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EMPLOYEE BENEFITS

Impact of the End of the National Emergency and Public Health Emergency on Employee Benefit Plans

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As part of the federal response to the COVID-19 pandemic, multiple temporary rules were implemented for employer-sponsored group health plans. The duration of the temporary rules was, in many cases, tied to the federal government's declarations of both a Public Health Emergency and a National Emergency. These temporary federal rules include mandates related to group health plan coverage for COVID-19 testing and vaccines and the tolling, or extension of, certain timeframes applicable under HIPAA, COBRA and ERISA.

On January 30, 2023, the White House issued a Statement of Administrative Policy declaring its intent to end both the Public Health Emergency and the National Emergency on May 11, 2023. The DOL, HHS and the Treasury (the Departments) released FAQ Part 58 on March 29, 2023, providing further clarity on many of the issues impacted by the White House's Statement of Administrative Policy. Subsequently, the President of the United States signed legislation to end the National Emergency on April 10, 2023, much earlier than the previously declared end date (May 11, 2023).

The end of the Public Health Emergency and National Emergency will have consequences for group health plans and ERISA health and welfare plans, as summarized below.

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Public Health Emergency – End to Certain Coverage Requirements for COVID-19 Testing and Vaccines

The Public Health Emergency, first declared by the Department of Health and Human Services in January 2020 (and extended several times thereafter), will end on **May 11, 2023**, per the Biden Administration's announcement.

Relevant to group health plans, the end of the Public Health Emergency affects coverage requirements related to COVID-19 testing and vaccines.

Once the Public Health Emergency expires, such plans will no longer be required to cover COVID-19 testing (including certain over-the-counter (OTC) tests) and related services without cost-sharing, as was required by the FFCRA and CARES Act during the Public Health Emergency.

Additionally, the end of the Public Health Emergency means that group health plans no longer have to cover COVID-19 vaccines obtained from out-of-network providers without cost-sharing. Note, however, that coverage for COVID-19 vaccinations from in-network providers without cost-sharing will still be required under the Public Health Services Act preventive care mandate.

If an employer continues to provide COVID-19 diagnostic testing and related services (or out-of-network vaccines) without cost-sharing beyond the end of the Public Health Emergency, the plan sponsor should be aware of the following:

- During the Public Health Emergency, a high-deductible health plan (HDHP) must cover COVID-19-related testing services without cost-sharing prior to an individual satisfying their IRS HDHP minimum deductible. In addition, the IRS previously provided relief that an HDHP that provides coverage for COVID-19 testing and/or treatment services with no cost-sharing (prior to satisfying the minimum deductible), does not lose its qualified HDHP status. That relief was issued as a result of the Public Health Emergency.

  Question 8 of FAQ Part 58[1] provides some general relief to HSA-eligible individuals (to be addressed in future guidance) who are enrolled in HDHP coverage that continues to cover COVID-19 diagnostic testing and/or treatment services with no cost-sharing (prior to the satisfaction of their IRS minimum deductible) for a limited time after the end of the Public Health Emergency. Employers should consult legal counsel on whether this rule allows employees to remain HSA-eligible under local/state tax laws.

- The plan sponsor should consult with legal counsel whether continuing to provide such coverage to participants/enrollees could raise other issues under any other laws, including any parity concerns under the Mental Health Parity and Addiction Equity Act and potential state taxation issues related to HSA eligibility.

*[1]Question 8 of FAQ Part 58 – **"Q8. May an individual covered by an HDHP that provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible contribute to an HSA?***

Yes. An individual covered by an HDHP that provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible may continue to contribute to an HSA until further guidance is issued. The Treasury Department and the IRS are reviewing the appropriateness of continuing this relief given the anticipated end of the PHE and COVID-19 National Emergency and anticipate issuing additional guidance in the near future. Any future modifications to the guidance previously provided in Notice 2020-15 will not generally 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."

- Under prior Department FAQ guidance, Employee Assistance Programs (EAPs) qualifying as an excepted benefit that offered COVID-19 testing/vaccination services during the Public Health Emergency remained an excepted benefit. Because this relief is not currently extended beyond the Public Health Emergency, plan sponsors of excepted benefit EAPs should consider excluding COVID-19 related services from the EAP coverage.

- The Departments also previously provided relief to stand-alone telehealth benefits (that normally would not qualify as an excepted benefit) from certain (but not all) group health plan mandates for the duration of the Public Health Emergency.[2] After May 11, 2023, plan sponsors of stand-alone telehealth benefits may want to consider only offering telemedicine benefits that are integrated with an ACA compliant medical plan.

The plan sponsor should review its plan document, Summary Plan Description and other plan-related documentation and communications and make any necessary changes to ensure that the documents accurately reflect the coverage provided by the plan. In addition, Question 2 of FAQ Part 58 reminds employers that if a material modification is made to the plan that affects the contents of the Summary of Benefits and Coverage (SBC), a 60-day advance notice of that change must be provided to plan participants/enrollees[3]. Employers should work with their legal counsel to determine what plan amendments, summary of material modifications (SMMs), notices of material modification to SBCs, etc., are needed.

