National Compliance Update

USI EMPLOYEE BENEFITS

February 2, 2023

Emergency Periods Related to COVID-19 to End May 11, 2023

On January 30, 2023, the Biden Administration announced[1] its intent to end the Public Health Emergency and the National Emergency related to the COVID-19 pandemic on May 11, 2023. They are currently set to expire after February 28, 2023 and on April 11, 2023, respectively.

This announcement came in response to two bills[2] in the House of Representatives proposing to end the national emergencies at an earlier date.

As previously reported,[3] various employee benefit plan requirements are directly impacted by the Public Health Emergency and the National Emergency. Employers sponsoring health and welfare programs will need to make some decisions with respect to their programs.

END OF THE PUBLIC HEALTH EMERGENCY

When the Public Health Emergency ("PHE") ends on May 11, 2023 various requirements as it relates to group health plan coverage, along with some helpful relief, will come to end.

- **COVID-19 Testing**. During the PHE, all group health plans must cover COVID-19 tests and other services resulting in the order for a test without cost-sharing (both in-network and out-of-network), prior authorization, or medical management and includes both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered. This includes coverage for over-the counter (OTC) tests. When the PHE ends, this requirement no longer applies.
- **COVID-19 Vaccines**. All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers. When the PHE ends, non-grandfathered plans must continue to provide the vaccine under the ACA preventive care mandate in-network; however, cost-sharing may apply out-of-network.

[1] See Statement on Administration Policy (Jan. 30, 2023) https://www.whitehouse.gov/wp-content/uploads/2023/01/SAP-H.R.-382-H.J.-Res.-7.pdf.
[2] H.R. 382 and H.J. Res 7.
[3] See USI's National Compliance Update, HHS Extends Public Health Emergency until April 11, 2023 (January 12, 2023).

- **Expanded Telehealth Relief for Large Employers**. Large employers (51 or more employees) with plan years that begin before the end of the PHE may offer telehealth or other remote care services to employees (and their dependents) who are not eligible for other group health plan coverage offered by the employer. This relief expires for plan years that begin on or after May 11, 2023 (e.g., a June 1, 2023 plan year).
- **Summary of Benefits and Coverage (SBC)**. Group health plans may notify plan members of changes as soon as practicable and are not held to the 60-day advance notice requirement for changes affecting the SBC during the plan year or for the reversal of COVID-19 changes once the PHE ends, provided the plan members are timely made aware of any increase and/or decrease in plan benefits summarized on the SBC.
- **Grandfathered Plans**. If a grandfathered plan enhanced benefits related to COVID-19 for the duration of the PHE (e.g., added telehealth or reduced or eliminated cost-sharing), the plan will not lose grandfathered status if the changes are later reversed when the PHE ends.

See the Appendix for a comprehensive summary and checklist to help employers navigate the end of the PHE.

Employers should review these changes and decide how to manage the expiration in May of these requirements. Carriers and third-party administrators ("TPAs") may also issue information for you to review and provide directions on next steps. In some cases (and to the extent allowed) carriers or TPAs may make changes with the next plan year.

END OF THE NATIONAL EMERGENCY

The Outbreak Period started March 1, 2020. It applies on an individual basis to group health plans, disability, and other employee welfare programs. Government plans (e.g., a health plan of a city or county) are not required to comply.

During this time, a plan must disregard the period of one year from the date an individual is first eligible for relief, or 60 days after the announced end of the National Emergency, whichever occurs first, when determining the following:

- **COBRA**. The timeframe for the employer to provide a COBRA election notice; the 60-day election period for a qualified beneficiary to elect COBRA; the COBRA premium payment deadlines (45 days for initial payment, 30-day grace period for ongoing payments); the deadline to notify the plan of qualifying events or disability determinations.
- **HIPAA Special Enrollment**. 30 days (60 days for Medicaid/CHIP events) to request a special enrollment right due to loss of health coverage, marriage, birth, adoption, or placement for adoption.
- **ERISA Claims Deadlines**. Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes to request external review and perfect an incomplete request.
  - This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.

