FAQS ABOUT FAMILIES FIRST CORONAVIRUS RESPONSE ACT, CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT, AND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT IMPLEMENTATION PART 58

March 29, 2023

Set out below are Frequently Asked Questions (FAQs) regarding implementation 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). These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments). These FAQs answer questions from stakeholders to help people understand the law and benefit from it, as intended. Previously issued FAQs are available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs#Affordable_Care_Act.

On January 31, 2020, HHS Secretary Alex M. Azar II declared that a nationwide public health emergency has existed since January 27, 2020, as a result of the 2019 novel coronavirus, the virus that causes coronavirus disease-2019 (COVID-19) (referred to in this document as the PHE).[1] This declaration was continually renewed, most recently by HHS Secretary Xavier Becerra, effective February 11, 2023.[2] On January 30 and February 9, 2023, respectively, the Biden-Harris Administration and Secretary Becerra announced that they intend to end the National Emergency Concerning the Novel Coronavirus Disease 2019 (COVID-19) Pandemic (COVID-19 National Emergency) and the PHE,[3] at the end of the day on May 11, 2023.[4]

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[1] See HHS Office of the Assistant Secretary for Preparedness and Response, Determination of the HHS Secretary that a Public Health Emergency Exists (Jan. 31, 2020), available at https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx.

[2] See HHS Office of the Assistant Secretary for Preparedness and Response, Renewal of Determination That A Public Health Emergency Exists (Feb. 9, 2023), available at https://aspr.hhs.gov/legal/PHE/Pages/COVID19-9Feb2023.aspx.

[3] On March 13, 2020, by Proclamation 9994, President Trump declared a national emergency concerning the COVID-19 pandemic beginning March 1, 2020. 85 FR 15337 (March 18, 2020). The national emergency has since been extended, with the last announcement of continuation made by President Biden on February 10, 2023. See The White House, Notice on the Continuation of the National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Pandemic (Feb. 10, 2023), available at https://www.whitehouse.gov/briefing-room/presidential-actions/2023/02/10/notice-on-the-continuation-of-the-national-emergency-concerning-the-coronavirus-disease-2019-covid-19-pandemic-3/.

[4] See Executive Office of the President, Office of Management and Budget, Statement of Administration Policy: H.R. 382 and H.J. Res. 7 (Jan. 30, 2023), available at https://www.whitehouse.gov/wp-content/uploads/2023/01/SAP-H.R.-382-H.J.-Res.-7.pdf; Letter to U.S. Governors from HHS Secretary Xavier

COVID-19 Diagnostic Testing

Section 6001 of the FFCRA, enacted on March 18, 2020,[5] generally requires group health plans and health insurance issuers offering group or individual health insurance coverage, including grandfathered health plans, to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 (the virus that causes COVID-19) or the diagnosis of COVID-19. This requirement applies to items or services furnished during any portion of the PHE beginning on or after March 18, 2020.[6] Plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization, or other medical management requirements.

Section 3201 of the CARES Act, enacted on March 27, 2020,[7] amended section 6001 of the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover without any cost-sharing requirements, prior authorization, or other medical management requirements.[8] Under section 3202(a) of the CARES Act, if a provider of diagnostic testing has a negotiated rate with a plan or issuer for COVID-19 diagnostic testing, the plan or issuer must reimburse the provider an amount that equals the negotiated rate. If the plan or issuer does not have a negotiated rate with such provider, the plan or issuer must reimburse the provider the cash price for the service that is listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the cash price.)

During the PHE, beginning on or after March 27, 2020, COVID-19 diagnostic test providers must make public the cash price of the diagnostic test on the provider's public internet website. This requirement is specified in section 3202(b) of the CARES Act and implementing regulations at 45 CFR Part 182.

Becerra on renewing COVID-19 Public Health Emergency (PHE) (Feb. 9, 2023), available at https://www.hhs.gov/about/news/2023/02/09/letter-us-governors-hhs-secretary-xavier-becerra-renewing-covid-19-public-health-emergency.html; Executive Office of the President, Notice on the Continuation of the National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Pandemic (Feb. 10, 2023), available at https://www.whitehouse.gov/briefing-room/presidential-actions/2023/02/10/notice-on-the-continuation-of-the-national-emergency-concerning-the-coronavirus-disease-2019-covid-19-pandemic-3/. See also HHS Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap (Feb. 9, 2023), available at https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html.

[5] Pub. L. No. 116-127 (2020).

[6] Section 6001 of the FFCRA applies to items and services furnished during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act beginning on or after the date of enactment of the FFCRA (March 18, 2020). Paragraph (1)(B) of section 1135(g) of the Social Security Act defines an emergency period as "a public health emergency declared by the Secretary [of HHS] pursuant to section 319 of the Public Health Service Act."

