

**NEA Informational Bulletin: Possible
Health Care Implications of the COVID
National and Public Health Emergency
Unwinding**

February 2023

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ANNOUNCEMENT OF THE UNWINDING OF THE COVID NATIONAL AND PUBLIC HEALTH EMERGENCY (PHE)

The White House released a [Statement of Administration Policy](#) on January 30, 2023 announcing the intent to end the COVID national and public health emergencies (PHE) on May 11, 2023. On February 10, 2023, the Department of Health and Human Services (HHS) released a COVID [Public Health Emergency Transition Roadmap](#). HHS also updated and sent a [letter](#) to all State Health Officials on January 27, 2023 and a [letter](#) to Governors on February 9, 2023.

BACKGROUND OF THE COVID PHE

Pursuant to the *Public Health Service Act*, the public health emergency was declared by HHS in January 2020. The national emergency declaration was issued in March 2020 pursuant to the *National Emergencies Act*. Together, the public health emergency and the national emergency declarations will be referred to as “PHE” throughout. While set to expire on March 1 and April 11, respectively, the Administration extended the declarations until May 11, 2023 when at that time, the PHE will end.

The announcement by Secretary Xavier Becerra marks the 13th renewal of the PHE since the pandemic began in 2020. Each PHE declaration lasted 90 days before expiring or getting renewed. While it is not required by law or department rules, Secretary Becerra had committed to give state governments and health care stakeholders a 60-day notice before the PHE expired. This wind-down of the PHE aligns with that commitment and gives more than 60 days’ notice prior to termination of the PHE. The PHE declarations gave the federal government the ability to waive or modify certain requirements in programs, such as Medicare, Medicaid, CHIP, and in private health insurance.

BACKGROUND OF THE EMERGENCY USE AUTHORIZATION AND DECLARATION UNDER THE PUBLIC READINESS AND EMERGENCY PREPAREDNESS (PREP) ACT

In addition to the public health emergency initially declared in January 2020 and the national emergency declared in March 2020, HHS has issued two other emergency declarations that provide broader access to medical measures for COVID.

Emergency Use Authorization

Pursuant to the *Federal Food, Drug, and Cosmetic (FD&C) Act*, HHS issued an emergency declaration in February 2020, which granted emergency use authorization of medical countermeasures for COVID and allowed the use of medical countermeasures that are determined to be safe and effective but not have been formally approved. The emergency use authorization particularly addresses tests, vaccines, and treatments under the Food and Drug Administration (FDA). The result of this declaration is that existing emergency use authorizations for COVID vaccines, tests or treatments likely will not be affected, and the agency may continue to issue emergency use authorizations. The Administration has stated, “[i]mportantly, the ending of the public health emergency declared by HHS under the *Public Health Service Act* will not impact FDA’s ability to authorize devices (including tests), treatments or vaccines for emergency use. Existing emergency use authorizations (EUAs) for products will remain in effect and the agency may continue to issue new EUAs going forward when criteria for issuance are met.” For more information on the emergency use authorization process for vaccines and frequently asked questions, FDA initially released the following explanation [here](#). This emergency declaration remains in effect until termination by the Secretary of HHS, and as such will not conclude on May 11, 2023 with the other PHE declarations. A date has not been announced at this time.

Declaration under the Public Readiness and Emergency Preparedness (PREP) Act

Pursuant to the *Public Readiness and Emergency Preparedness (PREP) Act*, HHS also issued another declaration that provides liability immunity to pharmacists who administer COVID vaccines to children and to health care providers who vaccinate people in states outside of the state in which they are licensed. More information regarding the declaration under the PREP Act can be found in the federal register [here](#). This emergency declaration remains in effect until termination by the Secretary of HHS, and as such will not conclude on May 11, 2023 with the PHE declarations. This declaration is set to expire by HHS on October 1, 2024.

WHAT THE UNWINDING OF THE PHE DOES NOT IMPACT

In addition to the aforementioned policies governed by the emergency use authorization and declaration under the PREP Act, Congress also addressed additional policies within legislation that will not be impacted by the PHE unwinding. Congress enacted legislation that provided additional flexibilities including the *Families First Coronavirus Response Act (FFCRA)*, *Coronavirus Aid, Relief and Economic Security (CARES) Act*, *American Rescue Plan Act (ARPA)*, *Inflation Reduction Act (IRA)*, and *Consolidated Appropriations Act, 2023 (Omnibus)*.

Regarding the Omnibus, Congress passed and the President signed into law the *Consolidated Appropriations Act of 2023 (HR 2617)* or often referred to as the “Omnibus.” The Omnibus funds the government through September 30, 2023. The full text of the legislation can be accessed [here](#). For a NEA summary of key health care and education takeaways in the Omnibus, please contact cblankenship@nea.org.

In summary, while the Omnibus does not address the end date of the COVID PHE, it does address many health policies including:

- end of the continuous Medicaid enrollment;
- gradual phase-down of the temporary Federal Medical Assistance Percentage (FMAP) increase;
- required unwinding process for states;
- extension of the Medicare telehealth access;
- extension of the high-deductible health plan telehealth flexibilities;
- expansion of hospital-at-home care; and
- uncoupling of the Supplemental Nutrition Assistance Program emergency benefits from the PHE.

