

# Frequently Asked Questions regarding the OIC COVID-19 Emergency Order (Order 20-01)

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**March 12, 2020**

(NOTE: Additional FAQ's may be issued as more information is available)

## Questions related to Emergency Order 20-01

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### Subsection A. Deductible and Cost Sharing Waiver

1. **Question:** To simplify administration of this provision, can you clarify that the waiver of cost-sharing in the emergency order applies only to treatments with the specific code for COVID testing. We would also ask that this subsection be made contingent on federal guidance for enrollees covered by HSA compliant high-deductible health plans.

**Answer:** CMS has established a specific code for the COVID-19 test itself (see <https://www.cms.gov/newsroom/press-releases/cms-develops-additional-code-coronavirus-lab-tests>). However, OIC is not aware of there being a specific E&M code for the provider visit associated with the testing. OIC has asked CMS/CCIIO staff if CMS has plans to develop a COVID-19 specific code for provider visits related to testing. OIC is interested in any suggestions as to how that information is, or could be, included in the provider's claim submission.

On March 11, 2020, the IRS issued Notice 2020-15 – High Deductible Health Plans and Expenses Related to COVID-19. "[In Notice 2020-15 \(PDF\)](#)... the IRS said that health plans that otherwise qualify as HDHPs will not lose that status merely because they cover the cost of testing for or treatment of COVID-19 before plan deductibles have been met." IRS guidance concerning HDHPs also allows plans to cover "all medical care services received and items purchased associated with testing for and treatment of COVID-19 that are provided by a health plan."

2. **Question:** We assume cost-sharing associated with provider/ER visits where the person is not given the test (e.g. they do not meet the DOH criteria) will be adjudicated per benefit design.

**Answer:** Your assumption is correct. The emergency order directs carriers to cover, prior to application of any deductible and with no cost-sharing the health care provider visit and COVID-19 testing only for enrollees who meet the current CDC testing criteria. We would note

however, that the determination of whether an enrollee meets the criteria is made by the enrollee's health care provider, and not the carrier. OIC is also aware that the CDC has recently broadened the criteria for testing. . In addition, where the test is ordered, the cost of the test and the provider visit must be covered regardless of the outcome of the test.

3. **Question:** Can OIC clarify regarding covering services without cost sharing or deductibles beyond the specific COVID-19 test and associated provider visit? Plans are not sure if other diagnostic tests at a covered visit need to be covered without cost sharing , such as such as lung imaging for pneumonia, or a flu test.

**Answer:** The emergency order applies to COVID-19 testing and the provider visit associated with the testing. It does not require coverage, prior to deductible and with no cost-sharing, of services other than those specifically included in the order. However, if in the future, additional testing or protocol were to be required by CDC or other governmental entities as part of COVID-19 testing, those tests or protocols also would be required to be covered.

4. **Question:** Some local media coverage of the OIC emergency order gives the impression that all COVID-19 related services will be covered with no cost-sharing. Assuming this is not the case (per question #3), can OIC reach out to local media to clarify for further press coverage?

**Answer:** OIC has established a Coronavirus website with frequently asked questions. This website is a resource for local media, as well as consumers, providers and other interested persons. The website (<https://www.insurance.wa.gov/health-insurance-and-coronavirus-covid-19-frequently-asked-questions>) answers this question in the highlighted response below:

**Will my health insurer waive my deductible since this has been declared an emergency?**

Commissioner Kreidler has [instructed all state-regulated health plans \(PDF, 251KB\)](#) to waive deductibles and copays for people who need testing for COVID-19. [State law gives him the authority \(leg.wa.gov\)](#) to do so, once the governor has issued an emergency proclamation. The waiver only applies to the testing for COVID-19 and the provider visit to order the testing. This does not include tests and services for other conditions that may occur as part of the visit. People who suspect they need testing should [check with the Department of Health \(doh.wa.gov\)](#) and contact their provider's office first. People who do not need to be tested for COVID-19 may still need to meet their deductibles and pay a copay when visiting a provider.

5. **Question:** Some carriers have reported that providers are not using the COVID claims coding released last week. Can OIC reach out to DOH and ask them to communicate the expectation to use the new codes to providers?

**Answer:** On March 12, 2020, OIC reached out to the Washington State Department of Health and asked them to include this information on the provider resources page of their COVID-19 website.

6. **Question:** If consumers are on vacation in California (or any other state that does not border Washington) and do not have out-of-network benefits, will their insurance plan in Washington be expected to cover the costs for any COVID-19 testing in these cases?

**Answer:** If a consumer is out of state and their Washington health plan does not have out-of-network benefits, their health plan will not be expected to cover the costs of COVID-19 testing unless the testing is provided as part of emergency services to “evaluate and stabilize a patient.”

