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MEMORANDUM

To: Board of Trustees

From: Klausner, Kaufman, Jensen and Levinson

Subject: Continued Guidance on the Families First Coronavirus Response Act (FFCRA) and the CARES Act

Date: April 27, 2020

FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA): GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE

§3201 (CARES)

• Section 3201 of the CARES Act amended section 6001 of the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover without any cost-sharing requirements or prior authorization or other medical management requirements.

§6001 (FFCRA)

• Section 6001 of the FFCRA applies to group health plans[1] and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans as defined in section 1251(e) of the Patient Protection and 2 5 U.S.C. § 553(b)(B) and (d)(3). Does NOT apply to group health plans that do not cover at least two employees who are current employees (such as plans in which only retirees participate).

• Requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the

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[1] The term "group health plan" includes both insured and self-insured group health plans. It includes private employment-based group health plans (ERISA plans), non-federal governmental plans (such as plans sponsored by states and local governments), and church plans.

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diagnosis of COVID-19 (referred to collectively in this document as COVID-19), as determined by the individual's attending healthcare provider in accordance with accepted standards of current medical practice, when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period[2].

• Plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements.

REQUIRED COVERAGE:

• Coverage must be provided for the following items and services:

(1) An in vitro diagnostic test as defined in section 809.3 of title 21, Code of Federal Regulations, for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that—

A. Is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb3);

B. The developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request has been denied or the developer of such test does not submit a request within a reasonable timeframe;

C. Is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or

D. Other tests that the Secretary of HHS determines appropriate in guidance.

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[2] Generally, under section 319 of the Public Health Service (PHS) Act, a public health emergency declaration lasts until the Secretary of HHS declares that the public health emergency no longer exists, or upon the expiration of the 90-day period beginning on the date the Secretary declared a public health emergency exists, whichever occurs first. The Secretary may extend the public health emergency declaration for subsequent 90-day periods for as long as the public health emergency continues to exist, and may terminate the declaration whenever he determines that the public health emergency has ceased to exist. Unless extended or terminated earlier, the public health emergency related to COVID-19 is effective through April 25, 2020.

(2) Items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and 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 in paragraph (1), 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.

• Plans and issuers are required to provide coverage for items and services that are furnished by providers that have not agreed to accept a negotiated rate as payment in full (i.e., out-of-network providers).

1. If the plan or issuer has a negotiated rate with such provider in effect before the public health emergency declared under section 319 of the PHS Act, such negotiated rate shall apply throughout the period of such declaration.

2. If the plan or issuer does not have a negotiated rate with such provider, the plan or issuer shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website, or the plan or issuer may negotiate a rate with the provider for less than such cash price.

• The term "visit" includes both traditional and non-traditional care settings in which a COVID-19 diagnostic test is ordered or administered, including COVID-19 drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing.

PLAN AMENDMENTS:

• Plans and issuers are permitted to amend the terms of a plan or coverage to add benefits, or reduce or eliminate cost sharing, for the diagnosis and treatment of COVID-19 prior to satisfying any applicable notice of modification requirements and without regard to otherwise applicable restrictions on mid-year changes to health insurance coverage.

• If a plan or issuer makes a material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage, to include telehealth coverage, that would affect the content of the SBC that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification

to enrollees not later than 60 days prior to the date on which the modification will become effective, or as soon as reasonably practicable. They may either provide an updated SBC reflecting the modification or provide a separate notice describing the material modifications.

• If a plan or issuer maintains any such changes beyond the emergency period, plans and issuers must comply with all other applicable requirements to update plan documents or terms of coverage.

**States may impose additional standards or requirements on health insurance issuers with respect to the diagnosis or treatment of COVID-19, to the extent that such standards or requirements do not prevent the application of a federal requirement.

EXCEPTED BENEFITS and EAP's:

Background:

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the respective requirements of title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code generally do not apply to the provision of certain types of benefits, known as "excepted benefits." Under section 2791(c)(1) of the PHS Act, section 733(c)(1) of ERISA, and section 9832(c)(1) of the Code, benefits that are generally not health coverage, including on-site medical clinics, are excepted benefits.

Limited excepted benefits, which may include limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home healthcare, or community-based care are excepted only if certain conditions are met. Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code authorize the Secretaries of HHS, Labor, and the Treasury (collectively, the Secretaries) to issue regulations establishing other, similar limited benefits as excepted benefits. The Secretaries exercised this authority previously with respect to certain employee assistance programs (EAPs).

• EAP's are excepted if they satisfy all of the following requirements:

(A) The EAP does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.

(B) The benefits under the EAP are not coordinated with benefits under another group health plan:

(1) Participants in the other group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

(2) Participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan.

(C) No employee premiums or contributions are required as a condition of participation in the EAP.

(D) There is no cost sharing under the EAP.

• The Departments' final regulations provide that for the purpose of determining whether an EAP provides benefits that are significant in the nature of medical care, the amount, scope, and duration of covered services are taken into account.

• An EAP will not be considered to provide benefits that are significant in the nature of medical care solely because it offers benefits for diagnosis and testing for COVID-19 while a public health emergency declaration under section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies Act,26 related to COVID-19 is in effect.

• Benefits offered by an employer under an EAP for diagnosis and testing for COVID-19 at an on-site medical clinic will constitute an excepted benefit in all circumstances .

**Note that guidance concerning the application of the FFCRA and the CARES Act continues to be updated frequently. This memo represents our considered view as of the date issued to the proper application after reviewing the Act and available resources.

**FAQ's prepared jointly by the Department of Labor (DOL), Health and Human Services (HHS), and the Treasury are available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs and www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html.

If you have any questions, email Bonni Jensen (bonni@robertdklausner.com) or Bob Klausner (bob@robertdklausner.com). This memo will be posted on our website, https://klausnerkaufman.com and will be updated as additional guidance becomes known.