What Does the End of the COVID-19 Public Health Emergency Mean for Health Benefits?

Filed in Wages and Benefits, Health and Retirement Benefits, Safety and Health, Coronavirus resources • **By: Lisa M. Gomez** • March 29, 2023

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Over three years have passed since the start of the COVID-19 public health emergency in January of 2020. We have come a long way from the time of businesses being closed and mandatory quarantine periods. While we faced one of the most challenging times for our country, we also were able to show our resilience by working together to respond to – and overcome – these trying times. We've opened our businesses back up and brought employees back to the office. We've worked together to control the spread of COVID-19 by making testing and vaccines widely available. It is clear that this hard work has paid off as we look towards the end of the public health emergency. While we've accomplished a lot, there is still more to do. It is imperative that we continue to work together to ensure a safe and informed transition out of the public health emergency. And while we are unwinding some of the policies that were in place during the public health emergency, it is important to make sure that this unwinding is done in a manner that protects the individuals in your health plan.

So, what should employers and other plan sponsors do as we approach the end of the COVID-19 public health emergency and national emergency?

To start, we all understand that the end of the COVID-19 public health emergency means that many employers and other plan sponsors are evaluating what changes to make to their health benefits. For example, plans will no longer

be required to cover some 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 and payment, and claims and appeals deadlines, may soon lapse.

In thinking about changes to benefits after the end of the COVID-19 public health emergency and national emergency and the reinstatement of normal timeframes to make key decisions related to health coverage, I urge employers and other plan sponsors to keep in mind the best interests of their workers and their families, who rely on their health benefits for their physical and mental wellbeing. It is critical to communicate with your participants as we enter the next chapter of the COVID-19 experience. What health benefits are changing? When? Can they still receive free COVID-19 tests? If not, what will the new benefits be? What are the new deadlines by which participants and their families need to make key health decisions? These are all important questions for workers and their families. We need to work together to ensure that individuals in your health plan are informed about changes to their benefits and continue to have access to COVID-19 testing, vaccines, and treatment, when at all possible.

In addition, as further explained below, some of your employees and their family members may not have enrolled in your health plan because they were eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage and may be losing that eligibility. Because of this, they may have special enrollment opportunities to participate in their employment-based health coverage. We need your partnership to help make sure individuals are informed during that transitional period.

Together with our colleagues at the Departments of Health and Human Services and the Treasury, we have issued a new set of FAQs that address the health plan-related changes to requirements that relate to the end of the COVID-19 public health emergency.

Here are a few things that employers and other plan sponsors should keep in mind:

- After the end of the COVID-19 public health emergency, group health plans will no longer be required to cover COVID-19 diagnostic testing (including over-the-counter tests) at no cost to individuals. Plans are encouraged to continue to cover these tests without out-of-pocket costs, as testing is still a critical component to reducing the spread of COVID-19. If plans are making changes to coverage for COVID-19 tests (or other benefits), be sure to communicate those changes, including any key limitations, to individuals in advance of those changes taking effect.
- While many plans must continue to cover COVID-19 vaccines at no cost to employees from an in-network provider, the requirement to cover COVID-19 vaccines out-of-network will generally lapse after the end of the COVID-19 public health 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.
- The end of the COVID-19 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 emergenc Several timeframes were extended for many plans to give individuals more time to take action such as requesting special enrollment to join their employment-based health plan, electing COBRA continuation coverage and paying COBRA premiums, and submitting health plan claims and appeals. Employers should consider making reasonable accommodations to existing timeframes by amending the deadlines in their plans to minimize the possibility of individuals losing their benefits because of a failure to comply with one of these deadlines. Plans need to communicate key deadlines to impacted individuals in advance.
- 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. Many states are beginning to unwind this "continuous enrollment" and resume eligibility determinations for Medicaid coverage. These determinations may result in some of your employees or their dependents losing coverage. Employers and plans are encouraged to make sure that employees who may be impacted are aware of their special enrollment right to enroll into the group health plan. Employers are also encouraged to amend their plans to provide additional time for individuals to exercise their special enrollment rights, to help ensure that these individuals can maintain health coverage. We've also developed a flyer that you can use to provide employees with information about these options.

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Our agency is committed to working with employers, plan sponsors, participants, and other stakeholders to ensure a safe transition from the COVID-19 public health emergency. More specific information about the changing requirements is available in DOL's Employee Benefits Security Administration's Frequently Asked Questions. Any individual, employer, or other plan sponsor with questions about the end of the COVID-19 public health emergency can contact EBSA for assistance at askebsa.dol.gov or 1-866-444-3272.

Tags: Employee Benefits Security Administration, COVID-19, pandemic, health care, health benefits

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