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COVID-19 — Health and Welfare Provisions in the CARES Act

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The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was signed into law on March 27, 2020. The CARES Act makes emergency supplemental appropriations and other changes to law to help the U.S. respond to the COVID-19 pandemic. This article discusses: (1) the health plan provisions in the CARES Act, (2) possible plan amendments for those provisions, (3) certain other interesting health and welfare plan provisions in the CARES Act, and (4) some other potential legal updates that are not in the CARES Act, but that may appear in later legislation.

Health Plan Provisions in the CARES Act

COVID-19 Testing. Prior to the CARES Act, COVID-19 testing benefits were included in the Families First Coronavirus Response Act (FFCRA), which was passed on March 18, 2020. FFCRA requires group health plans to provide coverage, and not impose any cost-sharing requirements, prior authorization or other medical management requirements, for the following: (1) COVID-19 diagnostic testing and (2) related items and services. Related items and services are those furnished to an individual during healthcare provider visits (in-person and telehealth), urgent care center visits and emergency room visits — but only to the extent that such services or items relate to the COVID-19 diagnostic testing or to the evaluation of the need for COVID-19 diagnostic

testing. The rule applies to **ALL** ERISA group health plans (self-funded and insured) (GHPs), except for excepted benefit plans (such as vision-only plans or dental-only plans). The rule became effective on March 18, 2020 and continues until the Secretary of Health and Human Services (HHS) determines that the public health emergency has expired.

The CARES Act expanded this requirement. First, it expanded the types of tests that were covered to include: (1) tests for which the developer has requested, or intends to request, emergency use authorization from the FDA (until the request is denied or the developer does not submit a request within a reasonable timeframe), (2) tests that are developed in and authorized by a State, or (3) tests that the Secretary of HHS deems appropriate.

Second, the CARES Act expanded this requirement to add the reimbursement rates for which GHPs must pay for these tests. If the GHP had a negotiated rate with a provider before the public health emergency was declared, then that rate shall continue through the emergency. If there was no existing negotiated rate, then the GHP must pay the provider's cash price, as listed by the provider on a public website, or a lower negotiated price.

> ***Trucker Huss Comment:*** Until additional guidance is provided, we believe that this provision requires that the COVID-19 testing be covered when provided by in-network providers and out-of-network providers. This provision does not seem to preclude out-of-network providers from sending individuals additional "surprise" bills for amounts in excess of the price listed on their website, if that individual signs an agreement to pay a higher price. We could imagine a scenario, for example, such as an out-of-network provider including an "expedited fee" on a bill.

Rapid Coverage of Preventive Services and Vaccines for COVID-19. GHPs must cover, without any cost-sharing, any "qualifying coronavirus preventive service" which means an item, service or immunization that is intended to prevent or mitigate COVID-19 and that is: (1) an evidenced-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force or (2) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. This requirement takes effect 15 business days after the date the recommendation is made.

> ***Trucker Huss Comment:*** Under the Affordable Care Act, the rules regarding preventive health care services specify a one-year period from the date the service is recommended by the applicable agency and the date it must be included in the GHP as a covered service. This new CARES Act provision related to COVID-19 has a 15-day lag period — which is much faster. As under the Affordable Care Act, we believe this only applies for in-network services.

Exemption for Telehealth Services. The CARES Act provides that a plan shall not fail to be treated as a high deductible health plan (HDHP) by reason of failing to have a deductible for telehealth and other remote care services. In other words, an HDHP can cover telehealth and remote care services for any medical care (not just medical care related to COVID-19) prior to the deductible. This provision applies for plan years that begin on or before December 31, 2021.

> ***Trucker Huss Comment:*** This is a permissive provision — it is not required. While an HDHP must cover COVID-19 testing (and the related healthcare visits) prior to the deductible and without cost-sharing, there is not a requirement that the HDHP cover all other telehealth and remote care services. However, plan sponsors may want to include this benefit as a way to encourage social distancing.

Over-the-Counter (OTC) Medical Products and Menstrual Care Products Treated as Qualified Medical Expenses. Account-based plans, such as Health Savings Accounts (HSAs), health flexible spending accounts ("Health FSAs") and health reimbursement arrangements (HRAs), can be amended to permit the reimbursement of: (1) OTC medical products without a prescription and (2) menstrual care products. For HSAs, this provision applies to amounts paid after December 31, 2019. For Health FSAs and HRAs, the provision applies to expenses incurred after December 31, 2019. This is a permissive provision.

Plan Amendments for the Healthcare Provisions in the CARES Act

GHPs should be amended, as soon as possible, for the provisions set forth above.

