



CARES Act Makes Changes for Health Plans

On March 27, 2020, President Trump signed the Coronavirus Aid, Relief and Economic Security Act (CARES Act) into law to provide \$2.2 trillion in federal funding to address the COVID-19 crisis. The CARES Act makes a variety of changes affecting health plans. These changes include:

- Expanding the types of coronavirus testing that all health plans and health insurance issuers must cover without cost-sharing (such as deductibles, copayments or coinsurance) or prior authorization;
- Accelerating the process that will require health plans and issuers to cover preventive services and vaccines related to COVID-19;
- Allowing telehealth and other remote care services to be covered under a high deductible health plan (HDHP) before the deductible is met, without affecting the HDHP's compatibility with health savings accounts (HSAs) (applicable for HDHP plan years beginning on or before Dec. 31, 2021); and
- Treating over-the-counter (OTC) medications, along with menstrual care products, as qualified medical expenses that may be paid for using HSAs or other tax-advantaged arrangements, such as health flexible spending accounts (FSAs) or health reimbursement arrangements (HRAs).

Action Steps

Employers that sponsor group health plans should become familiar with the CARES Act changes for their plans. While many of the changes are mandatory, there are some discretionary changes that employers can decide whether to make (in consultation with their issuers or benefits administrators). Any health plan changes should be communicated to plan participants.

Coverage Requirement for Coronavirus 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. The CARES Act expands the FFCRA's coverage requirement for COVID-19 testing.

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 the COVID-19 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 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.

Provider Reimbursement Rates

The CARES Act also addresses provider reimbursement rates for COVID-19 testing. A health plan or issuer must pay a health care provider the negotiated rate for COVID-19 testing. However, if a health plan or issuer does not have a negotiated rate with a provider, it must pay the cash price published by the provider on its public website or negotiate or lower price.

Accelerated Coverage for COVID-19 Preventive Services and Vaccines

The ACA requires non-grandfathered group health plans and health insurance issuers to cover certain preventive health services without imposing cost-sharing requirements for the services. The recommended preventive care services covered by these requirements are:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines; and
- For women, evidence-informed preventive care and screening provided in guidelines supported by HRSA.



In general, health plans and issuers are not required to cover a new preventive care recommendation or guideline until at least one year after the new recommendation or guideline goes into effect.

The CARES Act shortens this deadline to ensure that health plans and issuers cover COVID-19 preventive services and vaccines without cost-sharing once they are approved and available. Under the CARES Act, health plans and issuers must cover COVID-19 preventive services and vaccinations without cost-sharing within 15 days after a recommendation from USPSTF or the CDC.

HDHP Coverage of Coronavirus Costs

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.

- IRS Notice 2020-15 provides that HDHPs can pay for COVID-19 testing and treatment before plan deductibles have been met, without jeopardizing their status. As noted above, the FFCRA requires health plans and issuers to cover COVID-19 testing without imposing any cost sharing or prior authorization or other medical management requirements.
- 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. This rule is applicable for plan years beginning before Jan. 1, 2022. This is a discretionary change for employer-sponsored health plans, and not a coverage mandate.

Tax-Free Coverage for OTC Drugs and Menstrual Products

Effective Jan. 1, 2020, the CARES Act provides that OTC medicines are qualifying medical expenses that may be paid for (or reimbursed) on a tax-free basis by an HSA, health FSA or HRA. This change eliminates an ACA provision that required individuals to have a prescription for an OTC medication (except insulin) to pay for it on a tax-free basis with their HSA, health FSA or HRA.

In addition, effective Jan. 1, 2020, menstrual care products are qualifying medical expenses that can be paid for (or reimbursed) on a tax-free basis by an HSA, health FSA or HRA. Menstrual care products include tampons, pads, liners, cups, sponges or similar products used by individuals with respect to menstruation.

These changes are discretionary for employers that sponsor health FSAs and HRAs. However, because HSAs are individual accounts, and not employer plans, employers do not control how HSA funds are used.

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