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Insider

U.S. Supreme Court blocks OSHA vaccine-or-test mandate

By Anu Gogna and Ben Lupin

On January 13, 2022, the U.S. Supreme Court **issued a stay** on the Department of Labor's Occupational Safety and Health Administration (OSHA) COVID-19 Vaccination and Testing Emergency Temporary Standard (ETS). The ETS, released on November 4, 2021, mandates COVID-19 vaccinations or at least weekly testing for workers at companies in the U.S. with 100 or more employees.[1]

In its order, the court states that "although Congress has indisputably given OSHA the power to regulate occupational dangers, it has not given that agency the power to regulate public health more broadly. Requiring the vaccination of 84 million Americans, selected simply because they work for employers with more than 100 employees, certainly falls in the latter category."

As a result of the Supreme Court's order, the OSHA ETS is stayed and now goes back to the U.S. Court of Appeals for the Sixth Circuit for a final determination (although in light of the Supreme Court's ruling, the Biden administration faces an uphill climb to be able to ever implement the rule, if it even decides to continue the lawsuit).

Employers may still choose to impose a COVID-19 vaccination mandate on their own, subject to any applicable state laws. All employers should review and comply with any other applicable COVID-19 vaccine-related mandates (both state and local).

Note: The Centers for Medicare & Medicaid Services COVID-19 vaccine mandate for employees in healthcare facilities that receive Medicare or Medicaid was upheld and can proceed.

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[1] For more information on the OSHA ETS, see "**OSHA issues COVID-19 vaccine mandate guidance**," *Insider*, November 2021.

Departments issue FAQs on over-the-counter COVID-19 test coverage

By Anu Gogna and Ben Lupin

Under **Affordable Care Act Implementation FAQs Part 51** – recently issued by the departments of Labor, Health and Human Services, and Treasury – group health plans and insurance companies must cover at least eight over-the-counter (OTC) at-home COVID-19 tests per person each month. For example, a family of five all enrolled in the same group health plan would be able to get at least 40 OTC COVID-19 tests covered by their health plan *per calendar month.*

The guidance provides that, starting January 15, 2022, and through the end of the public health emergency, employees enrolled in group health plans can buy an OTC COVID-19 test online or at a pharmacy or store and either get the test paid for at the point of sale by their health plan or pay for the test upfront and then get reimbursed by submitting a claim to their health plan.

Health plans must provide the coverage with no cost-sharing requirements (i.e., deductibles, copays or coinsurance), prior authorization or other medical management requirements, or a healthcare provider's order or clinical assessment. Coverage is not required for OTC COVID-19 tests used for employment purposes (e.g., return-to-work testing).

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The Centers for Medicare & Medicaid Services also issued **FAQs** on the OTC COVID-19 testing guidance.

Note: There is *no limit* on the number of COVID-19 tests, including OTC tests, that must be covered when they are ordered or administered by a healthcare provider following an individualized clinical assessment.

2 options for OTC COVID-19 test group health plan coverage

Option 1: Direct coverage program with limited out-of-network reimbursement

Under the "direct coverage" option, which the departments "strongly encourage," plans and issuers cover the costs upfront (at the point of sale) via a network of OTC COVID-19 testing providers, eliminating the need for participants to submit a claim for reimbursement. Plans or issuers may not impose any prior authorization or other medical management requirements on participants who obtain OTC COVID-19 tests via a direct coverage program.

Because a plan or issuer sets up a network of pharmacies or retailers where plan participants can buy their OTC COVID-19 tests, the amount reimbursed per test for retailers outside of that network can be capped at $12 or the actual price, if lower. (Note: In this instance, participants would pay upfront for the costs of their OTC COVID-19 tests and submit for reimbursement.) The departments view this ability to limit the reimbursement amount as an "incentive" for plans and issuers to choose this option.

