https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf

FAQS ABOUT FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT IMPLEMENTATION PART 42

April 11, 2020

Set out below are frequently asked questions (FAQs) regarding implementation of the Families First Coronavirus Response Act (the FFCRA), the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), and other health coverage issues related to Coronavirus Disease 2019 (COVID-19). These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments). Similar to previously issued FAQs (available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs and www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help individuals understand the law and benefit from it, as intended.

The Departments are working together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and are working with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) group health plans, health insurance issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. The Departments anticipate issuing additional guidance about the FFCRA, the CARES Act, and other health coverage issues related to COVID-19.

Section 6001(c) of the FFCRA authorizes the Departments to implement the requirements of section 6001 of the FFCRA, as amended by section 3201 of the CARES Act, through sub-regulatory guidance, program instruction, or otherwise. Due to the urgent need to help facilitate the nation's response to the public health emergency posed by COVID-19, the Departments are exercising discretion to adopt temporary policies of relaxed enforcement in connection with certain standards identified below under the conditions outlined in this guidance. The Departments therefore believe that this guidance is a statement of policy not subject to the notice and comment requirements of the Administrative Procedure Act (APA).[1] For the same reasons explained above, the Departments additionally find that, even if this guidance were subject to the public participation provisions of the APA, prior notice and comment for this guidance is

[1] 5 U.S.C. § 553(b)(A).

impracticable and/or contrary to the public interest, and there is good cause to issue this guidance without prior public comment and without a delayed effective date.[2]

The FFCRA and the CARES Act

The FFCRA was enacted on March 18, 2020.[3] Section 6001 of the FFCRA 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. Under the FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements.

The CARES Act was enacted on March 27, 2020.[4] Section 3201 of the CARES Act amended section 6001 of the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover without any cost-sharing requirements or prior authorization or other medical management requirements. Additionally, section 3202 of the CARES Act generally requires plans and issuers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the cash price.)

As discussed in Q9 below, nothing in the FFCRA or the CARES Act prevents a state from imposing additional standards or requirements on health insurance issuers with respect to the diagnosis or treatment of COVID-19, to the extent those standards or requirements do not prevent the application of a federal requirement.

Q1. Which types of group health plans and health insurance coverage are subject to section 6001 of the FFCRA, as amended by section 3201 of the CARES Act?

Section 6001 of the FFCRA, as amended by section 3201 of the CARES Act, applies to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans as defined in section 1251(e) of the Patient Protection and

[2] 5 U.S.C. § 553(b)(B) and (d)(3). Good cause exists for the same reasons underlying the issuance of the March 13, 2020 Proclamation on Declaring a National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Outbreak and the determination, under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121 *et seq*., that a national emergency exists nationwide as a result of the COVID-19 pandemic, and the same reasons underlying the issuance of the January 31, 2020 declaration that a public health emergency exists, under section 319 of the Public Health Service Act (PHS Act).

[3] Pub. L. No. 116-127 (2020).

[4] Pub. L. No. 116-136 (2020).

Affordable Care Act).[5] The term "group health plan" includes both insured and self-insured group health plans.[6] It includes private employment-based group health plans (ERISA plans), non-federal governmental plans (such as plans sponsored by states and local governments), and church plans.

"Individual health insurance coverage" includes coverage offered in the individual market through or outside of an Exchange, as well as student health insurance coverage (as defined in 45 CFR 147.145).

Section 6001 does not apply to short-term, limited-duration insurance (as defined in 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103), or to a plan or coverage in relation to its provision of excepted benefits (as defined in 26 CFR 54.9831-1(c), 29 CFR 2590.732(c), and 45 CFR 146.145(b) and 148.220).[7] It also does not apply to group health plans that do not cover at least two employees who are current employees (such as plans in which only retirees participate).[8]

Q2. When are plans and issuers required to comply with section 6001 of the FFCRA and for how long?

