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# AGENDA ITEM

☒ Action Item
☐ Information Only

**Date:** December 2, 2021

**Item Number:** VI

**Title:** COVID-19 Update, Coverage Options and Potential COVID Surcharge for Unvaccinated Members

**SUMMARY**

This report will provide the Board, participants, public, and other stakeholders information on PEBP COVID-19 claims experience and discuss potential coverage and premium options. This report provides follow up information to the September 30th COVID-19 Update report.

**REPORT**

## 6.1 COVID COST SHARING

At the beginning of the pandemic, the Governor's Emergency Declaration placed a requirement on health plans to cover COVID testing at no cost. In addition, many health plans opted to waive cost sharing for COVID-19 related treatments and hospitalizations. Although PEBP was not subject to the requirements of the Emergency Declaration, the Board opted to cover COVID testing (consistent with the regulation) and treatment at 100%. The requirement to cover COVID testing at 100% became a federal mandate, however, toward the end of 2020, as vaccines became readily available, private insurers began phasing this out and restoring cost sharing for COVID treatment.

PEBP reached out to other public employers throughout the country and state and confirmed the same trend was true within public sector health plans. Out of 11 states, only one state (Hawaii) indicated plans to continue waiving cost sharing through the end of the emergency declaration. The remaining states, plus six of Nevada public sector plans and the Culinary Health Plan, whom

PEBP contacted, either did not waive cost sharing at all or have already restored previously waived cost sharing to their plans. Cost sharing for members on PEBP's fully insured HMO plan offered in Southern Nevada was waived by HPN beginning in February 2020 but returned to normal in December 2020. As a result, there are existing inconsistencies among PEBP plans.

This is in line with an analysis of nationwide insurers by Peterson-KFF Health System Tracker that found with safe and effective vaccines now widely available that 72% of the two largest insurers in each state and DC (102 health plans) are no longer waiving these costs, and another 10% of plans phased out waivers by the end of October 2021 (healthsystemtracker.org/brief/most-private-insurers-are-no-longer-waiving-cost-sharing-for-covid-19-treatment/).

Since the vaccine became widely available in April 2020, PEBP has waived approximately $3.2M in member cost-sharing out-of-pocket expenses for COVID-19 treatment and hospitalization for members on the self-insured plans.

At the September 30th meeting, the Board requested additional information regarding various cost sharing reinstatement options, such as:

- Restoring cost sharing for unvaccinated members only
- Restoring cost sharing for those who are age-eligible for the vaccine only

HIPAA prohibits health plans, like PEBP, from discrimination based on a health condition (https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance.pdf). PEBP is unable to waive cost sharing benefits for vaccinated individuals and restore cost sharing for vaccinated individuals. If cost sharing is restored, it must be applied to all members regardless of health status and age.

*Options:*

1. Restore cost sharing for COVID-19 treatment related claims on January 1, 2022.
2. Continue 100% coverage for COVID-19 treatment related claims until the declaration of emergency is repealed on a federal or state level.

## 6.2 Employer Mandated Testing

### State Testing Mandate

Last August, the State of Nevada implemented a weekly testing requirement for unvaccinated employees. Unvaccinated employees who work remotely or in a workplace with over a 70% vaccination threshold are exempt from testing; however, the remainder of employees have been required to test weekly since the requirement was implemented. The Division of Public and Behavioral Health (DBPH) procured a vendor to perform these tests on-site at various state offices throughout the state. The cost to the state for this service is approximately $130 per test and in the first 10 weeks of testing, an average of 2700 employees tested weekly with the number

dropping to 1200 in the last week of the data that was provided to PEBP. The PEBP has been informed that the funding for the DPBH's contract with its testing vendor will run out in mid-December. PEBP has been asked to provide support in state testing activities moving forward.

### Federal Testing Mandate

On September 10, 2021, the Biden administration announced a new rule requiring large employers to mandate vaccinations or weekly testing for employees who remain unvaccinated. On November 4, the Occupational Safety and Health Administration (OSHA) published an Emergency Temporary Standard (ETS) that set the start date for many of the requirements to begin January 4, 2022. The mandate does not require the employer to pay for costs related to surveillance testing; therefore, employers can require employees to burden the costs. Employers who do not comply with the testing mandates may be subject to OSHA penalties ranging from $14,000 - $140,000 per incident.

The ETS was challenged by several states and businesses, arguing that the rule was unconstitutional and beyond the OSHA's statutory authority. On November 12th, the Fifth Circuit Court of Appeals granted a motion to stay the ETS. As a result, OSHA has suspended activities related to the implementation and enforcement of the ETS "pending future developments in the litigation."

