MarshMcLennan Agency

COMPLIANCE CENTER OF EXCELLENCE

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The End in Sight

A Guide for the End of the COVID-19 Public Health Emergency and Outbreak Periods

Federal, state, and local governments implemented a wide range of provisions affecting employers and, where applicable, their benefit plans during the COVID-19 pandemic. On February 10, 2023, President Biden signaled his intent to declare an end to the COVID-19 national emergency as of May 11, 2023. Under pressure from Congress to end the national emergency earlier, President Biden signed a joint Congressional resolution ending the national emergency on April 10, 2023.

Many of the COVID-19 mandates and related relief are tied – directly or indirectly – to this national emergency. Its end sets in motion a return to a pre-pandemic normal, although changes will occur at different times. The federal agencies administering and enforcing this relief exercised their discretionary authority to use **May 11, 2023** as the end date for certain relief and the beginning of a countdown to end other relief. We will address this in more detail later in this Guide.

This Guide focuses solely on the end of federal mandates and other relief related to the national emergency that are applicable to employer-provided health and welfare plans, optional and/or required changes to plan design and administration, insights, communication obligations, and other related issues.

We will generally refer to COVID-19 mandates and other relief collectively as “relief” and the U.S. Departments of Labor (DOL), Health & Human Services (HHS), and the Treasury (IRS) as the “Agencies” for the remainder of this Guide.

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The COVID-19 relief periods

While many relief provisions were temporary,[1] the duration of several other relief provisions affecting employer-provided group health plans are tied to one of two relief periods related to the national emergency:

1. The COVID-19 Public Health Emergency Period (PHE); and
2. The COVID-19 Outbreak Period (the "Outbreak Period").

Although the two periods are frequently confused with each other and/or used interchangeably, they cover different ground as addressed in detail later in this Guide. The relief under the PHE and Outbreak Period also end at different times in relation to the end of the national emergency.

The end of the Public Health Emergency Period

HHS has the authority to declare a public health emergency for a period of up to 90 days and may extend that declaration for successive 90-day periods. The declaration gives HHS certain emergency rulemaking powers and/or enforcement discretion during an identifiable health crisis.[2]

The Trump Administration's declaration of COVID-19 as a national emergency, and its continuation by the Biden Administration, gave HHS the cover to declare and maintain the PHE. From a health and welfare benefits perspective, the PHE affects the following:

- Coverage for COVID-19 diagnostic testing;
- Coverage for COVID-19 vaccination;
- The ability to offer telemedicine as a standalone benefit;
- Employee assistance program relief; and
- Parity rule relief.

PHE duration

The PHE was initially effective January 27, 2020, and HHS extended it thirteen times. HHS issued the most recent extension on February 9, 2023, with an effective date of February 11, 2023. This was only a month after the prior extension, but HHS did this to time the end of the PHE with May 11, 2023.[3]

HHS intends to end the PHE on May 11, 2023, even though the national emergency ended on April 10th. Except where noted below, the PHE relief will no longer apply as of **May 12, 2023**.

COVID-19 diagnostic testing

The requirement for medical plans and policies to cover COVID-19 testing ends with the PHE. This includes the requirement to provide certain coverage for over-the-counter COVID-19 testing products. After May 11, 2023 (*without* regard to the plan or policy year), medical plans can:

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[1] Examples include the emergency paid sick and family leaves, the extended grace periods and unlimited carryovers for flexible spending accounts, the unrestricted or "amnesty" qualifying life events, and the COBRA subsidy.

[2] Please see the HHS Public Health Emergency Declaration site for more information.

[3] HHS knew the Biden Administration's February 11th announcement would indicate May 11, 2023 as the end of the national emergency.

- Determine whether to continue coverage for testing;
- Impose cost sharing for testing services;
- Choose to require referrals or prior authorization before providing coverage for testing; and/or
- Exert greater control over the distribution channels for testing services.

Note: For now, testing remains available and free through various federal and state-funded health centers, but the funding for these centers is not indefinite now that the national emergency is over.

COVID-19 vaccination

The vaccination coverage requirement for medical plans and policies that are not grandfathered under the Affordable Care Act (ACA) continues after the PHE with a modification.

