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Federal Agencies Publish Affordable Care Act FAQs

Reiterate that Medical Necessity Criteria, Other Standards Must be Provided Upon Request

On Friday the Departments of Health and Human Services, Labor, and the Treasury (the Agencies) published Frequently Asked Questions with answers and other guidance on a variety of issues related to the Affordable Care Act and the Mental Health Parity and Addiction Equity Act (MHPAEA). Among other things, the Agencies emphasized that health plans must, upon request, disclose to plan participants the "criteria for making medical necessity determinations, as well as any processes, strategies, evidentiary standards, or other factors used in developing [and applying 'non-quantitative treatment limitations'] regardless of any assertions as to the proprietary nature or commercial value of the information" and "even in cases where the source of the information is a third-party commercial vendor." The requirement applies to medical/surgical benefits as well as mental health and substance use disorder benefits. "Non-quantitative treatment limitations" are non-numerical limitations on the scope or duration of benefits covered under a plan, such as limiting coverage based on medical necessity, experimental treatment, step therapy, or the geographic location of a provider facility.

The FAQs also elaborate on (a) a health plan's obligation to cover without cost sharing certain health care services that are "an integral part of a colonoscopy," (b) requirements for coverage related to lactation counseling, and (c) other matters.

Click here for the FAQs published on Friday. The FAQs are the 29th set of questions addressed by the agencies to provide health plans with guidance in implementing the Affordable Care Act and MHPAEA. Links to all 29 sets of FAQs are published on the Department of Labor's website at http://www.dol.gov/ebsa/faqs/ (*see* FAQs under the heading "**Health**") and the Department of Health and Human Services' website at http://cciio.cms.gov/resources/factsheets/index.html (*see* FAQs under the heading "**Affordable Care Act**").

Click here (or see the "Resources" page at tbixbylaw.com) for my compilation of the Agencies' FAQs that address MHPAEA (*see* first bullet under "Other Resources").

Disclosure Requirements

The Agencies explain the MHPAEA requirement that a health plan may impose a non-quantitative treatment limitation (NQTL) (*e.g.*, limiting benefits to those that are medically necessary) on mental health or substance-use disorder benefits only to the extent the health plan similarly imposes the NQTL on medical/surgical benefits. Thus, with respect to any classification of benefits (*e.g.*, "inpatient, in-network" or "in-patient, out-of-network" benefits), a health plan must implement a NQTL for mental health or substance use disorder benefits in a manner that is comparable to and no more stringent than the manner in which the health plan implements the NQTL for medical/surgical benefits. This requirement applies to "the terms of the plan as written and in operation," including "any processes, strategies, evidentiary standards, or other factors used in applying the NQTL."

The Agencies then remind readers of various disclosure requirements in MHPAEA, the Affordable Care Act, and ERISA, and conclude that "[t]he criteria for making medical necessity determinations, as well as any processes, strategies, evidentiary standards, or other factors used in developing [an] underlying NQTL and in applying it, must be disclosed [upon request] with respect to both [mental health/substance use disorder] benefits and medical/surgical benefits." The agencies then emphasize that, in keeping with long-standing Department of Labor policy, the information must be disclosed, "regardless of any assertions as to the proprietary nature or commercial value of the information" and "even in cases where the source of the information is a third-party commercial vendor."

A health plan that contracts with third-party vendors either to adjudicate claims using NQTLs or to provide the health plan with processes, strategies, evidentiary standards, or other criteria the health plan uses itself as NQTLs to adjudicate claims should therefore evaluate whether contracts with its vendors interfere with these disclosure requirements, if the health plan has not already done so.

Preventive Services FAQs

The Agencies devote ten of the 13 FAQs to the Affordable Care Act provisions on coverage of preventive services. Two FAQs address colonoscopies and explain that (1) a required consultation prior to the colonoscopy "is an integral part of the colonoscopy" if the attending provider determines the consultation is medically appropriate and (2) any pathology exam arising from a polyp removal (as well as the polyp removal itself) is also "an integral part of a colonoscopy." Accordingly, a health plan must cover both without cost sharing. The Agencies explain that, with respect to these two FAQs, "[b]ecause the Departments' prior guidance may reasonably have been interpreted in good faith as not requiring coverage [of these services] without cost sharing[, the Agencies] will apply this clarifying guidance for plan years (or, in the individual market, policy years) beginning on or after the date that is 60 days after publication of these FAQs."

No less than five FAQs address lactation counseling and breastfeeding equipment. The FAQs clarify that a health plan cannot limit coverage of lactation counseling to an in-

network benefit unless the health plan has (and provides information on) a network of lactation counselors. Moreover, a health plan cannot limit lactation counseling to an inpatient benefit or impose a limitation on breast-feeding equipment based on a time period (*i.e.*, within 6 months of delivery), other than limiting coverage to the duration of breast-feeding.

Other FAQs

The FAQs also:

- Explain how an employer with religious objections to coverage of contraceptive care may activate the Agencies' accommodation for coverage of such services;
- Clarify that a "general exclusion for weight management services for adult obesity" is generally prohibited by the preventive care mandate and (at least with respect to some plans) other Affordable Care Act provisions;
- Emphasize that women at increased risk of gene mutation (based on family history) are entitled to genetic counseling without cost sharing, "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."
- Stress that gift cards, sports gear, and other non-financial rewards provided by employers (or others) for participation (or achievements) in wellness programs are subject to the requirements of Wellness program regulations issued by the Agencies.

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