**VERMONT DEPARTMENT OF FINANCIAL REGULATION**

**EMERGENCY RULE H-2020-06-E**

**ACCESS TO HEALTH CARE SERVICES DURING THE COVID-19 PANDEMIC**

Withdrawn 07/01/2021

**Section 1. Purpose.**

(a) This emergency rule is adopted under Acts 91, 140, and 159 of 2020 and in response to the continuing State of Emergency declared by the Governor of the State of Vermont on March 13, 2020 and extended thereafter regarding the outbreak of COVID-19.

(b) Under Act 140 of 2020 § 8, this emergency rule shall be in effect until July 1, 2021.

(c) This emergency rule rescinds and supersedes the provisions of Rules H-2020-02-E, H-2020-03-E, and H-2020-04-E, and Insurance Bulletins #209 and #214.

(d) The purposes of this emergency rule are to:

(1) expand health insurance coverage for, and waive or limit cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention;

(2) suspend health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and

(3) expand patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services.

**Section 2. Definitions.**

Terms used in this emergency rule shall have the meanings given to such terms, if any, in Executive Order 01-20; 8 V.S.A. §§ 4089b, 4100k; 18 V.S.A. §§ 4601 and 9402; 26 U.S.C. § 223; and 42 U.S.C. § 1395x, and accompanying IRS guidance, including IRS Notices 2004-23, 2004-50, 2013-57, and 2019-45.

**Section 3. Coverage of COVID-19 Diagnosis, Treatment, and Prevention.**

(a) Coverage of COVID-19 (SARS-CoV-2) Testing. Health insurers shall process all claims for FDA-authorized SARS-CoV-2 testing with the following procedure codes without member cost-sharing:

(1) Tests: U0001, U0002, U0003, U0004, 87635; and

(2) Specimen collection: G2023, G2024.

(b) Coverage of Testing for Influenza, Pneumonia, or Other Respiratory Illness Performed in Connection with Making a COVID-19 Diagnosis.

(1) Health insurers shall process all claims for FDA-authorized combined influenza and SARS-CoV-2 testing with procedure codes 87636, 87637, 0240U, and 0241U without member cost-sharing;

(2) Consistent with section 6001(a) of the Families First Coronavirus Response Act (FFCRA), health insurers shall process all medically necessary claims for other testing for influenza, pneumonia, or respiratory illness related to the furnishing or administration of COVID-19 diagnostic testing without member cost-sharing.

(c) Services Associated with COVID-19 Testing. Consistent with section 6001(a)(2) of the FFCRA, Health insurers shall process items and services related to the furnishing or administration of COVID-19 diagnostic testing, including facility fees, without member cost-sharing when one of the following diagnosis codes is the primary diagnosis on the claim:

(1) U07.1: Confirmed COVID-19 diagnosis;

(2) Prior to January 1, 2021—Z20.828: Contact with and (suspected) exposure to other viral communicable diseases; and

(3) After January 1, 2021—Z20.822: Contact with and (suspected) exposure to COVID-19; Contact with and (suspected) exposure to SARSCoV-2.

(d) Administration. Health insurers shall establish appropriate contractual, billing, and other administrative arrangements to reimburse providers for the cost of collecting specimens and conducting testing.

(e) Coverage of COVID-19 Treatment. Health insurers shall process all claims for the following services without member cost-sharing:

(1) medically necessary COVID-19 treatment, whether delivered in an inpatient or outpatient setting;

(2) medication administered or prescribed in connection with medically necessary COVID-19 treatment as described in paragraph (1) of this subsection; and

(3) emergency and nonemergency ambulance transport of members diagnosed with or suspected of having COVID-19 to and from recovery or isolation areas.

(f) Coverage of COVID-19 Prevention. Consistent with section 4203 of the Coronavirus Aid, Relief, and Economic Security Act, health insurers shall cover any qualifying coronavirus preventive service without member cost-sharing.