With the announced end of the National Emergency on May 11, 2023, the Outbreak Period will end **July 10, 2023**. This means original deadlines will begin to run after July 10, 2023.

> ***USI Note***. There is retroactive application with respect to COBRA, special enrollment rights for birth of a child or adoption, and claims.

Hopefully, additional guidance as it relates to the end of the Outbreak Period and measuring deadlines is forthcoming. There are many unanswered questions as it relates to this relief. Based on existing guidance, the following example highlights the practical application of the end of the Outbreak Period as we currently understand it.[4] However, further guidance would be helpful and may change the result of this example.

Mary is eligible for, but did not enroll in, group health plan coverage offered by her employer. On October 15, 2022, Mary had a baby.

- Under "normal" rules, Mary has 30 days (by Nov. 14, 2022) to enroll herself and the baby in the employer's group health plan (coverage is retroactive to the date of the birth)
- Under the Outbreak Period – the deadline is suspended – Mary can exercise her special enrollment right by the earlier of:
  - One year from the date first eligible for the relief (Nov. 14, 2023); OR
  - 30 days following the end of the Outbreak Period (August 9, 2023).

Result: Mary must exercise her special enrollment right by August 9, 2023

- Coverage is retroactive to the DOB (Oct. 15, 2022) and Mary can be required to pay her share of the premium costs.

In addition, there is fiduciary relief available during the Outbreak Period as it relates to certain notice and disclosure deadlines. Notably, many employers took advantage of good faith relief that allowed furnishing of certain notices and disclosure through electronic means, such as email or text, without having to satisfy more burdensome electronic delivery requirements. This relief will also expire after July 10, 2023.

OTHER RELIEF

There is other relief for qualified high deductible health plans ("HDHPs") with a health savings account ("HSA") that came about as a result of the COVID-19 pandemic but is not tied to the PHE or National Emergency. As such, these provisions should not be affected when these timeframes end.

- **IRS Notice 2020-15**. Allows a qualified HDHP to provide coverage for COVID-19 testing or treatment before the IRS deductible is satisfied without jeopardizing HSA eligibility. This relief applies until further guidance is issued. It does not appear that the end of the PHE will affect this relief, unless the IRS issues guidance stating otherwise.
- **Telehealth Relief.** For plan years that begin after December 31, 2022 and before January 1, 2025, an HDHP/HSA plan may offer telehealth or other remote care services before the minimum IRS deductible is satisfied without jeopardizing HSA eligibility.[5]

SPECIAL ENROLLMENT OPPORTUNITY

As a result of the end of the PHE, it is expected that many individuals will lose eligibility for Medicaid and the Children's Health Insurance Program ("CHIP"). The loss of Medicaid or CHIP coverage is a special enrollment opportunity onto a group health plan sponsored by an employer.

[4] USI previously covered this guidance in National Compliance Updates issued February 26, 2021 and May 5, 2020.
[5] See USI Compliance Update, Telehealth Relief for HSAs Extended in Last Minute Funding Package (December 23, 2022).

Employers should be prepared to address requests for special enrollment from otherwise eligible employees who lose Medicaid or CHIP coverage.

EMPLOYER NEXT STEPS

- With respect to the end of the PHE, employers should discuss benefit plan design changes with carriers and TPAs. The checklist in the appendix should help identify the specific issues and decision points. Employers should be prepared to address requests for special enrollment as a result of a loss of eligibility for Medicaid or CHIP.
- Employers should also monitor developments as the government funding to purchase COVID-19 vaccines is expected to end. Most group health plans will need to cover the cost of the vaccine as required preventive care (along with the administration) in-network and without cost-sharing. Reports from Pfizer and Moderna indicate the commercial cost could range between $110-130 per dose.
- With respect to the end of the Outbreak Period, employers should:
  - Await additional guidance from the regulators; and
  - Consider providing notice to employees that the extended deadlines will come to an end on July 10, 2023 and discuss COBRA implications with COBRA vendors.

