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End of the COVID-19 National and Public Health Emergencies—Action Items for Health Plan Sponsors

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Introduction

- It has been a long three years!
- The COVID-19 National Emergency ("NE") and Public Health Emergency ("PHE") end on May 11, 2023
- During the NE and PHE periods, the government issued guidance providing various forms of temporary relief to plan sponsors and participants, and required plan sponsors to make certain plan design changes
- Recently, the Departments of Labor, Health and Human Services, and Treasury/IRS (the "Departments") issued guidance about the impact of ending these emergency periods on health plans

Agenda

- The topics we will discuss include:
  - The difference between the PHE and the NE
  - The date that the PHE and NE ends
  - Changes to certain rules that are contingent on the PHE or the NE
  - The impact of *Braidwood Management Inc. v. Becerra* on the COVID-19 preventive care rules
  - Notification Requirements

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PUBLIC HEALTH EMERGENCY VERSUS NATIONAL EMERGENCY

Public Health Emergency vs National Emergency

One set of rules is tied to the PHE and one set is tied to the NE

Rules Tied to the Public Health Emergency:

- COVID-19 Testing
- COVID-19 Vaccines
- Stand-Alone Telehealth
- Certain Mental Health Parity Rules
- Excepted Benefit Status for Employee Assistance Plans (EAPs)

Rules Tied to the National Emergency:

- Tolling of Certain Plan Deadlines During the "Outbreak Period", which ends 60 days after the end of the National Emergency

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Public Health Emergency (PHE)

- Under §319 of the Public Health Services (PHS) Act, the HHS Secretary can declare a PHE if they determine, after consulting with such public health officials as may be necessary, that a disease presents a PHE
- The PHE was initially declared on January 31, 2020, by HHS Secretary Azar
- This declaration was continually renewed, most recently by HHS Secretary Becerra, effective February 11, 2023
- On January 30 and February 9, 2023, respectively, the Biden Administration and Secretary Becerra announced that they intend to end the PHE on May 11, 2023

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National Emergency (NE)

- On March 13, 2020, by Proclamation 9994, President Trump declared a national emergency concerning the COVID-19 pandemic beginning March 1, 2020
- The NE has since been extended
- On January 30 and February 9, 2023, respectively, the Biden Administration and Secretary Becerra announced that they intend to end the NE on May 11, 2023

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CONFUSION!

- On April 10, President Biden signed into law joint resolution (HR Res 7) that was passed by Congress to end the NE effective that day, about a month earlier than the May 11 end date the administration had previously announced
- Both the DOL and the IRS have provided informal guidance that this does not mean that the Outbreak Period ends earlier
- How can that be?? What is going on?! CONFUSION!

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National Emergency

- The guidance issued by the Departments regarding the tolling of certain plan deadlines during the "Outbreak Period" stated the basis for these rules: (1) Proclamation 9994, signed by President Trump **and** (2) Section 501(b) of the Stafford Disaster Relief and Emergency Assistance Act ("Stafford Act")
- The resolution that President Biden signed that ended the National Emergency on April 10th stated that it ended the, "…national emergency declared by the finding of the President on March 13, 2020, in Proclamation 9994…"
- It did not change, or impact, the National Emergency determination under the Stafford Act

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National Emergency

- In addition, the regulations regarding the tolling of certain plan deadlines defined the Outbreak Period as, "…the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency **or such other date announced by the Agencies** in a future notification…"
- The point is that the IRS and the DOL take the position that—for rules regarding the tolling of certain plan deadlines—the NE ends on May 11, which means that the Outbreak Period ends on July 10

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END OF THE PUBLIC HEALTH EMERGENCY PERIOD

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End of the PHE—COVID Testing

- Under the Families First Coronavirus Response Act ("FFCRA") and the CARES Act, during the PHE, health plans are required to cover COVID-19 tests and testing-related services without cost-sharing (e.g., deductibles, copayments, co-insurance), prior authorization, or other medical management techniques, regardless of whether the tests are obtained in-network or out-of-network
- In addition, health plans are required to cover up to eight Over-The-Counter ("OTC") COVID-19 tests per person, per month, without cost-sharing (but plans may cap reimbursement at $12 per test if certain requirements are met)
- After the end of the PHE, health plans will no longer be required to cover COVID-19 tests and testing-related services for free, and health plans may impose cost sharing, prior authorization, or other medical management requirements for such services

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COVID Testing (Continued)

- The change to the rule applies to tests and associated items or services that are "furnished" after the PHE ends
- A COVID-19 test, or associated item or service, is considered "furnished" on the date the item or service was rendered to the individual (or for an OTC COVID-19 test, the date on which the test was purchased)
- If a COVID-19 test involves multiple items or services, the plan sponsor should look to the earliest date on which an item or service is furnished

