Health Insurance Coverage During the COVID-19 Pandemic

Below are highlights of State and Federal provisions that affect group health plans:

- Health plans (and insurers) are required to cover specific services related to testing for COVID-19 testing without cost sharing. The new requirements apply to all group health plans, including self-insured plans
  - Applies to medically necessary office, urgent care or emergency room visits related to COVID-19 testing
- Testing without cost extends to the following types of tests:
  - Products approved by the Federal Food, Drug and Cosmetic Act (FDA)
  - Products for which the developer has requested or intends to request an emergency use authorization by the FDA (and where such authorization has not been denied)
  - Products developed in and authorized by a state that has notified HHS of its intent to review COVID-19 tests
  - Products that HHS approves through published guidelines
- No cost for telehealth (telemedicine) services where plans include a telehealth benefit
- The prohibition on cost sharing means that these services cannot be subject to a deductible, copayments or coinsurance
- Plans and insurers are also prohibited from imposing prior-authorization or other medical-management requirements for these services
- No laws require plans to cover services for treating COVID-19
  - Some health plans and insurers have voluntarily waived cost sharing for treatment of COVID-19
- Plan reimbursement rates for COVID-19 diagnostic testing are established as follows:
  - If the plan (or insurer) has a negotiated rate with the provider that was in effect before January 27, 2020, the start of the public health emergency, that rate will apply throughout the public health emergency
  - If the plan (or insurer) does not have a negotiated rate with the provider (out-of-network provider), the plan must either reimburse the published "cash price" for the test, or negotiate a lower reimbursement rate
  - The CARES Act requires providers of diagnostic tests to post their cash price on a website. Failure to do so may result in civil monetary penalties imposed by HHS

- High Deductible Health Plans (HDHP) are permitted to cover testing (and treatment) for COVID-19 before the deductible is met
  - In effect until further IRS guidance is issued, per IRS Notice 2020-15
- HDHP's can comply with the new testing requirements without jeopardizing the ability of employees to contribute to Health Savings Accounts (HSA)
- The CARES Act includes a new safe harbor that permits HDHP's to provide telehealth or other remote-care services before the deductible is met
- The CARES Act removes the ACA restriction that applies to Flexible Spending Accounts (FSA), HSA's and Health Reimbursement Accounts (HRA) of reimbursing over-the-counter medications without a prescription
  - Sponsors will need to amend plan documents to allow for the new OTC reimbursements before coverage may be offered
  - This provision expands coverage to include menstrual care products as of January 1, 2020
- Fully insured health plans in NYS are suspending for 90-days, pre-authorizations and other administrative requirements, including certain utilization review and notification requirements for hospitals
  - This does not apply to self-funded plans, although the NYS Department of Financial Services is strongly encouraging third party administrators to apply the same provisions so that hospitals can direct resources to patient care in order to handle in-patient volume due to COVID-19
- Early medication refills are available for prescriptions during the state of emergency at the discretion of providers
- The CARES Act makes preventive care related to COVID-19 part of the preventive care mandate under the ACA. Therefore, plans must cover COVID-19 preventive care (such as vaccines) on a first dollar basis without any cost sharing
  - Although there is no preventive care yet related to COVID-19, this requirement will become effective within 15 days (instead of the typical one-year lead time) after a service receives an "A" or "B" rating by the U.S. Preventive Services Task Force or a recommendation by the Advisory Committee on Immunization Practices of the CDC.
- NYS Department of Financial Services (DFS) directs health plans to provide financial and administrative relief to New York Hospitals
  - Immediately process for payment outstanding claims;
  - Work with hospitals in insurers' networks to provide additional financial assistance if needed and feasible, focusing on community, rural, and safety-net hospitals;
  - Suspend preauthorization requirements for all services performed at hospitals, including lab work and radiology, until June 18, 2020; and
  - Not make any necessity denials related to emergency department and inpatient hospital treatment for COVID-19.
- NYS DFS issues new emergency regulation requiring individual and small group commercial health insurers to extend the period for the payment of premiums to the later of the expiration of the applicable contractual grace period and 11:59 p.m. on June 1st and to continue paying claims during this period, for those demonstrating financial hardship due to the COVID-19 pandemic
  - Waive late payment fees and not report late payments to credit agencies

- No retroactive policy terminations for non-payment during such period
- Work with individuals to help them transition to new coverage, if appropriate

- The New York State of Health, New York's official Health Plan Marketplace, has extended a special enrollment period through June 15, 2020
  - If you lose employer coverage, you must apply within 60 days of losing coverage
  - Because of loss of income, New Yorkers may also be eligible to Medicaid, the Essential Plan, subsidized Qualified Health Plans or Child Health Plus

- U.S. Department of Labor and the IRS provide relief for plan participants and beneficiaries by extending certain timeframes regarding participants' healthcare coverage portability and continuation of group health plan coverage. Benefit plans must waive timeframes from March 1, 2020 until 60 days after the announced end of the National Emergency, or such other date announced by the Agencies in a future notification for all plan participants, beneficiaries, qualified beneficiaries, or claimants wherever located in determining the following periods and dates:
  - HIPAA Special Enrollment: within 30-days of the occurrence of the event (60-days under CHIP)
  - COBRA Election: 60-day election period
  - COBRA Premium Payments: 30-day premium grace period
  - Claims Procedure: the date within which individuals may file a benefit claim under the plan's claims procedure
  - Appeals of Adverse Benefit Determinations: the date within which claimants may file an appeal under the plan's claims procedure
  - External Review: the date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination (or upon finding that the request was not complete)