COMPLIANCE

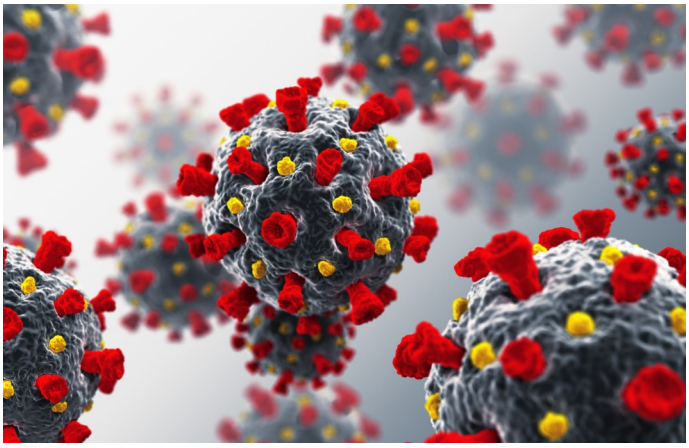
END OF THE NATIONAL AND PUBLIC HEALTH EMERGENCIES

Over the course of the last three years, the US has been operating under two separate legal emergencies related to the COVID-19 pandemic:

- The National Emergency (NE) originally declared by President Trump on March 1, 2020 and renewed periodically since then by both Presidents Trump and Biden; and
- The Public Health Emergency (PHE), originally declared by HHS in March 2020 and renewed every three months since then.

Through a combination of legislation and agency action and guidance, these two emergencies had several impacts on employee benefit plans, including the temporary suspension of certain legal deadlines; mandatory coverage of certain COVID-19 related products and services; and relaxing of certain legal rules that often indirectly impacted employers' plans.

These emergencies are both scheduled to end in the Spring of 2023, bringing an end to most (but not all) of these temporary legal adjustments – sometimes right away, other times with some delay. This article is an effort to catalog the most significant of those changes that will impact employer benefit plans and describe action steps for employers to take as a result of those changes.



NATIONAL EMERGENCY

When Does It End – The NE ended on April 10, 2023 when President Biden signed H.J. Res. 7. Under existing Department of Labor (DOL) guidance, this would mean the Outbreak Period should end June 9, 2023. However, there have been reports of informal comments by DOL officials that they intend to extend the Outbreak Period to July 10, 2023 to coincide with the date the Outbreak Period would have ended had the NE ended on May 11 as originally planned. The examples below use the June 9, 2023 date but may need to be updated if the DOL does announce an extension of the Outbreak Period.

Legal Rules Affected – COVID-19 Outbreak Period deadline suspensions. The following benefits-related deadlines were temporarily suspended during the Outbreak Period:

- The 30- or 60-day period to request special enrollment under HIPAA;
- The 60-day period to elect COBRA coverage;
- The 30- or 45-day grace period for making COBRA premium payments;
- The 60-day period by which an individual must notify the plan of a COBRA qualifying event (e.g. divorce) or a determination of disability for the 11-month COBRA disability extension;
- The date by which an individual may file claim, an appeal or request external review under the ERISA claims procedure rules; and
- The 44-day time frame for providing the COBRA election notice.

Under the NE, these deadlines were suspended from the date they would otherwise start running for a period of one year or the end of the Outbreak Period, whichever is shorter (the "disregarded period"). Once the disregarded period ends, the original deadline will start to run as normal.

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HIPAA SPECIAL ENROLLMENT EXAMPLES

Example 1H (HIPAA Special Enrollment)	Example 2H (HIPAA Special Enrollment)
Facts: Jerold is enrolled on his employer's health plan on single coverage and gets married on April 9, 2022. What is the latest date Jerold can enroll his new spouse under HIPAA special enrollment?	*Facts:* Same as to the left except Jerold gets married on October 9, 2022.
Answer: The normal HIPAA special enrollment period would begin on the date Jerold got married, April 9, 2022 but was suspended for one year until April 8, 2023, which is shorter than the end of the Outbreak Period. So Jerold has until May 7, 2023, 30 days after the end of the disregarded period, to request special enrollment	*Answer:* Here the end of the Outbreak Period (end of the NE plus 60 days, June 9 2023) is shorter than one year from date of the marriage (October 9, 2023). Thus the disregarded period ends June 9, 2023 and Jerold has until July 9, 2023 to enroll his new spouse.
Example 3H (HIPAA Special Enrollment)	**Example 4H (HIPAA Special Enrollment)**
Facts: Same as above except Jerold gets married on April 11, 2023.	*Facts:* Same as above except Jerold gets married on June 30, 2023.
Answer: While the NE emergency has ended by the time Jerold gets married, the Outbreak Period continues another 60 days so Jerold still gets the benefit of the disregarded period until June 9, 2023 and again has until July 9, 2023 to enroll his new spouse.	*Answer:* Now, since the marriage occurred outside the Outbreak Period, there is no more disregarded period and Jerold has until July 30, 2023 to request special enrollment for his new spouse.

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COBRA ELECTION EXAMPLES

Example 1C (COBRA Election)	Example 2C (COBRA election)
Facts: Angela is enrolled in family coverage on her employer's health plan. Angela terminates employment on May 20, 2023. The employer issues a COBRA election notice May 27, 2023 and her coverage ends May 31, 2023. How long does Angela have to elect COBRA?	*Facts:* Same as to the left except the employer does not issue an election notice until June 20, 2023.
Answer: The normal 60-day COBRA election period would begin May 31, 2023, the later of the date coverage ends or the election notice was issued. While this is after the NE ended it is still within the Outbreak Period so the deadline extension applies. The end of the Outbreak Period (June 9, 2023) is shorter than one year from the date the original election period began (May 30, 2024) thus the disregarded period ends June 9, 2023 and Angela has until August 8, 2023 to elect COBRA.	*Answer:* In this case, while Angela's coverage ended before the Outbreak Period ended, the COBRA election period did not begin until June 20, 2023, when the election notice was issued, because that date was later. Since that date follows outside the Outbreak Period, Angela does not receive a deadline extension and she must elect COBRA by August 19, 2023.

ERISA CLAIM PROCEDURE EXAMPLE

Example 1E (ERISA Claims Procedures)
Facts: Margot is enrolled in her employer's Health FSA, which is subject to ERISA (employer is not a government employer or church). The Health FSA runs on a calendar year plan year and the end of the run out period (i.e. the last day to submit claims for the 2022 plan year) is normally 90 days after the end of the plan year, i.e. March 31, 2023. How long does Margot actually have to submit her 2022 claims?
Answer: A Health FSA is an ERISA plan subject to the ERISA claims procedure rules. Since the normal deadline for submitting claims (90 days after the end of the plan year) falls within the Outbreak Period that deadline is suspended until the end of the Outbreak Period and Margot then has 90 days after the end of the Outbreak Period (September 7, 2023) to submit her 2022 claims.

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Employer Action Steps:

- Employers who handle their own COBRA may need to modify their initial COBRA notices and COBRA election notices to reflect the return to the original qualifying event notice, election and payment deadlines after June 9, 2023.
- Employers who administer their own Health FSAs and HRAs subject to ERISA may need to adjust their policies and procedures around the run-out period for the 2022 plan year.
- If plan documents were amended to reflect these extended deadlines (most were not), the plan documents may need to be amended to eliminate the extended deadline language.
- Internal policies and procedures concerning HIPAA special enrollment may need to be amended.
- It is not clear to what extent an employer is required to notify individuals who may be impacted by the return to normal for the affected deadlines. The official agency FAQs do not seem to require such advance notice but other informal DOL guidance suggests such notice might be required or at least encouraged. Employers will need to decide whether to provide notice of the end of the NE and Outbreak period and to whom such notices will be provided based on relevant factors such as the number of individuals who would need to be notified, what the employer or it's vendors have previously communicated about the deadline extensions and the end of the Outbreak Period, the cost and expenses of providing such notice, and the potential risks that might exist if notice is not provided.
- If the employer chooses to provide notice, there are three categories of participants to consider.

  HIPAA Special Enrollment. For this deadline, the affected individuals would be all employees eligible for the employer's group health, whether or not they are enrolled on the plan (since it is the employees/dependents who need special enrollment). The notice would remind employees that they will only have 30/60 days to notify the employer of special enrollment events once the Outbreak Period ends.

  ERISA Claims and Appeal Deadlines. Here, the affected individuals are employees who were enrolled in the Health FSA or an HRA for a plan year that ended before the end of the Outbreak Period that has a runout period, informing them of when the runout period will actually end in light of the Outbreak Period ending.

