DOL Guidance on At-Home COVID Tests

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Yesterday the DOL issued a series of FAQs regarding President Biden's directive to cover over-the-counter (OTC) or at-home COVID testing. This new legal requirement comes at a time where tests are scarce, cases are rising, and the Supreme Court is considering what to do with the federal vaccine or test mandates.

Here is a summary of what the new rules require for multiemployer plans and how they would - based on the current state of the law - interact with the OSHA, CMS, and federal contractor mandates:

Q: When does our plan have to start covering OTC at-home COVID tests?

A: The requirement takes effect on January 15, 2022, and will remain until the end of the national health emergency, which is not anticipated to end anytime soon.

Q: How many tests does our plan have to cover?

A: Your plan may choose to limit each eligible participant to 96 tests per year (8 per month) provided it adheres to certain conditions, which we discuss below.

Q: Can our plan require prior authorization or a doctor's note to purchase the tests?

A: No. Your plan could require participants to sign a form stating the tests are medically necessary, that the tests will not be used for employment purposes, and that the tests will not be resold. However, the guidance does provide a penalty for false statements and further provides that any procedures to police fraud and waste cannot be "overly burdensome." Ultimately, it will difficult if not impossible to limit purchases only for medical reasons.

Q: How does our plan pay for the tests?

A: There are two options: directly paying for them through your plan's pharmacy network or by requiring that participants purchase them and then seek reimbursement from the plan. Not surprisingly, the guidance is written in a way

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that steers plans toward direct coverage and away from requiring participants to seek reimbursement.

Q: How much are these tests going to cost?

A: This is where steerage toward direct coverage comes into play. If a plan provides direct coverage through its pharmacy network (i.e., no requirement for participants to seek reimbursement) then it can cap the cost of tests *obtained out of network* to $12 or the cost of the test, whichever is less. However, the price cap is permitted only if there are enough tests available through the direct coverage option. Determining whether or not enough tests are available involves applying a facts-and-circumstances-test which is not surprisingly, very vague. Factors to consider include geographic location, how many tests are available at local pharmacies, and consideration of the "overall intent" to create easy access to testing. Without more guidance, a reasonable approach for plans to take is not to apply the $12 cap during any period where it is clear there is a testing shortage in the areas where most plan participants are concentrated. Your plan's PBM should be able to assist if not be able to make this determination outright since it will undoubtedly be up-to-date on any ongoing supply chain challenges.

Q: What if participants want to buy more than the maximum number of tests?

A: If your plan implements the safe harbor and a participant wants to buy more than their allotment of 8 monthly tests, they will have to pay for them. If your plan has a medical reimbursement account, the participant should be able to use it to cover this cost.

Q: Can participants use these OTC tests for return-to-work purposes under any of the federal vaccine mandates?

A: No, not for any state or federally imposed vaccine mandates. All of the federal mandates (including the OHSA Emergency Standard) require a negative COVID test that is conducted by a medical professional and even the new DOL guidance directly states that the OTC tests cannot be used for this purpose. However, in the absence of state or federal mandates, private employers remain free to require vaccination or alternatives such as masking and testing. In that situation, it is possible a private employer could decide that at-home tests are sufficient.

Q: How does the OTC guidance impact our plan's coverage of professional tests (rapid/PCR)?

A: It does not have any impact. Rapid and PCR tests are still required to be covered by the CARES Act for medical purposes. However, *keep in mind that no federal laws require the coverage of return-to-work testing*. While the law does not require such coverage, it is likely occurring since most testing centers are not asking for a reason when someone get a test. We are evaluating options to address this concern with our clients' network providers and PBMs.

Q: What should be communicated to plan participants who call the union hall or the fund office?

A: Plan participants that contact the fund office can be advised that the plan will cover at-home COVID tests and that the limit is likely going to be 8 per person per month. They can also be told to expect a notice in the very near future either from the fund office or from the plan's PBM concerning this topic. Participants can also be told that at-home COVID tests *cannot* be used to satisfy any government mandated return to work testing requirements.

Yesterday's guidance will undoubtedly add costs and administrative complexity to your health plan's operations. PBMs are likely to try and provide a direct coverage option to take advantage of the safe harbor. As the guidance is just over 24 hours old, we expect more information and clarity to emerge in the next few days as PBMs and network providers get their arms around this new requirement.

We will communicate any significant developments to you as they occur. In the meantime, please feel free to contact us with any questions.