Termination of the Public Health Emergency and End of the National Emergency

FAQ

BLUE Benefit ADMINISTRATORS OF MASSACHUSETTS

With both the federal Public Health Emergency and National Emergency ending, this FAQ has been prepared to advise on the various timelines and impacts on benefit plans and documents.

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What impact does the end of the National Emergency have on group health plans?

The tolling relief granted under "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak" will begin to wind down, including extensions for special enrollment, COBRA elections and premium payments, notifications of disability, claim filing and appeal deadlines, IRO requests, and submission of additional information to perfect an external review request. Any deadline tolling which has not already ended due to hitting the one-year maximum will end at the expiration of the "Outbreak Period," which occurs 60 days following the expiration of the National Emergency.

When does the Outbreak Period end?

With the National Emergency having ended on April 10, 2023, it was believed that the Outbreak Period would end on June 9, 2023. However, it now appears that the Outbreak Period will still end on July 10 because H.J. Res. 7 – the Congressional action ending the National Emergency under the National Emergencies Act – does not impact the Outbreak Period. Rather, The Timeline Extension Rule, and the Outbreak Period, stem from a distinct National Emergency declared under the Stafford Act. This Stafford Act National Emergency is still expected to continue through May 11, meaning the Outbreak Period and the timeframe extensions will continue through July 10.

When does the Public Health Emergency end and what impact will that have on group health plans?

The Public Health Emergency, which imposed group health plan mandates for coverage of COVID-19 testing and COVID-19 preventive services (such as vaccines) is scheduled to end on May 11, 2023.

Upon the termination of the Public Health Emergency, group health plans will no longer be required to provide coverage for COVID-19 tests (both prescribed by a physician and over-the-counter) with no cost-share or medical management. Importantly, group health plans may still provide coverage for these items at no cost-share if they choose to do so.

Regarding coverage for COVID-19 preventive services, group health plans will still be required to cover vaccines for COVID-19 (with no cost-share) when provided at an in-network provider. After the termination of the Public Health Emergency, coverage is no longer required when provided by out-of-network providers.

How do these changes impact Plan Documents?

Plan documents have been updated to account for these changes and include a statement that the Plan will comply with all Federal regulations during a public emergency. Any clients who wish to discuss benefit/coverage changes outside of the federal requirements can work with their dedicated client service team to determine the appropriate next steps.

Is there any impact on SBCs (Summaries of Benefits and Coverage)?

When there is a material modification to any plan or coverage terms affecting SBC content the plan or issuer must provide notice of modification to participants and enrollees no later than 60 days before the date on which the modification becomes effective. *SBC's will be updated and re-issued when applicable.*

Recent guidance provides the following as it relates to the end of the Public Health Emergency:

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.

As such, if there is a material modification to the content of the SBC, *it is recommended to notify* Participants as soon as reasonably possible.

When the COVID-19 Public Health Emergency ends, what will happen to "HIPAA Rules" that ensured telehealth services were provided in a private and secure setting?

The U.S. Department of Health and Human Services' Office for Civil Rights (OCR) is providing a 90-calendar day transition period for covered health care providers to comply with the HIPAA Rules regarding telehealth. The transition period will start on May 12, 2023, and expire at 11:59 p.m. on August 9, 2023. OCR will continue to exercise its enforcement discretion and will not impose penalties on covered health care providers for noncompliance with the HIPAA Rules that occurs in connection with the good faith provision of telehealth during the 90-calendar day transition period.

May an individual covered by an HDHP providing medical care services and items purchased related to testing for and treatment of COVID-19 contribute to an HSA before satisfying the applicable minimum deductible?

Yes, that individual may continue to contribute to an HSA until further guidance is issued. The Treasury Department and IRS are reviewing the appropriateness of continuing relief with the National Emergency ending and anticipate issuing additional guidance in the near future.

Please contact your BBA Client Services team directly if you have any questions.