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Key health and welfare provisions in CARES Act

The Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law by President Trump on March 27, after the U.S. House of Representatives followed the Senate and approved the bill.

Background

The $2.2 trillion CARES Act is intended to provide economic relief for individuals and businesses adversely impacted by the coronavirus pandemic. Several of the provisions directly impact employer health and welfare benefit programs. The key H&W provisions are summarized below.

COVID-19 diagnostic testing mandate

The Families First Coronavirus Response Act (FFCRA) mandated that group health plans (including grandfathered plans) cover COVID-19 diagnostic testing products that are approved, cleared or authorized by the Food and Drug Administration (FDA). (See our March 19 *FYI Alert*.) While guidance is needed, this requirement appears to apply to both in-network and out-of-network services.

The CARES Act expands this mandate to include tests that are (1) under review by the FDA, (2) developed and authorized by a state, or (3) determined to be appropriate by the Secretary of Health and Human Services (HHS).

> **Comment.** This mandate must be communicated to employees. Also, although not required by the CARES Act, employers should ensure that Summaries of Benefits and Coverage are updated to include this coverage and that SMMs are distributed to employees.

Expedited coverage of new COVID-19 preventive services and vaccines

The ACA requires non-grandfathered health plans to cover in-network preventive services in full. A plan must cover a new preventive service recommendation or guideline that has a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force (USPSTF) beginning with the first plan year that starts on or after the date that is one year after the new recommendation or guideline is adopted. For example, if the USPSTF adopts a new "A" or "B" preventive service coverage recommendation on April 1, 2020, a calendar year plan must begin covering this service on January 1, 2022. (See our August 7, 2015 *FYI*.)

The CARES Act expedites this timing by requiring coverage for COVID-19 preventive services and vaccines within 15 business days after the new recommendation or guideline is adopted. Unlike the diagnostic testing mandate, 100% coverage of preventive services and vaccines appears to only be required in-network.

Telehealth services

The FFCRA COVID-19 diagnostic coverage mandate applies to all patient settings, including telehealth visits. The IRS had previously provided guidance allowing COVID-19 diagnostic testing, including telehealth visits, to be provided pre-deductible under high-deductible health plans (HDHP) intended to be compatible with a health savings account (HSA). (See our March 11 *FYI Alert*.) However, many telehealth providers are unable to waive telehealth cost-sharing only for COVID-19 diagnostic testing. Failure to impose cost-sharing for non-COVID-19-related services arguably could prevent the health plan from being HSA-compatible.

The CARES Act addresses this issue by allowing an HDHP to cover all telehealth services in full before the HDHP deductible is satisfied. Note that this expansion is optional for employers and is not a required change. This provision is effective for plan years beginning on or before December 31, 2021.

> **Comment.** The FFCRA diagnostic testing mandate applies to provider office visits, including in-person and telehealth visits. This provision could be read as requiring all health plans to cover telehealth services for COVID-19 diagnostic testing, including plans that currently don't include those benefits. Clarification is needed.
>
> Some employers are considering offering a standalone telehealth benefit to employees who are not eligible for medical coverage, or who have waived coverage. However, a standalone telehealth benefit would not satisfy ACA market reform requirements, unless it qualifies as an excepted benefit. (See our February 27, 2019 *FYI In-Depth*.)

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Coverage of OTC medical products under account-based plans

Prior to the enactment of the ACA, account-based plans (health flexible spending accounts, health reimbursement arrangements and HSAs) could reimburse the cost of over-the-counter (OTC) drugs and medicines without a prescription. The ACA imposed the prescription requirement on all OTC medicines and drugs, except for insulin.

The CARES Act reverses this ACA provision and again permits account-based plans to reimburse the cost of OTC drugs even when not prescribed. It also provides that the cost of menstrual care products may also be reimbursed as a qualified medical expense. These changes apply retroactively to expenses incurred after December 31, 2019.

> **Comment.** Plan documents for health flexible spending accounts and health reimbursement arrangement will likely need to be amended to permit reimbursement of OTC drugs obtained without a prescription.

Employer payment of student loans

Section 127 of the Internal Revenue Code permits employers to provide employees with up to $5,250 of educational assistance benefits each year.

The CARES Act expands Section 127 to add the repayment of qualified student loans as "educational assistance." Such payments may be made to the employee or the lender. This provision only applies to education payments made during 2020.

> **Comment.** The plan document for an employer's educational assistance program will likely have to be amended to include the repayment of student loans as an eligible expense.

In closing

Employers should review the CARES Act provisions to determine what changes are required and whether they want to implement any of the other changes.

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