[7] Pub. L. No. 116-136 (2020).

[8] For purposes of this document, references to section 6001 of the FFCRA include the amendments made by section 3201 of the CARES Act, unless otherwise specified. Under section 6001(c) of the FFCRA, the Departments are authorized to implement the requirements of section 6001 of the FFCRA through sub-regulatory guidance, program instruction, or otherwise.

The Departments have issued multiple sets of FAQs to implement these provisions of the FFCRA and CARES Act and to address other health coverage issues related to COVID-19.[9] The Departments are issuing these FAQs to clarify how the COVID-19 coverage and payment requirements under the FFCRA and CARES Act will change when the PHE ends. Specifically, as discussed in more detail below, under section 6001 of the FFCRA and section 3202 of the CARES Act, plans and issuers are not required to provide coverage for items and services related to diagnostic testing for COVID-19 that are furnished after the end of the PHE, and if they provide such coverage, they may impose cost-sharing requirements, prior authorization, or other medical management requirements for such items and services.

These FAQs do not address other sources of authority that may also impact coverage of these items and services, including state, Tribal, local, and other Federal laws or the terms of applicable contracts.

Q1: Do the COVID-19 testing coverage requirements under section 6001 of the FFCRA apply to items and services furnished after the end of the PHE?

No. Section 6001 of the FFCRA requires plans and issuers to cover COVID-19 diagnostic tests that meet statutory requirements and certain associated items and services without imposing any cost-sharing requirements, prior authorization, or other medical management requirements. However, that requirement is applicable only to diagnostic tests and associated items and services furnished during any portion of the PHE beginning on or after March 18, 2020. Therefore, a plan or issuer is not required under section 6001 of the FFCRA to cover COVID-19 diagnostic tests and associated items or services furnished after the PHE ends.

[9] See FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42 (Apr. 11, 2020), available at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf and https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf (FAQs Part 42); FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43 (June 23, 2020), available at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf and https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf (FAQs Part 43); FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 44 (Feb. 26, 2021), available at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-44.pdf and https://www.cms.gov/files/document/faqs-part-44.pdf (FAQs Part 44); FAQs about Affordable Care Act Implementation Part 50, Health Insurance Portability and Accountability Act and Coronavirus Aid, Relief, and Economic Security Act Implementation (Oct. 4, 2021), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-50.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-50.pdf (FAQs Part 50); FAQs about Affordable Care Act Implementation Part 51, Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation (Jan. 10, 2022), available at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-51.pdf (FAQs Part 51); and FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 52 (Feb. 4, 2022), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-52.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-52.pdf (FAQs Part 52).

Any plan or issuer that provides coverage for COVID-19 diagnostic testing furnished after the PHE ends, including over-the-counter (OTC) COVID-19 diagnostic tests purchased after the PHE ends, is not prohibited from imposing cost-sharing requirements, prior authorization, or other medical management requirements for those items and services under section 6001 of the FFCRA. **However, plans and issuers are encouraged to continue to provide this coverage, without imposing cost sharing or medical management requirements, after the PHE ends.**[10]

In general, an item or service is furnished on the date the item or service was rendered to the individual (or for an OTC COVID-19 diagnostic test, the date the test was purchased) and not the date the claim is submitted. Plans and issuers should look to the earliest date on which an item or service is furnished within an episode of care to determine the date that a COVID-19 diagnostic test is rendered, when the test involves multiple items or services. For example, if a health care provider collects a specimen to perform a COVID-19 diagnostic test on the last day of the PHE but the laboratory analysis occurs on a later date, the plan or issuer should treat both the specimen collection and laboratory analysis as if they were furnished during the PHE and are therefore subject to the FFCRA and CARES Act requirements.

Q2: Must plans and issuers notify participants and enrollees if they change the terms of their coverage for the diagnosis or treatment of COVID-19 after the end of the PHE?