Plans and issuers are required to comply with section 6001 of the FFCRA as of March 18, 2020, the date of enactment of the FFCRA.[9] This means that, beginning March 18, 2020, plans and

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[5] Compliance with section 6001 of the FFCRA, as amended by section 3201 of the CARES Act, will not cause a plan or coverage to cease to be a grandfathered health plan, provided that no other changes are made that would cause a loss of grandfather status under 26 CFR 54.9815-1251(g), 29 CFR 2590.715-1251(g), and 45 CFR 147.140(g), as applicable.

[6] The terms "group health plan," "health insurance issuer," "group health insurance coverage," and "individual health insurance coverage" have the meanings given such terms in section 2791 of the PHS Act, section 733 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 9832 of the Internal Revenue Code of 1986 (Code), as applicable. See section 6001(d) of the FFCRA. Group and individual health insurance coverage includes certain non-grandfathered health insurance coverage in the individual and small group markets subject to an HHS non-enforcement policy (also known as "grandmothered" or "transitional" plans). See Centers for Medicare & Medicaid Services, Insurance Standards Bulletin Series – INFORMATION – Extension of Limited Non-Enforcement Policy through 2021 (January 31, 2020), available at: https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2021.pdf.

[7] Section 6001(b) of the FFCRA provides that its requirements shall be applied by the Departments to group health plans and health insurance issuers offering group or individual health insurance coverage as if included in the provisions of part A of title XXVII of the PHS Act, part 7 of ERISA, and subchapter B of chapter 100 of the Code, as applicable.

[8] See section 732(a) of ERISA and section 9831(a) of the Code.

[9] Section 6001 of the FFCRA applies to items and services furnished during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (SSA) beginning on after the date of enactment of the FFCRA (March 18, 2020). Paragraph (1)(B) of section 1135(g) of the SSA defines an emergency period as, "a public health emergency declared by the Secretary [of HHS] pursuant to section 319 of the Public Health Service Act." Section 319 of the PHS Act authorizes the Secretary of HHS to make a determination that a public health emergency exists if, among other things, the Secretary determines that a disease or disorder (including significant outbreaks of infectious diseases) presents a public health emergency. 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

issuers must provide coverage for the items and services described in section 6001(a) of the FFCRA and Q3 below that were furnished on or after March 18, 2020, and must not impose any cost-sharing requirements, prior authorization, or other medical management requirements with respect to those items and services.

Plans and issuers must continue to comply with section 6001 of the FFCRA for applicable items and services furnished during the public health emergency related to COVID-19.[10]

Q3. What items and services must plans and issuers provide benefits for under section 6001 of the FFCRA?

Section 6001(a) of the FFCRA, as amended by section 3201 of the CARES Act, requires plans and issuers to provide coverage for the following items and services:[11]

(1) An in vitro diagnostic test as defined in section 809.3 of title 21, Code of Federal Regulations,[12] (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that—

A. Is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);

B. The developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C.

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result of the 2019 novel coronavirus. See Determination of the HHS Secretary that a Public Health Emergency Exists, available at https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx.

[10] Generally, under section 319 of the PHS Act, a public health emergency declaration lasts until the Secretary of HHS declares that the public health emergency no longer exists, or upon the expiration of the 90-day period beginning on the date the Secretary declared a public health emergency exists, whichever occurs first. 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. Unless extended or terminated earlier, the public health emergency related to COVID-19 will end on June 16, 2020.

[11] Prior to enactment of the CARES Act, section 6001(a) of the FFCRA required group health plans and health insurance issuers to provide coverage for the following items and services: (1) in vitro diagnostic products (as defined in 21 CFR 809.3(a)) for the detection of SARS-CoV-2 or the diagnosis of COVID-19 that are approved, cleared, or authorized under section 510(k), 513, 515 or 564 of the Federal Food, Drug, and Cosmetic Act, and the administration of such in vitro diagnostic products and (2) Items and services furnished to an individual during healthcare provider office visits (which term includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in (1), but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

[12] Section 809.3(a) of title 21, Code of Federal Regulations, provides that in vitro diagnostic products are those reagents, instruments, and systems intended for use in the diagnosis of disease or other conditions, including a determination of the state of health, in order to cure, mitigate, treat, or prevent disease or its sequelae. Such products are intended for use in the collection, preparation, and examination of specimens taken from the human body. These products are devices as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act, and may also be biological products subject to section 351 of the PHS Act.

