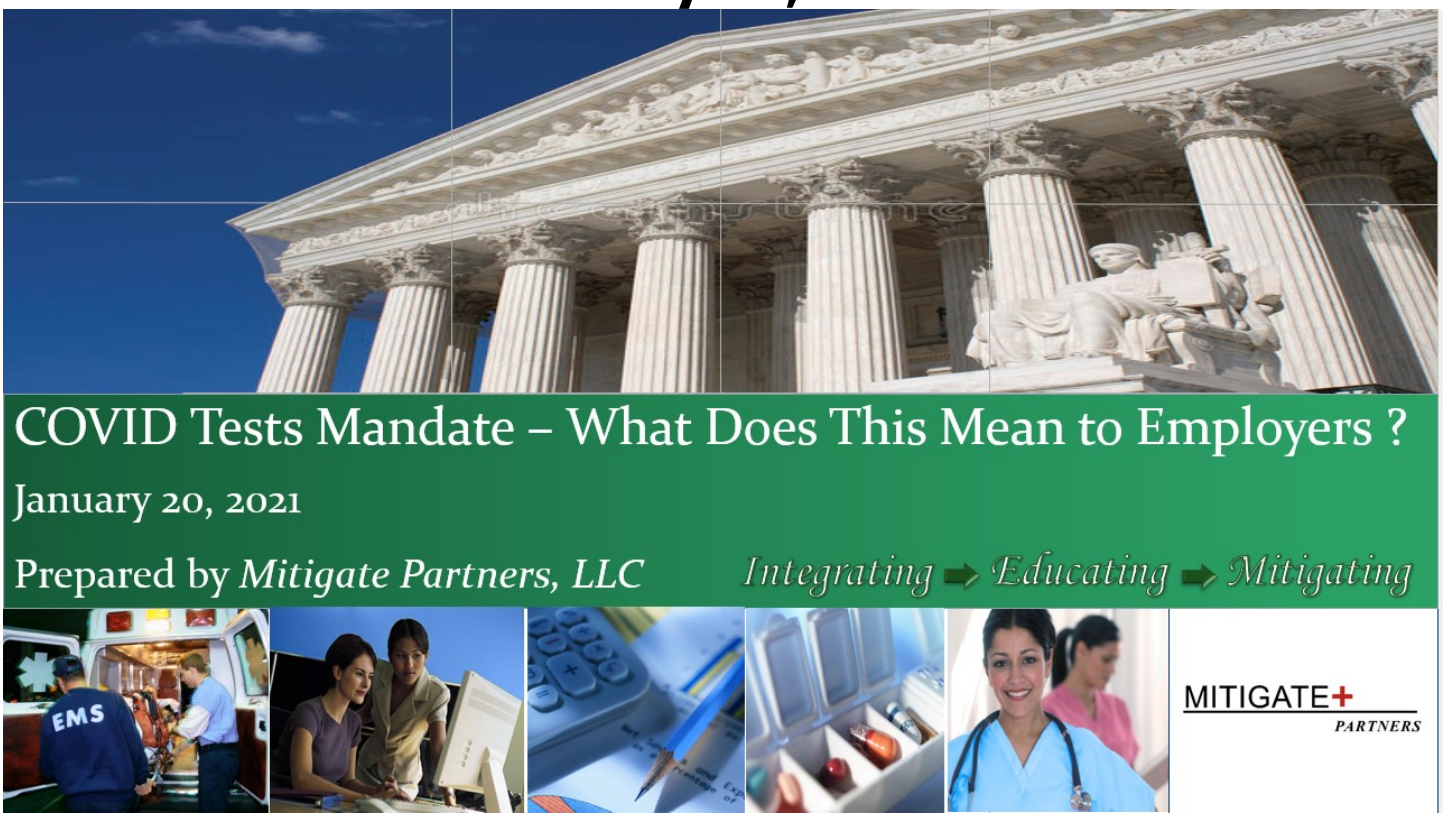
MITIGATE+ PARTNERS

Fair Cost Health Plan

Mitigate Partners
Webinar – COVID OTC Mandate
January 20, 2022



1. **We are an independent pharmacy. My question is regarding reimbursement. We pay as much if not more than $17 and $24 reimbursement rate for at home test kits. Who set the rate? I am either giving it away for free or losing money.**

   $12 is the maximum member reimbursement amount per single test allowed per the mandate if the Plan wants to meet the safe harbor requirement. Pharmacies can charge whatever they want for COVID-19 OTC tests. Health plan members would be responsible for any balance between the charged price and reimbursement amount.

   If a pharmacy elects to participate with a PBM or plan's preferred network for the tests, the negotiated amount is determined between the PBM/Plan and the pharmacy.