The Departments encourage plans and issuers to notify participants, beneficiaries, and enrollees of key information regarding coverage of COVID-19 diagnosis and treatment, including testing. This includes the date when the plan or issuer will stop coverage if the plan or issuer chooses to no longer cover COVID-19 diagnostic tests or when the plan or issuer will begin to impose cost-sharing requirements, prior authorization, or other medical management requirements on COVID-19 tests, to the extent applicable under the plan or coverage. **The Departments also encourage plans and issuers to continue covering benefits for COVID-19 diagnosis and treatment and for telehealth and remote care services after the end of the PHE.**

In addition, if a plan or issuer makes a material modification to any of the plan or coverage terms that would affect the content of the summary of benefits and coverage (SBC), that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to participants and enrollees not later than 60 days prior to the date on which the modification will become effective.[11]

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[10] In addition, note that FAQs Part 52, Q5 states that the cost of OTC COVID-19 tests purchased by an individual is a medical expense and therefore generally reimbursable by health flexible spending arrangements (health FSAs) and health reimbursement arrangements (HRAs), to the extent the cost is not paid or reimbursed by a plan or issuer. Additionally, expenses incurred for OTC COVID-19 tests that are not paid or reimbursed by a plan or issuer are qualified medical expenses under section 223(d)(2) of the Internal Revenue Code (Code) for purposes of health savings accounts (HSAs). See also Q8 below.

[11] PHS Act section 2715(d)(4); 26 CFR 54.9815-2715(b), 29 CFR 2590.715-2715(b) and 45 CFR147.200(b). PHS Act section 2715 is incorporated into Employee Retirement Income Security Act (ERISA) section 715 and Code section 9815. For this purpose, the term "material modification" is defined consistent with section 102 of ERISA. The notice of modification must be provided in a form that is consistent with the rules of 26 CFR 54.9815-2715(a)(4), 29 CFR 2590.715-2715(a)(4) and 45 CFR 147.200(a)(4).

Notwithstanding the above, 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.[12]

However, with respect to notices that were issued pursuant to the previous guidance, the Departments clarify that a notification provided with respect to a prior plan year will not be considered to satisfy the obligation to provide advance notice for coverage in the current plan year.

Q3: Do the reimbursement and cash price posting requirements under section 3202 of the CARES Act apply to COVID-19 diagnostic tests furnished after the end of the PHE?

No. Section 3202(a) of the CARES Act requires plans and issuers providing coverage for COVID-19 diagnostic tests under section 6001 of the FFCRA to reimburse any COVID-19 diagnostic test provider the cash price listed on the provider's website if a negotiated rate was not in effect before the PHE. This applies only to COVID-19 diagnostic tests furnished during the PHE beginning on or after March 27, 2020.

Similarly, section 3202(b) of the CARES Act, which requires COVID-19 diagnostic test providers to make public the cash price of a COVID-19 diagnostic test on the provider's public internet website, applies only during the PHE beginning on or after March 27, 2020.

However, providers of diagnostic tests for COVID-19 are encouraged to continue to make the cash price of a COVID-19 diagnostic test available on the provider's public internet website for a sufficient time period (e.g., at least 90 days) after the end of the PHE. This will help plans and issuers process claims for tests furnished prior to the end of the PHE in accordance with the cash price reimbursement requirements.[13]

[12] See FAQs Part 43, Q13, available at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf and https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf.
[13] See FAQs Part 43, Q11, which explains that section 3202(a) of the CARES Act is silent with respect to the amount to be reimbursed for COVID-19 testing in circumstances in which the provider has not made public the cash price for a test and the plan or issuer and the provider cannot agree upon a rate that the provider will accept as payment in full for the test.

Rapid Coverage of Preventive Services and Vaccines for Coronavirus

Section 3203 of the CARES Act requires non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage to cover, without cost-sharing requirements, any qualifying coronavirus preventive service pursuant to section 2713(a) of the Public Health Service Act (PHS Act) and its implementing regulations (or any successor regulations). Under the statute, the term "qualifying coronavirus preventive service" means an item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is:

- An evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); or
- An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved.

Coverage of a qualifying coronavirus preventive service must begin 15 business days after the date on which an applicable recommendation is made by USPSTF or ACIP.

On November 6, 2020, the Departments published in the Federal Register interim final rules implementing section 3203 of the CARES Act (November 2020 interim final rules).[14] The November 2020 interim final rules include the statutory definition of a qualifying coronavirus preventive service and clarify that the definition includes an immunization recommended by ACIP, regardless of whether it is recommended for routine use.[15] The November 2020 interim final rules also implement the 15-business-day requirement. The November 2020 interim final rules additionally require that a plan or issuer must cover a qualifying coronavirus preventive service without cost sharing regardless of whether it is provided by an in-network or out-of-network provider. If a plan or issuer does not have a negotiated rate for the service, the plan or issuer must reimburse the provider for the service in an amount that is reasonable, as determined in comparison to prevailing market rates for the service.

As set forth below, under section 3203 of the CARES Act, plans and issuers are required to provide coverage for COVID-19 vaccines and their administration after the end of the PHE. Although section 3203 of the CARES Act is not limited to the duration of the PHE, the November 2020 interim final rules include a sunset provision[16] under which certain regulatory provisions[17] will not apply to qualifying coronavirus preventive services furnished after the end of the PHE.

