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HEALTHCARE REFORM UPDATE 2015-28

DOL Issues FAQ on Mental Health Parity and ACA Market Reform Provisions

In October 2015, the Department of Labor (DOL) provided an informational FAQ relating to the Mental Health Parity and Addiction Equity Act (MHPAEA) and Patient Protection and Affordable Care Act (ACA) market reform provisions.

Non-grandfathered group health plans and individual or group market health insurance must cover a variety of preventive services without any cost-sharing requirements. Required preventive services include "breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies," obesity screening and weight management services for certain individuals, colonoscopies for certain age groups, and contraception coverage for women.

Lactation Counseling

The FAQ clarified that plans and issuers are required to provide a list of lactation counseling providers within the network. The plan's Summary of Benefits and Coverage (SBC) should include an Internet address or other contact information so a beneficiary may be able to obtain a list of network providers. Further, plans subject to ERISA must ensure that provider network information accompany the Summary Plan Description (SPD). Similar obligations exist for issuers of qualified health plans and the ACA's Marketplace plans and SHOP plans.

If a plan does not have in-network lactation counseling providers, the plan may not impose cost sharing for lactation counseling services obtained out of network. If a state does not license lactation counselors and plans require providers to be licensed by the state, and the service could not be provided in the scope of another type of provider license (such as a registered nurse), the plan will have to provide coverage for the services without cost sharing. Plans may not limit lactation counseling services without cost sharing to an inpatient basis. Coverage for lactation support services must extend for the duration of breastfeeding. Plans may not require individuals to obtain equipment within a specified time period, such as within six months of delivery, in order for it to be covered without cost sharing.

Obesity Screening and Interventions

The FAQ clarified that non-grandfathered group health plans and issuers must cover, without cost sharing, screening for obesity in adults. In addition, federal guidelines recommend that, for an adult patient with a body mass index of 30 or higher, intensive multicomponent behavior interventions should be provided. Plans and issuers may use reasonable medical management techniques to determine the scope of such services, but may not impose general exclusions on those services which can encompass group and individual high intensity sessions, behavior management activities, and others.

Colonoscopies

Plans may not impose cost sharing for the required specialist consultation prior to colonoscopy screenings, if a provider determines the pre-procedure consultation is medically appropriate. Furthermore, pathology exams on a polyp biopsy from a colonoscopy performed as a preventive service must be covered without cost sharing.

Contraception Coverage Accommodations for Self-Funded Plans

Qualifying non-profit or closely held for-profit employers with an ERISA-covered self-insured plan have two methods for obtaining their religious accommodation in relation to the objection to provide coverage of contraceptive services. They may either complete EBSA Form 700 or provide a letter to the Department of Health and Human Services. The DOL will use either method to notify the plan's third party administrator (TPA) so the TPA may provide coverage for contraception separately.

BRCA Testing

The DOL has previously provided FAQs regarding BRCA testing (relating to breast cancer susceptibility) requirements. The DOL now clarifies that women found to be at increased risk for breast cancer, using a screening tool designed to identify family history that may be associated with an increased risk of having a potentially harmful gene mutation, must receive coverage, without cost sharing, to test for BRCA mutations.

Wellness Programs

The FAQ clarified that wellness programs with non-financial or in-kind incentives, such as gift cards, thermoses and sports gear, for wellness program participants that satisfy a standard relating to a health factor are subject to federal wellness program regulations.

Mental Health Parity

The MHPAEA amended various laws and regulations to provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits. Generally financial requirements such as coinsurance and copays and treatment limitations for mental health and substance use disorder benefits cannot be more restrictive than requirements for medical and surgical benefits. Regulations also provide that a plan or issuer may not impose a nonquantitative treatment limitation (NQTL) unless it is comparable and no more stringent than limitations on medical and surgical benefits in the same classification.

The FAQ provided that any criteria for making medical necessity determinations, as well as processes, strategies, evidentiary standards, or other factors used in developing NQTLs and applying them must be disclosed for both mental health and substance use disorder benefits and medical and surgical benefits, regardless of assertions that the information is proprietary or has commercial value. Furthermore, although group health plans are not required to provide a summary description of medical necessity criteria that is written to be understandable for a layperson, they may do so. It is not, however, a substitute for providing the underlying criteria if the documents are requested.

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