FAQs about FFCRA, CARES Act, and HIPAA Implementation, Part 58

April 6, 2023

The Biden administration has announced its intent to end the COVID-19 National Emergency (National Emergency) and the COVID-19 Public Health Emergency (PHE) effective May 11, 2023. As a result, group health plans will no longer be required to cover certain services related to COVID-19 (such as diagnostic testing, including over-the-counter tests) at no cost to the participant, but can still choose to do so. Additionally, some of the flexibility that was provided to extend the timeframes for participants for certain health plan-related deadlines, such as special enrollment, COBRA election, COBRA premium payments, and claims and appeals filings, will lapse.

To aid plan sponsors and other stakeholders in transitioning out of the PHE and National Emergency, the Department of Labor (DOL), Department of Health and Human Services (HHS), and the Internal Revenue Service(IRS) (together, the federal agencies) jointly issued FAQ 58 on March 29, 2023, addressing requirements of the Families First Coronavirus Response Act (FFCRA), the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), and the Health Insurance Portability and Accountability Act (HIPAA). As emphasized in the FAQ, there are a several key items that plan sponsors must consider in transitioning out of the PHE and National Emergency.

Covered Testing at No Cost

After the end of the PHE, group health plans will no longer be required to cover COVID-19 diagnostic testing (including over-the-counter tests) at no cost to individuals. The FAQ, however, encourages plans to continue to do so. If a plan sponsor chooses to reinstate permitted cost-sharing for coverage of COVID-19 tests (or other benefits), such changes must be clearly communicated, including any key limitations.

Vaccines at No Cost

While many group health plans must continue to cover COVID-19 vaccines at no cost to employees from an in-network provider under ACA preventive care guidelines, the requirement to cover COVID-19 vaccines out-of-network will generally lapse after the end of the PHE and National Emergency. Plans should make sure that participants and beneficiaries are aware of which providers are available to provide qualifying coronavirus preventive services at no cost. If plans are making changes to coverage for COVID-19-related preventive services, be sure to communicate those changes, including any key limitations, to individuals in advance of those changes taking effect.

Deadline Extensions

The end of the PHE and National Emergency also means that the extensions of certain time frames for employee benefit plans are expected to end on July 10, 2023 (60 days after the end of the National Emergency). Several timeframes were extended for group health plans to give individuals more time to take certain actions, such as requesting special enrollment under HIPAA, electing COBRA continuation coverage, paying COBRA premiums, and submitting health plan claims and appeals. The FAQ encourages plan sponsors to consider making reasonable accommodations to existing timeframes by keeping the deadline extensions in effect. However, any amendments to group health plan documents to extend the regular enrollment deadlines for COBRA and HIPAA special enrollment must be approved by the insurance carrier for fully insured plans and the stop loss carrier for self-insured plans.

In addition, the FAQs provide examples relating to the application and termination of extended time periods for elections under COBRA and HIPAA special enrollment. As a reminder, various group health plan deadlines were suspended in 2021 until the earlier of (a) one year from when an individual was first eligible for deadline relief, or (b) 60 days after the end of the National Emergency. Taken together, the National Emergency period plus 60 days are referred to as the "Outbreak Period." Generally, the deadline extensions have allowed participants significant time beyond the statutory and regulatory deadlines to:

- Request HIPAA special enrollment
- Elect COBRA coverage
- Pay COBRA premiums
- Notify the group health plan of a disability determination or a COBRA-qualifying event
- File a claim or appeal under the ERISA claims procedures
- Request an external review
- Perfect a request for external review

Under the FAQ guidance, plans can stop suspending relevant deadlines at the end of the Outbreak Period on July 10, 2023. For some participants who have already had a full one-year extension, the deadline extensions may end sooner (for example, a participant who had a COBRA qualifying event and lost coverage on May 1, 2022). Deadlines that begin during the Outbreak Period will still be subject to the IRS and DOL extension. For example, participants who have COBRA qualifying events on May 12, 2023, would have an extended deadline that is 60 days after the end of the Outbreak Period (that is, September 8, 2023).

Loss of Medicaid and Children's Health Insurance Program (CHIP) Eligibility

Many employees and dependents who are currently enrolled in Medicaid or CHIP coverage may lose eligibility for that coverage after March 31, 2023. With some limited exceptions, state Medicaid agencies have not terminated coverage for any beneficiary who was covered at any time on or after March 18, 2020, as part of COVID-19 relief efforts, but this practice is generally ending March 31, 2023. This may lead to a large group of employees or dependents losing Medicaid coverage on April 1 and potentially becoming eligible for HIPAA special enrollment into employer group health plans if they otherwise qualify. Individuals who lose coverage March 31, 2023, must be allowed to enroll in plans until September 8, 2023, which is 60 days after the end of the Outbreak Period (July 10, 2023), unless the plan allows a longer notice period.

Health Savings Account (HSA) Relief

The FAQs confirm that individuals covered by a high deductible health plan (HDHP) will remain HSA-eligible until further notice even if the HDHP chooses to provide medical care services and items purchased related to testing for and treatment of COVID-19 on a first dollar basis. The FAQ guidance notes that if this relief is eliminated in the future, the federal agencies will likely not require a mid-year change to plan coverage.

In light of the significance of the changes to participant deadlines and the impact on group health plan coverage for certain COVID-19 items and services, plan sponsors should take the following actions now:

1. Analyze whether to impose permitted cost-sharing, prior authorization or other medical management requirements for COVID-19 diagnostic tests or provide other relief suggested by the FAQ such as continued extension of applicable deadlines for claims, and COBRA and HIPAA special enrollment.
2. Work with plan advisors to implement the changes to ensure that insurance carriers, including stop loss carriers, are on board with any COVID-19 enhancements the plan sponsor chooses to keep in place.
3. Review plan documents and employee communications, including summary plan descriptions, to determine whether amendments are required to reflect the changes (note that language providing that the enhanced benefits only apply during the National Emergency and PHE periods may not need to be amended).
4. Immediately communicate changes in group health plan benefits and deadlines for claims, and COBRA and HIPAA special enrollment resulting from the end of the PHE and National Emergency.
5. Review and update current COBRA notices to reflect the end of the Outbreak Period and work with your COBRA administrator to communicate with qualified beneficiaries regarding the end of extended deadlines to make coverage elections and pay premiums.

It is particularly important that plan sponsors provide notice to participants and beneficiaries of the upcoming changes. Generally, a modification to a group health plan impacting the contents of the summary of benefits and coverage (SBC) must be provided 60 days in advance of the effective date. Other material modifications must be disclosed no later than 60 days following execution of the amendment. However, the FAQs continuously emphasize the importance of advance notice and communication regarding these changes in

coverage due to the end of the National Emergency and PHE. Accordingly, plan sponsors should make every effort to provide adequate and sufficient advance notice of the group health plan changes affecting participants and beneficiaries as a result of the end of the PHE and National Emergency.