How the End of the COVID-19 Emergency Periods Will Impact Health Plans

UPDATE – COVID-19 National Emergency Ends Sooner Than Previously Announced

On March 29, 2023, the U.S. Senate passed a resolution that would end the COVID-19 *national emergency declaration* that has been in place since 2020. The U.S. House of Representatives voted in February to terminate the order, and President Joe Biden had indicated that he would sign the bill despite strongly opposing it. Biden had previously announced plans to end the national emergency declaration implemented by former President Donald Trump in May 2023. This resolution will not change the end date of the *public health emergency* which remains May 11, 2023.

On April 10, 2023, President Biden signed a resolution ending the COVID-19 national emergency. Since the national emergency now has been determined to end on April 10, 2023, the 60-day period would end on June 9, 2023 (rather than July 10, 2023, as previously predicted). **But we understand the DOL has indicated that it will continue to use the May 11 date, meaning the outbreak period would end on July 10, 2023 (60 days after May 11) as originally announced.** We are hopeful the agencies will issue formal, written guidance to confirm the end of the outbreak period.

Our original post about the plans to end the national emergency and public health emergency is included below. We also hosted a Q&A webinar on this topic on March 2. Click here to watch the webinar recording.

The Biden Administration has announced its plan to end the COVID-19 national emergency and public health emergency (PHE) on **May 11, 2023**. Employer-sponsored health plans have been required to comply with certain coverage requirements during the COVID-19 emergency periods, including the following:

- Health plans must cover COVID-19 diagnostic tests and related services without imposing any cost sharing (such as deductibles, copayments or coinsurance) during the PHE; and
- Non-grandfathered health plans must cover certain preventive services, including recommended COVID-19 vaccines and boosters, without cost sharing. During the PHE, this coverage mandate applies to COVID-19 immunizations provided by all providers, regardless of whether they are in-network or out-of-network.

In addition, during the COVID-19 outbreak period (which is tied to the national emergency), certain health plan deadlines are extended, including the deadlines to request special enrollment under HIPAA, elect COBRA continuation coverage and comply with the plan's claims and appeals procedures.

Impact on Health Plans

When the PHE ends, health plans will no longer be required to cover COVID-19 diagnostic tests and related services without cost sharing. Health plans will still be required to cover recommended preventive services, including COVID-19 immunizations, without cost sharing, but this coverage requirement will be limited to in-network providers. In addition, once the COVID-19 outbreak period ends, health plans can go back to their nonextended deadlines for purposes of HIPAA special enrollment, COBRA continuation coverage, and claims and appeals procedures.

Public Health Emergency

Background

The U.S. Department of Health and Human Services (HHS) first declared that a PHE exists due to the COVID-19 pandemic on Jan. 31, 2020. A PHE declaration lasts for 90 days unless it is terminated early by HHS. At the end of the 90-day period, HHS can extend the PHE or let it expire. HHS has repeatedly extended the COVID-19 PHE since it began in early 2020. Most recently, HHS renewed the PHE on Jan. 11, 2023. HHS has promised to provide at least 60 days' notice to the public before the PHE's end date.

On Jan. 30, 2023, the Biden Administration announced its plan to end the PHE on **May 11, 2023**. The Biden Administration noted that it opposes proposed legislation that would immediately end the COVID-19 emergency periods, stating that this would create chaos and uncertainty for the U.S. healthcare system.

Health Plan Changes

When the PHE ends, the following health plan coverage rules related to the COVID-19 pandemic **will no longer apply:**

- **COVID-19 Diagnostic Testing Without Cost Sharing**—During the PHE, health plans and health insurance issuers must cover COVID-19 tests and related services without imposing any cost sharing or prior authorization or other medical management requirements. As of Jan. 15, 2022, this coverage requirement extends to at-home COVID-19 diagnostic tests. Health plans and issuers will no longer be required to provide this first-dollar coverage when the PHE ends.
- **COVID-19 Vaccines**—Out-of-Network Providers—Non-grandfathered group health plans and health insurance issuers must cover coronavirus preventive services, including recommended COVID-19 immunizations, without cost sharing requirements. During the PHE, covered services may be provided by in-network or out-of-network providers. Once the PHE ends, health plans and issuers must continue to cover recommended COVID-19 immunizations without cost sharing but can limit this coverage to in-network providers.
- **Cost of COVID Vaccines** – During the PHE, the federal government is subsidizing the cost of COVID-19 vaccines, boosters, treatments and tests. This federal funding is depleting and once the supply of vaccines purchased by the federal government runs out, plan sponsors will see an increase in cost.
- **Standalone Telehealth Benefits**—For plan years beginning during the PHE, a large employer (more than 50 employees) may offer standalone telehealth benefits and other remote care services to individuals who are not eligible for coverage under any other group health plan offered by the employer without violating the Affordable Care Act's market reforms. These types of standalone arrangements will not be permitted after the PHE ends.
- **Medicaid Eligibility** — The Families First Coronavirus Response Act (FFCRA) included a requirement that Medicaid programs keep people continuously enrolled through the end of the month in which the COVID-19 public health emergency (PHE) ends, in exchange for enhanced federal funding. The Consolidated Appropriations Act, 2023 (CAA) will end this provision (prior to the end of the PHE) on March 31st, 2023. States will begin Medicaid disenrollment on April 1st, 2023. Employers can expect an increase in mid-year enrollment due to loss of Medicaid.

