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The End of the COVID-19 Emergency Declarations Raises Questions, but We've Got Answers

by Karen K. Hartford on May 8, 2023

It seems the COVID-19 pandemic is ending in the benefits world the same way it started: in a flurry of new laws, announcements, and notices intended to offer clarity but sowing confusion. To begin, it is important to remember that COVID-19 triggered not one, but two federal emergency declarations: the Public Health Emergency ("PHE"), declared January 31, 2020 by Health and Human Services ("HHS") Secretary Alex M. Azar, effective January 27, 2020, and the National Emergency ("NE") declared March 13, 2020 by former President Trump, effective March 1, 2020. A PHE lasts for 90 days and must be renewed to continue. An NE remains in effect for one year unless renewed or terminated by the President, or terminated through a joint resolution of Congress.

Both the PHE and NE have been continuously renewed. On January 30, 2023, however, the Biden administration announced that it anticipated ending *both* emergency declarations on May 11, 2023. True to its word, on February 9, 2023, HHS Secretary Xavier Becerra announced the final 90-day extension of the PHE, to be effective February 11, 2023 and to end on May 11, 2023; and on February 10, 2023, President Biden announced his intent to again extend the NE but with an anticipated termination date of May 11, 2023.

Generally speaking, the PHE temporarily enhanced medical coverage for COVID-19, requiring, for example, first dollar coverage for COVID-19 vaccination, diagnostic tests, and certain associated services, whether in-network or out; and the NE was the basis for what became known as the "Outbreak Period," which is the timeframe that began March 1, 2020 and ends 60 days following the announced end of the NE. During the Outbreak Period, certain notice and election deadlines for HIPAA special enrollment, benefit claims and appeals, and COBRA were tolled until the *earlier of*: one year after becoming entitled to the deadline relief (the "one-year rule"), or the announced end date for the Outbreak Period.

On March 29, 2023, the Departments of Labor ("DOL"), HHS, and Treasury (the "Departments") jointly published guidance regarding the implementation of the Families First Coronavirus Response Act, Coronavirus Aid, Relief, and Economic Security Act, and Health Insurance Portability and Accountability Act. The guidance appears in the form of Frequently Asked Questions ("FAQs") Part 58 and includes detailed guidance regarding the impact of the end of the COVID-19 emergency declarations on fully insured and self-insured medical plans. Summarizing and interpreting all that is included in the FAQs Part 58 is beyond the scope of this post, but suffice it to say that the guidance is required reading for all that operate a group health plan.

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Significantly, FAQs Part 58 and its examples use May 11, 2023 as the announced and anticipated end of the PHE and NE, consistent with the Biden administration's earlier announcements.

The FAQs provide that as the result of the end of the PHE, COVID-19 diagnostic tests (whether administered by a clinician, prescribed, or over-the-counter), are no longer required to be covered under group health plans, effective May 12, 2023. The FAQs nevertheless "encourage" plans and insurers to continue to cover COVID-19 diagnostic tests beyond the end of the PHE, even if such continued coverage is subject to ordinary cost-sharing or other permissible limitations. The FAQs also provide that coverage for out-of-network COVID-19 vaccines will no longer be required, or may be subject to ordinary cost sharing for plans with a network of providers, effective May 12, 2023. First dollar coverage for in-network COVID-19 vaccines continues to be required. In addition, FAQs Part 58 provide that the Departments anticipate that the Outbreak Period will end July 10, 2023 (60 days following the anticipated end of the NE) and any HIPAA Special Enrollment, benefit claims and appeals, or COBRA deadline that was tolled beginning on a date after July 10, 2022, will return to its pre-pandemic timeframe, effective July 11, 2023. Tolled deadlines that occurred on or before July 10, 2022, will remain subject to the one-year rule.

To make things more interesting, however, on April 10, 2023 President Biden signed into law joint resolution H.J.Res.7, immediately ending the NE—one month earlier than anticipated. This law impacts the NE only; Secretary Becerra's final extension of the PHE to May 11, 2023 remains intact. Following the enactment of H.J.Res.7, we began receiving questions from plan sponsors about the meaning of this hodge-podge of dates and announcements. Here are the two most common questions we have received and our thoughts about them:

1. **Does the NE, and consequently the Outbreak Period deadline tolling, end on July 10, 2023 (60 days after the previously anticipated end of the NE), or does it now end one month earlier, on June 9, 2023, due to the enactment of joint resolution H.J.Res.7 which ended the NE on April 10, 2023?**

In telephone conversations, the DOL has informally confirmed its position that the end of the Outbreak Period remains July 10, 2023. Pursuant to EBSA Disaster Relief Notices 2020-01 and 2021-01 the Outbreak Period deadline relief continues until 60 days after the announced end of the Covid-19 National Emergency or such other date announced by the relevant agency or agencies in a future notification, and it is the DOL's position that FAQs Part 58 announced the end of the National Emergency as July 10, 2023.

