JRW Associates INC
Employee Benefit Advisors

Frequently Asked Questions on Issuer Flexibility for Utilization Management and Prior Authorization Due to COVID-19

The Centers for Medicare and Medicaid Services (CMS) has issued frequently asked questions (FAQs) on utilization management and prior authorization under individual, large group, and small group plans offered by health insurance issuers to mitigate the impact of the Coronavirus Disease 2019 (COVID-19) public health emergency on providers.

The FAQs reiterate the requirements provided by the Families First Coronavirus Response Act (FFCRA), as amended by the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), that group health plans and health insurance issuers offering group or individual health insurance coverage must provide benefits for certain items and services related to diagnostic testing for COVID-19 when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. The 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.

The FAQs encourage issuers to relax otherwise applicable utilization management processes, as permitted by state law, to ensure that staff at hospitals, clinics, and pharmacies can focus their limited time and resources on care delivery, and to ensure that patients have no delay in receiving needed care. For example, when patients transition out of acute care settings, issuers could waive prior authorization for post-acute care settings to allow for faster turnover.

The FAQs note that access to in-network providers may be limited, for example, due to illness or workforce shortages. Issuers are encouraged to work with out-of-network providers to agree on a rate to ensure that enrollees are not balance billed. The CARES Act requires plans and issuers to reimburse any provider of COVID-19 diagnostic testing at an amount that equals the negotiated rate. However, if the plan or issuer does not have a negotiated rate with the provider, the reimbursement rate will be the price listed by the provider on a public website or a lower rate that is negotiated with the provider. The FAQs encourage issuers to consider additional administrative flexibilities that are consistent with state and federal law during the public health emergency.

The FAQs also address issuers using utilization management regarding formulary drugs that are being prescribed for off-label use to treat COVID-19. Individual plan and small group plan issuers must continue to comply with applicable prescription drug essential health benefits (EHB) regulations. For example, under 45 CFR 156.125, an issuer does not comply with the requirement to provide EHB if the plan discriminates on the basis of age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Issuers must ensure that any changes to prior authorization requirements and utilization management practices are clinically based and are applied in a non-discriminatory manner.

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