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COVID Testing (Continued)

- Plan Sponsors will need to decide whether to:
  - (1) keep the benefits as is—there is no requirement to reduce the benefit;
  - (2) amend health plans to cease providing any coverage for COVID-19 tests at the end of the PHE; or
  - (3) amend the plan so that it continues to offer coverage for COVID-19 testing, but impose requirements on this testing (such as cost-sharing)

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COVID Testing (Continued)

- If the benefit is removed or reduced, the plan must provide participants with notice (the rules regarding the notice requirements are explained later in the webinar)
- If the plan does remove or reduce the benefit, the plan sponsor should consider communicating with plan participants that COVID-19 tests purchased by an individual may be reimbursed through the individual's Health Flexible Spending Account ("Health FSA"), Health Reimbursement Arrangement ("HRA"), or Health Savings Account ("HSA") (as applicable)

End of the PHE—COVID Vaccines

- The CARES Act requires plans to cover "qualifying coronavirus preventive care services" (e.g., COVID-19 vaccines and boosters) without cost-sharing, both in-network and out-of-network. This CARES Act requirement will end as of May 11, 2023 (the end of the PHE)
- However, non-grandfathered health plans will still be required to cover in-network COVID-19 vaccines without cost-sharing as part of the Affordable Care Act ("ACA") preventive services mandate that applies indefinitely for certain in-network immunizations

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End of the PHE—COVID Vaccines

- FAQs issued by the Departments clarify that if a non-grandfathered health plan does not have a service provider in its network that provides COVID-19 vaccines, then the health plan must cover COVID-19 vaccines provided by out-of-network providers without cost-sharing

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CONFUSION—AGAIN—What About that Texas Case?!?

- A lower court judge in the 5th Circuit ruled that preventive care recommendations by the USPSTF were not authorized because the members of that task force are not subject to confirmation by the Senate and their recommendations are not reviewed by constitutionally appointed government officials
- The court vacated every action taken by the government pursuant to the USPSTF's recommendations since the ACA was passed into law in 2010 (*Braidwood Management Inc. v. Becerra)*

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CONFUSION—AGAIN—What About that Texas Case?!?

- A reminder about the ACA preventive care requirements
- ACA requires non-grandfathered group health plans to cover, without the imposition of any cost-sharing requirements, the following items or services:
  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"), except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in 2009;
  - Immunizations that have a recommendation from the Advisory Committee on Immunization Practices ("ACIP");
  - Preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration ("HRSA"); and
  - With respect to women, such additional preventive care and screenings as provided for in guidelines supported by HRSA

CONFUSION—AGAIN—What About that Texas Case?!?

- The *Braidwood* decision applies to items and services required to be covered by plans without cost sharing in response to an "A" or "B" recommendation by the USPSTF on or after March 23, 2010
- This means that plans must continue to cover, without cost sharing, items and services recommended with an "A" or "B" rating by the USPSTF before March 23, 2010

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CONFUSION—AGAIN—What About that Texas Case?!?

- In addition, the *Braidwood* court did not enjoin enforcement of PHS Act section 2713 or vacate its implementing regulations
- Hence, guidance related to immunizations recommended by ACIP, as well as preventive care and screenings provided for in guidance supported by HRSA, are not impacted by the *Braidwood* decision
- Plans must continue to cover such items and services—which include, immunizations recommended by ACIP, as well as contraceptive services, breastfeeding services and supplies, cervical cancer screening, and pediatric preventive care recommended by HRSA—without cost sharing, consistent with all applicable regulations and guidance

CONFUSION—AGAIN—What About that Texas Case?!?

- To the extent a health plan elects to make changes to preventive coverage, the plan must comply with applicable notice requirements
- This includes complying with the requirements regarding the Summary of Benefits and Coverage ("SBC"), which provide that if a health plan makes a material modification to any of the terms that would affect the content of the SBC, and that modification occurs mid-year, the plan must provide notice of the modification not later than 60 days **prior** to the date to which the modification will become effective

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So what about the COVID Vaccine?

- The *Braidwood* decision does not change the requirement for non-grandfathered plans to cover, without cost sharing, immunizations recommended by ACIP
- Therefore, because the COVID-19 vaccine is an immunization recommended by ACIP, non-grandfathered health plans must continue to provide coverage, without cost sharing, for COVID-19 vaccines and their administration

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CONFUSION—AGAIN—What About that Texas Case?!?

- In addition, the Biden Administration has appealed the ruling and requested a stay (or pause) of the lower court ruling
- If a stay is granted by the appeals court, the lower court ruling will not be effective
- Even if the Biden Administration loses on appeal, it is likely this will go to the Supreme Court
- At this point, we do not suggest taking any action based on the lower court's decision
- So…back to our regular programming!

