OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

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Guidance regarding Coverage for COVID-19 PCR and Antigen Testing

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The Office of the Health Insurance Commissioner (OHIC), consistent with its obligation under Rhode Island law to protect the interests of consumers and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality and appropriate access, issues this Bulletin to provide guidance regarding OHIC's expectations that carriers provide coverage for certain items and services related to testing for the detection of SARS-CoV-2, the virus that causes COVID-19, or the diagnosis of COVID-19. The coverage expectations set forth in this bulletin apply to testing that has been conducted and that will be conducted throughout the duration of the Rhode Island COVID-19 State of Emergency.[1] This Bulletin takes into account relevant current federal law and guidance regarding carriers' coverage obligations for COVID-19 testing and services related thereto given the critical importance of expanding the availability of COVID-19 testing through safe and accurate tests to combat the COVID-19 pandemic, including section 6001(c) of the Families First Coronavirus Response Act (the FFCRA)[2], as amended by section 3201 of the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act)[3] and the FAQs about Families First Coronavirus

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[1] On March 9, 2020 Governor Gina M. Raimondo issued Executive Order 20-02 declaring a state of emergency due to the dangers to health and life posed by COVID-19 (COVID-19 State of Emergency). On March 13, the *Rhode Island Office of the Health Insurance Commissioner & Medicaid Program Instructions During the COVID-19 State of Emergency* (March 13, 2020 Instructions) were issued to ensure access and continuity of care in light of the COVID-19 public health crisis and to reduce the transmission of the virus in the state of Rhode Island. The March 13 Instructions, in effect for the duration of the COVID-19 State of Emergency, included guidance to carriers to ensure coverage of COVID-19 testing and screening consistent with CDC guidelines (including test administration and analysis) without prior authorization and without patient cost-sharing.

[2] The FFCRA was enacted on March 18, 2020. Section 6001 of the FFCRA generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. Under the FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements.

[3] The CARES Act was enacted on March 27, 2020. Section 3201 of the CARES Act amended section 6001 of the FFCRA to include a broader range of diagnostic items and services that plans, and issuers must cover without any cost-sharing requirements or prior authorization or other medical management requirements. Additionally, section 3202 of the CARES Act generally requires plans and issuers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan

Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Parts 43[4] (issued June 23 , 2020) and 42[5] (issued April 11, 2020).

At present, there are three types of COVID-19 tests:

- Nucleic Acid Amplification tests, frequently called PCR (Polymerase Chain Reaction) tests, look for the presence of the unique RNA of COVID-19 virus.
- Antigen tests look for a unique part of COVID-19 virus, such as a specific protein on one of the unique COVID-19 spikes.
- Antibody tests (also known as serology tests) look for presence of antibodies in a patient's immune system that recognize and may fight off the COVID-19 virus.

While the FFCRA and CARES Act set forth the carrier coverage requirements for all three of the above described COVID-19 tests, this Bulletin addresses itself only to coverage expectations in the context of COVID-19 PCR and Antigen testing that is appropriate to detect or diagnose COVID-19 and which constitute "in vitro diagnostic tests" described in section 6001(a)(1) of the FFCRA, as amended by section 3201 of the CARES Act. This Bulletin may be amended or superseded in the future, as appropriate, including as availability of and/or information regarding COVID-19 screening and testing methods develop.

Coverage for PCR and Antigen Testing. It is the expectation of OHIC that carriers shall cover for the duration of the Rhode Island COVID-19 State of Emergency, PCR and Antigen testing and the administration of such tests where an ordering provider has determined the test is medically appropriate for an individual beneficiary in accordance with accepted standards of medical practice, inclusive of guidance issued by the Rhode Island Department of Health.

The following sets forth a non-exhaustive list of situations in which coverage for PCR and Antigen testing and the administration of such tests shall be provided without cost-sharing, prior authorization or other medical management practices:

- **Symptomatic Testing.** All symptomatic individuals, as identified by a healthcare provider, even those with mild signs or symptoms consistent with COVID-19. Symptoms of COVID-19 include but are not limited to:
  - Fever or chills
  - Cough
  - Shortness of breath or difficulty breathing
  - Lowered oxygen saturation
  - Fatigue
  - Muscle or body aches/myalgia

or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the cash price.)

[4] https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf
[5] https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf

- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea
- Rash
- Inflammatory conditions such as "COVID toes"
- Thromboembolic events
- Trouble breathing
- Bluish lips or face
- Persistent pain or pressure in the chest
- New confusion or other alterations in mental status
- Alterations in blood glucose control
- Inability to wake or stay awake
- Children with multisystem inflammatory syndrome

- **Asymptomatic Testing**.
  - Close Contact Testing. All individuals identified as a close contact of a confirmed or clinically diagnosed COVID-19 Case by a state department of health, a state-run contact tracing program, or a healthcare provider. Identification as a close contact by a state department of health or state-run contact tracing program shall be considered an individualized assessment by a provider that a COVID-19 test is medically appropriate for an individual and constitute grounds for coverage without cost-sharing, prior authorization or other medical management practices.

    Close contact is defined as:

    a) Being within less than 6 feet of a COVID-19 case. Close contact can occur while caring for, living with, visiting, or otherwise sharing a space (e.g., healthcare waiting area, restaurant, workspace) with a confirmed or clinically diagnosed COVID-19 case while the case was symptomatic or within the 48 hours before symptom onset (or, for asymptomatic patients, 2 days prior to positive specimen collection);

    OR

    b) Having direct contact with infectious secretions of a confirmed or clinically diagnosed COVID-19 case (e.g., being coughed on) while not being appropriately attired in recommended personal protective equipment (e.g., gown, gloves, N95 facemask, eye protection);

    OR

    c) As otherwise determined or defined by the Rhode Island Department of Health.

