July 19, 2021 | 1:41 pm

COVID-19 Updates

The COVID-19 vaccine is here. It is safe, effective and free. Walk in to get vaccinated at sites across the state. Continue to mask up and stay distant where directed.

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Department of Financial Services

Insurance Circular Letter No. 3 (2020)

March 3, 2020

TO:	**All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, Health Maintenance Organizations, Student Health Plans Certified Pursuant to Insurance Law § 1124, and Municipal Cooperative Health Benefit Plans**
RE:	**Preparedness for Coronavirus (COVID-19)**

STATUTORY AND REGULATORY REFERENCES: N.Y. Ins. Law §§ 3201, 3216, 3217-f, 3217-h, 3221, 3241, 3242(b), 4303, 4306-e, 4306-g, 4329(b), and 4804 and Article 49; N.Y. Financial Services Law Article 6; 11 NYCRR 52.16(c); N.Y. Pub. Health Law §§ 4403 and 4406-g, and Article 49; 42 U.S.C. § 300gg-1 et seq.; 42 U.S.C. § 18001 et seq.; 29 C.F.R. Part 2560; 29 C.F.R. Part 2590; 45 C.F.R. Part 147; and 45 C.F.R. § 156.122(c)

I. Purpose

A new Coronavirus ("COVID-19") was detected in China that has not been previously found in humans. There are thousands of confirmed cases in China, and additional cases have been identified in the United States, including two cases confirmed in New York State as of March 3, 2020. The purpose of this circular letter is to instruct insurers authorized to write accident and health insurance in this state, Article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law § 1124, and municipal cooperative health benefit plans (collectively "issuers") to take action related to the potential impact of

COVID-19 in New York. Issuers should ensure that they are prepared to address COVID-19 cases in New York, including by providing insureds with information and timely access to all medically necessary covered health care services. As the COVID-19 situation continues to evolve, issuers should continually assess their readiness and make any necessary adjustments.

II. Keep Consumers Informed

Access to accurate information and avoiding misinformation are critical. Therefore, issuers should devote resources to informing insureds of available benefits, quickly respond to insured inquiries, and consider revisions needed to streamline responses and benefits for insureds. Issuers should make all necessary and useful information available on their websites and staff their nurse-help lines accordingly.

III. Testing for COVID-19

It is important to remove barriers to testing for COVID-19. Currently, COVID-19 tests are being conducted at New York State's Wadsworth Center and are fully covered. However, it is anticipated that additional labs will be approved for testing. Issuers are reminded that laboratory tests are an essential health benefit ("EHB"), and as such, must be covered under individual and small group comprehensive health insurance policies and contracts. Insurance Law §§ 3221(l)(3) and 4303(e) and (f) require issuers of large group comprehensive health insurance policies and contracts to make available coverage for laboratory tests, and such tests are typically covered in the base policy or contract. The Superintendent of Financial Services ("Superintendent") is advising issuers that they should waive any cost-sharing for COVID-19 laboratory tests so that cost-sharing does not serve as a barrier to access to this important testing. In addition, issuers should waive the cost-sharing for an in-network provider office visit and an in-network urgent care center visit when testing for COVID-19. Issuers should also waive the cost-sharing for an emergency room visit when testing for COVID-19. The Superintendent will promulgate an emergency regulation to ensure that issuers do not impose cost-sharing for COVID-19 testing consistent with this circular letter. In addition, if in-network providers are unable to conduct testing for COVID-19, issuers are reminded that they must cover testing out-of-network.

IV. Telehealth Delivery of Services

Given that COVID-19 is a communicable disease, some insureds may be using telehealth services instead of in-person health care services. Issuers are reminded that Insurance Law §§ 3217-h and 4306-g and Public Health Law § 4406-g prohibit issuers from excluding a service that is otherwise covered under a comprehensive health insurance policy or contract because the service is delivered via telehealth. The term "telehealth" means the use of electronic

information and communication technologies by a provider to deliver health care services to an insured individual while the individual is located at a site that is different from the site where the provider is located. Issuers are directed to ensure that, as applicable, their telehealth programs with participating providers are robust and will be able to meet any increased demand.

