Implications of COVID-19

Coverage Under Private Group Health and Disability Plans

By Milanna Datlow

Federal legislation in response to the COVID-19 pandemic has involved limited private group health plan mandates so far, but pandemic-induced fears and financial instability will likely lead to an increase in disability benefit claims over the coming months.

As the new coronavirus (COVID-19) spreads in the United States, questions arise over the potential effect that it may have on private group health and disability plans during and after the current pandemic.

This article discusses recent federal legislation and directives in response to growing concerns regarding the coverage of and cost sharing for diagnosis and treatment of COVID-19 under group health plans, and it analyzes possible developments for claims seeking long-term disability benefits after the pandemic.

Implications for Private Group Health Plans

At the rise of the nationwide COVID-19 public health emergency, the U.S. Department of Health and Human Services (HHS) issued guidance for the Medicare, Medicaid, and Children's Health Insurance Program (CHIP) to reimburse the costs of COVID-19 diagnostic testing and services. Additionally, some states took steps to require health insurance companies to waive costs for in-network COVID-19 diagnostics testing.

However, states lack the authority to regulate private employer-sponsored health plans governed by the Employee Retirement Income Security Act (ERISA), which insure more than 153 million Americans. Press Release, U.S. Rep. Rosa DeLauro, DeLauro, Porter, Underwood Raise Concerns About COVID-19 Diagnostics Costs for People Covered by ERISA & Short-Term Health Plans, Medicare, Medicaid, CHIP (Mar. 6, 2020), **https://delauro.house.gov**. Additionally, federal law does not mandate that private, employer-sponsored health plans cover COVID-19 treatment.

Coverage of COVID-19 Diagnostic Tests and Testing-Related Services

Two primary types of employer-sponsored health plans are fully insured plans and self-funded plans. Under a fully insured plan, employers pay a premium to health insurers, and in return, the insurers pay health-care claims as they occur, based on the benefits outlined in the policy purchased by the employers. The covered persons under the plan (such as the employees

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and their dependents) pay any deductibles, coinsurance, or co-payments outlined in their policy. Under a self-funded plan, employers pay for their plan members' benefits, but they use health insurers or other third-party administrators to administer benefit claims under their plans.

On March 5, 2020, Congresswomen Rosa DeLauro (CT-03), Katie Porter (CA-45), and Lauren Underwood (IL-14) sent a letter to the HHS Secretary Alex Azar, Department of Labor Secretary Eugene Scalia, and Internal Revenue Service Commissioner Charles Rettig, addressing the need to provide coverage of COVID-19 diagnostic testing and services for all Americans. *Id*. Additionally, Vice President Pence met with a group of large private insurers, who agreed to waive copayments and deductibles voluntarily for COVID-19 tests.

However, America's Health Insurance Plans (AHIP) clarified that the out-of-pocket costs for treatment, such as hospitalizations for more serious cases, would not be waived. Matthew Rae et al., Peterson Ctr. on Healthcare, *Potential Costs of COVID-19 Treatment for People with Employer Coverage* (Mar. 13, 2020), **www.healthsystemtracker.org**.

On March 18, 2020, President Donald Trump signed into law H.R. 6201, the Families First Coronavirus Response Act (the Coronavirus Act). The Coronavirus Act requires both fully insured and self-funded employer-sponsored group health plans to provide coverage for COVID-19 testing for all individuals enrolled and covered by a health plan, with no copay or any other cost to the individual. The coverage must include related services furnished during urgent care, emergency room, in-person, or telehealth provider visits that result in an order for or administration of a covered diagnostic test. The Coronavirus Act does not require treatment for an individual after being diagnosed for COVID-19 to be covered or of no cost to the individual.

The Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), H.R. 748, signed into law on March 27, 2020, expanded coverage of COVID-19 testing and testing-related services to include laboratory tests that have not been approved by the U.S. Food and Drug Administration (FDA) but meet certain conditions, provided that the applicable state or territory has assumed responsibility for the validity of the tests. In addition, health plans are required to cover qualifying COVID-19 preventive services, such as an item, service, or immunization recommended by the U.S. Preventive Services Task Force or the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices.

The CARES Act, H.R. 748, also directs health plans either to pay providers of laboratory services the full negotiated rate, or to reimburse the provider for the cash price for the service, if the provider and plan do not have a contract in place. Each provider of such laboratory services will be required to post a cash price for COVID-19 testing on a public website, and failing to comply could result in civil monetary penalties.

On April 11, the Departments of Labor (DOL), the HHS, and the U.S. Department of Treasury issued a set of FAQs about the Coronavirus Act and the CARES Act that provide guidance to group health plans on various issues related to the implementation of COVID-19 diagnostic-testing requirements. *FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42* (Apr. 11, 2020).

The FAQs clarify that in addition to tests that determine whether an individual has COVID-19 virus genetic material in the body, a group health plan must also cover serological testing to detect COVID-19 antibodies. Additionally, if the attending provider determines that a patient has signs and symptoms compatible with COVID-19 and orders other tests, such as influenza or blood tests that help determine whether COVID-19 diagnostic testing should be conducted, the plan must cover the related tests in full, as long as "the visit results in an order for, or administration of, COVID-19 diagnostic testing." *Id.* If COVID-19 diagnostic testing is not ordered or administered as a result of the visit (in-person or telehealth), full coverage for these services is not required.

The departments anticipate releasing additional guidance in the future. The FAQs, among other things, state that plans must provide no-cost coverage for COVID-19 testing-related items and services that were furnished by both in- and out-of-network providers on and after March 18, 2020, until the end of this public health emergency. Under section 319 of the Public Health Service Act, a public health emergency declaration lasts until the HHS Secretary declares that the public health emergency no longer exists, or upon the expiration of the 90-day period beginning on the date that the secretary declared a public health emergency exists, whichever occurs first.

The HHS Secretary may extend the public health emergency declaration for subsequent 90-day periods for as long as the public health emergency continues to exist and may terminate the declaration whenever he determines that the public health emergency has ceased to exist. *Id*. at 4 n.10. On April 21, 2020, the HHS Secretary extended the public health emergency as the result of COVID-19 for subsequent 90 days, effective April 26, 2020. Sec. Health & Hum. Servs. Public Health Emergency Declaration (Apr. 21, 2020), **www.phe.gov/emergency/news/healthactions/phe**.

Coverage for Treatment of COVID-19

As mentioned briefly above, federal law does not mandate that private, employer-sponsored health plans cover COVID-19 treatment. The larger insurers (e.g., Anthem, UnitedHealthcare, Cigna, and Humana) voluntarily agreed to provide fully insured plan members with coverage for in-network treatment of COVID-19, waiving prior authorization and patient cost-sharing requirements, although this applied only through May 31 for Anthem, Cigna, and UnitedHealthcare, while Humana did not impose an end date. Louis Norris, *State and Federal Efforts to Improve Access to COVID-19 Testing, Treatment*, Health Insurance.org (May 13, 2020).

Aetna announced that it would waive cost sharing for inpatient admissions at all in-network facilities for treatment of COVID-19 or health complications associated with COVID-19. This policy applies to all Aetna-insured commercial plan sponsors and was effective immediately for any such admission through June 1, 2020. *Health Insurance Providers Respond to Coronavirus (COVID-19)*, America's Health Insurance Plans blog (May 14, 2020).

Self-funded plans can opt to waive their members' cost sharing for COVID-19 treat-

ment, but they are not required to do so. The majority of workers with employer-sponsored coverage are enrolled in self-funded plans. *Employer Health Benefits: 2019 Summary of Findings*, Kaiser Family Found. (Sept. 25, 2019). Even if those plans are administered by a health insurance company that has opted to waive cost sharing for fully insured plans, any decision regarding waiver of cost sharing for members of self-funded plans ultimately lies with the employer, as opposed to the insurer. Norris, *supra*.

