KRIEG DEVAULT

Insights

The CARES Act: Changes Posed to Health Plans and HSAs

April 2, 2020

By: and Alexander L. Mounts

The Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") provides financial relief to employees facing economic hardships as a result of the pandemic. Below are provisions applicable to health plans and health savings accounts.

Exemption for Telehealth Services

For plan years beginning on or before December 31, 2021, a health plan may, but is not required to, provide first dollar coverage for telehealth and remote care services without it losing its high deductible health plan status or disqualifying an individual's ability to contribute to an HSA.

Certain Over-The-Counter Medical Products Treated as Qualified Medical Expenses

Retroactive to January 1, 2020, HSAs, Archer MSAs, health flexible spending arrangements, and health reimbursement arrangements now permanently can provide coverage for qualified reimbursement of amounts paid for (i) menstrual care products and (ii) over-the-counter drugs without a prescription. Under these new provisions, "menstrual care products" means a "tampon, pad, liner, cup, sponge, or similar product used by individual with respect to menstruation or other genital-tract secretions." Group health plans are not required to expand plan reimbursement to include the new qualified medical expenses, though most are likely to do so.

Expanded Coverage and Reimbursement Rules for COVID-19 Testing and Immunizations

The CARES Act further expands the requirement that group health plans provide first-dollar coverage of COVID-19 testing. Further, the CARES Act requires group health plans and health insurers to reimburse providers of COVID-19 testing according to rates negotiated as of January 31, 2020. Lastly, the CARES Act requires group health plans and health insurers to cover any "qualifying coronavirus preventive service" at no cost-share. Group health plans and health insurers must cover any "item, service, or immunization that is intended to prevent or mitigate" COVID-19 within 15 business days after being rated "A" or "B" by the United States Preventive Services Task Force, or, with respect to an immunizations, after being recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

These provisions are required of group health plans and insurers. For more information, America's Health Insurance Plans ("AHIP") has compiled a comprehensive list of prevention, testing, and treatments of COVID-19 that fully-insured carriers have announced they will cover at no cost-share to their members. While not required by the Act, but perhaps much more impactful, is the recent decision by some of the nation's largest health insurance carriers (e.g. Cigna, Humana and UnitedHealthcare) to waive cost-sharing of COVID-19 treatment for their fully-insured members. As treatment costs (e.g hospitalization) are likely to be very high in some cases, the decision by self-funded plans of whether to follow suit will likely depend on their ability to absorb costs and whether their stop-loss carrier will agree to such coverage changes.

Coronoavirus Resource Center

In addition, please look to Krieg DeVault's Coronavirus Resource Center for other pertinent articles and links addressing a number of legal and other issues caused by COVID-19, including employee pay and FMLA leave. We are with you all through this pandemic and are standing by to help with any challenges and questions you may have.