V. Network Adequacy and Access to Out-of-Network Services

Issuers are directed to verify that their provider networks are adequate to handle a potential increase in the need for health care services in the event more COVID-19 cases are diagnosed in New York. Issuers are also reminded that Insurance Law §§ 3217-d(d), 4306-c(d), and 4804(a) and Public Health Law § 4403(6) provide that if an issuer does not have a health care provider in its network with the appropriate training and experience to meet the particular health care needs of an insured, the issuer must provide access to an out-of-network provider at the in-network cost-sharing.

VI. Utilization Review

Timely decision making is essential to responding appropriately to COVID-19, and it is particularly important with respect to utilization review. Issuers are reminded that utilization review decisions must be made in the timeframes required by Articles 49 of the Insurance Law and Public Health Law, 29 C.F.R. Parts 2560 and 2590, and 45 C.F.R. Part 147, or sooner. Issuers should not use preauthorization requirements as a barrier to access necessary treatment for COVID-19, and issuers should be prepared to expedite utilization review and appeal processes for services related to COVID-19 when medically appropriate.

VII. Immunizations

Although a vaccine is not currently available for COVID-19, it has been reported to be in development. In the meantime, issuers are reminded that the Insurance Law requires immunizations to be covered for children and adults. Insurance Law §§ 3216(i)(17)(B)(ii) and (iii), 3221(l)(8)(B)(ii) and (iii), and 4303(j)(2)(B) and (C) require individual, small, and large group comprehensive health insurance policies and contracts to cover immunizations, at no cost-sharing, for children through the attainment of 19 years-of-age if determined to be a necessary immunization by the Superintendent in consultation with the Commissioner of Health. In the event an immunization becomes available for COVID-19 and is recommended for children through the attainment of 19 years-of-age, the Superintendent has determined that issuers must cover the immunization at no cost-sharing for children through the attainment of 19 years-of-age.

Insurance Law §§ 3216(i)(17)(B), 3221(l)(8)(B), and 4303(j)(2) further require individual, small, and large group comprehensive health insurance policies and contracts, except for a grandfathered health plan,[1] to provide coverage at no cost-sharing for preventive care and screenings that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Taskforce ("USPSTF") and immunizations that have in effect a recommendation from the advisory committee on immunization practices of the Centers for Disease Control and Prevention ("CDC"). In the event an immunization is recommended for COVID-19 for adults who are 19 years-of-age and older, issuers (including those offering grandfathered health plans) should cover the immunization immediately at no cost-sharing.

VIII. Access to Prescription Drugs

There have been reports of potential issues involving access to prescription drugs due to COVID-19. Issuers are reminded that prescription drugs are an EHB, and as such, are required to be covered under individual and small group comprehensive health insurance policies and contracts. Although large group comprehensive health insurance policies are not required to generally cover prescription drugs, most do. Insurance Law §§ 3242(b) and 4329(b) and 45 C.F.R § 156.122(c) require issuers that cover prescription drugs to provide access to non-formulary prescription drugs through a standard and expedited formulary exceptions process. The insured, the insured's designee, or the insured's prescribing health care provider may request a formulary exception for a clinically appropriate prescription drug. For standard formulary exception requests, the issuer must make a decision and notify the insured or the insured's designee and the insured's prescribing health care provider by telephone no later than 72 hours after receipt of the request. If the issuer approves the request, the issuer must cover the prescription drug while the insured is taking the prescription drug, including any refills.

An expedited formulary exception may be requested if the insured is suffering from a health condition that may seriously jeopardize the insured's health, life, or ability to regain maximum function or if the insured is undergoing a current course of treatment using a non-formulary prescription drug. The issuer must make a decision and notify the insured or the insured's designee and the insured's prescribing health care provider by telephone no later than 24 hours after receipt of the request. If the issuer approves the request, the issuer must cover the prescription drug while the insured suffers from the health condition that may seriously jeopardize the insured's health, life, or ability to regain maximum function or for the duration of the insured's current course of treatment using the non-formulary prescription drug. If the issuer denies a standard or expedited formulary exception request, in addition to the telephonic notification, the issuer must also provide written notice to the insured or the

insured's designee, and the insured's prescribing health care provider, within three business days of receipt of the exception request. The written notice must be considered a final adverse determination for the purposes of external appeal.