End of the PHE—COVID Vaccines

- Plan sponsors of non-grandfathered plans will need to decide whether to:
  - (1) keep the plan benefit as is—there is no requirement to reduce the benefit, or
  - (2) amend the health plan to only cover in-network COVID-19 vaccines without cost-sharing after the end of the PHE, or
  - (3) amend the health plan to continue covering both in-network and out-of-network COVID-19 vaccines, but to apply cost sharing for out-of-network COVID-19 vaccines
- Plan sponsors of grandfathered plans will have more flexibility regarding coverage of COVID-19 vaccines both in-network and out-of-network

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End of the PHE—Stand-Alone Telehealth

- A large employer can offer stand-alone telehealth benefits to employees who are not enrolled in the employer's major medical coverage
- This provides relief from many of the ACA market reform rules (e.g., mandated coverage of preventive health services, etc.)
- This relief applies for the full duration of any plan year that begins on or before the last day of the PHE
- A plan sponsor will need to determine if this is a benefit offered to employees and if a change is needed for the next plan year (January 1, 2024, for calendar year plans)

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End of the PHE—Mental Health Parity

- The Departments said that they will not take any enforcement action against a plan that disregards benefits for the COVID-19 testing items and services that are required to be covered without cost-sharing for purposes of testing
- This relief appears to end when the PHE ends because at that time, plans are no longer required to cover COVID-19 testing with no cost-sharing
- A plan sponsor should review how the plan's mental health parity tests were performed and determine if this change will impact that testing

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End of the PHE—EAP Excepted Benefit Status

- An EAP will not be considered to provide benefits that are significant in the nature of medical care solely because it offers benefits for COVID-19 diagnosis and testing during the PHE and NE
- In addition, the EAP will not be considered to provide "significant benefits" solely because it offers benefits for COVID-19 vaccines and their administration
- If the employer added COVID-19 diagnosis, testing, and/or vaccine benefits to the EAP, evaluate whether those rise to the level of significant medical care to preserve the excepted benefit state of the EAP
- Remember that the removal of the benefit may trigger a notice requirement to participants

END OF THE NATIONAL EMERGENCY PERIOD

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End of National Emergency—Certain Plan Deadlines

- During the COVID-19 "Outbreak Period", certain deadlines under ERISA-covered plans are paused until the **earlier of:** (1) one year after the end of the original deadline or (2) the end of the Outbreak Period
- The deadlines that were "paused" include:
  - (1) HIPAA special enrollment rights,
  - (2) COBRA 60-day election period,
  - (3) COBRA premium payment deadline,
  - (4) Notification to the plan by an individual of a qualifying event or determination of disability under COBRA,
  - (5) Filing a claim for benefits,
  - (6) Filing an appeal of a claim denial,
  - (7) Request for an external review of a final claim denial,
  - (8) Filing information to perfect a request for external review, and
  - (9) The date for providing COBRA election notices

End of National Emergency—Certain Plan Deadlines

- The normal deadlines will apply and regular timeframes begin to run again 60 days after the NE period ends
- In other words, the "Outbreak Period" ends 60 days after the end of the NE
- **As explained earlier, for purposes of this rule, the COVID-19 NE ends on May 11, 2023, and the Outbreak Period ends 60 days later on July 10, 2023**

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Example—HIPAA Special Enrollment

- A health plan paused the normal 30-day enrollment deadline for a maximum of one year for an eligible employee to request a HIPAA special enrollment: (a) because of marriage, birth, adoption, or placement for adoption or (b) upon loss of other health plan coverage
- **Effective July 10, 2023, those deadlines will no longer be paused and the normal deadlines will apply**

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Example—HIPAA Special Enrollment Cont.

EXAMPLE:

- Employee gives birth on April 1, 2023, and she would like to enroll herself and her newborn in the health plan (normally, a 30-day special enrollment period)
- The health plan's 30-day special enrollment period is extended (i.e., paused) by disregarding the Outbreak Period (the period ending July 10, 2023)
- Accordingly, the employee would have until 30 days after the end of the Outbreak Period to enroll herself and her child in the health plan
- In this case, the employee has until August 9, 2023 (which is 30 days after July 10, 2023)

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Example—Deadline to Pay COBRA Premiums

- For a maximum of one year, the health plan paused the COBRA deadlines for qualified beneficiaries to make:
  - (1) their first COBRA premium payment within 45 days of their COBRA enrollment date and
  - (2) subsequent monthly COBRA premium payments by the end of the 30-day grace period that starts at the beginning of each coverage month
- **Effective July 10, 2023, those deadlines will no longer be paused and the normal deadlines will apply**