Specifically, the Omnibus impacts health care policies, including but not limited to, the following:

- **Extends Medicare’s Expanded Access to Telehealth.** For Medicare beneficiaries, the Omnibus extends COVID telehealth flexibilities for an additional two years, through December 31, 2024. The Omnibus eases Medicare rules allowing expanded access to telehealth, which HHS created and Congress codified in the *CARES Act*, and that would have expired five (5) months after the end of the PHE. The Omnibus effort to extend such provisions until December 31, 2024 comes after thirty-four (34) Representatives and Senators sent a [letter](#), led by Senator Brian Schatz (D-HI) and Representative Mike Thompson (D-CA), asking Senate and House leaders to continue rules that made it easier for Medicare patients to have virtual visits. The Omnibus extends Medicare telehealth flexibilities such as: waiving the geographic restrictions and originating site requirements (Sec. 4113(a)); expanding the list of practitioners eligible to furnish telehealth services (Sec. 4113(b)); allowing telehealth services for Rural Health Clinics and Federally Qualified Health Centers (Sec. 4113(c)); delaying the in-person visit requirement before a patient receives mental health services furnished through telehealth and telecommunications (Sec.

4113(d)); allowing for telehealth services through audio-only telecommunications (Sec. 4113(e)); and allowing for telehealth to be used for a required face-to-face encounter prior to the recertification of a patient's eligibility for hospice care (Sec. 4113(f)).

- **Extends High Deductible Health Plans (HDHPs) Telehealth Flexibilities.** The Omnibus allows HDHPs to offer subscribers telehealth appointments before they've hit their deductibles through 2024. Congress first allowed HDHPs to pay for virtual visits in the March 2020 *CARES Act*. This benefit expired at the end of 2021 before Congress passed another extension in March where the benefit would have expired on December 31, 2022. The Omnibus provides HDHP participants coverage for telehealth services without requiring them to first meet the minimum required deductible and allows HDHP beneficiaries to contribute to their HSAs. Therefore, for HDHPs with plan years beginning after December 31, 2022, and before January 1, 2025, the Omnibus extends the safe harbor and allows HDHPs to continue to cover telehealth services on a first-dollar basis without disqualifying HDHP participants from making HSA contributions.
- **Uncouples the Supplemental Nutrition Assistance Program (SNAP) Emergency Benefits from the PHE.** The increase in SNAP benefits will now end nationwide on March 1, 2023. Additional information can be found on the Department of Agriculture's [website](#). After almost three years, the amount of aid provided to low-income families to combat food insecurity through the SNAP will return to pre-pandemic levels. According to USDA [data](#), more than 41 million Americans used SNAP benefits in 2022. The emergency allotments allowed SNAP households to receive an additional \$95 or more in monthly benefits. The emergency allotments have already ended in 18 states, including Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Mississippi, Missouri, Montana, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, and Wyoming. For the remaining 32 states, plus Washington, D.C., Guam and the U.S. Virgin Islands, the extra funding will end with the March benefit. CMS has developed several SNAP resources including [a Back to School Media Toolkit that can be accessed here](#); changes to SNAP benefit amounts for 2023 that can be accessed [here](#); SNAP State Directory of Resources that can be accessed [here](#); and WIC program resource that can be accessed [here](#).
- **Uncouples the Medicaid Disenrollment from the PHE.** During the PHE, the Medicaid program has operated under flexibilities to provide increased funding to states to ensure that individuals kept their Medicaid coverage during the pandemic. The Omnibus addresses both the disenrollment of Medicaid beneficiaries as well as the increased funding to states.

Federal Medical Assistance Percentage (FMAP) Funding

The Omnibus addressed the increased funding to states by reducing the impact of the loss of federal funding tied to the end of the PHE. This federal funding, referred to as FMAP, is used to determine federal and state contribution amounts in Medicaid and an enhanced FMAP under the PHE meant that the federal government paid a larger percentage toward programs such as foster care, adoptions, guardianships, etc. The percentage varies by state. With the PHE expected to end in April 2023, the 6.2 percentage point increase in federal matching Medicaid funds provided by the *Families First Coronavirus Response Act* (FFCRA) was set to end swiftly at the end of June 2023. However, the Omnibus created a gradual phase-down of the increased federal funding: from April to June of 2023, states will receive a 5 percentage point FMAP increase; from June to September 2023, states receive a 2.5 percentage point FMAP increase; and from October to December 2023, states receive a 1.5 percentage point FMAP increase. The gradual phase-down of federal funding has conditions. States cannot restrict eligibility standards, methodologies, and procedures and states cannot increase premiums as required in the FFCRA. States must also

comply with federal rules about conducting renewals. States are required to maintain up-to-date contact information and attempt to contact enrollees prior to disenrollment.

End of Continuous Coverage for Medicaid Beneficiaries

In addition to addressing the FMAP funding, the Omnibus also addressed the continuous enrollment of Medicaid beneficiaries. Outside of a PHE declaration, generally states are allowed to determine whether a beneficiary remains eligible for Medicaid at least once a year and remove anyone who no longer qualifies. In the first year of the COVID pandemic, the federal government provided an extra 6.2 percentage points in FMAP funding in exchange for allowing continuous enrollment by pausing the annual review of eligibility for most Medicaid beneficiaries for as long as the PHE declaration remained in place. Under this flexibility during the PHE, enrollment in Medicaid and the Children's Health Insurance Program (CHIP) grew by almost 30 percent and, as of September 2022, nearly 91 million individuals were enrolled across the programs. The Omnibus allows states to begin reevaluating who is still eligible for Medicaid beginning April 1, 2023 with requirements as to how states can do so, such as requiring states to attempt to contact beneficiaries before they are disenrolled from the program. In order to provide guidance on the unwinding process, the Centers for Medicare and Medicaid Services (CMS) released an [Informational Bulletin](#) on key dates of the Medicaid disenrollment.

