SLEVIN & HART, P.C.
Attorneys at Law
WWW.SLEVINHART.COM

1625 Massachusetts Avenue, NW, Suite 450
Washington, DC 20036

14 Wall Street, 20th Floor
New York, NY 10005

MEMORANDUM

TO: Group Health Plan Clients

FROM: Slevin & Hart, P.C.

DATE: April 1, 2020

RE: Coronavirus Aid, Relief and Economic Security Act - Summary of Health Plan Provisions

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On Friday, March 27, 2020, the President signed the Coronavirus Aid, Relief and Economic Security Act ("Act") into law. The CARES Act builds upon the federal emergency assistance and health care response efforts under the Families First Coronavirus Response Act ("FFCRA") for individuals, families and businesses impacted by 2020 Coronavirus pandemic ("COVID-19"). Among other emergency relief measures to address COVID-19, the Act expands the types of COVID-19 testing and preventative services that must be covered by group health plans, provides clarifications and changes to the FFCRA provisions concerning emergency paid sick and family leave, and clarifies that high deductible health plans will continue to be qualified even without requiring a deductible for telehealth services. Below is a summary of the relevant provisions of the Act that apply to group health plans. Unless otherwise noted below, these provisions are generally effective as of March 27, 2020. This Memorandum also contains decision points regarding the relevant issues related to providing coverage without cost-sharing for COVID-19 testing provided by out-of-network providers.

Summary of Changes Impacting Group Health Plans

- **Expanded Coverage for COVID-19 Testing Without Cost-Sharing For Out-Of-Network Providers:** As noted above, group health plans must reimburse providers of COVID-19 diagnostic testing at the plan's negotiated rate in existence with the provider before the COVID-19 public health emergency was declared. If there is no existing negotiated rate with the provider (as with out-of-network providers), the plan can either reimburse the provider the cash price for the service that is listed by the provider on a public website, or negotiate a lower rate with the provider.

  Although the Act provides plans with the ability to negotiate such out-of-network claims that are more costly than its corresponding in-network prices, it is silent on how to resolve

pricing disputes over claims that exceed the plan's in-network price. The Act also does not address how to resolve an out-of-network provider claim that is based on an unpublished price and/or when such provider refuses to negotiate a lower price or accept the plan's negotiated price for such claims. Please refer to the Section herein entitled "Decision Points" for a discussion on the relevant considerations and a possible approach on how to administer such out-of-network claims in the absence of further guidance.

- **Plan Requirement to Cover Patient's Cost-Sharing for Qualifying COVID-19 Preventive Services:** The Act also provides that certain items, services, or immunizations intended to prevent or mitigate COVID-19 are required to be provided by a group health plan without imposing a cost-sharing obligation on the patient. In order to qualify as being preventive for this purpose, the item, service or immunization must be intended to prevent or mitigate COVID-19 and meet certain criteria and ratings of the U.S. Preventative Services Task Force or be recommended by the Centers for Disease Control and Prevention ("CDC") for the individual involved.

  However, unlike the requirement to cover the cost of COVID-19 diagnostic testing, since these are categorized as "preventive services," it is unclear whether the cost-sharing requirement is applicable to qualifying services performed by both in-network and out-of-network providers (as with the other COVID services) or in-network only (as with other ACA preventive services). This will require further guidance. In the meantime, the conservative approach would be to cover out-of-network provider services to the same extent as in-network.

  This requirement will go into effect 15 business days after the date on which a recommendation from either the U.S. Preventive Services Task Force or the Advisory Committee on Immunization Practices of the CDC is made relating to the service.

- **Expansion of COVID-19 Testing Required to be Covered Without Cost-Sharing:** The Act expands the testing mandate to also include: (1) in vitro diagnostic testing for which a developer has requested, or intends to request, emergency use authorization from the Food and Drug Administration ("FDA"), unless such request has not been timely submitted to the FDA for consideration or until such request has been denied by the FDA; (2) in vitro diagnostic testing authorized by a State that has notified the Secretary of Health and Human Services ("HHS") of its intention to review such tests; and (3) any COVID-19 diagnostic testing that the Secretary of HHS determines to be appropriate and for which guidance has been issued.