2. **Must group health plans provide notice to participants about changes to the plan resulting from the end of the emergency declarations, and if so, when?**

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End of Public Health Emergency

In the majority of circumstances, yes, group health plans and issuers (*i.e.*, insurers) are either required or "encouraged" to provide notice of COVID-19-related benefits coverage changes to plan participants, and in some cases beneficiaries and other enrollees; and even if a plan is not technically required to provide notice, it may be sensible to provide it anyway.

Q&A 2 of FAQs Part 58 provides that plans and issuers are encouraged "to notify participants, beneficiaries, and enrollees of key information regarding coverage of COVID-19 diagnosis and treatment, including testing." Key information is described to include the date coverage will stop or when cost-sharing, prior authorization, or other medical management requirements will resume. These broad introductory statements essentially urge plans and issuers to provide notice of COVID-19 coverage changes, and particularly reductions in coverage, to all plan enrollees whether required or not.

Q&A 2 further explains that plans and issuers are ordinarily required to provide 60 days advance notice to participants and enrollees of any material modification to the plan or coverage terms that take effect mid-year and would "affect the content of the summary of benefits and coverage (SBC)." The regulations define "material modification" for this purpose to include any modification to the coverage offered under a plan that, independently, or in conjunction with other contemporaneous modifications or changes, would be considered by an average plan participant to be an important change in covered benefits or other terms of coverage under the plan or policy. Notwithstanding this general advance notification requirement, however, the guidance provides two exceptions for changes to increase or reduce coverage for COVID-19-related diagnosis, treatment, or services:

A. If participants, beneficiaries, and enrollees were previously notified of the general duration of any COVID-19-related changes to benefits (*e.g.,* if they were notified that reduction or elimination of cost-sharing for diagnosis or treatment of COVID *would be available only during the PHE*, or something similar) and such general duration information continues to appear in current plan materials, then the plan is not *required* to provide additional advance notification of the revocation of such changes at the end of the PHE, or
B. The plan may provide notice "within a reasonable time" in advance of the effective date of the reversal of changes.

What is not clearly addressed by the guidance is whether advance notice is needed *at all* if the plan's SBC was never updated to reflect the special coverage of COVID-19-related services. In other words, could this be a case where an ordinary ERISA Summary of Material Modifications (SMM) would suffice? If so, the ordinary SMM timelines (no later

than 60 days *following* a material reduction in services or benefits under the plan, or for all other material changes, no later than 210 days following the end of the plan year in which they were adopted) would apply. However, given the generous tone of FAQs Part 58 and general commentary regarding material modifications to SBCs, and absent further clarification from the Departments, our view is that the guidance to date strongly suggests that the COVID-19 related coverage changes would be most appropriately communicated in advance of their effective date.

To summarize, if the plan's/issuer's prior communications regarding these changes meet the criteria of exception A above, no additional advance notice is *required* at this time; otherwise, we recommend furnishing a notice of material modifications within a reasonable time in advance of May 11 or such other, later effective date as mutually agreed upon among the plan and its vendors. In all cases, providing some notice to participants, beneficiaries, and enrollees is "encouraged." We also suggest that self-insured plans check with their third-party administrator to determine what, if anything, it may be communicating to plan enrollees regarding these matters, as it is possible the administrator's communications will satisfy any advance notice requirement.

End of National Emergency

Separate from the COVID-19 *benefits coverage changes* described above, we note that FAQs Part 58 also highlights that the Outbreak Period deadline extensions for HIPAA special enrollment, benefit claims and appeals, and COBRA will cease to apply effective 60 days after the end of the National Emergency. Here again, the Departments note that nothing prevents a plan or issuer from permitting longer timeframes to provide notices and elections under these provisions and plans are encouraged to do so.

FAQs Part 58 do not explicitly state that notice of the end of these extensions is required and these deadlines are not content that is typically addressed in the SBC, so the changes are unlikely to require advance communication. That said, most plans/issuers provided notice early in the pandemic of these temporary changes in an SMM, on administrative forms, or via some other employee communication. In light of this, an updated SMM may now be required. In addition, as a matter of good faith and conscience, we recommend bringing the end of this deadline flexibility to the participants' and other plan enrollees' attention as soon as practicable and in no uncertain terms, particularly for those individuals who currently may be availing themselves of such relief. These changes could easily be included in any employee communication being prepared for the above-described benefit coverage matters.

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As the COVID-19 pandemic at long last winds down, FAQs Part 58 provide some helpful guidelines for plan sponsors navigating a sea of changes and deadlines. If you have questions regarding how the guidance applies to your plan, please contact any member of Verrill's Employee Benefits and Executive Compensation Group.

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