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EMPLOYEE BENEFITS

Coverage for At-Home COVID-19 Tests – Employer FAQ

January 2022

Following the release of the Departments of Labor, Health and Human Services (HHS) and the Treasury (collectively, the Departments) FAQ Part 51, a significant number of unanswered questions remain regarding the coverage of over-the-counter (OTC) COVID-19 tests. In addition, we are seeing insurance carriers, third-party administrators (TPAs) and pharmacy benefit managers (PBMs) implement solutions that differ based on varying interpretations of the guidance, which can create additional confusion for plan sponsors, who must make decisions regarding how their plans should be amended to comply with the new coverage requirements. The Brown & Brown Regulatory and Legislative Strategy Group has compiled frequently asked questions highlighting common concerns facing employers.

Q1. Are employers required to notify their employees with respect to coverage of OTC COVID-19 tests?

FAQ Part 51 does not describe any specific requirement under section 6001 of the FFCRA to notify employees of the information contained within the guidance. However, under certain circumstances, plan sponsors may be required to furnish a summary of material modifications (see Q2 below).

The Departments do state that plans and issuers may provide education and information resources so long as the resources "make clear that the plan or issuer provides coverage for, including reimbursement of, all OTC COVID-19 tests that meet the statutory criteria under section 6001(a)(1) of the FFCRA (subject to the safe harbors in Q2 and Q3), and such information is consistent with the test's emergency use authorization (EUA)."[1]

Q2. Are plans required to furnish a summary of material modifications (SMM) with respect to plan changes for coverage of OTC COVID-19 tests that meet the criteria under section 6001(a)(1) of the FFCRA and are obtained without the involvement of a health care provider?

Possibly. If a plan has a general exclusion for OTC medicines and supplies without a health care provider's order, a change in coverage to include OTC COVID-19 tests without a health care provider's order may trigger the requirement to provide an SMM. In addition, if a plan sponsor chooses to impose a limit on the number of COVID-19 tests purchased by participants, beneficiaries or enrollees during a specified amount of time, these restrictions should be reflected in the SPD (and/or SMM).

[1] FAQ Part 51, Q5. https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf

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Q3. Will cost changes due to the coverage of OTC COVID-19 tests permit self-insured group health plans to adjust employee contribution levels midyear?

While plans are generally allowed to increase employee contribution levels midyear, it is unclear whether plan sponsors may do so if the stated reason is solely to cover the cost of OTC COVID-19 tests. An argument could be made that doing so goes against the spirit of the Department's current directive which could lead to increased legal scrutiny. Plan sponsors considering these changes should consult with their legal counsel prior to doing so.

When it comes to general considerations, plans that wish to change employee contributions levels midyear must ensure that the plan document gives the plan sponsor the power to amend the plan. In the event the Plan documents permits mid-year changes to employee contributions, prior to implementing the cost change, the plan sponsor should ensure its Section 125 plan document recognizes cost change as an event that will permit employees to change their elections midyear.

If the cost change *is not* considered "significant," the Section 125 plan document will often permit employers to automatically update employee elections.

If the cost change *is* considered "significant," most Section 125 plan documents give employees the option to make a midyear pre-tax election change to elect coverage midyear (in the case of a significant decrease) or terminate coverage midyear (in the case of a significant increase). Whether a change in cost is considered "significant" will depend on the specific facts and circumstances. In addition to the cafeteria plan, plan sponsors will need to ensure that the medical plan itself allows for participants to terminate coverage midyear.

Plan sponsors considering adjustments to employee contribution levels must take into account that in most cases, COBRA rates may not be increased mid-year and must be maintained for a full 12-month determination period.

Applicable large employers (ALEs) will need to consider the impact increasing costs have on the affordability of coverage for purposes of the employer shared responsibility provisions.

Q4. How long will the OTC COVID-19 test reimbursement take? Is there a deadline to submit reimbursements for OTC COVID-19 tests?

According to the Centers for Medicare & Medicaid Services (CMS), health plans are encouraged to provide prompt reimbursement for claims for at-home tests.[2] In FAQ Part 51, the Departments state that reimbursement should be in accordance with the plan or issuer's reasonable internal claims procedures, consistent with applicable federal and state law.[3]

Q5. Can plans and issuers using a direct coverage program limit reimbursement amounts for OTC COVID-19 tests purchased from preferred pharmacies or retailers?

