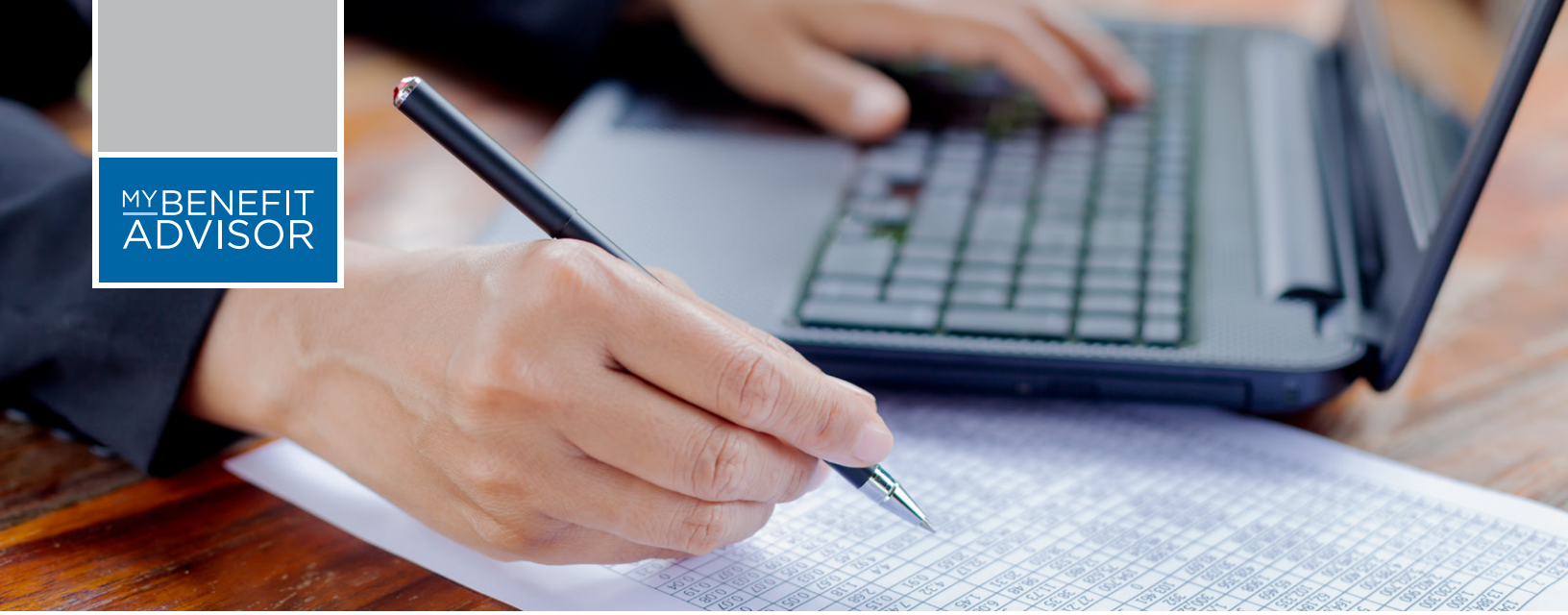


The Departments Issue 29th Set of ACA FAQs

Issued date: 12/15/15

The Departments of Labor, Treasury, and Health and Human Services (collectively, the Departments) have issued the 29th set of Affordable Care Act ("ACA") frequently asked questions ("FAQs"). This time, the Departments tackle various questions on the preventive care mandate, wellness programs, and medical necessity determinations under the Mental Health Parity and Addiction Equity Act of 2008.

Unless otherwise noted, this guidance is effective as of October 23, 2015.

Preventive Care

A non-grandfathered group health plan must provide coverage for in-network preventive items and services and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services. The FAQs address some of those preventive items and services.

Lactation counseling

Comprehensive prenatal and postnatal lactation support, counseling, and equipment rental are part of the ACA's mandated preventive care requirements. This includes lactation counseling. FAQs 1-4 address a number of issues related to lactation counseling:

- Plans are required to provide a list of lactation counseling providers within a network. This requirement is generally met through providing the SBC, which includes an Internet address for obtaining a list of the network providers. Further, ERISA requires a group health plan to provide an SPD that, among other things, provides information on providers including a description of any provider networks and how to obtain a provider list without charge.

- If a plan does not have in its network a provider who can provide lactation counseling services, the plan must cover the item or service when performed by an out-of-network provider without cost sharing.

- If a state does not license lactation counseling providers, then, subject to reasonable medical management, lactation counseling must be covered without cost sharing by the plan when it is performed by any provider acting within the scope of his or her license or certification under applicable state law (e.g., a registered nurse).

- It is not a reasonable medical management technique to limit coverage for lactation counseling to services provided on an in-patient basis (e.g., in a hospital setting). Moreover, coverage for lactation support services without cost sharing must extend for the duration of the breastfeeding.

Breastfeeding equipment

Under the preventive care mandate, the rental or purchase of breastfeeding equipment must be covered without cost-sharing. A plan may not require individuals to obtain breastfeeding equipment within a specified time period (e.g., 6 months from the date of delivery) in order for the equipment to be covered without cost sharing. Additionally, the coverage extends for the duration of breastfeeding, provided the individual remains continuously enrolled in the plan or coverage.

Weight management exclusions

Screening for obesity in adults is a preventive service. Additionally, the guidelines currently recommend, for adult patients with a body mass index ("BMI") of 30 kg/m2 or higher, intensive, multi-component behavioral interventions for weight management. While plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified in the recommendation or guideline, plans are not permitted to impose general exclusions that would encompass recommended preventive services.