Option 2: Reimbursement program

If the group health plan or issuer has not set up a direct coverage program as described above, then it must reimburse the cost of the tests. The participant will need to save receipt(s) to submit to the plan for reimbursement. Employer group health plan sponsors should be aware that there is no dollar limit on the cost of OTC COVID-19 tests under the reimbursement option; the plan and issuer must reimburse the *full* cost of the test.

Coverage is not required for OTC COVID-19 tests used for employment purposes (e.g., return-to-work testing).

Although plans cannot impose medical management techniques, the departments provide several examples of how they may act to prevent, detect and address fraud and abuse. Among the permissible actions, plans can (1) require the participant to attest that the test was purchased for the covered individual, is not for employment purposes, has not and will not be reimbursed by another source, and is not for resale; and (2) require reasonable documentation of proof of purchase.

Going forward

- Employer plan sponsors that choose to use a direct coverage program will want to discuss implementation with their third-party administrators (TPAs) and pharmacy benefit managers (PBMs) as soon as possible. The plan or issuer must also make the systems and technology changes necessary to process the direct payments.
- Employer plan sponsors that do not use a direct coverage program should work with their TPAs and PBMs to implement a reimbursement system (including verifying receipts, requiring an attestation and developing reimbursement processing procedures).
- Employers should consider amending the terms of their group health plans and inform employees on whether their qualified OTC COVID-19 tests will be covered via a direct coverage program or a reimbursement program.

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Washington announces delay in collecting long-term care payroll tax

By Maureen Gammon and Ben Lupin

Update after publication: On December 23, 2021, Washington Governor Jay Inslee issued a statement clarifying that the law requiring the WA Cares Fund payroll tax that took effect January 1, 2022, remains in effect until the legislature changes it (the next legislative session starts January 10, 2022). The governor further announced that the state of Washington will begin collecting the payroll tax from its own employees' paychecks on January 1. Given the uncertainty surrounding this law, employers with employees in Washington should discuss with legal counsel whether to start withholding the payroll tax starting January 1, 2022.

On December 17, 2021, Washington Governor Jay Inslee, Senate Majority Leader Andy Billig and House Speaker Laurie Jinkins **announced** that the state is delaying the January 1, 2022 effective date for employers to start withholding the WA Cares Fund payroll tax. According to the announcement, the legislature intends to pass legislation that formally extends the law's implementation date through the 2023 legislative session.

The WA Cares Fund, enacted in 2019, established the country's first state-run long-term care insurance program. Funding for the program is from an employee-paid payroll tax that employers would be responsible for withholding from employees' wages.[1]

Governor Inslee announced that the Washington Employment Security Department will not be collecting premiums until the legislature addresses some issues with the law and, during that time, employers will not be subject to penalties and interest for not withholding the payroll tax. The announcement explicitly encourages employers not to start collecting the payroll tax during the delayed implementation period. Washington employers will want to work with their payroll providers to ensure that they don't start withholding the payroll tax on January 1, 2022.

There is currently a legal challenge against the law on the grounds that it is preempted by ERISA, and the Washington legislature is expected to make a number of changes to the law during the 2022 legislative session.

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[1] For more information on the WA Cares Fund, see "**Washington's new long-term care payroll tax**," *Insider,* June 2021.

News in Brief

CMS releases 2023 out-of-pocket expense limits

By Maureen Gammon and Ben Lupin

The U.S. Department of Health & Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) have issued the 2023 annual dollar limits on cost sharing. The maximum annual limits on cost sharing that a group health plan can impose for 2023 are $9,100 for individual coverage and $18,200 for family coverage (up from $8,700 and $17,400, respectively, for 2022).

Note that these maximum limits on cost sharing are different from the 2023 IRS high-deductible health plan limits, which are expected to be released in the second quarter of 2022.

In prior years, these amounts have been included in the Notice of Benefit and Payment Parameters that CMS issues each year. Under a new policy, however, starting with the 2023 plan year, HHS will publish the premium adjustment percentage, maximum annual limits on cost sharing, reduced maximum annual limits on cost sharing and required contribution percentage by January of the year preceding the applicable benefit year (so by January 2022 for the 2023 benefit year).

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