State's Timeline. Beginning on April 1, states claiming the temporary FMAP will be able to end Medicaid or CHIP enrollment for individuals, following a review of their eligibility. As explained in a CMS letter to State Health Officials, states may begin disenrollment as early as February 1, 2023. Eligibility and renewal systems, staffing capacity, and investment in end-of-PHE preparedness vary across states. Also, in its [Communications Toolkit for Continuous Enrollment Unwinding](#), CMS identifies **schools**, health care providers and clinics, local health departments, community-based organizations, and places of worship as effective avenues for outreach.

State's Process. Pursuant to this timeline, states must initiate eligibility renewals for the state's entire Medicaid and CHIP population within twelve (12) months and complete renewals within fourteen (14) months. States can begin this process in February, March, or April but may not terminate eligibility for most individuals in Medicaid prior to April 1, 2023. States have four (4) months to resume timely processing of all applications, including those received after April 1, 2023. Not all states have the same renewal process – some take sixty (60) days, some take ninety (90) days, etc. As such, February 1, 2023 was the first day in which states could initiate renewals for April terminations. On March 31, 2023, the continuous enrollment conditions expire and on April 1, 2023, the termination can begin. States must begin the renewal process by first attempting to predetermine eligibility based on reliable information available to the agency without requiring information from the individuals. If the information is sufficient, the state can renew and send notice of such renewal. If the information is insufficient, the state will send a renewal form. Individuals have thirty (30) days to complete and return with documentation. If the individual is determined to be ineligible for Medicaid, the state must determine if they are eligible for other programs and transfer their information to those programs.

State's Challenges. The challenges ahead for states include the large volume of renewals impacted by the increase in Medicaid beneficiaries. States are also facing workforce challenges and staffing shortages in state Medicaid and CHIP agencies. In addition, a long amount of time has passed since many enrollees have had to complete paperwork or they may be new to Medicaid during this time and never went through his process. In addition, the agency has warned of outdated mailing addresses and other contact information. It is essential that Medicaid beneficiaries update their contact information NOW to ensure they receive all communications.

Other Health Care Coverage Options for Individuals who are Disenrolled from Medicaid.

Individuals that are disenrolled from Medicaid, may be eligible under the qualifications of the CHIP or Medicare programs. In addition to options of coverage under CHIP or Medicare, individuals can obtain coverage through the *Affordable Care Act* Marketplace Exchange (Exchange). To obtain the NEA Resource on the ACA Marketplace Exchange, please contact cblankenship@nea.org.

Special Enrollments for the Exchange. For individuals that qualify for Medicare, CMS released information on a Special Enrollment Period for consumers losing Medicaid and CHIP coverage but eligible for Medicare. For example, if the consumer turned 65 during the PHE but did not sign up for Medicare at that time, that consumer will have a Special Enrollment Period to apply for Medicare once their Medicaid coverage is terminated. Resources can be accessed [here](#). A fact sheet on the final rule can be accessed [here](#). The final rule can be accessed [here](#). In addition, HHS released an announcement that it will open a Special Enrollment Period for the Exchange to individuals who lose their coverage under Medicaid or CHIP due to the end of the PHE. This open enrollment period will allow these individuals to apply for coverage through the Exchange outside of the annual open enrollment period. 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 Special Enrollment Period (SEP). Consumers who are eligible for the Unwinding SEP will have sixty (60) days after they submit their application to select a plan within the Exchange. Coverage starts the first day of the month after they select a plan. After July 31, 2024, consumers who were unable to enroll in Exchange coverage due to the fact that 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 to request an SEP, which will be granted on a case-by-case basis. It is important to note that consumers do not have to wait for their Medicaid or CHIP coverage to end before submitting an application for Exchange coverage. Per regulation, consumers losing minimum essential coverage, which includes Medicaid or CHIP, can report that loss of coverage up to sixty (60) days prior to their last day of coverage. It is also worth noting that a majority of the states, thirty-three (33) in total, use healthcare.gov as their insurance marketplace. The seventeen (17) states that run their own marketplaces can implement a Special Enrollment Period but are not required to do so. For states that have State-Based Marketplaces, resources can be found [here](#) and [here](#).

Exchange Costs for Coverage. Even if an individual has looked at the costs of plans previously in the Exchange, those costs have drastically decreased due to subsidies within the *Inflation Reduction Act*. As such, reports now indicate that due to the subsidies within the IRA, for 2023, four (4) out of five (5) beneficiaries who sought coverage in the Exchange received such coverage at ten (\$10) dollars or less. In addition, for families, the “Family Glitch” has long prevented families from obtaining the same subsidies within the Exchange. **That has changed.** The Department of the Treasury announced a final rule that addresses the *Affordable Care Act* “Family Glitch.” In the final rule, the Department amended the regulations for premium tax credits meant to reduce the cost of coverage for plans on the Health Insurance Marketplace and expanded eligibility for ACA tax credits for people whose employer-sponsored insurance is unaffordable (roughly 10 percent of household income in 2023). As such, the final rule allows family members of workers to now qualify for premium tax credits if the family coverage exceeds the threshold. The final rule is expected to assist nearly one (1) million people in gaining coverage or seeing insurance costs decrease.

