TRINIDAD NAVARRO
COMMISSIONER

STATE OF DELAWARE
DEPARTMENT OF
INSURANCE

DOMESTIC AND FOREIGN INSURERS BULLETIN NO. 115 (UPDATED)

TO: **ALL INSURANCE CARRIERS AUTHORIZED TO TRANSACT HEALTH INSURANCE IN DELAWARE AND OTHER INTERESTED PARTIES**

RE: **COVERAGE FOR COVID-19 (CORONAVIRUS)**

DATED: **March 9, 2020**
UPDATED: **February 4, 2022**

The purpose of the original version of this bulletin was to encourage health insurers to be proactive in planning for Coronavirus disease 2019 (COVID-19).

The purpose of this update is to encourage health insurers to proactively provide Delaware's hospitals with much needed relief and to remind insurers of federal requirements pertaining to at-home tests and the now-effective Federal No Surprises Act.

With more COVID-19 hospitalizations in Delaware than ever before, Delaware's hospitals are running over capacity, placing significant strain on hospital staff and resources. Accordingly, Section D of this bulletin encourages forms of relief for hospitals (the Hospital Relief Provisions) concerning:

- Prior authorization requirements, particularly for patient transfers
- Claim submission limits and appeal limits
- Audits, prepayment reviews, recoupment actions and payment suspensions
- Requests for itemized bills, medical record requests and other information.

I. What is COVID-19?

COVID-19 is a disease that is caused by a respiratory virus, named SARS-CoV-2. It has the potential to cause severe illness in some people.

COVID-19 spreads through the air by coughing and sneezing, close personal contact such as touching or shaking hands, and touching an object or surface with the virus on it and then touching one's mouth, nose, or eyes.

The Delaware Division of Public Health's (DPH) website contains up-to-date information concerning COVID-19, including downloadable/printable materials. The website may be accessed at https://coronavirus.delaware.gov/. DPH has also set up a COVID-19 call center, 2-1-1.

Additionally, the Federal Centers for Medicare and Medicaid Services (CMS) provides updated information on the range of CMS activities to address COVID-19 on its website, https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.

II. What obligations do carriers have under the Delaware Insurance Code?

Coverage requirements applicable to individual health insurance policies are promulgated at Title 18, Chapters 33 and 36, and provisions applicable to group and blanket health insurance are promulgated at Title 18, Chapter 35, Subchapter III. Some provisions that are particularly germane to COVID-19 preparations are discussed below.

A. Testing for COVID-19

It is important to remove barriers to testing for COVID-19. Carriers are therefore reminded that laboratory tests are an essential health benefit ("EHB") that must be covered under individual and small group comprehensive health insurance policies and contracts, and that annual and lifetime dollar limits with respect to essential health benefits are prohibited (*see* 18 *Del. C.* §§ 3368 and 3571I). Federal requirements for testing coverage are described in IV.

B. Telemedicine and Telehealth

COVID-19 is a communicable disease, and therefore, some insureds may choose to seek medical advice through telehealth services instead of in-person health care services. House Bill 160 w/ HA 1 of the 151st General Assembly, known as the **Telehealth Access Preservation and Modernization Act of 2021**, continues and enhances Delawareans' access to telehealth and telemedicine services and, through the adoption of the Interstate Medical Licensure Compact, ensures that telehealth services can be provided through qualified medical practitioners in a streamlined and efficient pathway to licensure that meets the health care delivery system needs of the 21st century. **The bill was signed, effective July 1, 2021 for the telehealth provisions, and July 1, 2022 for the Compact provisions.**

Accordingly, carriers are directed to ensure that, as applicable, their telehealth and telemedicine programs with participating providers are robust and will be able to meet any increased demand. Services may be provided through a variety of platforms, including telephones, remote patient monitoring devices, and other electronic means such as web cameras and mobile facetime.

C. Network Adequacy and Access to Out-of-Network Services

Carriers are directed to verify that their provider networks are adequate to handle a potential increase in the need for health care services if any COVID-19 cases are diagnosed in Delaware.

Carriers are also reminded that the Delaware Insurance Code at 18 *Del. C.* §§ 3348 and 3564 provides that if a carrier does not have a health care provider in its network with the appropriate training and experience to meet the particular health care needs of an insured, the carrier must provide access to an out-of-network provider at the in-network cost-sharing reimbursement level.

