

STATE OF NEW MEXICO

OFFICE OF SUPERINTENDENT OF INSURANCE

SUPERINTENDENT OF INSURANCE
Russell Toal



DEPUTY SUPERINTENDENT
Robert E. Doucette, Jr.

BULLETIN 2020-016

August 4, 2020

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RECEIVED
OFFICE OF SUPERINTENDENT OF INSURANCE

TO: ALL HEALTH INSURANCE CARRIERS, GROUP HEALTH PLANS, HEALTH MAINTENANCE ORGANIZATIONS, AND NON-PROFIT HEALTH CARE PLANS

RE: COVID-19 TESTING DETERMINATIONS AND CHARGES

The rules of the OSI require health insurers licensed in the state to remove cost barriers to COVID-19 testing and treatment by waiving any associated cost sharing. Prohibited cost sharing obligations include co-pays, deductibles and coinsurance. The expectation of the OSI has been and is that insurers will affirmatively notify their contracted providers that there must be no charges to an insured patient for COVID-19 testing or treatment. Under Subsection B of 13.10.13.12 NMAC, provider charges for an office visit, and any other administrative fee relating to the administration of a COVID-19 test, are part of the billing for the test and the insurer and the provider must waive any associated cost sharing for such billings. These requirements apply regardless of whether the COVID-19 test comes back positive or negative.

The federal Families First Coronavirus Response Act prohibits prior authorization or other medical management requirements on COVID-19 testing. In addition, we interpret the OSI's provisions on network adequacy to require insurers to have in-network testing services available for covered members. In [Bulletin 2020-009](#) we provided guidance on how to treat emergency testing and treatment during the COVID-19 Public Health Emergency.

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www.osi.state.nm.us

Under Sec. 6001 of FFCRA and Sec. 3202 of CARES Act, FDA approved or authorized “diagnostic tests” for COVID-19 are to be covered by all group health plans and plans providing individual coverage with no cost sharing. CMS has clarified that this also applies to self-funded plans, all group and individual insurers (including grandfathered and transition plans) on and off a Health Insurance Exchange, and to state or local government health plans. The federal rules were effective March 18, 2020 and continue through the end of the Public Health Emergency.

CMS recently clarified that for a COVID-19 diagnostic test to be covered by the insurer a health care provider must make a determination that the individual’s condition or circumstance warrants a test. This determination must be made by a medical professional but it need *not* be a physician and it need not be a medical professional directly involved in the routine care of the individual. So, for example, a test ordered by a provider in an urgent care center, emergency room or at a drive-through testing site is acceptable, even though the provider is not the medical professional normally caring for the individual. CMS notes that an individual can receive several tests if the additional testing is determined to be indicated by a medical professional.

The federal provisions also require at-home COVID-19 tests to be covered if a medical professional reviews information provided by the individual and determines that an at-home test is warranted and appropriate.

Under the federal amendments to the Public Health Act, the states are the primary enforcers of the COVID-19 provisions. CMS has noted that “[s]tates can provide more protection for consumers”.

The most recent CMS FAQs have caused some confusion among payers and providers, in part because this new federal guidance states that “related items”, i.e., any items related to the test or needed for the evaluation as to whether a test is needed, including x-rays, lab fees and physician or facility fees, must be covered if a visit results in a COVID-19 diagnostic test. This is a CMS interpretation of the federal law, but it is *not* the position of the OSI. Our position is that the costs associated with making a determination as to whether a test is indicated or not *are* to be covered and shall not be subject to any patient cost sharing. It is not in the public’s interest to impose cost barriers to individual testing, and we do not want to discourage individuals from seeking an assessment as to whether a test is appropriate.

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Despite the stance outlined immediately above, we agree with the CMS statement in its last FAQs that “broad-based screening not based on individual symptoms or exposure – like, return to work requirements or surveillance testing – are not included in the requirement” for testing coverage. We have received questions related to coverage of students returning to school or universities, and our instruction has been that only those students whom a medical professional determines meet the federal and state testing appropriateness guidelines should be tested. When such a determination is made, the costs associated with both the assessment and the test are to be covered. So, we would not expect that all students returning to a college would be covered for testing, but an individual student who may have been exposed to the virus should have a determination of testing appropriateness and the costs of such an assessment must be covered by an insurer. This same principle would apply to child care settings and with child care workers.

The same general principles apply to “back to work” testing. If an employer wishes to require such testing, it is not our or CMS’s expectation that such testing must be covered by an insurer. Again, there may be individual employees who should be tested because of their unique situation, but coverage of all employees would rarely be indicated and an insurer is not responsible for covering such testing. However, insurers should recognize that a medical professional is within their professional discretion to decide that individuals who are in high-risk environments (e.g., healthcare sites, correctional facilities, long-term care and congregate settings, etc.), or who are members of special populations at increased risk, should undergo screening for testing appropriateness, irrespective of whether the individual to be tested presents with clinical indications, and insurers must give deference to providers as to whether a test is ordered. As stated above, in such a situation both the assessment cost and the test cost are to be covered. We note that if an employer is self-insured and wishes to have the testing of all employees covered by their plan, it is within their discretion to do so.

We want to underscore that the position of the OSI is that carriers should give deference to providers on whether an individual should be tested, but we also recognize that under no circumstances should a provider be administering the test to all who present. When a carrier

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believes a provider is inappropriately or fraudulently administering testing, the carrier has an obligation to report this to the proper authorities for investigation and action (where indicated).

The decision as to reasonableness of charges from a provider is one that resides with the insurer exclusively, but a decision to deny coverage of charges must be reasonable and must not result in cost sharing obligations being imposed on the individual who sought or received the COVID-19 test. We do not and will not regulate provider payment amounts but we will take action aggressively if consumers are being inappropriately charged.

Carriers are reminded that both our and the federal guidance makes it clear that costs related to testing must be covered; so, for example, if there is an office visit or facility fee charged as part of the testing it must be covered, and **no** cost sharing can be applied to the individual taking the test. We have received calls from providers who say that their contracts with insurers require them to charge a co-pay for any and all office visits, but you will recall that in March each of you provided direction to your network providers that no co-pays were to be charged for COVID-19 testing or treatment. It may be time for you to remind your contracted providers of this exception to co-pay charge requirements. For non-COVID-19 related services, cost sharing obligations (such as specific service or deductible obligations) may apply, even if the non-COVID-19 services were provided at the same time. However, there should not be an office visit or facility charge co-pay if the non-related services were incidental to the prime reason for the visit, namely, receiving an assessment as to COVID-19 testing appropriateness.

Carriers are reminded of the request made through OSI [Bulletin 2020-006](#) regarding Consumers Affected by COVID-19 and the Emergency Public Health Measures. In that Bulletin, carriers are asked to refrain from cancelling or non-renewing policies of businesses and individuals negatively impacted by the disruption due to the non-payment of premiums during this public health emergency, or at a minimum, provide extended grace periods for payment of premiums. Since we are still in a state of public health emergency please be sure that you are taking action to avoid coverage cancellations. For those who are losing coverage, please refer them to our website, the [YESNM](#) website of HSD/Medicaid, or the [beWellnm](#) website. You may use the attached flyer to make the information readily available.

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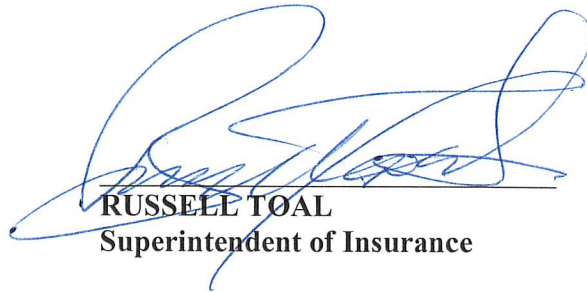
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We recognize that these are difficult, challenging and fluid times for us all. We hope that you have taken all necessary steps to ensure the safety and health of your own employees, and we thank you for your cooperation on this issue, on coverage of both telemedicine and telehealth and premium forbearance. We value the partnership you have shown New Mexico. Our goal is to build on that success. We hope you will accept and follow this Bulletin in that light.

ISSUED this 4th day of August, 2020.



RUSSELL TOAL
Superintendent of Insurance

Attachments

In these difficult times, you can get health coverage.

We are here to help.

During the Pandemic, **EVERYONE QUALIFIES** for coverage. We will help you get covered for free or at a low-cost to you.

Start Here Do you qualify for Medicaid?

Depending on your income and family size, you may qualify for Medicaid. To apply, call 1-855-637-6574 or apply online at the YES New Mexico portal.

1-855-637-6574
yes.state.nm.us

Are you eligible to enroll in a plan through beWellnm?

If you don't qualify for Medicaid, you **may now qualify** for no or low-cost private insurance through beWellnm. **If you have recently lost your job or seen a reduction in your income, call 1-833-862-3935 to see if you qualify for coverage.**

1-833-862-3935
bewellnm.com

Another option: The New Mexico Medical Insurance Pool

If you don't qualify for Medicaid or coverage through beWellnm, **everyone in New Mexico** can get coverage through the New Mexico Medical Insurance Pool. To request an application call 1-844-728-7896 or visit www.nmmip.org.

1-844-728-7896
nmmip.org

No matter what, you can get covered.



be well nm®

THE PLACE TO SHOP, COMPARE AND BUY HEALTH INSURANCE. *Affordably.*

How to qualify for coverage.

Federal Poverty Level (FPL), is a measure of income used to determine eligibility for Medicaid and the Children's Health Insurance Program (CHIP), as well as premium subsidies and cost-sharing reductions (cost-sharing subsidies) in the exchange, and other federal programs.

Light Blue = Could qualify for a discounted premium.

Blue = Could qualify for a premium tax credit and cost-sharing reduction.

Dark Blue = Could qualify for Medicaid coverage.

What is your monthly household income? (FPL = Federal Poverty Level)							
	New Mexico Insurance Pool Coverage available if you cannot get covered through Medicaid or beWellnm Discounted premiums available for individuals with incomes under 400% FPL						
	beWellnm (Lawfully present immigrants who do not qualify for Medicaid)		beWellnm with Premium Assistance				beWellnm without Premium Assistance
	Medicaid for Kids (age 0-5)						
	Medicaid for Kids (age 6-18)						
	Medicaid for Adults (age 19-64)						
How many people are in your household?	0-100% FPL	138% FPL	139% FPL	240% FPL	300% FPL	400% FPL	Over 400% FPL
Individuals	\$1,064	\$1,468	\$1,469	\$2,552	\$3,190	\$4,256	\$4,256+
Family of 2	\$1,437	\$1,983	\$1,984	\$3,449	\$4,311	\$5,748	\$5,748+
Family of 3	\$1,810	\$2,498	\$2,499	\$4,344	\$5,430	\$7,240	\$7,240+
Family of 4	\$2,184	\$3,013	\$3,015	\$5,240	\$6,550	\$8,736	\$8,736+
Family of 5	\$2,557	\$3,529	\$3,530	\$6,137	\$7,671	\$10,228	\$10,228+
Family of 6	\$2,930	\$4,044	\$4,045	\$7,032	\$8,790	\$11,720	\$11,720+

The FPL amounts are valid through March 31, 2021. If you think you qualify or are unsure what you qualify for, give us a call so we can help!

MEDICAID

 HUMAN SERVICES
 DEPARTMENT
1-855-637-6574
yes.state.nm.us


1-833-862-3935
bewellnm.com

New Mexico
 Medical Insurance Pool

1-844-728-7896
nmmip.org

En estos tiempos difíciles, puede obtener cobertura de salud.

Estamos aquí para ayudar.

Durante la pandemia, TODOS CALIFICAN para la cobertura.
Le ayudaremos obtener una cobertura gratuita o de bajo costo para usted.

Comience aquí ¿Califica para Medicaid?

Dependiendo de sus ingresos y el tamaño de su familia, puede calificar para Medicaid. Para aplicar, llame al 1-855-637-6574 o llene una solicitud en la página web de YES New Mexico.

1-855-637-6574
yes.state.nm.us

¿Es usted elegible para inscribirse en un plan a través de beWellnm?

Si no califica para Medicaid, ahora puede calificar para un seguro privado gratuito o de bajo costo a través de beWellnm. **Si recientemente perdió su trabajo o vio una reducción en sus ingresos, llame al 1-833-862-3935 para ver si califica para cobertura.**

1-833-862-3935
bewellnm.com

Otra opción: **The New Mexico Medical Insurance Pool**

Si no califica para Medicaid o cobertura a través de beWellnm, **todos en Nuevo México** pueden obtener cobertura a través de The New Mexico Medical Insurance Pool. Para obtener una solicitud, llame al 1-844-728-7896 o visite www.nmmip.org.

1-844-728-7896
nmmip.org

Pase lo que pase, usted puede estar cubierto.



be well nm®

THE PLACE TO SHOP, COMPARE AND BUY HEALTH INSURANCE. Affordably.

Cómo calificar para la cobertura.

El Nivel Federal de Pobreza (FPL) es una medida de ingresos utilizada para determinar la elegibilidad para Medicaid y el Programa de Seguro Médico para Niños (CHIP), así como subsidios de primas y reducciones de costos compartidos (subsidios de costos compartidos) en el intercambio, y otros programas federales.

Azul claro = Podría calificar para una prima con descuento.

Azul = Podría calificar para un crédito fiscal premium y una reducción de costos compartidos.

Azul Oscuro = Podría calificar para la cobertura de Medicaid.

¿Cuál es el ingreso mensual de su hogar? (FPL = Nivel de pobreza federal)							
	New Mexico Insurance Pool Cobertura disponible si no puede obtenerla a través de Medicaid o beWellnm Primas con descuento disponibles para personas con ingresos inferiores al 400% del FPL						
	beWellnm (inmigrantes legalmente presentes que no califican para Medicaid)	beWellnm con Asistencia Premium					beWellnm sin Asistencia Premium
	Medicaid para niños (age 0-5)						
	Medicaid para niños (age 6-18)						
	Medicaid para Adultos (age 19-64)						
¿Cuántas personas hay en su hogar?	0-100% FPL	138% FPL	139% FPL	240% FPL	300% FPL	400% FPL	Over 400% FPL
Individuos	\$1,064	\$1,468	\$1,469	\$2,552	\$3,190	\$4,256	\$4,256+
Familia de 2	\$1,437	\$1,983	\$1,984	\$3,449	\$4,311	\$5,748	\$5,748+
Familia de 3	\$1,810	\$2,498	\$2,499	\$4,344	\$5,430	\$7,240	\$7,240+
Familia de 4	\$2,184	\$3,013	\$3,015	\$5,240	\$6,550	\$8,736	\$8,736+
Familia de 5	\$2,557	\$3,529	\$3,530	\$6,137	\$7,671	\$10,228	\$10,228+
Familia de 6	\$2,930	\$4,044	\$4,045	\$7,032	\$8,790	\$11,720	\$11,720+

Los montos de FPL son válidos hasta el 31 de marzo del 2021. Si cree que califica o no está seguro para qué califica, llámenos para que podamos ayudarlo!

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