COVID-19: Frequently Asked Questions

These FAQs summarize the provisions of the new federal rules related to the coronavirus pandemic. Please refer to HPI's Compliance Alerts of March 26, 2020 and April 3, 2020, for additional details about the laws' provisions.

Summary of Federal Legislation
General Testing and Treatment Coverage
Telehealth Coverage
Paid Leave and Furlough Provisions
Flexible Spending Accounts
How to Contact HPI

Summary of Federal Legislation

What are the new pieces of federal legislation enacted in response to the coronavirus pandemic that affect the design and administration of group health plans?

- The Families First Coronavirus Response Act (the "Families First Act") enacted on March 18, 2020,
- The Coronavirus Aid, Relief, and Economic Stimulus ("CARES") Act enacted on March 27, 2020.

In brief, the Families First Act:

- Mandated that all fully insured and self- insured group health plans cover testing and diagnosis for COVID-19 without cost-sharing, prior authorization or other medical management requirements
- Provided for two types of coronavirus related leaves

The CARES Act addressed a host of issues, including:

- Clarifications on the Families First leave provisions
- Coverage of non-COVID-19 related telemedicine
- Unemployment assistance
- Business assistance
- Medical supplies for fighting COVID-19 and more

How is HPI handling the incorporation of the new rules or additional amendments requested by groups?

HPI's Account Service Team will reach out to every client to review the mandated and optional provisions that will be incorporated into a Summary of Material Modifications (SMM) applicable to all the clients' plans, as specified in the SMM. Details about this process are included in HPI's COVID-19 Update issued on April 3, 2020 and posted on HPI's web site.

COVID-19: Frequently Asked Questions

General Testing and Treatment Coverage

What are the requirements for covering testing for COVID-19?
All fully insured and self-funded group health plans (including grandfathered health plans and retiree health plans) must cover testing and diagnosis for COVID-19 without any cost share (e.g. deductibles, copayments or coinsurance), prior authorization, or other medical management requirements**.**

The coverage includes all of the following related to determining the need for a test, administering the test, and any related medical services provided at that time:

- In- and out-of-network telemedicine visits
- Office visits
- ER visits
- Urgent care visits

In addition, coverage is required for new tests under development for which the developer intends to request emergency use authorization from the Department of Health & Human Services (HHS), tests developed in individual states which have notified HHS of their intent to review the tests, and any other test otherwise deemed appropriate by HHS.

What if the member paid cost shares or copays up front?
The member will be reimbursed by the provider once the paid claim is received.

What are the requirements for paying COVID-19 testing providers?
COVID-19 testing providers are required to be paid at the network contracted or negotiated rate. In the absence of a negotiated rate, plans must pay the price posted on the provider's web site. Posting the price is a statutory requirement, and providers are subject to financial penalties for failing to do so.

How is HPI covering treatment and prevention of COVID-19?
In accordance with our March 11, 2020 and March 17, 2020 communications to clients, all plans, including Qualified High Deductible Health Plans (QHDHPs), will cover COVID-19-related **treatment** received via telehealth or outpatient with no member cost share.

In accordance with our April 3, 2020 COVID-19 Update, all plans will cover COVID-19 **vaccines**, without cost-sharing, after they have received an A or B recommendation from the United States Preventive Services Task Force (USPSTF) or a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention. The first such vaccine became available and was recommended by the ACIP in December 2020. All subsequently developed vaccines which receive USPSTF or ACIP recommendations will also be covered without cost-sharing.

What if the services received were out-of-network?
Cost-sharing for services received from out-of-network providers also will be waived should the urgent services be unavailable from in-network providers. HPI will continue to review coverage and cost-sharing policies to ensure that members can receive the appropriate COVID-19 testing and treatment without difficulties.

Does this requirement apply to ERISA self-funded plans and grandfathered plans?
Yes.

Is there a limit on the number of COVID-19 tests covered with no-cost sharing?
No.

Can plans limit testing to certain facility types?
The Families First Act requires testing to be covered without "prior authorization or other medical management requirements" in addition to being covered without cost-sharing.