Assistance for the Exchange. For assistance in the Exchange, Marketplace Assisters are certified community partners. They conduct outreach and education to raise awareness about the Exchange

and other coverage options and provide free and impartial enrollment assistance. For Exchange assistance, an individual can connect with Assisters, Navigators, and Certified Application Counselor Designated Organizations (CDOs). All of these individuals can be found through the CMS find local help tool by searching zip code at <https://www.healthcare.gov/find-assistance/>.

WHAT THE UNWINDING OF THE PHE IMPACTS

The unwinding of the PHE will occur on May 11, 2023, and the flexibilities granted by the PHE touched on almost all aspects of the U.S. health care system. The PHE ensured policies like expanded Medicaid benefits, telehealth coverage, and extra payments to hospitals and doctors. **Please note that due to the ambiguity surrounding some of the coverage of COVID benefits following the ending of the PHE and the uncertainty of the out-of-pocket costs of obtaining such benefits, an Association can bargain for COVID benefits coverage to decrease any out-of-pocket expenses for the employee and remove any ambiguity.** Below includes some, but not all, of the health care programs that might be impacted by the unwinding of the PHE.

COVID TESTS

Most beneficiaries with coverage by Medicare, Medicaid, and private insurance plans have been able to obtain COVID tests and vaccines at no cost during the pandemic. Those covered by Medicare and private insurance have been able to receive up to eight (8) at-home tests per covered individual per month with no charge and without a prescription. Medicaid also paid the cost of at-home tests, though coverage can vary by state.

- **COVID Tests for Schools.** The Administration has stated that it plans to provide COVID tests to schools dependent on supply and resources.
- **Medicare Beneficiaries.** Generally, beneficiaries in Medicare, Medicaid, and CHIP could face more cost-sharing for tests. Coverage for tests could expire with the end of the PHE while coverage and costs for oral antivirals would continue. Once the PHE ends, Medicare beneficiaries generally will face out-of-pocket costs for at-home testing. Medicare beneficiaries who are enrolled in Medicare Part B will continue to have coverage without cost sharing for laboratory-conducted COVID tests only when ordered by a provider. It is worth noting that recently more than twenty (20) Members of Congress sent a letter to CMS asking the agency to continue coverage of at-home COVID tests for Medicare beneficiaries after the PHE ends. The Members of Congress asked for more information about the agency's authority to continue the program beyond the PHE.
- **Medicaid and CHIP Beneficiaries.** Medicaid and CHIP beneficiaries will have continued coverage of COVID tests ordered by a physician and vaccines at no charge but could experience the end of this coverage for COVID tests after the last day of the first calendar quarter that begins one year after the end of the PHE. With the PHE ending on May 11, 2023, the mandatory Medicaid coverage will end September 30, 2024 and coverage after will vary by state.
- **Private Insurance Beneficiaries.** For group health plan sponsors, the PHE determined the period during which group health plans and insurers are required to pay for COVID tests (laboratory tests as well as certain over-the-counter tests) and related services without charging cost sharing. For beneficiaries covered by private insurance, once the PHE ends, private insurance may not cover the full price of over-the-counter tests, and patients may need a prescription first for a PCR test. The requirement that group health plans and individual health insurance, including grandfathered plans, reimburse out-of-network providers for tests and related services will end.

- **Reporting Lab Results of COVID Tests.** The requirement for labs to report the results of the test will end when the PHE expires. At the end of the PHE, HHS will no longer have express authority to require this data from labs. However, the Centers for Disease Control and Prevention has stated that it is working to sign voluntary Data Use Agreements, which encourage states and jurisdictions to continue sharing vaccine administration data beyond the PHE.

COVID VACCINES AND TREATMENTS

Generally, COVID vaccines will still be considered preventive care and covered without cost-sharing by most health plans, Medicare, and Medicaid.

- **Government Supply.** Similar to tests, vaccines and treatments will also likely remain free, so long as the government supply lasts. According to the White House COVID Response Coordinator, “[o]n May 12, you can still walk into a pharmacy and get your bivalent vaccine for free. On May 12, if you get COVID, you can still get your Paxlovid for free. None of that changes.” However, once the federal supply of vaccines and treatments is exhausted, individuals and/or their insurance/coverage may be responsible for the costs. The agency has stated that the transition to traditional market will likely occur in late Summer or early Fall, but is dependent on many factors, including, but not limited to: the amount of supply; the utilization rate of the supply (trajectory of disease); and manufacturer readiness to distribute the vaccine.
- **Medicare Beneficiaries.** Generally, beneficiaries of Medicare, Medicaid and CHIP could face more cost-sharing for tests and some COVID antivirals, though vaccines will likely remain free. After the PHE ends, Medicare beneficiaries may face out-of-pocket costs for at-home testing and treatments. However, vaccines will likely continue to be covered at no cost, as will testing ordered by a health care provider. Pursuant to the *Inflation Reduction Act*, for Medicare Part D beneficiaries, beginning in 2023, cost sharing for vaccines recommended by the Advisory Committee on Immunization Practices will be \$0. This is expected to benefit 4.1 million. Under Medicare Part B, currently COVID vaccinations are covered without cost sharing and this will continue.
- **Medicaid Beneficiaries.** For Medicaid beneficiaries, Medicaid will have to continue covering COVID tests ordered by a physician. Medicaid will also continue to cover all COVID vaccinations without a copay or cost sharing through September 30, 2024, and will then cover all vaccines recommended by the Advisory Committee on Immunization Practices for most beneficiaries thereafter. However, Medicaid enrollees may face out-of-pocket costs for treatments. Medicaid will continue to cover COVID treatments without cost sharing through September 30, 2024, but thereafter, coverage and cost sharing will vary by state.
- **Private Insurance Beneficiaries.** During the PHE, plans and issuers were required to cover COVID vaccines without cost sharing even when the vaccine was provided by an out-of-network provider. The requirement to cover out-of-network providers will end at the end of the PHE. However, pursuant to the *Affordable Care Act*, non-grandfathered plans must cover vaccines and may limit this coverage to in-network providers. As such, for non-grandfathered plans, the COVID vaccinations by an in-network provider will likely remain free for those with insurance even when the PHE ends.

