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Nineteenth Set of FAQs on the ACA Issued

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On June 23, 2020, the Departments of Labor, the Treasury, and Health and Human Services ("HHS") (collectively, "the Departments") issued FAQ Part 43, which includes certain guidance on the Families First Coronavirus Response Act ("FFCRA") and the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), as well as other COVID-19 health plan issues.

Briefly, FAQ 43:

- Confirms the type of testing and services required to be covered by group health plans and reinforces that plans must provide coverage for COVID-19 diagnostic testing without cost sharing;
- Excludes workplace and surveillance testing for COVID-19 from the coverage mandate;
- Allows plan sponsors to revoke COVID-19 plan changes upon the expiration of the public health emergency through modified notice requirements;
- Temporarily allows large employers to offer coverage for telehealth or other remote care services to employees who are not otherwise eligible for the employer's group health plan;
- Allows grandfathered plans to maintain their grandfathered status despite COVID-19-related changes being made and then subsequently revoked after the public health emergency has ended; and
- Allows employers to waive a standard for obtaining a reward under a health contingent wellness program due to COVID-19 circumstances.

Additional details are described below.

Items and Services that must be Covered under FFCRA (As Amended by the Cares Act)

Health plans must provide coverage for the following items and services without cost-sharing (including deductibles, copayments, and coinsurance), prior authorization or other medical management techniques for the duration of the public health emergency period (currently set to end July 25, 2020, unless extended or shortened by HHS):

- An in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test that:
  - Is approved, cleared or authorized by the Federal Food, Drug and Cosmetic Act ("FDCA");
  - The developer has requested (or intends to request) emergency use authorization ("EUA") under the FDCA, unless and until the EUA request is denied or if the developer does not submit a request within a reasonable timeframe;
  - Is developed in and authorized by a state that has notified HHS of its intention to review tests intended to diagnose COVID-19; or
  - Is another kind of test that HHS deems appropriate in guidance.
- Items and services furnished to an individual during healthcare provider office visits (including telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described above, but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

The guidance provides links to appropriate websites a plan or carrier may use to determine which COVID-19 tests are required to be covered without cost sharing.

In addition, FAQ 43 clarifies:

- Health plans must provide coverage for certain items and services when medically appropriate for the individual as determined by the individual's provider.
- Health plans are also required to cover COVID-19 diagnostic testing for at-home testing, when ordered by the individual's provider and it is medically appropriate and meets the current accepted standards of medical practice.
- Health plans must cover multiple diagnostic tests for an individual, when medically necessary.

Coverage of Testing for Employment Purposes or Surveillance is not Required

Group health plans are not required to cover COVID-19 testing for surveillance or employment purposes, including "return to work" situations. The FFCRA only requires coverage of items and services for diagnostic purposes.

Out of Network Providers and Balance Billing

As previously covered in the FAQ Part 42, health plans are required to provide coverage for items and services related to a COVID-19 diagnosis without cost-sharing when furnished by out-of-network ("OON") providers. Where there is no negotiated rate with an OON provider, the plan must reimburse the provider at the cash price for the services as listed by the provider on a website (or a negotiated lower price than the listed cash price).

The FAQ clarifies:

- Participants and beneficiaries should not be balance billed for an applicable COVID-19 test.
- The reimbursement rate requirements apply only the diagnostic testing for COVID-19. Balance billing may be allowed for all other services, subject to applicable state laws and other plan provisions.

With respect to individuals who receive a COVID-19 test in an emergency department of a hospital that is OON, the group health plan must reimburse the OON provider of the COVID-19 test an amount equal to the cash price for the services as listed by the provider on a website (or a negotiated lower price than the listed cash price). For any other OON services provided in an emergency setting, a non-grandfathered plan must comply with minimum payments standards under the Affordable Care Act ("ACA").

Summary of Benefits & Coverage ("SBC") Relief

Generally, if there is a mid-year material modification in any of the terms of the plan or coverage that would affect the content of the SBC, the plan must provide 60 days advance notice of the change. In prior guidance, the Departments allowed for plans to provide a notice of the COVID-19 related changes as soon as reasonably practicable.

The guidance clarifies that if a plan reverses the changes related to COVID-19 once the public health emergency is no longer in effect, the Departments will consider the plan to have satisfied its obligation to provide advance notice, provided the plan had previously notified the participants that the changes were temporary (such as through the COVID-19 public health emergency). The plan may also notify participants within a reasonable timeframe in advance of the reversal of the changes.

Expanding Access to Telehealth and Other Remote Care Services for Non-Benefit Eligible Employees

Although typically prohibited under the ACA's market reforms, the Departments are providing temporary relief allowing large employers to offer telehealth and other remote care services to employees and their dependents who are not otherwise eligible for any group health plan offered by the employer. For this purpose, a large employer is an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

This relief applies for the duration of any plan year that begins before the end of the public health emergency period (currently July 25, 2020). The Departments will require these arrangements to comply with the following requirements:

- Prohibition on discrimination based on a pre-existing condition or health status;
- Prohibition on rescissions of coverage; and
- Parity in mental health and substance use disorder benefits.

Grandfathered Health Plans

In the guidance, the Departments provide that if a plan added benefits, or reduced or eliminated cost sharing pursuant to the Departments' safe harbor outlined in FAQs Part 42, Q9 and Q14, only for the period in which the COVID-19 public health emergency is in effect, the plan will not lose its grandfathered plan status solely because the changes are later reversed and the terms of the plan that were in effect prior to the emergency period are restored.

Wellness Programs

The Departments provided guidance allowing for employers to waive a standard for obtaining a reward under a health contingent wellness program if the participants face difficulty meeting the standard as a result of COVID-19 as long as the waiver is offered to all similarly situated individuals.

Resources

For a copy of FAQs Part 43, visit: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf