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It’s Over: DOL, Treasury, and HHS Confirm End of (Most) COVID-19 Rules for Health Plans

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Earlier this week, the Departments of Labor, Treasury, and Health and Human Services (the “Departments”) jointly issued guidance confirming that most COVID-19-related benefit coverage mandates, as well as the special tolling of benefit plan deadlines, will terminate in connection with the expected end of the Public Health Emergency (PHE) and the COVID-19 National Emergency on May 11, 2023. The guidance, which was issued in the form of FAQs, can be downloaded here.

How did we get here?

Over three years ago, the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act imposed a number of COVID-19-related coverage mandates on group health plans. For the duration of the PHE, most group health plans were required to cover, regardless of whether provided in-network or out-of-network: (1) COVID-19 testing and administration (including over-the-counter COVID-19 tests), and (2) COVID-19 vaccines and administration—without participant cost-sharing, medical management, or prior authorization.

Separately, on May 4, 2020, the DOL, IRS, and Treasury announced that health and retirement benefit plans were required to toll participant deadlines for making COBRA and special enrollment elections, filing claims and appeals, and making COBRA premium payments until sixty days after the end of the COVID-19 National Emergency (referred to as the “Outbreak Period”). Later guidance confirmed that the tolling period applied until the earlier of: (1) one year from the date the participant would have been required to take action; or (2) the end of the Outbreak Period.

What changed?

Earlier this year, the Biden Administration and the Department of Health and Human Services announced they intended to jointly end the COVID-19 National Emergency and the PHE on May 11, 2023. This announcement means that the special benefit plan mandates in place during the COVID-19 pandemic will also end, leading the Departments to issue guidance about the timing and scope of these changes.

Are group health plans required to cover COVID-19 testing after the PHE ends?

No. While the FFCRA requires plans to cover COVID-19 testing and related items and services furnished during the PHE without participant cost-sharing, the guidance confirms that this requirement does not apply after the PHE ends. If a plan chooses to provide coverage for COVID-19 testing after the PHE ends (including over-the-counter COVID-19 testing), the plan may impose cost-sharing, prior authorization, or other medical management rules. In the FAQs, the Departments clarified that if the COVID-19 test is furnished during the PHE, the fact that the laboratory analysis occurs after the PHE ends does not eliminate the plan's obligation to cover the COVID-19 test without cost-sharing.

Are group health plans required to cover COVID-19 vaccines after the PHE ends?

Yes, if the plan is a non-grandfathered plan because COVID-19 vaccines are preventive services under the Affordable Care Act. However, the coverage requirement is limited to in-network COVID-19 vaccines.

During the PHE, non-grandfathered group health plans must cover COVID-19 vaccines and administration without participant cost-sharing, regardless of whether the vaccine is administered in-network or out-of-network. After the PHE ends, non-grandfathered plans must continue to cover COVID-19 vaccines and administration provided *in-network* without participant cost-sharing but may either: (1) not cover out-of-network COVID-19 vaccines; or (2) impose participant cost-sharing on out-of-network COVID-19 vaccines. However, if the plan does not have any in-network COVID-19 vaccine providers, the plan must cover out-of-network COVID-19 vaccines without participant cost-sharing.

Are group health plans required to provide advance notice before discontinuing or reducing coverage for COVID-19 vaccines or COVID-19 tests?

Yes, in most cases. In general, if a group health plan were to discontinue coverage of COVID-19 items and services mid-plan year *and* that change would affect the content of the plan's most recently provided summary of benefits and coverage (SBC), the plan must provide 60 days' advance notice of the modification. However, the Departments confirmed two exceptions to this rule: (1) If the plan previously notified participants that the special COVID-19 coverage rules would apply only during the PHE, or (2) If the plan provides advance notice "within a reasonable timeframe in advance of the reversal of the changes."

Key to the first exception is a statement by the Departments that a notification made with respect to a prior plan year would *not* be sufficient to provide advance notice for coverage in the current plan year. This suggests that unless the plan already provided notice with respect to the *2023* plan year confirming that special COVID-19 coverage would apply only during the PHE, the plan would be required to provide reasonable advance notice before discontinuing COVID-19 coverage.

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 that case, even while reasonable advance notice may not be required, it is worth considering.

May high deductible health plans continue to provide coverage for COVID-19-related services before satisfaction of the minimum deductible without impacting HSA eligibility?

For the time being, yes. By way of reminder, a high deductible health plan (HDHP) cannot provide coverage for medical items and services before the participant satisfies the minimum deductible (with limited exceptions) without impacting a covered participant's ability to make contributions to a health savings account (HSA). At the beginning of the COVID-19 pandemic, the IRS issued guidance confirming that an HDHP could provide coverage for COVID-19 testing and treatment before satisfying the minimum deductible without impacting the participant's eligibility to contribute to an HSA. In the FAQs, the Departments confirmed that this rule remains in place until further guidance is issued and stated that any future modifications to this rule would not require mid-plan-year changes.

When does the required tolling of benefit plan deadlines end?

July 10, 2023— 60 days after the COVID-19 National Emergency is scheduled to end.

As a reminder, under the current status quo, for purposes of determining participant deadlines to make COBRA elections and payments, request HIPAA special enrollment, and file claims and appeals, benefit plan administrators are required to disregard the period ending on the earlier of: (1) 60 days after the COVID-19 National Emergency ends, or (2) one year from the date on which the participant was first eligible for the tolling relief. In the FAQs, the Departments confirmed that benefit plan deadlines previously required to be suspended under this rule would begin to run again after July 10, 2023.

If a participant's benefit plan deadline was tolled, does the participant need to take action by July 10, 2023?

No. Plan administrators are not required to toll benefit plan deadlines after July 10, 2023, but this does not mean that the participant must take action by July 10, 2023. Stated differently, benefit plan deadlines previously tolled during the COVID-19 National Emergency will start to run after July 10, 2023, but the participant would still have the benefit of the otherwise applicable deadline period to take action.

By way of example, if a participant were provided a COBRA election notice on May 1, 2023, the deadline for the participant to elect COBRA would be September 8, 2023 (60 days after July 10, 2023, because the period from May 1 to July 10 would not count toward the 60-day COBRA election period). As another example, if an individual had a child on April 1, 2023, the participant would have until August 9, 2023 (30 days after July 10, 2023) to exercise the individual's HIPAA special enrollment rights to enroll in the plan, provided that premiums are paid for the period of coverage after the birth.

Takeaways for plan sponsors?

Plan sponsors and administrators should be aware of the effect that the expiration of the two emergency periods will have on their benefit plans and consider whether they intend to allow previously mandated COVID-19 benefits to lapse after the PHE ends or to voluntarily continue them as-is or in a revised form (*e.g.*, by imposing cost-sharing on COVID-19 testing) for some period of time, as well as whether to continue benefit plan deadline tolling. In any case, plan sponsors and administrators will want to consider whether and how to timely communicate with participants about these issues, even if they are not obligated to do so.

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