	In-Network No Cost Sharing	Out-of-Network No Cost Sharing	Required Vaccination Coverage
During PHE	Yes	Yes	Must cover within 15 business days after the CDC publishes a recommendation for use
After PHE	Yes	No (so long as in-network access available) balance billing permitted	

As with testing, a plan could change coverage for out-of-network vaccination after May 11, 2023, in the middle of an existing plan or policy year. The rules also require coverage for preventive items or services with an 'A' or 'B' recommendation from the United States Preventive Services Task Force, but these will not include vaccines.[4]

After May 11, 2023, ACA grandfathered plans can choose to apply cost sharing to COVID-19 vaccinations received from any providers, or could even exclude coverage entirely.

Clearing up misconceptions

Many industry professionals (including this author for a time) shared one or two misconceptions about the required coverage for COVID-19 vaccination after the PHE.

First, there appeared to be an argument that the requirement to cover vaccinations after the PHE ended was defective because the Centers for Disease Control and Prevention (CDC) skipped a technical step in the recommendation process under the applicable regulations.[5] Specifically, the regulation indicates the CDC's Advisory Committee on Immunization Practices (ACIP) must recommend a COVID-19 immunization (i.e., a vaccine), and the CDC director must adopt it. To our knowledge, the CDC director has never adopted a recommendation for any specific vaccine.

[4] The validity of the 'A' and 'B' recommendations is the subject of a legal challenge as of the publication date of this Guide.

[5] 29 CFR §2590.715-2713(a)(v). Treasury and HHS issued similar regulations.

The Agencies take the view that the CDC director issued a blanket adoption for all ACIP vaccine recommendations and no adoptions for individual vaccines were necessary.[6] The Agencies did not discuss this issue in their recent FAQs addressing the end of the PHE and Outbreak Periods (the "March FAQs").[7] It's also worth a mention that while the regulations indicate the CDC director needs to adopt ACIP's immunization recommendations for them to be effective, the underlying statute does not.[8]

Second, many believed that the effective date for future immunization recommendations would revert to the ACA's standard for preventive services.[9] This is because the 15-business day coverage requirement in the regulations sunsets with the expiration of the PHE. However, the Agencies correctly point out in their recent March FAQs that the underlying statute also includes the 15-day rapid coverage requirement with no corresponding sunset provision.[10] This means non-grandfathered plans or policies must still cover new COVID-19 recommendations issued after the PHE within 15 business days.

Insurance carrier and third party administrator input for testing and vaccination

Although the testing relief and a portion of the vaccination relief expire with the PHE, it may be administratively cumbersome to implement coverage changes during the middle of a plan or policy year. That said, we expect many insurers for fully insured plans will drop free and/or unrestricted coverage for testing and free coverage for out-of-network vaccination as of May 12, 2023.

Employers generally have much more discretionary control over self-insured plans, although we expect many third party administrators (TPAs) will make the same recommendations and/or apply pressure for the same outcomes described above. Many TPAs are also insurers, and it is in their self-interests to standardize administration across their books of business. Some TPA communications may be subtle and implement the recommendations if the employer does not respond.

We will address any necessary communication requirements under Communications.

Telemedicine as a standalone benefit

Our Compliance Center of Excellence position has been that telemedicine does not qualify as an "excepted benefit" for compliance purposes if:

1. It allows for a large (e.g., >10) or theoretically unlimited number of visits per plan year without regard to how many visits a participant actually uses; or

2. The telemedicine benefit providers can write prescriptions, even if the allowable list of prescriptions is limited.

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[6] FAQS About ACA Implementation Part 50, October 4, 2021, Q1.

[7] FAQs About FFCRA, CARES Act, and HIPAA Implementation Part 58, March 29, 2023.

[8] CARES Act §3203(b).

[9] In general, ACA preventive service recommendations are effective for plan years beginning on or after the one-year anniversary of the recommendation.

[10] FAQs About FFCRA, CARES Act, and HIPAA Implementation Part 58, March 29, 2023, Q4.

If true, this means most telemedicine benefits are subject to the ACA's plan design mandates,[11] which a standalone telemedicine benefit cannot satisfy by itself. Unless another exception applies, this means employers should limit telemedicine coverage to participants enrolled in traditional employer-provided medical coverage.

In 2020, the Agencies released guidance specifically excluding standalone telemedicine benefits from the ACA's plan design mandates[12] for 2020 and future telemedicine plan years that began during the PHE. The relief ends for telemedicine plan years that begin on or after May 12, 2023. This relief confirms the position that most employer telemedicine plans are not excepted benefits.

Note: Technically, this standalone telemedicine relief only applied to employees who were ineligible for the employer's medical plan and not also to those who were eligible for medical coverage but waived it. That said, it appears this distinction was largely ignored during the PHE.

Example 1

ABC Company maintains a calendar year telemedicine benefit. The relief applies through December 31, 2023. ABC Company should limit eligibility for the telemedicine benefit to participation in employer medical coverage as of January 1, 2024.

Example 2

ABC Company maintains a July 1 to June 30 plan year telemedicine benefit. The relief ends on June 30, 2023. ABC Company should limit eligibility for the telemedicine benefit to participation in employer medical coverage as of July 1, 2023.

Will Congress provide further relief?

A bipartisan bill (H.R. 824) introduced in the House of Representatives in February would address this by permanently making telemedicine an excepted benefit. We are unable to predict if this or other similar proposed legislation will become law, but we are monitoring the situation.

Employee assistance program relief

The Agencies previously issued guidance excluding COVID-19 testing and vaccination for the purposes of determining an EAP's excepted benefits status during the PHE.[13]

This relief expires as of May 12, 2023, but it is not clear that an EAP that provides a limited number of behavioral health counseling sessions per year and coverage for COVID-19 testing and vaccination as its sole health care benefits will automatically lose excepted benefits status under the EAP exception for providing significant medical care.

Parity rule relief

During the PHE, medical/Rx plans can ignore $0 COVID-19 testing and vaccination when determining quantitative treatment limitation compliance under the Mental Health Parity and Addiction Equity Act. This relief ends on May

[11] We recently addressed telemedicine benefits and HSA eligibility in a separate alert.

[12] FAQs About FFCRA and CARES Act Implementation Part 43, June 23, 2020, Q14.

[13] FAQs About FFCRA and CARES Act Implementation, Part 42, April 11, 2020, Q11; FAQs About FFCRA and CARES Act Implementation, Part 44, February 26, 2021 Q12.

12, 2023. We suspect this will have little or no effect on parity testing even if plans continue to cover these services at $0. Non-grandfathered plans must still cover COVID-19 vaccination in-network without cost sharing after the PHE under the ACA's preventive services mandate.

The end of the Outbreak Period

In April 2020, the Departments of Labor and Treasury exercised their authority to act in a national emergency and issued regulations and other guidance granting certain group health plan relief for participants and plan administrators.[14] The following relief applies to ERISA plans (as applicable) during the Outbreak Period:

- Participant relief temporarily suspending deadlines to exercise certain rights for:
  - HIPAA special enrollments;
  - COBRA elections, premium payments, disclosures of qualifying events, and notices of disability for extensions; and
  - Claims and appeals.
- Plan administrator relief providing:
  - Relaxed "good faith" delivery of ERISA plan disclosures and notices including the electronic disclosure rules; and
  - Extension of time to provide COBRA election notices.

Church plans

The HIPAA special enrollment and claims and appeals relief applies to church plans. Church plans claiming an exemption from ERISA are not subject to federal COBRA or ERISA's disclosure requirements. A church plan could voluntarily provide the same or similar continuation coverage relief to participants.

State/local governmental plans

The Outbreak Period relief is not mandatory for state/local governmental plans. HHS encouraged state/local governmental employers to provide the same participant relief, but it made all participant relief optional (although employers cannot generally grant relief to some participants but not others). HHS did provide plan administrator relief for required notices and disclosures.

Outbreak Period duration

The Outbreak Period officially began on March 1, 2020 and the relief applies until the earlier to occur of:

1. One year from the date the relief for the particular event began; or
2. 60 days after the announced end of the national emergency ends *or such other date announced by the Agencies in a future notification* (the "Countdown").[15]

[14] Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak Final Rule, 85 Fed. Reg. 26351 (pub. May 4, 2020) (the "Final Rule"); EBSA Disaster Relief Notice 2020-01.

[15] This is found in the Final Rule on page 26353 (and as later interpreted by EBSA Disaster Relief Notice 2021-01).