(g) Out-of-Network Services. Consistent with § 5.1(K)(2) of Department Rule H-2009-03, health insurers shall cover out-of-network services described in subsections (a), (b), (c),

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(e), and (f) of this section without member cost-sharing. The liability of a health insurer to a non-contracted provider for services rendered to a member under this subsection shall be limited to the reasonable and customary value for the health care services rendered, except that it shall be the responsibility of the health insurer to respond to, defend against, and resolve any provider request or claim for payment exceeding the amount it paid or reimbursed the under this subsection. There shall be no additional liability to the member.

**Section 4. Suspension of Prescription Drug Deductibles for Preventive Medications.**

(a) Applicability. Self-insured or publicly funded health care benefit plans offered by public and private entities are encouraged but not required to comply with this section.

(b) Generic Drugs. Health insurers shall suspend prescription drug deductibles for all generic drugs on their existing formularies classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C).

(c) Brand and Biological Drugs. Health insurers shall suspend prescription drug deductibles for brand and biological drugs on their existing formularies classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C) when no generic drug alternative is available in that drug class.

(d) Effect of Suspension. Deductibles suspended under this section shall not at any time be due or payable, and no insurer may make any attempt to collect such deductibles at any time.

**Section 5. Coverage of Health Care Services Delivered Through Telehealth, Telephone, or Store-and-Forward Means.**

(a) Coverage of Telehealth and Audio-Only Telephone Services.

(1) Where clinically appropriate, health insurance plans shall provide coverage for all health care services delivered remotely through telehealth or audio-only telephone by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation. Services covered under this paragraph shall include services that are covered when provided in the home by home health agencies.

(2) Health insurance plans shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through in-person consultation with a health care provider or through telehealth or audio-only telephone.

(3) A health insurance plan may charge an otherwise permissible deductible, co-payment, or coinsurance for a health care service delivered remotely through

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telehealth or audio-only telephone so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(4) Nothing in this subsection shall be construed to require a health insurance to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.

(5) Health insurance plans may require practices to notify members in advance that services delivered remotely through telehealth or audio-only telephone will be billed as an in-person visit. Any such notification requirements shall permit providers to notify members during the same call in which services are rendered. No other consent to receive services remotely shall be required.

(6) Health insurance plans shall not require providers to have an existing patient relationship with a member in order for the member to be reimbursed for health care services described in paragraph (1) of this subsection.

(b) Coverage of Telephone Triage Services.

(1) Health insurance plans shall provide coverage and reimbursement for Healthcare Common Procedure Coding System (HCPCS) code G2012 (virtual check-in via telephone) to allow providers to receive payment for telephone calls used to determine whether an office visit or other service is needed.

(2) Health insurance plans shall not charge a deductible, co-payment, or coinsurance for telephone triage services.

(c) Coverage of Store-and-Forward Services. Health insurance plans shall provide coverage and reimbursement for store-and-forward HCPCS code G2010 (remote evaluation of a recorded video or image) to determine whether an office visit or other service is needed without member cost-sharing.

(d) Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Consistent with guidance issued by the Office for Civil Rights at the Department of Health and Human Services (HHS) announcing enforcement discretion for noncompliance with the regulatory requirements under the HIPAA Privacy, Security and Breach Notification Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency, health insurance plans shall permit providers to utilize any non-public facing remote communication product that is available to communicate with patients.

Further guidance is available on the HHS website at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

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(e) Mental Health Parity. Consistent with 8 V.S.A. § 4089b, health insurance plans may not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental condition delivered remotely through telehealth, audio-only telephone, store-and-forward, and brief telecommunication services than for access to treatment for other health conditions; the co-payment for primary mental health care or services shall be no greater than the co-payment for care or services provided by a primary care provider under an insured's policy; and the co-payment for specialty mental health care or services shall be no greater than the co-payment applicable to care or services provided by a specialist provider under an insured's policy.

(f) Physical Location of Remote Services. Health insurance plans may not deny or limit coverage or reimbursement of health care services delivered remotely through telehealth, audio-only telephone, store-and-forward, or brief telecommunication services based solely on the physical location of the patient or provider.

**Section 6. Severability.**

If any provision of this emergency rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provisions to other persons or circumstances shall be not affected thereby.

**Section 7. Conflict with Federal Law.**

Nothing in this emergency rule is intended to or should be construed to be in conflict with federal law.

**Section 8. Effective Date.**

This emergency rule shall become effective on adoption.

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