Legislative Brief

HCR - FAQs about ACA and MHPAEA

December 2015

FAQs about ACA and Mental Health Parity

SUMMARY:

- The DOL released FAQs about Affordable Care Act Implementation (Part XXIX) and Mental Health Parity Implementation that were prepared by the DOL, HHS, and Treasury.
- The FAQs address questions regarding four subject matters: (1) preventive services; (2) coverage of breast cancer susceptibility gene (BRCA) testing; (3) non-financial rewards in wellness programs; and (4) disclosures under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
- FAQs related to coverage of preventive services address the requirement of **non-grandfathered group health plans (GHP)** and health insurance coverage offered in the individual group market **to cover without imposition of any cost-sharing requirements.**
- Wellness programs: The FAQ regarding wellness clarifies that group health plans may reward participants with non-financial or "in-kind" incentives. In-kind incentives (non-financial) must also comply with wellness program requirements.

The Department of Labor (DOL) issued Frequently Asked Questions (FAQs) about Affordable Care Act (ACA) Implementation (Part XXIX) and Mental Health Parity Implementation. The FAQs were used to address questions regarding: (1) preventive services; (2) coverage of BRCA testing; (3) non-financial rewards under wellness programs; and (4) MHPAEA disclosures.

The FAQs clarify existing requirements under the ACA and MHPAEA and provide additional guidance on specific aspects of the laws and regulations that had not been previously addressed.

BACKGROUND

The FAQs pertaining to coverage of preventive services clarify that **non-grandfathered group health plans (GHP)** and health insurance coverage offered in the individual or group market **must provide the following preventive care benefits without imposing cost-sharing:**

- Evidence based items or services that have a "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Routine immunizations for children, adolescents, and adults that are recommended by the Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC);
- Evidence-informed preventive care and screening provided with respect to infants, children and adolescents supported by the Health Resources and Services Administration (HRSA); and
- Evidence-informed preventive care and screening with respect to women supported by the HRSA.

If a recommendation or guideline does not specify the frequency, method, treatment or setting for a recommended preventive service, plans may use a reasonable medical management technique to determine coverage.

• PREVENTIVE SERVICES

The FAQs pertaining to preventive services specifically deal with cost-sharing requirements regarding: (1) lactation counseling; (2) weight management services for adult obesity; (3) colonoscopy; and (4) contraception, providing:

1. LACTATION COUNSELING

- **Plans and issuers are required to provide a list of lactation counseling providers within the network**. Group health plans and insurance issuers are also required to provide a Summary of Benefits and Coverage (SBC) that includes an internet address (or other contact information) for obtaining a list of the network providers.
- **Group health plans subject to ERISA must provide a Summary Plan Description (SPD) that describes provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances coverage is provided for out-of-network services**. For plans with provider networks, the list of providers can be furnished in a separate document accompanying the SPD, as long as the SPD describes the provider network and states the provider lists will be furnished automatically, without charge, as a separate document. Issuers of qualified health plans in the individual market exchanges or SHOPs must make their provider directories available online and for plan years beginning on January 1, 2016 must publish an up-to-date provider directory.
- **A plan must not impose cost sharing with respect to lactation counseling services if obtained out-of-network**. If the plan's network does not include any in-network lactation counseling providers, then the plan must cover out-of-network lactation counseling services without cost sharing.
- **If a participant lives in a state that does not provide licensure for lactation counseling, the participant may receive lactation counseling by another provider acting within the scope of the license (such as a registered nurse) without cost sharing.**
- **A plan or issuer may not limit lactation counseling without cost sharing to an inpatient basis.** Outpatient lactation counseling without cost sharing must be permitted since some births do not take place within hospitals and lactation support must extend for the duration of breastfeeding.
- **Plans and issuers may not require an individual to purchase or rent breastfeeding equipment within a certain time period (e.g. within 6 months of delivery) in order for the equipment to be covered without cost sharing**. The coverage must extend for the duration of breastfeeding given the participant remains continuously enrolled in the plan or coverage.

2. WEIGHT MANAGEMENT SERVICES FOR ADULT OBESITY

Non-grandfathered plans and issuers must cover obesity screening for adults without cost sharing. The USPSTF also recommends for adults with a BMI of 30 or higher other intensive, multicomponent behavioral interventions such as:

- Group and individual session of high intensity (12 to 26 session in a year);
- Behavioral management activities, such as weight-loss goals;
- Improving diet or nutrition and increasing physical activity;
- Addressing barriers to change;
- Self-monitoring; and
- Strategizing how to maintain lifestyle changes.

Plans are not permitted to impose general exclusions that would include recommended preventive services.

3. COLONOSCOPY

- When a colonoscopy is scheduled and performed as a screening procedure, a plan or issuer may not impose cost sharing for the pre-procedure consultation prior to the screening if medically appropriate.
- Plans and issuers are required to cover any pathology exam or polyp biopsy without cost sharing when the colonoscopy is scheduled and performed as a screening procedure.

