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REFORM UPDATE

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FAQS ON ACA ISSUES AND MENTAL HEALTH PARITY IMPLEMENTATION

The Departments of Labor (DOL), Health and Human Services (DHHS) and the Treasury (collectively referred to as the Departments) recently published the 29th set of *Frequently Asked Questions* (FAQs). The questions concern the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA).

These answers to stakeholders' questions explain specific ACA requirements, wellness program incentives and mental health parity provisions. They cover the following topics:

- Preventive care coverage specifics
- Wellness program incentives
- MHPAEA disclosures

This *Reform Update* summarizes these FAQs.

PREVENTIVE CARE COVERAGE SPECIFICS

Non-grandfathered health plans must cover specific preventive care services in-network with no member cost-sharing. The list of covered preventive services is based on recommendations from various government organizations. The FAQs on preventive care clarify covered services.

Lactation Counseling

The Health Resources and Services Administration (HRSA) guidelines require health plans to cover pre- and postnatal lactation support, counseling and equipment rental for breastfeeding. Following are answers to several FAQs on required lactation services:

- *Are plans required to provide a list of lactation consultants within the network?* The preventive services rules do not directly require plans to provide a list of in-network lactation consultants. However, the plan's *Summary of Benefits and Coverage* (SBC) must include a link or contact information on how to obtain a list of network providers. ERISA also requires plans to provide participants access to the list of network providers.

- *If a plan does not include lactation counseling providers in its network, can it require participants that use out-of-network lactation counseling providers to share the cost?* No. If the plan or network does not have a provider for a particular service, the plan must cover the cost of an out-of-network provider without cost-sharing.
- *If a state does not license lactation counseling providers and the plan covers only services from licensed providers, does that mean the plan does not have to cover lactation counseling services?* No. Lactation counseling is covered when providers are acting within the scope of their licenses under applicable state law. For example, lactation counseling provided by registered nurses could be covered when it is within the scope of their licenses.
- *Can a plan cover lactation counseling without cost-sharing for inpatients only?* No. It would not be reasonable to limit coverage without cost sharing to only inpatients for two reasons. First, some births, such as home births with nurse midwives, do not result in an inpatient hospital stay. Second, coverage for lactation support services without cost-sharing must continue for the duration of breastfeeding, which in most cases extends beyond the hospital stay.

Breastfeeding Equipment

The FAQs included one question on coverage for breastfeeding equipment.

- *Can plans require women to obtain breastfeeding equipment within a specified period of time (for example, within six months of delivery) for the plan to cover the equipment without cost-sharing?* No. This coverage must extend for the duration of breastfeeding, so long as the woman stays enrolled in the plan.

Weight Management Coverage

This section has one question.

- *Is it permissible for my non-grandfathered group health plan to exclude weight management services for adult obesity?* No. Non-grandfathered plans must cover screening for obesity in adults without cost-sharing. In addition, the United States Preventive Services Task Force (USPSTF) also recommends intensive, multicomponent behavioral interventions for adult patients with a body mass index (BMI) of 30 or higher including:
  - High intensity group and individual sessions (12 to 26 sessions a year)
  - Behavioral management activities such as weight loss goals
  - Improving diet or nutrition and increasing physical activity
  - Overcoming barriers to change
  - Self-monitoring
  - Strategies for maintaining lifestyle changes

While plans may use reasonable medical management techniques to determine frequency, method, treatment, or setting for recommended preventive services, plans cannot impose general exclusions for recommended preventive services.

Colonoscopy Coverage

Two FAQs concern preventive colonoscopy coverage.

1. *Can a plan require cost sharing for consultation with a specialist before a preventive colonoscopy?* No. A plan can't impose cost-sharing for a required consultation before a *preventive* colonoscopy if the attending provider considers the pre-procedure consultation medically appropriate. Pre-procedure consultation is an integral part of a colonoscopy. As with any invasive procedure, the pre-procedure consultation can be essential for the patient to understand the procedure and the required preparation.
2. *After a screening colonoscopy is performed as the USPSTF recommendation requires, must the plan cover any pathology exam on a polyp biopsy without cost sharing?* Yes. The Departments view the pathology exam as an essential part of the routine colonoscopy. The pathology exam determines whether polyps are malignant.

