CARES Act Signed Into Law

Provisions Affecting Health and Welfare Plans

Congress worked overtime to pass a stimulus bill intended to assist employers and the economy during the COVID-19 pandemic, and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law on March 27, 2020. While most of the CARES Act provisions involve economic relief for employers and employees that are beyond the scope of this Alert, there were several changes affecting group health plans. Some of these changes are permanent while others are of limited duration to address the COVID-19 pandemic period.

Mandate to Cover COVID-19 Testing (and Vaccination)

Effective March 18, 2020, the Families First Coronavirus Response Act (FFCRA) required all fully insured and self-insured group health plans (and individual health insurance policies) to provide coverage for COVID-19 diagnosis and testing without cost sharing or prior authorization when performed during a health care provider office visit, telemedicine visit, urgent care center visit, or emergency room visit. Plans are not required to cover other care or services received during a visit that are unrelated to COVID-19 diagnosis or testing without cost sharing.

The CARES Act redefined covered testing to include:

1. All testing approved by the Food & Drug Administration (FDA),
2. Non-FDA approved testing under an emergency use authorization request unless denied or the test developer fails to timely file the request with the FDA,
3. State-approved testing when the state has notified the U.S. Department of Health & Human Services (HHS) of its intent to use the test, and
4. Other tests approved by HHS.

Note: The CARES Act also requires health care providers to publish their costs for COVID-19 testing on their websites. A plan must pay a provider the lower of its negotiated provider rate or the published cost. This generally means the plan must pay the published cost when an individual receives care from an out-of-network provider.

The CARES Act also mandates health plans cover COVID-19 vaccinations as a preventive service, which first requires the development of a vaccine and FDA approval for its use. This CARES Act mandate is effective within 15 days of the date the U.S. Preventive Services Tax Force (USPSTF) issues a preventive service recommendation for the vaccine.

Changes for Spending Account Plans

The CARES Act amended the Internal Revenue Code (the Code) to permit reimbursement for over-the-counter (OTC) medication as a qualified medical expense without a prescription by health savings accounts (HSAs), health reimbursement arrangements (HRAs), health flexible spending accounts (health FSAs), and Archer medical savings accounts (Archer MSAs). Previously, OTC medication (other than insulin) required a prescription in order to be reimbursable from these spending accounts.[1]

The CARES Act also amended the Code to permit HSAs, HRAs, health FSAs, and Archer MSAs to provide tax-free reimbursements for menstrual care products, including tampons, pads, cups or other similar feminine hygiene products. Both spending account changes are permanent and apply to expenses incurred after December 31, 2019.

Note: This expansion is not a qualifying life event under the Code permitting a mid-year election change for health FSAs. As always, HSA-eligible individuals may change their HSA contribution at least monthly without a qualifying life event.

Telemedicine and HSAs

Under the CARES Act, a qualifying high deductible health plan (HDHP) may provide telemedicine services before a participant satisfies the minimum statutory HDHP deductible for the plan year without affecting an individual's eligibility to make HSA contributions. This applies to all telemedicine visits and not just those relating to COVID-19 testing and treatment. This is temporary relief and applies to HDHP plan years beginning on or before December 31, 2021, which includes HDHP plan years already underway. As drafted, this relief will not apply to HDHP plan years beginning on or after January 1, 2022.

Example: An employer with a calendar year HDHP can provide telemedicine benefits – whether or not COVID-19 related – at a $0 or below fair market value copayment before a participant has met the applicable minimum statutory deductible for both the 2020 and 2021 HDHP plan years without affecting the participant's ability to make or receive HSA contributions. The exemption would also apply to an HDHP with a plan year beginning on July 1st for the July 1, 2020 – June 30, 2021 and July 1, 2021 – June 30, 2022 plan years.

Student Loan Repayment Assistance

For a limited time, an employer may pay up to $5,250 of an employee's existing student loans on a tax-free basis through an educational assistance program. The employer may pay the lender directly or reimburse the employee for the employee's loan payments. This temporary expansion applies to student loan payments paid on or after March 27, 2020 through December 31, 2020.

Educational assistance programs are normally limited to reimbursement for an employee's current tuition expenses, but a program may cover both purposes during 2020. The $5,250 limit applies to all tax-free educational assistance benefits provided by the employer for the year. Tax-free educational assistance program benefits require the employer to adopt an educational assistance program, and an existing program would need modified to permit payment for existing loans.

[1] An HSA could have been used to pay for an OTC medication without a prescription, but the reimbursement would be taxable and also subject to penalty if the account holder was under age 65.

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