4. CONTRACEPTION

Due to religious affiliation, there are some instances where sponsors of non-profit or closely held for profit ERISA-covered self-insured plans may choose to relieve plans from any obligation to contract, arrange, pay or refer for contraception. The DOL provides two methods to accomplish this: 1) complete EBSA Form 700 or 2) provide notice of objection to HHS.

1. Complete EBSA Form 700 and provide to the plan's third party administrator (TPA)

Form 700 will be a plan instrument that relieves the sponsor from any obligation to contract, arrange, or pay for contraception which is objectionable and has the legal effect of designating the third party TPA as the ERISA plan administrator responsible for separately providing payment for those services.

2. Provide appropriate notice of the objection to the Department of Health and Human Services

This completed model form will be forwarded by Health and Human Services to the DOL, which will notify the TPA, designating it as the ERISA plan administrator responsible for separately providing coverage for any objectionable contraceptive services. This notice will be a plan instrument that relieves the sponsor from any obligation to contract, arrange, or pay for contraception services which are objected, but will not have the legal effect of designating the TPA as the ERISA plan administrator for those services. Instead, the notification from the DOL to the TPA will be a separate plan instrument that will serve to designate the TPA as the ERISA plan administrator responsible for separately providing payments for any objectionable contraceptive services.

- **COVERAGE OF BRCA TESTING**

The USPSTF recommends, with a "B" rating, that women who have family members with breast, ovarian, tubal or peritoneal cancer be screened to identify family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2). **Women with positive screening results should receive genetic counseling, and, if indicated after counseling, BRCA testing.** The scope of the recommendation includes genetic counseling and BRCA testing (if appropriate for a woman as determined by a health care provider), and addresses services for women who previously had breast cancer, ovarian cancer, or other cancer.

These FAQs clarify that women found to be at risk (using a screening tool to identify a family history that may be associated with an increased risk of a potentially harmful gene mutation) **must receive coverage without cost sharing for genetic counseling, and if indicated, testing for harmful BRCA mutations.** Coverage without cost sharing applies to women previously diagnosed with cancer, as long as the woman is not currently symptomatic or receiving breast, ovarian, tubal or peritoneal cancer.

- **WELLNESS PROGRAMS**

Group health plans and health insurers are generally prohibited from discriminating against individuals when establishing eligibility, benefits, or premiums based on a health factor. However, a wellness program may offer premium discounts, rebates, or modification of other cost sharing (such as copayments or deductibles) in return for adherence to the wellness program. In 2013, final regulations were issued setting the **maximum permissible reward under a health-contingent wellness program that is part of a group health plan at 30% of the total cost of coverage under the plan** (or 50% for wellness programs designed to prevent or reduce tobacco use).

The FAQs explain that **group health plans may reward participants in the form of financial and/or non-financial (or in-kind) incentives for adherence to a wellness program.** In-kind incentives may come in the form of time off, awards, prizes, and other items of value. Any in-kind reward is subject to the same wellness program regulations (i.e., when calculating the maximum permissible incentive, both financial incentives and non-financial incentives must be counted).

- **MHPAEA DISCLOSURES**

The MHPAEA generally requires that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health/substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits.

The FAQs clarify that any criteria used in making medical necessity determinations, as well as any processes, strategies, evidentiary standards, or other factors used in developing or applying an underlying nonquantitative treatment limitation (NQTL), must be disclosed with respect to both (MH)/(SUD) benefits and medical/surgical benefits. **This information will be required to be provided regardless of any assertions as to proprietary nature or commercial value of the information**. A 1996 DOL Advisory Opinion rejected the notion that a plan that is subject to ERISA can refuse to provide instruments under which the plan is established or operated on the basis that the information is proprietary. The documents or processes would constitute "instruments under which the plan is established and operated" and must be provided, regardless of whether the information is proprietary.

Additionally, group health plans and issuers **may** provide an SPD that provides a description of the medical necessity criteria for both MH/SUD benefits and medical surgical benefits in layperson's terms, **but such information is not a requirement**. Further, providing a summary document will not substitute the actual underlying medical necessity criteria , if such documents are requested.

- **ACTION TO BE TAKEN**

There are no dates on the FAQs, so it is recommended that employers review their group health plans to ensure that coverage is being provided at no cost to participants for the full range of preventive services described in the FAQs, as well as in previous recommendations. In addition, wellness programs that offer in-kind (non-financial) incentives must include those incentives when determining whether the requirements of the wellness program regulations are being met. Finally, the employer should be prepared to disclose medical necessity criteria for both mental health/substance use disorder and medical/surgical benefits. If you have any questions about these FAQs, please contact your Client Executive.

Health Care Reform —the Affordable Care Act (ACA)—has many complex requirements for employers and health plans. Please contact Kapnick Insurance Group with any questions about how you can prepare for any of the health care reform requirements. This Kapnick Insurance Group Update is not intended to be exhaustive nor should any discussion or opinions be construed as legal or tax advice. The information contained in this communication is intended to provide general information regarding health care reform and related topics, and is based on general information available at the time it was prepared. Readers should contract their tax and/or legal counsel for advise that is appropriate to their specific circumstances. This information cannot be used by any taxpayer to avoid tax penalties.

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