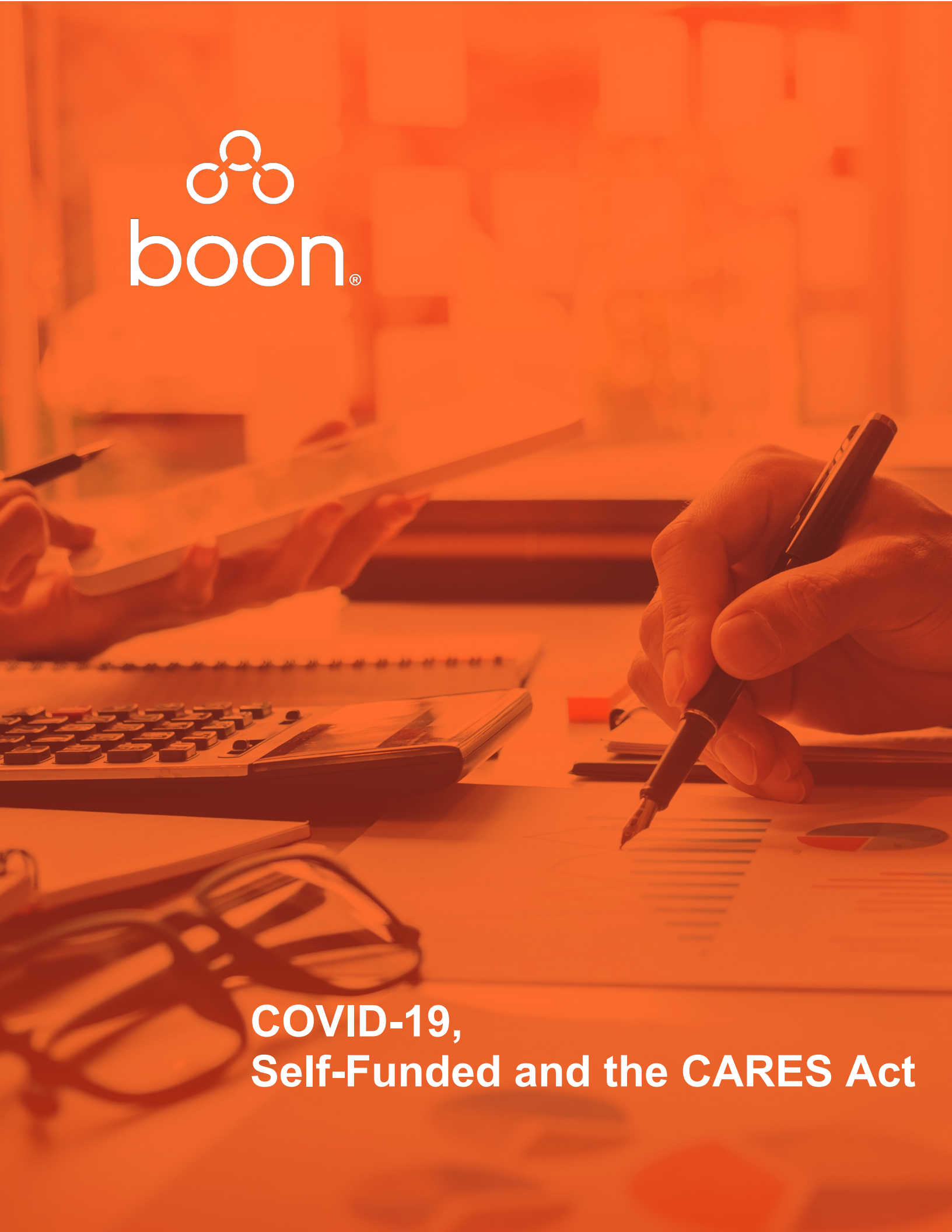

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COVID-19, Self-Funded and the CARES Act

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As an employer with a self-funded plan, will you be required to provide coverage for the COVID – 19 illness?

Yes and No.

The Families First Coronavirus Response Act (H.R. 6201), the 'FFCRA Act', that was signed into law on March 18, 2020, generally requires private and government health plans **– including self-funded group health plans** – to provide coverage for COVID-19 testing and other services at no cost to the individual.

On March 30, 2020, President Trump signed into law the Coronavirus Aid, Relief, and Economic Security Act (H.R. 748), the 'CARES Act'. This supplemental legislation builds upon the FFCRA Act to provide additional relief for individuals and businesses that have been negatively impacted by the coronavirus outbreak.

It is important to keep in mind that the plan type will determine what, if any, additional coverages or waiver of costs will be impacted by the Act.

- For MVP Silver or a 2020 Choice Plan, the answer is **YES**. Under these plans, even though they are self-funded, a plan member must be provided COVID-19 diagnostic testing and related services referenced above to employees and covered dependents without any cost; member responsibility is $0. This means no deductibles, co-payments, or co-insurance costs.

- For a preventive Minimum Essential Coverage (MEC)-only group health plan, the answer is **NOT YET**. These plans do NOT currently have to pay for the COVID-19 testing as an included preventive measure. Coverage for the testing and/or treatment of COVID-19 will only be required if added to the list of preventive services as an item or service with an 'A' or 'B' rating from the U.S. Preventive Services Task Force (USPSTF). **However, MEC-only group health plans will be required to provide COVID-19 testing at no charge to the member upon implementation of certain provisions within the CARES Act (see below for more details).**

What COVID-19 testing is required to be provided?

