Bolton ALERT

January 2022

Guidance for Required Coverage of OTC COVID-19 Tests

On January 10, 2022, the Departments of Labor, Health and Human Services (HHS), and the Treasury issued FAQ guidance regarding the requirements for group health plans and health insurance issuers to cover over-the-counter (OTC) COVID-19 diagnostic tests.

Legal Requirements

Plans and issuers must cover the costs of COVID-19 tests during the COVID-19 public health emergency without imposing any cost-sharing requirements, prior authorization, or other medical management requirements.

Under guidance issued in June 2020, at-home COVID-19 tests had to be covered only if they were ordered by a health care provider who determined that the test was medically appropriate for the individual. At that time, the FDA had not yet authorized any at-home COVID-19 diagnostic tests. Since then, several types of OTC at-home tests have been approved.

As of January 15, 2022, the cost of these tests must be covered, even if they are obtained without the involvement of a health care provider. However, the FAQs do not require tests to be covered if they are not for individualized diagnosis (such as tests for employment purposes).

Plan Options

Plan and insurance issuers may place some limits on coverage, such as:

- Requiring individuals to purchase a test and submit a claim for reimbursement, rather than providing direct coverage to sellers.
- Providing direct coverage through pharmacy networks or direct-to-consumer shipping programs and limiting reimbursements to other sources (the actual cost of the test or $12, whichever is lower).
- Setting limits on the number or frequency of OTC COVID-19 tests that are covered (no less than eight (8) tests per person enrolled per month or 30-day period).
- Taking steps to prevent, detect and address fraud and abuse.

Employer Considerations

The individual reimbursement option prohibits the imposition of a dollar limit per test, which could increase costs for plan sponsors. Under the direct coverage option, plan sponsors can limit the cost of seller

reimbursements to $12/test. However, this option requires coverage through the medical benefit and/or the pharmacy benefit to meet access requirements. Health plans may be subject to increased costs if claims cannot be accumulated between medical and pharmacy benefits, reducing the plan's ability to impose limits. To help ease plan cost, plan sponsors can direct participants to this Federal resource which provides four (4) free OTC tests per home address. Plan sponsors should contact Bolton or their insurance carrier(s) for plan-specific coverage details and communications.

Contact your Bolton Consultant to discuss how this requirement may impact your Group Health Plan.