Additionally, several states introduced legislation requiring insurers that transact business in the state to cover the cost of COVID-19 testing and related treatment.

Additionally, several states introduced legislation requiring insurers that transact business in the state to cover the cost of COVID-19 testing and related treatment. *Id*. For example, New Mexico requires health plans to waive cost sharing for medical services related to COVID-19, pneumonia, and influenza. Massachusetts requires health plans to provide coverage for COVID-19 treatment with no cost sharing, although it only applies to care provided in a doctor's office, urgent care clinic, or emergency room. The legislatures of several other states (Ohio, Minnesota and Michigan) also introduced bills on this subject. *Id*. While Minnesota's bill was not successful (**https://www.billtrack50.com/BillDetail/1223265**), the bills in Ohio and Michigan have not yet received a vote. **https://www.billtrack50.com/BillDetail/1226052**; **https://www.billtrack50.com/BillDetail/1224155**.

As is the case with any state regulation, these rules will only apply to health plans that are regulated by the state insurance department. So self-funded plans and any other non-state-regulated plans would not have to comply with the rules, although they can comply voluntarily.

Coverage of Telemedicine Services During the COVID-19 Emergency

During this public health emergency, travel by patients—even to physicians' offices, clinics, hospitals, or other healthcare facilities—could risk their own or others' exposure to further illness. Consequently, there has been an urgency to expand telemedicine to help patients, particularly those at a higher risk for experiencing complications from COVID-19, and to reduce exposure to the virus while maintaining patient access to care from their homes.

To address this problem, the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 (Coronavirus Appropriations Act), signed into law on March 6, 2020, authorized, among other things, the HHS Secretary to waive certain Medicare requirements for telehealth services temporarily during the COVID-19 pandemic. Specifically, for claims submitted during this public health emergency, HHS will not conduct audits to ensure that the patient had a previous, established relationship with a particular health-care practitioner. Additionally, Medicare will temporarily pay clinicians to provide telehealth services for beneficiaries residing across the entire country in all settings, including their homes.

Furthermore, President Trump has called for all insurance companies to expand and clarify their policies around telehealth services. Press Release, Ctrs. for Medicare & Medicaid Servs., President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak (Mar. 17, 2020), **https://www.cms.gov/newsroom**. Of note, while group health plans are not required to include a benefit with a telehealth provider, any services offered by a provider through a telehealth visit or other remote visit for COVID-19 diagnostic testing must be covered in full. Richard Stover et al., *Guidance Clarifies COVID-19 Diagnostic Testing Mandate: Along with Tests to Detect the Virus, Plans Must Cover Screening for Antibodies*, Soc. for Human Resource Mgmt. (Apr. 21, 2020).

Currently, forty-two states and the District of Columbia have laws that govern private payer telehealth reimbursement policies. *State Telehealth Laws & Reimbursement Policies*, Center for Connected Health Policy (Spring 2020), **www.cchpca.org**. These are often referred to as "parity" laws. Thirty-seven states have telehealth parity laws that require private insurers to reimburse healthcare providers for services delivered through telemedicine. *Private Payer Reimbursement for Telemedicine*, Chiron Health.

Each law is different, but they generally say that private payers cannot take the patient's location into account when deciding to cover a video visit, making it possible for covered patients to be at home or work during the encounter. *Id*. Of note, many states with parity laws have made exceptions for certain types of insurance plans, e.g., small group plans may be eligible to opt out of coverage for telemedicine. *Id*.