While most in-network vaccinations will likely continue to be covered for individuals with private insurance, those on private insurance may have to pay for treatment once the federal

supply of monoclonal antibody treatments runs out. Beneficiaries with private insurance generally have not been charged for monoclonal antibody treatment while covered by the federal government while patients may have been charged for the office visit or administration of the treatment. These free treatments for beneficiaries with private insurance will likely be available until the federal supply is exhausted. It is worth noting that some of the treatments have already been exhausted and in those instances, private insurance may be covering the costs.

It is also worth noting that even in instances where vaccines remain free to beneficiaries with private insurance, costs could be reflected in premiums. Where insurers cover the costs of preventive care, such as vaccines, insurers have charged deductibles or require cost-sharing for drugs. In addition, even with private insurance, beneficiaries could see costs if they use an out-of-network provider. Furthermore, in the future, treatments, such as Paxlovid, may also see cost-sharing for beneficiaries who have coverage under private insurance.

- **Uninsured Individuals.** Uninsured individuals will have no guaranteed access to tests or treatments, but the Administration has indicated that a future plan to address uninsured individuals might be in the works.

HOSPITAL AND NURSING HOME FLEXIBILITIES

The unwinding of the PHE may also impact hospitals and nursing home flexibilities enabled by the emergency declarations.

- **Medicare Beneficiaries.** Medicare coverage requirements waived during the PHE will resume. For example, Medicare patients seeking admission to a skilled nursing facility will first have to spend three (3) days in a hospital. Hospitals will also lose the twenty (20) percent increase in Medicare payments they've received for treating COVID patients.
- **Long Term Care Requirements.** Long term care facility staff testing requirements will expire at the end of the PHE. However, the long term care requirement to report will not expire because the requirement to report was finalized in a prior final rule. During the PHE, flexibilities were granted in terms of training to allow more people in the workforce. At the end of the PHE, nurse aides will have four (4) months after the end of the PHE to complete any required training.
- **Hospital Reporting.** Contrary to the reporting by labs, hospital data reporting will continue as required by CMS' conditions of participation through April 30, 2024, but the frequency of reporting might be reduced from the current daily reporting requirement to a lesser frequency.
- **Community Level Determination.** The community levels will still be able to be reported as community levels are determined by COVID admissions to hospitals and COVID positive tests. As such, community level will still be able to be determined and posted by the agency, which translates into guidance on how a community should address such level (low, medium, or high).

TELEHEALTH

It is important to note that telehealth in schools must not be used to undermine needed or existing in-person services or to count against required staff ratios. To the contrary, telehealth in schools must supplement not supplant in-person services.

Telehealth largely expanded services and access during the PHE. Services such as check-ins with specialists including obstetrics, surgery follow-ups, primary care needs, and mental health services could be conducted via telehealth during the PHE. With geographic locality limitations largely lifted, residents in places with fewer providers experienced access to providers that they would have once had to drive hours to visit. During the PHE, wait times for some providers, like child psychiatrists, decreased significantly in several states and students and parents did not have to miss school and work to travel to such providers. Some telehealth flexibilities were extended permanently while others only temporarily.

HHS also offers additional resources at [Telehealth.HHS.gov](https://www.hhs.gov/telehealth) including information about recent policy changes that extended telehealth flexibilities [after the COVID PHE](#), provider [fact sheets](#) about COVID PHE waivers and flexibilities, and [Medicaid telehealth webpages](#). HHS developed a resource entitled, “Developing a School-Based Telehealth Strategy” specifically for schools, and that resource can be accessed [here](#). In addition, to assist with the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) concerns, HHS Office for Civil Rights released [guidance](#) to help health care providers and health plans bound by HIPAA Privacy, Security, and Breach Notification Rules (HIPAA Rules) understand how they can use remote communication technologies for audio-only telehealth post-COVID PHE. More information about the guidance is available on the [Legal Considerations](#) page and [FAQs on Telehealth and HIPAA during the COVID nationwide public health emergency](#).

