DFR | Division of Financial Regulation
Department of Consumer and Business Services

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Division of Financial Regulation
End of the COVID-19 Public Health Emergency Frequently Asked Questions

Q. When is the COVID-19 Public Health Emergency ending?

A. Based on current COVID-19 trends, the U.S. Department of Health and Human Services is planning for the federal Public Health Emergency for COVID-19 (PHE), declared under Section 319 of the Public Health Service Act, to expire at the end of the day on **May 11, 2023**.

Q. How will COVID testing, vaccines, and treatment be covered by commercial health insurance after the end of the PHE?

A. Testing – During the PHE, federal law required health insurers to cover over-the-counter and laboratory-based COVID-19 PCR and antigen tests without cost sharing or network restrictions. These requirements were tied to the PHE and sunset with the PHE on May 11.

- DFR expects health benefit plans will continue to cover medically necessary COVID-19 tests after the PHE ends. However, COVID-19 tests administered after May 12, 2023, may be subject to cost sharing, network requirements, and medical management review.
- Most health insurers are no longer providing free at-home COVID-19 tests, but you can still get four free tests from the federal government.
- Restrictions may vary by plan, and consumers are encouraged to contact their health insurer for the most up to date information.
- The division encourages insurers to continue covering COVID-19 tests without cost sharing or medical management review; and to notify enrollees of any changes to their coverage as a result of the end of the PHE.

Vaccines – Both state and federal law require insurers to cover approved COVID-19 vaccines without cost sharing. While some federal requirements for vaccine coverage, including requirements for out-of-network providers, will be sunsetting with the PHE, Oregon has issued a public health declaration under ORS 743A.264 that remains in place. Consumers are encouraged to contact their health care provider for vaccine information.

- Under this declaration, health benefit plans subject to the Oregon Insurance Code must continue to reimburse COVID-19 vaccines without cost sharing.

Treatment – Consistent with practices during the pandemic, the division expects health insurance plans to continue to cover medically necessary procedures, items, and services to treat COVID-19 under existing inpatient, outpatient, emergency, and pharmacy benefits. Coverage for COVID-19 treatment generally may be subject to cost sharing and any limits or conditions of the policy.

Q. How will telehealth be covered by commercial health insurance after the end of the PHE?

A. During the 2021 legislative session, the Oregon legislature enacted HB 2508, which established expanded telehealth coverage for private insurance and the Oregon Health Plan. The bill increased the number and type of telehealth technologies that must be reimbursed and requires insurers to reimburse telehealth services at the same level as in person services.

- Under HB 2508, health benefit plans must cover any medically necessary health service covered by the plan (including physical, oral, and behavioral health) so long as the service can be safely and effectively provided via telehealth in accordance with privacy laws.
- HB 2508 remains in effect today and will continue to apply after the PHE sunsets.

Q. What is happening with Oregon Health Plan (OHP) Medicaid Redeterminations?

A. The federal Consolidated Appropriations Act of 2023 signed into law Dec. 29, 2022, directed state Medicaid agencies to resume normal eligibility determinations no later than April 1, 2023. The Oregon Health Authority (OHA) is determining Oregon Health Plan (OHP) member eligibility using a phased approach from April 2023 through January 2024.

Disenrollment timing will be based on criteria established by OHA, the state agency responsible for OHP and the Marketplace. OHA and the Oregon Department of Human Services are working together to prepare the upcoming changes to Medicaid to preserve benefits for individuals and families.

For those losing OHP benefits, there is a Marketplace Special Enrollment Period (SEP) from April 1, 2023, through June 30, 2024. If a member is no longer eligible for benefits, that member will be referred to the Marketplace to consider other affordable coverage options. OHP will send participant information directly to the Marketplace, which will communicate information and assist with a Marketplace plan enrollment.

An SEP also exists for OHP members that lose coverage and have access to employer based coverage. The employee must request enrollment in the employer plan within 60 days of their OHP termination date.

In October 2022, CMS issued a rule to permit an SEP for Medicare enrollment if Medicaid coverage is terminated after the COVID-19 PHE ends on or after Jan. 1, 2023. For more information visit: https://www.cms.gov/newsroom/fact-sheets/implementing-certain-provisions-consolidated-appropriations-act-2021-and-other-revisions-medicare-2

For more information on Oregon’s PHE Medicaid unwinding visit: https://www.oregon.gov/oha/PHE/Pages/index.aspx

Q. If my Oregon Health Plan insurance is terminated because of the end of the PHE can I purchase a Medicare Supplement Insurance policy?

A. Yes, Medicare Supplement Insurance policies are available in Oregon on a guaranteed issue basis to eligible people who:

- Enrolled under a state Medicaid plan as described in Title XIX of the Social Security Act that provides health benefits that supplement the benefits under Medicare, and the plan terminates or the plan ceases to provide all such supplemental health benefits to the individual. *See:* OAR 836-052-0142(2)(a); and

    - Who apply for a Medicare Supplement Insurance policy during the 63 days following the later of their notice of termination or disenrollment from Medicaid or their date of termination from Medicaid; as well as,

    - Submit evidence of the date of termination or disenrollment from Medicaid with the application for a Medicare supplement policy.

Oregon Medicare Supplement regulations prohibit insurers from using a pre-existing condition to deny or condition the issuance of a Medicare supplement policy that is available for issuance to new enrollees by the issuer. Insurers also cannot discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition.

Requests for additional information or other inquiries regarding this FAQ may be directed to DFR's consumer advocacy and education team at 1-888-877-4894 (toll-free) or email DFR.InsuranceHelp@dcbs.oregon.gov.