State of Utah
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Insurance Department

TODD E. KISER
Insurance Commissioner

BULLETIN 2020-16

TO: Insurers Offering a Health Benefit Plan

FROM: Todd E. Kiser, Utah Insurance Commissioner

DATE: August 12, 2020

SUBJECT: **Coverage for COVID-19 Testing**

The Utah Insurance Department ("Department") issues this Bulletin to provide insurers updated guidance concerning federal requirements for coverage of COVID-19 testing. On March 18, 2020, the Families First Coronavirus Response Act (FFCRA) went into effect to ensure that Americans will not have to pay for COVID 19 testing.

These measures apply to all group health plans and health insurance issuers offering group or individual health insurance. The Department interprets these federal requirements to apply to all insurers, including managed care organizations, that are offering group or individual health benefit plans in Utah.

The FFCRA requires coverage for the cost of administering COVID-19 testing (in vitro diagnostic, including serological tests) and related office visits and emergency room services as determined by the attending healthcare provider. Testing coverage ordered by a healthcare provider is required regardless of whether the services are provided during an in-person office visit with a health care provider, a telehealth visit, an urgent care center visit, an emergency room visit, or at-home (including tests where the individual performs self-collection of a specimen at home). Testing costs ordered by a healthcare provider must be covered without imposing any cost-sharing, including deductibles, coinsurance, copayment requirements, prior authorization, or medical management requirements.

On March 27, 2020, President Donald J. Trump signed the Coronavirus Aid, Relief, and Economic Securities Act (CARES Act), which reinforces the goal of making COVID-19 testing free to Americans. Under the CARES Act, coverage shall be provided with no cost-sharing, regardless of the network status of the provider or lab, and regardless of whether the testing is done on an emergency basis. The CARES Act instructs insurers to pay a provider's negotiated rate or, if a health plan does not have a negotiated rate with the provider, pay the provider's publicly available cash price for testing, or the insurer may negotiate a rate for less than such cash price.

Coverage for COVID-19 testing is not limited with respect to the number of diagnostic tests for an individual, provided that the tests are diagnostic and medically appropriate for the individual, as determined by an attending health care provider and current accepted standards of medical practice. Insurers may not impose prior authorization or medical management requirements to deny coverage for individuals who are tested multiple times.

There is no requirement for coverage of COVID-19 testing for surveillance or employment purposes. Clinical decisions about testing are to be made by the individual's attending health care provider and may include testing of individuals with signs or symptoms compatible with COVID-19, as well as asymptomatic individuals as determined to be medically appropriate by the individual's health care

provider. Testing conducted to screen for general workplace health and safety (such as employee "return to work" programs), for public health surveillance of SARS-CoV-2, or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19 or another health condition is beyond the scope of Section 6001 of the FFCRA.

If a facility fee is charged for a visit that results in an order for or administration of a COVID-19 diagnostic test, the insurer must provide coverage for the facility fee, as long as the facility fee is assessed in relation to items or services required by the FFCRA. A facility fee is a fee for the use of facilities or equipment an individual's provider does not own or that are owned by a hospital. Insurers should provide coverage for items and services furnished to an individual during health care provider office visits (including in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic test. Coverage shall be provided without imposing any cost-sharing requirements, prior authorization, or other medical management requirements.

Additional guidance may be found in the Affordable Care Act Implementation FAQs Parts 42 & 43 addressing the CARES Act and Families First Coronavirus Response Act, available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs> and https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.

If you have any questions or comments, please contact the Health and Life Division at health.uid@utah.gov.

DATED this 12th day of August 2020.

Todd E. Kiser
Insurance Commissioner