### Other Federal Requirements

Section 6001 of the Families First Act (FFA) requires health plans to cover COVID-19 diagnostic testing at no cost to the member through the National Public Emergency period (set to expire on January 15, 2022; however, this may be extended). The FFA does not require health plans to cover employer surveillance testing (e.g. workplace testing costs). PEBP's self-funded plans currently cover all types of COVID testing claims at 100%, however, United Healthcare health plans, including the HPN HMO plan offered in Southern Nevada, and the majority of insurers nationwide generally do not cover COVID-19 surveillance testing or COVID-19 tests purchased over-the-counter without a prescription.

### Fiscal and Policy Considerations

While the federal mandate remains in limbo, it is critical that PEBP evaluate the current and potential costs associated with employer mandates as well as the consideration of options moving forward.

**2021 PEBP Testing costs***

| | |
|---:|---|
| January | **$378,527.58** |
| February | **$570,025.77** |
| March | **$352,154.08** |
| April | **$416,760.09** |
| May | **$252,015.37** |
| June | **$177,069.77** |
| July | **$327,301.42** |
| August | **$390,438.86** |

| September | **$492,755.12** |
| --- | --- |
| Total | **$3,357,048.06** |

**Costs through medical only*

The Division of Public and Behavioral Health (DPBH) estimates approximately 5000 State employees remain unvaccinated and will be subject to the mandate if it goes into effect in January. As noted above, the contract with the on-site testing vendor is set to expire in December, meaning employees will no longer have access to zero cost on-site testing and will likely be required to schedule and manage their own testing moving forward. Additionally, it is important to remember that the 70% building vaccination threshold the state currently has in place will not apply if the federal mandate is implemented. This will significantly increase the volume of employees who must submit for weekly testing. Meanwhile, NSHE has also indicated each institution is exploring contracting with vendors to provide on-site testing at their campuses to administer weekly testing for their approximately 1400 unvaccinated employees. We must also not lose sight that PEBP covers dependents, who may also be subject to testing mandates. Ultimately, all these factors have an impact on PEBP's costs.

Anticipating the impact this might, the Governor’s Office and DPBH contacted PEBP for assistance and to discuss coordinating efforts to meet the requirements of the mandate. Leveraging existing resources and steering members will help contain costs for members and the plan. This will also help better project associated expenses. The Governor’s Office is aware the program may require additional funding sources to cover the additional expenditures that come with this effort and has pledged to work closely with PEBP staff to reduce impact.

As PEBP staff began working with our vendor partners to research these efforts, it was discovered that COVID testing costs are anything but simple. COVID tests are available in numerous types of facilities and billing can vary dramatically. A COVID test can range anywhere from $0 to several hundred dollars depending on how and where the test is administered. Claims that are billed through the Pharmacy Benefit Manager (PBM) are 100% absorbed through federal agreements between HHS and pharmacies. However, COVID tests billed through the medical channel can vary drastically. For example, a drive through testing clinic at a CVS pharmacy can cost the plan approximately $130 because the claim is billed as both testing/lab and a correlating provider visit. Meanwhile, a test administered through the pharmacy is free for the plan because it is billed directly to HHS. Additionally, in many cases, such as county health district testing sites, insurance information is never even collected, meaning there is no cost to the plan in those instances either. Consequently, PEBP has no data on how many people have received testing through these no-cost channels.

Why not deny surveillance testing claims and shift the cost entirely on to employees subject to the testing mandate? The answer is simple; although insurers are not required to cover surveillance testing, insurers *are* required to provide COVID testing at 100% for diagnostic purposes. This makes it relatively easy to circumvent the system because a surveillance test can easily be paid at 100% if the member states they have been exposed or have symptoms. Furthermore, providers may be motivated to bill insurance as exposure testing knowing it will

trigger 100% coverage. Therefore, the reality is PEBP can expect to see the costs of testing rise regardless of whether the plan chooses to cover surveillance testing or not so the program must be plan accordingly.

Despite the wide range of costs and testing options, by leveraging existing partnerships for better pricing and by steering members to specific options, PEBP may be able to better control costs. For example, PEBP has explored replicating the State's current on-site testing process by securing a vendor who can administer tests at various locations throughout the state for $60/test. Testing costs for employees who participate in PEBP can be billed through the normal claims process, while those who do not may have the option to cash pay at a slightly lower price. This type of solution would allow the State to continue operating in the same manner it does today with little disruption for agencies and employees. PEBP will also be able to pivot quickly and offer other options as they become available and more reasonably priced.

