MARSH & McLENNAN AGENCY
Known locally as McGraw Wentworth

REFORM UPDATE

Issue One Hundred Twenty-One **May 2016**

May 11, 2016

FREQUENTLY ASKED QUESTIONS ON COMPLIANCE ISSUES

The Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively referred to as the Departments) recently released a set of FAQs addressing a number of compliance issues. They can be viewed at http://www.dol.gov/ebsa/healthreform/regulations/acaimplementationfaqs.html.

The FAQs address the following:

- Affordable Care Act (ACA) issues
- Mental Health Parity and Addiction Equity Act (MHPAEA)
- Women's Health and Cancer Rights Act (WHCRA)

The Departments regularly publish FAQs to address real questions received as part of compliance with these laws.

AFFORDABLE CARE ACT (ACA) ISSUES

The FAQs address a number of different aspects of the ACA.

Coverage of Preventive Services

Non-grandfathered plans are required to cover specified preventive care services with no cost-sharing. The list of covered services is determined by a number of governmental agencies. The following must be covered with no cost-sharing:

- Evidenced-based items or services that have an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF)
- Immunizations for children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings for infants, children and adolescents as recommended by the Health Resources and Services Administration (HRSA)
- Preventive care screenings for women, in accordance with guidelines supported by HRSA

The FAQs have two questions related to the preventive services requirements:

- *Does the plan have to cover with no cost-sharing the bowel preparation medications prescribed prior to a preventive colonoscopy?* Yes, the required preparation for a preventive colonoscopy screening is an integral part of the procedure. It must be covered without cost-sharing, subject to reasonable medical management criteria. Many of these medications can be purchased over-the-counter (OTC). In order for the medication to be covered, however, the OTC medication must be purchased with a prescription.
- *If a plan uses a reasonable medical management technique within a specified method of contraception, can the plan use a standard exception form to insure it is providing an easily accessible exceptions process that is not an undue burden?* Yes, plans can develop a standard exceptions form with instructions that attending providers can use to request and support, based on medical necessity, an exception to the plan's coverage rules. The Medicare Part D Coverage Determination Request Form may serve as a model for plans when developing their own standard exception form.

Rescissions

The ACA prohibits rescissions, a retroactive termination of coverage, except in very limited circumstances. The FAQs include a question from a school teacher.

> The teacher was employed by a school district with a 10-month contract. The contract ran from August 1 through May 31 of the following year. The teacher's health coverage was paid for during that same 10-month period for the entire plan year (which ran from August 1 to the following July 31). The teacher resigned on July 31, and the district retroactively terminated the teacher's coverage to May 31. *Was this retroactive termination permissible?*
>
> No, this termination would be considered a rescission for the following reasons:
> - It is a cancellation that has retroactive effect.
> - It is not attributable to a failure to timely pay premiums associated with coverage.
> - There was no fraud or intentional misrepresentation of material fact.
> - None of the other limited circumstances in the regulations apply.

In this case, the plan needed to terminate coverage prospectively.

Out-of-Network Emergency Services

Non-grandfathered health plans cannot impose cost-sharing (coinsurance or copay) on out-of-network emergency services in a greater amount than what is imposed for in-network services. Although balance-billing is permitted for out-of-network emergency room services, the rules require the health plan to pay a reasonable amount for the expense. The health plan must pick the greatest of the following three amounts to determine the approved amount for out-of-network emergency room services:

1. The median amount negotiated with in-network providers for the emergency service

2. The amount for the emergency room service calculated using the same method used to determine the approved amount for other out-of-network services, such as using the usual, customary and reasonable amount
3. The amount that would be paid by Medicare for the emergency service

These rules are designed to create a minimum payment amount for out-of-network emergency room treatment. If state law prohibits balance-billing, or if a carrier is contractually responsible for balance-billed amounts, then plans are not required to meet the minimum payment amounts detailed above.

The FAQs have only one question on coverage for out-of-network emergency services.

> *Is a plan required to disclose how it calculated the minimum payment amount, including how the plan usually determines payment amounts for out-of-network services?* Yes. For ERISA plans, the way in which usual and customary fees are determined is considered an instrument of the plan. Instruments under which a plan operates must be disclosed by request under ERISA. The information must be furnished to the plan participant or their authorized representative within 30 days of the request. Non-ERISA requirements must furnish such information under the claim and appeal rules that apply to non-grandfathered health plans. A failure to make payment in whole or in part on a claim is considered an adverse benefit determination. As part of the appeal process, the plan is required to provide reasonable access to documents and records relevant to the claim determination.

The process for determining the minimum payment amount for out-of-network emergency services must be disclosed upon request.

Coverage for Approved Clinical Trials

The ACA requires non-grandfathered health plans to provide coverage for specific services when a plan member participates in an approved clinical trial. The guidance to date has been high-level. Plans must meet the following:

1. Plans cannot deny a 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. Plans cannot deny or impose limitations/conditions on the coverage for routine items and services furnished in connection with the trial.
3. Plans may not discriminate against the individual on the basis of the individual's participation in the trial.

