Recent Legislative and Regulatory Changes Impacting Group Health Plans

May 27, 2020

The Families First Coronavirus Response Act ("FFCRA") and the Coronavirus Aid, Relief and Economic Security Act ("CARES Act"), both enacted in March 2020, provide temporary emergency assistance and relief to group health plan participants impacted by the COVID-19 health crisis. This update briefly summarizes these relief provisions and also provides a summary of the updated model notices regarding continuation coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") that were issued by the U.S. Department of Labor ("DOL") on May 1, 2020.

Mandated Coverage for COVID-19 Testing and Related Items and Services

Beginning as of March 18, 2020 and continuing until the end of the national public health emergency period, the FFCRA and CARES Act require group health plans to provide coverage for the following categories of COVID-19 in-vitro diagnostic testing without cost-sharing or prior authorization requirements:

- Testing approved by the Food and Drug Administration ("FDA");
- Testing awaiting FDA emergency use authorization;
- Testing authorized by a State that has notified HHS; and
- Testing that HHS determines to be appropriate pursuant to issued guidance.

Serological tests used to detect antibodies against the virus that causes COVID-19 are considered in vitro diagnostic tests and must be covered without cost-sharing if the test falls into one of the categories listed above.

In addition, group health plans must provide coverage without cost sharing for items and services furnished to an individual during a health care provider visit (including drive-through screening visits, urgent care visits, or emergency room visits) if the visit results in, and the services are related to, the administration of, or order for, a COVID-19 diagnostic test or the evaluation of the need for such a test. This mandate applies to both in-network and out-of-network provider claims, and the provider (not the plan) has discretion to determine whether items or services are related to COVID-19 testing or the evaluation of the need for such test.

Group health plans must reimburse providers of COVID-19 diagnostic testing at the plan's negotiated rate in existence with the provider before the COVID-19 public health emergency was

declared. If there is no existing negotiated rate (as with out-of-network providers), the plan may either reimburse the provider at the cash price for the service that is listed by the provider on a public website, or negotiate with the provide for a lower rate.

This coverage mandate does not apply to retiree-only group health plans, short-term and limited-duration insurance, or excepted benefit plans.

Mandated Coverage for COVID-19 Preventive Services

The CARES Act provides that certain items, services, or immunizations intended to prevent or mitigate COVID-19 must be provided by a group health plan without cost-sharing. This requirement will go into effect for a particular service 15 business days after the date on which a recommendation regarding the service is issued by either the U.S. Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. To date, no such recommendations have been made.

Communication of COVID-19 Coverage Changes

ERISA's Summary of Benefits and Coverage ("SBC") notice requirements generally require group health plans to provide 60 days' advance notice of a material modification in coverage that would change the contents of the SBC. However, the FAQs issued by the DOL relating to the FFCRA and the CARES Act provide that federal agencies will not take enforcement action against a plan that makes such modifications during the COVID-19 public health emergency without providing the required advance notice, as long as the modifications provide greater coverage related to the diagnosis and/or treatment of COVID-19 or the modifications add benefits or reduce cost-sharing for telehealth and other remote care services.

Employee Assistance Programs ("EAPs") and COVID-19 Testing

EAPs are programs, provided on a stand-alone basis or as part of a larger health plan, that provide employees with various wellness services at no cost. EAPs are considered excepted benefits exempt from the requirements of the Affordable Care Act ("ACA"), provided they do not offer "significant benefits in the nature of medical care." Recent DOL FAQs provide that an EAP will not lose its status as an "excepted benefit" if it offers benefits for the diagnosis and treatment of COVID-19 during this public health emergency.

High Deductible Health Plans ("HDHPs") and Spending Accounts

Under the CARES Act, HDHPs are permitted to provide telehealth and other remote care services with no deductible requirement for plan years beginning on or before December 31, 2021. The CARES Act also adds certain over-the-counter medical products and menstrual care products as qualifying medical expenses eligible for payment or reimbursement from a health savings account or other spending account, such as a flexible spending arrangement or health reimbursement arrangement. These permanent changes to the rules that apply to spending

accounts apply retroactively to reimbursements from savings accounts for expenses incurred after December 31, 2019.

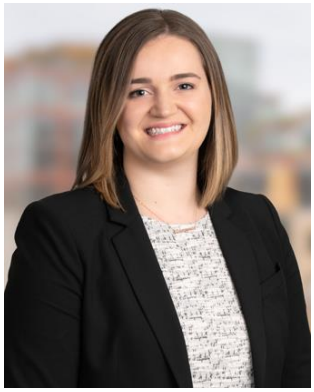
DOL Update to Model COBRA Notices

Group health plans are required to provide a general notice of COBRA rights to participants upon enrollment, and must provide notice of the participant's right to elect COBRA within 14 days of receiving notification of a qualifying event, such as termination of employment. The DOL provides a model version of each notice, which it updates from time to time. While plans are not required to use these model notices, they provide a compliance safe harbor if used.

The new 2020 model notices recently issued by the DOL do not reflect a change in the applicable law but have been revised to explain the interaction between Medicare and COBRA in more detail, including potential penalties and coverage gaps individuals may face by failing to enroll in Medicare when they first become eligible.

Please contact Slevin & Hart for more information about how these legislative and regulatory changes affect your plan.

Attorneys



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