[2]This relief was available only with respect to telehealth plans sponsored by large employers solely covering employees who were not eligible for the employer's group medical plan.

[3]Question 2 of FAQ Part 58 allows an exception to the rule requiring 60-days advanced notice for material modifications made in conjunction with the end of the Public Health Emergency that impact a plan's SBC:

> *"Notwithstanding the above, if a plan or issuer made changes to increase benefits or 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, as previously explained in guidance, the Departments will consider the plan or issuer to have satisfied its obligation to provide advance notice of the material modification if the plan or issuer:*
>
> - *previously notified the participant, beneficiary, or enrollee 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, beneficiary, or enrollee 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.*
>
> *However, with respect to notices that were issued pursuant to the previous guidance, the Departments clarify 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."*

End of the National Emergency (and Corresponding Outbreak Period) – End of Extended Deadline Relief

Even though the recent legislation signed by the President ended the National Emergency on April 10, 2023 and the final rule issued by the DOL and IRS in 2020 indicates the Outbreak Period ends sixty (60) days following the end of the National Emergency (i.e., June 9, 2023), informal comments made by the government suggest the Outbreak Period will actually end on **July 10, 2023**.

Under the final rule issued by the DOL and IRS, plan participants were granted relief from many of the deadlines associated with their rights to request HIPAA special enrollment, rights related to COBRA elections/payments and rights related to ERISA plan claims and appeals. Plan administrators were also granted relief from the deadline to distribute COBRA election notices. During the Outbreak Period, the timeframes for taking these actions were tolled (i.e., did not run). The tolling ends at the earlier of a) the expiration of one year from the date of the event; or b) the end of the Outbreak Period (see our earlier discussion related to the timeline relief here).

As a result of the end of the Outbreak Period, the tolling of these timeframes will cease on the anticipated date of **July 10, 2023**, and the applicable timelines that apply to these deadlines will recommence.

The affected timelines include:

- The applicable 30- or 60-day period to request mid-year enrollment based upon a HIPAA special enrollment event;
- The applicable COBRA notice periods, election periods and premium grace periods for qualified beneficiaries;
- The applicable period for plan administrators to deliver COBRA election notices to qualified beneficiaries; and
- The applicable periods under ERISA health and welfare plans to file claims, appeal adverse benefit determinations and request external reviews. This includes annual run-out periods for health FSAs.

Electing COBRA Example:

Jane terminates employment and loses coverage under her employer's group health plan on April 1, 2023. Her employer's COBRA administrator delivers her COBRA election notice on May 1, 2023, during the Outbreak Period. Jane's 60-day COBRA election period does not begin to run at that time. Rather, the Outbreak Period ends on July 10, 2023, and Jane will have 60 days from July 10, 2023 (i.e., September 8, 2023), to make her COBRA coverage election.

Special Enrollment Example:

Jessica previously declined coverage during open enrollment. On April 1, 2023, Jessica gave birth and would like to enroll herself and the child in her employer's health plan. However, open enrollment for the health plan does not begin until November of 2023. Due to the HIPAA Special Enrollment rules, her employer's policy generally allows an employee up to 30 days following the HIPPA special enrollment event of the birth of a child to request a mid-year election change. Due to the end of the Outbreak Period, Jessica may enroll herself and her child into the group health plan up to 30 days after July 10, 2023 (i.e., August 9, 2023) with a retroactive effective date of April 1, 2023.

Health FSA Annual Run-Out Period:

Bob enrolled in a health FSA plan for the 2022 calendar year (i.e., January 1, 2022 – December 31, 2022). The health FSA has a 90-day annual run-out period, typically occurring between January 1, 2023 and March 31, 2023. However, due to the tolling of all plan claims/appeals procedures during the Outbreak Period, Bob's annual run-out period now ends 90 days following the end of the Outbreak Period (i.e., October 8, 2023).

In summary, plan sponsors should review their plan documentation and related participant communications, including notices, to ensure they accurately reflect the appropriate timeframes following the end of the Outbreak Period. Plans may require an amendment to their plan document and/or SPDs to reflect the reinstatement of the applicable plan-related deadlines following the end of the Outbreak Period.

Conclusion

Employers/plan sponsors should begin preparing for the end of the Public Health Emergency by reviewing any COVID-19-related provisions contained within their plan-related documents (e.g., plan document, SPD, SBC). Thereafter, an employer/plan sponsor should decide if it wants to modify its plan to adopt cost-sharing for certain COVID-19-related diagnostic tests or out-of-network vaccines. Plan sponsors should also be planning for the end of the Outbreak Period by reviewing whether appropriate communications were previously sent (or will be sent in the future) to employees and plan participants/members regarding any plan deadlines that may apply (or previously applied) both during and after the end of the Outbreak Period. Finally, any material modifications to the group health plan should be reflected in a written amendment and disclosed to plan participants/members, and any material modifications to a plan's SBC typically require 60 days advanced written notice to plan participants, prior to the effective date of the material modification. All of these issues should be closely reviewed with legal counsel.

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