During the Countdown: An event subject to Outbreak Period relief that occurs during the Countdown is still subject to Outbreak Period relief until July 11, 2023.

On April 11, 2023, the DOL indicated the Agencies intend to exercise their discretion and use May 11, 2023 to start the Countdown instead of the April 10th end of the national emergency. This means the Countdown will end on July 10, 2023, and all suspended deadlines will begin to run again on **July 11, 2023**. There are likely other reasons for this, but May 11, 2023 keeps the examples describing the end of the PHE and Outbreak Period relief in the March FAQs accurate.

HIPAA special enrollment rights

This is an exhaustive list of HIPAA's special enrollment rights. The Outbreak Period relief does not generally apply to other qualifying life events (but see COBRA rights).

- Marriage
- Birth or adoption
- Loss of other health coverage
- Loss of eligibility for Medicaid or CHIP
- Gain of Medicaid or CHIP premium assistance

Group health plans subject to HIPAA's special enrollment rights (primarily medical coverage) must allow a participant at least 30 days to request enrollment from the date of the event, and at least 60 days for the Medicaid/CHIP events.

Follow your plan rules

Coverage for a birth or adoption must be effective retroactive to the date of the event, and it is the only HIPAA special enrollment right that allows employees to pay for retroactive coverage on a pre-tax basis. If your plan rules provide that coverage for the other events is effective as of the date of the election or the first of the following month after an election, this still applies during the Outbreak Period.

Example 3

Kristen had a baby on February 25, 2023. Her employer's plan allows a special enrollment period of 30 days for the birth of a child. The 30-day period is suspended until July 10, 2023 and begins to run on July 11th. Kristen will have until August 9, 2023 to add herself, her spouse, and her baby to her employer's medical plan. Coverage will be effective retroactive to February 25, 2023, and Kristen will owe premiums for this retroactive coverage. Kristen can pay for this coverage on a pre-tax basis from future payroll deductions.

Example 4

Chris got married on September 12, 2022. His employer's plan allows a special enrollment period of 31 days for marriage with coverage effective on the day of the election. The 31-day election period is suspended until July 10, 2023 and begins to run on July 11th. Chris will have until August 10, 2023 to enroll himself, his spouse, and any other newly eligible dependents. If Chris enrolls on July 24th, coverage is effective on July 24th.

Example 5

Clay's spouse terminated employment with her employer, and she and Clay lost her employer medical coverage on May 31, 2023. Clay's employer plan allows a special enrollment period of 30 days to enroll following a loss of other health coverage with coverage effective on the first of the following month after the election. The 30-day period

is suspended until July 10, 2023 and begins to run on July 11th. Clay will have until August 9, 2023 to enroll himself, his spouse, and any other eligible dependents losing coverage. If Clay enrolls on August 3, 2023, coverage is effective on September 1st.

Example 6

Matt loses eligibility for Medicaid on May 31, 2023. Matt's employer plan allows a special enrollment period of 60 days to enroll following a loss of Medicaid eligibility with coverage effective on the first of the following month after the election. The 60-day period is suspended until July 10, 2023 and begins to run on July 11th. Matt will have until September 8, 2023 to enroll himself and any dependent also losing Medicaid coverage. Matt enrolls quickly on June 8, 2023, and his coverage is effective on July 1st.

Note: The cafeteria plan rules allow employers to permit employees to enroll other eligible dependents who are not directly affected by the HIPAA special enrollment right (often referred to as "tag-along"). Tag-along is not subject to Outbreak Period relief, although we believe most employers administering it allow this.

COBRA rights

The Outbreak Period significantly affected COBRA administration, and the list of affected COBRA rights is below:

- Election;
- Initial and ongoing premium payment;
- Participant disclosure of a divorce or loss of dependent eligibility (e.g., aged-out); and
- Participant notice of disability for COBRA extension.

The deadlines for these events vary. A participant generally has 60 days to elect COBRA and another 45 days to pay the initial premium. A group health plan must allow at least a 30-day grace period for subsequent premium payments. A group health plan must allow an employee (or other participant) up to 60 days to notify the plan administrator of a divorce or an aged-out dependent. The deadline to provide notice of a disability for the COBRA extension is somewhat flexible.

