

Expedited coverage of COVID-19 preventive care when available

The CARES Act requires group health plans and issuers to cover a COVID-19 vaccine or other preventive service — once available — without cost sharing in a more expedited timeframe than normally required for coverage of new ACA preventive care items. Under the ACA, nongrandfathered group health plans

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must extend cost-free coverage for new preventive services by the plan year that begins one year after the last day of the month in which the US Preventive Services Task Force (USPSTF) makes the recommendation. Once COVID-19 preventive care is available, plans will need to cover it without cost sharing within 15 days of the recommendation from the USPSTF or the Centers for Disease Control and Prevention (CDC). The ACA's preventive care rules only apply to nongrandfathered plans, and the language in the CARES Act suggests only those plans will have to provide cost-free coverage of COVID-19 preventive services.

New coverage flexibilities to address access to care

Federal regulators have provided new flexibilities to help expand access to healthcare and coverage. Some of these changes are temporary, while others are permanent clarifications of existing law.

Telehealth and health savings accounts (HSAs)

The CARES Act provides a temporary safe harbor allowing high-deductible health plans (HDHPs) to cover telehealth and other remote care services before participants have met their deductibles. The act also provides that having telehealth coverage outside of an HDHP will not make an individual ineligible for HSA contributions. This expansion of permissible telehealth for individuals with HDHPs and HSAs applies to all types of care, not just COVID-19 care. These changes took effect March 27, 2020, but only apply for plan years beginning on or before Dec. 31, 2021. So for calendar-year arrangements, the temporary changes expire Dec. 31, 2021.

Notice 2020-15. The CARES Act's telehealth provisions differ from other COVID-19 relief for HDHPs under IRS Notice 2020-15. The notice allows HDHPs to cover COVID-19 testing and treatment before individuals have met their deductibles, without affecting eligibility for HSA contributions. Unlike the CARES Act's telehealth provisions, the relief under Notice 2020-15 does not have an expiration date. Although the notice states that it is meant to facilitate the response to COVID-19, the relief remains in effect until further guidance is issued.

In sum, predeductible telehealth coverage of COVID-19 testing and treatment is permissible for HDHP participants until further notice. In contrast, other predeductible telehealth coverage is only permissible for HDHPs through 2021 (or plan year-end in 2022 for noncalendar-year plans).

Testing through employee assistance programs (EAPs) and on-site medical clinics

Many employers want to ensure that their employees can access COVID testing and treatment, even if they are not covered by the group health plan. The FAQs confirm that EAPs and on-site medical clinics can provide COVID-19 diagnosis and testing without losing excepted-benefit status.

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This confirmation relieves concerns that providing COVID-19 testing and diagnostic services to employees not enrolled or eligible for health coverage could cause an EAP or an on-site medical clinic to become subject to the full scope of ERISA and the ACA rules. However, when limited coverage is considered an excepted benefit, employers face fewer compliance obligations. This could open up access to COVID-19 testing and/or care for all employees, whether covered by the group health plan or not.

The FAQs discuss two opportunities to provide COVID-19 services as an excepted benefit:

- Temporary coverage through an excepted-benefit EAP. Under current regulations, EAPs are excepted benefits if they do not provide "significant benefits in the nature of medical care" and meet certain other criteria. The FAQs say that during the public health and national emergency, employers can provide COVID-19 diagnostic and testing services through an excepted-benefit EAP. While the agencies won't consider those services to be "significant" medical care, actual treatment for COVID-19 symptoms may go beyond the permitted scope of an excepted-benefit EAP.

- Permanent coverage through an excepted-benefit on-site medical clinic. The FAQs confirm that under current law, employer-sponsored on-site medical clinics are excepted benefits in all circumstances. Care at the clinic does not have to be limited to something less than "significant" or satisfy other criteria required for excepted-benefit EAPs. Employers can provide COVID-19 testing and even treatment through an on-site clinic to all employees — regardless of health plan enrollment — without the clinic having to meet all of the ERISA or ACA rules for group health plans. This is welcome guidance that is relevant beyond the public health emergency.