D. Timely Utilization Review

General requirements:

Timely decision-making is essential to responding appropriately to COVID-19, and it is particularly important with respect to utilization review. Carriers are reminded that utilization review decisions must be made in the timeframes set forth in Chapter 33 Subchapter II and Chapter 35, Subchapter V of the Insurance Code.

Additionally, appeals after claim denial must be timely addressed within the timeframes set forth 18 *Del. C.* § 6416.

Carriers should not use pre-authorization requirements as a barrier to access necessary treatment for COVID-19 and should be prepared to expedite utilization review and appeal processes for services related to COVID-19 when medically appropriate. *See* Pre-Authorization Transparency requirements set forth in 18 *Del. C.* Chapter 33, Subchapter II and Chapter 35, Subchapter V.

The Hospital Relief Provisions

1. Prior authorization requirements, particularly for patient transfers – Carriers are encouraged to temporarily waiving all prior authorization requirements concerning transferring patients out of the acute care setting and into post-acute settings, including long term care facilities, Skilled Nursing Facilities (SNFs) and home care.

2. Claim submission limits and appeal limits – Carriers are encouraged to allow hospitals up to twelve (12) months to submit claims to ensure they are filed appropriately. Additionally, carriers are encouraged to allow providers six months to appeal a denial. Finally, carriers should endeavor to pay any corrected claim/appeal as promptly as possible, and in accordance with Delaware's prompt payment statutes and regulations.

3. Audits, prepayment reviews, recoupment actions, payment suspensions – Carriers are encouraged to temporarily suspend actions, including by way of example audits, prepayment reviews, recoupment actions, payment suspensions, that could interfere with the flow of desperately needed funds to pay for ongoing healthcare delivery operations. Carriers can do this by focusing on reducing backlogs and expediting claim processing for those audits and other reviews currently underway.

4. Requests for itemized bills, medical record requests and other information – Carriers are encouraged to temporarily suspend excessive itemized bill and medical

record requests during the current staffing challenges as hospitals may not have the staff available to respond to these requests at this time.

E. Immunizations

Carriers are reminded that 18 *Del. C.* §§ 3363 and 3558 require carriers to cover certain immunizations for children and adults.

F. Prescription Drugs

Carriers are reminded that prescription drugs are an EHB, and therefore must be covered under individual and small group comprehensive health insurance policies and contracts. Additionally, 18 *Del. C.* §§ 3350B and 3566A set certain limitations on co-payment and co-insurance for prescription drugs, and carriers are required to abide by these limitations.

An expedited formulary exception may be requested if the insured is suffering from a health condition that may seriously jeopardize the insured's health, life, or ability to regain maximum function or if the insured is undergoing a current course of treatment using a non-formulary prescription drug. Additionally, a pharmacy benefit manager is prohibited from requiring prior authorization for coverage of a 72-hour supply of medication that is for a noncontrolled substance in an emergency. 18 *Del. C.* § 3336A.

Access to health care services and supplies is a concern when consumers are required to self-isolate in their homes with little notice without the ability to refill their prescription drugs or other necessary medical supplies. The Department expects insurers to provide for early refills or replacements of lost or damaged medications and expects this flexibility to continue when the potential for quarantine is high. It is expected that insurers will allow affected consumers to obtain emergency supplies or refills without applying additional authorization requirements.

In addition, consumers must be able to access their necessary prescriptions from a local retail pharmacy (*see* 18 *Del. C.* § 7303), even if their prescription supply is normally provided by mail order, without concern of a penalty. Insurers may require that prescriptions containing opioids be obtained using the standard process.

G. Inpatient Hospital, Emergency and Ambulatory Patient Services

Carriers are reminded that hospitalization, ambulatory patient, and emergency services are categories of EHBs that individual and small group market carriers are generally required to include in their benefit packages. *See* 18 *Del. C.* Chapters 33 and 35.

H. Surprise Medical Bills

Carriers are reminded that the Federal No Surprises Act is now in effect. A fact sheet summarizing the Act is accessible at https://www.cms.gov/nosurprises. The Department's implementation plan is detailed in Domestic & Foreign Bulletin No. 127 - Implementation of the Federal No Surprises Act.