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Example—Deadline to Pay COBRA Premiums

EXAMPLE:

- An employee terminates employment from the company on May 15, 2023, and loses coverage under the health plan on May 31, 2023 (a COBRA qualifying event)
- He is provided with a COBRA Election notice on June 1, 2023, and elects COBRA coverage that day
- The employee would have until 45 days after the end of the Outbreak Period (which is August 24, 2023) to make his initial COBRA premium payment for the months of June and July
  - Premium payment for August 2023 must be paid by August 30, 2023

SPECIAL CONSIDERATION FOR LOSS OF MEDICAID OR CHIP

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Special Consideration

- In FAQs, the Departments explain that since the beginning of the PHE, state Medicaid agencies generally have not terminated the enrollment of any Medicaid beneficiary who was enrolled on or after March 18, 2020 through March 31, 2023 (referred to as the "Continuous Enrollment Condition")
- The Departments clarify that many consumers will lose Medicaid and Children's Health Insurance Program ("CHIP") coverage as state agencies resume their regular eligibility and enrollment practices
- These individuals will need to transition to other coverage, including employer-sponsored group health plan coverage
- To help facilitate this transition, the Departments remind employers that if an employee loses eligibility for Medicaid or CHIP coverage, then the employee will have a HIPAA special enrollment period to enroll in employer-sponsored coverage mid-year

Special Consideration

- An individual who loses Medicaid or CHIP coverage from March 31, 2023 until July 10, 2023 (the end of the Outbreak Period) can request special enrollment in the employer's group health plan
- The employer must offer an election window that is at least 60 days long (running from July 10, 2023)
- The Departments also state that a group health plan is always allowed to be more generous and offer an election window that is longer than what is statutorily required (i.e., an employer can offer a HIPAA special enrollment window that is longer than 60 days)

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Special Consideration

- While this follows the general rule stated in the previous slides about the end of the Outbreak Period, the Departments encourage employers to take additional actions (but that is not required)
- For example, in FAQs the Departments state:
  - Employers are encouraged to ensure that their benefits staff are aware of the upcoming resumption of Medicaid and CHIP eligibility determinations
  - Employers can also encourage their employees who are enrolled in Medicaid or CHIP coverage to update their contact information with the state Medicaid or CHIP agency
  - Employers may also encourage employees to respond promptly to any communication from the state

OTHER BENEFITS RELATED TO COVID-19

Pre-Deductible COVID-19 Diagnosis and Treatment

- In IRS Notice 2020-15, the IRS provided that a health plan will not fail to be a high deductible health plan ("HDHP") merely because it provides benefits associated with testing and treatment of COVID-19 prior to satisfying the applicable minimum deductible
- The relief lasts "until further guidance is issued"
- In recently issued FAQs, the IRS said it was reviewing the appropriateness of continuing this relief given the end of the PHE and NE periods and it anticipates issuing additional guidance soon
- Those FAQs also stated that any future modifications to the guidance provided in Notice 2020-15 will not require HDHPs to make changes in the middle of a plan year in order for covered individuals to remain eligible to contribute to an HSA

HSA Telehealth Relief

- Recent legislation passed before the end of 2022 extended the HSA relief permitting HDHPs to provide first dollar coverage of telehealth services without impacting HSA eligibility
- This relief applies for the 2023 and 2024 plan years
- It is not impacted by the ending of the PHE or NE

NOTICE REQUIREMENTS IF PLAN CHANGES ARE MADE

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Notice Requirements

- If a health plan makes a material modification to any of the plan terms that would affect the content of the SBC and that modification occurs mid-year, the plan must provide notice of the modification to participants not later than 60 days prior to the date on which the modification will become effective

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Notice Requirements

- Notwithstanding the previous slide, if a health plan made changes to increase benefits, reduce or eliminate cost sharing for the diagnosis or treatment of COVID-19, or for telehealth or other remote care services and revokes these changes upon the expiration of the PHE, the Departments will consider the plan to have satisfied its obligation to provide advance notice of the material modification if the plan:
  - previously notified the participant of the general duration of the additional benefits coverage or reduced cost sharing (such as, that the increased coverage applies only during the PHE), or
  - notifies the participant of the general duration of the additional benefits coverage or reduced cost sharing within a reasonable timeframe in advance of the reversal of the changes

Notice Requirements

- In an FAQ, the Departments also stated that a notification provided with respect to a prior plan year will not be considered to satisfy the obligation to provide advance notice for coverage in the current plan year

Notice Requirements

- The guidance in the previous slides do not apply to any changes made by a health plan in reliance on *Braidwood Management Inc. v. Becerra*
- If the health plan removes any of the preventive care benefits in reliance on *Braidwood*, the 60-day prior notice rule would apply

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