Employer implementation issues

Employers sponsoring health plans must implement these coverage changes, while making other difficult decisions due to the pandemic — including decisions on workforce changes (such as furloughs, layoffs or reductions in hours); health coverage continuation for impacted employees; CARES Act relief opportunities; and other issues. Employers implementing the health coverage requirements should review the FAQs and keep a number of key issues in mind.

Benefit changes

Mandated benefits. Plan sponsors will want to make sure their third-party administrators (TPAs) are properly processing claims — dating back to March 18 — to cover COVID-19 testing and related services without cost sharing, as mandated by the relief legislation:

- Coverage without cost sharing. The FAQs provide some parameters as to when plans must provide COVID-19 testing and related items and services without cost sharing, but plan sponsors should confirm how their TPAs make these distinctions. Complications administering this mandate may arise, depending on how a provider codes a visit and how the claim is processed. For example, plans

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can't assess cost sharing for related items and services when a COVID-19 test has been ordered but not actually performed. Some patients may have seen a provider and received an order for COVID-19 test, but didn't get tested due to the limited availability of test kits. In addition, plans may have to provide cost-free related services, such as an influenza or blood test, if a COVID-19 test is ordered, but not if the coronavirus test is never ordered or administered. Yet under current guidance, plans don't have to provide cost-free services when a participant is evaluated and given a presumptive COVID-19 diagnosis based on symptoms, but a test is not ordered.

- Coverage of all visit types. The statutory language and the FAQs together suggest a plan must provide no-cost coverage of COVID-19 testing and related items and services, even if provided in a setting not otherwise covered by the plan. For example, a plan with no coverage for out-of-network office visits must cover them without cost sharing for COVID-19 testing and related services. A plan with no telehealth coverage likewise must cover a telemedicine visit without cost sharing if the visit results in an order for a COVID-19 test. The FAQs state that the agencies broadly interpret "visit" to include traditional healthcare facilities and nontraditional settings, such as temporary drive-thru screening and testing sites.

- Provider reimbursement. Plans' obligation to reimburse the "cash price" for out-of-network diagnostic testing could present some administrative challenges, so sponsors should check how their TPAs are dealing with this issue. While providers must disclose the cash price for the test on a public website, questions remain about when, where and how this is being done; how HHS is overseeing this requirement; or what a plan should do if a participant's test provider hasn't disclosed the cash price. How to reimburse out-of-network test-related "items and services" is also unclear, since only the test's cash price is subject to the public disclosure requirement. Future guidance might address these issues. In the meantime, an HHS condition for providers to qualify for the CARES Act's Provider Relief Fund (which, in part, reimburses testing and treatment costs for uninsured patients) prohibits balance billing any patient for COVID-19 treatment. This balance-billing ban appears to extend to privately insured patients of Provider Relief Fund recipients, but confirmation from HHS would be welcome.

Benefit reduction. The FAQs state that the agencies could take enforcement action against plans and issuers that make midyear changes to limit or eliminate benefits or increase cost sharing for other benefits to offset the expense of covering COVID-19 tests and related services without cost sharing.

Telehealth. The CARES Act's temporary safe harbor and the relief in Notice 2020-15 provide new opportunities for employers sponsoring HDHPs with HSAs to encourage employees' use of telemedicine. Plans may wish to add a separate telehealth benefit and promote its ability to meet many healthcare needs during the pandemic. Nevertheless, employer sponsors should be cautious about making a stand-alone telehealth program available to all employees, regardless of enrollment in the group health plan. A

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robust telehealth program, unlike a limited excepted-benefit EAP, might be subject to all ERISA and ACA requirements.

Excepted benefits. Some employers may consider adding COVID-19 tests, including antibody testing, as a temporary EAP benefit or a permanent offering through an on-site medical clinic. This testing could become part of a return-to-work strategy. Employers will want to partner with or seek advice from clinical experts on which test to offer, particularly since the efficacy of some tests rushed to market may be in question. Alternatively, an excepted-benefit EAP or an on-site clinic could conduct a telehealth evaluation of an employee's symptoms and arrange for COVID-19 testing elsewhere. Employers can decide what services — whether COVID-19 related or not — to provide through an on-site clinic, without jeopardizing its excepted-benefit status. In addition, no federal restrictions appear to prevent on-site clinics from providing telehealth services, including to evaluate an employee for COVID-19 testing or to care for an employee working from home. However, an on-site clinic's telemedicine services could create problems for HDHP participants — for example, if predeductible telehealth coverage continues after the public health emergency and the CARES Act's temporary safe harbor end.

