
April 21, 2020

FAQs on Issuer Flexibilities for Utilization Management and Prior Authorization

Q1. What flexibilities can health insurance issuers, including those offering coverage in the individual and large and small group markets offer with respect to utilization management to mitigate the impact of the Coronavirus Disease 2019 (COVID-19) public health emergency on providers?

A1. Section 6001 of the Families First Coronavirus Response Act (the FFCRA), as amended by section 3201 of the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), 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 COVID-19 when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period.¹ 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.

In addition, in response to the nationwide public health emergency in effect due to COVID-19 and the disease's impact on providers, facilities, and hospitals,² we 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.

We expect in some cases enrollees may not be able to access treatment by an in-network provider if in-network providers are experiencing illness or workforce shortages. Providers may also need to modify their practices to treat only COVID-19 patients, further limiting in-network availability. There may be other circumstances that may impact in-network provider availability not noted here. To the extent that balance billing is allowed by state and federal law, CMS

¹ Section 6001 of the FFCRA. See FAQs About FFCRA and the CARES Act Implementation Part 42, <https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf>.

² On January 31, 2020, HHS Secretary Alex M. Azar II declared that as of January 27, 2020, a public health emergency exists nationwide as the result of the 2019 novel coronavirus. See Determination of the HHS Secretary that a Public Health Emergency Exists, <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>. On March 13, 2020, President Donald J. Trump declared that the outbreak of COVID-19 in the United States constitutes a national emergency beginning March 1, 2020. See Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, issued March 13, 2020, <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novelcoronavirus-disease-covid-19-outbreak/>

encourages issuers to work with out-of-network providers that provide (or may provide) services to their enrollees to agree upon a rate to ensure that enrollees are not balance billed.³

We encourage issuers to consider additional administrative flexibilities as the public health emergency continues, consistent with state and federal law.

Q2. What flexibilities are available to issuers regarding the application of utilization management to formulary drugs that are being prescribed for off-label use to treat COVID-19?

A2. As emerging treatments for COVID-19 are discovered or existing therapies show promise for treating COVID-19, issuers may wish to consider applying utilization management practices to those treatments, to the extent consistent with applicable law, to prevent drug shortages and ensure that these drugs are available to all who may benefit from their use.

While we understand that the COVID-19 public health emergency presents an unusual situation in which it may be appropriate for issuers to change policies on utilization management, issuers must remain compliant with applicable prescription drug essential health benefits (EHB) regulations, including those at 45 CFR 156.122 throughout the year. For example, under 45 CFR 156.125, an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, 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. In addition, 45 CFR 156.225(b) states that a QHP issuer must not employ marketing practices or benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. Issuers should thus ensure that any changes to prior authorization requirements and utilization management practices are clinically based and are applied in a non-discriminatory manner.

³ CMS notes that section 3202 of the CARES Act generally requires plans and issuers subject to section 6001 of the FFCRA to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan 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.)