IX. Inpatient Hospital Care

Issuers are reminded that individual, small, and large group comprehensive health insurance policies and contracts are required to cover inpatient hospital services. Insurance Law §§ 3217-f and 4306-e prohibit issuers from imposing lifetime and annual limits on hospital care since it is an EHB.

X. Emergency Care

Insurance Law §§ 3216(i)(9), 3221(k)(4), and 4303(a)(2) require individual, small, and large group comprehensive health insurance policies and contracts to cover services to treat an emergency condition in hospital facilities. Issuers offering individual and small group comprehensive health insurance policies and contracts are reminded that worldwide coverage for emergency services in hospital facilities has been required as part New York's EHB package. Issuers offering large group comprehensive health insurance policies and contracts are reminded that they are required to cover emergency services in hospital facilities in the United States, its possessions, and the countries of Mexico and Canada pursuant to 11 NYCRR § 52.16(c)(12). Insurance Law § 3241(c) further requires issuers, when insureds receive emergency services from a health care provider that does not participate in the issuer's provider network, to ensure that insureds incur no greater out-of-pocket costs for the emergency services as they would have incurred with a participating provider. In addition, Insurance Law § 4905(m) and Public Health Law § 4905(13) prohibit issuers from requiring an insured or the insured's provider to obtain preauthorization prior to the provision of emergency care, including emergency treatment or an emergency admission.

XI. Ambulance Services

Issuers are reminded that Insurance Law §§ 3216(i)(24), 3221(l)(15), and 4303(aa) require individual, small, and large group comprehensive health insurance policies to cover pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service. "Pre-hospital emergency medical services" means the prompt evaluation and treatment of an emergency condition and non-airborne transportation to a hospital. The services must be provided by an ambulance service that has a certificate to operate under the Public Health Law. An ambulance service must hold the insured harmless and may not charge or seek reimbursement from the insured for pre-hospital

emergency medical services, except for the collection of any applicable deductibles, copayments, and coinsurance.

XII. Surprise Medical Bills

Issuers are reminded that they must cover insureds who receive surprise medical bills under individual, small, and large group comprehensive health insurance policies and contracts as required pursuant to Financial Services Law Article 6. Financial Services Law § 603(h) defines a "surprise bill" as a bill for health care services, other than emergency services, received by: (1) an insured for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable, or a non-participating physician renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered; provided, however, that a surprise bill does not mean a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a non-participating physician; or (2) an insured for services rendered by a non-participating provider where the services were referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the issuer. A referral to a non-participating provider occurs when: (1) the health care services are performed by a non-participating health care provider in the participating physician's office or practice during the course of the same visit; (2) the participating physician sends a specimen taken from the patient in the physician's office to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under the insured's policy or contract.

XIII. Conclusion

Issuers must be prepared to address COVID-19 cases in New York. In order to protect the public health, issuers should remove barriers to testing and treatment for COVID-19. Insureds must have access to all medically necessary covered health care services, and issuers must ensure that their provider networks are able to handle a potential increase in demand for health care services. Issuers must also cover out-of-network services if there is not an in-network provider who can meet the health care needs of an insured. In addition, since the COVID-19 situation continues to evolve, issuers should continually assess their readiness and be prepared to make any necessary adjustments.

Please direct any questions regarding this circular letter to Tobias Len, Assistant Chief, Health Bureau, by mail at New York State Department of Financial Services, Health Bureau, One

Commerce Plaza, 19th Floor, Albany, New York 12257 or by email at Tobias.Len@dfs.ny.gov.

Very truly yours,

Lisette Johnson
Chief, Health Bureau

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[1] A “grandfathered health plan” means coverage provided by an issuer in which an individual was enrolled on March 23, 2010, for as long as the coverage maintains grandfathered status in accordance with 42 U.S.C § 18011(e). Ins. Law §§ 3216(i)(17)(F), 3221(l)(8)(G), 4303(j)(4).

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