United Actuarial Services, Inc.
Actuaries and Consultants

2016-22

April 29, 2016

BENEFIT NEWS BRIEFS

ACA FAQ Set 31 Released

Affordable Care Act (ACA) Frequently Asked Questions (FAQs) Set 31 was recently released. This set includes FAQs regarding: (1) implementation of the market reform provisions of the *Affordable Care Act*, (2) the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*, and (3) the *Women's Health and Cancer Rights Act of 1998 (WHCRA)*.

At times, each of the FAQs contains lengthy background discussions of the respective portions of the *ACA* that is the subject of the FAQ. In addition, some of the FAQs have limited application to plans depending upon plan design. As such, we will hit the highlights of each relevant FAQ and interested readers can review the FAQ and background discussion in detail, as necessary. We will not discuss the FAQs that pertain to insured plans, keeping our focus on self-insured plans.

The Breakdown of the FAQs

The 12 FAQs are broken out as below. FAQs 1-7 apply to non-grandfathered plans only; FAQs 7-12 are of general applicability to grandfathered and non-grandfathered plans.

- Coverage of Preventive Services – FAQs 1-2
- Rescissions - FAQ 3
- Out-of-Network Emergency Services – FAQ 4
- Coverage for Individuals Participating in Approved Clinical Trials – FAQs 5-6
- Limitations on Cost-Sharing under the Affordable Care Act – FAQ 7
- Mental Health Parity and Addiction Equity Act of 2008 – FAQs 8-11
- The Women's Health and Cancer Rights Act – FAQ 12

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Coverage of Preventive Services

Non-grandfathered plans are required under the *ACA* to cover certain preventive services with no cost-sharing. FAQs 1 and 2 clarify certain aspects of such coverage in relation to colonoscopies and contraceptives.

Coverage of Colonoscopies

FAQ 1 clarifies that the required preparation for a preventive screening colonoscopy is an integral part of the procedure and, accordingly, bowel preparation medications are an integral part of the preventive screening colonoscopy and are required to be covered without cost sharing, subject to reasonable medical management.

Coverage of Food and Drug Administration (FDA)-approved Contraceptives

Non-grandfathered plans must cover without cost sharing at least one form of contraception in each of the methods (currently 18) identified for women by the FDA. If an individual's attending provider recommends a particular service or FDA-approved item that is not covered by the plan based on a determination of medical necessity with respect to that individual, then the plan must cover that service or item without cost sharing. The plan must defer to the determination of the attending provider. Medical necessity may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives and ability to adhere to the appropriate use of the item or service, as determined by the attending provider.

FAQ 2 notes that if a plan utilizes reasonable medical management techniques within a specified method of contraception, the plan can develop and utilize a standard exception form and instructions as part of its steps to ensure that it provides a process that is not unduly burdensome on the individual or a provider acting as a patient's authorized representative. The FAQ suggested the Medicare Part D Coverage Determination Request Form may serve as a model for plans when developing a standard exception form when an individual's provider prescribes a form of contraception not covered by the plan.

Rescissions

Generally, the *ACA* provides that group health plans must not rescind coverage unless the individual commits fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. A rescission is a cancellation or discontinuance of coverage that has a *retroactive effect*, except to the extent attributable to a failure to pay timely premiums towards coverage (including *COBRA* premiums) or in certain other limited circumstances specified in the regulations.

FAQ 3 contained a straightforward example of a plan retroactively terminating an individual's coverage (school teacher) and noted that under the facts such a termination was prohibited because (i) it is a cancellation or discontinuance of coverage that has retroactive effect, (ii) it is not attributable to a failure to timely pay premiums toward coverage, (iii) there was no fraud or intentional misrepresentation of material fact, and (iv) the other limited circumstance exceptions specified in the implementing regulations do not apply.

Out-of-Network Emergency Services

Non-grandfathered group health plans cannot impose cost sharing (expressed as a copayment amount or coinsurance rate) on out-of-network emergency services in a greater amount than what is imposed for in-network emergency services. However, balance billing is not included in the statutory definition of "cost sharing". Balance billing refers to the practice of providers billing patients for the difference between (i) the provider's billed charges and (ii) the amount collected from the plan or issuer plus the amount collected from the patient in the form of a copayment or coinsurance amount.

To avoid an end-run around the protections of against cost-sharing on out-of-network emergency services, the governing regulations require that a "reasonable amount" be paid by a plan before a patient becomes responsible for a balance billing amount. A plan satisfies the out-of-network emergency care copayment or coinsurance limitations in the statute if it provides benefits for out-of-network emergency services in an amount at least equal to the greatest of the following three amounts (adjusted for in-network cost sharing): (1) the median amount negotiated with in-network providers for the emergency service; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable (UCR) amount); or (3) the amount that would be paid under Medicare for the emergency service (collectively, minimum payment standards).

FAQ 4 notes that a plan is required to disclose how it calculated the amount under the minimum payment standards, including the method the plan generally uses to determine payments for out-of-network services (e.g., the UCR amount). The FAQ explains that for *ERISA* plans, the documentation and data used to calculate each of the minimum payment standards, including the UCR amount, for out-of-network emergency services are considered to be instruments under which the plan is established or operated and would be subject to the disclosure provisions under *ERISA*, which generally require such information be furnished to plan participants (or their authorized representatives) within 30 days of request.

Coverage for Individuals Participating in Approved Clinical Trials

The *ACA* requires that if a non-grandfathered group health plan provides coverage to a qualified individual, then such plan (1) may not deny the qualified individual participation in an approved clinical trial with respect to the prevention, detection, or treatment of cancer or another life-threatening disease or condition; (2) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) may not discriminate against the individual on the basis of the individual's participation in the trial.