2. **We are getting conflicting information of where the claim should be filed, should it be a medical claim or a prescription drug claim? Who pays the claim, the insurer or PBM?**

   We are self-funded with BCBS of LA, but we carve out our PBM to an independent PBM. They seem to be pointing the finger at each other.

   This depends on your plan and there is not standard in the new law for whether pharmacy or medical should pay.
   - *If insured, your medical carrier should let you know where any reimbursement requests should be filed. Some carriers are coordinating with their integrated PBMs for this as well.*
   - *If your plan is self-funded, we suggest collaborating with your PBM and medical TPA to see what services they are offering and whether you have choices about this.*

   Your benefit consultant should be able to navigate this in partnership with your organization.

3. **I own a pharmacy. I have been selling these tests for 20 dollars. That is barely above our cost. We certainly cannot purchase the tests at 12 dollars at the moment. With that being said, am I in violation? I am not billing them through insurance. I have been just charging cash and giving them a receipt that they can bill their insurance company.**

   Pharmacies can charge whatever they want for the tests. Members who submit reimbursement claims to their health plan will receive whatever reimbursement amount is in place for their plan. If a plan is "safe harbor", the reimbursement is $12. If the plan is not "safe harbor" and test is not ordered by an attending health care provider, the full cost charged to the individual is reimbursed. If the test is ordered by a physician and out of network, the reimbursement is at the posted rate on the pharmacy's public website.

4. **Are you hearing any legal chatter about a legal challenge to this mandate or the federal government doing anything more to avoid price gauging?**

In Michigan, I've seen at least one major retailer with a pharmacy promoting their private labeled OTC tests for $89 since they are out of the lower cost alternatives.

There is a potential for legal challenge; nothing has occurred to date.

5. **We are an independent TPA in the Midwest and are seeing the same thing from the BUCA carriers. Cigna, even though they own Express Scripts has said they are still trying to figure it out. All of our independent, nimble PBM's and MBM's rolled out a point-of-sale solution very quickly.**

   It certainly has been an interesting process.

6. **What do fully insured employers need to think about as they explore building a self-funded / partially self-funded program to ensure they are limiting the financial impacts of this new requirement? Best to let the pharmacy benefit manager handle the adjudication vs medical TPA?**

   Employers with insured health plans have many considerations to consider for potential self-funding. Risk mitigation, including financial considerations, are a very important component of the evaluation process. We recommend working with an independent, experienced benefit advisor who is a self-funded expert.

7. **If a pharmacy decides to dispense an OTC test to the patient/customer and directs them to bill to their insurance, will they be reimbursed the "set" rate or the rate charged by the pharmacy?**

   In this instance, the member would pay the pharmacy's price for the test and submit the receipt and required reimbursement information to their health plan. Whether the member is reimbursed the full cost or $12 depends on whether the plan is safe harbor. If the plan had a free test adequately available, but the member chose another option for purchase, the member's reimbursement is limited to $12. If the group health plan made no tests available free at the point of sale, the full cost is reimbursed to the member.

8. Considering the supply constraints and potential price gouging: Do you recommend employers buy tests in bulk (if they can find them around $12 per test) and provide them to employees as needed? Can employers do that legally or could there be a potential HIPAA violation?

Many questions have been raised regarding the ERISA group health plan status of employers making tests available to employees under the OSHA ETS. While limiting that test giveaway to employees in the group health plan, there are still many practical and legal considerations. If an employer wants to make tests available as the distribution model to comply with the safe harbor requirements under the ACA mandate to make tests adequately available and free at point of sale, it could end up not only costing more per test, but result in legal penalties. First, remember that it is not only employees on the jobsite who are entitled to 8 tests a month. The employer would need to ensure employees on leave, remote employees, COBRA beneficiaries and other dependents (particularly adults living away from home) are also able to request and receive their 8 tests per month with adequate access. Assuming that any employer with the purchasing power to obtain tests at $12 per test in the current market must be a large employer, ensuring adequate access to tests in an ongoing manner to eligible recipients under the safe harbor would be an administrative challenge if not handled through its TPA, ASO, Carrier or PBM. Failure to meet the adequate access requirement on an ongoing basis could result in the employer being responsible for the full cost of tests purchased elsewhere. If the employer did not then pay the full cost, that failure would be deemed an ACA violation at $100 per day, per person, per violation. Any employer deciding to opt out of the safe harbor offered by its PBM or medical TPA/ASO/carrier should be aware of the potential penalties and risks and at least ensure it can quickly opt back in. Acting as the group health plan rather than the sponsor also raises issues under HIPAA and laws protecting employees from discrimination on a health status. An employer considering this strategy to satisfy the safe harbor under the Biden-Harris Mandate should consult experienced legal counsel.