VERMONT DEPARTMENT OF FINANCIAL REGULATION

EMERGENCY RULE H-2022-01-E

ACCESS TO HEALTH CARE SERVICES RELATED TO COVID-19

Section 1. Background and Purpose.

(a) This emergency rule is adopted under Act 85 of 2022.

(b) This emergency rule rescinds and supersedes the provisions of Rules H-2020-01-E, H-2021-01-E, and H-2021-02-E.

(c) The purpose of this emergency rule is to expand health insurance coverage for and waive or limit certain cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention.

Section 2. Definitions.

Terms used in this emergency rule shall have the meanings given to such terms, if any, in 18 V.S.A. § 9402 and Rule H-2009-03, Consumer Protection and Quality Requirements for Managed Care Organizations.

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 COVID-19 (SARS-CoV-2) Antigen Tests. Health insurers shall process all eligible claims for retail purchase of FDA-authorized SARS-CoV-2 antigen test kits without member cost-sharing to the extent required by federal law. Further guidance regarding implementation of federal law may be found at: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf.

(c) 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.

(d) 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) Z20.822: Contact with and (suspected) exposure to COVID-19; Contact with and (suspected) exposure to SARSCoV-2.

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

(f) 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.

(g) 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.

(h) 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), (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. 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 5. Conflict with Federal Law.

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

Section 6. Effective Dates.

This emergency rule shall become effective on adoption and, pursuant to the authority granted in Act 85 of 2022 (§ 4), shall remain in effect until March 31, 2023.