HHS Terminates COVID-19 Emergency Declarations, Shifting Treatment Landscape

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For three years, the COVID-19 public health emergency declarations shaped how clinicians managed SARS-CoV-2 infection, from testing protocols to treatment availability. The US Department of Health and Human Services (HHS) has now terminated these declarations, effective May 11, 2023, ushering in a new era for disease management.

This shift moves COVID-19 care into the established healthcare system, impacting everything from vaccine distribution to the reimbursement for antiviral therapies and diagnostics. Clinicians must now navigate a landscape where emergency use authorizations (EUAs) no longer dictate the immediate availability and funding mechanisms for many interventions.

KEY TAKEAWAYS

- The Pivot: The termination of COVID-19 emergency declarations transitions care from an emergency response to standard medical practice, impacting access and reimbursement.
- The Data: The shift means federal funding for tests, vaccines, and treatments, previously covered under emergency provisions, will largely cease.
- The Action: Clinicians should prepare for changes in patient access to free testing and therapeutics, and understand new insurance coverage requirements for COVID-19 interventions.

The COVID-19 public health emergency (PHE) declaration, initially enacted in January 2020, provided HHS with broad authority to waive or modify certain requirements under Medicare, Medicaid, and CHIP, and to issue emergency use authorizations for medical products. These provisions allowed for rapid development, deployment, and reimbursement of vaccines, diagnostic tests, and therapeutic agents. The termination of the PHE, alongside the national emergency declaration, signifies a formal end to this extraordinary period of federal intervention in healthcare delivery.

This change means that many of the flexibilities and funding streams established during the emergency will expire. For instance, the federal government's direct purchasing and distribution of COVID-19 vaccines and treatments, which ensured broad access regardless of insurance status, will largely cease. Instead, these products will transition to commercial markets, with pricing and coverage determined by manufacturers and private insurers or government programs like Medicare and Medicaid.

The Operational Shift

The immediate impact on clinical practice centers on access to diagnostics and therapeutics. During the PHE, COVID-19 tests, including PCR and rapid antigen tests, were often available at no out-of-pocket cost, supported by federal funding.

That coverage has now largely ended. Patients will face co-pays or full costs for tests, depending on their insurance plans and the setting of care. This could reduce testing rates, potentially hindering early diagnosis and timely initiation of antiviral treatments.

Antiviral therapies like Paxlovid (nirmatrelvir/ritonavir) and remdesivir, which received EUAs and were procured and distributed by the federal government, are also transitioning. While existing federal stockpiles of these drugs will be depleted, future supplies will be purchased through commercial channels. This means that while the drugs remain available, their cost and accessibility will depend on individual insurance coverage and pharmacy benefit managers. The EUA status for these drugs will eventually be replaced by full FDA approval, but the immediate change is in the funding mechanism, not necessarily the regulatory status of the drugs themselves.

Vaccines, too, will see a significant shift. The federal government previously purchased and distributed COVID-19 vaccines free of charge to all individuals. With the end of the PHE, vaccine procurement will move to the commercial market. Private insurance, Medicare, and Medicaid will cover the cost of recommended COVID-19 vaccines, similar to how other routine immunizations are handled. Uninsured individuals may face challenges accessing vaccines without specific state or federal programs in place to cover costs, though the Vaccines for Children program will continue to cover COVID-19 vaccines for eligible children.

Telehealth flexibilities, which expanded access to virtual care during the pandemic, are also affected. Many of the waivers allowing for broader telehealth reimbursement and cross-state practice expired with the PHE. Some of these flexibilities were extended by Congress through December 31, 2024, but the long-term landscape for telehealth reimbursement and licensure remains in flux. Clinicians relying on these expanded telehealth services must now ensure compliance with state-specific regulations and insurer policies.

Data collection and reporting also change. During the emergency, hospitals and states were required to report specific COVID-19 data to federal agencies, including case numbers, hospitalizations, and deaths. These mandatory reporting requirements have largely ceased, transitioning to voluntary reporting or integration into existing public health surveillance systems. This could lead to less comprehensive, real-time data on disease prevalence and severity, making it harder for clinicians and public health officials to track outbreaks and allocate resources effectively.

The termination of the PHE does not mean COVID-19 has disappeared. It simply means the federal government's emergency response framework has been dismantled. The virus continues to circulate, and clinicians will continue to manage patients with acute infection and long COVID. The shift requires a re-evaluation of practice workflows, patient education regarding costs, and an understanding of evolving insurance coverage for what is now considered an endemic respiratory virus.

CLINICAL IMPLICATIONS

The termination of the COVID-19 emergency declarations forces a rapid recalibration of clinical practice, particularly regarding patient access to diagnostics and therapeutics. For three years, federal funding cushioned the blow of out-of-pocket costs for tests and treatments; that safety net is now gone. Clinicians will inevitably spend more time discussing insurance coverage and financial implications with patients, a task that detracts from direct medical care.

The shift to commercial markets for vaccines and antivirals means that disparities in access, already present

> in the healthcare system, will likely widen. Patients with robust insurance plans will continue to receive care, but the uninsured or underinsured may face significant barriers to essential interventions. This move effectively privatizes much of the COVID-19 response, placing the burden of cost directly on individuals and their insurers.
> Furthermore, the reduction in mandatory data reporting will create blind spots for public health surveillance. Without comprehensive, real-time data, identifying emerging variants or localized outbreaks becomes more challenging. This lack of granular information could hinder proactive public health interventions and leave clinicians less informed about local disease activity, complicating treatment decisions.
> Ultimately, the end of the emergency declarations signals a return to a pre-pandemic model of healthcare delivery, but for a virus that remains a significant public health concern. Clinicians must now integrate COVID-19 management into routine practice, navigating a complex web of insurance policies and commercial availability, rather than relying on a federally coordinated emergency response.

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REFERENCES

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