How is inpatient treatment of COVID-19 covered?
Coverage for inpatient treatment of COVID-19 continues under the same terms of the plan applicable to inpatient treatment for other illnesses or injuries.

Can a group amend its plan to cover inpatient COVID-19 treatment without cost-sharing?
Yes, subject to carrier approval. Any plan may request this coverage, and QHDHPs may request to cover COVID-19-related treatment before the minimum deductible has been met without affecting the plan's classification under IRS rules as a QHDHP.

How will claims be processed?
Claims related to COVID- 19 will be processed manually. For outpatient services, claims will be processed to apply no member cost sharing. For inpatient services, member cost sharing may or may not apply based on the group's plan design.

Telehealth Coverage

How is telehealth covered for non-COVID-19-related services?
All plans except Qualified High Deductible Health Plans (QHDHPs) will cover non-COVID-19-related telehealth with no member cost-share.

QHDHPs may request to cover non-COVID-19-related telehealth before the minimum deductible has been met without affecting the plan's classification under IRS rules as a QHDHP.

COVID-19: Frequently Asked Questions

Will telehealth benefits be added if they were not already offered?
Yes.

What telehealth coverage is provided for mental health services?
Telehealth coverage is being applied to all providers equally, including mental health.

Summary of Telehealth Coverage		
In-Network	**Doctor On Demand**	**All other Providers**
Telehealth visit - COVID-19	100% coverage	100% coverage
Telehealth visit - all other medical	100% coverage*	All plans, excluding QHDHPs (unless the group requests otherwise), will cover all other services received via telehealth providers with no member cost-share.*
Telehealth visit - behavioral health	100% coverage*	All plans, excluding QHDHPs (unless the group requests otherwise), will cover all other services received via telehealth providers with no member cost-share.*
Out-of-Network	**Doctor On Demand**	**All other Providers**
Telehealth visit - COVID-19	N/A	100% coverage
Telehealth visit - all other medical	N/A	All plans, excluding QHDHPs (unless the group requests otherwise), will cover all other services received via telehealth providers with no member cost-share.*
Telehealth visit - behavioral health	N/A	All plans, excluding QHDHPs (unless the group requests otherwise), will cover all other services received via telehealth providers with no member cost-share.*

*This may vary by client. Please refer to the client's Plan Document to confirm how these services are covered.

rev.12/17/2020

The information contained in this FAQ is based on our current understanding of how significant developments may affect group benefit plans. It should not be construed as specific legal advice or legal opinion. The contents are for general information purposes only and are not a substitute for the advice of legal counsel.

Paid Leave and Furlough Provisions

What are the paid leave provisions under the new federal rules?
The chart below summarizes the leave provisions included in the Families First and CARES Acts.
Important: Workplace closures that prevent an employee from working or teleworking do not trigger these leave requirements.

Leave Provisions		
	Emergency Paid Sick Leave Act	**Paid FMLA/Emergency Family and Medical Leave Expansion Act**
Applies to:	Employers with fewer than 500* employees and government employers. (Employers of healthcare providers and emergency responders are not required to provide paid sick leave to those employees.)	Employers with fewer than 500* employees and government employers. (Employers of healthcare providers and emergency responders are not required to provide paid sick leave to those employees.)
Available to:	All employees who qualify as employees under the Fair Labor Standards Act regardless of length of employment.	Employees who qualify as employees under the Fair Labor Standards Act AND have been employed at least 30 calendar days, or who were: 1. Laid off by the employer on or after March 1, 2020, 2. Had worked for the employer for at least 30 of the last 60 days before the layoff, and 3. Are rehired by the employer.
Mandatory when:	Employee is unable to work or telework because the employee: 1. Is subject to a quarantine, isolation order, or medical advisement related to COVID-19; or 2. Is caring for an individual who is subject to a quarantine, isolation order, or medical advisement related to COVID-19; or 3. Is caring for a child whose school or day care has been closed, or the regular child care provider is unavailable.	Employee is unable to work or telework because the employee: 1. Is caring for a child under age 18 whose school or day care has been closed, 2. Or the regular child care provider is unavailable due to a public health emergency