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[14] 85 FR 71142 (Nov. 6, 2020).

[15] On February 9, 2023, the CDC approved the 2023 child and adolescent and adult immunization schedules recommended by ACIP, including COVID-19 vaccines, which are available on the CDC immunization schedule website at https://www.cdc.gov/vaccines/schedules/. However, the CDC immunization schedules have referenced COVID-19 vaccines since ACIP recommended their use in December 2020.

[16] 26 CFR 54.9815-2713T(e); 29 CFR 2590.715-2713(e); 45 CFR 147.130(e).

[17] The interim final rules specify that paragraphs (a)(1)(v), (a)(3)(iii), and (b)(3) of 26 CFR 54.9815-2713T, 29 CFR 2590.715-2713, and 45 CFR 147.130 will not apply to a qualifying coronavirus preventive service furnished after the end of the PHE.

Q4: Do the statutory requirements related to rapid coverage of preventive services for coronavirus under section 3203 of the CARES Act apply to qualifying coronavirus preventive services furnished after the end of the PHE?

Yes. The statutory provisions will continue to apply. However, the regulatory requirements under the November 2020 interim final rules will not apply for qualifying coronavirus preventive services furnished after the end of the PHE.[18] Therefore, after the end of the PHE, plans and issuers subject to section 3203 of the CARES Act must continue to cover, without cost sharing, qualifying coronavirus preventive services, including, consistent with the applicable ACIP recommendation, all COVID-19 vaccines within the scope of the Emergency Use Authorization (EUA) or Biologics License Application (BLA) for the particular vaccine and their administration,[19] pursuant to section 2713(a) of the PHS Act and its implementing regulations. This coverage must be provided within 15 business days after the date on which an applicable recommendation is made by USPSTF or ACIP regarding the qualifying coronavirus preventive service.

After the end of the PHE and the sunset of the November 2020 interim final rules, nothing in the preventive services regulations requires a plan or issuer to provide benefits for qualifying coronavirus preventive services delivered by an out-of-network provider if the plan or issuer has a network of providers. Similarly, nothing precludes a plan or issuer that has a network of providers from imposing cost sharing for qualifying coronavirus preventive services delivered by an out-of-network provider. However, if a plan or issuer does not have a provider in its network who can provide a qualifying coronavirus preventive service, the plan or issuer must cover the item or service when furnished by an out-of-network provider and may not impose cost sharing with respect to the item or service.[20]

[18] The following provisions established through the November 2020 interim final rules that are not explicit in the statute will not apply to qualifying coronavirus preventive services furnished after the end of the PHE: (1) 26 CFR 54.9815-2713T(a)(1)(v), 29 CFR 2590.715-2713(a)(1)(v), and 45 CFR 147.130(a)(1)(v), which define a qualifying coronavirus preventive service to include an immunization that has in effect a recommendation from ACIP but is not recommended for routine use (however, note that as of the date of publication of this guidance, all COVID-19 vaccines authorized under an EUA or approved under a BLA by the Food and Drug Administration are recommended for routine use, and therefore, the coverage requirement remains effectively unchanged); and (2) 26 CFR 54.9815-2713T(a)(3)(iii), 29 CFR 2590.715-2713(a)(3)(iii), and 45 CFR 147.130(a)(3)(iii), which require a qualifying coronavirus preventive service to be covered without cost sharing when the item or service is furnished by an out-of-network provider; and, if the plan or issuer does not have a negotiated rate for the service, to reimburse the provider in an amount that is reasonable, as determined in comparison to prevailing market rates for the service).

[19] See FAQs Part 50, Q1, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-50.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-50.pdf.

[20] 26 CFR 54.9815-2713(a)(3); 29 CFR 2590.715-2713(a)(3); 45 CFR 147.130(a)(3).

Extension of Certain Timeframes for Employee Benefit Plans subject to ERISA and the Code, Participants, and Beneficiaries Affected by the COVID-19 Outbreak

On March 13, 2020, the COVID-19 National Emergency was declared, effective March 1, 2020.[21] On May 4, 2020, in response to the COVID-19 National Emergency, DOL, the Department of the Treasury (Treasury Department), and the Internal Revenue Service (IRS) issued the Joint Notification of Extensions of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak (Joint Notice) in the Federal Register.[22] The Joint Notice stated that certain time periods and dates for HIPAA special enrollment, COBRA continuation coverage, and internal claims and appeals and external review must be disregarded (disregarded periods) when determining the due dates for certain elections and other actions by employee benefit plans subject to ERISA and the Code, and participants and beneficiaries of these plans during the COVID-19 National Emergency.[23]

On February 26, 2021, DOL, with the concurrence of HHS, the Treasury Department, and the IRS, issued Employee Benefits Security Administration (EBSA) Disaster Relief Notice 2021-01 (EBSA Notice), which clarified that the disregarded periods apply from the date each individual or plan was first eligible for relief under the Joint Notice until the earlier of (a) 1 year from the date they were first eligible for relief, or (b) 60 days after the announced end of the COVID-19 National Emergency. On October 6, 2021, the IRS released Notice 2021-58,[24] which clarified that the disregarded period for an individual to elect COBRA continuation coverage and the disregarded period for the individual to make initial and subsequent COBRA premium payments generally run concurrently.