Notice rules

The FFRCA does not include any notice requirements specific to the COVID-19 coverage mandate, but ERISA health plans must comply with existing disclosure rules, including the summary of benefits and coverage (SBC), summary of material modifications (SMM), and summary plan description (SPD).

Enforcement safe harbor for SBCs. Plans usually must provide updated SBCs reflecting any benefit change to prior SBC content no later than 60 days before the change will take effect. This requirement is, of course, impractical during this pandemic, even though communications with employees are key. According to the FAQs, a plan that communicates the mandated COVID-19 coverage terms as soon as possible — via an updated SBC or a separate communication — won't face enforcement action for failing to provide 60 days' advance notice of the change. Plans must comply with normal requirements to update documents or coverage terms if these benefit changes remain in place beyond the emergency period.

This temporary nonenforcement policy also applies to plans voluntarily enhancing benefits, such as to add telehealth and other remote care services or to reduce or eliminate cost sharing for such services. To encourage employees to seek care safely as part of a strategy to fight the virus and return employees to work, plans should consider providing information on telehealth options in the notice about the new coverage for COVID-19 testing and preventive services without cost sharing.

Other document changes. The FAQs do not address SMMs or updated SPDs, which are typically not required until long after a plan has made benefit modifications. Because the COVID-19 coverage mandates — with the exception of preventive care, once available — are temporary, the benefit changes may no longer be in place when the deadline to issue an SMM or updated SPD arrives. In that scenario,

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the notice about the temporary changes might serve as the SMM. Sponsors keeping the mandated benefit changes beyond the public health emergency and/or adding new benefits like telehealth for a longer period will have to distribute SMMs or revised SPDs and update other plan documents or coverage terms. Even some temporary changes might warrant a plan amendment for legal and operational purposes.

Uninsured employees

Many plan sponsors are concerned about employees lacking health coverage and may want to ensure they have access to care beyond just COVID-19 evaluation, testing and perhaps limited treatment available through an EAP or on-site health clinic. Options include the following:

- Midyear enrollment in employer health plan. Cafeteria plan rules limit midyear enrollment of eligible employees unless they experience certain events. However, some health insurance carriers are allowing midyear enrollment of otherwise eligible employees who have not experienced such events. Some employers view the addition of no-cost-sharing coverage of COVID-19 testing and related services or expanded telehealth benefits as a significant improvement in coverage. Under the cafeteria plan rules, a significant change in coverage is one of the events can give rise to a midyear opportunity to change elections. Plan sponsors should discuss midyear-enrollment options with compliance professionals to evaluate pros and cons, including regulatory obstacles.

- Special enrollment in a state health insurance exchange. Employees typically cannot enroll in health coverage through a public insurance exchange outside of the annual open enrollment period, unless they have actually lost coverage or experienced another special-enrollment event. Most state-run exchanges have created a new special-enrollment opportunity due to the pandemic, allowing uninsured employees to enroll in an exchange plan. However, the vast majority of states use the federal Healthcare.gov platform, which has not created a similar special-enrollment opportunity. Updated information on the HealthCare.gov website addresses special enrollment on the federal exchange during the pandemic. The National Association of Insurance Commissioners (NAIC) has a National Coronavirus Resource Center that includes a chart showing which state exchanges offer special-enrollment periods (SEPs) for the uninsured due to the pandemic.

- Medicaid. Lower-income employees without coverage could enroll in Medicaid. Thirty-eight states have expanded Medicaid under the ACA to individuals with incomes up to 138% of the federal poverty level. States that have not expanded Medicaid for adults still might offer coverage for children through Medicaid or the Children's Health Insurance Program. Medicaid coverage and eligibility rules differ from state to state. The Kaiser Family Foundation tracks state Medicaid actions to address COVID-19.

- CARES Act's Provider Relief Fund. The CARES Act includes a $100 billion fund intended to reimburse eligible providers for "health care related expenses or lost revenues that are attributable to

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coronavirus," including COVID-19 testing and treatment costs for the uninsured. HHS has announced that it will reimburse these providers at Medicare rates and ban balance billing uninsured patients.