Routine patient costs include "all items and services consistent with the coverage provided in the plan (or coverage) that are typically covered for a qualified individual who is not enrolled in a clinical trial." Routine patient costs <u>do not</u> include (i) the investigational item, device, or service being studied in the approved clinical trial; (ii) items and services that are provided solely to satisfy the clinical trial's data collection and analysis needs and that are not used in the direct clinical

management of the patient; and (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

FAQ 5 states that if a plan generally covers chemotherapy to treat cancer it cannot limit coverage of chemotherapy for an individual due to the fact that chemotherapy is provided in connection with the individual's participation in an approved clinical trial for a new anti-nausea medication.

FAQ 6 clarifies that if a plan typically covers items and services to diagnose or treat certain complications or adverse events the plan cannot deny coverage of such items and services when provided to diagnose or treat complications or adverse events (*e.g.*, side effects) in connection with an individual's participation in an approved clinical trial.

Limitations on Cost-Sharing

A non-grandfathered group health plan must comply with the *ACA* limits on any annual cost-sharing (coinsurance/copayments/deductible) imposed under the plan. This cost-sharing limit is often referred to as the maximum out-of-pocket limit (MOOP).

For 2016, the MOOP limits are - $6,850 for self-only coverage and $13,700 for other than self-only coverage; and for 2017, the MOOP limits will be $7,150 for self-only coverage and $14,300 for other than self-only coverage. FAQ 7 addresses the MOOP limit in the context of plans that may use "reference pricing" for certain procedures. Reference pricing is a pricing structure in which the plan pays a fixed amount (sometimes called a "reference price") for a particular procedure. Plans that use such pricing structures must ensure that participants have adequate access to quality providers.

FAQ 7 states that if a non-grandfathered plan uses reference pricing but the plan does not ensure that participants have adequate access to quality providers that will accept the reference price as payment in full, then the plan is required to count an individual's out-of-pocket expenses for providers who do not accept the reference price toward the individual's MOOP limit.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Generally, the *MHPAEA* requires that the financial requirements and treatment limitations imposed on mental health and substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits.

The regulations contain formulas to determine the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits. For example, a type of financial requirement (such as copay or coinsurance) or quantitative treatment limitation (such as day or visit limits) is considered to apply to substantially all medical/surgical benefits in a classification if it applies *to at least 2/3 of all medical/surgical benefits in the classification*.

Financial Requirements and Quantitative Treatment Limitations

FAQ 8 is aimed mostly at insured plans and states that when performing the "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations under *MHPAEA* the insurer may not base the analysis on an issuer's entire overall book of business for the year, but the tests must be plan specific.

The FAQ notes that to the extent group health plan-specific data is available, self-insured group health plans must use such data in making their *MHPAEA* projections.

Disclosure

FAQ 9 addresses a situation where a provider is acting as an authorized representative for an *ERISA* group health plan participant. The FAQ notes the health plan has requested that the provider complete a pre-authorization form after the patient's 9th visit for the treatment of depression. The FAQ answers the provider's request about what documents a plan must provide that would be most useful in helping the provider understand the plan's compliance with *MHPAEA* in regard to this pre-authorization requirement. According to the FAQ, the provider may request the following documents and plan information, which could be helpful in evaluating the plan's compliance with *MHPAEA*.

1. A Summary Plan Description (SPD) from an *ERISA* plan, or similar summary information that may be provided by non-*ERISA* plans;

2. The specific plan language regarding the imposition of any non-quantitative treatment limits (NQTL)) (such as a preauthorization requirement);

3. The specific underlying processes, strategies, evidentiary standards and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to this particular MH/SUD benefit;

4. Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue;

5. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and

6. Any analyses performed by the plan as to how the NQTL complies with MHPAEA.

The FAQ notes in this situation that the plan must produce documentation of how the factor, evidentiary standard and analysis is applied in the outpatient, in-network classification for medical/surgical benefits to demonstrate that the NQTL is not being applied to MH/SUD benefits more stringently than to medical/surgical benefits in the classification. The FAQ emphasized that the fact that any information (including factors and evidentiary standards used for medical/surgical benefits) may be characterized as proprietary or commercially valuable is not legitimate grounds for not providing the information.

FAQ 10 explains that plans must provide a *prospective* enrollee, upon request, a copy of the medical necessity criteria for coverage of mental health conditions.

Medication Assisted Treatment for Opioid Use Disorder

FAQ 11 explains that the *MHPAEA* applies to any benefits a plan may offer for Medication Assisted Treatment for opioid use disorder. Medication Assisted Treatment (MAT) is any treatment for opioid use disorder that includes medication that is FDA-approved for detoxification or maintenance treatment in combination with behavioral health services. Opioid use disorder is a "substance use disorder benefit" within the meaning of the term as defined by *MHPAEA*.

Group health plans that offer MAT benefits must do so in accordance with the requirements of *MHPAEA*. Accordingly, any financial requirements and treatment limitations may not be more restrictive than the predominant financial requirements and quantitative treatment limitations that apply to substantially all medical and surgical benefits in a classification. In addition, the special rule for multi-tiered prescription drug benefits also applies to the medication component of MAT. The behavioral health services components of MAT should be treated as outpatient benefits and/or inpatient benefits as appropriate for purposes of *MHPAEA.*

The Women's Health and Cancer Rights Act (WHCRA)

The *WHCRA* provides if a group health plan covers mastectomies, the plan must provide coverage for certain reconstructive and other services, in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema.

FAQ 12 clarifies that group health plans that cover mastectomies are required to provide coverage for nipple and areola reconstruction as a requirement under *WHCRA*, including nipple and areola repigmentation to restore the physical appearance of the breast as a required stage of reconstruction. The FAQ noted plans may impose deductibles and coinsurance for these benefits only if such cost-sharing requirements are consistent with those established for other benefits under the plan.

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