SPECIAL COMPLIANCE ALERT

Guidance Released for Health Plan Coverage of OTC COVID-19 Tests

EPIC Insurance Brokers & Consultants

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Quick Facts

- On January 10, 2022, guidance was released requiring group health plans and insurers to cover over-the-counter (OTC) COVID-19 diagnostic tests without cost-sharing or provider authorization.
- Coverage for COVID-19 OTC tests begins Saturday, January 15, 2022.
- Plans may choose to reimburse sellers of COVID-19 home test kits directly or reimburse plan participants directly for the purchase.
- The guidance applies to self-funded, fully insured, grandfathered and individual health plans.

Background

On January 10, 2022, the Department of Labor (DOL), Department of Health and Human Services (HHS) and the Treasury Department ("The Departments") released a series of **Frequently Asked Questions (FAQs)** under the Affordable Care Act (ACA) Part 51, in response to the Biden administration's directive to issue guidance requiring group health care plans and insurers to provide coverage of OTC, in-home COVID-19 diagnostic tests. Beginning Saturday, January 15, 2022, group healthcare plans, including fully insured and self-funded plans and individual insurance policies, will be required to cover the cost of OTC, in-home COVID-19 tests without any cost-sharing or requirements that participants obtain authorization for the tests.

The FAQs build upon the requirements of the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) for coverage of COVID-19 diagnostic testing and the Affordable Care Act preventive care requirements. In addition, the FAQs include guidance on coverage of preventive services.

Summary of OTC COVID-19 Tests Coverage (FAQs One through Six)

The guidance is applicable to self-funded and fully insured group health care plans, including grandfathered health plans ("plans").

- As of Saturday, January 15, 2022, plans and issuers must cover the cost of OTC COVID-19 tests, including tests obtained without a healthcare provider's order or authorization.
- Coverage must be provided without cost-sharing (deductibles, copayments and coinsurance) or prior authorization requirements.
- Plans must reimburse participants for the cost of testing per the plan's claims procedures.
- Plans are not required to reimburse sellers of the kits directly but may do so voluntarily.
  - The guidance "strongly encourages" plans to provide direct coverage for OTC COVID-19 tests by reimbursing sellers directly without requiring participants to seek reimbursement.

NOTE: the guidance specifically states that plans and issuers are not required to provide coverage of testing (including an OTC COVID-19 test) that is for employment purposes. Although as a practical matter, it may be difficult for plans and issuers to distinguish the difference between tests purchased for medical necessity versus those purchased for employment purposes.

Safe Harbor for Direct Plan Reimbursements to Sellers

Plans may not restrict reimbursements to OTC tests provided only by certain pharmacies or other retailers; however, plans may limit reimbursements for tests purchased from non-network pharmacies or other retailers to $12 per test or the actual price, whichever is lower.

- To satisfy this "safe harbor," plans must ensure there is adequate in-network access to OTC COVID-19 tests, based on all the relevant facts and circumstances, and must implement the system changes necessary to process payment to the pharmacy or retailer directly.
- Plans may set a limit of no less than eight tests per 30-day period (or calendar month) per participant for tests that do not involve a provider. For example, a family of four covered by a health plan may obtain 32 tests in a 30-day period.

The Departments note that this safe harbor applies only with respect to the coverage of OTC COVID-19 tests that are administered without a provider's involvement or prescription. Plans and issuers must continue to provide coverage for COVID-19 tests that are administered with a provider's involvement or prescription, as required by section 6001 of the FFCRA and the Departments' guidance, even when relying on this safe harbor.

Plans may take reasonable steps to ensure that the covered test is purchased for the individual's own use including an attestation by the participant that the test is for the participant's (or beneficiary's or enrollee's) own use as long as these steps do not create "significant barriers" for these individuals to obtain the test. Plans may require reasonable documentation, such as a receipt, as proof of purchase with an individual's claim for reimbursement.

Facilitating Access, Use and Payment for COVID-19 Tests

The guidance encourages plans (and thus, plan sponsors) to educate and support participants seeking OTC and provider involved COVID-19 testing including providing the following information:

- Explaining the difference between OTC tests and tests ordered by a health care provider;
- The reliability of tests, shelf life, and expiration dates;
- How to obtain tests directly from the plan or designated sellers; and
- How to submit a claim for reimbursement.

Summary

Employers/plan sponsors must ensure the plan is prepared to provide reimbursements to participants for OTC COVID-19 testing, or that the plan will be able to reimburse the sellers of test kits directly. This will require working with your insurance carrier or self-funded third-party administrator (TPA). The **Departments' FAQ Part 51** also includes new guidance for the coverage of preventive colonoscopies and clarifications on coverage for FDA-approved contraceptive products. We will provide additional details on the full FAQ in our next Compliance Matters alert released in February.

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