DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

June 5, 2020

Dear Sponsors of non-Federal governmental plans,

The Centers for Medicare & Medicaid Services (CMS) applauds efforts that states, issuers and plans are taking to increase access to testing and treatment for Coronavirus Disease 2019 (COVID-19), and to reduce transmission of COVID-19, including removing barriers to accessing covered services through telehealth and other remote care service options. This letter highlights COVID-19 guidance relevant to non-Federal governmental plan sponsors.

We encourage you to monitor the Center for Consumer Information and Insurance Oversight (CCIIO) website for any subsequent guidance related to COVID-19. All CCIIO guidance related to COVID-19 is available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs#COVID-19.

Requirement to Cover COVID-19 Diagnostic Testing and Certain Related Items and Services without Cost-Sharing or Medical Management

The Families First Coronavirus Response Act (FFCRA) was enacted on March 18, 2020.[1] Section 6001 of the FFCRA, which was amended by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) enacted on March 27, 2020,[2] generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 (referred to collectively in this document as COVID-19) when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period.[3] Under the FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or

[1] Pub. L. No. 116-127 (2020).
[2] Pub. L. No. 116-136 (2020).
[3] On January 31, 2020, HHS Secretary Alex M. Azar II declared that as of January 27, 2020, a public health emergency exists nationwide as the result of the 2019 novel coronavirus. *See* Determination of the HHS Secretary that a Public Health Emergency Exists, https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx. On April 21, 2020, the HHS Secretary renewed the COVID-19 public health emergency declaration, effective April 26, 2020. *See* https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-21apr2020.aspx. The 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.

prior authorization or other medical management requirements.[4] Non-Federal governmental plans, whether grandfathered or non-grandfathered, are group health plans subject to these requirements under the FFCRA and the CARES Act. On April 11, 2020, the Departments of Health and Human Services, Labor, and the Treasury (collectively, the Departments) released guidance implementing these requirements and providing guidance on other health coverage issues related to COVID-19.[5] The Departments anticipate releasing additional guidance about the FFCRA and the CARES Act in the future.

In addition to complying with the COVID-19 diagnostic testing-related requirements under the FFCRA and CARES Act, CMS encourages all non-Federal governmental plans to offer services related to the treatment of COVID-19 to their members without cost-sharing and without prior authorization or other medical management restrictions.

Temporary Period of Relaxed Enforcement of Certain Timeframes Related to Group Market Requirements under the Public Health Service Act (PHS Act)

On April 28, 2020, the Department of Labor (DOL) issued two notices giving plan participants, beneficiaries, and employers additional time to make critical health coverage and other decisions affecting benefits and to send certain required notices during the COVID-19 outbreak.[6] One of the notices was issued jointly with the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS).

As stated in guidance issued on May 14, 2020, CMS concurs with the relief specified in these notices.[7] Between March 1, 2020 and 60 days after the end of the COVID-19 National Emergency, or such other date announced by DOL or jointly by DOL and the Treasury Department/IRS in future notices, CMS will adopt a temporary policy of relaxed enforcement to extend similar time frames otherwise applicable to non-Federal governmental group health plans, and their participants and beneficiaries, under applicable provisions of title XXVII of the PHS

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[4] Section 6001(b) of the FFCRA provides that the coverage requirement in section 6001 shall be applied to group health plans and health insurance issuers offering group or individual health insurance coverage as if included in Part A of title XXVII of the PHS Act.

[5] *See* FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42 (April 11, 2020), available at https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf and https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf.

[6] *See* Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak (April 28, 2020), available at https://www.federalregister.gov/documents/2020/05/04/2020-09399/extension-of-certain-timeframes-for-employee-benefit-plans-participants-and-beneficiaries-affected; and EBSA Disaster Relief Notice 2020-01, Guidance and Relief for Employee Benefit Plans Due to the COVID-19 (Novel Coronavirus) Outbreak (April 28, 2020), available at https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2020-01.pdf. DOL also issued FAQs to help employee benefit plan participants and beneficiaries, plan sponsors, and employers impacted by the coronavirus outbreak understand their rights and responsibilities under ERISA. *See* COVID-19 FAQs for Participants and Beneficiaries (April 28, 2020), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/covid-19.pdf.

