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ERISA AND EMPLOYEE BENEFITS ATTORNEYS

135 Main Street, 9th Floor
San Francisco, California 94105-1815

15760 Ventura Blvd, Suite 910
Los Angeles, California 91436-2964

329 NE Couch St., Suite 200
Portland, Oregon 97232-1332

Tel: (415) 788-3111
Fax: (415) 421-2017
Email: info@truckerhuss.com
www.truckerhuss.com

The End of the COVID-19 Emergency Periods Is Fast Approaching

ELIZABETH LOH

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During the COVID-19 National Emergency (NE) and Public Health Emergency (PHE) periods, the government issued guidance providing various forms of temporary relief to plan sponsors and plan participants, and also requiring plan sponsors to make certain plan design changes during these emergency periods (e.g., covering COVID-19 testing, the extension of health plan-related deadlines, etc.). On January 30, 2023 the Biden administration announced that it planned to extend both the NE and PHE to **May 11, 2023**, and then end both emergencies on that date. On March 29, 2023, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the "Departments") issued guidance in the form of FAQs[1] which provide helpful information to assist plan sponsors regarding the administration and implementation of the end of these emergency periods.

With the end of the emergency periods fast approaching, plan sponsors should begin evaluating whether any changes should be made to their plans and coordinating with their vendors (e.g., third-party administrators, etc.) to ensure that any changes are implemented correctly. A checklist of "Action Items" for plan sponsors is included at the end of this article.

Ending of the Public Health Emergency Period

The Secretary of HHS first established the Public Health Emergency for COVID-19 (PHE) in January of 2020. This PHE, which has been extended multiple times in 90-day increments, is now anticipated to expire at the end of the day on May 11, 2023. With the end of the PHE approaching, plan sponsors will need to make decisions regarding their health plan offerings as described below.

COVID-19 Testing

Under the Families First Coronavirus Response Act (FFCRA) and the CARES Act, health plans currently are required to cover COVID-19 tests and testing-related services without cost-sharing (e.g., deductibles, co-payments, co-insurance), prior authorization, or other medical management techniques, whether the tests are obtained in-network or out-of-network. In addition, health plans are required to cover up to eight Over-The-Counter (OTC) COVID-19 tests per person, per month without cost-sharing (but plans may cap reimbursement at $12 per test if certain requirements are met).

After the end of the PHE, health plans will no longer be required to cover COVID-19 tests and testing-related services for free, and health plans may impose cost-sharing, prior authorization, or other medical management requirements for such services. The FAQs clarify that health plans are not required to cover COVID-19 tests and associated items or services that are "furnished" after the PHE ends. A COVID-19 test, or associated item or service, is considered "furnished" on the date the item or service was rendered to the individual (or for an OTC COVID-19 test, the date on which the test was purchased). Further, if a COVID-19 test involves multiple items or services, the plan sponsor should look to the earliest date on which an item or service is furnished. For example, if a health care provider collects a specimen to perform a COVID-19 test on the last day of the PHE, but the laboratory analysis occurs on a later date, the plan sponsor should treat both the specimen collection and the laboratory analysis as if they were furnished during the PHE and, accordingly, subject to the FFCRA and CARES Act requirements.

- Plan Sponsors will need to decide whether to amend their health plans to either (i) cease providing any coverage for COVID-19 tests at the end of the PHE (e.g., on May 11, 2023); or (ii) continue offering coverage for COVID-19 testing, but impose requirements on this testing (such as cost-sharing). Note: The Plan Sponsor could also choose to continue offering coverage for COVID-19 testing for a certain period of time after the end of the PHE (e.g., through the end of the plan year) and then eliminate coverage. In their FAQs, the Departments emphasize that while Plan Sponsors are not required to cover COVID-19 testing after the end of the PHE, they are "encouraged to continue to provide this coverage without imposing cost sharing or medical management requirements, after the PHE ends." The Plan Sponsor should consult with their vendors (e.g., their pharmaceutical benefits manager and third-party administrator) to determine each vendor's capabilities should the plan continue to offer coverage of COVID-19 tests.
- If a Plan Sponsor decides not to offer coverage for COVID-19 testing under its health plan, it should consider communicating with its plan participants that COVID-19 tests purchased by an individual may be reimbursed through the individual's Health Flexible Spending Account, Health Reimbursement Arrangement, or Health Savings Account (as applicable).