For the events or circumstances listed below, the relief generally continues until 60 days after the announced end of the COVID-19 National Emergency or another date announced by DOL, the Treasury Department, and the IRS (the "Outbreak Period"). However, as clarified in the EBSA Notice, ERISA[25] and the Code[26] limit the disregarded period for individual actions "required or permitted" by statute to a period of 1 year from the date the action would otherwise have been required or permitted.

Therefore, timeframes to complete elections or other actions subject to the Joint Notice, EBSA Notice, and Notice 2021-58 (together, the emergency relief notices) are extended until 1 year

[21] 85 FR 15337 (March 18, 2020).
[22] 85 FR 26351 (May 4, 2020).
[23] The Centers for Medicare & Medicaid Services (CMS) adopted a temporary policy of relaxed enforcement to extend similar timeframes otherwise applicable to non-Federal governmental group health plans, and their participants and beneficiaries, under applicable provisions of title XXVII of the PHS Act and encouraged sponsors of non-Federal governmental plans to provide relief to participants and beneficiaries similar to that specified by DOL, the Treasury Department, and the IRS. See Center for Consumer Information and Insurance Oversight, Insurance Standards Bulletin Series – INFORMATION, Temporary Period of Relaxed Enforcement of Certain Timeframes Related to Group Market Requirements under the Public Health Service Act in Response to the COVID-19 Outbreak (May 14, 2020), available at https://www.cms.gov/files/document/Temporary-Relaxed-Enforcement-Of-Group-Market-Timeframes.pdf.
[24] 2021-43 IRB 660.
[25] ERISA section 518.
[26] Code section 7508A(b).

from the date the participant, beneficiary, or plan was first eligible for relief or 60 days after the announced end of the COVID-19 National Emergency (i.e., 1 year after the date they were first eligible or the end date for the Outbreak Period), whichever is earlier. In no case will a disregarded period exceed 1 year. All disregarded periods will end as of the last day of the Outbreak Period.

The disregarded periods extend the following periods and dates:

(1) the 30-day period (or 60-day period, if applicable) to request special enrollment,[27]

(2) the 60-day election period for COBRA continuation coverage,[28]

(3) the date for making COBRA premium payments,[29]

(4) the date for individuals to notify the plan of a qualifying event or determination of disability,[30]

(5) the date within which individuals may file a benefit claim under the plan's claims procedure,[31]

(6) the date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure,[32]

(7) the date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination,[33]

(8) the date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete,[34] and

(9) the date for providing a COBRA election notice.[35]

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[27] ERISA section 701(f) and Code section 9801(f).
[28] ERISA section 605 and Code section 4980B(f)(5). The term ''election period'' is defined as ''…the period which—(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event, (B) is of at least 60 days' duration, and (C) ends not earlier than 60 days after the later of—(i) the date described in subparagraph (A), or (ii) in the case of any qualified beneficiary who receives notice under section 606(4) of this title, the date of such notice.'' ERISA section 605(a)(1). See also Code section 4980B(f)(5).
[29] ERISA section 602(2)(C) and (3) and Code section 4980B(f)(2)(B)(iii) and (C). Under this provision, the group health plan must treat the COBRA premium payments as timely paid if paid in accordance with the periods and dates set forth in this document. Regarding coverage during the election period and before an election is made, see 26 CFR 54.4980B-6, Q&A 3; during the period between the election and payment of the premium, see 26 CFR 54.4980B-8, Q&A 5(c).
[30] ERISA section 606(a)(3) and Code section 4980B(f)(6)(C).
[31] 29 CFR 2560.503-1.
[32] 29 CFR 2560.503-1(h).
[33] 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i).
[34] 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii).
[35] ERISA section 606(c) and Code section 4980B(f)(6)(D).

The anticipated end of the COVID-19 National Emergency is May 11, 2023. Consistent with previous guidance, DOL, the Treasury Department, and the IRS are also announcing that the disregarded periods under the emergency relief notices will end 60 days after the end of the COVID-19 National Emergency. DOL, the Treasury Department, and the IRS are issuing this FAQ to clarify how the requirements under the emergency relief notices related to disregarded periods for individual actions will change after the COVID-19 National Emergency ends.