## **Part B: Prescription Refills**

1. **Question:** Will OIC provide carriers flexibility in how they ensure members are given access to these permitted one-time refills, for example filling refills online or by phone through our mail order pharmacy.

**Answer:** The emergency order does not limit the means that are used by carriers to refill enrollee’s medications, as long as enrollees can access their medications and any policy is fully and clearly disclosed to enrollees.

2. **Question:** There is some concern that the current language could cause alarm for consumers, inciting some to unnecessarily refill medications. Carriers want to avoid creating a shortage of medication for all our members. We request that OIC work with carriers’ plans to monitor for and avoid such a scenario.

**Answer:** OIC is open to suggestions from carriers as to how best to monitor the extent to which enrollees are requesting refills. OIC does not have access to medication supply or current claims data needed to determine whether a shortage of medication is occurring.

3. **Question:** The order states that consumers can get an early refill of their medication. For example, consumers are asking to get their prescriptions seven days prior to their refill – or even earlier. The order also mentions an “adequate supply” of medication. What is that meaning of adequate? Consumers may want to prepare for at least a 14-day quarantine.

**Answer:** What is an adequate supply will depend on the type of drug that is prescribed and the needs of the enrollee, and should be guided by the recommendations of the prescribing provider and pharmacist. Drugs that can be easily abused, (such as those listed in the emergency order, or on the DOH Schedule II list) may need to be limited by the provider and pharmacy. OIC does not interpret the emergency order to override federal or state statutory or regulatory requirements related to dispensing medication. OIC understands that state or federal law may limit early refill of certain types of prescription drugs by a pharmacist, and that pharmacists are obligated to comply with these laws.

4. **Question:** The language of the prescription refill provision authorizes carriers to “take into consideration patient safety risks” when allowing enrollees to obtain refills for certain drug classes. This appears to put the decision of patient safety in the hands of the carrier, not the providers. Are carriers permitted to continue to use their own criteria for the listed categories of drugs? Is that list of drugs exclusive or could it include all schedule II drugs?

**Answer:** The language of the order grants carriers the authority to “consider patient safety risk associated with” early refills of opiates, benzodiazepines, and stimulants and other “certain drug classes.” WAC 284-43-2020 establishes drug utilization review criteria, and establishes timelines that the carrier must meet to respond to enrollee requests for medications for, and enrollee appeal rights. WAC 284-43-2020 distinguishes between a “nonurgent review request” and an “urgent review request”. It establishes different requirements for each. A carrier that denies a

patient's request for an early refill of a drug such as oxycodone based on patient safety considerations must still comply with WAC 284-43-2020.

## Part C: Prior authorization

1. **Question:** Although the emergency order states that carriers must suspend prior authorization requirements that apply to covered diagnostic testing and treatment of COVID-19, would carriers still be permitted to apply restrictions as outlined in guidance provided by public health officials (i.e., CDC or DOH guidelines)? Or, is the expectation that only health care providers can apply those restrictions (e.g., testing for at-risk populations showing symptoms)? Please clarify.

**Answer:** Testing for at-risk populations showing symptoms is addressed in Paragraph A of the order. The enrollee's health care provider makes this determination, which must be consistent with CDC guidelines. OIC would be concerned about a carrier's application of a CDC or DOH guideline in a manner that is contrary to a clinician's determination.

2. **Question:** Please clarify whether the prohibition on prior authorization requirements would still permit carriers to direct enrollees to in-network facilities for testing and treatment. We understand that if the health plan does not have a sufficient type or number of providers in their network, enrollees may access care outside the network as directed.

**Answer:** Yes, the prohibition on prior authorization requirements would permit carriers to direct enrollees to in-network facilities for testing and treatment, consistent with WAC 284-170-200.

## Part D: Provider network access

1. **Question:** Carriers are unsure of how to ensure compliance with network adequacy for testing. There are currently only two testing facilities. If those exceed their capacity to process tests we would have no way to ensure timely access. As for timely access to providers, would OIC permit single case agreements and/or relax geographic proximity requirements to assist in compliance? System capacity and/or workforce shortages could render plans unable to go through the normal process to add network providers.

**Answer:** It is OIC's understanding that additional testing facilities have been approved by the FDA, including the University of Washington and several commercial laboratories.

2. **Question:** To the extent this provision relates to enrollees that are treated in non-clinical settings (i.e. quarantine sites), carriers request additional dialogue with OIC as to how best to ensure carriers are appropriately reimbursing for medically necessary care received by our members.