360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

C. Is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or

D. Other tests that the Secretary of HHS determines appropriate in guidance.

(2) Items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

Q4. Do "in vitro diagnostic tests" described in section 6001(a)(1) of the FFCRA, as amended by section 3201 of the CARES Act, include serological tests for COVID-19?

Yes. Serological tests for COVID-19 are used to detect antibodies against the SARS-CoV-2 virus, and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-CoV-2, the virus which causes COVID-19. The Food and Drug Administration (FDA) currently believes such tests should not be used as the sole basis for diagnosis.[13] FDA has advised the Departments that serological tests for COVID-19 meet the definition of an in vitro diagnostic product for the detection of SARS-CoV-2 or the diagnosis of COVID-19.[14] Therefore, plans and issuers must provide coverage for a serological test for COVID-19 that otherwise meets the requirements of section 6001(a)(1) of the FFCRA, as amended by section 3201 of the CARES Act.[15]

Q5. The FFCRA requires plans and issuers to cover items and services provided during a visit that "relate to the furnishing or administration" of COVID-19 diagnostic testing or that relate "to the evaluation of such individual for purposes of determining the

[13] U.S. Food and Drug Administration, Center for Devices and Radiological Health, Policy for Diagnostic Tests for Coronavirus Disease-2019 during the Public Health Emergency (Mar. 16, 2020), available at https://www.fda.gov/media/135659/download.

[14] Regulations issued by FDA define in vitro diagnostic products as "reagents, instruments, and systems intended for use in the diagnosis of disease or other conditions, including a determination of the state of health, in order to cure, mitigate, treat, or prevent disease or its sequelae. Such products are intended for use in the collection, preparation, and examination of specimens taken from the human body." 21 CFR 809.3(a).

[15] To date, FDA has authorized one emergency use authorization for a serological test that is intended for use by clinical laboratories. See U.S. Food and Drug Administration, Letter to Cellex Inc. Regarding qSARS-CoV-2 IgG/IgM Rapid Test (Apr. 1, 2020), available at https://www.fda.gov/media/136622/download.

need" for diagnostic testing. What types of items and services must be covered pursuant to this requirement?

Plans and issuers must cover items and services furnished to an individual during visits that result in an order for, or administration of, a COVID-19 diagnostic test, but only to the extent that the items or services relate to the furnishing or administration of the test or to the evaluation of such individual for purposes of determining the need of the individual for the product, as determined by the individual's attending healthcare provider.[16]

The Centers for Disease Control and Prevention (CDC) advises that clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. In addition, the CDC strongly encourages clinicians to test for other causes of respiratory illness.[17] Therefore, for example, if the individual's attending provider determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed during a visit (which term here includes in-person visits and telehealth visits) to determine the need of such individual for COVID-19 diagnostic testing, and the visit results in an order for, or administration of, COVID-19 diagnostic testing, the plan or issuer must provide coverage for the related tests under section 6001(a) of the FFCRA. This coverage must be provided without cost sharing, when medically appropriate for the individual, as determined by the individual's attending healthcare provider in accordance with accepted standards of current medical practice. This coverage must also be provided without imposing prior authorization or other medical management requirements.

Q6. May a plan or issuer impose any cost-sharing requirements, prior authorization requirements, or medical management requirements for benefits that must be provided under section 6001(a) of the FFCRA, as amended by section 3201 of the CARES Act?

No. Section 6001(a) of the FFCRA provides that plans and issuers shall not impose any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization requirements, or other medical management requirements for these items and services. These items and services must be covered without cost sharing when medically appropriate for the individual, as determined by the individual's attending healthcare provider in accordance with accepted standards of current medical practice.