The extension of time to notify the plan of a divorce or loss of dependent eligibility should mean that employees can make election changes to drop coverage for affected participants outside the usual 60-day window.

The end of the Outbreak Period does not affect a plan's "pend and pay" or "pay and chase" approach to collecting premiums and paying claims during a COBRA continuation coverage period.

Example 7

ABC Company laid off a number of employees during September 2022. Group health coverage for the affected employees terminated on the last day of the month, and their COBRA qualifying event date was October 1, 2022. The 60-day COBRA election period is suspended until July 10, 2023 and begins to run on July 11th. The COBRA qualifying beneficiaries have through September 8, 2023 to elect COBRA. If an individual elects COBRA, coverage will be retroactive to October 1, 2022, and the individual will owe premiums back to that date.

Example 8

Todd elected COBRA and his maximum COBRA continuation coverage period began on February 1, 2022 and ends on July 31, 2023. Todd paid COBRA premiums from February through December but then stopped. The medical plan allows a 30-day grace period to pay COBRA premiums measured from the due date. The 30-day COBRA premium payment grace period is suspended until July 10, 2023 and begins to run on July 11th. Todd has

until August 9, 2023 to pay the applicable COBRA premiums for January through May or COBRA will be lost. Todd could choose to pay for only some of these months, but there must be an unbroken chain of continuation coverage beginning with January.

Note: A COBRA qualifying beneficiary can choose to continue COBRA for only a limited time, but they cannot pick and choose which months they want COBRA coverage based on their medical expenses. COBRA continuation coverage is an unbroken chain of coverage and premium payment retroactive to the initial COBRA qualifying event date. The 2021 COBRA subsidy created a brief exception to this rule, but it no longer applies.

Claims and appeals

Insurers/TPAs usually administer the claims and appeals process for group health plans, so the headaches associated with this relief tended to be less obvious to employers. The relief applies to:

- Filing claims – The Outbreak Period suspended the usual deadlines to file a claim for benefits. This includes the run-out period to submit health FSA and HRA claims (but not a dependent care FSA). Please note that the relief only provides additional time to submit claims. It does not provide additional time to incur them.

- Filing appeals – The Outbreak Period also suspended the usual deadlines to file an appeal of a denied claim for benefits. This includes the time to request an external review.

This relief has proven problematic when changing vendors related to medical/Rx coverage. For example, the extended time to submit claims makes it more likely for a participant to timely file a claim after the employer has already changed plan options and the corresponding insurer/TPA. There have been some difficulties getting the prior insurer/TPA (who was terminated by the employer) to process these claims, requiring some manual troubleshooting to resolve. Similar concerns exist with stop-loss coverage, particularly when the contract limits coverage to claims filed during the policy period instead of the date the claims were incurred.

Clearing up misconceptions

First, the additional time to file claims does not also separately apply to the plan's requirement to provide substantiation for a submitted claim. Once a participant submits a claim, the plan's usual rules for providing substantiation apply.

Second, many FSA vendors are sending emails to employers addressing the end of the Outbreak Period and its effect on the run-out period to submit health FSA and HRA claims for the most recent plan year. The emails correctly indicate that the applicable run-out period will begin to run on July 11, 2023, but we are aware that certain vendors are giving employers the choice to opt-out of this "extended" run-out administration by notifying the vendor. To be clear, the Outbreak Period relief for health FSA and HRA run-out periods is not optional, and an employer that opts out is violating federal law. We are not sure why certain vendors are presenting this as voluntary.

Example 9

ABC Company's medical plan requires participants to submit claims within one year from the date incurred. Hilary incurred a medical expense on July 19, 2022. The one-year period to submit the claim is suspended until July 10, 2023 and begins to run on July 11th. Hilary (or the provider) has until July 11, 2024 to submit the claim to the plan for reimbursement.

Example 10

ABC Company maintains a calendar year health FSA and requires participants to submit claims incurred during the plan year and/or grace period within 90 days after the end of the plan year. Brianna incurred reimbursable out-of-pocket expenses during the plan year and grace period. The health FSA run-out period is suspended until July 10,

2023 and begins to run on July 11th. Brianna has until October 8, 2023[16] to submit any remaining health FSA claims from the 2022 plan year (including the corresponding grace period) for reimbursement.