  - Testing of individuals with recent known or suspected exposure to COVID-19 where the ordering provider has determined the test is medically appropriate for the individual

beneficiary in accordance with current accepted standards of medical practice, inclusive of guidance issued by the Rhode Island Department of Health. "Suspected exposure to COVID-19" is not limited to exposure to an identifiable individual suspected of having COVID-19 but may encompass circumstances, the totality of which, cause an ordering provider, in accordance with current accepted standards of medical practice, inclusive of guidance issued by the Rhode Island Department of Health, to suspect an individual was recently at reasonable risk of having been exposed to COVID-19.

- Testing to determine resolution of COVID-19 infection where the ordering provider has determined the test is medically appropriate for the individual beneficiary in accordance with current accepted standards of medical practice, inclusive of guidance issued by the Rhode Island Department of Health.

- Testing upon or prior to admission to a Rhode Island healthcare facility.

- Testing prior to undergoing a medical procedure, where the ordering provider has determined the test is medically appropriate for the individual beneficiary in accordance with current accepted standards of medical practice, inclusive of guidance issued by the Rhode Island Department of Health.

- **Non-Traditional Testing Scenarios (Asymptomatic Or Symptomatic) Whereby A Test Is Determined To Be Medically Appropriate By A Provider.** Certain entities operating within the state of Rhode Island, such as laboratories or testing sites, may employ one or both of the following non-traditional methods for a licensed healthcare provider working within the scope of their license to determine the medical appropriateness of a COVID-19 test for an individual and order a test when deemed appropriate. Carriers shall cover tests and the administration of such tests ordered pursuant to non-traditional scenarios without cost-sharing, prior authorization or other medical management practices. These include the following scenarios:

    - A licensed healthcare provider who reviews an individual's written or electronic responses to a survey about that individual's demographics (medical conditions, age, etc.), symptoms and/or contacts and makes an individualized determination that a COVID-19 diagnostic test would be appropriate for that individual (i.e. makes the determination based on individualized clinical information but without a face-to-face or real-time audio or audio-visual encounter with the individual).

    - A diagnostic survey that an individual completes electronically by answering individualized questions about their demographics, symptoms and/or reason for wanting to test, which responses are then run through an algorithm, developed

and approved by a licensed healthcare provider and the Rhode Island Department of Health, that determines whether a COVID-19 diagnostic test is medically appropriate for that individual.

- **Testing That May Serve Or Give The Appearance Of Serving A Dual Purpose.** OHIC envisions that situations may arise where a COVID-19 diagnostic test, or a series of COVID-19 diagnostic tests, ordered for an individual by a provider who has determined the test is medically appropriate for that individual may also serve or give the appearance of serving a secondary purpose, such as meeting a workplace health and safety requirement or recommendation. In any such situation a carrier shall consider the test's primary purpose to be the individualized diagnosis or treatment of COVID-19 or another health condition and provide coverage for the test and the administration of the test without cost-sharing, prior authorization or other medical management practices.

Coverage for Items and Services Furnished During a Visit That Results in An Order for Or Administration of a Diagnostic Covid-19 Test. Items and services furnished to an individual during a provider visit (whether in-person or via telehealth), urgent care center visit, emergency room visit or non-traditional care setting visit (including COVID-19 drive-through and walk-up screening and testing sites) that results in an order for or administration of a diagnostic COVID-19 test, shall also be covered without imposing any patient cost-sharing requirements (copayments, deductibles or coinsurance), prior authorization, or other medical management requirements with respect to those items and services, but need only be covered to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product, as determined by the individual's healthcare provider.[6] Any facility fees must also be covered to the extent the facility fee relates to the furnishing or administration of a COVID-19 test or to the evaluation of an individual to determine the individual's need for testing.[7] Pursuant

[6] FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, And Economic Security Act Implementation Part 42, issued April 11, 2020, provides:

> The Centers for Disease Control and Prevention (CDC) advises that clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. In addition, the CDC strongly encourages clinicians to test for other causes of respiratory illness. Therefore, for example, if the individual's attending provider determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed during a visit (which term here includes in-person visits and telehealth visits) to determine the need of such individual for COVID-19 diagnostic testing, and the visit results in an order for, or administration of, COVID-19 diagnostic testing, the plan or issuer must provide coverage for the related tests under section 6001(a) of the FFCRA. This coverage must be provided without cost sharing, when medically appropriate for the individual, as determined by the individual's attending healthcare provider in accordance with accepted standards of current medical practice. This coverage must also be provided without imposing prior authorization or other medical management requirements.

[7] 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. Therefore, to the extent a facility fee is assessed in relation to items or services required to be covered under section 6001, the plan or issuer must provide coverage for the facility fee. Consistent with section 6001 of the FFCRA, this coverage must be provided without imposing any cost-sharing requirements, prior authorization, or other medical management requirements.

to 230-RICR-20-30-9.9.A.1.b carriers must contractually prohibit network providers from billing, charging, collecting a deposit from, or seeking compensation, remuneration or reimbursement from a beneficiary, to include but not be limited to facility or administrative fees, for covered services.

Carriers Acting as Administrators- Self Funded Plans. Due to the public health crisis caused by COVID-19, when Carriers are acting as administrators for employment sponsored self-funded health benefit plans, OHIC expects Carriers to ensure compliance with federal requirements as well as encourage plan sponsors to take steps that are consistent with the provisions of this Bulletin. Plan sponsors should be made aware of the public health risks to all state residents, and Carriers should do all they can to encourage plan sponsors to take steps to remove barriers to accessing medically necessary screening, triage, testing, diagnosis, counseling, and treatment of COVID-19.

Dated at Cranston, Rhode Island this 21st day of July 2020.

Marie Ganim

Marie Ganim, PhD., Commissioner