[16] An attending provider means an individual who is licensed under applicable state law, who is acting within the scope of the provider's license, and who is directly responsible for providing care to a patient. Therefore, a plan, issuer, hospital, or managed care organization is not an attending provider.

[17] Centers for Disease Control and Prevention, Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19), available at https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html.

Q7. Are plans and issuers required to provide coverage for items and services that are furnished by providers that have not agreed to accept a negotiated rate as payment in full (i.e., out-of-network providers)?

Yes. Section 3202(a) of the CARES Act provides that a plan or issuer providing coverage of items and services described in section 6001(a) of the FFCRA shall reimburse the provider of the diagnostic testing as follows:

1. If the plan or issuer has a negotiated rate with such provider in effect before the public health emergency declared under section 319 of the PHS Act, such negotiated rate shall apply throughout the period of such declaration.

2. If the plan or issuer does not have a negotiated rate with such provider, the plan or issuer shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website, or the plan or issuer may negotiate a rate with the provider for less than such cash price.

Section 3202(b) of the CARES Act also requires providers of diagnostic tests for COVID-19 to make public the cash price of a COVID-19 diagnostic test on the provider's public internet website. Section 3202(b) of the CARES Act also grants the Secretary of HHS authority to impose civil monetary penalties on any provider that does not comply with this requirement and has not completed a corrective action plan, in an amount not to exceed $300 per day that the violation is ongoing.[18]

Q8. Section 6001(a)(2) of the FFCRA requires plans and issuers to provide benefits for certain items and services that are furnished during healthcare provider office visits, which include in-person and telehealth visits, as well as visits to urgent care centers and emergency rooms. Under what circumstances are items or services considered to be furnished during a visit?

The Departments construe the term "visit" in section 6001(a)(2) of the FFCRA broadly to include both traditional and non-traditional care settings in which a COVID-19 diagnostic test described in section 6001(a)(1) of the FFCRA is ordered or administered, including COVID-19 drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing. Therefore, the items and services described in section 6001(a) of the FFCRA, as amended by section 3201 of the CARES Act, must be covered when furnished in non-traditional settings, as well as when provided in traditional settings.

Q9. In light of the COVID-19 public health emergency, will the Departments permit plans and issuers to amend the terms of a plan or coverage to add benefits, or reduce or eliminate cost sharing, for the diagnosis and treatment of COVID-19 prior to satisfying any applicable notice of modification requirements and without regard to

[18] Section 3202(b)(2) of the CARES Act.

otherwise applicable restrictions on mid-year changes to health insurance coverage in the group and individual markets?

Yes. Section 2715(d)(4) of the PHS Act and final rules issued by the Departments regarding the Summary of Benefits and Coverage (SBC) provide that if a plan or issuer makes a material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective.[19] However, to help facilitate the nation's response to COVID-19, the Departments will not take enforcement action against any plan or issuer that makes such modification to provide greater coverage related to the diagnosis and/or treatment of COVID-19, without providing at least 60 days advance notice. Plans and issuers must provide notice of the changes as soon as reasonably practicable.[20] HHS encourages states to take a similar approach and will not consider a state to have failed to substantially enforce section 2715(d)(4) of the PHS Act if it takes such an approach.

Additionally, issuers are generally not permitted to modify the health insurance coverage for a product mid-year under section 2703 of the PHS Act and 45 CFR 147.106, subject to certain exceptions. However, HHS will not take enforcement action against any health insurance issuer that changes the benefits or cost-sharing structure of its plans mid-year to provide increased coverage for services related to the diagnosis and/or treatment of COVID-19. HHS encourages states to take a similar approach, and will not consider a state to have failed to substantially enforce section 2703 of the PHS Act if it takes such an approach.

These non-enforcement policies will apply with respect to changes made during the period during which a public health emergency declaration under section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies Act,[21] related to COVID-19 is in effect.[22] Although enforcement relief is being provided during this period for the *advance* notice requirements of section 2715(d)(4) of the PHS Act, to the extent a plan or issuer maintains any such changes beyond the emergency period, plans and issuers must comply with all other applicable requirements to update plan documents or terms of coverage.

