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Regulatory Update

New Guidance on the ACA, Mental Health Parity, and Other Health Plan Issues

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On April 20, 2016, the Departments of Labor, Health and Human Services, and the Treasury released the 31st set of Frequently Asked Questions (FAQs) on the implementation of the Affordable Care Act (ACA) and other health plan-related laws.

The FAQs address questions on preventive services, coverage rescissions, mental health parity, and more. This article summarizes the key provisions affecting the typical employer-sponsored group health plan.

Preventive Services

Non-grandfathered health plans are required to cover specific preventive services at 100 percent without "cost-sharing" (i.e., without imposing deductibles, co-pays, or co-insurance).

The FAQs clarify that:

- Plans may not impose cost-sharing on bowel preparation medications prescribed for a preventive screening colonoscopy.
- Plans may use reasonable medical management for coverage of contraceptives, such as covering generic drugs at 100 percent and imposing a co-pay for equivalent branded drugs, provided the plan offers an expeditious exceptions process. The attending physician may request an exception based on medical necessity. Plans should consider using the Medicare Part D Coverage Determination Request Form as a model for developing a standard exception form.

Coverage Rescissions

Rescission means retroactively terminating coverage for which the enrollee has already paid any required premiums on time. Rescissions are prohibited under the ACA, except in specific cases involving fraud or intentional misrepresentation. This has raised questions from schools and colleges that often have employees working a 10-month year with coverage continuing over the summer break.

For clarification, the FAQs provide an example of a rescission that violates the ACA:

- A teacher is employed under a 10-month contract from August 1 to May 31. She enrolls for coverage under the school's health plan for the August 1 through July 31 plan year and pays premiums for the full period.
- The teacher decides not to return for the following school year and resigns effective July 31. The plan terminates the teacher's coverage retroactively to May 31.
- The plan's action is a rescission in violation of the ACA. The teacher had already paid for coverage through July 31 and there had been no fraud or intentional misrepresentation.

Out-of-Network Emergency Services

Non-grandfathered plans are prohibited from imposing greater cost-sharing on emergency services provided out-of-network than on those provided in-network. Out-of-network providers often bill patients for the difference between the plan's allowed amount and the provider's billed charges. Although the ACA's cost-sharing rule cannot protect patients entirely from this type of balance billing, plans are required to make at least a minimum payment for out-of-network emergency care. The minimum required payment is equal to the greatest of the following:

- The median amount negotiated with in-network providers;
- The amount calculated using the plan's usual method for out-of-network providers, such as the usual, customary, and reasonable (UCR) amount; or
- The amount that would be paid under Medicare.

The FAQs also clarify that plans subject to ERISA must disclose information about how the minimum payment standard amount is calculated within 30 days of a request. Disclosure also is required under ERISA's claim procedure rules.

Mental Health Parity and Addiction Equity Act (MHPAEA)

Financial requirements (e.g., co-pays, co-insurance) and treatment limits (e.g., day or visit limits) for mental health and substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limits that apply to substantially all medical and surgical benefits. "Substantially all" means the requirement or limit applies to at least two-thirds of the medical/surgical benefits in a classification, and "predominant" means the level that applies to more than half of the medical/surgical benefits in the classification.

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The FAQs clarify that in performing the "substantially all" and "predominant" tests, the plan cannot base its analysis on the carrier's entire overall book of business for the year. To the extent that plan-specific data is available, it must be used. For instance, a self-insured group health plan, or a large experience-rated insured plan, should have plan-specific data on which to base its analysis.

Plans that contract with managed behavioral health organizations for MH/SUD benefits must provide enough information to the vendor to ensure compliance with the MHPAEA.

Further, the FAQs reiterate prior guidance regarding disclosure requirements. Upon request, current or potential enrollees and their representatives and healthcare providers must be given reasonable access to and copies of all relevant documents, including information on medical necessity criteria. Plans and carriers cannot avoid disclosure by claiming the information is proprietary or commercially valuable.

Miscellaneous

The FAQs also clarify the following:

- The Women's Health and Cancer Rights Act (WHRCA) requires health plans covering mastectomies to provide coverage for all stages of reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedema. This includes coverage for nipple and areola reconstruction, including re-pigmentation to restore physical appearance.
- Non-grandfathered plans are prohibited from denying qualified enrollees the right to participate in clinical trials or denying coverage for routine items and services furnished in connection with participating. Plans cannot impose additional conditions on coverage of chemotherapy that would otherwise be covered, and must cover items and services to diagnose or treat adverse events and complications if they would be covered for persons not participating in a clinical trial.
- Non-grandfathered plans are subject to the ACA's annual limits on cost-sharing; e.g., the limits on out-of-pocket maximums for plan year 2016 are $6,850 per person and $13,700 per family. Generally, plans that offer in-network benefits are not required to count out-of-network expenses toward the out-of-pocket maximums. Plans that use reference pricing, such as a fixed amount for a particular procedure, must use an adequate method to ensure access to quality providers at the reference price. If not, the plan will not be considered to have established a network for purposes of the cost-sharing rule.

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