  COBRA Deadlines. The affected individuals here could be any qualified beneficiary with a qualifying event date or missed COBRA premium payment going back to April 2022. But realistically, anyone who has not elected COBRA or made a COBRA premium payment in nearly a year is unlikely to do so now. So it may be appropriate to focus on qualified beneficiaries with more recent qualifying events or missed premium payments.

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PUBLIC HEALTH EMERGENCY

When Does It *End* – May 11, 2023

Legal Rules Affected:

1. Health plan coverage of COVID-19 diagnostic testing;
2. Health plan coverage of COVID-19 vaccines and preventive services;
3. Stand-alone telehealth plans no longer allowed;
4. Telehealth providers prescribing controlled substances;
5. Medicaid/CHIP Coverage Special Enrollment; and
6. Qualified High Deductible Health Plan (QHDHP) Coverage for COVID-19 testing and treatment below the deductible.

DIAGNOSTIC TESTING

During the PHE, health plans were required to cover the cost of COVID-19 diagnostic tests at no cost and were required to pay the published cost of such tests to out-of-network providers. This obligation to pay for COVID-19 testing with no cost sharing will end on May 11, 2023 when the PHE expires.

The agencies are encouraging plans to continue this coverage, but many fully insured carriers have already announced they will be ending such coverage as soon as the PHE expires. Employers with self-funded plans may be asked to decide whether to continue such coverage beyond the end of the PHE.

Employer Action Steps:

- Fully insured employers – determine if health plan carrier intends to end coverage for COVID-19 testing immediately at the end of the PHE.
- Self-funded employers – decide whether to immediately end coverage for COVID-19 testing at the end of the PHE.
- If plan documents were amended to reflect coverage of COVID-19 testing, those documents may need to be amended to eliminate that coverage.
- Eliminating coverage for COVID-19 testing may be a material modification that may require a Summary of Material Modifications (SMM) to covered participants. Employers do not need to duplicate efforts if the carrier/TPA notifies participants of the change in coverage.

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VACCINES

During the PHE, health plans were required to cover COVID-19 vaccines and other preventive services at no cost at both in- and out-of-network providers. The obligation to cover COVID-19 vaccines with no cost sharing at in-network providers will continue after the end of the PHE. However, plans will no longer be required to cover vaccines at out-of-network providers and can charge their normal cost sharing amount for out-of-network preventive services.

Again, many fully insured carriers have already announced they will no longer coverage COVID-19 vaccines at out-of-network providers with no cost sharing once the PHE expires. Employers with self-funded plans may be asked to decide whether to continue such out-of-network coverage beyond the end of the PHE.

Employer Action Steps:

- Fully insured employers – determine if health plan carrier intends to end no cost coverage for COVID-19 vaccines out-of-network immediately at the end of the PHE.
- Self-funded employers – decide whether to end no cost coverage for COVID-19 vaccines out-of-network immediately at the end of the PHE.
- If plan documents were amended to reflect coverage for no cost COVID-19 vaccines out-of-network, those documents may need to be amended to eliminate that coverage.
- Eliminating no-cost coverage for COVID-19 vaccines out-of-network may be a material modification that may require an SMM to covered participants. Employers do not need to duplicate efforts if the carrier/TPA notifies participants of the change in coverage.

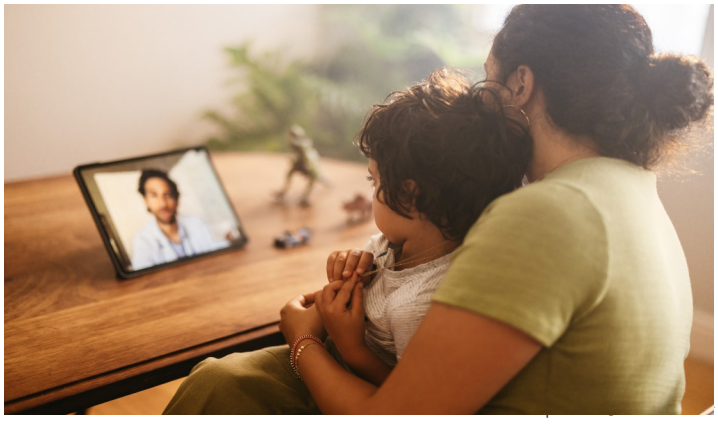
STAND-ALONE TELEHEALTH PLANS

Employer-sponsored stand-alone telehealth plans (that is telehealth services offered to employees who are not enrolled on the employer's group health plan) will typically violate the Affordable Care Act (ACA). During the PHE, employers were allowed to offer stand-alone telehealth services to employees who were not eligible for the employer's major medical plan without violating the ACA. (This relief did not extend to employees who were eligible for, but not enrolled in the employer's major medical plan.) This temporary relief will expire when the PHE ends.

