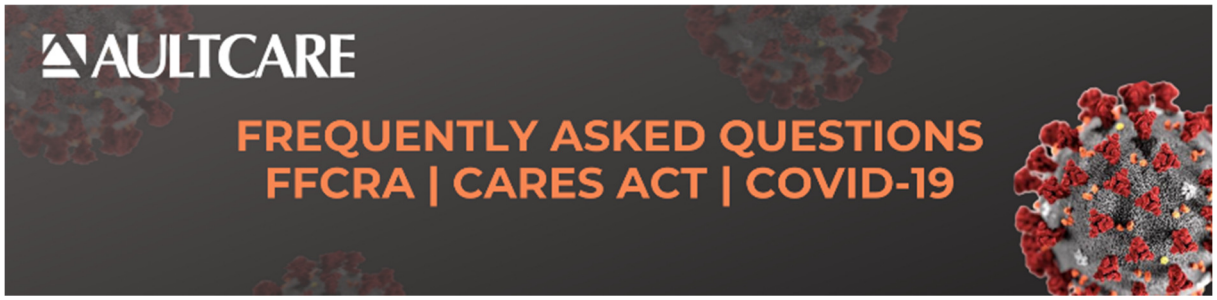


The Families First Coronavirus Response Act (FFCRA) was enacted on March 18, 2020. Section 6001 of the FFCRA generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19.

The CARES Act was enacted on March 27, 2020. Section 3201 of the CARES Act amended section 6001 of the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover without any cost-sharing requirements or prior authorization or other medical management requirements.

The Federal Government released a set of Frequently Asked Questions (FAQs) regarding implementation of the Families First Coronavirus Response Act (the FFCRA), the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), and other health coverage issues related to Coronavirus Disease 2019 (COVID-19). The FAQs were prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments).

Below is a summary of each FAQ. This summary is not intended to provide legal advice and is not a complete analysis, but provides highlights of those areas that are most applicable to your health plan(s). The FAQs can be found in their entirety at:

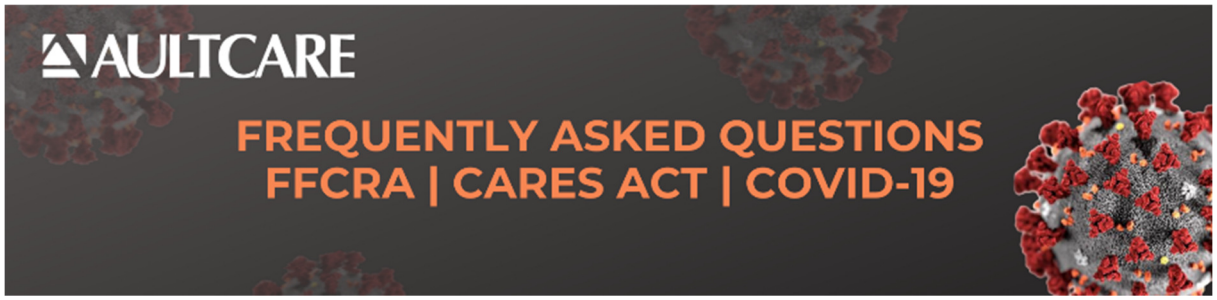
https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf

Question 1. Which types of group health plans and health insurance coverage are subject to section 6001 of the FFCRA, as amended by section 3201 of the CARES Act?

All group health plans including self-funded plans, insured group health plans and individual plans offered by insurers. It also includes grandfathered health plans and references the definitions of health plans in the Patient Protection and Affordable Care Act (PPACA). It does not apply to short-term limited duration insurance, a plan or coverage in relation to its provision of excepted benefits, nor does it apply to group health plans that do not cover at least two employees who are current employees.

Question 2. When are plans and issuers required to comply with section 6001 of the FFCRA and for how long?

FFCRA was passed on March 18, 2020. Plans and issuers must comply as of that date and continue to comply with section 6001 of the FFCRA for applicable items and services furnished during the public health emergency related to COVID-19.



Question 3. What items and services must plans and issuers provide benefits for under section 6001 of the FFCRA?

An in vitro diagnostic test for the diagnosis of COVID-19. Also 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 an in vitro diagnostic product related to COVID-19 testing, 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.

In addition, any other tests that the Secretary of HHS determines appropriate in guidance.

Question 4. Do "in vitro diagnostic tests" described in section 6001(a)(1) of the FFCRA, as amended by section 3201 of the CARES Act, include serological tests for COVID-19?

