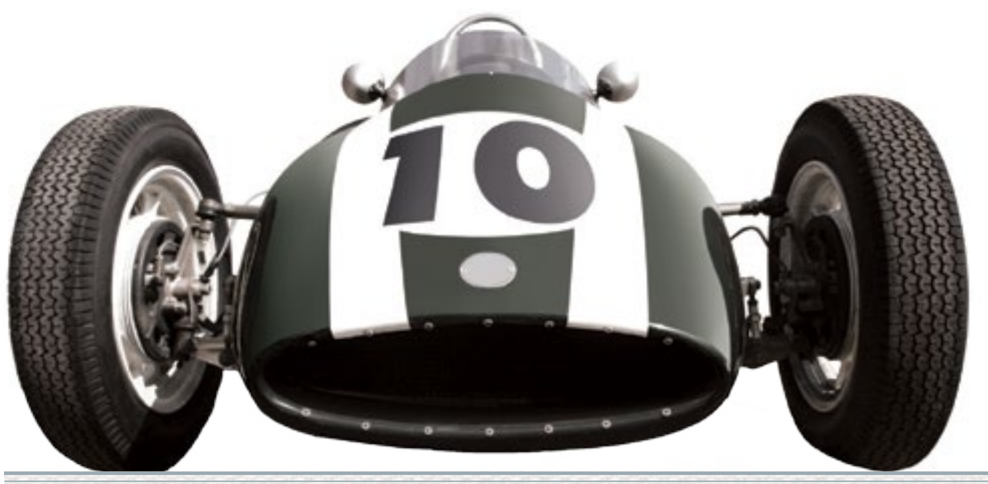
ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, and Carolyn Smith provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley Gillihan and Carolyn Smith are senior members of the Health Benefits Practice. Answers are provided as *general guidance* on the subjects covered in the question and are *not provided as legal advice* to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.



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CORONAVIRUS IMPACT ON HEALTH BENEFITS: A DEEPER DIVE

Congress enacted a flurry of new law impacting health benefits in response to the coronavirus. Congress enacted the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid Relief and Economic Security Act (the "CARES Act"). The tri-agencies followed with additional FAQ guidance clarifying the impact of these laws.[1] This FAQ guidance clarifies the scope of the FFCRA and CARES Act requirements.

The following addresses the tri-agency FAQs as well as other health and welfare related issues arising during this pandemic. Things are very fluid and further guidance will undoubtedly be issued. More to come.

DIAGNOSTIC TESTING AND RELATED SERVICES

What services do the FFCRA and the Cares Act require health plans to cover?

Beginning March 18, the FFCRA, as amended by the CARES Act, requires group health plans and health insurance issuers to provide the following services without cost sharing or imposition of prior authorization and other medical management limitations through the end of the public health emergency declared by the Secretary of HHS (which is currently set to end on June 14, 2020):

- In vitro, the FDA approved diagnostic products ("diagnostic testing") to determine if you have COVID-19 or the virus that causes the illness (SARS-CoV-2) and the administration of that diagnostic testing. This coverage includes both kits and lab-developed tests (LDTs) that are used to test—not just the physical kit itself. Covered tests include:
    - Tests approved, cleared, or authorized under section the Federal Food, Drug, and Cosmetic Act;
    - Tests where the developer has requested, or intends to request, emergency use authorization under the Federal Food, Drug, and Cosmetic Act, unless and until the emergency use authorization request has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;
    - Tests 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
    - Other tests that the Secretary of HHS determines appropriate in guidance ("diagnostic testing").

  Subsequent tri-agency FAQs clarify that approved serological tests for COVID must be covered as well.

- 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 a diagnostic testing 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 ("related services"). As noted in the FAQs, if the treating physician orders an influenza and/or blood tests in an attempt to rule out COVID 19, but ultimately orders the COVID 19 test, the influenza and blood tests, along with the cost of the office visit, would also have to be covered without cost share.

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To which group health plans do the diagnostic testing and related services requirement apply?

The FAQs clarify that the testing and related services requirement applies to all group health plans that provide minimum essential coverage, including grandfathered health plans. The FAQs further clarify that the testing and related services requirement do not apply to the following:

- Excepted benefits
- Short Term Limited Duration Insurance
- Retiree only health plans

Also, the FAQs clarify that testing provided through an EAP that is otherwise an excepted benefit will not cause the EAP to cease being an excepted benefit.

Can the plan limit its coverage of testing and related services to in-network services?

No. The CARES Act clarified that the required testing services described in the FFCRA shall reimburse the provider of the diagnostic testing as follows:

- 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.
- 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 CARES Act also requires providers of diagnostic tests for COVID-19 to make public the cash price of a COVID-19 diagnostic test on the provider's public internet website. Failure to post the price on the public website can result in a $300 per day penalty on the provider.

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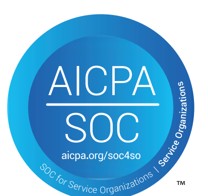

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Are plans required to provide treatment beyond covered testing and related services without any cost share or medical management limitations?

No. Plans are not required to cover treatment beyond diagnostic and related administration expenses. Plan sponsors that wish to provide coverage for treatment of COVID-19 without cost sharing may do that. In some cases, if the plan is fully insured, state-law requirements may impose coverage requirements in addition to those required by the FFCRA. Plan sponsors should consult with their insurance carrier about what is required for fully insured plans. For self-insured plans with stop-loss insurance, plan sponsors should consult with their stop-loss insurance carrier before providing coverage beyond that required by the FFCRA and CARES Act.