Even in states without parity laws, the larger insurers voluntarily have taken steps to expand coverage for telehealth services by lessening members' out-of-pocket costs (e.g., Anthem, Aetna, Cigna, Blue Cross Blue Shield [BCBS], and UnitedHealthcare). America's Health Insurance Plans, *supra*. For example, Aetna, Cigna, Humana, and all thirty-six independent and locally operated BCBS companies have waived members' deductibles, co-insurance, and co-pay amounts related to telehealth visits. Selena Simmons-Duffin, *Some Insurers Waive Patients' Share of Costs For COVID-19 Treatment*, WBEZ (Mar. 30, 2020).

Pre-Deductible Coverage Under High-Deductible Health Plans with a Health Savings Account

Many employees have employer-sponsored healthcare coverage through high-deductible health plans (HDHPs), a benefit design that allows an employee (or an employer) to contribute to a health savings account (HSA) as long as the employee is not enrolled in other disqualifying coverage. An HDHP can only cover certain services (primarily preventive care) before the minimum statutory deductible (currently $1,400 for employee-only coverage and $2,800 for family coverage) is met for the employee to remain HSA-eligible. Anne Tyler Hall & Eric Schillinger, *Insight: New*

COVID-19 Guidance for Employer-Sponsored Health Coverage, Bloomberg Law (Mar. 19, 2020).

To facilitate access to COVID-19 screening and mitigate costs for employees who participate in an HDHP, the Internal Revenue Service (IRS) released Notice 2020-15. Under this notice, an HDHP will not lose its status as such (i.e., it will remain HSA compatible) if it covers, before the statutory deductible is met, qualifying medical care, both services and items, for the testing and treatment of COVID-19. This relief may encourage sick employees to seek medically necessary COVID-19 screening because they will not have to worry about out-of-pocket annual deductible expenses.

Notice 2020-15 is intended to address uncertainty over whether COVID-19 diagnosis or treatment is considered preventive care that is eligible for pre-deductible coverage under an HDHP without disqualifying the employee's eligibility to make HSA contributions. The relief under Notice 2020-15 does not have an expiration date. Although the notice states that it is meant to facilitate the response to COVID-19, the relief remains in effect until further guidance is issued. *Employer Health Plans Have to Meet New COVID-19 Coverage Mandate*, Mercer (Apr. 21, 2020).

Further, the CARES Act, H.R. 748, allows HDHPs with HSAs to cover telehealth services before a patient reaches his or her deductible amount. This expansion of permissible telehealth for individuals with HDHPs and HSAs applies to all types of care, not just COVID-19 care. These changes took effect March 27, 2020, but they only apply for plan years beginning on or before December 31, 2021. So for calendar-year arrangements, the temporary changes expire December 31, 2021. *Id.*

Thus, pre-deductible telehealth coverage of COVID-19 testing and treatment is permissible for HDHP participants until further notice. Other pre-deductible telehealth coverage is only permissible for HDHPs through 2021 (or plan-year end in 2022 for non-calendar-year plans). *Id.* The CARES Act also allows reimbursement from pre-tax accounts, such as HSAs, flexible spending accounts (FSAs), and health reimbursement arrangements (HRAs), for over-the-counter drugs and supplies (e.g., masks), waiving the prescription requirement. This is a permanent change. *See What You Need to Know About the CARES Act*, Benefit Resources Inc. (Mar. 27, 2020).

IRS Allows Mid-Year Changes to Coverage, Flex Savings Accounts, and Dependent Care Assistance Programs

In response to the COVID-19 pandemic, on May 12, 2020, the IRS issued Notice 2020-29 and Notice 2020-33, which permit, but do not require, employers to make certain changes to IRS Code section 125 cafeteria plan documents, retroactive to January 1, 2020. Under Notice 2020-29, employers were provided with increased flexibility regarding mid-year election changes made under a section 125 cafeteria plan for calendar year 2020, as it related to employer-sponsored health coverage, health FSAs, and Dependent Care Assistance Programs (DCAPs). The relief granted under this notice is *not* limited to those directly affected by the pandemic. Bruce Barth et al., *IRS Issues Guidance on Cafeteria Plan Elections and Other Changes Amid COVID-19Pandemic*, Robinson + Cole (May 13, 2020), **http://www.rc.com/publications.cfm**.

