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The New Requirement for Health Plans and Insurance to Cover the Cost of Over-the-Counter COVID-19 Tests

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1. How does the new requirement for cost-free coverage of COVID-19 tests work?

Starting January 15, 2022, group health plans (self-insured plans) and health insurance issuers (such as insurance companies) must cover the cost of FDA-approved at-home over-the-counter COVID-19 tests even when obtained without a health care provider's involvement. Coverage must be provided without cost-sharing, prior authorization, or other medical-management requirement. Prior to the new requirement, no-cost coverage of COVID-19 tests required that the individual had an order or individualized clinical assessment from a health care provider.

For more information, please can review the following.

- Guidance from the Department of Health and Human Services, Department of Labor, Treasury Department
- Guidance from the Centers for Medicare & Medicaid Services

2. How many tests can people obtain, and how frequently can they get them?

Under the new requirement, health plans and health insurance issuers can limit the number of tests to no more than eight per 30-day period per member per month; however, they cannot establish limits for shorter periods of time, such as four (4) tests every 15 days. For example, for a family of four who are covered health plan members, health plans and health insurance issuers are required to cover 32 tests a month. The limit can be applied to the number of tests provided as opposed to the number of packages purchasd; absent language more generous than the requirement, this means if a single box contains two tests, it would count as two tests toward the limit.

3. Can cost-free coverage be limited to antigen tests?

Given that the new requirement does not establish differences in no-cost test acquisition based antigen and PCR tests, we do not believe that health plans and health insurance issuers can restrict the type of test covered. However, if the plan or issuer puts in place preferred test providers or preferred online distribution requirements, PCR tests obtained outside those preferred approaches can cost more than antigen tests and, if above the cost cap for such situations, can lead to higher out-of-pocket costs. See Question 6 for more information about preferred test providers and the cap.

4. Can I submit for reimbursement of tests purchased before January 15, 2022?

No, the new requirement only covers tests obtained without health care provider involvement on or after January 15, 2022. However, a health plan or health insurance issuer might cover such tests obtained prior to that date. The new requirement is in effect for the duration of this public health emergency. Your state may have other requirements related to coverage of COVID-19 tests.

5. Will tests be provided directly or will I have to submit for reimbursement?

The goal of the new requirement is to ensure that people covered by health plans or health insurance have easy, cost-free access to COVID-19 tests. Health plans and health insurance issuers can require individuals to submit receipts for reimbursement of the out-of-pocket cost of purchasing tests, or they can provide direct access to tests so that there are no upfront costs. Health plans and health insurance issuers might allow for both options.

6. If direct access to tests is offered, can the source of tests be limited?

As long as health plans and health insurance issuers cover at least a minimum amount of tests obtained through non-preferred providers, they can limit completely cost-free tests directly to those provided through their preferred network, using pharmacies or other retail stores and direct-to-consumer shipping programs. However, health plans and health insurance issuers must ensure that tests are available through their preferred providers; for example, they cannot have delays that are significantly longer than the amount of time it takes individuals to receive other items under their direct-to-consumer shipping programs. They also have to ensure adequate tests are available in person and online through preferred retail outlets.

If preferred test providers are used for direct access to tests without out-of-pocket costs, the cap for non-preferred providers is lower than the actual cost of the test—or $12 per test. As a result, if a covered individual purchased a test for $15 through a non-preferred provider, the individual would be responsible for payment of $3.

7. If a system for preferred test providers is not established, can coverage amounts be capped?

No, if a preferred test provider system is not established, health plans or health insurance issuers cannot limit how much they will reimburse. If they do not set up a process in which members can obtain at-home tests with no upfront costs, then health plans or health insurance issuers must reimburse the full cost of the test.

8. Does the new requirement cover costs related to employment-related tests?

No, the new requirement is for individual testing, not employment-related use of COVID-19 surveillance tests. If an employer requires COVID-19 testing for work purposes—such as access to a place of employment or returning to work after a COVID-19 infection—health plans and health insurance issuers do not need to cover the cost of the tests. However, they can cover such costs without cost-sharing.

9. Can I give tests obtained under the new requirement to other people?

Tests obtained under the new requirement are for members and their covered dependents only; they are not for friends, coworkers, or non-covered family members.

10. Can I be required to prove I am only using tests for myself or my covered dependents?

Health plans and health insurance issuers can require you to attest to obtaining tests for personal use by you or your covered dependents. However, they cannot require you to submit multiple documents to demonstrate that you were doing so.

11. Can implementation of the new requirement wait for plan amendments?

No, the implementation of the new requirements must be in place by January 15, 2022, and must remain in place for the duration of the public health emergency. Health plans and health insurance issuers are permitted to amend the terms of the plan or coverage to add benefits or reduce or eliminate cost-sharing for the diagnosis and treatment of COVID-19 without taking into account otherwise applicable requirements regarding notice of modifications and mid-year changes to coverage.

12. Are Medicare, Medicaid, and CHIP included?

The new requirement does not apply to Medicare, but community health centers and Medicare-certified health clinics are expected to make no-cost at-home tests available for Medicare enrollees in the very near future.

Although Medicaid and the Children's Health Insurance Program (CHIP) are not covered under the new requirement, they are already required to cover cost-free at-home COVID-19 tests.

13. What should unions and union members consider and ask for?

Keep in mind that, generally, self-insured health plans have greater flexibility in adopting the new requirement than fully insured plans because third-party and other plan administrators do not carry the financial risk of covering plan costs. In general, fully insured plans are more likely to dictate the terms of changes to employers. At the same time, for self-insured plans, increased costs from the new at-home COVID-19 test requirement will need to be addressed by the employer plan, trust, or other arrangement. On the other hand, health plans and health insurance issuers that face costs for treating people who get sick with COVID-19 have a strong incentive to facilitate no-cost at-home testing to help slow the spread of the disease, safeguard the health of covered individuals, and minimize costs.

The National Education Association (NEA) strongly encourages employers to provide COVID-19 tests to employees for employment-related purposes, if needed; for example, this would apply to individuals who are required to access a workplace or return to work after quarantine, isolation, or recovery from a COVID-19 related illness. For more information on federal and state programs to facilitate no-cost COVID-19 tests in public schools, see NEA's website: COVID-19 Testing in Schools.

NEA affiliates and members should seek:

- Direct coverage of no-cost tests for non-employer-related purposes rather than the need to submit receipts for reimbursement;
- Inclusion of employment-related testing within health plan or health insurance coverage where employers do not already provide cost-free tests or have other access to cost-free tests for these purposes;
- Establishment of a broad, efficient preferred test provider system to minimize unnecessary out-of-pocket test-related costs for members and their covered dependents;
- Clear written information in all appropriate languages on how the new requirement will be implemented and how tests can be obtained;
- Phone- and internet-based provision of information in all relevant languages on how the new requirement will be implemented and how tests can be obtained; and
- An explanation of any state-specific testing requirements that differ from those of the new requirement.