LEGAL UPDATE

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

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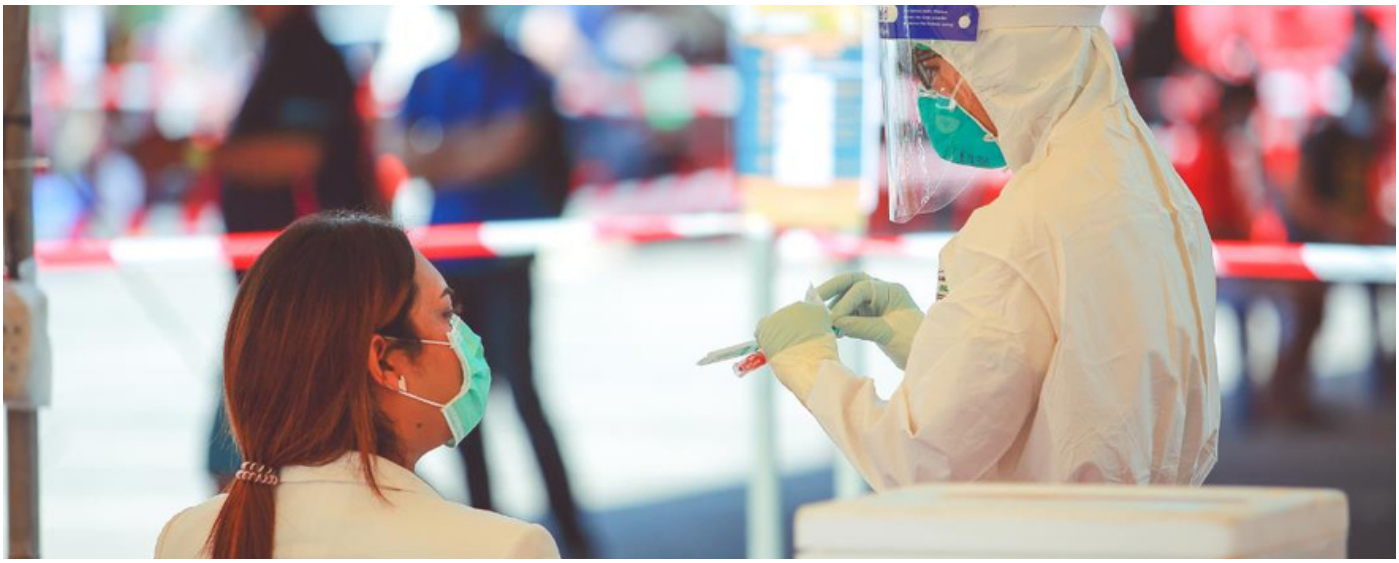
The Biden Administration has announced its plan to end COVID-19 emergency orders – the National Emergency (NE) and the Public Health Emergency (PHE) on **May 11, 2023**. While most COVID-related requirements for plans had previously expired, the formal expiration of the NE and the PHE will mark the last mandates that apply to employer-sponsored health plans. Those final obligations include:

- 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.
- 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 from providers, regardless of whether they are in-network or out-of-network.
- Health plan deadlines have been extended up to 12 months during the outbreak period (60 days after the end of the NE), including the deadlines to request special enrollment under HIPAA, elect COBRA continuation coverage and comply with the plan's claims and appeals procedures.

Effect on Health Plans

When the PHE and outbreak period expire, health plans will no longer be required to cover COVID-19 diagnostic tests and related services without cost sharing. Note that plans can still do so voluntarily if they choose. Health plans will still be required to cover recommended preventive services, including COVID-19 immunizations which have been added to the list of those services, without cost sharing but will be permitted to limit the no cost-sharing to in-network providers.

More importantly, from a compliance perspective, 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. Any of those deadlines that had been tolled will start to run again. That means that health plans can have some comfort that "late" COBRA elections that could have been made (with the negative financial implications associated with that possibility) will have to be made within the traditional deadline.



PUBLIC HEALTH EMERGENCY

Background

The Department of Health and Human Services (HHS) first declared a PHE due to the COVID-19 pandemic on Jan. 31, 2020. A PHE declaration lasts 90 days unless it is terminated early by HHS. At the end of the 90 days, HHS can extend the PHE or let it expire. HHS has repeatedly extended the PHE since COVID-19 began in early 2020. Most recently, HHS renewed the PHE on Jan. 11, 2023. 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 emergency periods, stating that this would create chaos and uncertainty for the healthcare system.

Health Plan Changes

When the PHE ends, the following health plan coverage mandates related to the COVID-19 pandemic will no longer be required but can continue to be part of a plan if so desired:

- **COVID-19 Diagnostic Testing Without Cost Sharing**—During the PHE, health plans and health insurance issuers were required to cover COVID-19 tests and related services without cost sharing, prior authorization, or other medical management requirements. As of Jan. 15, 2022, this coverage requirement was extended to over-the-counter (OTC) 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 as part of the standard ACA preventative care guidelines but can limit this coverage to in-network providers.