Specifically, employers may amend their health plans to permit an employee prospectively (1) to make a new election if the employee had initially declined coverage; (2) to revoke an existing election for one type of coverage and elect a different coverage option available under the employer's plan; or (3) to revoke an existing election without electing a different coverage option available through the employer's plan, provided that the employee attests in writing that he or she is enrolled, or will immediately enroll, in other health coverage not sponsored by the employer. *Id.* For health FSAs and DCAPs, employers may amend their plans to permit employees to revoke an election prospectively, make a new election, or decrease or increase an existing election, regardless of whether such election is consistent with any change in status. *Id.*

Employers have also been permitted to allow employees with amounts in a health FSA or DCAP that will be forfeited as of the end of a grace period in 2020, or as of the end of a plan year ending in 2020, to use those amounts for their designated purpose for expenses incurred through December 31, 2020. For example, if an employee would have amounts that were carried over until March 15, 2020, or if the employee would have amounts that would be forfeited upon a plan year ending June 30, 2020, the employer may permit the employee to extend the use of those amounts through December 31, 2020. *Id.*

Lastly, the IRS also clarified that both the exemption from the high-deductible health plan rules for use of telehealth services and coverage of expenses relating to testing and treatment of COVID-19 without a deductible by a high-deductible health plan may be applied retroactively to January 1, 2020. *Id.*

In Notice 2020-33, the IRS modified Notice 2013-71 to increase the carryover limit from $500 to $550 of unused amounts remaining as of the end of a plan year in a health FSA under a section 125 cafeteria plan. That amount may be carried over to pay or reimburse a participant for medical care expenses incurred during the following plan year. The increase reflects indexing for inflation, and this indexing parallels the indexing that applies to the limit on salary reduction contributions under IRS Code section 125(i). The $550 limit is 20 percent of the current inflation-adjusted $2,750 limit on health FSA contributions. Sally Schreiber, *IRS Allows Midyear Changes to Health Coverage, Dependent Care Elections*, Journal of Accountancy (May 12, 2020), **www.journalofaccountancy.com/news**.

Of note, under section 125 cafeteria plan rules, the carryover limit must be adopted on or before the last day of the plan year from which amounts may be carried over to be effective retroactive to the first day of that plan year. Therefore, only those plans that incorporate the increase by reference or that are timely amended to set forth the increased amounts may begin applying the increased carryover limit for a plan year beginning in 2020. Barth et al., *supra*.

Additionally, under current rules, health plans such as premium-reimbursement plans or individual coverage health reimbursement arrangements may not reimburse medical care expenses that were incurred before the beginning of the plan year and qualify for exclusion from income and wages. Such expenses are generally treated as incurred when the covered individual is provided with the medical care

giving rise to the expense, not when it is billed or paid.

Under Notice 2020-33, premiums for health insurance coverage can be treated as medical care expenses on (1) the first day of each month of coverage on a pro rata basis; (2) the first day of the period of coverage; or (3) the date on which the premium is paid. For example, an individual coverage health reimbursement account with a calendar year plan year may immediately reimburse a substantiated premium for health insurance coverage that begins on January 1, 2020, even if the covered individual paid the premium for the coverage on December 31, 2019. *Id.*

To state a valid claim for long-term disability benefits due to COVID-19, the claimant must establish that the COVID-19 caused long-term health complications (for example, a chronic respiratory illness) that continuously interfered with the claimant's ability to continue working at his or her own occupation.

Special Benefits for Health Plan Participants in Response to the COVID-19 Pandemic

UnitedHealthcare and Aetna both opened a special enrollment period for some of their existing commercial customers to enable them to access coverage in response to the COVID-19 emergency. Notice from UnitedHealthcare to Customers, Notice of Special COVID-19 Enrollment Opportunity for Small Businesses, Key and National Account Customers; Aetna Details on COVID-19 Special Enrollment Period And Downgrades, Beere & Purves (Apr. 3, 2020).