Scale not scope

The participant administration issues related to the end of the Outbreak Period relief are not new. Remember, relief can also time out one year from the date the relief for the particular event began. Covered events began timing out in 2021, and insurers/TPAs have been processing these for a long time now. The difference beginning on July 11, 2023 will be one of scale, because the relief for all remaining events ends simultaneously.

Relief for disclosures and notices

The Outbreak Period suspended the standard delivery deadlines for many required plan disclosures and notices, including changes to summary plan descriptions (SPDs) and summaries of benefits and coverage (SBCs). In general, a plan meets the disclosure and notice requirements if it provides the material in good faith as soon as it is administratively practical to do so. This is a subjective standard, but later guidance clarified that the standard durational limits for Outbreak Period relief apply.[17] This means the standard delivery deadlines will begin to run again as of July 11, 2023. Generally it is in the plan's interest to provide the material as soon as it reasonably can. It can be difficult for a plan to enforce provisions or procedures that have not been communicated to participants, so there is an incentive to provide information as soon as possible.

Relaxed electronic delivery standard expiring

The Outbreak Period relief significantly relaxed the standards for the electronic delivery of plan-related material to employees and participants. During the Outbreak Period, employers and plan administrators can rely on the delivery of materials via email, by posting on internal or external websites, and text messaging in good faith as long as there is a reasonable belief the recipients have effective access to the information.

Beginning on July 11, 2023, the electronic delivery standard reverts to the DOL's prior safe harbor guidance for the electronic delivery of many health and welfare disclosures and notices subject to ERISA.

1. Employee has work-related computer access – An employer can rely on electronic delivery to employees who are issued and/or use computers as an integral (i.e., core) part of their job without prior consent.

2. Employee does not use computer as an integral part of job – An employer may only rely on electronic delivery if the employee provides advance written consent.

Note: The DOL recently updated its electronic delivery rules for retirement plans (e.g., 401(k) plans, pension plans, etc.). We are not aware of any significant lapse in delivery of materials during the Outbreak Period and hope the DOL will view this as an opportunity to update its 20+ year old electronic delivery rules for health and welfare plans.

[16] The plan might allow until October 9th since October 8, 2023 is a Sunday.

[17] EBSA Disaster Relief Notice 2021-01.

Other related issues

This section addresses other compliance-related issues related to the end of the COVID-19 national emergency.

Communications

We believe there are two communications issues to address from a plan administration perspective:

1. Changes to plan design and/or administration; and
2. A general communication to employees about a change in plan rights.

Changes to plan design and/or administration

The elimination or reduction in coverage for COVID-19 testing and vaccination is a material change to the underlying plan requiring amendments (or "material modifications") to SPDs. If disclosed in the SPD, this also applies to the removal of any description of extended deadlines to exercise participant rights under the Outbreak Period. The Agencies previously suggested that they will apply a reasonableness standard for notification in lieu of the usual deadlines to amend SPDs. While not specifically addressed in the March FAQs, we believe the Agencies will follow this approach.

An explicit reasonableness standard applies to SBCs, although the notification must still occur within a reasonable time *before* the change occurs instead of the usual 60-day advance notice.[18] We think it was rare for SBCs to specifically disclose coverage for COVID-19 testing and vaccination, so the removal or reduction of this coverage should not affect most of them.

The March FAQs also indicate that no additional notification is necessary if the plan materials already provide an expiration date for coverage, such as at the conclusion of the PHE, but this only applies if this disclosure appears in the current plan year material. We think the Agencies will apply this rationale to both SPDs and SBCs.

COBRA administrators and insurers/TPAs (including FSA administrators) should generally handle updating participant communications they administer for their clients, but an employer/plan may still need to update its COBRA general notice and notice of HIPAA special enrollment rights if they describe extended deadlines available due to the Outbreak Period relief.

As discussed under Relief for disclosures and notices, plans were generally given relaxed deadlines to disclose plan changes to participants during the Outbreak Period. In our experience, plans resumed following the usual rules to communicate plan design and administration changes as early as 2021, so the only upcoming changes applicable to most plans in relation to the end of COVID-19 relief are the elimination or reduction of COVID-19 mandated benefits and administration. While the Agencies may continue to apply a reasonableness standard, we believe the usual deadlines for any remaining delayed amendments unrelated to COVID-19 will begin to run on July 11, 2023.