Q5: Following the anticipated end of the COVID-19 National Emergency, on what date does the Outbreak Period end?

DOL, the Treasury Department, and the IRS anticipate that the Outbreak Period will end July 10, 2023 (60 days after the anticipated end of the COVID-19 National Emergency). As of the last day of the Outbreak Period, the extensions under the emergency relief notices for timeframes that began during the COVID-19 National Emergency no longer apply. The following examples show how these rules work. These examples assume that the Outbreak Period will end July 10, 2023, as anticipated, and that the group health plan is using the minimum timeframe that the statute permits for individuals to complete certain elections or other actions. **However, nothing in the Code or ERISA prevents a group health plan from allowing for longer timeframes for employees, participants, or beneficiaries to complete these actions, and group health plans are encouraged to do so.**

Example 1 (Electing COBRA)

Facts: Individual A works for Employer X and participates in Employer X's group health plan. Individual A experiences a qualifying event for COBRA purposes and loses coverage on April 1, 2023. Individual A is eligible to elect COBRA coverage under Employer X's plan and is provided a COBRA election notice on May 1, 2023.

What is the deadline for Individual A to elect COBRA?

Conclusion: The last day of Individual A's COBRA election period is 60 days after July 10, 2023 (the end of the Outbreak Period), which is September 8, 2023.

Example 2 (Electing COBRA)

Facts: Same facts as Example 1, except the qualifying event and loss of coverage occur on May 12, 2023, and Individual A is eligible to elect COBRA coverage under Employer X's plan and is provided a COBRA election notice on May 15, 2023.

What is the deadline for Individual A to elect COBRA?

Conclusion: Because the qualifying event occurred on May 12, 2023, after the end of the COVID-19 National Emergency but during the Outbreak Period, the extensions under the emergency relief notices still apply. The last day of Individual A's COBRA election period is 60 days after July 10, 2023 (the end of the Outbreak Period), which is September 8, 2023.

Example 3 (Electing COBRA)

Facts: Same facts as Example 1, except the qualifying event and loss of coverage occur on July 12, 2023, and Individual A is eligible to elect COBRA coverage under Employer X's plan and is provided a COBRA election notice on July 15, 2023.

What is the deadline for Individual A to elect COBRA?

Conclusion: Because the qualifying event occurred on July 12, 2023, after the end of both the COVID-19 National Emergency and the Outbreak Period, the extensions under the emergency relief notices do not apply. The last day of Individual A's COBRA election period is 60 days after July 15, 2023, which is September 13, 2023.

Example 4 (Paying COBRA Premiums)

Facts: Individual B participates in Employer Y's group health plan. Individual B has a qualifying event and receives a COBRA election notice on October 1, 2022. Individual B elects COBRA continuation coverage on October 15, 2022, retroactive to October 1, 2022.

When must Individual B make the initial COBRA premium payment and subsequent monthly COBRA premium payments?

Conclusion: Individual B has until 45 days after July 10, 2023 (the end of the Outbreak Period), which is August 24, 2023, to make the initial COBRA premium payment. The initial COBRA premium payment would include the monthly premium payments for October 2022 through July 2023. The premium payment for August 2023 must be paid by August 30, 2023 (the last day of the 30-day grace period for the August 2023 premium payment). Subsequent monthly COBRA premium payments would be due the first of each month, subject to a 30-day grace period.

Example 5 (Special Enrollment Period)

Facts: Individual C works for Employer Z. Individual C is eligible for Employer Z's group health plan, but previously declined participation. On April 1, 2023, Individual C gave birth and would like to enroll herself and the child in Employer Z's plan. However, open enrollment does not begin until November 15, 2023.

When may Individual C exercise her special enrollment rights?

Conclusion: Individual C and her child qualify for special enrollment in Employer Z's plan as early as the date of the child's birth, April 1, 2023. Individual C may exercise her special enrollment rights for herself and her child until 30 days after July 10, 2023 (the end of the Outbreak Period), which is August 9, 2023, as long as she pays the premiums for the period of coverage after the birth.

Example 6 (Special Enrollment Period)

Facts: Same facts as Example 5, except that Individual C gave birth on May 12, 2023.

When may Individual C exercise her special enrollment rights?

Conclusion: Individual C and her child qualify for special enrollment in Employer Z's plan as of the date of the child's birth, May 12, 2023. Because Individual C became eligible for special enrollment on May 12, 2023, after the end of the COVID-19 National Emergency but during the Outbreak Period, the extensions under the emergency relief notices still apply. Individual C may exercise her special enrollment rights for herself and her child until 30 days after July 10, 2023 (the end of the Outbreak Period), which is August 9, 2023, as long as she pays the premiums for the period of coverage after the birth.

