SPECIAL COMPLIANCE ALERT

End of Emergency Periods Sparks Health Plan Compliance Requirements

February 14, 2023

Quick Facts

- On January 31, 2023, the President announced that the Public Health Emergency (PHE) and the National Emergency (NE) will both end on May 11, 2023.
- Under the PHE, group health plans and issuers must provide certain COVID-19 services at no cost-sharing.
- Under the NE, certain deadlines, claims, reviews and rights are extended through the outbreak period.
- Plan sponsors should take note of the end of the PHE and NE and consider the effect of the emergency end dates on their plans.

Background

On January 31, 2023, President Biden **announced** that both the National Emergency (NE) as declared by the President, and Public Health Emergency as declared by the Department of Health and Human Services (HHS), will end on May 11th, 2023.

The **first PHE was effective January 31, 2020**, and has been renewed more than a dozen times. Under the PHE, group health plans were required to, among other things:

- Continue to cover COVID-19 diagnostic tests and related services to plan participants at no cost-sharing.
- Provide COVID-19 vaccines at no cost-sharing both in and out of network.
- Provide over-the-counter (OTC) COVID-19 tests with no cost-sharing under certain specifications.

The National Emergency was originally declared on March 1, 2020. The Department of Labor (DOL) and Internal Revenue Service (IRS) issued a final rule in April 2020. It was extended in 2021, and President Biden **formally extended** the COVID-19 National Emergency on February 18, 2022.

The rule extended the time participants were given to comply with certain deadlines under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), and the Employee Retirement Income Security Act (ERISA). Additionally, the DOL granted some leniency to plan sponsor disclosures required under ERISA. The guidance applied to the period beginning March 1, 2020, and ending 60 days after the National Emergency is declared over (the “outbreak period”). During the outbreak period, the deadlines are “tolled,” meaning group health plans must disregard this period when administering plans with respect to notices, disclosures and other deadlines covered by the rule.

Public Health Emergency

When the PHE ends on May 11, 2023, certain COVID-19 requirements for health plans and issuers will also expire. Under **IRS Notice 2020-15**, high deductible health plans (HDHPs) with health savings accounts (HSAs) received relief from the first-dollar requirement, which states that an individual will be ineligible to contribute to an HSA if they receive coverage for an item or service that is non-preventive before meeting the deductible. As of the date of this publication, it is unclear whether the IRS guidance under Notice 2020-15 will expire at the end of the PHE. On February 9, 2023, the Department of Health and Human Services (HHS) published **Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap** (Transition Roadmap) outlining the new protocol for COVID-19 vaccines, tests and treatments under Medicare and private insurance. Additional guidance from the Department is anticipated in the coming weeks.

COVID-19 Testing

During the PHE, COVID-19 tests and related services must be provided without cost-sharing, prior authorization, or other medical management requirements. After the PHE ends, plans will no longer be required to cover COVID-19 tests, including OTC tests, and related services at no cost-sharing. Plans should consider whether they want to charge for testing. HDHP plan sponsors who choose to continue covering tests with no cost-sharing should consider potential impacts to HSAs absent additional guidance from the IRS about relief for COVID-19 testing. Additional guidance from the IRS on this issue is likely. Plans may continue to impose the $12 reimbursement for OTC out-of-network tests or not covered OTC tests.

The Transition Roadmap reiterates that the requirement for private insurance companies to cover COVID-19 tests without cost-sharing, will end, but reminds plan sponsors and issuers that plans may continue if plans choose to continue to include it. HHS is encouraging private insurers and plan sponsors to continue to provide such coverage going forward.

Plan sponsors should amend their plans to reflect changes and send a summary of material modification (SMM) within 60 days of making a change, as this will likely constitute a material reduction in benefits.

COVID-19 Treatments

Under the PHE, some state issuers covered COVID-19 treatment at no or reduced cost-sharing. Many self-funded plans chose to cover treatments at no cost-sharing but were not required to do so. The Transition Roadmap reminds plan participants that when the PHE emergency ends, out-of-pocket expenses for certain treatments may change, depending on an individual's healthcare coverage. Medicaid programs will continue to cover COVID-19 treatments without cost-sharing through September 30, 2024, after which cost-sharing may vary by state.