UnitedHealthcare allowed a special enrollment period from March 23 to April 13, 2020, with new enrollees' coverage becoming effective on April 1, 2020. Aetna allowed a special enrollment period from April 6 through April 17, 2020, and new enrollees could choose between an April 1, 2020, and May 1, 2020, effective coverage date. *Id.* Also, UnitedHealthcare self-funded plans could choose to amend their eligibility requirements to align with this special enrollment period. Press Release, UnitedHealthcare, UnitedHealthcare Offers Special Enrollment and Reduces Administrative Requirements to Improve Access to Care and Coverage in Response to COVID-19 (Mar. 24, 2020).

Additional benefits for health plan participants and beneficiaries affected by COVID-19 include coverage by some insurers, such as BCBS, for early prescription refills for maintenance medications and waiver of cost-sharing obligations that are usually required for these services. America's Health Insurance Plans, *supra*.

Also, Cigna announced that it would waive prior authorization requirements for the transfer of its non-COVID-19 customers from acute inpatient hospitals to in-network long-term, acute care hospitals to help manage the demands of increasingly high volumes of COVID-19 patients. *Id.*

COVID-19 Implications for Private Employer-Sponsored Group Disability Plans

Coverage for a disability caused by COVID-19 under employer-sponsored group disability plans will continue to be assessed on a case-by-case basis, applying the facts of each claim to the definition of disability in the plan. Though the definition of disability will vary from plan to plan, a typical definition provides that a person will be found disabled if he or she is unable, due to sickness or injury, to perform each of the material and substantial duties of his or her own occupation.

Under that definition, not everyone who tests positive for COVID-19 will be eligible for disability benefits. For example, those who test positive but have only minor symptoms that do not prevent them from performing the material and substantial duties of their job would not qualify for disability benefits. However, if the symptoms are severe enough to prevent them from performing those duties, they might be entitled to those benefits.

Long-Term Disability Plans

Most long-term disability plans require that the inability to perform relevant duties continue over a set period of time (i.e., the elimination period) for the claimant to be eligible for benefits; this is typically either ninety or one hundred eighty days. To state a valid claim for long-term disability benefits due to COVID-19, the claimant must establish that the COVID-19 caused long-term health complications (for example, a chronic respiratory illness) that continuously interfered with the claimant's ability to continue working at his or her own occupation.

Even in such circumstances, long-term disability benefits may only be available for a limited period of time if the claimant's plan includes a test change for the plan's definition of disability after a specified period of time. Specifically, many long-term disability plans include a change in the disability definition from the claimant's "own occupation" to "any reasonable occupation" after the claimant receives benefits under the plan for a specified period (typically twenty-four months). At that point, the claimant will be required to show that he or she continues to be disabled from performing the duties of any reasonable occupation consistent with the claimant's education, training, and experience.

Short-Term Disability Plans

Further, short-term disability and long-term disability plans will typically provide coverage for disability only if the claimant has a clear medical reason for being unable to work. Inability to work due to a legal or social restriction, such as a state mandated quarantine intended to prevent the spread of the virus, normally will not provide a basis for disability benefits. *See Gates v. Prudential Ins. Co.*, 240 A.D. 444, 270 N.Y.S. 282 (1934) (holding that insured who was not physically impaired from performing the job duties, but was banned by state

statute from his occupation due to being a disease carrier, was not disabled within the meaning of the policy). *See also Dang v. Northwestern Mutual Life Ins. Co.*, 960 F. Supp. 215 (D. Neb. 1997) (same).