[7] *See* Temporary Period of Relaxed Enforcement of Certain Timeframes Related to Group Market Requirements under the Public Health Service Act in Response to the COVID-19 Outbreak (May 14, 2020), available at https://www.cms.gov/files/document/Temporary-Relaxed-Enforcement-Of-Group-Market-Timeframes.pdf.

Act. CMS encourages (but will not require) sponsors of non-Federal governmental plans to provide relief to participants and beneficiaries similar to that specified in the two notices.

Expanding and Promoting Access to Telehealth Options and Prescription Drugs During the COVID-19 Outbreak

The use of telehealth and other remote care service options to obtain covered services is vital to combat the spread of COVID-19 by allowing individuals the ability to visit their health care providers from home. CMS strongly encourages all non-Federal governmental plans to expand and promote the use of telehealth and other remote care services by:

- notifying plan participants and beneficiaries of their availability;
- ensuring access to a robust suite of telehealth and other remote care services, including mental health and substance use disorder services; and
- covering telehealth and other remote care services without cost sharing or other medical management requirements.

CMS encourages plans to cover telehealth and other remote care services even if the specific covered services are not related to COVID-19. In addition, section 3701 of the CARES Act amends the laws applicable to high deductible health plans (HDHPs) and Health Savings Accounts (HSAs) to provide temporary flexibility with respect to telehealth and other remote care services. As added by section 3701 of the CARES Act, section 223(c)(2)(E) of the Internal Revenue Code (the Code) allows HSA-eligible HDHPs to cover telehealth and other remote care services without a deductible or with a deductible below the minimum annual deductible otherwise required by section 223(c)(2)(A) of the Code, for plan years beginning on or before December 31, 2021.[8]

To the extent applicable state or local law prohibits non-Federal governmental plans from making mid-year changes, we have encouraged applicable state and local authorities to not take enforcement action against any plan that makes mid-year changes to provide greater coverage for telehealth or other remote care services or for diagnosis or treatment of COVID-19, or to reduce or eliminate cost-sharing requirements for these services. To the extent that plans make these changes, CMS strongly encourages such plans to promptly communicate this information to plan participants and beneficiaries, to ensure that plan participants and beneficiaries can benefit from these changes as soon as possible. CMS will not take enforcement action against any plan or issuer that makes such a modification to provide greater coverage for telehealth or other remote care services, or related to the diagnosis and/or treatment of COVID-19 without providing at

[8] *See* Q13 in FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42 (April 11, 2020), available at https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf and https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf. Notice 2020-29, 2020-22 IRB 864, issued by the Treasury Department and the IRS provides that treatment of telehealth and other remote care services under section 3701 of the CARES Act applies with respect to services provided on or after January 1, 2020, with respect to plan years beginning on or before December 21, 2021. https://www.irs.gov/pub/irs-drop/n-20-29.pdf.

least 60 days advance notice as required by section 2715(d)(4) of the PHS Act and final rules issued by the Departments regarding the Summary of Benefits and Coverage.[9]

CMS also encourages non-Federal governmental plans that provide prescription drug benefits to lift fill restrictions when appropriate, while also taking into consideration patient safety risks associated with early refills for certain drug classes, such as opioids, benzodiazepines, and stimulants. The Food and Drug Administration (FDA) monitors the prescription supply chain and provides detail on specific prescription drug shortages at https://www.fda.gov/drugs/drug-safety-and-availability/drug-shortages. We recommend that non-Federal governmental plans monitor this website to ensure plan participants and beneficiaries have access to the affected drugs or a therapeutic alternative.[10]

Sincerely,

Samara Lorenz
Director, Oversight Group
Center for Consumer Information and Insurance Oversight

[9] *See* Q9 and Q14 in FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42 (April 11, 2020), available at https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf and https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf.
[10] S*ee* FAQs on Prescription Drugs and the Coronavirus Disease 2019 (COVID-19) for Issuers Offering Health Insurance Coverage in the Individual and Small Group Markets (March 24, 2020), available at https://www.cms.gov/files/document/faqs-rx-covid-19.pdf.