- **Clarifications Regarding High Deductible Health Plans ("HDHP") and Spending Accounts:** The Act allows a HDHP to not have a deductible for telehealth or other remote care services for plan years beginning on or before December 31, 2021.

  The Act also includes certain over-the-counter medical products and menstrual care products (e.g., tampon, pad, liner, cup, sponge or other similar products used by individuals with respect to menstruation or other genital secretions) as qualifying medical expenses eligible for payment or reimbursement from a health savings account or other spending

account, such as flexible spending arrangements and health reimbursement arrangements. This provision applies retroactively to reimbursements from savings accounts for expenses incurred after December 31, 2019.

- **Multiemployer Fund as Vehicle for Paid Sick Leave/FMLA Leave Payments:** FFCRA provides that multiemployer funds can be the vehicle that provides paid leave benefits to affected employees, assuming that the bargaining parties negotiate to provide that benefit through the fund. The FAQs on the FFCRA provide further details about how employers can receive a dollar-for-dollar tax credit or direct payment from the Internal Revenue Service ("IRS") for amounts equal to the paid leave provided. Given that employers will receive a tax credit or direct payments from the IRS for providing paid leave, and the practical barriers to providing such benefits through a multiemployer fund, we think it is unlikely that employers (or other bargaining parties) will seek to provide the paid leave benefits through a fund.

- **Protected Health Information:** The Act provides for the Secretary of HHS to issue guidance on the sharing of patient's protected health information during the COVID-19 public emergency. Such guidance is expected to be forthcoming within 180 days from March 27, 2020, the date of enactment of the CARES Act.

Decision Points

As discussed above, the Act clarifies that group health plans (insured and self-insured) must reimburse providers for covered COVID-19 diagnostic testing services rendered by all providers, including out-of-network providers. Although the Act provides plans with the ability to negotiate out-of-network claims that are more costly than its corresponding in-network prices, it is silent on how to resolve pricing disputes over claims that exceed the plan's in-network price. The Act also does not address how to resolve an out-of-network provider claim that is based on an unpublished price and/or when such providers refuse to negotiate a lower price or accept the plan's negotiated price for such claims. In the absence of further guidance, it seems that plans could be placed in the difficult position of having to decide whether to pay more for diagnostic testing performed by out-of-network providers or to impose some reasonable measures to challenge high-priced claims, which may be viewed as creating a technical compliance risk under the Act.

To avoid a delay in processing diagnostic testing claims submitted by out-of-network providers, the following claims processing approach could be considered:

- If the billed charges are lower than the in-network rate, the plan would pay the lower charge.
- If the billed rate is higher, the plan would research each out-of-network provider's published cash price and, if appropriate, contact the provider to attempt to negotiate for the in-network price. For this purpose, the plan could provide settlement authority to the claims administrator up to a certain monetary threshold to resolve such claims. If the provider does not negotiate and insists on charging a price that exceeds the plan's in-network price (or the authorized monetary limit for settlement purposes), plan counsel could be consulted as to next steps. We hope that this will be an infrequent occurrence.

- If there is no out-of-network provider's published cash price and the provider does not negotiate, plan counsel could be consulted as to next steps. We hope that this also will be an infrequent occurrence.

If there are any questions about this approach or you want to consider other options, please contact us. Once a determination on a claims processing approach for out-of-network claims has been made for this purpose, that approach can always be re-evaluated after more experience with the testing process and as further guidance is released.

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We anticipate that the relevant government agencies will issue guidance on many aspects of these provisions in the near future and we will communicate that guidance to you when it is issued. In the interim, we look forward to speaking with you to address any questions you may have.

cc: Co-Counsel

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