*Options Available:*

1. The PEBP Board could opt to deny coverage for employer mandated testing. Employees would bear the cost of testing under this option; however, the declared diagnostic "loophole" exists and would continue to leave the plan exposed to higher costs..
2. The PEBP Board could opt to provide coverage for surveillance testing *only* through approved low-cost testing options, such as a PEBP sponsored on-site employee testing.
3. The PEBP Board could continue to provide coverage for all types of COVID testing claims, including employer mandated testing. To ensure these costs can be absorbed by the plan, PEBP may need to implement a vaccine surcharge for unvaccinated members.

***All the options above will result in increased costs to the plan and will require a new funding source to avoid impacts to benefit levels.**

## **6.3** COVID SURCHARGES

A recent survey indicated that almost 70% of unvaccinated employees would be motivated to get vaccinated if their health plan imposed a premium surcharge (https://www.affordablehealthinsurance.com/insurance-surcharge-would-motivate-vaccination/). Delta Airlines has arguably trailblazed this idea, with other private insurers quickly following in Delta's footsteps. Delta has argued that COVID-19 hospitalizations, which typically occur more frequently among unvaccinated members, have cost their self-funded health plan on average of $50,000 per incident. They believe the surcharge will help recoup the costs of avoidable COVID related hospitalizations.

PEBP reached out to other public sector health plans and while most had not implemented this type of surcharge, many were highly interested and expected to consider it at some point in the future. One large public sector health plan in Texas provided PEBP with some information on their unique approach. Their program implemented a $100 surcharge for unvaccinated

employees but also went a step further by offering two additional paid days off for those employees who are vaccinated by the end of 2021.

2021 PEBP COVID Medical claims
*(Treatment and Hospitalization)*

| Month | Amount |
|---|---|
| January | **$1,068,116.81** |
| February | **$706,084.24** |
| March | **$967,375.62** |
| April | **$512,548.24** |
| May | **$178,015.89** |
| June | **$387,269.40** |
| July | **$751,307.20** |
| August | **$667,145.96** |
| September | **$937,199.74** |
| YTD TOTAL | **$6,175,063.10** |

In response to the overwhelming interest on this subject, the Department of Labor recently released new guidance confirming the legality of COVID surcharges and also provided a much clearer "roadmap" for health plans to use when considering the implementation of these types of surcharges.

*Why Are Surcharges Necessary?*

Although employers that have implemented COVID surcharges have done so with the intent of recouping increased hospitalization costs among the unvaccinated, PEBP will also be faced with the additional factor of increased costs due to the testing mandate.

The combination of both of these potential cost drivers puts the plan in situation where we must identify revenue sources to cover these increases and because PEBP does not have the ability to change the employer subsidy amounts, the only revenue option remaining is through employee premiums.

Failing to assess surcharges will require PEBP absorb these costs in other ways such as higher premiums for all members or benefit reductions (which may impact the discussion in Agenda Item VII).

*Legal Requirements and Background:*
HIPAA prohibits group health plans, like PEBP, from discriminating against participants in eligibility, benefits, or premiums based on a health factor. A "health factor" includes an individual's health status, medical condition, receipt of health care, and medical history. A participants vaccination status is considered a health factor. Currently, there is no exemption for COVID-19. See PHS Act section 2705, ERISA section 702, Code section 9802.

However, HIPAA permits different premiums for participant's complying with programs of health promotion and disease prevention (Health and Wellness programs). There are two categories of Health and Wellness programs: Participatory and Health-Contingent.

Participatory wellness programs are akin to a "carrot" method in that it does not require the participant to satisfy a health-specific requirement (vaccination). An example would include attending a seminar or watching an educational video for a reward or benefit.

Health-Contingent programs are broken into two main categories: Activity-based or outcome-based. Requiring a participant to pay a higher premium to obtain or maintain a particular health status (like being vaccinated against COVID-19) is an outcome-based program under HIPAA wellness rules. It is noted, an outcomes-based program has to offer a reasonable alternative standard to any participant where it is "unreasonably difficult" or "medically inadvisable" for a member to be vaccinated. In other words, the Plan will have to provide another way for an unvaccinated participant to avoid the surcharge and pay the same premium as a vaccinated person. Currently, waivers exist for health or religious purposes. The Plan can provide a reasonable alternative with a preformatted waiver form that is signed by a medical professional or ecclesiastical leader.

With regards to a surcharge amount, several federal laws must be taken into consideration, such as the Affordable Care Act (ACA), the Americans with Disabilities Act (ADA) the Health Insurance Portability and Accountability Act (HIPAA) and wellness rules. Health insurance must still be deemed "affordable" under the ACA, meaning that the least expensive premium option must be less than 9.83% of the employee's household income. Since employers do not have access to household income information, the IRS provides safe harbor rules to determine affordability. These safe harbor rules account for things like federal poverty levels and minimum wage. Ultimately, the surcharge is limited to 30% of the total cost of employee-only coverage. Using this information, PEBP determined the **employee surcharge limit to be approximately $55**.