Plan sponsors and issuers making changes to costs for COVID-19 treatments should amend their plans to reflect changes and send a summary of material modification (SMM) within 60 days of making a change, as this will likely constitute a material reduction in benefits.

COVID-19 Vaccines

Under the Coronavirus, Aid Relief, and Economic Security (CARES) Act signed into law on March 27, 2020, a COVID-19 vaccine, when available, would be considered a "preventive health service." Plans and issuers were required to cover it without cost-sharing both in and out of network within 15 days of its authorization by the Centers for Disease Control and Prevention (CDC). The requirement to cover the vaccine both in-network and out-of-network without cost-sharing will remain in effect until the end of the PHE. Under the Affordable Care Act (ACA), health plans and issuers must cover preventive

services such as in-network immunizations at the start of the plan year that begins a year after approval by the preventive services task force.

After the end of the PHE, plans must cover COVID-19 vaccines with no-cost-sharing in-network under the ACA preventive services requirement but may choose to continue to cover out-of-network COVID-19 vaccines at no-cost-sharing. Plans that are making a change to out-of-network services should send a notice to plan participants within 60 days of the decision to drop the benefit.

The Transition Roadmap reiterates that when the transition to traditional healthcare coverage occurs, many individuals will continue to pay nothing out-of-pocket for the COVID-19 vaccine. This is because vaccines are a preventive health service recommended by the Advisory Committee on Immunization Practices (ACIP), and most private insurance plans will cover the vaccine at no cost-sharing.

Stand-Alone Telehealth Relief

During the PHE, employers were permitted to provide stand-alone telemedicine benefits to employees who were ineligible for major medical coverage without subjecting the telehealth plan to additional requirements under the ACA. This relief only applied to employees who were not eligible for the employer's medical plan. This relief ends when the PHE ends. Employers who took advantage of this relief should send a notice to their employees within 60 days of dropping the benefit.

Telehealth Relief for Qualified HDHPs

Under the CARES Act, HDHPs were permitted to provide telemedicine coverage at less than fair market value (FMV) before meeting the deductible, without interfering with HSA eligibility, from January 1, 2020, through December 31, 2021. This relief was extended in March of 2022 for the period April 1, 2022, through December 31, 2022. It was again extended through the Consolidated Appropriations Act of 2023 for plan years beginning in 2023 and 2024. Refer to this previous **EPIC Compliance Alert** for more information on this additional relief.

Plan sponsors should determine whether to extend this relief, and any changes should be reflected in a summary of material modification (SMM) or an updated summary plan description (SPD).

Mental Health Parity Non-Compliance Relief

During the PHE, the Departments will not take enforcement action on group health plans that disregard COVID-19 items and services provided at no cost-sharing to comply with the financial tests required for Mental Health Parity quantitative treatment limitations (QTL).

When the relief ends, plans that maintain no cost-sharing for COVID-19 testing and related services should perform financial testing to ensure Mental Health Parity quantitative treatment limitation compliance.

Summary of Benefits and Coverage Relief

During the PHE, plan sponsors were assumed to have satisfied requirements to provide advanced notice of material modification regarding COVID-19 testing, treatment and telemedicine if they previously provided information about additional benefits or reduced cost-sharing, or provided such notice within a reasonable timeframe after making changes.

When the PHE ends, plan sponsors should send notice of changing benefits or reduced cost-sharing if such notice was not previously provided.

Relief for Employee Assistance Programs

Employee assistance programs (EAPs) normally are considered "excepted benefits" under the ACA to avoid being subject to additional requirements such as ACA market reforms. EAPs that provide "significant medical care" are not generally considered to be excepted benefits. During the PHE, EAPs that provided benefits for COVID-19 testing were not considered "significant medical care."

Plans that continue to provide COVID-19 testing following the end of the PHE should assess whether the plan provides significant medical care, and if so, subjects the plan to additional requirements under the ACA. If the plan removes testing from the EAP, it may trigger the requirement to provide a 60-day advance notice, as this is likely a material reduction in benefits.

National Emergency

The NE was originally declared on March 1, 2020, and the Department of Labor (DOL) and Internal Revenue Service (IRS) issued a final rule in April 2020. It was extended in 2021, and then again on **February 18, 2022**. In November 2022, the United States Senate pushed for an end of the NE, and on January 31, 2023, the Biden Administration announced that it will end on May 11, 2023.

