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Insider

FAQs provide flexibility in coverage of OTC COVID-19 tests

By Anu Gogna, Ben Lupin and Kathleen Rosenow

The Departments of Labor, Health and Human Services, and the Treasury have issued **Affordable Care Act FAQs Part 52** on the coverage of over-the-counter (OTC) COVID-19 tests authorized by the Food and Drug Administration (FDA). The new guidance provides *flexibility* for group health plans and issuers in how they meet certain direct coverage requirements, effective February 4, 2022. The FAQs also address how the requirements interact with account-based plans, such as flexible spending accounts (FSAs), health reimbursement arrangements (HRAs) and health savings accounts (HSAs).

Background

On January 10, 2022, the Departments issued FAQs Part 51, which provided that group health plans and health insurance issuers must cover *at least* eight free OTC COVID-19 tests *per person per month* purchased on or after January 15, 2022, and throughout the public health emergency — without cost sharing, prior authorization or other medical management requirements. These include those tests purchased without a prescription or individualized clinical assessment from a healthcare provider.[1]

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 ("direct coverage") or pay for the test upfront and then get reimbursed by submitting a claim to their health plan.

The Part 52 FAQs clarify the direct coverage program safe harbor and modify some of the previous guidance, as discussed below.

Direct coverage program safe harbor

Under the direct coverage program, the plan or issuer sets up a network of preferred pharmacies or retailers (including the direct-to-consumer shipping program) where plan participants can buy their OTC COVID-19 tests with no upfront out-of-pocket costs or need to request reimbursements. Plans and issuers may limit reimbursement of tests purchased *outside* of that network to $12 (or the cost of the test, if lower).

The recent guidance clarifies the following issues related to the direct coverage program safe harbor:

- In general, OTC COVID-19 tests must be made available through *at least one* direct-to-consumer shipping mechanism and *at least one* in-person mechanism.
- For a direct-to-consumer shipping program, plans and issuers must cover reasonable shipping costs in the same way they cover shipping costs for other items or products provided by the plan or issuer via mail order.
- Plans or issuers are not required to make *all* OTC COVID-19 tests available to participants through the direct coverage program (although all FDA-approved tests must be covered either inside or outside of the direct coverage program, except as otherwise provided in the guidance).
- The Departments will not consider a plan or issuer to be in noncompliance if it is unable to provide adequate access to covered tests due to a supply shortage.

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[1] For more information on FAQs Part 51, see "**Departments issue FAQs on coverage of over-the-counter COVID-19 tests**," *Insider*, January 2022.

Other guidance

- Only OTC COVID-19 tests that are self-administered *and* self-read must be covered. Coverage is not mandated for COVID-19 tests that must be processed by a lab or other healthcare provider.
- A plan or issuer may establish a policy that only OTC COVID-19 tests purchased from established retailers will be covered (i.e., plans may decline reimbursing tests purchased from a private individual or via online auctions, resale marketplaces or resellers).
- The cost of OTC COVID-19 tests paid or reimbursed by a plan or issuer cannot also be reimbursed by a health FSA, HRA or HSA (i.e., no "double-dipping"). Plans and issuers should consider notifying participants not to seek such reimbursement and not to use a health FSA, HRA or HSA debit card to purchase the tests.

Going forward

- Employer plan sponsors using a direct coverage program should work with their third-party administrators, pharmacy benefit managers or issuers to ensure the safe harbor is being met and to determine whether the flexibility allowed by the Departments should be incorporated into their program.
- Employer plan sponsors should inform participants of how to access OTC COVID-19 tests for either direct coverage or reimbursement.
- Employer plan sponsors should consider establishing a written policy disallowing reimbursement of OTC COVID-19 tests purchased from certain resellers.

Only OTC COVID-19 tests that are self-administered and self-read must be covered.