Unlike uninsured employees, employees enrolled in an employer-sponsored health plan who lose that coverage due to a layoff or furlough have the option to enroll in COBRA coverage or special-enroll on any public insurance exchange, including Healthcare.gov. COBRA coverage is generally effective retroactive to the date of coverage loss, while public exchange coverage obtained through special enrollment is prospective only. As a result, employees losing coverage due to job loss might have a gap before their exchange coverage is effective. Employers will want to keep this in mind in deciding when to end coverage for a furloughed or laid-off worker. Temporarily extending existing employer coverage after job loss allows time for exchange coverage to take effect without coverage gaps.

Employer next steps

Regulators are expected to issue additional guidance to clarify existing ambiguities and may offer new flexibilities to help health plans address the next phase of the pandemic. In the meantime, here are some actions for employers:

- Provide notice about the mandated COVID-19 testing coverage to group health plan participants as soon as possible, and determine if any coverage changes require amendments to the plan (including HDHPs opting to provide telehealth predeductible).
- Consider identifying in-network providers offering COVID-19 testing and related services to reduce the plan's and participants' financial liabilities for out-of-network providers or services that do not result in an order for or administration of a COVID-19 diagnostic test.
- Consider amending self-insured plans to provide telehealth without cost sharing or medical-management requirements, confirm change with the plan's stop-loss carrier, and communicate the new coverage to participants. Employers sponsoring fully insured plans should verify whether the carrier will cover telehealth services without cost sharing during the pandemic.
- Employers adding or expanding telehealth benefits (or reducing or eliminating participant cost sharing for those benefits) beyond public health emergency should consider the mental health parity rules and the implications for mental health services provided by the group health plan.
- Consider expanding coverage to employees not already enrolled in the group health plan by offering COVID-19 evaluation and testing through an EAP or existing on-site clinic.
- Employers considering COVID-19 diagnostic or antibody testing as part of a return-to-work strategy should carefully review guidance from the Equal Employment Opportunity Commission that

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addresses relevant nondiscrimination requirements under the Americans with Disabilities Act and other federal laws.

- Look for USPSTF or CDC recommendations on COVID-19 preventive care, confirm that the plan's TPA or carrier can put that coverage in place within 15 days of the recommendation, and determine whether a plan amendment or communication to participants is needed.
- Watch for additional guidance addressing compliance ambiguities and the operational and practical challenges of implementing no-cost-sharing coverage of COVID-19 testing and related items and services.

Related resources

Non-Mercer resources

- ACA FAQs, Part 42 (DOL/HHS/Treasury, April 11, 2020)
- Press release on expanded coverage for essential COVID-19 diagnostic services (HHS, April 11, 2020)
- Medicaid emergency authority tracker: Approved state actions to address COVID-19 (Kaiser Family Foundation, regularly updated)
- Chart: State actions on life/health, including special-enrollment periods (SEPs) (NAIC Coronavirus Resource Center, regularly updated)
- State action related to COVID-19 coverage of critical services by private insurers (The Commonwealth Fund, regularly updated)
- Answering the call: Health insurance providers act swiftly as part of the COVID-19 solution (AHIP, April 9, 2020)
- Pub. L. No. 116-136, the CARES Act (Congress, March 27, 2020)
- Pub. L. No. 116-127, the FFCRA (Congress, March 18, 2020)
- FAQs on EHBs and the coronavirus (CMS, March 12, 2020)
- Notice 2020-15 (IRS, March 11, 2020)

Mercer Law & Policy resources

- CARES Act boosts telehealth, makes other health, paid leave changes (March 27, 2020)

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- Virus aid legislation includes cost-sharing curbs, new leave rights (March 18, 2020)
- COVID-19 spurs IRS relief for HDHPs, state insurance guidance (March 18, 2020)

Other Mercer resources

- Stay informed on coronavirus (regularly updated)
- Mid-plan-year health benefit options for nonparticipants (April 9, 2020)
- Do benefits continue during furloughs? It's a matter of plan interpretation (March 26, 2020)

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