The Departments would continue to take enforcement action against any health insurance issuer or plan that attempts to limit or eliminate other benefits, or to increase cost-sharing, to offset the

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[19] 26 CFR 54.9815-2715(b); 29 CFR 2590.715-2715(b); 45 CFR 147.200(b).

[20] The Departments note that plans and issuers may either provide an updated SBC reflecting the modification or provide a separate notice describing the material modifications. See 77 Fed. Reg. 8668, 8677 (Feb. 14, 2012).

[21] 50 U.S.C. § 1601, *et seq.*

[22] 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 (now known as Coronavirus Disease 2019 or COVID-19). 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 March 13, 2020, the President declared that the outbreak of COVID-19 in the United States constitutes a national emergency beginning March 1, 2020. See Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, issued March 13, 2020, available at https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/.

costs of increasing the generosity of benefits related to the diagnosis and/or treatment of COVID-19.

Q10. May states impose additional requirements on health insurance issuers to respond to the COVID-19 public health emergency?

Yes. Nothing in the FFCRA prevents a state from imposing additional standards or requirements on health insurance issuers with respect to the diagnosis or treatment of COVID-19, to the extent that such standards or requirements do not prevent the application of a federal requirement.

Excepted Benefits

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the respective requirements of title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code generally do not apply to the provision of certain types of benefits, known as "excepted benefits." Excepted benefits are described in section 2791(c) of the PHS Act, section 733(c) of ERISA, and section 9832(c) of the Code. The parallel statutory provisions establish four categories of excepted benefits, of which only the first and second are relevant here. The first category, under section 2791(c)(1) of the PHS Act, section 733(c)(1) of ERISA, and section 9832(c)(1) of the Code, includes benefits that are generally not health coverage, including on-site medical clinics. The benefits in this category are excepted in all circumstances.

The second category of excepted benefits is limited excepted benefits, which may include limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home healthcare, or community-based care. The benefits in this category are excepted only if certain conditions are met. Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code authorize the Secretaries of HHS, Labor, and the Treasury (collectively, the Secretaries) to issue regulations establishing other, similar limited benefits as excepted benefits. The Secretaries exercised this authority previously with respect to certain employee assistance programs (EAPs).[23] Under the Departments' final regulations, EAPs are excepted if they satisfy all of the following requirements[24]:

> (A) The EAP does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.
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> (B) The benefits under the EAP are not coordinated with benefits under another group health plan:
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> > (*1*) Participants in the other group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

[23] 79 Fed. Reg. 59130 (Oct. 1, 2014).
[24] 26 CFR 54.9831-1(c)(3)(vi); 29 CFR 2590.732(c)(3)(vi); 45 CFR 146.145(b)(3)(vi).

(*2*) Participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan.

(C) No employee premiums or contributions are required as a condition of participation in the EAP.

(D) There is no cost sharing under the EAP.

Q11. May an employer offer benefits for diagnosis and testing for COVID-19 under an EAP that constitute an excepted benefit?

Yes. The Departments' final regulations provide that for the purpose of determining whether an EAP provides benefits that are significant in the nature of medical care, the amount, scope, and duration of covered services are taken into account.[25] An EAP will not be considered to provide benefits that are significant in the nature of medical care solely because it offers benefits for diagnosis and testing for COVID-19 while a public health emergency declaration under section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies Act,[26] related to COVID-19 is in effect.

Q12. May an employer offer benefits for diagnosis and testing for COVID-19 at an on-site medical clinic that constitute an excepted benefit?

Yes. Coverage of on-site medical clinics is an excepted benefit in all circumstances.[27]

Telehealth and Other Remote Care Services

Q13. How can plans and issuers use telehealth and other remote care services to mitigate the impact of the COVID-19 public health emergency?