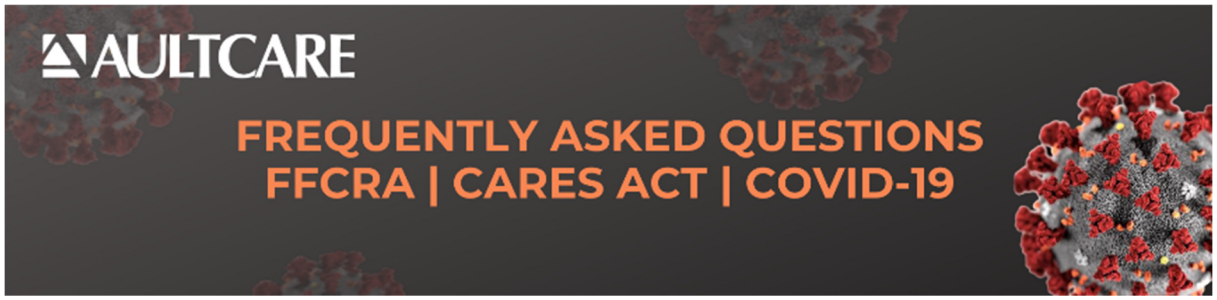
Yes. See our AultCare Bulletin previously released regarding serological (antibody) tests.

Question 5. The FFCRA requires plans and issuers to cover items and services provided during a visit that "relate to the furnishing or administration" of COVID-19 diagnostic testing or that relate "to the evaluation of such individual for purposes of determining the need" for diagnostic testing. What types of items and services must be covered pursuant to this requirement?

Plans and issuers must cover items and services furnished to an individual during visits that result in an order for, or administration of, a COVID-19 diagnostic test, but only to the extent that the items or services relate to the furnishing or administration of the test or to the evaluation of such individual.

Question 6. May a plan or issuer impose any cost-sharing requirements, prior authorization requirements, or medical management requirements for benefits that must be provided under section 6001(a) of the FFCRA, as amended by section 3201 of the CARES Act?

No. Section 6001(a) of the FFCRA provides that plans and issuers shall not impose any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization requirements, or other medical management requirements for these items and services.



Question 7. Are plans and issuers required to provide coverage for items and services that are furnished by providers that have not agreed to accept a negotiated rate as payment in full (i.e., out-of-network providers)?

Yes. Section 3202(a) of the CARES Act provides that a plan or issuer providing coverage of items and services described in section 6001(a) of the FFCRA shall reimburse the provider of the diagnostic testing as follows:

1. If the plan or issuer has a negotiated rate that would serve as the reimbursement rate.
2. If there is not a negotiated rate then the reimbursement is determined by a provider's published rate or may be negotiated.

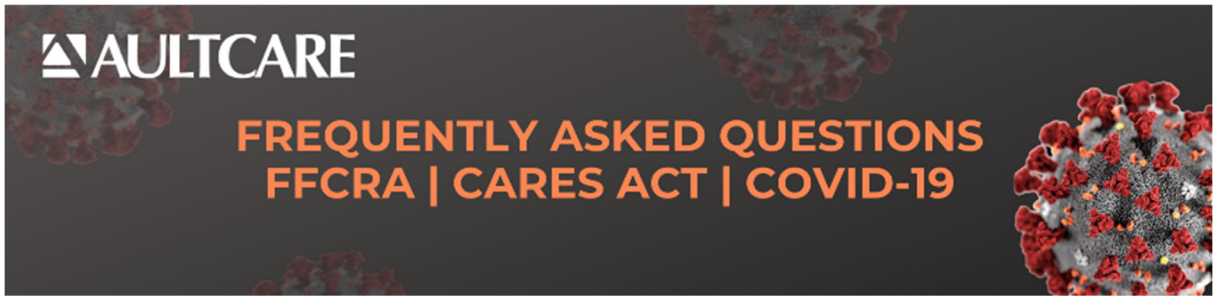
Note: The CARES Act requires providers to make public the cash price of COVID-19 diagnostic testing.

Question 8. Section 6001(a)(2) of the FFCRA requires plans and issuers to provide benefits for certain items and services that are furnished during healthcare provider office visits, which include in-person and telehealth visits, as well as visits to urgent care centers and emergency rooms. Under what circumstances are items or services considered to be furnished during a visit?