Leave Provisions		
	Emergency Paid Sick Leave Act	**Paid FMLA/Emergency Family and Medical Leave Expansion Act**
Duration:	Full Time Employees: 80 Hours Part Time Employees: Entitled to the number of hours they are regularly scheduled to work during a two-week period.	Up to 12 Weeks**
Benefit:	Employees taking leave due to their own COVID-19 quarantine/symptoms: • 100% of regular pay up $511 per day and $5,110 in the aggregate in addition to and before any existing paid time off provisions would apply Employees taking leave to provide care: ▪ 2/3 of regular pay, up to $200 per day and $2,000 in the aggregate in addition to and before any existing paid time off provisions which would apply	2/3 of regular pay for 10 weeks up to f $200 per day and $10,000 in the aggregate following a 10-day period which may be unpaid. ▪ The first 10 days may consist of unpaid leave, but the employee may get paid for those 10 days under the Sick Leave Act if he/she qualifies for the emergency paid sick leave.

*The rule leaves room to issue regulations to exempt employers with fewer than 50 employees when it would jeopardize the viability of the business as a going concern, but those regulations have not yet been issued.
** It is HPI's understanding that the 2 weeks of leave under the Emergency Paid Sick Leave Act stands on its own, independent of the FMLA provision and has no effect on FMLA availability. Clients are encouraged to consult with their employment counsel for any questions or concerns regarding the new Families First Act and the FMLA.

Can an employer furlough employees instead of applying the law's leave provisions?
The federal leave provisions are for employers with fewer than 500 employees, and whose employees would be able to work or telework, but cannot because of the rules related to possibly having or caring for someone with COVID-19, or are caring for a son or daughter whose school or day care closed as outlined above. If the client also wants to extend coverage to furloughed employees not eligible for leave under the federal rules, and/or continue coverage beyond the 12 weeks period mandated, they could amend their plan to provide the additional coverage, with the amendment subject to carrier approval.

rev.12/17/2020

What if the furlough ends and the EEs are terminated?
COBRA would be offered. COBRA is available to terminated employees, but not to furloughed employees.

Can COBRA rates be adjusted during this time?
HPI recommends that any adjustment should be approached as an employer subsidy of the cost of COBRA coverage, rather than a change in the COBRA rate, so that the plan maintains the ability to eliminate the subsidy without violating the 12-month determination period requirement.

What are the leave requirements if we employ 500 or more employees?
Employers with 500 or more employees are not subject to the new federal leave requirements. They may, however, elect to amend their plans to provide similar provisions, subject to carrier approval.

Flexible Spending Accounts

Do the new federal rules impact health FSAs?
Yes. Retroactive to plan years beginning on and after January 1, 2020, over-the-counter (OTC) drugs and medicine and menstrual care products are reimbursable under a general purpose health FSA. Under limited purpose FSAs, OTC medicines and drugs related to dental or vision care would be reimbursable, but menstrual care products would not.

What happens to the FSA of an employee's spouse if he/she is laid off?
The spouse needs to work with his/her former employer on that plan's provisions.

In the event an employee is laid off, is this a qualifying event for a new election under the FSA spousal plan?
The spouse should work with his/her employer to confirm eligibility to make a new election.

How to Contact HPI

Where can members obtain more information?
Via Web:
HPI members may visit healthplansinc.com/COVID-19 for timely information regarding COVID-19, including links to the Centers for Disease Control and Prevention website resources.

rev.12/17/2020

The information contained in this FAQ is based on our current understanding of how significant developments may affect group benefit plans. It should not be construed as specific legal advice or legal opinion. The contents are for general information purposes only and are not a substitute for the advice of legal counsel.

Via Phone:
Additionally, our members may call our COVID-19 dedicated phone number at 877-213-5225 with specific questions about how their plan covers COVID-19-related testing and treatment.

How can I get answers to additional questions?
If you have any questions about your plan and how it may be impacted by the COVID-19 outbreak, please reach out to your HPI account executive by phone or email, or email COVID-19@healthplansinc.com.

rev.12/17/2020

The information contained in this FAQ is based on our current understanding of how significant developments may affect group benefit plans. It should not be construed as specific legal advice or legal opinion. The contents are for general information purposes only and are not a substitute for the advice of legal counsel.