Once the PHE ends, telehealth coverage for employees who are not enrolled in the employer's group health plan will once again violate the ACA. This includes not only employees who are not eligible for coverage under the employer's group health plan (who were eligible for the PHE temporary relief) but also employees who are eligible for but not enrolled in the employer's group health plan. It may be possible to avoid this outcome by applying the HRA integration rules to the telehealth plan.

Employer Action Steps:

If employers offered a stand-alone telehealth service to employees who are ineligible for the employer's group health plan during the PHE, this coverage must either be eliminated or integrated with other group health plan coverage.



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TELEHEALTH PLANS AND CONTROLLED SUBSTANCES

Prior to the pandemic, telehealth providers could not prescribe controlled substances unless the patient first had an in-person visit with a provider. This rule was relaxed by the Drug Enforcement Administration (DEA) for the duration of the PHE. Once the PHE ends, the old rule will be reinstated and patients will once again need an in-person visit before their telehealth provider can prescribe any controlled substance. The DEA has proposed rules that would modify, but not eliminate, this requirement but they are not yet finalized.

This most often affects mental health patients but could apply to any telehealth user being prescribed a controlled substance.

Employer Action Steps:

- Check with telehealth providers about how they intend to handle the in-person visit requirement for controlled substance prescriptions once it goes into effect.
- While no specific notice is required, consider whether to communicate the telehealth provider's response to telehealth participants.

MEDICAID/CHIP COVERAGE SPECIAL ENROLLMENT

During the PHE, state Medicaid programs generally were not terminating coverage of Medicaid recipients or otherwise checking eligibility for Medicaid on an ongoing basis (referred to as the "continuous enrollment condition"). This continuous enrollment condition ended on March 31, 2023 in anticipation of the end of the PHE and states can resume their normal eligibility and enrollment practices after that date, which may result in individuals who were previously enrolled in Medicaid losing that coverage if they no longer meet the state's eligibility requirements (e.g. based on income). Different states are preceding at different speeds as to how quickly they are reviewing eligibility and terminating coverage for ineligible recipients.

Loss of Medicaid eligibility is a HIPAA special enrollment event. Any employee or dependent who was previously enrolled in Medicaid and loses that coverage has 60 days to request special enrollment on the employer's group health plan. (Note that if the loss of Medicaid coverage occurs during the Outbreak Period, the 60-day special enrollment is suspended until June 9, 2023 and the employee will have under August 8, 2023 to request special enrollment).

Technically, the 60-day special enrollment window is measured from the date coverage is lost but we anticipate that there will be many cases where the employee will be notified after the fact they have lost Medicaid coverage, perhaps even outside the 60 day special enrollment window. Employers may have to consider relaxing the special enrollment window, e.g. by measuring it from the date the employee is informed that their Medicaid coverage has been terminated (provided the carrier/stop loss carrier will agree).

Employer Action Steps:

While no specific notice is required, employers with a potentially large population of Medicaid participants should consider whether to communicate a reminder to eligible employees not enrolled on the plan that they have 60 days to request special enrollment following a loss of Medicaid coverage (or the end of the Outbreak Period plus 60 days if the loss occurs before June 9, 2023).

QHDHPS AND COVERAGE FOR COVID-19 TESTING AND TREATMENT

Normally, a Qualified High Deductible Health Plan (i.e., a HDHP compatible with making contributions to a health savings account (HSA)) may not cover any medical expenses, other than preventive care, until the minimum required QHDHP deductible is met. In 2020, the IRS issued guidance relaxing this rule with respect to COVID-19 testing and treatment and stated that a QHDHP would not lose its qualified status if it covered such expenses before the deductible is met.

This relief was not tied specifically to either the NE or the PHE, and the IRS has indicated they will allow the relief to continue for now but they will be reviewing the propriety of continuing this relief now that the NE and PHE have ended. They have also promised that any future change to this guidance will not require the QHDHP to change coverage mid-plan year.

QHDHPs are not required to cover COVID-19 testing and treatment below the deductible. They are merely permitted to do so without losing their qualified status.

Employer Action Steps:

If the employer's QHDHP currently covers COVID-19 testing and treatment below the deductible, no action required at this time – but employers should continue to monitor for additional guidance from IRS.