COVID-19 Vaccines

The CARES Act required plans to cover "qualifying coronavirus preventive care services" (e.g., COVID-19 vaccines and boosters) without cost-sharing, both in-network and out-of-network. This CARES Act requirement will end as of May 11, 2023. However, it is important to note that non-grandfathered health plans will still be required to cover in-network COVID-19 vaccines without cost-sharing as part of the Affordable Care Act preventive services mandate that applies indefinitely for certain in-network immunizations. The FAQs issued by the Departments also clarify that if a health plan does not have a service provider in its network that provides COVID-19 vaccines, then the health plan must cover COVID-19 vaccines provided by out-of-network providers without cost-sharing.

- Plan sponsors of non-grandfathered plans will need to decide whether to amend their health plans to only cover in-network COVID-19 vaccines without cost-sharing after the end of the PHE, or to continue covering both in-network and out-of-network COVID-19 vaccines, but to apply cost-sharing for out-of-network COVID-19 vaccines. Plan sponsors of grandfathered plans will have more flexibility regarding coverage of COVID-19 vaccines both in-network and out-of-network.

End of the National Emergency Period

On March 13, 2020, the COVID-19 National Emergency was declared by former President Trump, effective March 1, 2020, and was subsequently continued by both President Trump and President Biden. A National Emergency declaration is in effect until it is terminated by the President, through a joint resolution of Congress, or is not continued by the President. As noted above, the Biden Administration has announced that the National Emergency period is anticipated to end on May 11, 2023.[2]

Certain Plan Deadline Extensions Ending

At the outset of the National Emergency period, the government recognized that employers, employees and their dependents might have difficulty meeting certain plan-related deadlines (e.g., HIPAA special enrollment deadlines, COBRA deadlines, ERISA claims and appeal deadlines) due to the pandemic. Accordingly, the Departments issued guidance extending those deadlines to assist employers and employees with the process of maintaining ERISA plan coverage.

In 2020, the Departments issued a Joint Notice that requires ERISA-covered plans to disregard the period beginning March 1, 2020 and ending 60 days after the National Emergency period terminates (the "Outbreak Period") in determining deadlines for:

1) HIPAA special enrollment
2) The COBRA 60-day election period
3) COBRA premium payment
4) Notification to the plan by an individual of a qualifying event or determination of disability under COBRA
5) Filing a claim for benefits
6) Filing an appeal of a claim denial
7) Requesting external review of a final claim denial by a health plan; and
8) Filing information to perfect a request for external review.

For more detailed information regarding the way in which these extended deadlines are calculated, see our prior newsletter article:
https://www.truckerhuss.com/2021/03/outbreak-extension-period-when-does-it-end/

The recently issued FAQs confirm plans will no longer be required to disregard the Outbreak Period from applicable ERISA, COBRA, and HIPAA deadline calculations as of **July 10, 2023** (i.e., the anticipated end of the Outbreak period). The examples below illustrate the way deadlines will be calculated upon the anticipated end of the Outbreak Period. Note: These examples assume that the National Emergency period ends on May 11, 2023 and that the Outbreak Period ends 60 days after that (i.e., on July 10, 2023).

Example 1. COBRA Elections, COBRA qualifying event occurs during the Outbreak Period

- Lenny works for Employer A and participates in Employer A's group health plan. Lenny experiences a COBRA qualifying event and loses group health plan coverage on May 12, 2023 (i.e., after the end of the National Emergency Period, but before the end of the Outbreak Period).
- Lenny is provided a COBRA election notice on May 15, 2023.
- The COBRA rules generally provide that a COBRA qualifying beneficiary must elect COBRA coverage within 60 days of receiving their COBRA election notice. However, because Lenny's COBRA qualifying event occurred on May 12, 2023, after the end of the National Emergency Period, *but during the Outbreak Period* — Lenny is eligible for the extension deadlines available under the Outbreak Period relief.
- The last day of Lenny's COBRA election period is 60 days after July 10, 2023 (i.e., the end of the Outbreak Period), which is September 8, 2023.