Additionally, carriers are reminded that the Delaware Patient Bill of Rights contains prohibitions against balance billing, starting with the definition of balance billing in Section 102 and going into prohibitions for balance billing in Chapters 33 and 35. Balance billing is defined in the Insurance Code at 18 *Del .C.* § 102 as "a health-care provider's demand that a patient pay a greater amount for a given service than the amount the individual's insurer, managed care organization or health service corporation has paid or will pay for the service."

Carriers should review and ensure compliance with Title 18 Sections 3348 and 3564 concerning referrals from an in-network provider to an out-of-network provider, Sections 3349 and 3565 concerning emergency care, and Sections 3370A and 3571S concerning non-network providers providing in-patient facility-based care.

III. What else can insurers do?

The Department applauds carriers who have already pledged to help meet the challenges posed by the Coronavirus strain COVID-19 by taking the following measures, and encourages all carriers to do the same:

- Ensure that out-of-pocket costs are not a barrier to people seeking physician testing for, and treatment of, COVID-19, **by covering diagnostic testing and waiving patient cost sharing** (deductibles, co-pays and coinsurance), including for in-person and telemedicine visits;

- Increase member communications as needed on such topics as when to seek medical care and the availability of options such as telemedicine and nurse lines that can provide quick access to care and limit exposure to new infections in waiting rooms;

- Provide access to accurate information and avoiding misinformation which is of critical importance. Therefore, carriers should devote resources to informing insureds of available benefits, quickly respond to insured inquiries, and consider revisions needed to streamline responses and benefits for insureds. Carriers should also make all necessary and useful information available on their websites and staff their nurse-help lines accordingly;

- As the COVID-19 situation continues to evolve, review and update contingency plans to ensure that those plans are up to date and add resources to answer calls, staff nurse lines or member chat services, or provide similar customer assistance.

IV. Federal COVID-19 Testing Coverage Requirements

"At-home tests" are defined as over-the-counter diagnostic COVID-19 tests approved or authorized by the U.S. Food and Drug Administration that can be self-administered and self-read at home or elsewhere without the involvement of a health care provider.

These tests, when not used solely for employment purposes, are to be covered by insurers with no cost-sharing as of January 15, 2022 per the January 10, 2022 guidance (https://www.hhs.gov/about/news/2022/01/10/biden-harris-administration-requires-insurance-companies-group-health-plans-to-cover-cost-at-home-covid-19-tests-increasing-access-free-tests.html) from the federal government, and the Department of Insurance expects carriers to comply with all current guidance regarding COVID-19 testing.

Carriers are encouraged to provide coverage by directly reimbursing legitimate sellers of at-home tests and create a preferred network. Carriers must also provide clear processes for an insured to submit for and receive reimbursement for at-home tests up to $12 if purchasing outside of the preferred network or at full cost of the at-home tests if no preferred network has been created.[1]

Carriers may not apply a limit to the number of at-home COVID-19 tests that is fewer than 8 tests for each covered person in a household within a 30-day period or calendar month. Carriers may not impose equivalent limits for shorter time periods. For individualswith underlying medical conditions who receive an order from a healthcare provider, there is no limit to the number of tests covered.

It is recommended that insurers update relevant consumer-facing materials including policyholder portals and websites to describe how members may obtain at-home tests, identify a list of preferred retailers where members may obtain at-home tests without submitting a claim for reimbursement, and explain how members can purchase at-home tests outside of a preferred network and submit for reimbursement.

The federal order does not modify the existing requirements for coverage of COVID-19 tests that are administered or obtained with a provider's involvement.

More information from the Centers for Medicare and Medicaid Services:

https://www.cms.gov/how-to-get-your-at-home-OTC-COVID-19-test-for-free

https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf

Questions concerning this Bulletin should be directed to **consumer@delaware.gov**.

[1] *See also* Delaware's Unfair Claims Settlement Practices Act at 18 *Del.C.* §2304(16) and its implementing Regulation 902, which address reimbursing clean claims in a timely manner.

This Bulletin shall be effective immediately and shall remain in effect unless withdrawn or superseded by subsequent law, regulation or bulletin.

Trinidad Navarro
Delaware Insurance Commissioner