CMS Letter Summarizing COVID-19 Guidance for Non-Federal Governmental Plan Sponsors

The Centers for Medicare & Medicaid Services (CMS) issued a letter highlighting COVID-19 guidance relevant to non-federal governmental plan sponsors. The letter highlights guidance that has previously been released and does not issue any new requirements.

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

Under the Families First Coronavirus Response Act (FFCRA) and as amended by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), health plans must provide coverage and not impose any cost sharing (including deductibles, copayments, and coinsurance), prior authorization, or medical management requirements for the following services during the public health emergency due to COVID-19:

- An in vitro diagnostic product for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such an in vitro diagnostic product, that 1) has been approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act (FDA); 2) is a clinical laboratory service performed in a laboratory certified to conduct high-complexity testing and the developer has requested, or intends to request, emergency use authorization under the FDA; 3) is developed in a state that has notified HHS of its intention to review tests intended to diagnose COVID-19; or 4) is another test that HHS determines to be appropriate.

- Items and services furnished to an individual during healthcare provider visits that result in an order for or administration of an in vitro diagnostic product described above, but only to the extent that those items and services relate to furnishing or administering the in vitro diagnostic products or to determine the need of the individual for such product.

Non-federal governmental plans, whether grandfathered or non-grandfathered, are group health plans subject to these requirements under the FFCRA and the CARES Act as of March 18, 2020. See our Advisor for more information. 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)

The Department of Labor (DOL) and the Department of the Treasury (Treasury) issued a final rule that extends certain timeframes under the Employee Retirement Income Security Act (ERISA) and Internal Revenue Code (IRC) for group health plans, disability, and other welfare plans, pension plans, and participants and beneficiaries of these plans during the COVID-19 national emergency. See our Advisor on the final rule. The DOL also issued Notice 2020-01 (Notice) that applies to employee benefit plans, employers, labor organizations, and other plan sponsors, plan fiduciaries, participants, beneficiaries, and covered service providers. The Notice supplements the extended timeframes final rule issued by the DOL and the Treasury. See our Advisor on the Notice.

Following the release of the final rule and Notice, CMS issued a bulletin providing that between March 1, 2020, and the end of the outbreak period, CMS will adopt a temporary policy of relaxed enforcement to extend similar timeframes otherwise applicable to non-federal governmental group health plans, and their participants and beneficiaries under the group market requirements imposed by Title XXVII of the Public Health Service (PHS) 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 final rule and Notice. See our Advisor on the CMS bulletin.

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

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
- 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. Also, the Internal Revenue Code (the Code) allows HSA-eligible high deductible health plans (HDHPs) to cover telehealth and other remote care services without a deductible or with a deductible below the minimum annual deductible required for HSA-eligible HDHPs for plan years beginning on or before December 31, 2021. See our Advisor for more on health savings accounts (HSAs).

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 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. CMS recommends that non-federal governmental plans monitor this website to ensure plan participants and beneficiaries have access to the affected drugs or a therapeutic alternative.

Mid-Year Changes

CMS has encouraged applicable state and local authorities to not take enforcement action against any plan that makes mid-year changes, when such changes are prohibited under state or local law, 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. If such changes are made, CMS strongly encourages 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 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. See our Advisor for FAQs about the FFCRA and CARES Act.

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