Example 2. COBRA Elections, COBRA qualifying event occurs after the end of the Outbreak Period

- Phil works for Employer B and participates in Employer B's group health plan. Phil experiences a COBRA qualifying event and loses group health plan coverage on July 12, 2023.
- Phil is provided with a COBRA election notice on July 15, 2023.
- Because Phil's COBRA qualifying event occurred on July 12, 2023 (after the end of the National

Emergency Period and the end of the Outbreak Period), the extensions under the Outbreak Period relief do not apply.

- The last day of Phil's COBRA election period is September 13, 2023 (i.e., 60 days after receiving his July 15, 2023 COBRA election notice).

Example 3. Paying COBRA Premiums

- Julie participates in Employer C's group health plan. Julie has a COBRA qualifying event and receives a COBRA election notice on October 1, 2022. Julie elects COBRA continuation coverage on October 15, 2022, and such coverage is retroactive to October 1, 2022.
- The COBRA rules generally provide that a COBRA qualifying beneficiary has at least 45 days after they make a COBRA election to make their first COBRA premium payment.
- Here, Julie elected COBRA coverage on October 15, 2022 which is during the Outbreak Period. Accordingly, the extensions under the Outbreak Period relief apply.
- Julie has until 45 days after July 10, 2023 (the end of the Outbreak Period), which is August 24, 2023, to make her initial COBRA premium payment.
- Julie's initial COBRA premium payment would include the monthly premium payments for October of 2022 through July of 2023.
- Julie's premium payment for August 2023 must be paid by August 30, 2023 (i.e., the last day of the 30-day grace period for the August 2023 premium payment).
- Her subsequent monthly COBRA premiums would be due by the first of each month, subject to a 30-day grace period.

Example 4. HIPAA Special Enrollment Deadline

- Malia works for Employer D and is eligible for Employer D's group health plan, but previously declined this group health plan coverage.
- On May 12, 2023, Malia gives birth.
- Malia and her child qualify for special enrollment in her employer's plan as of the date of her child's birth (i.e., May 12, 2023).
- Under the HIPAA special enrollment rules, an eligible individual must be provided with at least 30 days from the date of their special enrollment event (e.g., birth) to elect group health plan coverage. However, because Malia became eligible for special enrollment on May 12, 2023, which is after the end of the National Emergency Period, but during the Outbreak Period, she is eligible for the extensions available under the Outbreak Period relief.
- Malia may exercise her special enrollment rights for herself and her child until August 9, 2023 (i.e., 30 days after July 10, 2023 (the end of the Outbreak Period)).
- Malia will need to make premium payments for the period of coverage after the birth.

Example 5. Health Flexible Spending Account Run-Out Period Deadline

- Janet was enrolled in her employer's Health Flexible Spending Account ("Health FSA") for the 2022 plan year.
- The Health FSA Plan has a 90-day run-out period (i.e., claims must be submitted within 90 days of the end of the plan year — by March 31, 2023).
- The Health FSA's 90-day run-out period for the 2022 plan year is extended by disregarding the Outbreak Period.
- Janet's last day to file her 2022 plan year Health FSA claim is 90 days after the end of the Outbreak Period (i.e., October 8, 2023).

Employers must offer Special Enrollment Period for individuals who lose Medicaid or CHIP coverage.