We also believe a reasonableness standard will apply for amendments to plan documents related to COVID-19, such as wrap plans and cafeteria plans, but we are not aware of any guidance from the Agencies addressing this. We do not recommend relying on a reasonableness standard to unnecessarily delay executing plan amendments.

General communication to employees

The existing COVID-19 guidance does not specifically require plans to notify individuals before the relief ends and deadlines to exercise participant rights begin to run again. However, we believe general fiduciary and plan administration principles dictate that plans should give affected individuals sufficient warning to exercise their rights before they expire. We also note that the earlier EBSA Disaster Relief Notice 2021-01 encouraged plan

[18] FAQs About FFCRA, CARES Act, and HIPAA Implementation Part 58, March 29, 2023, Q2.

administrators to notify affected individuals when suspended timeframes to complete events would begin to run again.

We will provide a brief sample general communication to employees below addressing changes to plan design and administration due to the end of the COVID-19 pandemic for employers to review and consider. Please remember that certain participant rights described at the end of the notice may not apply to church plans and state/local governmental employers, and the sample notice below may not be appropriate for them.

> *"You may be aware that the Biden Administration declared an end to the COVID-19 national emergency on April 10, 2023. As a result, a number of mandates affecting your health benefits will soon end.*
>
> [Use this paragraph if coverage for testing and/or vaccination will change before the next plan year. Adjust as necessary]
> *As of [insert date], cost sharing will apply to coverage for COVID-19 testing and supplies under the [insert employer medical coverage], even when a physician recommends the test. This will also apply to coverage for COVID-19 vaccination received out-of-network.*
>
> [Use this paragraph if there are no changes for testing and/or vaccination before the next plan year. Adjust as necessary.]
> *As of May 12, 2023, medical plans are no longer required to provide free coverage for COVID-19 testing or out-of-network COVID-19 vaccination. Despite this, we do not anticipate any change to our coverage for the remainder of this plan year. We will let you know of any future changes.*
>
> *The federal relief extending the deadlines for employees and/or plan participants to exercise certain rights in their group health benefits is also expiring. These include:*
>
> - *The right to enroll in medical coverage due to marriage, a birth or adoption, a loss of other health coverage, and certain events involving Medicaid/CHIP;*
> - *The time to file claims for benefits and appeal denied claims; and*
> - *COBRA elections and payment.*
>
> *We anticipate the usual deadlines to exercise these rights will begin to run on July 11, 2023. This will also affect your remaining time to exercise a right for an event described above that has already occurred. If you have any questions about this notice or how your rights may be affected, please contact [insert contact information]. For information about COVID-19 testing and vaccination, you may also call the number on your insurance card.*

ACA grandfathered status

A grandfathered group health plan that added or enhanced benefits for COVID-19 does not lose grandfathered status merely because it later eliminates or reduces them.[19]

HSA eligibility relief for testing and vaccination

IRS Notice 2020-15 permits qualified high deductible health plans (HDHPs) to provide coverage for COVID-19 testing and treatment before a participant satisfies the minimum statutory HDHP deductible for the plan year without affecting the participant's ability to make or receive HSA contributions. IRS Notice 2020-29 expanded the exception for testing and treatment to include diagnostic testing for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV).

This relief is effective until revoked by the IRS and does not automatically expire with the end of the PHE or Outbreak Period. In the March FAQs, the IRS indicate this relief will remain in effect until further notice. We have no indication

[19] FAQs About FFCRA and CARES Act Implementation Part 43, June 23, 2020, Q15.

when this may occur, but we do not expect the IRS to revoke this relief prior to plan years beginning in 2024.

The end of Medicaid continuous enrollment

As a condition of receiving increased federal funding, state Medicaid programs have generally been unable to terminate Medicaid for participants who enrolled on or after March 18, 2020 (referred to as the "Medicaid continuous enrollment provision"). The federal funding ended on March 31, 2023, which freed up states that accepted the federal funding to resume eligibility testing.