The Departments acknowledge that prior guidance may have been reasonably interpreted in good faith as not requiring full coverage for pre-procedure consultations and pathology exams. As a result, this clarifying guidance will apply for plan years beginning on or after December 22, 2015.

Religious Non-Profit or Closely-Held For-Profit Employers Opposed to Contraceptive Coverage

There is one question on this topic.

I am a qualifying non-profit or closely-held for profit who sponsors an ERISA-covered self-insured plan and I have a sincerely held religious objection to covering contraceptive services. How do I accommodate my religious beliefs and still meet the requirements?

There are two ways to claim the accommodation:

1. Complete the EBSA Form 700 and send it to the plan's third party administrator (TPA)
2. Provide appropriate notice of the objection to the DHHS. A model notice is available at www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Model-Notice-8-22-14.pdf.

Completing EBSA Form 700 and sending it to the TPA relieves your organization of the obligation to cover contraceptive services. The form legally designates the TPA as the ERISA plan administrator responsible for providing separate payments for contraceptive services.

If you notify DHHS directly, it will forward the information to the DOL. The DOL will then notify the TPA designating the TPA as the ERISA plan administrator responsible for providing payments for contraceptive services separately. For this process, notifying DHHS relieves you of the obligation to cover contraceptive services.

Coverage of BRCA Testing

BRCA testing may need to be covered under specific circumstances. If a woman screens positive for the BRCA gene mutation, recommended genetic counseling should be covered. If genetic counseling indicates that it is necessary to look for possible gene mutations, BRCA tests should then also be covered. These FAQs contain one additional question on BRCA testing.

- *Which women must receive coverage without cost-sharing for genetic counseling and, if indicated, testing for harmful BRCA mutations?* Women at increased risk because of a family history of a harmful mutation of the BRCA gene must receive genetic counseling with no cost-sharing. If that counseling reveals a risk, the plan must cover BRCA testing also without cost-sharing. The testing must be covered whether or not the woman has been previously diagnosed with cancer as long as she currently has no symptoms and is not being treated for breast, ovarian, tubal or peritoneal cancer.

WELLNESS PROGRAM INCENTIVES

A number of rules apply to wellness programs if employers offer incentives to participate or achieve specific health goals. Wellness plan rules are detailed in our *Benefit Advisor* at http://mcgrawwentworth.com/wp-content/uploads/BA_Issue_V18_3.pdf.

One FAQ concerns wellness incentive rules.

- *My group health plan has non-financial (or in-kind) incentives (for example, gift cards and sports gear) to participate in the wellness program. Do wellness program regulations apply to non-financial incentives?* Yes. The regulations apply to rewards whether they are financial or non-financial (or in kind).

MHPAEA DISCLOSURES

The MHPAEA significantly changed how health plans need to offer parity in coverage for mental health and substance abuse treatment. The details are covered in our *Benefit Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2014/BA_Issue_1.pdf.

The FAQs include two questions on mental health and substance abuse benefits.

1. *I am a participant in a group health plan that provides treatment for anorexia as a mental health benefit. In accordance with plan terms, my provider requested prior authorization for a 30-day inpatient stay to treat my anorexia. The request was denied because a 30-day inpatient stay was not deemed medically necessary under the terms of the plan. I requested a copy of the medical necessity criteria for both medical/surgical and mental health services as well as any other factors that were used in determining medical necessity. May a plan decline to provide that information because the information is "proprietary" and/or has "commercial value"?* No. The information must be provided upon request if there has been an adverse benefit determination. In your case, you can request the information because the plan declined your inpatient treatment citing lack of medical

necessity. The plan must provide this information even if it is considered proprietary or determined to have commercial value.

2. *Can my plan, upon request, provide a summary description of medical necessity criteria for mental health and medical/surgical benefits that is written for a layperson?* Yes. Plans **are not required to do so** but they can provide a document that summarizes medical necessity criteria in layperson's terms. However, this summary is not a substitute for providing the actual underlying medical necessity criteria if such documents are requested.

The Departments will continue to issue FAQs on practical situations regarding compliance with federal regulations. These FAQs will provide a greater understanding of how to comply with various federal requirements.