

Publications

The End of the COVID-19 Public Health Emergency and National Emergency Are Near – Are You Ready?

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The COVID-19 Public Health Emergency (“PHE”) and National Emergency (“NE”) have been in place since early 2020. In January 2023, President Biden stated his intention for both to end on May 11, 2023. There have been many questions about how certain rules would apply once these emergencies end, and on March 29, 2023, the Departments of Treasury, Labor, and Health and Human Services issued [FAQs \(the “2023 FAQs”\)](#) to address some of these open questions.¹

Note that on March 29, 2023, the Senate passed a bill to end the NE, which is expected to be signed into law by President Biden. While the effective date of this bill is unclear, it is likely that it will be effective upon signature – causing the NE, but not the PHE, to end before May 11, 2023.

Below we explain the key takeaways and considerations for employers and issuers.

COVID-19 Tests

During the PHE, plans and issuers are required to cover COVID-19 tests, including over-the-counter tests, with no cost sharing or prior authorization or other medical management requirements. Plans and issuers must cover the tests both in- and out-of-network. These requirements end when the PHE ends. The 2023 FAQs explain that a test is furnished on the date it was rendered to the individual or purchased and not the date the claim is submitted or paid.

If the plan or issuer makes a change to the coverage of COVID-19 tests post-PHE and this changes the information on the Summary of Benefits and Coverage (“SBC”), the plan or issuer must provide a 60-day notice. Under prior relief, a plan or issuer generally was not subject to this 60-day rule as long as the plan or issuer previously notified participants of the general duration of the testing coverage (e.g., that the reduced cost sharing and/or OTC tests are only available during the PHE). However, notably, the 2023 FAQs provide that a

notification given for a prior plan year will not be considered to satisfy the obligation to provide advance notice for coverage in the current plan year.

GROOM INSIGHT: Plans and issuers should review their SBCs to see whether they address coverage for COVID-19 tests. If so, and the plan or issuer did not give notice of the duration of the benefit with respect to the current plan year, then the plan or issuer should send a notice of the changes to participants.

The 2023 FAQs clarify that the IRS' relief in Notice 2020-15 (that allows HDHPs to cover COVID-19 testing and treatment pre-deductible **without affecting HSA eligibility**) continues to apply post-PHE until the IRS issues further guidance. That means that HSA-compatible HDHPs can continue to cover COVID-19 tests (and treatment) pre-deductible for now. The 2023 FAQs state that any further guidance will apply on a plan year basis, so plans and issuers will not be required to make changes until the next plan year.

COVID-19 Vaccines

Currently, plans and issuers must provide COVID-19 vaccines with no cost-sharing, both in- and out-of-network. The 2023 FAQs clarify that the requirement to provide coverage in-network without cost-sharing continues to apply post-PHE. However, plans and issuers are no longer required to cover the vaccines out-of-network (or can cover them out-of-network, but require cost-sharing), unless there is no in-network provider available.

Outbreak Period Extensions

During the NE, certain deadlines do not begin to run until the earlier of (1) one year from the date on which they would have started to run or (2) 60 days after the end of the NE (which is July 10, 2023 if the NE ends on May 11, 2023). These deadlines are generally related to COBRA, claims and appeals, external review, and HIPAA special enrollment. The 2023 FAQs provide helpful examples illustrating how the deadlines will apply post-NE. For example, an employee has a qualifying event and receives a COBRA election notice on October 1, 2022. The employee elects COBRA on October 15, 2022, retroactive to October 1, 2022. The employee has until 45 days after July 10, 2023, which is August 24, 2023, to make the initial COBRA premium payment. The initial COBRA premium payment would need to include the monthly premium payments for October 2022 through July 2023. The employee must pay the premium payment for August 2023 by August 30, 2023 (the last day of the 30-day grace period for the August 2023 premium payment under the standard COBRA rules). The subsequent monthly COBRA premium payments would be due the first of each month, subject to the standard 30-day grace period.

GROOM INSIGHT: With this relief ending, employers should review and, if necessary, revise their general and COBRA election notices, SPDs, and any other notices to remove language regarding these tolled deadlines. While there is no requirement to do so, employers could consider sending notices to individuals informing them that the extensions are ending, and their deadlines with respect to COBRA, to request HIPAA special enrollment, and to file claims, appeals, and requests for external review may be upcoming.

Some employers were more generous than required and extended the deadline for other change in election events under the cafeteria plan beyond HIPAA special enrollment. Employers should keep in mind that cafeteria plan amendments must be prospective only. Thus, if the employer needs to amend its cafeteria plan to reflect the end of this relief, employers must do so on or before they would like the change to be effective.

Medicaid-Related Special Enrollment

Since March 18, 2020, Medicaid agencies have generally been unable to terminate Medicaid beneficiaries. However, this "continuous enrollment condition" ended March 31, 2023. The 2023 FAQs remind employers and issuers that individuals who lose Medicaid or CHIP coverage due to loss of eligibility are entitled to a special enrollment period in a group health plan and the individual market.

GROOM INSIGHT: The tolling of the 60-day HIPAA special enrollment event deadlines for requesting enrollment in a group health plan due to the loss of Medicaid/CHIP will expire 60 days after the end of the NE. The 60-day deadline to request HIPAA special enrollment will then begin to run the earlier of (1) 1 year from the date it would have begun running for that individual or (2) 60 days after termination of the NE.

Other Implications

- *MHPAEA* – During the PHE, plans could disregard COVID-19 benefits that were required to be covered without cost-sharing for purposes of the quantitative treatment limitations test. However, upon expiration of the PHE, this relief will no longer apply.

GROOM INSIGHT: Plans should perform financial requirement testing if they intend to continue these benefits without cost-sharing to ensure MHPAEA compliance.

- Telehealth – During the PHE, employers were permitted to offer stand-alone telehealth/remote care benefits to employees not eligible for their major medical coverage. This relief will end at the end of the plan year that begins on or before May 11, 2023.

GROOM INSIGHT: Employers that currently provide this benefit to employees should consider whether or not to end this benefit once the current plan year ends. Employers interested in offering stand-alone telehealth coverage should evaluate whether they could do so as an EAP.

- Qualified disaster relief payments – Employers and issuers could make tax-free qualified disaster relief payments during the NE. This ends when the NE ends.

GROOM INSIGHT: Employers and issuers that adopted these programs should cease excluding these payments from their employees' incomes once the NE ends, unless another tax exclusion applies.

- Employee assistance programs – During the PHE/NE, an EAP could offer COVID-19 diagnosis, testing, and vaccination without impacting its excepted benefit status. This relief ends when the PHE/NE end.

GROOM INSIGHT: Employers that would like to continue to provide this benefit through the EAP should consider whether it would continue to meet the excepted benefit requirements.