

NEW ACA, ET. AL. FAQs COVER ITEMS FROM “TOP” TO “BOTTOM”

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On April 20, the “Big Three” agencies (DOL, Treasury/IRS, and HHS) released another set of FAQs (the 31st, for those of you counting at home). Consistent with earlier FAQs, the new FAQs cover a broad range of items under the Affordable Care Act, Mental Health Parity and Addiction Equity Act, and Women’s Health Cancer Rights Act. The authors are admittedly curious about how “Frequently” some of these questions are really asked, but we will deal with all of them in brief form below.

1. **Bowel Preparation Medication** – For those getting a colonoscopy, there is good news. (No, you still have to go.) But the ACA FAQs now say that medications prescribed by your doctor to get you ready for the procedure should be covered by your plan without cost sharing. Plans that were not already covering these at the first dollar will need to start.
2. **Contraceptives** – As a reminder, plans are required to cover at least one item or service in all the FDA-approved contraceptive methods. However, the FAQs also hearkened back to earlier FAQs reminding sponsors that they could use medical management techniques to cover some versions of an item (such as a generic drug) without cost sharing while imposing cost sharing on more expensive alternatives (like a brand name drug). However, plans must have an exception for anyone whose provider determines that the less expensive item would be medically inappropriate. None of this is news. However, the FAQs did acknowledge that plans can have a standard form for requesting these kinds of exceptions. They referred issuers and plan sponsors to a Medicare Part D form as a starting point. While the Medicare Part D form is a useful starting point, it would likely need significant customization for anyone to use it properly for these purposes.
3. **No Summer Recess for Recession Rules** – As most people know by now, ACA prohibits almost all retroactive cancellations of coverage. The FAQs confirm that school teachers who have annual contracts that end in the summer cannot have their coverage retroactively cancelled to the end of the school year (unless one of the limited circumstances for allowing rescissions applies, of course).
4. **Disclosure of the Calculation of Out-of-Network Payments is Now Required** – The ACA requires that plans generally provide a certain level of payment for out-of-network emergency services that is

designed to approximate what the plan pays for in-network emergency services. The regulations provide three methods a plan may choose from to determine the minimum it has to pay. Out-of-network providers are permitted to balance bill above that. The FAQs confirm that plans are required to disclose how they reached the out-of-network payment amount within 30 days of a request by a participant or dependent and as part of any claims review. The penalties associated with failing to provide such information on request (up to \$110/day) are steep. Additionally, failing to strictly follow the claims procedures can allow a participant or dependent to bypass the process and go straight to court or external review. Given these consequences, insurers and plan sponsors should make sure they have processes in place to provide this information.

5. Clinical Trial Coverage Clarifications – The FAQs confirm that “routine patient costs” that must be covered as part of a clinical trial essentially include items the plan would cover outside the clinical trial. So, if the plan would cover chemotherapy for a cancer patient, the plan must cover the treatment if the patient is receiving it as part of a clinical trial for a nausea medication, for example. In addition, if the participant or dependent experiences complications as a result of the clinical trial, any treatment of those complications must also be covered on the same basis that the treatment would be covered for individuals not in the clinical trial.

6. MOOPing Up After Reference-Based Pricing – Non-grandfathered plans that use a reference-based pricing structure are generally required to make sure that participants and dependents have access to quality providers that will accept that price as payment in full. However, the FAQs say that if a plan does not provide adequate access to quality providers, then any payment a participant or dependent makes above the reference price has to be counted toward the maximum out-of-pocket limit that the participant or dependent pays.

7. Mental Health Parity and Addiction Equity Analysis Must be Plan-by-Plan – The Mental Health Parity and Addiction Equity Act (MHPAEA) tries to put mental health and substance abuse benefits on par with medical/surgical benefits by providing that the cost-sharing and other types of treatment limitations must be the same across particular categories of benefits. Where these types of limitations vary, the MHPAEA rules look at the “predominant” financial requirement that applies to “substantially all” medical/surgical benefits in a particular category. For purposes of determining which limitations are “predominant” and apply to “substantially all” the benefits, the rules generally require that a plan look at the dollars spent by the plan on those benefits. In other words, the determination is not based on how many types of services a particular cost-sharing requirement or limitation (like a copayment) applies to, but how much money is spent on the various services. These types of analysis require looking at claims experiences. The FAQs confirm that an issuer may not look at its book of business to make these determinations. Instead, the determinations must be made plan-by-plan. As a practical matter, most plans that provide mental health and substance abuse benefits try to apply as uniform of levels of cost sharing and treatment limitations as they can to help simplify this analysis.

8. Playbook for Authorized Representatives Requesting Information about MHPAEA Coverage – The FAQs also provide a list of items that a provider may request in an effort to determine a plan’s compliance with the MHPAEA provisions or in trying to secure treatment for an individual. Plan sponsors and issuers would be well-advised to peruse the FAQs to look at the types of documents since these will likely find their way into a form document request that plan sponsors and issuers are likely to see. The FAQs also list items that the agencies say a plan must provide. Plans and issuers should review their processes to determine if all the relevant information is being provided in response to these types of requests.

While not relevant for group plan sponsors, the FAQs also confirm that individuals applying for individual market coverage are required to receive a copy of the medical necessity determination the issuer uses for mental health and substance abuse benefits on request.

9. Going to the MAT – The FAQs confirm that Medication Assisted Treatment (MAT) for opioid use disorder (think: methadone maintenance) is a substance use disorder benefit that is subject to the MHPAEA limitations on cost-sharing, etc. described above.

10. Nipple/Areola Reconstruction Coverage Required to Be Covered – Under the Women’s Health Cancer Rights Act, health plans and health insurance coverage must cover post-mastectomy reconstruction services. The FAQs confirm that this includes reconstruction of the nipple and areola, including repigmentation.