The widespread availability and use of telehealth and other remote care services are vital to combat the COVID-19 public health emergency. By using these services, patients are able to seek treatment from a healthcare professional in their home, without having to go to a medical office or hospital, helping minimize the risk of exposure to and community spread of COVID-19. The Departments recognize that many plans and issuers are currently offering benefits for telehealth and/or other remote care services in some form. Many states have encouraged issuers to cover robust telehealth and other remote care services without cost sharing, and many plans and issuers have taken steps to promote the use of these services by providing expanded access to them without cost sharing. The Departments strongly encourage all plans and issuers to promote the use of telehealth and other remote care services, including by notifying consumers of their availability, by ensuring access to a robust suite of telehealth and other remote care

[25] 26 CFR 54.9831-1(c)(3)(vi); 29 CFR 2590.732(c)(3)(vi); 45 CFR 146.145(b)(3)(vi).
[26] 50 U.S.C. § 1601 *et seq.*
[27] Section 9831(b) of the Code, section 732(b) of ERISA, and section 2722(b) of the PHS Act.

services, including mental health and substance use disorder services, and by covering telehealth and other remote care services without cost sharing or other medical management requirements.

Section 3701 of the CARES Act amends the laws applicable to high deductible health plans (HDHPs) and Health Savings Accounts (HSAs) to provide flexibility with respect to telehealth and other remote care services. Specifically, section 3701 of the CARES Act amends section 223(c) of the Code to provide a temporary safe harbor for providing coverage for telehealth and other remote care services. As added by section 3701 of the CARES Act, section 223(c)(2)(E) of 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. Section 3701 also amends section 223(c)(1)(B)(ii) of the Code to include telehealth and other remote care services as categories of coverage that are disregarded for purposes of determining whether an individual who has other health plan coverage in addition to an HDHP is an eligible individual who may make tax-favored contributions to his or her HSA under section 223 of the Code. Thus, an otherwise eligible individual with coverage under an HDHP may also receive coverage for telehealth and other remote care services outside the HDHP and before satisfying the deductible of the HDHP and still contribute to an HSA. The amendments to section 223 of the Code under section 3701 of the CARES Act are effective March 27, 2020, and apply to plan years beginning on or before December 31, 2021.

The Departments expect that the flexibilities provided through the amended provisions under section 223 of the Code will increase healthcare access for patients who may have signs or symptoms compatible with COVID-19 and protect other individuals from potential exposure. However, the Departments note that the amendments to section 223 of the Code apply generally to coverage for healthcare provided through telehealth and other remote care services and are not limited to coverage for COVID-19-related telehealth and other remote care services.

The Departments also encourage states to support efforts to increase access to telehealth and other remote care services. In particular, the Departments urge states to consider whether state licensing laws could be relaxed during the period in which a public health emergency declaration under section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies Act, 50 U.S.C. section, 1601 *et seq*., related to COVID-19 is in effect, to enable more in-state and out-of-state providers to offer telehealth and other remote care services in the state.

Q14. In light of the public health emergency posed by COVID-19, will the Departments allow plans and issuers to add benefits, or reduce or eliminate cost sharing, for telehealth and other remote care services prior to satisfying any applicable notice of modification requirements and without regard to restrictions on mid-year changes to provide coverage for telehealth services?

Yes. The Departments will apply the same non-enforcement policies described in Q8 to situations where a plan or issuer adds benefits, or reduces or eliminates cost sharing, for telehealth and other remote care services. These non-enforcement policies will apply with

respect to changes made for the period during which a public health emergency declaration under section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies Act,[28] related to COVID-19 is in effect. Plans and issuers must provide notice of the changes as soon as reasonably practicable. Although enforcement relief is being provided for the *advance* notice requirements of section 2715(d)(4) of the PHS Act, to the extent a plan or issuer maintains any such changes beyond the emergency period, plans and issuers must comply with all other applicable requirements to update plan documents or terms of coverage.

The Departments would continue to take enforcement action against any health insurance issuer or plan that attempts to limit or eliminate other benefits, or to increase cost-sharing, to offset the costs of increasing the generosity of benefits related to the diagnosis and/or treatment of COVID-19.

[28] 50 U.S.C. § 1601 *et seq.*