Appendix: Employer Checklist for End of PHE

Provision	Explanation	Impact When PHE Ends	Employer Considerations
COVID-19 Testing	All group health plans must cover COVID-19 tests (including OTC tests)[6] and other services resulting in the order for a test without cost-sharing (both in-network and out-of-network), prior authorization, or medical management and includes both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered.	Requirement no longer applies.	❑ Continue "as is." ❑ Continue 100% in-network only. ❑ Continue, but subject to cost-sharing. ❑ Exclude OTC tests. ❑ Exclude all COVID-19 testing. ❑ Provide timely notice of change, if applicable.
COVID-19 Vaccines	All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers. For now, the government pays for the COVID-19 vaccine and commercial payers (like group health plans) pay for administration. However, the cost for the vaccine is expected to shift to commercial plans when funding runs out.	Non-grandfathered plans must still cover COVID-19 vaccines in-network without cost-sharing under the ACA's preventive care mandate. Coverage OON is no longer required. Any new recommendations related to the COVID-19 vaccine apply immediately.	❑ Exclude OON vaccines or impose cost-sharing. ❑ Continue to cover OON without cost-sharing. ❑ Provide timely notice of change, if applicable.
Excepted Benefits and COVID-19 Testing	An Employee Assistance Program ("EAP") will not be considered to provide significant medical benefits solely because it offers benefits for diagnosis and testing for COVID-19 during the PHE and therefore, will be able to maintain status as an excepted benefit.	*If applicable.*	❑ Remove testing benefits from EAP. ❑ Provide timely notice of change.

[6] Beginning January 15, 2022, all group health plans must cover OTC COVID-19 tests for diagnostic purposes without cost-sharing (both in network and out-of-network), prior authorization, medical management and without requiring medical assessment or prescription. Plans may limit the reimbursement for the purchase of OTC COVID-19 tests to eight tests per month per enrollee. Plans with established networks and direct coverage may limit the reimbursement for out-of-network OTC COVID-19 tests to up to $12 or the actual cost of the test, if less.

Expanded Telehealth and Remote Care Services	Large employers (51 or more employees) with plan years that begin before the end of the PHE may offer telehealth or other remote care services to employees (and their dependents) who are not eligible for other group health plan coverage offered by the employer.	*If applicable.* For plan years that begin after May 11, 2023 (e.g., June 1, 2023 and thereafter), this relief is no longer available.	❑ Prepare to revoke this coverage first plan year after PHE ends. ❑ Provide timely notice of change, if applicable. Should not trigger COBRA.
Summary of Benefits and Coverage ("SBC") Changes	Group health plans may notify plan members of changes as soon as practicable and are not held to the 60-day advance notice requirement for changes affecting the SBC during the plan year or for the reversal of COVID-19 changes once the PHE expires, provided the plan members are timely made aware of any increase and/or decrease in plan benefits summarized on the SBC.	When reversing any COVID-19 changes at the end of the PHE, 60 days advance notice is not required when the change affects the SBC. However timely notice of any increase or decrease to the benefit should be made. Any other mid-year changes to the SBC made after the end of the PHE will be subject to the 60 days advance notice requirement.	❑ Once PHE ends, provide 60-day advance notice of any mid-year change that affects the SBC.
Grandfathered plans	If a grandfathered plan enhanced benefits related to COVID-19 for the duration of the PHE (e.g., added telehealth or reduced or eliminated cost-sharing), the plan will not lose grandfathered status if the changes are later reversed when the PHE expires. Other changes may impact this status.	*If applicable.*	❑ Continue "as is." ❑ Remove benefits enhanced during the related to COVID-19 pandemic.