In addition, one item of flexibility around the ability to offer telehealth will terminate:

- **Standalone Telehealth Benefits**—For plan years beginning during the PHE, a large employer (more than 50 employees) could offer standalone telehealth benefits and other remote services to individuals who are not eligible for coverage without violating the ACA's market reforms. In general, since telehealth benefits do not meet the ACA mandates for all health plans, if the only coverage offered was the ability to access telehealth, the "plan" would violate the ACA. (That would not be an issue if telehealth were just a component of the larger healthcare plan.) During the PHE, that requirement was not enforced which enabled employers and issuers to offer access to telehealth to individuals who did not have access to the larger healthcare plans. These types of standalone arrangements will not be permitted after the PHE ends. A different rule that would permit telehealth to be accessed by members of HSA/HDHPs without cost or reduced cost below the HDHP deductible level was also part of the original PHE flexibility. That was formalized by the CAA 21 and extended by CAA 23 through 2025. That extension will not be affected by the termination of the PHE.

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NATIONAL EMERGENCY - OUTBREAK PERIOD

Background

Several deadlines related to employer-sponsored group health plans were extended during the COVID-19 outbreak. The outbreak began in March 2020, when former President Trump declared a national emergency (NE) due to the COVID-19 pandemic. The NE would have originally continued until 60 days after the end of the COVID-19 NE or another date, as announced by the federal government.

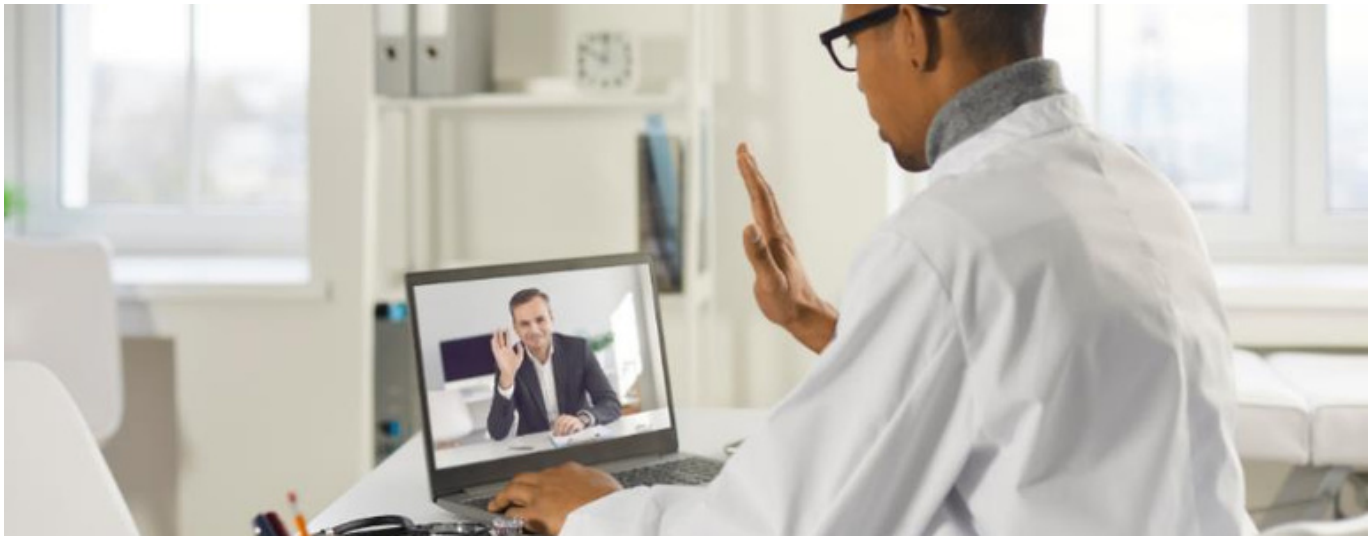
On Jan. 30, 2023, the Biden Administration announced its plan to end the COVID-19 national emergency on May 11, 2023. Under this timeline, the outbreak period will end on July 10, 2023.

Deadline Extensions

During the outbreak period, some key deadlines for employee benefit plans and participants were tolled. Deadline extensions that apply during the outbreak period include the following:

- **HIPAA Special Enrollment**—The 30-day period (or 60-day period, if applicable) to request special enrollment under the HIPAA rules:
    - A loss of eligibility for other health coverage
    - Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP)
    - The acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption
    - Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP
- **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)
    - 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, appeal an adverse benefit determination, or request an external review of a claim under the plan's claims and appeals procedures.

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.



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 before plan deductibles were met. This relief was not linked to the PHE or outbreak period; it applied for plan years beginning before Jan. 1, 2022 and was extended by two additional bills. The Consolidated Appropriations Act, 2023 (CAA) extended the ability of HDHPs to provide benefits for telehealth before plan deductibles have been met without jeopardizing HSA eligibility. This extension applies for plan years beginning after Dec. 31, 2022, and before Jan. 1, 2025. Therefore, these benefits are not subject to the end of the COVID-19 emergency periods and 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.