The Departments construe the term "visit" in section 6001(a)(2) of the FFCRA broadly to include both traditional and non-traditional care settings in which a COVID-19 diagnostic test described in section 6001(a)(1) of the FFCRA is ordered or administered, including COVID-19 drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing.

Question 9. In light of the COVID-19 public health emergency, will the Departments permit plans and issuers to amend the terms of a plan or coverage to add benefits, or reduce or eliminate cost sharing, for the diagnosis and treatment of COVID-19 prior to satisfying any applicable notice of modification requirements and without regard to otherwise applicable restrictions on mid-year changes to health insurance coverage in the group and individual markets?

Yes. During the public health emergency, mid-year modifications that affect the SBC will be permitted without 60 day advance notification. In addition, the Departments will not take enforcement action if plan amendments are made to provide increased coverage for COVID-19 related services and treatment.



Question 10. May states impose additional requirements on health insurance issuers to respond to the COVID-19 public health emergency?

Yes. Nothing in the FFCRA prevents a state from imposing additional standards or requirements on health insurance issuers with respect to the diagnosis or treatment of COVID-19, to the extent that such standards or requirements do not prevent the application of a federal requirement.

Question 11. May an employer offer benefits for diagnosis and testing for COVID-19 under an EAP that constitute an excepted benefit?

Yes. An EAP will not be considered to provide benefits that are significant in the nature of medical care solely because it offers benefits for diagnosis and testing for COVID-19 while a public health emergency declaration under section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies Act,26 related to COVID-19 is in effect.

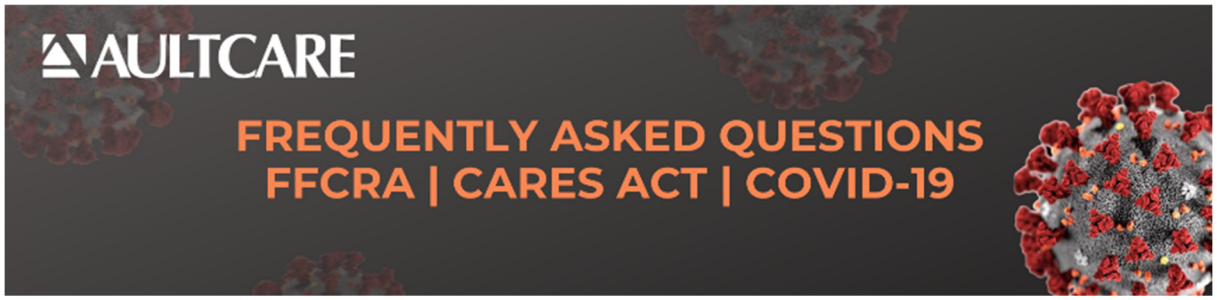
Question 12. May an employer offer benefits for diagnosis and testing for COVID-19 at an on-site medical clinic that constitute an excepted benefit?

Yes. Coverage of on-site medical clinics is an excepted benefit in all circumstances.

Question 13. How can plans and issuers use telehealth and other remote care services to mitigate the impact of the COVID-19 public health emergency?

The Departments strongly encourage all plans and issuers to promote the use of telehealth and other remote care services, including by notifying consumers of their availability, by ensuring access to a robust suite of telehealth and other remote care services, including mental health and substance use disorder services, and by covering telehealth and other remote care services without cost sharing or other medical management requirements.

In addition, the CARES Act amends the laws applicable to high deductible health plans (HDHPs) and Health Savings Accounts (HSAs) to provide flexibility with respect to telehealth and other remote care services. Specifically, section 3701 of the CARES Act amends section 223(c) of the Code to provide a temporary safe harbor for providing coverage for telehealth and other remote care services. As added by section 3701 of the CARES Act, section 223(c)(2)(E) of the Code allows HSA-eligible HDHPs to cover telehealth and other remote care services without a deductible or with a deductible below the minimum annual deductible otherwise required by section 223(c)(2)(A) of the Code.



Question 14. In light of the public health emergency posed by COVID-19, will the Departments allow plans and issuers to add benefits, or reduce or eliminate cost sharing, for telehealth and other remote care services prior to satisfying any applicable notice of modification requirements and without regard to restrictions on mid-year changes to provide coverage for telehealth services?

Yes. The Departments will apply the same non-enforcement policies described in **Question 9** to situations where a plan or issuer adds benefits, or reduces or eliminates cost sharing, for telehealth and other remote care services. These non-enforcement policies will apply with respect to changes made for the period during which a public health emergency declaration under section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies Act, 28 related to COVID-19 is in effect.