Tolling of Deadlines During the Outbreak Period

During the NE, under Employee Benefits Security Administration **EBSA Disaster Relief Notice 2020-01**, certain deadlines are "tolled" (disregarded) for either one year from the date of the triggering event, or the end of the "outbreak period", whichever is sooner. Assuming that the May 11, 2023, date does not change, the "outbreak period" will end 60 days after the declared end of the NE, which is July 10, 2023. Tolling will end on that date. The end of the tolling period restarts the timeframe for notices, payments, claims, and special enrollment rights that were previously disregarded. Because the tolling period is applied on an individual basis, tolling may end prior to the outbreak for some individuals.

COBRA

The following deadlines regarding COBRA notice and payments are tolled during the outbreak period:

- 60-day election period
- 60-day period for COBRA-qualified beneficiaries to notify the plan of a qualifying event or Social Security determination of disability
- 45-day grace period for initial premium payment
- 30-day grace period (or longer) for subsequent premium payments
- 14-day deadline for plan sponsors/administrators to provide election notices

When tolling ends, plan sponsors who took advantage should send election notices and revise any COBRA notices to remove language regarding tolled deadlines. Additionally, plan sponsors should provide notices to qualified beneficiaries of the upcoming election and payment deadlines and inform them that they will lose COBRA rights for not meeting deadlines.

ERISA Plan Claims and Appeals

During the outbreak period, the deadlines for participants to file a claim for benefits and/or appeal an adverse benefit determination were tolled. At the end of the outbreak period, plan sponsors should send notices to individuals informing them that the deadline extensions to file claims and appeals is expiring, and provide them with upcoming deadlines.

External Review

The following deadlines for claimants to request an external claim review were tolled during the outbreak period:

- 4-month period (federal review process) to file a request for an external review
- 4-month period (or 48-hours after receipt of an incomplete request notification, if later) to complete an incomplete request for external review

When the outbreak period ends, plan sponsors should send notices to individuals advising them of the deadline expiration and providing them with new deadlines.

HIPAA Special Enrollment

The following 30- or 60-day deadlines to request enrollment in a group health plan following a HIPAA special enrollment event were tolled during the outbreak period:

- Birth
- Adoption or placement for adoption
- Marriage
- Loss of other health coverage
- Loss of state premium-assistance subsidy

At the end of the outbreak period, plan sponsors should send notices to individuals informing them of expiring deadline extensions to file claims and appeals, and providing them with new upcoming deadlines. Additionally, plan sponsors should review their cafeteria plan documents to confirm whether amendments are needed to remove language related to this provision.

Examples

HIPAA Special Enrollment Right

On May 1, 2023, employee A is married and has a 30-day special enrollment right to add their spouse to the plan. Under the outbreak period guidance, employee A's HIPAA special enrollment right is tolled for one year from the date of their qualifying event, or until the end of the outbreak period, whichever is sooner. The NE ends on May 11, 2023, and the outbreak period ends 60 days later on July 10, 2023. Employee A's 30-day HIPAA special enrollment window begins on July 11, 2023.

Claims and Appeals Right

On April 1, 2023, employee B incurred a claim and has 12 months to file. Under the outbreak period guidance, employee B's time to file their claim is tolled for one year from the date the claim was incurred, or until the end of the outbreak period, whichever is sooner. The NE ends on May 11, 2023, and the outbreak period ends 60 days later on July 10, 2023. Employee B's 12-month window to file their claim begins on July 11, 2023.

EBSA Disaster Relief Notice 2020-01 provided relief for certain notice deadlines. The notice states that, during the NE, a plan will not be in violation of ERISA rules for failure to furnish a notice, disclosure, or document in a timely manner if the plan acts in good faith to provide the notice, disclosure or document as soon as administratively practicable under the circumstances.

When the NE ends, plan sponsors that have not sent required notices, such as SMMs or SPDs, should send these notices as soon as administratively practicable.

Summary

The end of the PHE and NE, while welcomed, does create some confusion for plan sponsors and participants. It is likely that the Departments will provide specific guidance clarifying how the various guidance tied to the ending of these emergencies will be affected. EPIC will continue to monitor the various guidance and will provide updates as information becomes available.

EPIC Employee Benefits Compliance Services

For further information on this or any other topic, please contact your EPIC benefits consulting team.