National Emergency – Outbreak Period

Background

Various deadlines related to employer-sponsored group health plans are extended during the COVID-19 outbreak period. The outbreak period began in March 2020, when former President Donald Trump declared a national emergency due to the COVID-19 pandemic, and it will continue until 60 days after the end of the COVID-19 national emergency (or such other date as announced by the federal government).

On Jan. 30, 2023, the Biden Administration announced its plan to end the COVID-19 national emergency on **May 11, 2023**. Under this timeline, the outbreak period will end on **July 10, 2023**.

Deadline Extensions

During the outbreak period, some key deadlines for employee benefit plans and participants are extended. Under the relief, **these deadline extensions end when the outbreak period is over** or, if earlier, after an individual has been eligible for a specific deadline extension for **one year**. Deadline extensions that apply during the outbreak period include the following:

- **HIPAA Special Enrollment**—The 30-day period (or 60-day period for Medicaid and CHIP, if applicable) to request special enrollment.
- **COBRA Notice and Premium Payment Deadlines**—The 60-day period to elect COBRA coverage; the date for making COBRA premium payments (generally at least 45 days after the day of the initial COBRA election, with a grace period of at least 30 days for subsequent premium payments); and the date for individuals to notify the plan of a qualifying event or disability determination (generally 60 days from the date of the event, loss of coverage or disability determination).
- **Claims and Appeals Deadlines**—The deadlines to file a benefit claim, file an appeal of an adverse benefit determination or request an external review of a claim under the plan's claims and appeals procedures.

Pre-Deductible Telehealth Coverage

In response to the COVID-19 pandemic, the Coronavirus Aid, Relief and Economic Security (CARES) Act allowed high deductible health plans (HDHPs) compatible with health savings accounts (HSAs) to provide benefits for telehealth or other remote care services before plan deductibles were met. This relief was not linked to the PHE or outbreak period; rather, it applied for plan years beginning before Jan. 1,

2022. A spending bill extended this relief to telehealth services provided in months beginning after March 31, 2022, and before Jan. 1, 2023.

The Consolidated Appropriations Act, 2023 (CAA), which was signed into law on Dec. 29, 2022, extends the ability of HDHPs to provide benefits for telehealth or other remote care services before plan deductibles have been met without jeopardizing HSA eligibility. Regardless of when the COVID-19 emergency periods end, HDHPs may be designed to waive the deductible for any telehealth services for plan years beginning in 2023 and 2024 without causing participants to lose HSA eligibility. This extension applies for plan years beginning after Dec. 31, 2022, and before Jan. 1, 2025. Non-calendar year plans will have a gap from January 1, 2023, to the beginning of the plan year in 2023 causing a mid-year gap in eligibility for reduced or no-cost telehealth prior to meeting the deductible.

Action Items & Key Takeaways

- **COBRA –** Amend COBRA election documents to inform Qualified Beneficiaries that the extensions no longer apply.
- **HIPAA Special Enrollment** – Plan administrators will no longer be required to honor requests to enroll new spouses or dependents mid-year beyond the 30- or 60-day timeframes.
- **Outbreak period deadlines** – these deadline extensions end when the outbreak period is over or, if earlier, after an individual has been eligible for a specific deadline extension for one year. Deciding on which date a deadline will fall must be an individual analysis depending on the date of eligibility.
- **Review/Modify** – review plan documents, policies, COBRA notices, and other employee communications to ensure they align with the pre-pandemic rules once the Public Health Emergency and Outbreak Period ends.
- **Summary of Material Modifications (SMM)** – mid-year changes may be considered a reduction in benefits that would require an SMM within 60 days of the change.
- **Mental Health Parity and Addiction Equity Act (MHPAEA)** – Plan sponsors should review coverage of COVID-19 and related costs to determine if any coverages will be continued. However, continued coverage may cause issues with complying with MHPAEA.