New Health Plan Requirements under the Families First Coronavirus Response Act

Late on March 18, 2020, President Trump signed into law the Families First Coronavirus Response Act (the Act), a package of new laws that had been pushed through Congress in response to the COVID-19 pandemic. The Act includes important provisions relating to mandated paid sick leave and other measures intended to assist individuals and businesses affected by the pandemic.

The Act also imposes new requirements on group health plans relating to the coverage of certain items and services associated with COVID-19 testing. These health plan requirements are summarized in this Information Memo.

Covered Items and Services

In general, the Act requires insured and self-insured group health plans to cover COVID-19 testing without any participant cost-sharing (including copays, coinsurance and deductibles) until the end of the declared public health emergency. Specifically, the Act requires covered group health plans to cover:

- COVID-19 Testing: All FDA-approved products needed for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such products, and
- Associated Medical Services, Including Evaluations: Any items or services provided during a visit to a health care provider that relate to COVID-19 testing or to the evaluation of the individual to determine the need for testing.

The items or services required to be covered could be provided during an in-person visit or a telehealth interaction with a health care provider's office, an urgent care center or an emergency room.

Covered Health Plans

The new requirements under the Act apply to all health plans sponsored by or contributed to by an employer (including both private employers and state and local governments) for the benefit of employees and their families. Both insured and self-insured plans are covered.

> Note: As written, the Act appears to exempt group health plan plans that cover only retirees (not active employees, or at most one active employee) from the new COVID-19 mandates. It is not clear whether Congress intended to apply this "retiree-only" exemption (which already applies to certain Affordable Care Act requirements) to the new COVID-19 mandate, but for now such plans appear to be exempt.

Coverage of COVID-19 Treatments Are Not Mandated

The Act only requires that plans cover, without cost sharing, COVID-19 testing and health care provider visits relating to that testing. The Act does not mandate coverage of COVID-19 *treatments*.

However, as we noted in an earlier Information Memo, the IRS recently issued guidance which permits high deductible health plans (HDHPs) to cover COVID-19 testing *and* treatment prior to the HDHP deductible being satisfied. So, a HDHP could cover COVID-19 treatments (beyond testing), although for now the coverage of COVID-19 treatments will depend on the terms of the plan.

What Health Plan Sponsors Must Do

The COVID-19 testing mandate is effective immediately.

For insured health plans, the insurer will likely effectuate the required coverage mandate, although the employer/sponsor should confirm that this has been done. Sponsors of self-insured plans must ensure that the coverage mandate is implemented by the third-party administrator or claims administrator, if the plan is not administered "in house."

In addition, if the sponsor is also the plan administrator (as is usually the case), the change should be reflected in an updated summary plan description or a "summary of material modifications."

Bond will continue to monitor COVID-19 legal issues and is hosting weekly webinars to update employers and businesses on the latest federal and state developments. You can register for the complimentary weekly webinar here.

If you have any questions about this memorandum, please contact the attorney at the firm with whom you are regularly in contact or any attorney in our Employee Benefits and Executive Compensation Practice Group.

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