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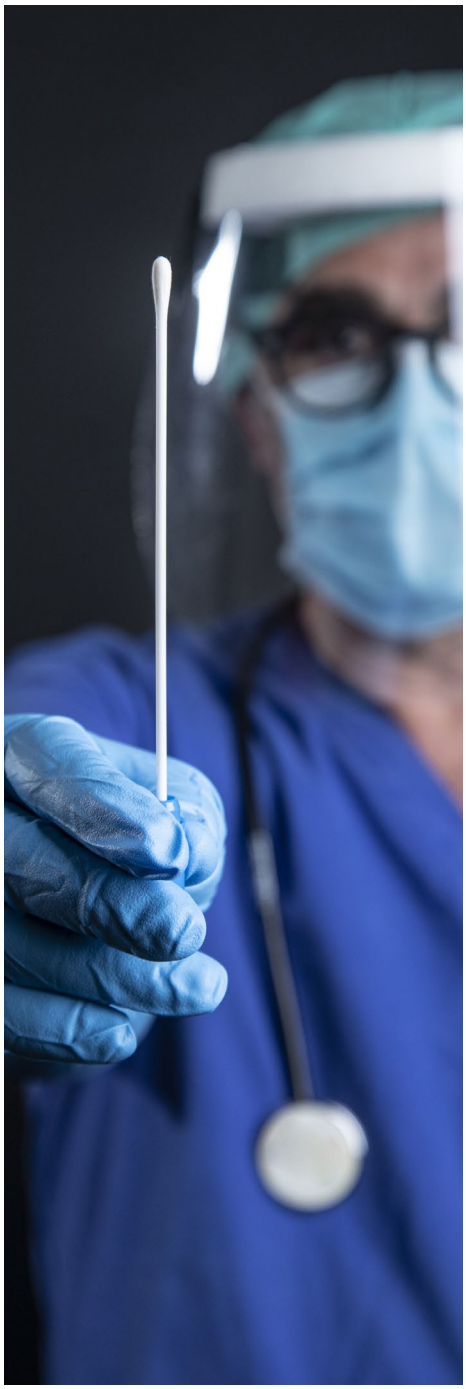
UPDATED GUIDANCE FOR COVID-19 TESTING

The DOL, HHS, and Treasury Department jointly issued an updated set of FAQs concerning the FFCRA, the CARES Act, and COVID-19. The following updates/clarifications are of note:



- COVID-19 tests intended for at-home testing (including tests where the individual performs self-collection of a specimen at home) must be covered, when the test is ordered by an attending health care provider who has determined that the test is medically appropriate for the individual. Plans and issuers are required to cover those tests without imposing any cost-sharing requirements, prior authorization, or other medical management requirements.
- If an individual receives multiple diagnostic tests for COVID-19, plans and issuers are required to cover each test, as well as other applicable items and services.
- If a facility fee is charged for a visit that results in an order for or administration of a COVID-19 diagnostic test, the plan or issuer must also cover the facility fee without imposing cost-sharing requirements (to the extent that the facility fee relates to the furnishing or administration of a COVID-19 test or the evaluation of an individual to determine the individual's need for testing).
- COVID-19 testing for surveillance or employment purposes is not required to be covered under the FFCRA. Testing conducted to screen for general workplace health and safety (such as employee "return to work" programs), for public health surveillance of COVID-19, or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19 or another health condition, is beyond the scope of the FFCRA.
- The CARES Act's reimbursement requirements do not apply to items and services other than diagnostic testing for COVID-19. The CARES Act describes the amount a plan or issuer must reimburse a provider for COVID-19 testing, but it does not address the reimbursement for any other items and services.
- The CARES Act generally precludes balance billing and generally protects participants, beneficiaries, and enrollees from balance billing for COVID-19 diagnostic testing.

- For out-of-network emergency services related to COVID-19 testing, a plan or issuer must reimburse an out-of-network provider of COVID-19 testing in an amount that equals the cash price for such service that is listed by the provider on a public website, or the plan or issuer may negotiate a rate that is lower than the cash price.
- In light of COVID-19, a large employer may offer coverage only for telehealth and other remote care services to employees who are not eligible for any other group health plan offered by the employer. This applies to any plan beginning before the end of the public health emergency related to COVID-19. In effect, it creates a temporary and partial exemption from ERISA and other federal regulations, but only as concerns telehealth and other remote medical care. Under this temporary relief, the Departments will continue to apply otherwise applicable federal non-discrimination standards. The specified market reforms that these arrangements must continue to satisfy are the following:
  - Prohibition of pre-existing condition exclusions or other discrimination based on health status;
  - Prohibition of discrimination against individual participants and beneficiaries based on health status;
  - Prohibition of rescissions; and
  - Parity in mental health or substance use disorder benefits.

For plans that adopted temporary changes to enhance benefits in response to the COVID-19 epidemic, the plan can revoke the changes made upon the expiration of the public health emergency without satisfying advance notice requirements so long as notice is provided "within a reasonable timeframe in advance of the reversal of the changes." What constitutes a 'reasonable timeframe' is not defined in the FAQs. It can be assumed that it is a period shorter than the 60-day prior notice required for material modifications to plan terms reflected in the most recent SBC.

A plan or issuer is not required to perform the mental health parity analysis each plan year unless there is a change in plan benefit design, cost-sharing structure, or utilization that would affect a financial requirement or quantitative treatment limitation within a classification (or sub-classification).

In the same vein, when performing the "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations under the Mental Health Parity Act regulations, plans and issuers **may** disregard benefits for items and services required to be covered without cost-sharing under the FFCRA. The Departments acknowledge how quickly these regulations have been put into effect and, in light of that, the Departments will not take enforcement action against any plan or issuer that disregards the benefits for the items and services that are covered without cost-sharing under the FFCRA for purposes of the "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations. Presumably, the Departments will take no action on this until at least the end of the national emergency; however, we are awaiting further guidance.

A plan or issuer **may** waive a standard for obtaining a reward (including any reasonable alternative standard) under a health-contingent wellness program if participants or beneficiaries are facing difficulty meeting the standard due to circumstances related to COVID-19. However, to the extent the plan or issuer waives a wellness program standard as a result of COVID-19, the waiver must be offered to all similarly situated individuals. The updated guidance does not address suspending wellness program rewards and carrying them over to a future year.