HCR ALERT!

Thursday, May 14, 2015

Agencies Issue FAQs on ACA Preventive Care Requirements

Earlier this week the Departments of Labor, Health and Human Services, and Treasury jointly issued a set of Frequently Asked Questions (FAQs) regarding the preventive care coverage mandate of the Affordable Care Act (ACA), which requires that non-grandfathered health plans cover in full preventive care services as recommended by designated health agencies. These FAQs clarify coverage requirements with regard to contraceptives and several other preventive services.

Coverage of Contraceptives

Plans are required to cover without participant cost-sharing all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling. Previous FAQs issued in 2013 clarified that the requirement includes the full range of FDA-approved methods including, but not limited to, barrier methods, hormonal methods, and implanted devices and also clarified that plans may use reasonable medical management techniques (e.g., imposing cost-sharing for a brand-name drug when a generic equivalent is available and medically appropriate).

The FAQs issued this week provide further guidance regarding the scope of coverage required for contraceptives and the extent to which medical management may be applied. Specifically, the FAQs state that:

- Plans must cover without cost sharing at least one form of contraception in each of the 18 methods identified in the FDA's Birth Control Guide, including clinical services needed for provision of the method.
- Within each method, cost-sharing may be imposed for some items and services to encourage use of other specific items or services within that contraceptive method (e.g., use of generic equivalent instead of brand or use of one of several available IUDs with progestin).
- A plan must defer to the attending provider if the provider determines a particular item or service is medically necessary (determination may include considerations such as severity of side effects, differences in permanence and reversibility, and ability to adhere to appropriate use) and the exceptions process must be completed in a timeframe and manner that takes into account the nature of the claim (e.g., pre-service, post-service, urgent care).

Coverage of BRCA Testing

The US Preventive Services Task Force (USPSTF) recommends "to screen women who have family members with breast, ovarian, tubal or peritoneal cancer with 1 of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing." The FAQs note that there was confusion as the whether the recommendation applies to women who have had prior non-BRCA-related breast cancer or ovarian cancer diagnosis, even if those women are currently asymptomatic and cancer-free, as a woman with a personal history of cancer may have an increased risk of a harmful mutation even if no other family members are known to have such history. Therefore, the FAQ confirms that, as long as the woman has not been diagnosed with BRCA-related cancer, if the attending provider determines it is medically appropriate for the individual, a plan must cover preventive screening, genetic counseling, and genetic testing without cost-sharing.

Coverage of Well-woman Preventive Care for Dependents

If a plan covers dependent children, it must cover without cost sharing recommended women's preventive care services for dependent children where an attending provider determines that well-women services are age- and developmentally-appropriate. This includes recommended preventive services related to pregnancy, such as preconception and prenatal care.

Coverage of Colonoscopies

If a colonoscopy is scheduled and performed as a preventive screening procedure for colorectal cancer pursuant to the USPSTF recommendation, a plan may not impose cost-sharing for anesthesia services performed in connection with the colonoscopy if the attending provider determines that anesthesia is medically appropriate for the individual.

Coverage of Sex-specific Preventive Services

A plan may not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity, or gender recorded by the plan. Where an attending provider determines that a recommended preventive service is medically appropriate for the individual – such as, for example, providing a mammogram or pap smear for a transgender man who has residual breast tissue or an intact cervix – and the individual otherwise satisfies the criteria in the relevant recommendation or guideline as well as all other applicable coverage requirements, the plan must provide coverage for the recommended preventive service without cost-sharing.

The FAQs indicate that, because the Departments' prior guidance regarding contraceptive coverage may have reasonably been misinterpreted, it will apply the clarifying guidance regarding coverage of contraceptives as of plan years beginning on or after July 10, 2015. The other clarifications in the FAQs appear to be already in effect.

Plan sponsors should review their plan coverage with their insurers, third-party administrators, and/or pharmacy benefit managers to ensure compliance with this latest guidance. Your Trion Strategic Account Managers are here to answer any questions you might have as you prepare to comply with upcoming ACA requirements. If you are not currently a Trion client, and would like assistance navigating the changes required by the ACA, please contact us today by emailing trionsales@trion-mma.com.

PPACA REGULATIONS & GUIDANCE ISSUED IN THE LAST 3 MONTHS

May 2015: ACA FAQs Part XXVI – **Preventive Care**

Apr. 2015: EEOC Issues **Proposed Regulations on Wellness Programs and the ADA**

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