- **Medicare Beneficiaries.** As aforementioned, telehealth for Medicare beneficiaries was extended in the Omnibus. During the PHE, more Medicare enrollees were able to receive care by telehealth regardless of geographic location when these services were no longer limited just to those living in rural areas. Medicare also allowed beneficiaries to remain in their homes for telehealth visits and reimbursed providers for such telehealth services. For Medicare beneficiaries, these telehealth services were expanded to allow services to occur via smartphone in lieu of equipment with both audio and video capability. The PHE also expanded the amount of Medicare-covered services that can be provided via telehealth. The Omnibus extended these flexibilities for Medicare beneficiaries through December 31, 2024. More information on Medicare changes to telehealth can be accessed [here](#).
- **Medicare Advantage Beneficiaries.** For Medicare Advantage beneficiaries, the plan may choose to cover telehealth services, but is not required to do so. The beneficiary would need to check with their Medicare Advantage plan to see if the plan provides coverage for telehealth services.
- **Beneficiaries on High Deductible Health Plans.** As also aforementioned, the flexibilities of telehealth for HDHPs were also extended in the Omnibus. The Omnibus allows HDHPs to offer subscribers telehealth appointments before they’ve hit their deductibles through 2024. The Omnibus provides HDHP participants coverage for telehealth services without requiring them to first meet the minimum required deductible and allows HDHP beneficiaries to contribute to their HSAs. Therefore for HDHPs with plan years beginning after December 31, 2022, and before January 1, 2025, the Omnibus allows HDHPs to continue to cover telehealth services on a first-dollar basis without disqualifying participants from making HSA contributions.
- **Medicaid Beneficiaries.** Medicaid telehealth flexibilities were available to states **prior** to the PHE and will continue to be available to states after the PHE. States can choose to allow telehealth services for Medicaid beneficiaries and are being encouraged to do so.
- **Private Insurance Beneficiaries.** For private insurance beneficiaries, the unwinding of the PHE may impact telehealth services and flexibilities. The most acutely impacted would likely be individuals with behavioral health needs and rural patients.

PRESCRIPTION MEDICATIONS

The Medicare prescription drug benefit will no longer provide coverage for patients to obtain an extended supply of many drugs. The requirement that Medicare Part D plans provide a 90-day supply of covered Part D drugs to beneficiaries that request it will end when the PHE expires.

VIRTUAL PRESCRIBING

The need is large for virtual prescribing according to a recent report from HHS' Substance Abuse and Mental Health Services Administration (SAMHSA). The [released data](#) demonstrates that a 2021 survey found that more than fifteen (15) percent of the population, about forty-six (46) million people, had a substance use disorder, and about one (1) in four (4) adults had a mental illness. And while the number of [people seeking](#) mental health care is growing, SAMHSA said that nearly ninety-four (94) percent of people with substance use disorder didn't receive treatment in 2021. Gender-affirming care providers have also expressed hope that expanded access to virtual controlled substance prescribing stays intact. Otherwise, testosterone access could become more limited.

- **Outside of an Opioid Treatment Program (OTP).** The Drug Enforcement Administration (DEA) has jurisdiction. The PHE waived the requirement for health care providers to meet patients in-person before prescribing prescription medications often used in behavioral and substance use treatment. Virtual prescribing of controlled substances used to treat opioid use disorder and some mental health conditions, which was allowed during the PHE, could end unless DEA sets out a process for it to continue. That could affect individuals seeking mental health care, transgender care, treatment for opioid use disorder, and remedies for severe coughs. DEA, however, has announced that it will be working to get rules out soon to address this concern. In addition, Senator Mark R. Warner (D-Va.) has [called on](#) DEA and the Department of Justice (DOJ) to explain their plans to ensure continuity of care for patients who have been prescribed controlled substances virtually. DOJ previously responded to an August letter from Warner, saying it is "committed to publishing regulations that will allow legitimate telehealth providers to continue treating patients" when the PHE ends. The Administration has stated in its newly released [policy agenda](#) that it expects to issue a proposed rule to facilitate virtual prescribing of buprenorphine, which is used to treat opioid use disorder. The Administration also includes in the agenda a separate regulation permitting access to controlled substances by telemedicine.
- **For an Opioid Treatment Program (OTP).** The Substance Abuse and Mental Health Services Administration (SAMHSA) has jurisdiction. SAMHSA released a [Notice of Proposed Rulemaking](#) in December 2022 that would make permanent the flexibility allowing patients to start buprenorphine in an OTP by telehealth without the required in-person physical examination first. Since this regulation is only a notice of proposed rulemaking and not a final rule, SAMHSA has stated that it will extend this flexibility for one year from the end of the PHE, which will be [May 11, 2024](#), in order to allow time for the agency to make these flexibilities permanent. In addition to buprenorphine, SAMHSA also announced that it will extend the flexibility of allowing an increased number of take-home doses to patients taking methadone in an OTP. Specifically, for methadone, take home doses for opioid treatment allowed twenty-eight (28) doses for stable patients and fourteen (14) doses for unstable patients without having to meet the time and treatment requirements. SAMHSA will extend this flexibility for one year from the end of the PHE, which will be [May 11, 2024](#), to allow time for the agency to make these flexibilities permanent.

SCOPE OF PRACTICE

Generally, state law governs scope of practice and licensing. However, under Medicare Part B, services are outlined that must be in the direct supervision of a provider. During the PHE, flexibilities were in place, and this flexibility will expire with the end of the PHE. CMS has committed to reviewing the end of this flexibility to determine if permanent flexibility is needed.