The FAQs include two questions related to coverage for clinical trials:

1. *If a plan generally covers chemotherapy to treat cancer, can the plan limit coverage of chemotherapy for an individual due to the fact that is provided in connection with the individual's participation in an approved clinical trial for a new anti-nausea medication?*

   No. The rules require that a plan cannot deny, limit or impose additional conditions on the

routine patient services furnished in connection with an approved clinical trial. The plan cannot limit the coverage of chemotherapy because the member is participating in an approved clinical trial.

2. *If a plan typically covers services to diagnose or treat certain complications, can the plan deny coverage for services if the complications or side effects are in connection with an individual's participation in an approved clinical trial?*

   No. A plan may not deny, limit or impose additional conditions on the coverage of routine services furnished in connection with participation in an approved clinical trial. Services to diagnose or treat complications arising from participation in an approved clinical trial must be covered if these types of services are covered for someone not participating in a clinical trial.

However, the ACA does allow plans to exclude coverage for some services when an individual participates in an approved clinical trial. Plans are not required to cover:

1. The investigational item, device, or service being studied in the approved clinical trial
2. An item or service provided solely to satisfy the clinical trial's data collection and analysis needs, which is not used in the direct clinical management of the patient.
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Although members may rarely participate in approved clinical trials, plans must be sure to handle their benefits with care. The fact that the member is participating in a clinical trial cannot influence whether the plan will cover services that are also covered for individuals not participating in a clinical trial.

Limitations on Cost-Sharing

Non-grandfathered plans now have to set an out-of-pocket limit, which is adjusted annually. Plans are only required to apply the out-of-pocket limit to in-network services. The Departments had received questions about how a reference-based price payment approach should apply to the out-of-pocket maximum. A plan that uses a reference-based price sets a maximum amount that it will pay for a specific service, such as a hip surgery. The amount set is determined by quality and prevailing fees in the geographic area. In a previous FAQ, the Departments allowed the out-of-pocket cost to be capped at the reference-based price amount, as long as the plan provides adequate access to quality providers at the reference-based price.

These FAQs include one question on reference-based price arrangements. For purposes of the out-of-pocket maximum, a plan can treat providers who accept their reference-based price as being in-network. However, the plan must use a reasonable method to ensure adequate access to quality providers at the reference price. If a plan sets a reference price without regard to access and quality, then all provider fees must apply to the out-of-pocket limit, even the amounts exceeding the reference-based price.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

The MHPAEA has very specific requirements for health plans to follow when determining if medical/surgical benefits are in parity with mental health and substance abuse benefits. The final regulations were reviewed in our Benefit Advisor at http://www.mcgrawwentworth.com/BenefitAdvisor/2014/BA_Issue_1.pdf.

These FAQs include a number of questions addressing MHPAEA compliance:

- *May an insurance carrier or plan perform the "substantially all" and "predominant" tests for financial requirements or quantitative treatment limits based on their entire book of business?*

  No. Conducting the analysis over the entire book of business in a specific region or state is not considered a reasonable method. To the extent group health plan-specific data is available, each self-funded plan must use their own data in making their projections. Insurance carriers should use group-specific data to make the projections for large fully-insured plans where group-specific information is available. For small group or individual insured plans, the carrier should use plan-level data, instead of product data, when making these projections.

- *A health plan has requested pre-authorization on a participant after the ninth visit for the treatment of depression. As a provider, I suspect this might be a violation of the MHPAEA. What documents can the participant request that will demonstrate compliance with the MHPAEA?*

  A plan participant has the right to request the following information that may provide insight into MHPAEA compliance:

  1. A Summary Plan Description (SPD) for ERISA-governed plans or similar summary information from non-ERISA plans.
  2. Specific plan language addressing the implementation of non-quantitative treatment limitations (NQTL), which should detail the pre-authorization requirement.
  3. The specific underlying processes, strategies, evidentiary standards, and any other factors considered by the plan in determining that the NQTL will apply to this particular mental/health or substance abuse benefit.
  4. Information regarding the application of NQTLs to any medical/surgical benefit within the same classification.
  5. The specific underlying processes, strategies, evidentiary standards, and any other factors considered by the plan in determining that the NQTL will apply to any medical/surgical benefits within the same classification.
  6. Any analysis performed by the plan as to how the NQTL complies with the MHPAEA.

  A participant should be able to use this information to determine if the plan is complying with the MHPAEA in respect to the pre-authorization requirement for the ninth visit for treatment of depression.

- The last question addressed the documentation that must be provided to a potential enrollee regarding the medical necessity determinations for mental health/substance abuse. This information must be provided to a potential enrollee in the individual marketplace upon request.

Many vendors are not providing coverage as required under the MHPAEA, which is a hot-button issue with the Departments.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

WHRCA requires health plans that provide coverage for mastectomies to provide coverage for other specified services. Required coverage includes all stages of breast reconstruction, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses and treatment of physical complications. These FAQs have one very specific question about the coverage required by the WHRCA. Plans that cover mastectomies must provide coverage for nipple and areola reconstruction as a stage of breast reconstruction.

CONCLUDING THOUGHTS

The Departments release FAQs on a regular basis to assist plans with practical applications related to compliance with various regulatory requirements. These are questions they receive from employers, health plans and even plan participants.

These FAQs are considered clarifications of in-force regulations. Your plan many need to modify coverage or processes based on the information provided.