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HHS announces 2022 federal poverty guidelines

By Maureen Gammon and Ben Lupin

The Department of Health and Human Services (HHS) has announced the **2022 federal poverty guidelines**, also referred to as federal poverty levels or lines (FPLs). These guidelines are published annually and used by a number of federal agencies to help determine eligibility for numerous federal assistance programs, including Medicare, Medicaid, the Children's Health Insurance Program and the Affordable Care Act (ACA).

The 2022 FPLs are currently in effect. Employers may use the FPL guidelines in effect six months prior to the beginning of the plan year.

Under the ACA, the FPLs are used to determine eligibility for premium tax credits or cost-sharing reduction subsidies on the public exchange and to calculate the employee's required contribution threshold under the FPL affordability safe harbor for the employer shared responsibility mandate.

Background

An employer with 50 or more full-time employees and full-time employee equivalents (i.e., an applicable large employer, or ALE) must offer minimum essential health coverage that is affordable and provides minimum value to its full-time employees and their eligible dependents.

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To meet the affordability requirement, the employee contribution for the lowest-cost health benefit option must not exceed 9.61% (for plan years beginning in 2022) of the full-time employee's household income. In lieu of requiring employers to calculate each full-time employee's household income for the year, the IRS allows the use of three affordability safe harbors: (1) Form W-2 (based on an employee's Form W-2, Box 1 compensation reported for the year); (2) rate of pay (based on an employee's hourly or monthly rate of pay); and (3) FPL.

FPL safe harbor for affordability

For purposes of applying the FPL safe harbor, the FPL is determined by the state in which the employee is employed. The 2022 FPLs for the continental U.S. (48 contiguous states and the District of Columbia), Alaska and Hawaii are as follows:

- Continental U.S. – $13,590 (up from $12,880 in 2021)
- Alaska – $16,990 (up from $16,090 in 2021)
- Hawaii – $15,630 (up from $14,820 in 2021)

For purposes of applying the FPL safe harbor, the FPL is determined by the state in which the employee is employed.

For 2022, the FPL safe harbor is determined by multiplying 9.61% by the applicable FPL threshold and dividing that product by 12. The result is the monthly limit on the employee-only contribution for the ALE's lowest-cost option that meets the FPL affordability safe harbor (i.e., $108.83 per month for the continental U.S.).

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Supreme Court requires fact-specific analysis to dismiss excessive fee lawsuits under ERISA

By Gary Chase, Alec Dike, Bill Kalten and Michael Weddell

On January 24, 2022, in **Hughes v. Northwestern University, No. 19-1401**, the U.S. Supreme Court unanimously held that court decisions on whether to dismiss a claim that a defined contribution retirement plan offers imprudent investment options must be based on a context-specific analysis, and offering inexpensive investment options does not automatically shield plan fiduciaries from allegations that other investment options are imprudently high cost. Fiduciaries may now face a higher burden when attempting to have these cases dismissed.

Under the Employee Retirement Income Security Act (ERISA), plan fiduciaries have a duty to act reasonably, prudently and in the best interests of employees when choosing investment options. In *Hughes,* the participants claimed the plan sponsor had violated its fiduciary duties by, among other things, offering needlessly expensive investment options. The Seventh Circuit Court of Appeals dismissed the lawsuit, in part based on the fact that the plan offered other low-cost options.

The Supreme Court sent the case back to the Seventh Circuit for reconsideration, ruling that even though a plan offers a broad mix of investment options, plan fiduciaries have a duty to monitor those options and *remove those deemed to be imprudent.*

Fiduciaries may now face a higher burden when attempting to have these cases dismissed.

The Supreme Court further stated that when courts perform the necessary context-specific analysis, they must consider that fiduciaries may make a range of reasonable judgments depending on circumstances and individual experience. The Supreme Court left the determination of detailed fiduciary duties to the lower courts. This "leave it to the lower courts" action is very consistent with what the Supreme Court did the last time it considered the duties to minimize investment fees, in the 2015 case of *Tibble v. Edison International.* In *Tibble,* the Supreme Court held that fiduciaries have ongoing duties

for investment monitoring, and not just a duty to make a good selection of investments. There, too, the Supreme Court declined to articulate bright-line criteria for determining how and when fiduciary duties are met. Since 2015, we have seen an explosion in lawsuits over recordkeeper and investment plan fees, with most filings leading to settlements, with the *Hughes* case being one of the very few going to trial.