Specifically, the following tests and services must be provided without any member cost sharing, prior authorization or other medical management requirements:

- In vitro diagnostic products (i.e. blood or body sample) for the detection or diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized by the U.S. Food and Drug Administration (FDA), and
- Items and services furnished to an individual during health care provider office visits (in-person and telehealth), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic test described in the bullet point above, but only to the extent that such items and services relate to the furnishing or administration of such an in vitro diagnostic test or to the evaluation of an individual for purposes of determining their need for the in vitro diagnostic test.

The CARES Act expanded the types of products that qualify as 'in vitro diagnosis test' for the detection of SARS-CcV-2 or diagnosis of the virus that causes COVID. Specifically, the CARES Act allows the use of products wherein (i) the developer has requested, or intends to request, FDA emergency use authorization, or at least until the FDA authorization request has been denied or when the developer does not submit a request within a reasonable timeframe; (ii) a test that is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or (iii) other tests that the Secretary determines appropriate in guidance.

How does the CARES Act change the testing requirement for MEC-only group health plans?

The CARES Act includes a requirement that group health plans and health insurance issuers offer coverage (without cost-sharing) for any 'qualifying coronavirus preventive service' once such items, services, and immunizations are provided with an evidence-based recommendation for the items or services with an 'A' or 'B' rating by the USPSTF and that an immunization recommendation is made from the ACIP. A 'qualifying coronavirus preventive service' means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019.

For MEC-only plans, this means that, once the USPSTF and/or ACIP provide a qualifying item or service (detailed above) with an 'A' or 'B' rating, it is added to the list of 'preventive services' required to be covered for minimum essential services. At such point, group health plans and insurers (including MEC-only plans) will be required to cover such expenses at no cost to the plan participant. Generally, there is a one-year implementation period for an item or service that is newly added by the USPSTF or ACIP, but the CARES Act requires a 'qualifying coronavirus preventive service' to be implemented within 15 days after the date that such recommendation is made. Coverage for the testing and/or treatment of COVID-19 will only be required if added to the list of preventive services as an item or service with an 'A' or 'B' rating from the U.S. Preventive Services Task Force (USPSTF).

Boon will coordinate with insurers and self-funded group health plans to coordinate the implementation of any new preventive item or service that must be added to coverage and provided at no-cost to the plan participant. Boon is currently reviewing the plan documents of our self-funded plans to determine whether a plan amendment will be required for this update. If needed, the amendment need only be executed prior to the end of the current plan year.

Provider reimbursement rates applicable for self-funded plans:

The CARES Act details provider reimbursement rates for items and services related to the diagnostic testing to detect and/or diagnosis of the virus. Specifically:

- If a 'negotiated rate' (e.g. an in-network rate) with the provider existed prior to the public health emergency, such negotiated rate shall apply throughout the 'public health emergency' period
- If there is not a 'negotiated rate' in place with the provider (e.g. out-of-network provider), the plan or insurer shall reimburse the provider an amount equivalent to the 'cash price' for such service as listed on the provider's public internet website, or may negotiate a rate.

The provider of a diagnostic test for COVID-19 must make public the cash price of such test on a public internet website. Failure to comply with these requirements could result in HHS assessing a civil monetary penalty of up to $300 per day.

Other notable provisions of the CARES Act include:

- Appropriates $1.3 billion for FY 2020 for supplemental awards to health care centers for the prevention, diagnosis, and treatment of COVID-19.

- Provides that within 180 days of the passage of the Act, the Secretary of HHS shall issue guidance on the sharing of patients' protected health information (PHI) related to COVID-19, including guidance on compliance with HIPAA regulations and applicable policies.

- Waives the 10% penalty for early withdrawals from 401(k) plans (up to $100,000) for a coronavirus-related distribution, which can be any distribution made on or after January 1, 2020 and before December 31, 2020, from an eligible retirement plan.

- Expands the DOL authority to postpone certain ERISA filing deadlines

- Allows HDHPs and HSAs to cover telehealth services prior to reaching a deductible, and allows the use of HSAs and FSAs to purchase certain over-the-counter medical products.

- Provides that within 180 days of the passage of the Act, the Secretary of HHS shall issue guidance on the sharing of patients' protected health information (PHI) related to COVID-19, including guidance on compliance with HIPAA regulations and applicable policies.

The general understanding is that the CARES Act will be the last Coronavirus-related legislation, but Boon will continue to monitor congressional actions or other activity taken by the Administration. Should you have any questions, please don't hesitate to reach out to your Account Manager directly.

The FFCR Act (H.R. 201): https://www.congress.gov/bill/116th-congress/house-bill/6201/all-actions?overview=closed&KWICView=false

The CARES Act (H.R. 748): https://www.congress.gov/bill/116th-congress/house-bill/748

Will the group health plan expenses related to COVID-19 be covered under the existing stop-loss carrier agreement?

If the COVID-19 testing and diagnosis is added to the SPSTF preventive services with a rating of 'A' or 'B' under the USPSTF or recommendation from the ACIP, then such expenses would likely be considered a 'Covered Expense' and covered by the carrier policy. The policy generally provides that 'any deductibles, coinsurance, co-payment amounts specified in the Plan document would not be considered 'Covered Expenses' and, therefore, ineligible for reimbursement under the policy. However, the stop-loss carrier recently provided confirmation that the waiver of cost-sharing for testing of COVID-19, telehealth services (if applicable), and FDA-approved COVID-19 immunizations would be included within the overall calculation and reimbursement. Therefore, the testing and diagnosis costs would be a 'Covered Expense' under the stop-loss policy and the plan's expenses related to the waiver of the above-mentioned cost-sharing will be included within the overall calculation and reimbursement.