**Answer:** OIC is willing to engage in dialogue on this issue.

3. **Question:** If an enrollee goes to an out-of-network provider for services covered prior to deductible and with no cost-sharing under the emergency order:
  - The provider cannot charge the patient anything relating to the testing or the kit – correct?
  - Is there any requirement around the amount that the carrier needs to pay the out-of-network provider for this visit?

**Answer:** The order requires coverage pre-deductible and with no cost-sharing of the health care provider visit and FDA-authorized COVID-19 testing for enrollees who meet CDC criteria for testing. If an enrollee receives services from an out-of-network provider because the carrier has an absence of or an insufficient number or type of participating providers to provide the service, the carrier must cover the service prior to the application of any deductible and with no-cost-sharing. The order does not establish any requirement related to the amount carriers need to pay out of network providers or laboratories.

## Other questions/issues:

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### Telehealth

1. **Question:** One area where we are focusing our efforts is around telehealth. This technology enables people who believe they have COVID-19 to be seen at home rather than visit offices or emergency departments where they may spread the disease or be close to people that have it. It also gives patients 24/7 access to care, allow surveillance of patients at risk while keeping them at home and ensure treatment in hospitals is reserved for high-need patients. In addition to treating confirmed or suspected cases of COVID-19, telehealth and virtual visits permit practices to provide for continuity of care for primary care, behavioral health, and other critical services, which is critical as we continue to socially isolate to prevent spread of the virus.

The insurance commissioner in Colorado is [advising](#) insurance carriers to remind Coloradans of the telehealth services available to them and is requiring coverage of in-network telehealth services related to COVID-19 at no cost share, including co-pays, deductibles and co-insurance that would normally apply to the telehealth visit. Has Commissioner Kreidler considered doing something similar? The OIC could even consider going a step farther and waive out-of-pocket expenses for all telehealth services (not just ones related to treatment of COVID-19) in order to incentivize patients to receive primary, behavioral health and other services at home.

**Answer:** RCW 48.43.735 sets out requirements related to health plan coverage of telemedicine and store and forward technology. In addition, ESSB 5385 was passed by the legislature on March 9 and is pending action by the Governor. Telemedicine and store and forward technology coverage of a service is required if the plan provides coverage of the service when provided in person, the service is medically necessary, the service is included in the essential health benefits, and the service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the service meets state and federal health information privacy and security requirements. The Commissioner's order does not specifically address coverage of telemedicine, but would support carriers' coverage of telemedicine services by its network providers to ensure appropriate access to care.

2. **Question:** Mental health providers are asking if they can receive telemedicine pay for their patients' treatment to reduce the number of patients coming into their offices for in-person consultations due to the COVID-19 outbreak. Is there anything that the Commissioner can do with his emergency powers about broadening telemedicine?

**Answer:** As noted above, the use of telemedicine is governed by RCW 48.43.735. The Commissioner must be very mindful of state and federal laws governing privacy and security of

protected health information, such as chapter 70.02 RCW, HIPAA health information privacy requirements and the requirements of 42 CFR Part 2 (related to substance use disorder treatment services).

## Other

1. **Question:** Can OIC clarify if this order applies to Medicare Advantage plans?

**Answer:** The emergency order does not affect Medicare Advantage plans. On March 10, 2020, [CMS issued guidance to all Medicare Advantage organizations \(CMS.gov\)](#), Part D sponsors and Medicare-Medicaid plans.

2. **Question:** While carriers anticipate OIC and carriers will work closely in the coming weeks to ensure enrollees have access to care, we ask that OIC reconvene carriers for discussion of extending the emergency order at least three weeks before the current order expires. This will give time to collaboratively evaluate the best way to proceed.

**Answer:** Yes, OIC will reconvene carriers for discussion of extending the emergency order at least three weeks before the current order expires, and will welcome input from providers and consumers as well.

3. **Question:** If an employer needs to reduce minimum number of hours worked below the stated minimum participation (i.e. reduce from 30 to 20 hours) but otherwise keep an employee on payroll, will we allow them to do so?

**Answer:** There is no emergency authority for OIC to make changes to our rate and form filing requirements. Any changes carriers would like to make will need to be filed through our normal process. Because rates cannot be changed mid-plan year, the only changes we could consider would be expansions of coverage.

4. **Question:** If an employer has to reduce their employees' hours due to COVID-19 temporarily and employees lose coverage due to ineligibility, will we allow them to come back on when the business recovers without having to satisfy the waiting period again?

**Answer:** There is no emergency authority for OIC to make changes to our rate and form filing requirements. Any changes carriers would like to make will need to be filed through our normal process. Because rates cannot be changed mid-plan year, the only changes we could consider would be expansions of coverage.