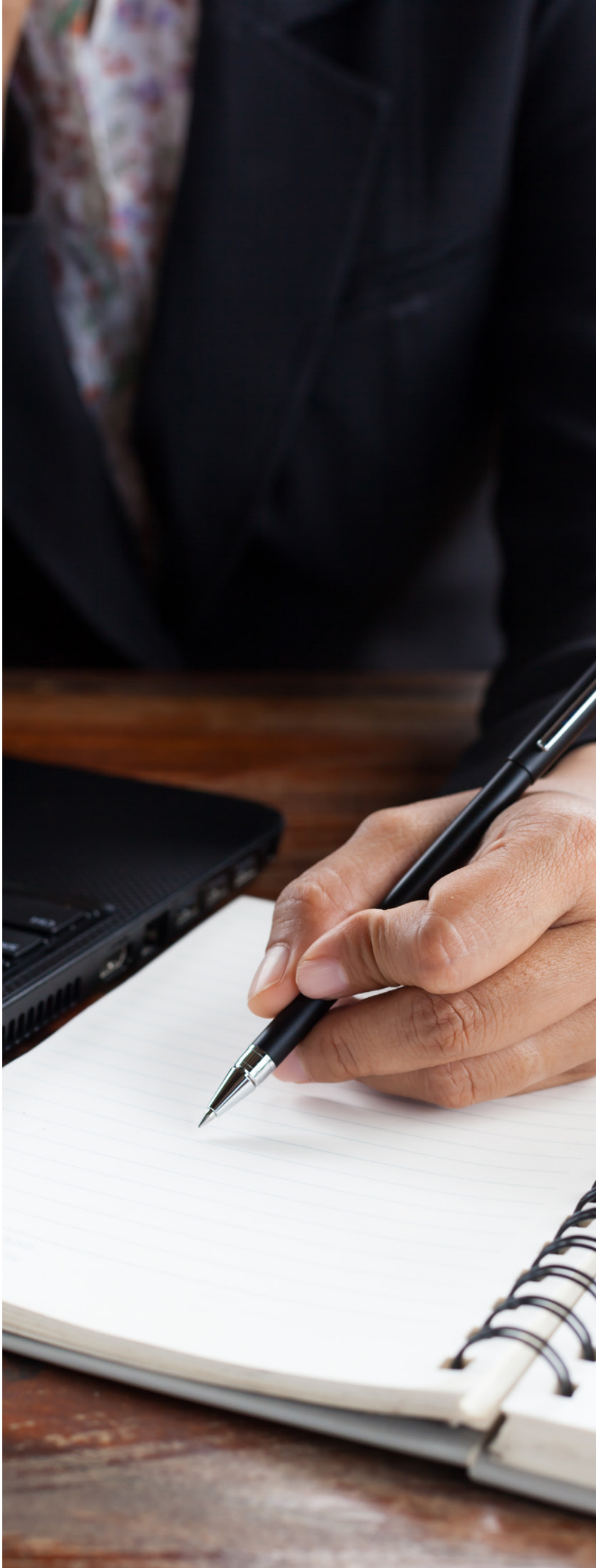
Colonoscopies

FAQs 8-9 clarify that if the colonoscopy is scheduled and performed as a preventive screening procedure, it is not permissible for the plan to impose cost-sharing on a required specialist consultation or any pathology exam or biopsy in connection with a preventive colonoscopy. This clarifying guidance is effective for plan years that begin on or after January 1, 2016.

Eligible organizations and contraceptive services

FAQ 9 outlines the two methods a qualifying non-profit or closely held for-profit employer with a self-insured group health plan can use to claim an accommodation:

- Complete EBSA Form 700 and provide the form to the third party administrator (TPA): http://www.dol.gov/ebsa/pdf/preventiveserviceseligibleorganizationcertificationform.pdf; or



- Provide notice of the objection to HHS: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Model-Notice-8-22-14.pdf.

The accommodation generally relieves the employer from any obligation to contract, arrange, or pay for the objectionable contraceptive and that has the legal effect of designating the third party administrator ("TPA") as the ERISA plan administrator responsible for separately providing payments for those services.

Note, the Supreme Court granted review of 7 cases contesting the contraceptives services mandate under the ACA, mainly centered on this accommodation process. The Court is expected to hear oral arguments in late March of 2016 with a decision likely in June.

BCRA Testing

FAQ 10 states that women found to be at increased risk, using a screening tool designed to identify a family history that may be associated with an increased risk of having a potentially harmful gene mutation, must receive coverage without cost sharing for genetic counseling and, if indicated, testing for harmful BRCA mutations. This is true regardless of whether the woman has previously been diagnosed with cancer, as long as she is not currently symptomatic of or receiving active treatment for breast, ovarian, tubal, or peritoneal cancer.

Wellness Programs

Non-financial rewards

FAQ 11 provides that if a group health plan offers non-financial (or in-kind) incentives (e.g., gift cards, thermoses, sports gear) to participants who adhere to a health-contingent wellness program, the program must comply with HIPAA's 5-factor test.

Mental Health Parity and Addiction Equity Act ("MHPAEA")

The final two FAQs (12 and 13) address issues under the MHPAEA. In general, MHPAEA requires that the financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health and 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.

Medical necessity

Notably, the FAQ clarifies:

- If a participant requests from the plan administrator a copy of its medical necessity criteria for both medical/surgical and MH/SUD, including any information regarding the processes, strategies, evidentiary standards, or other factors used in developing the medical necessity criteria and in applying them, the plan administrator may not refuse to provide this information based on the assertion that such information is "proprietary" and/or "has commercial value." Such information needs to be disclosed upon request, even if the source of the information is a commercial third-party vendor.

- While not required to do so, a plan may provide a document written in layperson's terms that provides a description of the medical necessity criteria. Providing this information is not a substitute for supplying the actual underlying medical necessity criteria, if those documents are requested.