Example 7 (Special Enrollment Period)

Facts: Same facts as Example 5, except that Individual C gave birth on July 12, 2023.

When may Individual C exercise her special enrollment rights?

Conclusion: Individual C and her child qualify for special enrollment in Employer Z's plan as of the date of the child's birth, July 12, 2023. Because Individual C became eligible for special enrollment on July 12, 2023, after the end of both the COVID-19 National Emergency and the Outbreak Period, the extensions under the emergency relief notices do not apply. Individual C may exercise her special enrollment rights for herself and her child until 30 days after July 12, 2023, which is August 11, 2023, as long as she pays the premiums for the period of coverage after the birth.

Special Enrollment in Group Health Plan and Group or Individual Health Insurance Coverage after Loss of Eligibility for Medicaid or Children's Health Insurance Program (CHIP) Coverage or after Becoming Eligible for Premium Assistance under Medicaid or CHIP

Group health plans and health insurance issuers providing group health insurance coverage are required to provide an opportunity to enroll under the terms of the plan (regardless of any open enrollment period) in certain circumstances (referred to as special enrollment). This opportunity must be provided to current employees and dependents who previously declined health coverage when it was offered due to having certain other types of coverage, and who then lose eligibility for that other coverage. Accordingly, a special enrollment period must be offered for circumstances in which an employee or their dependents lose eligibility for state Medicaid or CHIP coverage. A special enrollment period must also be offered when an employee or their dependents become eligible for state premium assistance under Medicaid or CHIP for group health plan coverage.[36]

[36] Code section 9801(f)(3); ERISA section 701(f)(3); PHS Act section 2704(f)(3).

In addition, health insurance issuers offering non-grandfathered individual health insurance coverage must provide a special enrollment period for individuals to enroll in individual health insurance through or outside the Health Insurance Marketplace®[37] or their state's Marketplace in certain circumstances, such as when an individual loses minimum essential coverage, including Medicaid or CHIP coverage.[38]

Since the onset of the PHE, with limited exceptions, 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). As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices and after the continuous enrollment condition ends on March 31, 2023, many consumers may no longer be eligible for Medicaid or CHIP coverage and will therefore need to transition to other coverage, such as coverage through a Marketplace[39] or coverage through an employer-sponsored group health plan. Nationwide, tens of millions of people will have their Medicaid or CHIP eligibility redetermined in the coming months.

The Departments are issuing the following FAQs to ensure that plans and issuers are aware of their obligation to provide special enrollment periods to impacted individuals who otherwise meet the applicable requirements and to encourage plans and issuers to make sure that impacted individuals are aware of opportunities to enroll into other forms of health coverage.

Q6: Following the expiration of the continuous enrollment condition, if an individual loses Medicaid or CHIP coverage due to a loss of eligibility for such coverage, is the individual entitled to a special enrollment period to enroll in an employer-sponsored group health plan for which they are otherwise eligible and had previously declined to enroll, or a special enrollment period in the individual market?

Yes. Employees and their dependents are eligible for special enrollment in a group health plan and group health insurance, if:

- they are otherwise eligible to enroll in the plan,
- the employee or dependent was enrolled in Medicaid or CHIP coverage, and
- the Medicaid or CHIP coverage was terminated as a result of loss of eligibility for that coverage.

Under these circumstances, the employee typically must request coverage under the group health plan (or health insurance coverage) within 60 days after termination of Medicaid or CHIP

[37] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.
[38] PHS Act section 2702(b); Affordable Care Act section 1311(c)(6); 45 CFR 147.104 and 155.420.
[39] Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition– Frequently Asked Questions (FAQ) (Jan. 27, 2023), available at https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf.

coverage. However, under the emergency relief notices issued by DOL, the Treasury Department, and the IRS, individuals who lose Medicaid or CHIP coverage from March 31, 2023 (the end of the continuous enrollment condition) until July 10, 2023 (the anticipated end of the Outbreak Period) are eligible for relief and can request special enrollment in a group health plan governed by ERISA and the Code until the date that is 60 days after the end of the Outbreak Period.[40] **Nothing in the Code or ERISA prevents a group health plan from allowing for a longer special enrollment period (i.e., a period that extends beyond the minimum 60-day statutory requirement) for employees, participants, or beneficiaries to complete these actions, and employers and group health plans are encouraged to do so.**