In their FAQs, the Departments explain that since the beginning of the PHE, state Medicaid agencies generally have not terminated the enrollment of any Medicaid beneficiary who was enrolled on or after March 18, 2020 through March 31, 2023 (referred to as the "Continuous Enrollment Condition"). The Departments clarify that many consumers will lose Medicaid and CHIP coverage as state agencies resume their regular eligibility and enrollment practices. Accordingly, these individuals will need to transition to other coverage, including employer-sponsored group health plan coverage. To help facilitate this transition, the Departments remind employers that if an employee loses eligibility for Medicaid or CHIP coverage, then the employee will have a HIPAA special enrollment period to enroll in employer-sponsored coverage mid-year.

Election window. An individual who loses Medicaid or CHIP coverage from March 31, 2023 until July 10, 2023 (the anticipated end of the Outbreak Period) can request special enrollment in the employer's group health plan. The employer must offer an election window that is at least 60 days long (running from July 10, 2023). In other words, if an individual loses eligibility for Medicaid or CHIP on or before July 10, 2023, they will have until at least September 8, 2023 to elect HIPAA special enrollment coverage under the employer's group health plan. The Departments also state that a group health plan is always allowed to be more generous and offer an election window that is longer than what is statutorily required (i.e., an employer can offer a HIPAA special enrollment window that is longer than 60 days).

Suggested employee communications. Employers also should reach out to employees who are enrolled in Medicaid or CHIP to encourage these employees to update their contact information with the state Medicaid or CHIP agency and to respond promptly to any communication from the state. The DOL has provided a flyer that employers may use when communicating to their employees about their health care options upon losing Medicaid or CHIP coverage. This flyer is found at: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/losing-medicaid-or-chip-flyer.pdf

COVID-19 treatment and testing may continue to be covered on a first dollar basis under a High Deductible Health Plan.

Under the Internal Revenue Service (IRS) Health Savings Account (HSA) rules, an individual must be covered under a High Deductible Health Plan (HDHP) to be HSA-eligible. Generally, the HDHP must not offer first dollar coverage (i.e., coverage before the individual has met their statutory deductible) except for certain narrow exceptions like preventive care services. At the beginning of the PHE, the IRS announced that HDHPs could provide COVID-19 testing and treatment for an HDHP participant who had not met their deductible without impacting the individual's HSA eligibility.

The recently issued FAQs clarify that this HDHP relief will continue past the end of the PHE. Accordingly, an individual who receives COVID-19 testing and/or treatment under their HDHP prior to meeting their deductible will not lose HSA eligibility (i.e., they can continue making and receiving HSA contributions on a tax-favored basis).

Telehealth relief is not impacted by the ending of the emergency periods.

Similarly, to promote the use of telehealth services during the pandemic, the government passed legislation allowing HDHPs to offer telehealth coverage on a first dollar basis. Recent legislation passed before the end of 2022 extended this HSA relief. Accordingly, HDHPs may choose to waive the deductible for any telehealth services through 2024 without causing plan participants to lose HSA eligibility. This relief applies for the 2023 and 2024 plan years and is not impacted by the ending of the emergency periods.

Action Items

- Plan Sponsors should evaluate whether they want to keep their plan designs in place through the end of the plan year (or longer), or amend their plans for the ending of the emergency periods (e.g., imposing cost-sharing for COVID-19 testing, or deciding to only cover in-network COVID-19 vaccines, etc.). Note: The Departments encourage (but do not mandate) that plans continue providing COVID-19

testing coverage without imposing cost-sharing or medical management requirements, even after the PHE ends, because the Departments believe that testing is still a critical component in reducing the spread of COVID-19.

- Plan Sponsors will need to coordinate any new plan design changes with their insurance carriers and third-party administrators (e.g., their self-funded medical plan third-party administrators, Health FSA third-party administrators, COBRA administrators, etc.).
- Plan sponsors will need to prepare and distribute participant communications describing plan design changes (e.g., regarding whether participants may still receive COVID-19 tests for free; what are the new deadlines by which participants need to make health plan benefit decisions; explaining the HIPAA special enrollment period available upon losing Medicaid or CHIP eligibility, etc.). These communications should be distributed reasonably in advance of the intended plan design changes.
- Plan sponsors will need to amend plan documents and update summary plan descriptions for changes in plan design.