The amount reimbursed for OTC COVID-19 tests purchased through a direct-to-consumer shipping program or from preferred pharmacies and retailers will likely depend on the plan or issuer's negotiated fee schedule with the preferred network provider. For example, if a plan had a negotiated fee of $15 per test with their in-network testing provider, the plan would reimburse the in-network provider $15 for the test obtained by participants. Reimbursement to participating providers would not be capped at $12 per test unless the plan and in-network provider had pre-determined that amount based on a negotiated fee arrangement.

The reimbursement limit described in FAQ Part 51 of $12 or the actual price of the test (whichever is lower) applies to tests obtained at ***nonpreferred*** pharmacies or other retailers through a direct coverage program.[4]

[2] https://www.cms.gov/how-to-get-your-at-home-OTC-COVID-19-test-for-free
[3] FAQ Part 51, Q1.
[4] FAQ Part 51, Q2.

Q6. For plans and issuers limiting reimbursements for OTC COVID-19 tests purchased from nonpreferred pharmacies or other retailers, must the direct coverage program include both preferred pharmacies and direct-to-consumer shipping programs (e.g., mail order options) to meet the safe harbor described in FAQ Part 51 Q2?

It is not entirely clear. Under the guidance in FAQ Part 51, when referring to the safe harbor the Departments state that they "will not take enforcement action related to coverage of OTC COVID-19 tests against any plan or issuer that provides coverage of OTC COVID-19 tests purchased by participants, beneficiaries, and enrollees during the public health emergency by arranging for direct coverage of OTC COVID-19 tests that meet the statutory criteria under section 6001(a)(1) of the FFCRA ***through both its pharmacy network and a direct-to-consumer shipping program***, and otherwise limits reimbursement for OTC COVID-19 tests from nonpreferred pharmacies or other retailers to no less than the actual price, or $12 per test (whichever is lower)."

While that statement seems to clearly require direct coverage through both a pharmacy network ***and*** a direct-to-consumer shipping program, we have seen statements from some PBMs stating they are not offering direct coverage for the OTC COVID-19 tests through a direct-to-consumer shipping program and are nevertheless indicating the safe harbor applies. Such a position might be based on another statement in the guidance, which indicates that "for purposes of this safe harbor, direct coverage of OTC COVID-19 tests means that a participant, beneficiary, or enrollee is not required to seek reimbursement post-purchase; instead, the plan or issuer must make the systems and technology changes necessary to process the plan's ***or*** issuer's payment to the preferred pharmacy or retailer directly (including the direct-to-consumer shipping program) with no upfront out-of-pocket expenditure by the participant, beneficiary, or enrollee."[5] Additional information provided by CMS refers to a "network of convenient options such as pharmacies ***or*** retailers" with respect to incentives for companies to establish a direct coverage program.[6] Those statements could potentially be interpreted to mean the plan needs to offer direct coverage either through its pharmacy network or a direct-to-consumer shipping program, but not both, in order to take advantage of the safe harbor.

Until the regulatory agencies issued guidance clarifying this issue, employers should discuss this issue with their legal counsel if their PBM is not implementing a direct-to-consumer shipping program.

Q7. Are the costs of at-home COVID-19 tests reimbursable under a health FSA or HSA?

Yes. According to IRS News Release IR-2021-181 (Sept. 10, 2021), the cost of home testing for COVID-19 is an eligible medical expense that can be paid or reimbursed by health FSAs, HSAs, HRAs or Archer MSAs.[7] The news release states that the reason is because the cost to diagnose COVID-19 is an eligible medical expense for tax purposes.

It should be noted that the IRS news release does not specify whether the at-home COVID-19 tests are purchased for diagnostic purposes or employment purposes. This would seem to indicate that the cost of home COVID-19 tests purchased for either reason are reimbursable as qualified medical expenses under section 213(d). Consultation with your legal counsel is advised because of the ambiguity.

[5] FAQ Part 51, Q2.
[6] https://www.cms.gov/how-to-get-your-at-home-OTC-COVID-19-test-for-free
[7] https://www.irs.gov/newsroom/irs-cost-of-home-testing-for-covid-19-is-eligible-medical-expense-reimbursable-under-fsas-hsas

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