Finally, there have been reports of some providers, such as Louisiana's self-insured Ochsner Health System, assessing a surcharge on spouses or domestic partners of $200 if they are not vaccinated against the coronavirus. This is allowed because spouses and partners can opt for health insurance outside the company's plan and thus, is not a mandate. While not subject to affordability rules, a dependent surcharge is still required to comply with HIPAA wellness rules.

Since the employee surcharge amount limit is capped at $55, PEBP will need to leverage dependent surcharges to collect sufficient revenue to cover the expected costs. Using the assumptions in the following section below, PEBP anticipates needing to implement a **$175 dependent surcharge. The dependent surcharge is assessed per unvaccinated dependent.**
*Cost Projections:*

Assumptions:

- **Costs: $40/test (low) $60/test (med) $80/test (high)**

Although testing costs can have a wide range depending on where they are administered, PEBP assumes it will be able to control costs based on steerage. Initial costs appear to be approximately $60/test if administered through on-site options. These numbers are expected to drop as surveillance testing becomes more widely used and the much of these costs are shifted to employers or employees.

- **5000 unvaccinated state employees, 1250 unvaccinated NSHE employees, 95% enrolled in PEPB.**
  This is based off numbers provided by State and NSHE leadership. PEBP does not know how many of these employees will be exempt from testing due to remote working, etc. It is expected the unvaccinated NSHE employees will decline once the Dec 31 vaccination deadline passes.

- **5% surcharge exemption rate for state, 100% rate for NSHE**
  The 5% is based off Aon internal tracking by SME's, using Boeing and Delta experience. NSHE has implemented mandates, so the assumption is that anyone unvaccinated has received an exemption.

- **Dependent surcharge assumes dependents 18 years of age or older**
  Dependent surcharges will only be assessed on dependents 18 and older and assumes a vaccination rate of 80%.

| | Surcharge Revenue | Testing Costs | | |
|---|---|---|---|---|
| | | Low | Med | High |
| State | ($15,359,273) | $9,900,492 | $14,850,738 | $19,800,983 |
| NSHE | ($3,045,997) | $2,475,123 | $3,712,684 | $4,950,246 |
| **Total** | **($18,405,270)** | **$12,375,615** | **$18,563,422** | **$24,751,229** |

It is important to note that this is a very fluid situation and as PEBP receives more accurate data around these numbers, the projections in the tables above may likely change. The following are just some of the dependencies that can greatly impact plan costs in the coming months:

- Legality of Federal Mandate
- State mandate
- Increase in surveillance testing
- Vaccination numbers
- Remote workers and terminations
- Hospitalization costs
- COVID Pill

As more information and data is gathered, PEBP expects to adjust the dependent surcharge amount.

*Process*

PEBP's new enrollment and eligibility system vendor has implemented functionality that allows employers to administer a COVID surcharge, similar to how smoking surcharges are managed. Employees would have the ability to upload copies of their vaccine cards beginning in January through the end of Open Enrollment (OE). The system also can accept vaccination data from an outside source, so PEBP is exploring the ability to acquire employee vaccination status from the state to ease the burden on employees who have already received their vaccination. Members who have not provided proof of vaccine by the end of OE would be assessed the appropriate surcharge on their PY23 premiums. As unvaccinated employees become fully vaccinated and provide the proof to PEBP the surcharge would be removed.

*Exemptions*

To meet the "reasonable alternative" requirement, PEBP would allow unvaccinated members to submit medical and religious exemption requests. NSHE, who recently mandated vaccination among both staff and students, has established an exemption process which requires those seeking a medical exemption to submit a form completed by a medical provider and those seeking a religious exemption to provide an attestation for review. PEBP, working closely with the Governor's Office and legal counsel, would likely establish a very similar exemption process.

***Recommendations:***

1. ***Reinstate cost-sharing for COVID related treatment and hospitalization and apply existing plan rules to COVID related treatment and hospitalization claims effective January 1, 2022.***
2. ***Allow surveillance testing coverage only through PEBP sponsored vendors.***
3. ***Implement a COVID surcharge effective 7/1/2022 for all unvaccinated primary members of $55/mo. per employee.***
4. ***Implement a $175/mo. COVID surcharge effective 7/1/2022 for unvaccinated spouses/domestic partners and dependents 18 years of age and older.***