In light of this latest Supreme Court decision, fiduciaries should actively monitor their plan offerings *and take responsive action* when necessary to ensure investment and recordkeeping fees are reasonable compared with market pricing. Conducting ongoing market comparisons and resultant negotiations is also consistent with the equitable relief often agreed to in many of the settlements. While settlements almost always involve some monetary award for affected participants, they typically also include an agreement within a specified period of time for the fiduciaries to retain an independent third party to support an investment structure review or review of specific plan investments and/or to conduct a request-for-proposal-based search to consider their recordkeeping needs and fees.

Fiduciaries should actively monitor their plan offerings and take responsive action when necessary to ensure investment and recordkeeping fees are reasonable compared with market pricing.

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Washington delays long-term care payroll tax

By Maureen Gammon and Ben Lupin

On January 27, 2022, Washington passed **House Bill 1732** delaying its long-term care program — known as the WA Cares Fund — by 18 months.1 Employers must now start collecting the required payroll tax to fund the program on July 1, 2023. Employers that began collecting the payroll tax on the original start date (January 1, 2022) must return those funds to employees within 120 days of the date the taxes were withheld. Benefits under the WA Cares Fund will now be available starting July 1, 2026.

This legislation was expected, as Washington Governor Jay Inslee had previously announced efforts to delay collecting the payroll tax and amend the law to address certain concerns.[2]

The new legislation also allows Individuals born before January 1, 1968, who have not paid into the WA Cares Fund for the requisite number of years to receive partial benefits so long as they have paid the required payroll tax for at least one year.

Governor Inslee also signed **HB 1733,** which makes the following individuals eligible to voluntarily opt out of the WA Cares Fund and avoid paying the payroll tax:

1. Veterans with a service-connected disability of 70% or higher
2. Spouses or domestic partners of active duty service members
3. Persons residing outside of Washington while working in Washington
4. Persons working in the U.S. under a temporary, nonimmigrant work visa

Individuals may begin submitting applications to the Washington State Employment Security Department (ESD) to opt out for any of these four reasons beginning January 1, 2023. An exemption may be discontinued if an employee no longer meets the eligibility requirements; the employee would then have 90 days to notify the ESD and the employer

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

[2] For more information on the delay, see "**Washington announces delay in collecting long-term care payroll tax**," *Insider,* December 2021.

that he or she is no longer exempt, at which point the employer would begin collecting the required payroll tax from the employee.

Remaining unchanged is the option to opt out for employees who had qualifying long-term care insurance in effect before November 1, 2021, if they submit an opt-out application on or before December 31, 2022, and receive an approval letter from the ESD.

Going forward

- Employers that started collecting the WA Cares Fund payroll tax as of January 1, 2022, should work with their payroll providers to immediately stop any additional payroll deductions from being taken (at least until the program's new July 1, 2023 effective date) and return to employees any payroll taxes that were already withheld (within the 120-day time limit).
- Employers should retain any opt-out letters they received from employees who applied and were approved for an opt-out exemption due to having qualifying long-term care insurance in place prior to November 1, 2021. As employees have until December 31, 2022, to submit an application to the state, employers may continue to receive opt-out letters from employees who have their applications approved.

Additional changes to the law before the WA Cares Fund's new July 1, 2023 implementation date are still possible.

- While not required, employers may wish to communicate to employees about the changes to the WA Cares Fund and inform them that any payroll taxes that were withheld are being returned.
- Employers should continue to monitor the law for additional updates and guidance. The WA Cares Fund has indicated that information about the changes will be provided on its **website**.

Additional changes to the law before the WA Cares Fund's new July 1, 2023 implementation date are still possible. Amid concerns about the program's solvency, a bill to repeal the law in its entirety has been proposed, and a class action lawsuit has also been filed.

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