ADDITIONAL RESOURCES

NEA Resources – To obtain the NEA Resources, please contact cblankenship@nea.org

- NEA Fact Sheet: *The Affordable Care Act* Marketplace
- NEA Resource Guide: Key Health Care and Education Takeaways in the *Consolidated Appropriations Act of 2023 (HR 2617)*
- NEA Resource Guide: Summary of Key Health Care Provisions in the *Inflation Reduction Act*
- NEA Resource: Bargaining and Advocating Beyond COVID-19
- NEA Health Plan Cost Comparison Worksheet
- NEA Health Plan Selection Guide
- NEA Decoding Educator Health Care Benefits
- NEA Health Care Communications Toolkit
- NEA Resource - High Deductible Health Plans and Health Savings Account
- NEA Resource - Mental Health Parity Laws and Health Plan Compliance

Other Resources

State Tracking/Reporting Resources

- Georgetown Health Policy Institute 50 State Unwinding Tracker can assist in determining the process of unwinding for your state and can be accessed at <https://ccf.georgetown.edu/2022/09/06/state-unwinding-tracker/>
- The Centers for Medicare and Medicaid Services resource and chart on “The Road to Unwinding: Key Dates and Activities for States” can be accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/60-day-notice-timeline-final.pdf>
- The Centers for Medicare and Medicaid Services “[State Renewal Report](#)” (**Print Only Version for Viewing**) provides information on the plans for prioritizing and distributing renewals following the end of the Medicaid continuous enrollment provisions
- The Centers for Medicare and Medicaid Services “[Unwinding Data Specifications](#)” addresses the Medicaid and CHIP eligibility and enrollment data specifications for reporting during unwinding

Unwinding Resources

- **Revised Resource.** **On February 28, 2023**, the Centers for Medicare and Medicaid Services released a revised COVID PHE Fact Sheet that can be accessed at <https://www.cms.gov/files/document/what-do-i-need-know-cms-waivers-flexibilities-and-transition-forward-covid-19-public-health.pdf>. The Fact Sheet entitled, “CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency” provides clarity on several topics including: COVID-19 vaccines, testing, and treatments; Telehealth services; and Health Care Access.

- The Department of Health and Human Services Public Health Emergency Transition Roadmap can be accessed at <https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html>
- The Centers for Medicare and Medicaid unwinding resource is the centralized location where states and stakeholders can learn more about unwinding and access resources to help them plan and prepare and can be accessed at <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html>
- The Centers for Medicare and Medicaid Services resource “Connecting Kids to Coverage: State Outreach, Enrollment and Retention Strategies Issue Brief” can be accessed at <https://www.medicaid.gov/state-resource-center/downloads/kids-coverg-outreach-enrolmnt-retention-strategies.pdf>
- Special Enrollment Period Resources
 - The Centers for Medicare and Medicaid Services released information on a temporary “Exceptional Circumstances Special Enrollment Period (SEP)” for consumers losing Medicaid or CHIP coverage due to unwinding of the Medicaid continuous enrollment condition and that resource can be accessed at <https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf>
 - The Centers for Medicare and Medicaid released information on a Special Enrollment Period for consumers losing Medicaid and CHIP Coverage but eligible for Medicare and that resource can be accessed at <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-strengthens-medicare-finalized-policies-simplify-enrollment-and-expand>. Fact sheet on the final rule can be accessed at <https://www.cms.gov/newsroom/fact-sheets/implementing-certain-provisions-consolidated-appropriations-act-2021-and-other-revisions-medicare-2>. The final rule can be accessed at <https://www.federalregister.gov/public-inspection/2022-23407/medicare-program-implementing-certain-provisions-of-the-consolidated-appropriations-act-2021-and>
- SNAP Resources
 - Back to School Media Toolkit can be accessed at <https://www.fns.usda.gov/nslp/back-to-school-media-toolkit>
 - Changes to SNAP benefit amounts for 2023 can be accessed at <https://www.fns.usda.gov/snap/changes-2023-benefit-amounts>
 - SNAP State Directory of Resources can be accessed at <https://www.fns.usda.gov/snap/state-directory>
 - WIC program resource can be accessed at <https://www.fns.usda.gov/wic/wic-how-apply>
- The Healcare.gov resource to find local help can be accessed at <https://localhelp.healthcare.gov/>
- The Centers for Medicare and Medicaid Services released guidance “COVID Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies” and it can be accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf>
- The Office of Health Policy “Issue Brief on the Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches” can be accessed at https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf
- The Centers for Medicare and Medicaid Services "Key Dates Related to the Medicaid Continuous Enrollment Condition" was released on January 5, 2023 and includes key dates related to the Medicaid Continuous Enrollment Condition. The resource can be accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf>

