Commonwealth Benefits Group
2 Barlo Circle
Suite C
Dillsburg, Pennsylvania 17019
(717) 432-1010
http://www.commonwealthbenefitsgroup.com

HEALTHCARE REFORM UPDATE 2015-9

PPACAAdvisor

WHAT EMPLOYERS NEED TO KNOW RIGHT NOW ABOUT HEALTH CARE REFORM

Preventive Service Requirement FAQ

On May 11, 2015, the Department of Labor (DOL) along with other federal agencies issued an FAQ regarding the implementation of the Patient Protection and Affordable Care Act (PPACA) that focused on coverage of preventive services. Non-grandfathered group health plans and health insurance offered in the individual or group markets must provide certain listed benefits with no cost-sharing to the beneficiary. The FAQ provided information on some commonly confusing or ambiguous requirements.

BRCA Testing

PPACA requires health plans to offer evidence-based services with a rating of A or B in the current recommendations provided by the United States Preventive Services Task Force (USPSTF), as well any additional coverage for women provided in guidelines supported by the Health Resources and Services Administration (HRSA). A 2013 FAQ left confusion as to whether the recommendation to provide BRCA screening applies to women who have had a prior non-BRCA-related breast cancer or ovarian cancer diagnosis, even if they are asymptomatic and cancer-free. The DOL clarified that a plan or issuer must cover (without cost-sharing) genetic counseling and BRCA genetic testing for women who have not been diagnosed with a BRCA-related cancer but previously had breast cancer, ovarian cancer, or other specific cancers.

Contraception

The FAQ provided information relating to contraception coverage that is applicable to plan years or policies beginning on or after July 10, 2015 (60 days from issuance of the FAQ). It made clear that if a plan or issuer covers some forms of contraception without cost-sharing, but completely

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excludes other forms of contraception, it will not be in compliance with regulations. Plans and issuers must cover the full range of FDA-identified methods and must cover without cost-sharing at least one form of contraception in each method identified by the FDA. There are 18 FDA-identified methods of contraception for women. The coverage must include clinical services, including patient education and counseling that is needed for the provision of the contraception method.

Plans and issuers may utilize reasonable medical management techniques. The plan may discourage the use of brand name pharmacy items over generic pharmacy items, or use cost sharing to encourage the use of one of several FDA-approved intrauterine devices (IUDs) with progestin. When utilizing reasonable medical management techniques the plans and issuers must have an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome on either the patient or the provider. If an individual's attending provider recommends a particular service or FDA-approved item based on medical necessity, the item must be covered without cost-sharing and the plan or issuer must defer to the medical provider.

Sex-Specific Recommended Preventive Services

The FAQ made clear that plans or issuers may not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity, or recorded gender. The decision regarding the medical appropriateness of a preventive service is to be determined by the individual's attending provider.

Well-Woman Preventive Care for Dependents

Plans or issuers that cover dependent children must cover recommended preventive services related to pregnancy, such as preconception and prenatal care for dependent children, without cost-sharing.

Colonoscopies and Anesthesia Charges

Colonoscopies that are scheduled and performed as a preventive screening procedure for colorectal cancer pursuant to USPSTF recommendations may not charge the patient for anesthesia services performed in connection with the colonoscopy.

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