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Health Plans Must Cover Over-the-Counter COVID-19 Tests for All Participants

Federal regulators recently released FAQs providing that health plans are now required to cover over-the-counter (OTC) COVID-19 tests for all participants through the remaining duration of the pandemic, without requiring an order from a health care provider. Previously, coverage of OTC tests was only required with respect to individuals who received a special order or clinical assessment from a health care provider. The new FAQs also provide guidance relating to required coverage of colonoscopies and contraceptives under the Affordable Care Act.

Section 6001 of the Families First Coronavirus Response Act (FFCRA), as amended by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), generally requires coverage of COVID-19 tests. Federal regulators have issued four sets of FAQs clarifying this requirement prior to the current FAQs. The latest FAQs expand this requirement to cover OTC tests without requiring any special assessment or order from a health care provider. In addition, coverage cannot be subject to any cost-sharing, prior authorization, or medical management requirements (except as noted below). This new rule is effective with respect to tests that are purchased on or after January 15, 2022, and prior to the end of the public health emergency (which is still ongoing).

Coverage of OTC COVID-19 tests may be limited in certain ways. Importantly, health plans are not required to cover testing that is intended for employment purposes. In addition, the FAQs permit certain specified limitations as to the frequency of and circumstances under which OTC COVID-19 tests may be covered. These are explained briefly as follows –

1. ***Fraud Reduction.*** Certain administrative procedures (such as requiring a signed statement indicating that the participant does not intend to re-sell the test) are expressly permitted for the purpose of reducing the risk of fraud, provided that they do not unduly hamper a participant's effective ability to take advantage of their right to obtain OTC COVID-19 tests.
2. ***Quantity Limitations.*** Health plans may impose a quantity limitation no less generous than 8 tests per 30-day period or per calendar month for each participant, beneficiary or enrollee.
3. ***Preferred Providers and Reimbursement.*** The FAQs clarify that health plans may require participants to pay for OTC COVID-19 tests upfront, and then file a claim for reimbursement. Health plans are also encouraged to establish direct payment systems where possible. A health plan may allow participants to purchase OTC COVID-19 tests directly through its pharmacy network (both mail order and store pharmacies) or at specific retailers at no cost to the participant. However, if a health plan limits the purchase of OTC COVID-19 tests directly from preferred pharmacies and/or preferred retailers at no cost, health plans must also allow manual reimbursement for OTC COVID-19 tests from non-preferred pharmacies or non-preferred retailers at no less than the actual price or $12 per test (whichever is lower).

For example, a health plan with a PBM may restrict participants to obtain OTC COVID-19 tests from its

mail order program and network pharmacies at no cost to the participant. However, if a participant purchases OTC COVID-19 tests from non-network pharmacies and non-preferred retailers, the health plan must allow the participant to file a manual claim for reimbursement and must reimburse such claim at the actual cost or $12 per test, whichever is lower. In this situation, the direct coverage program from preferred pharmacies and/or preferred retailers must be sufficiently broad for all participants to have adequate access to the no-cost direct coverage from the preferred pharmacies and/or preferred retailers.