However, a plan could have a different, more expansive definition of disability that includes coverage for members who must restrict themselves due to social quarantine rules. It is also important to note that a self-funded, short-term disability plan can be a payroll practice, which is exempt from ERISA, if the benefits constitute payment of an employee's normal compensation during a disability leave from the employer's general assets. *See* 29 C.F.R. §2510.3-1(b)(2). When a payroll practice is at issue, the employer may have great discretion in deciding whether a benefit is payable. Thus, there is a wide variety of ways someone could become eligible for disability benefits, depending on the disability definitions and other provisions of each particular plan.

Of note, New Jersey, New York, California, Rhode Island, Hawaii, and Puerto Rico have mandatory disability insurance requirements. *See 2020 State Disability and Paid Family Leave Insurance Wage Base and Rates*, Tax News Update (Dec. 19, 2019). Short-term disability leave benefits in those states are available for employees who are unable to work due to having symptoms, being exposed to COVID-19, or being subject to mandatory or precautionary quarantine. *Employee Pay During COVID-19 Leaves, Furloughs, and Closures*, Baker McKenzie (Mar. 15, 2020).

However, as noted above, states lack the authority to regulate most employer-sponsored benefit plans governed by ERISA, which provide coverage for 59 percent of covered workers employed by private sector employers and are regulated by the federal government. Matthew et al., *supra*. To date, there are no analogous federal regulations specific to COVID-19 with respect to employer-sponsored disability plans.

Employees whose occupations involve significant in-person communication or air travel and who contract COVID-19 on the job may also be eligible for income continuation under state workers' compensation laws. Virtually every state workers' compensation statute provides that an employee will be entitled to benefits for what is known as an "occupational disease."

To constitute an "occupational disease," two conditions must be met: (1) the disease must be proven to be due to causes and conditions that are *characteristic of and peculiar to a particular trade, occupation, or employment*; and (2) the disease cannot be an ordinary disease of life, to which the general public is equally exposed outside of employment. Whether COVID-19 constitutes an "occupational disease" and thus is covered under state workers' compensation law depends on whether a direct causal connection to the workplace can be established.

Some employer short-term disability plans cover occupational health claims with state workers' compensation time-off benefits offsetting any benefits payable. On the other hand, some employers' short-term disability plans completely exclude events covered under workers' compensation. In those cases, short-term disability benefits would not be payable if the claim related to COVID-19. Rich Fuerstenberg, *COVID-19 and Paid Leave: Three Scenarios to Plan For*, Mercer (Mar. 5, 2020).

COVID-19-related illness will likely result in an increase of disability claims for unrelated conditions that are difficult to diagnose, such as depression and back pain, as employees who are healthy but unwilling to work due to COVID-19 fears (e.g., work conditions will put them at risk for exposure to COVID-19) exhaust their allotted sick time and vacation days. The same may be true of employees whose compensation is tied to sales production or who experience financial stress as the outbreak curtails their ability to network or travel. *Id.* The longer the economy remains affected by the pandemic, the more likely it is that disability insurers and self-funded plans will see an uptick in COVID-19-related disability claims.

Summary

Recent federal legislation in response to the COVID-19 nationwide public health emergency only mandates that both fully insured and self-funded group health plans provide coverage for COVID-19 diagnostic testing and related services with no member out-of-pocket cost sharing.

However, with respect to fully insured plans, some larger private insurers have voluntarily expanded benefits in response to this national public health emergency, specifically for treatment, telemedicine services, and early prescription refills for maintenance medications. Some insurers have also voluntarily allowed their existing commercial customers to sign up new enrollees for coverage outside of normal, open enrollment periods.

While some states have regulations concerning short-term disability leave benefits for employees who are unable to work because they have COVID-19 symptoms, were exposed to COVID-19, or have been subject to mandatory or precautionary quarantine, states lack the authority to regulate most employer-sponsored benefits plans governed by ERISA. The DOL has not yet announced any analogous regulations specific to COVID-19. Overall, COVID-19 fears and financial instability caused by the pandemic are likely to cause a spike in the number of disability benefit claims that are filed over the next few months. FD