Employee Benefits Series

Health Plan Coronavirus (COVID-19) Guidance

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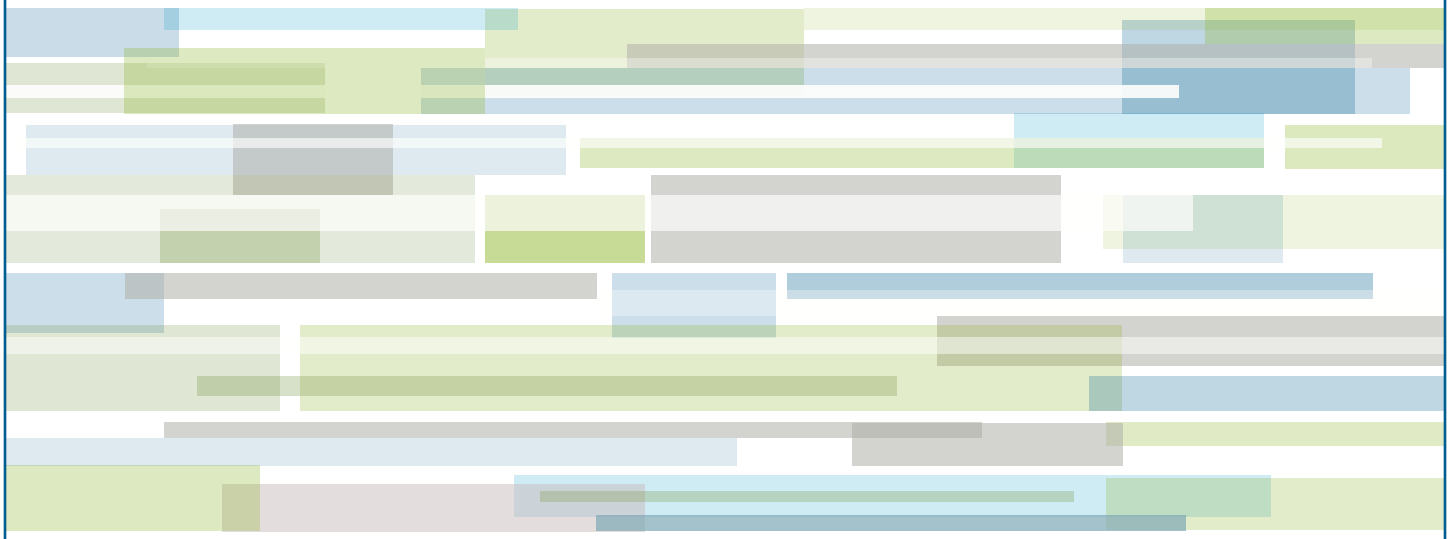

Health Plan Coronavirus (COVID-19) Guidance

To facilitate the nation's response to the coronavirus (COVID-19) pandemic, federal agencies have published guidance for health insurance issuers and group health plans regarding their compliance with certain Affordable Care Act (ACA) provisions and other Internal Revenue Service (IRS) requirements. The following provides a general overview of this guidance.

HEALTH PLANS MUST PROVIDE FREE COVID-19 TESTING

Effective March 18, 2020, the Families First Coronavirus Response Act (FFCRA) requires group health plans and health insurance issuers to cover COVID-19 testing without imposing any cost sharing (such as deductibles, copayments or coinsurance) or prior authorization or other medical management requirements.

Coverage Mandate

This coverage mandate applies to the following health plans and issuers, regardless of grandfathered status under the Affordable Care Act (ACA):

- All fully insured group health plans
- All self-insured group health plans
- Health insurance issuers offering group or individual coverage

During this public health emergency, health plans and issuers must cover FDA-approved diagnostic testing products for COVID-19, including any items or services provided during a visit to a provider (in-person or telehealth), urgent care center or emergency room that relate to COVID-19 testing.

Effective March 27, 2020, the Coronavirus Aid, Relief and Economic Security Act (CARES Act) expands this coverage mandate to include COVID-19 tests provided on an emergency basis, state-developed tests and any other tests approved by the U.S. Department of Health and Human Services.

This coverage cannot be subject to any plan deductible, copayment or coinsurance.

Guidance for HDHPs

On March 11, 2020, the Internal Revenue Service (IRS) issued Notice 2020-15 to allow high deductible health plans (HDHPs) to pay for COVID-19 testing and treatment before plan deductibles have been met, without jeopardizing their status. The IRS also noted that any COVID-19 vaccination costs count as preventive care and can be paid for by an HDHP without cost sharing.

Effective March 27, 2020, the CARES Act allows HDHPs to provide benefits for telehealth or other remote care services before plan deductibles have been met, for plan years beginning before Jan. 1, 2022.

Only individuals who are covered by HDHPs can make contributions to HSAs. To qualify as an HDHP, a health plan cannot pay medical expenses (other than preventive care) until the annual minimum deductible has been reached. IRS Notice 2020-15 and the CARES Act provide exceptions to this general rule to encourage testing for and treatment of COVID-19.

ACA CORONAVIRUS GUIDANCE

The Centers for Medicare & Medicaid Services (CMS) has issued a number of frequently asked questions (FAQs) on the coronavirus (COVID-19) as it relates to various Affordable Care Act (ACA) provisions. CMS' FAQs are included below.