Required Amendments. GHPs must be amended to cover the following:

1. COVID-19 Testing and
2. Rapid Coverage of Preventive Services and Vaccines for COVID-19.

For the COVID-19 testing, the GHP should be clear on the amount that it will pay for the services provided by out-of-network providers. With regard to the Rapid Coverage of Preventive Services and Vaccines for COVID-19, it may be that the GHP already contains language that would cover that benefit.

Permissive Amendments. The following are permissive amendments:

1. Coverage of all telehealth and remote care services by HDHPs prior to the deductible and without cost-sharing.
2. Coverage of OTC medical products and menstrual care products under Health FSAs and HRAs.

For the telehealth and remote care services provision, remember that the COVID-19 testing, including the related healthcare visit(s) for the evaluation and administration of the test, must be covered without cost-sharing. This permissive provision is more expansive, allowing for telehealth and remote care services for medical needs unrelated to COVID-19 to be covered without a deductible and without cost-sharing. For the OTC products and menstrual care products, note that employers do not sponsor or maintain the HSAs, so no action is needed by the employer with regard to the HSAs. The amendments, if elected by the employer, should be made to the employer-sponsored Health FSA and/or HRA.

Timing of Amendments and Notification. Generally, amendments to health plans should be adopted prior to their effective date. If an amendment impacts any provision in the summary of benefits and coverage (SBC), then advance notice of the amendment is to be provided to participants. However, advance notice cannot be required in this case given that the required provisions have an immediate effective date. We suggest that the required plan amendments, plus any permissive amendment approved by the employer, be made now and that a summary of material modifications (SMMs) be sent to participants as soon as possible. It is important that GHP documents clearly state the scope of the required COVID-19 coverage so that participants understand what costs will be covered by the GHP. Unfortunately, GHPs should assume that they will soon see an enormous number of COVID-19 claims.

Certain Other Interesting Provisions in the CARES Act

There are several other interesting provisions in the CARES Act that relate to health and welfare plans. Two of those provisions are described below.

Employer Payment of Student Loans. For qualified student loan payments made after March 27, 2020 and before January 1, 2021, the CARES Act amends Internal Revenue Code Section 127 to allow employers to reimburse employees (or directly pay a lender) the principal or interest for a "qualified education loan" incurred by the employee for the education of the employee. The maximum limit is $5,250, and that is the combined limit for loan repayment assistance and other education assistance permitted under Code Section 127. All other rules under Code Section 127 continue to apply (for example, there must be a written plan document that includes all of the applicable requirements, and the program cannot be discriminatory).

Expansion of DOL Authority to Postpone Certain Deadlines. The Employee Retirement Income Security Act (ERISA) sets forth numerous requirements for employee benefit plans, including retirement plans and

health and welfare plans. In the event of a Presidential-declared disaster or terrorist or military action, ERISA Section 518 provides that the Secretary of Department of Labor (DOL) may postpone (for up to one year) the date an action is required to be completed pursuant to ERISA. The CARES Act amends ERISA Section 518 to allow for an extension for "a public health emergency declared by the Secretary of Health and Human Services pursuant to Section 319 of the Public Health Service Act." This section provid es the DOL with significant leeway to delay filings, such as the Form 5500 filing and other required ERISA items, in response to COVID-19. The DOL has not yet issued any guidance under this provision.

Potential Legal Updates That Are Not in the CARES Act, but May Appear in Later Legislation

The CARES Act will not be the last federal legislation that is passed related to COVID-19. While we do not know what will be included in future legislation, the following are possible provisions.

Requirement to Cover Treatment of COVID-19. There is no requirement to cover the costs of the treatment for COVID-19. IRS Notice 2020-15 permits HDHPs to cover the cost of treatment for COVID-19 prior to the deductible being met—but there has been no legislation requiring coverage. We anticipate that one major issue will be that people will receive treatment for COVID-19 at whatever facility has space, and that could be an out-of-network provider. Many plans do not cover all costs associated with out-of-network providers. We anticipate that there will be pressure for Congress to take some action for people who have extraordinary medical bills due to COVID-19 treatment.

COBRA Subsidies. In 2009—what seems like a million years ago—the American Recovery and Reinvestment Act of 2009 was passed. It provided for a government subsidy of 65% of COBRA premiums for a period of nine months for employees laid off between September 1, 2008 and December 31, 2009. Due to the shelter-in-place orders in most States, the number of individuals who are (or will become) unemployed will skyrocket. In addition, due to the nature of the COVID-19 pandemic, this is an even more critical time to have healthcare coverage. Accordingly, we anticipate seeing legislation that provides a government subsidy for COBRA premiums.

We will continue to provide updates on COVID-19–related federal mandates and guidance that impact employee benefit plans.

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