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[1] The FAQs are titled "Frequently Asked Questions about Families First Coronavirus Response Act, Coronavirus Aid, Relief, and Economic Security Act, and Health Insurance Portability and Accountability Act Implementation Part 58."

[2] As of the publication of this article, it is currently unclear whether the National Emergency period will end earlier than May 11, 2023. On March 29, 2023, the U.S. Senate passed H.J. Res. 7 which terminates the "National Emergencies Act" declaration concerning COVID-19 made by President Trump on March 13, 2020. President Biden is anticipated to sign this bill into law. However, it is possible that the passage of this bill will not impact the other COVID-19 emergencies that have been declared including the National Emergency period enacted under President Trump's Stafford Act emergency declaration (i.e., the National Emergency period that determines the end of the Outbreak Period).

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Editor: Nicholas J. White, nwhite@truckerhuss.com

TRUCKER ✦ HUSS

Jahiz Noel Agard
jagard@truckerhuss.com
415-277-8022

John E. Barlow
jbarlow@truckerhuss.com
213-465-5122

Mia Butzbaugh
mbutzbaugh@truckerhuss.com
415-277-8073

Sarah Bowen
sbowen@truckerhuss.com
415-277-8059

Adrine A. Cargill
acargill@truckerhuss.com
415-277-8012

Nicolas D. Deguines
ndeguines@truckerhuss.com
415-277-8036

Joseph C. Faucher
jfaucher@truckerhuss.com
213-537-1017

Angel Garrett
agarrett@truckerhuss.com
415-277-8066

Scott E. Galbreath
sgalbreath@truckerhuss.com
415-277-8080

Robert R. Gower
rgower@truckerhuss.com
415-277-8002

Alaina C. Harwood
aharwood@truckerhuss.com
(415) 277-8047

R. Bradford Huss
bhuss@truckerhuss.com
415-277-8007

Zachary T. Isenhour
zisenhour@truckerhuss.com
415-277-8005

Ryan Kadevari
rkadevari@truckerhuss.com
415-788-3111

Clarissa A. Kang
ckang@truckerhuss.com
415-277-8014

Sarah Kanter
skanter@truckerhuss.com
415-277-8053

T. Katuri Kaye
kkaye@truckerhuss.com
415-788-3111

Elizabeth L. Loh
eloh@truckerhuss.com
415-277-8056

Brian D. Murray
bmurray@truckerhuss.com
213-537-1016

Kevin E. Nolt
knolt@truckerhuss.com
415-277-8017

Yatindra Pandya
ypandya@truckerhuss.com
415-277-8063

Barbara P. Pletcher
bpletcher@truckerhuss.com
415-277-8040

Mary E. Powell
mpowell@truckerhuss.com
415-277-8006

Catherine L. Reagan
creagan@truckerhuss.com
415-277-8037

Dylan D. Rudolph
drudolph@truckerhuss.com
415-277-8028

Robert F. Schwartz
rschwartz@truckerhuss.com
415-277-8008

Charles A. Storke
cstorke@truckerhuss.com
415-277-8018

Joelle Tavan
jtavan@truckerhuss.com
415-277-8030

Jennifer Truong
jtruong@truckerhuss.com
415-277-8072

Nicholas J. White
nwhite@truckerhuss.com
213-537-1018

PARALEGALS

Jenna McHenry
jmchenry@truckerhuss.com
415-277-8020

Susan Quintanar
squintanar@truckerhuss.com
415-277-8069

TRUCKER ✦ HUSS

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ERISA AND EMPLOYEE
BENEFITS ATTORNEYS

135 Main Street, 9th Floor
San Francisco, California 94105-1815

15760 Ventura Blvd, Suite 910
Los Angeles, California 91436-2964

329 NE Couch St., Suite 200
Portland, Oregon 97232-1332

Tel: (415) 788-3111
Fax: (415) 421-2017
Email: info@truckerhuss.com
www.truckerhuss.com