FAQS on Essential Health Benefit Coverage and Coronavirus

On March 12, 2020, CMS issued the following FAQs on essential health benefit (EHB) coverage and the coronavirus (COVID-19). EHB is a core set of items and services under the ACA that:

- Reflects the scope of benefits covered by a typical employer; and
- Covers at least 10 specified categories of items and services.

Q1. Does EHB currently include coverage for the diagnosis and treatment of COVID-19?

A1. Yes. EHB generally includes coverage for the diagnosis and treatment of COVID-19. However, the exact coverage details and cost-sharing amounts for individual services may vary by plan, and some plans may require prior authorization before these services are covered.

Non-grandfathered health insurance plans purchased by individuals and small employers, including qualified health plans (QHPs) purchased on the Exchanges, must provide coverage for 10 categories of EHB. These 10 categories include, among other things, hospitalization and laboratory services. Under current regulations, each state and the District of Columbia generally determines the specific benefits that plans in that state must cover within the ten EHB categories. This standard set of state-determined benefits is called the EHB-benchmark plan. All 51 EHB-benchmark plans currently provide coverage for the diagnosis and treatment of COVID-19.

Many health plans have publicly announced that COVID-19 diagnostic tests are covered benefits and that they will waive any cost-sharing that would otherwise apply to the tests. Furthermore, many states are encouraging their issuers to cover a variety of COVID-19-related services, including testing and treatment, without cost-sharing. Other states have announced that health plans must cover the diagnostic testing of COVID-19 without cost-sharing and waive any prior authorization requirements for such testing.

Q2. Is isolation and quarantine for the diagnosis of COVID-19 covered as EHB?

A2. All EHB-benchmark plans cover medically necessary hospitalizations. Medically necessary isolation and quarantine required by and under the supervision of a medical provider during a hospital admission are generally covered as EHB. The cost-sharing and specific coverage limitations associated with these services may vary by plan. For example, some plans may require prior authorization before these services are covered or apply other limitations. Quarantine outside of a hospital setting (such as at home) is not a medical benefit, nor is it required as EHB. However, other medical benefits that occur in the home may be covered as EHB if they are required by and provided under the supervision of a medical provider (such as home health care or telemedicine), but this may depend on prior authorization or be subject to cost-sharing or other limitations.

Q3. When a COVID-19 vaccine is available, will it be covered as EHB, and will issuers be permitted to require cost-sharing?

A3. A COVID-19 vaccine does not currently exist. However, current law and regulations require specific vaccines to be covered as EHB without cost-sharing, and before any applicable deductible is met, if the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) recommends them. Under current regulations, plans are not required to cover a new vaccine until the beginning of the plan year that is 12 months after ACIP issues a recommendation for it. However, plans may voluntarily choose to cover a vaccine for COVID-19, with or without cost-sharing, prior to that date.

In addition, as part of a plan's responsibility to cover prescription drugs as EHB, as described above to cover ACIP-recommended vaccines, if a plan does not provide coverage of a vaccine (or other prescription drugs) on the plan's formulary, enrollees may use the plan's drug exceptions process to request that the vaccine be covered under their plan.

FAQS on Catastrophic Plan Coverage and Coronavirus

On March 18, 2020, CMS issued the following FAQs on catastrophic plan coverage and the coronavirus (COVID-19).

Q.1 Do catastrophic plans currently include coverage for the diagnosis and treatment of COVID-19?

A1. Yes. Catastrophic plans must cover the essential health benefits (EHB) as required by ACA Section 1302(b), subject to certain limitations. However, the exact coverage details and cost-sharing amounts for individual services may vary by plan, and some plans may require prior authorization before these services are covered. EHB generally includes coverage for the diagnosis and treatment of COVID-19. For general information about EHB coverage of COVID-19, please refer to CMS' FAQs on EHB Coverage and the Coronavirus (above).

While catastrophic plans are required to cover EHB, they are also subject to certain limitations under ACA Section 1302(e) that address catastrophic plan coverage of EHB, including related cost-sharing requirements. A catastrophic plan may not provide coverage of EHB before an enrollee meets their catastrophic plan deductible for that applicable plan year, except as follows:

- A catastrophic plan must provide coverage for at least three primary care visits per year before reaching the deductible; and
- A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance or deductible) for preventive services.

Q2. In light of the public health emergency posed by COVID-19, will HHS allow issuers of catastrophic plans to provide coverage for the diagnosis and treatment of COVID-19 even before enrollees meet plan deductibles?

A2. Yes. To facilitate the nation's response to COVID-19, until further notice, HHS will not take enforcement action against any health insurance issuer that amends its catastrophic plans to provide pre-deductible coverage for services associated with the diagnosis and/or treatment of COVID-19. HHS encourages states to take a similar enforcement approach and would not consider a state to have failed to substantially enforce ACA Section 1302(e) if it takes this approach.

Issuers generally may not modify the health insurance coverage for a product mid-year. However, HHS will not take enforcement action against any health insurance issuer that changes the benefits or cost-sharing structure of its plans mid-year to provide pre-deductible coverage for services related to the diagnosis and/or treatment of COVID-19, and encourages states to do the same. This non-enforcement does not apply to actions issuers take to limit or eliminate non-COVID-19 benefits to offset the costs of increasing the generosity of COVID-19 benefits.

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