States are reacting to this in different ways. Some states began to examine eligibility as of April 1, 2023, while other states have yet to act and/or indicate they will act later this year. The estimates for the number of individuals who will ultimately lose Medicaid coverage vary significantly, but the generally accepted range is from 15 – 18 million with roughly one-third eligible for employer-provided medical coverage.[20]

The loss of Medicaid eligibility is a HIPAA special enrollment right and also subject to Outbreak Period relief while it lasts (see Example 6). The effect on any particular employer will be heavily based on its facts and circumstances, such as its state or states of operation and paid wages. Many employers may not see an appreciable increase in enrollment while others do.

That said, we are not convinced the increase in enrollment will be as significant as some seem to fear. The enhanced subsidies toward coverage in the public health insurance marketplace (the "Marketplace") remain in effect through 2025, and they can make coverage free or nearly free for those with household incomes within 200% of the federal poverty line.

The eligibility for subsidies is based on *household income*, which is modified adjusted gross income (MAGI) for federal income tax purposes. At a high level, MAGI is adjusted gross income from all sources reported on the taxpayer's federal personal income tax return with certain adjustments. The bulk of the adjusted gross income for most individuals is based on Form W-2, Box 1 reported income, and many lower income employees will not have significant adjustments.[21]

The use of household income for Marketplace subsidy eligibility purposes makes it possible for an individual to qualify for a subsidy even though their employer offered coverage that met an employer affordability safe harbor as demonstrated in the following example. If an individual within 200% of the federal poverty line has access to this information and qualifies for a subsidy, s/he may prefer to enroll in the Marketplace instead of employer coverage.

Example 11

ABC Company offers calendar year medical coverage and relies on the Rate of Pay affordability safe harbor. ABC Company's lowest paid hourly workers make $12/hour. For 2023, ABC Company charges $125/month for employee-only coverage, which satisfies the Rate of Pay safe harbor.

(130 hours × $12) × 9.12% = $142.27/month

The 130 hours/month × $12/hour calculation extrapolates to $18,720 for the entire year. Assume an employee earning $12/hour really does work an average of 130 hours per month, has estimated and actual Form W-2, Box 1 earnings of $16,000, and has no other adjustments to this figure for MAGI/household income purposes.

In this situation, the $125/month for ABC Company coverage is greater than 9.12% of the employee's household income, and the employee can qualify for a Marketplace subsidy. The Rate of Pay affordability safe harbor still protects ABC Company from a Section 4980H(b) penalty.

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[20] Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision, Kaiser Family Foundation, April 4, 2023.

[21] Adjusted gross income and MAGI do not take the standard or itemized deductions into account.

Beware: We do not recommend ACA large employers push the availability of Marketplace subsidies as a strategy for employees losing Medicaid eligibility (or in general) unless an employer is confident it meets an affordability safe harbor or is otherwise willing to live with the potential consequences. The employer should still make sure it at least offers coverage to 95% of its full-time employee workforce at all times.

Other qualifying life events

We do not believe employers must allow employees to make election changes – including dropping coverage altogether – merely because a plan is dropping or revising coverage for COVID-19 testing and/or vaccination. This limited change should not rise to the level of a significant curtailment of coverage. However, we suspect the IRS will not challenge an employer that does allow this as a qualifying life event.

Other plan design changes and whether they trigger a qualifying life event should be evaluated on a case-by-case basis.

Section 139 disaster recovery plans

COVID-19 related expenses incurred on or after April 10, 2023, are not eligible for tax-free reimbursement from an Internal Revenue Code §139 disaster recovery plan. Unlike other relief described in this Guide, this benefit is directly tied to a national emergency declaration.

COVID-19 related expenses incurred by or before April 10, 2023 during the national emergency are still eligible if timely submitted according to the plan's rules for claiming reimbursements. An employer can continue to maintain a §139 plan to reimburse expenses for other declared national emergencies or disasters.

What next?

Insurers/TPAs have already begun communicating plan design and administration changes to their clients. If you have not heard from your insurer/TPA, we recommend reaching out to them sooner rather than later. Participant communications may also be underway or will soon start. It is also time to begin discussing how other vendors assisting your plan will address administration and communication.

Realistically, we believe the end of the COVID-19 relief after more than three years of operation will result in a significant amount of issue troubleshooting for many employers and their plans through at least the remainder of 2023 and probably into 2024.

We will continue to monitor developments for the issues discussed in this Guide as well as others that may arise and keep you informed.

About the author

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