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Agencies Release COVID-19 FAQs on FFCRA and CARES Act Implementation for Health Plans

On April 11, the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments) released frequently asked questions (FAQs) on the implementation of the recently enacted Families First Coronavirus Response Act (the FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). The FAQs answer stakeholder questions and provide helpful clarifications that will assist health plans, insurers and others in understanding and complying with the new law.

Background

The FFCRA (as amended by the CARES Act) requires group health plans and health insurance issuers to cover the following items and services free of charge:

- In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such products:
    - that are approved by the FDA;
    - for which the developer has requested (or will request) emergency use authorization from the FDA;
    - that are developed in and authorized by a State that has notified the Secretary of HHS that it intends to review tests intended to diagnose COVID-19; or
    - that the Secretary of HHS determines to be appropriate.
- Items and services furnished during healthcare provider office visits (including telehealth visits), urgent care center visits and emergency room visits during which (i) COVID-19 testing is ordered or performed or (ii) the individual is evaluated for COVID-19.

These items and services must be covered without imposing any cost sharing (including deductibles, copayments and coinsurance). Additionally, prior authorization or other medical management requirements may not be imposed.

Clarifications Provided in the FAQs

The FAQs provide the following helpful clarifications with respect to these coverage requirements:

- The coverage requirements apply to fully insured and self-funded group health plans, non-federal governmental plans, church plans, and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans under the Affordable Care Act). The requirements do not apply to short-term, limited-duration insurance, excepted benefits or retiree plans.
- Plans must provide cost-free coverage with respect to items and services furnished on or after March 18, and this coverage must continue as long as the COVID-19 public health emergency exists. The HHS Secretary's public health emergency declaration is set to expire on April 25 but may be extended or terminated earlier.

- Serological tests used to detect antibodies against the virus causing COVID-19 (indicating a current or past infection) must be covered.
- Plans must cover items and services furnished during a visit that results in an order for, or administration of, a COVID-19 test, but only to the extent the items or services relate to the furnishing or administration of the test or the evaluation of the individual for purposes of determining whether such a test is needed, as determined by the individual's attending healthcare provider. For example, if an individual's attending provider determines that an influenza test should be performed during a visit, and the visit results in an order for a COVID-19 test, the plan must cover the influenza test.
- Plans must cover items and services furnished by out-of-network providers.
- The term "visit" will be construed broadly by the Departments to include drive-through screening and testing sites where licensed healthcare providers administer COVID-19 diagnostic testing.
- The Departments will not take enforcement action against any plan that is amended to add benefits (or eliminate cost sharing) for the diagnosis and/or treatment of COVID-19 without providing the 60-day advance notice that would otherwise be required for a material change that would affect the content of the Summary of Benefits and Coverage. However, plans must provide notice of the changes as soon as reasonably practicable.

The FAQs also highlight the CARES Act's amendment to Section 223(c) of the Internal Revenue Code of 1986, as amended (the Code), to allow high-deductible health plans to cover telehealth and other remote care services without a deductible (or with a deductible below the minimum deductible otherwise required). The Departments note that the amendments to Code Section 223 apply generally to all telehealth and other remote care services and are not limited to COVID-19 diagnosis or treatment, and encourage plans to cover such services without cost sharing or other medical management requirements.

For more Day Pitney alerts and articles related to the impact of COVID-19, as well as information from other reliable sources, please visit our COVID-19 Resource Center.

COVID-19 DISCLAIMER: As you are aware, as a result of the COVID-19 pandemic, things are changing quickly and the effect, enforceability and interpretation of laws may be affected by future events. The material set forth in this document is not an unequivocal statement of law, but instead represents our best interpretation of where things stand as of the date of first publication. We have not attempted to address the potential impacts of all local, state and federal orders that may have been issued in response to the COVID-19 pandemic.

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