Additionally, individuals who lose Medicaid or CHIP coverage are eligible for a special enrollment period for coverage offered through the Health Insurance Marketplace® or their state's Marketplace, as well as for individual health insurance coverage outside the Marketplaces, within 60 days before or 60 days after the date of the loss of coverage.[41] In addition, on January 27, 2023, the Centers for Medicare & Medicaid Services (CMS) announced a special enrollment period in Marketplaces served by HealthCare.gov for qualified individuals and their families who lose Medicaid or CHIP coverage due to the end of the continuous enrollment condition, also known as "unwinding."[42] CMS will update HealthCare.gov so that Marketplace-eligible consumers who submit a new application or update an existing application between March 31, 2023, and July 31, 2024, and attest to a last date of Medicaid or CHIP coverage within the same time period, are eligible for an "Unwinding SEP." Consumers who are eligible for the Unwinding SEP will have 60 days from the date they submit or update their application to select a Marketplace plan with coverage that starts the first day of the month after they select a plan.[43] For example, if an individual selects a plan on August 15, Marketplace coverage will start on September 1.

Information on Marketplace coverage is available at HealthCare.gov or by calling 1-800-318-2596 (TTY: 1-855-889-4325). Individuals who do not reside in a state with a Marketplace that uses the HealthCare.gov platform can learn more about their state's Marketplace at www.healthcare.gov/marketplace-in-your-state, including whether their state's Marketplace will offer a similar Unwinding SEP and any next steps to enroll.

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[40] See 85 FR 26351 (May 4, 2020); EBSA Disaster Relief Notice 2021- 01: Guidance on Continuation of Relief for Employee Benefit Plans and Plan Participants and Beneficiaries Due to the COVID-19 (Novel Coronavirus) Outbreak, available at https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2021-01.pdf; IRS Notice 2021-58, available at https://www.irs.gov/pub/irs-drop/n-21-58.pdf and Q4 above.

[41] 45 CFR 147.104(b)(2) and 155.420(d)(1).

[42] Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition– Frequently Asked Questions (FAQ) (Jan. 27, 2023), available at https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf.

[43] After July 31, 2024, consumers who were unable to enroll in Marketplace coverage because they did not receive a timely notice of termination of Medicaid or CHIP coverage may contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) to request an SEP, which will be granted on a case-by-case basis.

Q7: What else can employers, particularly those that employ workers who are likely benefiting from Medicaid or CHIP coverage, do to assist their employees in maintaining health coverage?

Employers can play an important role in helping their employees maintain health coverage. As noted above, they can work with their plan or issuer to extend the special enrollment period beyond the minimum 60 days required by statute. In addition to the special enrollment opportunities required by statute, the Departments encourage plans and issuers to offer a special enrollment opportunity that matches the Unwinding SEP discussed above.

Additionally, employers are encouraged to ensure that their benefits staff are aware of the upcoming resumption of Medicaid and CHIP eligibility determinations. Employers can also encourage their employees who are enrolled in Medicaid or CHIP coverage to update their contact information with the state Medicaid or CHIP agency. They may also encourage employees to respond promptly to any communication from the state.

Benefits for COVID-19 Testing and Treatment and Health Savings Accounts (HSAs)/High Deductible Health Plans (HDHPs)

In March 2020, the Treasury Department and the IRS issued Notice 2020-15,[44] which provides that a health plan that otherwise satisfies the requirements to be an HDHP under section 223(c)(2)(A) of the Code will not fail to be an HDHP merely because the health plan provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible. As a result, the individuals covered by such a plan will not fail to be eligible individuals under section 223(c)(1) of the Code who may contribute to an HSA merely because of the provision of those health benefits for testing and treatment of COVID-19.

Notice 2020-15 was issued due to the PHE. The notice states that the relief provided would continue until further guidance is issued. The notice further states that it does not modify previous guidance with respect to any of the HDHP requirements, other than with respect to the relief for testing for and treatment of COVID-19. The notice also reiterates that vaccinations continue to be considered preventive care under section 223(c)(2)(C) of the Code for purposes of determining whether a health plan is an HDHP. No further guidance regarding the treatment of an HDHP providing testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible has been issued.

Q8. May an individual covered by an HDHP that provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible contribute to an HSA?

Yes. An individual covered by an HDHP that provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible may continue to contribute to an HSA until further guidance is

[44] 2020-14 IRB 559.

issued. The Treasury Department and the IRS are reviewing the appropriateness of continuing this relief given the anticipated end of the PHE and COVID-19 National Emergency and anticipate issuing additional guidance in the near future. Any future modifications to the guidance previously provided in Notice 2020-15 will not generally require HDHPs to make changes in the middle of a plan year in order for covered individuals to remain eligible to contribute to an HSA.