Client Update
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Key CARES Act Provisions Affecting Health and Welfare Benefit Plans

The Coronavirus Aid, Relief and Economic Security Act (the "CARES" Act") contains several key provisions affecting employer-sponsored health and welfare benefit plans. This article outlines those provisions that are ***mandatory*** vs. those provisions that are ***permissible*** changes.

Required Plan Changes

Under the CARES Act, there are two categories of health care plan benefits that are now required to be covered without participant cost-sharing:

1. COVID-19 Testing; and
2. "Qualifying Coronavirus Preventive Services".

A "qualifying coronavirus preventive service" is specifically defined as an item, service, or immunization that is intended to prevent or mitigate COVID-19 and is either:

- An evidence-based item or service that has an ‘‘A’’ or ‘‘B’’ rating by the United States Preventive Services Task Force; or
- An immunization that has a recommendation from the CDC's Advisory Committee on Immunization Practices with respect to the individual involved.

Coverage is required without cost-sharing within 15 days of the date of the recommendation.

Permissible Plan Changes

Plans are permitted -- but not required -- to provide a lower copay or deductible charge for COVID-19 treatment and telehealth services.

IRS 2020-15 states that high deductible health plans ("HDHPs") can cover COVID-19 testing and treatment before an individual's deductible is met and the HDHP will NOT lose its qualified status. This means that individuals who participate in the HDHP remain eligible to contribute to a health savings account ("HSA").

Under the CARES Act, HDHPs may also cover telehealth and other remote care services before an individual's deductible is met without jeopardizing the HDHP's qualified status. This particular rule applies for plan years beginning before January 1, 2022.

It is also important to note that over-the-counter ("OTC") drugs can once again be paid for with HSA, flexible spending account ("FSA") and health reimbursement arrangement ("HRA") funds without a doctor’s prescription. This change is permanent. Likewise, menstrual care products are now a qualified medical expense that can be paid for under an HSA, health FSA and/or HRA.

Additional Plan Changes to Consider

In addition to the foregoing ***required*** and ***permissible*** changes, plan sponsors should also consider the following optional plan design changes:

- Waiving early refill limits for 30-day maintenance prescription medications.
- Waiving charges for home delivery of prescription medications.
- Establishing temporary revised eligibility policies.
    - Example: If employee's hours are reduced to less than 30 hours per week on average as a direct result of COVID-19, the employee can remain eligible for coverage for the next 30 days.

Employers of self-funded plans need to amend their medical plans as soon as possible to include the mandatory changes, and if desired, to make the additional optional plan changes. All changes will require a Summary of Material Modifications to be distributed to self-funded plan participants.

Contact Us

Reach out to Fraser Stryker's employee benefits & ERISA attorneys for more information:

Emily Langdon
elangdon@fraserstryker.com
(402) 978-5386

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