BEYOND TESTING

Will HSA eligibility be lost due to the extension of benefits for COVID-19 testing and treatment (including those required by the FFCRA) for employees who are otherwise eligible for an HSA?

No, the IRS indicated in Notice 2020-15 that otherwise-eligible employees will not be disqualified from HSA eligibility solely because a plan provides benefits for COVID-19 testing and treatment before satisfaction of the deductible. It should be noted that while the FFCRA is limited to COVID-19 diagnostic testing and services, the HSA guidance would extend to treatment for COVID-19 as well.

Will HSA eligibility be affected if telehealth (or other remote care) benefits are provided before an HDHP deductible is satisfied for those employees otherwise eligible for an HSA?

No. Section 3701 of the CAREs Act specifically allows telehealth (and other remote) services for any diagnosis to be provided below the minimum HDHP deductible for plan years commencing on or before 12/31/2021.

Likewise, the IRS issued Notice 2020-15, which allows HDHPs to provide services for COVID-19 related testing and treatment prior to satisfaction of the deductible without disqualifying employees from HSA eligibility. Unlike the CAREs Act telehealth provisions, the relief provided by the IRS notice does not have a sunset date.

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Will non-grandfathered health plans have to provide other COVID-19 related coverage?

Beginning March 27, non-grandfathered group health plans must provide coverage for "qualifying coronavirus preventive services". Qualifying coronavirus preventive services include the following preventive and vaccination services:

- an evidence-based item or service that has in effect a rating of "A" or "B" in the current rrecommendations of the United States Preventive Services Task Force; or (B) an immunization that has in effect a recommendation and
- from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Unlike other recommended preventive treatment services under the ACA which must be covered by the first day of the plan year that begins at least 12 months after the date a preventive service is recommended by the applicable agency, the qualifying coronavirus preventive services must be covered within 15 days of the USPTSF's or CDC's recommendation.

How did the CARES Act change the requirement that a prescription be obtained for an over-the counter (OTC) medical expense to be eligible for tax free reimbursement under an FSA, HRA, or HSA?

Section 3702 of the CAREs Act reversed the ACA requirement that an OTC drug be prescribed to receive tax free reimbursement under an FSA, HRA, or HSA. In addition, menstrual products qualify as an eligible medical expense. These changes are effective retroactively for expenses incurred (for an FSA or HRA) or for funds distributed (for an HSA) on or after January 1, 2020. Employers should consult with their tax and legal advisers to determine if an amendment is required for their plans and whether a retroactive amendment is permissible.

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What other benefit-plan-related issues should plan sponsors consider?

There are several other situations arising as a result of this pandemic that affect group health plans, such as:

- **Furloughed employees:** Check your plan to see if coverage eligibility is lost as a result of a furlough. If it is, furloughed employees would likely be eligible for COBRA. If you want to provide free or subsidized coverage to furloughed employees and your plan is fully insured or you have purchased stop-loss insurance, you should consult with the carrier before amending your plan to provide such coverage.
- **Impact on ACA employer responsibility requirements:** Employers should monitor the impact of any employment and coverage changes on compliance with the IRC 4980H "employer responsibility" requirements. Where the "look back" method of compliance is used, full time employees who remain employed but have no paid compensation would generally retain their full time status affecting compliance with IRC 4980H(a). In addition, in some cases, an extended furlough may result in a reduction in W-2 wages that could impact the overall affordability of coverage for purposes of IRC 4980H(b).
- **Continued coverage during paid leave under the Emergency Paid Sick Leave Act and the Emergency Family and Medical Leave Expansion Act:** The FFCRA also requires paid sick leave and expands Family and Medical Leave Act (FMLA) protections for affected employees of employers with less than 500 employees. The employer's paid leave policies and the FMLA's benefit plan continuation requirements would presumably apply. For a summary of the FFCRA's paid sick leave and expanded FMLA provisions, see "Employee Leave Requirements Under the Families First Coronavirus Response Act." Various federal tax credits may fund some or all of these leave requirements (including the cost of health care).
- **Health FSA election changes:** So far, the IRS has not provided relief from the Section 125 election change requirements. Consequently, changes made to the health plan in response to the COVID requirements or otherwise would not likely permit a health FSA election change; however, in many cases, an employment status change may trigger an election event. Other areas of health FSA administration should be analyzed as well. For example, employers may amend their plans to extend the run-out period for claims-filing purposes. An extension of the permitted grace period beyond March 15 or increase in the $500 health FSA carryover would, however, take further agency action.
- **Dependent care FSA election changes**. During this time, many employees are required to work from home. Also, many daycare facilities may be closed temporarily. These events will impact the need for daycare funds, resulting in a need to change elections. The Section 125 election change rules provide significant flexibility for employees to change their dependent care FSA elections because of changes in work or daycare status.
- **Commuter benefits:** Employees do not necessarily lose pre-tax salary reductions for parking or transit that were made before being required to work from home. The Section 132 regulations allow funds to carry over each month. Also, commuter salary reduction elections may be changed more frequently than under Section 125. Section 132 allows employees to reduce their pre-tax salary reductions to $0 while working from home. This should enable most employees to use any unused salary reductions when they return without accruing a surplus. ■

References:

1 https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf