United Actuarial Services, Inc.
Actuaries and Consultants

2015-57

November 5, 2015

BENEFIT NEWS BRIEFS

ACA FAQs on Preventive Services/MHPAEA, Set XXIX

The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) recently issued Frequently Asked Questions (FAQs) regarding implementation of the *Affordable Care Act* (*ACA*), and the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA*), as amended by the *ACA*. A specially prepared version of the FAQs with a table of contents added is available by "*clicking here*."The thirteen FAQs address:

- Preventive Services Required of Non-Grandfathered Plans (FAQs 1-8, 10)
- Wellness (FAQ 11)
- *MHPAEA* (FAQ 12-13)

We will provide an overview of the FAQs, omitting FAQ 9 as it deals with religious accommodations from providing contraceptive coverage. Plan professionals should review the FAQs and introductory material. Our focus is on self-funded multiemployer plans and references to insured plans are omitted. **NOTE: Only non-grandfathered plans are required to offer preventive services under the *ACA*.**

FAQs on Preventive Services Required of Non-Grandfathered Plans

All of the preventive services discussed below are required to be covered by non-grandfathered plans. Grandfathered plans are not affected by these preventive services FAQs.

Lactation Counseling

FAQs 1-4 address the preventive services of lactation counseling. The FAQs explain that plans that are required to provide lactation counseling are also required to provide a list of the lactation counseling providers within the plan's network.

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If a plan network does not include lactation counseling providers, the plan may not impose cost sharing for lactation counseling services obtained outside the network. This follows the general rule that if a plan does not have a network provider who can provide a particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider just like it would cover the item or service when performed by an in-network provider. Under these circumstances, the plan cannot impose cost sharing with respect to the item or service.

Similarly, if a State does not license lactation counseling providers and a plan will only cover services received from providers *licensed* by the State, the plan must allow another provider type acting within the scope of his or her license or certification (for example, a registered nurse) to provide lactation counseling without cost sharing.

Plans may use reasonable medical management techniques but cannot limit coverage for lactation counseling without cost sharing as only an inpatient service but must allow such counseling to be provided on an outpatient basis.

Breastfeeding

FAQ 5 explains that the requirement for a non-grandfathered group health plan to cover the rental or purchase of breastfeeding equipment without cost sharing extends for the duration of breastfeeding, provided the individual remains continuously enrolled in the plan. Specified time limits (for example, within 6 months of delivery) are not permitted.

Exclusions of Weight Management Services For Adult Obesity

FAQ 6 explains that a non-grandfathered group health cannot contain a general exclusion for weight management services for adult obesity. Non-grandfathered plans must cover, without cost sharing, screening for obesity in adults. In addition to such screening, the preventive service recommendation for individuals meeting certain criteria include higher, intensive, multicomponent behavioral interventions for weight management. The FAQ contains the details.

Colonoscopies

FAQs 7 and 8 state that a non-grandfathered group health plan may not impose cost-sharing for the required specialist consultation prior to the colonoscopy screening procedure if the attending provider determines that the pre-procedure consultation would be medically appropriate for the individual, because the pre-procedure consultation is an integral part of the colonoscopy.

In addition, if the colonoscopy is being performed as a screening procedure pursuant to the ACA, then the plan must cover any pathology exam on a polyp biopsy without cost sharing.

The FAQs clarified that the above interpretations will only apply for plan years beginning on or after the date that is 60 days after October 23, 2015. For a calendar year plan, that is January 1, 2016.

Coverage of BRCA Testing

FAQ 10 discusses BRCA testing which aims to detect potentially harmful mutations in breast cancer susceptibility genes. Women found to be at increased risk using a screening tool designed to identify a family history that may be associated with an increased risk of having a potentially harmful gene mutation must receive coverage without cost sharing for genetic counseling, and, if indicated, testing for harmful BRCA mutations. This is true regardless of whether the woman has previously been diagnosed with cancer, as long as she is not currently symptomatic of or receiving active treatment for breast, ovarian, tubal or peritoneal cancer.

Wellness

FAQ 11 explains that if a group health plan gives rewards in the form of non-financial (or in-kind) incentives (for example, gift cards, thermoses and sports gear) to participants who adhere to a wellness program that is related to a health factor is subject to the Department's wellness regulations.

Mental Health Parity and Addiction Equity Act

FAQ 12 explains that a health plan must provide a participant in a group health plan the criteria for making medical necessity determinations, as well as any processes, strategies, evidentiary standards, or other factors used in developing and applying the underlying Non Quantitative Treatment Limits, and must be disclosed with respect to both Mental Health/Substance Use Disorder (MH/SUD) benefits and medical/surgical benefits, regardless of any claims as to the proprietary nature or commercial value of the information.

In the FAQ, a participant sought treatment for anorexia as a mental health benefit and in accordance with the plan terms, the participant's provider requested prior authorization for a 30-day inpatient stay to treat the condition. The request was denied based on the plan's determination that a 30-day inpatient stay is not medically necessary under the plan terms. The plan then would not provide the information used for the determination, claiming that the information was "proprietary" and/or had "commercial value".

The DOL relied on a prior Advisory Opinion stating that any documents or instruments that specify formulas, methodologies or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan (in that case, a schedule of a plan's usual and customary fees) would constitute "instruments under which the plan is established or operated," and must be provided, notwithstanding that the plan asserted that such fee schedules are of a " proprietary" nature. Such information must be disclosed, even in cases where the source of the information is a third-party commercial vendor (see Advisory Opinion 96-14A).

FAQ 13 notes that a plan may, but is not required to, provide a summary description of the medical necessity criteria for both MH/SUD benefits and medical/surgical benefits. The summary description must be written to be understandable for a layperson. Moreover, the DOL stated that providing such a summary document is not a substitute for providing the actual underlying medical necessity criteria, if such documents are requested.

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