- The Centers of Medicare and Medicaid Services resource on provider-specific fact sheets for information about COVID PHE waivers and flexibilities can be accessed at <https://www.cms.gov/coronavirus-waivers>
- The Centers of Medicare and Medicaid Services resources on Section 1135 Waiver, Flexibility Requests, and Inquiry Form can be accessed at https://cmsqualitysupport.servicenowservices.com/cms_1135
- The Centers for Medicare and Medicaid Services resource on Section 1902(e)(14)(A) Waivers can be accessed at <https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html>
- The Centers for Medicare and Medicaid Services Emergencies Page offers the up-to-date information on all current emergencies and can be accessed at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>
- The Centers for Medicare & Medicaid Services resource on “Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations” can be accessed at <https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy.pdf>
- The Federal Communications Commission and Governmental Affairs Bureau issued a Declaratory Ruling responding to a letter from the Department of Health and Human Services Secretary Becerra regarding government Medicaid enrollment calls and text messages and that resource can be accessed at <https://www.fcc.gov/document/fcc-provides-guidance-enable-critical-health-care-coverage-calls>
- The Centers for Medicare and Medicaid Services resource “Ending Coverage in the Optional COVID-19 Group: Preparing States for the End of the Public Health Emergency” can be accessed at <https://www.medicaid.gov/resources-for-states/downloads/ending-covrg-optnl-covid-grp-guidance.pdf>
- The Centers for Medicare and Medicaid Services resource “Strategic Approaches to Support State Fair Hearings as States Resume Normal Eligibility and Enrollment Operations After the COVID-19 PHE” can be accessed at <https://www.medicaid.gov/resources-for-states/downloads/strat-apps-state-fair-hearings.pdf>
- The Centers for Medicare and Medicaid Services resource “Medicaid and CHIP Unwinding Planning Efforts: Summary of Best & Promising State Practices from CMS/State Discussions” can be accessed at <https://www.medicaid.gov/resources-for-states/downloads/state-unwinding-best-practices.pdf>
- The Centers for Medicare and Medicaid Services Resource “Strategies States and U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as they Return to Normal Operations” can be accessed at <https://www.medicaid.gov/state-resource-center/downloads/strategies-for-covrg-of-indiv.pdf>
- The Centers for Medicare and Medicaid Services resource “Ensuring Continuity of Coverage and Preventing Inappropriate Terminations – Part 2” can be accessed at <https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/ensrng-contnty-cvrg-prvntng-inprpte-trmntns-part-2.pdf>
- The Centers for Medicare and Medicaid Services resource “Ensuring Continuity of Coverage and Preventing Inappropriate Terminations – Part 1” can be accessed at <https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/ensrng-contnty-cvrg-prvntng-inprpte-trmntns-part-1.pdf>
- Kaiser Family Foundation report on “10 Things to Know about the Unwinding of the Medicaid Continuous Enrollment Provision” can be accessed at <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

State-Based Marketplaces

- For states that have State-Based Marketplaces, resources can be found at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces> and <https://www.healthcare.gov/marketplace-in-your-state/>

Medicaid and CHIP Renewal Resources

- The Centers for Medicare and Medicaid renewals resource, which is a webpage designed for people enrolled in Medicaid and CHIP and help them prepare to renew their coverage when states restart eligibility renewals, can be accessed at <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/renew-your-medicaid-or-chip-coverage/index.html>
- The Centers for Medicare and Medicaid resource “Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements” can be accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>

Telehealth Resources

- The Department of Health and Human Services [Telehealth.HHS.gov](https://www.hhs.gov/telehealth) offers resources, including information about recent policy changes that extended telehealth flexibilities [after the COVID PHE](#), provider [fact sheets](#) about COVID PHE waivers and flexibilities and [Medicaid telehealth webpages](#).
- The Department of Health and Human Service resource, “Developing a School-Based Telehealth Strategy” can be accessed at <https://telehealth.hhs.gov/providers/school-based-telehealth/developing-a-school-based-telehealth-strategy/#:~:text=Creating%20a%20school-based%20telehealth%20plan%201%20Design%20your,strategy%20to%20share%20what%20you%20are%20doing.%20>

Webinar Materials

- The Centers for Medicare and Medicaid PHE Webinars Slides and Recordings can be accessed at <https://www.cms.gov/outreach-education/partner-resources/cms-national-stakeholder-calls>
- The Centers for Medicare and Medicaid Services resource “Medicaid and CHIP Learning Collaborative Webinar: Medicaid and Children’s Health Insurance Program (CHIP) Eligibility and Enrollment Unwinding Data Reporting & Submission” can be accessed at <https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-learning-collaborative-webinar.mp4>

Letters to State Health Officials and Governors

- The **revised February 9, 2023** Department of Health and Human Services Letter to Governors on unwinding can be accessed at https://www.hhs.gov/about/news/2023/02/09/letter-us-governors-hhs-secretary-xavier-becerra-renewing-covid-19-public-health-emergency.html?utm_source=news-releases-email&utm_medium=email&utm_campaign=february-12-2023
- The **revised January 27, 2023** Centers for Medicare and Medicaid Services letter to State Health Officials on January 25, 2023 outlining new requirements in the *Consolidated Appropriations Act, 2023* that impact state activities for the Medicaid and CHIP programs to unwind from the

COVID-19 public health emergency can be accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf>

- The **May 10, 2022** Department of Health and Human Services Letter to Governors on the unwinding can be accessed at <https://www.medicaid.gov/resources-for-states/downloads/unwinding-gov-ltr-05102022.pdf>
- The **March 3, 2022** Centers for Medicare and Medicaid Services letter to “State Health Officials regarding Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency” can be accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>
- The **December 22, 2020** Centers for Medicare and Medicaid Services letter to State Health Officials regarding “Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency” can be accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>

Communications Resources

- The Centers for Medicare and Medicaid “Medicaid and CHIP Continuous Enrollment Unwinding Toolkit” can be accessed at <https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit.pdf>