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Group Health Plans Must Cover at-Home COVID-19 Tests

Labor & Employment Workforce Watch

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According to Frequently Asked Questions (FAQs) recently issued by the Departments of Labor, Treasury and Health and Human Services (collectively, the Departments), group health plans and insurers must cover over-the-counter COVID-19 tests (OTC Tests), including tests not ordered by a health care provider, without participant cost-sharing, preauthorization, or medical management.

Background

The Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) generally require group health plans and insurers to cover the cost of COVID-19 testing, but guidance previously issued by the Departments limited coverage for COVID-19 tests to those ordered by a health care provider.

At the time the prior guidance was issued, the FDA had not authorized any COVID-19 diagnostic test for use and processing completely at-home. Since then, FDA-approved at-home COVID-19 tests, which can be self-administered and self-read, have become widely available, either with a prescription or over-the-counter. Under the prior guidance, it was unclear whether OTC Tests were subject to the same coverage requirements if not prescribed by a health care provider.

On December 2, 2021, President Biden announced that the Departments would issue updated guidance to clarify that individuals who purchase OTC Tests during the public health emergency will be able to seek reimbursement from their group health plan or insurer. The FAQs confirm that group health plans and insurers must provide coverage of OTC Tests without participant cost-sharing, preauthorization, or medical management.

The FAQs

The FAQs provide the following guidance:

- The coverage requirement applies with respect to OTC Tests purchased on or after January 15, 2022, and continuing through the duration of the public health emergency. Coverage may, but is not required to, be provided for OTC Tests purchased without a provider order before January 15, 2022.
- Group health plans can make OTC Tests free to participants by directly reimbursing sellers of OTC Tests (referred to as “direct coverage”). Under direct coverage, the plan will make tests available through its pharmacy network or other retailers or through a direct-to-consumer shipping program without any out-of-pocket cost to the participant. Alternatively, group health plans can reimburse participants who purchase an OTC Test

from a pharmacy or other retailer and submit a claim for reimbursement. The guidance strongly encourages direct coverage of OTC Tests.

- Group health plans that provide direct coverage may not limit coverage to preferred pharmacies or retailers. However, if a plan provides direct coverage, the guidance provides a safe harbor allowing plans to limit reimbursement for tests purchased from non-preferred pharmacies or retailers to $12 per test or the actual cost of the test, whichever is less. In order to rely on this safe harbor, the plan must take reasonable steps to ensure participants have adequate access to OTC Tests by providing a sufficient number of retail locations to obtain the tests (both in-person and online). If a plan does not establish a direct coverage program, the plan may not limit the amount of reimbursement and must cover the participant's actual cost to purchase the OTC Tests.
- Group health plans will not be out of compliance with the safe harbor if they establish a compliant direct coverage program but are temporarily unable to provide adequate access due to a supply shortage of OTC Tests. If this happens, the plan can limit reimbursement to $12 (or the actual cost, whichever is lower) for OTC Tests purchased outside of the direct coverage program.
- Group health plans are required to cover at least eight OTC Tests per 30-day period (or per calendar month) for each participant, beneficiary or other family member enrolled in the plan. Plans cannot limit participants, beneficiaries, or enrollees to a smaller number of tests over a shorter period (for example, limiting individuals to four tests per 15-day period), but may set more generous limits. Where multiple tests are sold in one packet, plans may count each test separately.
- The FAQs confirm that group health plans are not required to cover OTC Tests purchased for employment purposes (such as employer-mandated testing) or COVID-19 tests that use a self-collected sample but require processing by a laboratory or health care provider.
- Group health plans may take reasonable steps to address fraud and abuse as long as such steps do not create "significant barriers" for participants to obtain the tests. For example, a plan may require an attestation, such as a signature on a brief attestation document, that the OTC Test was purchased for personal use and not employment purposes, and will not be reimbursed by another source or resold. Additionally, a plan may request proof of purchase, such as a receipt and/or UPC code.
- Plans can limit coverage of OTC Tests to tests purchased from established retailers that would typically be expected to sell OTC Tests. Plans may disallow reimbursement for OTC Tests purchased from private individuals, online auctions or resale marketplaces.
- OTC Tests that are paid for or reimbursed by a group health plan cannot be reimbursed by a health flexible spending account (FSA) or health reimbursement account (HRA). Similarly, expenses incurred for OTC Tests paid or reimbursed by a group health plan are not qualified medical expenses for purposes of distributions from an individual's health savings account (HSA). If an individual mistakenly receives reimbursement from the FSA or HRA for OTC Tests that have been reimbursed by the group health plan, the individual will need to correct the erroneous reimbursement in accordance with the plan's correction procedures. Employers may wish to advise individuals not to use a health FSA or HRA debit card to purchase OTC Tests for which the individual intends to seek reimbursement from the group health plan.

For fully insured plans, employers should contact the insurer to determine how they will comply with this change. For self-insured plans, employers should contact the pharmacy benefit managers and/or third party administrators to determine which vendor will be responsible for compliance. Plans should also consider how best to communicate this benefit change to participants.

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