Sibson Consulting

update

Compliance News for Plan Sponsors

May 28, 2015

Additional Coverage Required for Preventive Services Under the Affordable Care Act

The Affordable Care Act[1] requires non-grandfathered plans to provide certain preventive services in network without imposing cost sharing.[2] On May 11, 2015, the Departments of Labor, Treasury, and Health and Human Services (the "Departments"), which are responsible for implementing group health plan standards under the Affordable Care Act, released new answers to frequently asked questions (FAQs) clarifying these requirements.[3] Plan sponsors with non-grandfathered plans must take steps to ensure that those plans are administered consistently with this guidance.

This *Update* summarizes the new guidance on preventive services.

Contraceptive Coverage

The most significant FAQs address the requirement that group health plans (and insurers) cover all contraceptive methods for women approved by the Food and Drug Administration (FDA). The Departments will apply this rule for plan years beginning on or after July 10, 2015 (January 1, 2016 for calendar-year plans).

Non-grandfathered plans must cover, without cost sharing, at least one form of contraception in each of the FDA-approved methods (currently 18). One answer lists all of the currently approved methods for women, which are shown in the text box at the top of the next page. The new rule is a significant expansion over previously published coverage guidelines. Plans may not exclude coverage for any of the FDA-approved methods, for example, a plan cannot cover oral contraceptives without cost and impose cost sharing on the ring or patch.

Within each of the 18 methods, plan sponsors may continue to use reasonable medical techniques to encourage individuals to use specific items or services (such as generic pills or one of several IUDs with progestin) and apply cost sharing to other items or services. However, plan sponsors must ensure that there is an easily accessible, transparent and sufficiently expeditious exceptions process that is not unduly burdensome. The exceptions process must meet the applicable timeliness standards for claims and appeals determinations. In addition, if an individual's attending provider recommends a particular item or service as medically necessary for that individual, the plan must cover that method without cost sharing.

Health Compliance News:

- Contraceptive Coverage
- Well-Woman Coverage for Dependents
- Anesthesia During Colonoscopy
- Coverage of BRCA Testing and Counseling
- Coverage of Sex-Specific Preventive Services
- Implications for Plan Sponsors

Update is part of Sibson's new set of publications for employers and others who work with them. *Update* replaces all compliance publications Sibson previously produced, including *Bulletin*, *Capital Checkup* and *Compliance Alert*.

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[1] The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

[2] For background on the preventive services requirements, see Sibson Consulting's publication, "New Guidelines on Preventive Care Benefits for Non-Grandfathered Plans."

[3] The FAQs are available at http://www.dol.gov/ebsa/pdf/faq-aca26.pdf.

FDA-Approved Contraception Methods for Women

1. Sterilization surgery for women
2. Surgical sterilization implant for women
3. Implantable Rod
4. Intrauterine device (IUD) copper
5. IUD with progestin
6. Shot/injection
7. Oral contraceptives (combined pill)
8. Oral contraceptives (progestin only)
9. Oral contraceptives extended/continuous use
10. Patch
11. Vaginal contraceptive ring
12. Diaphragm
13. Sponge
14. Cervical cap
15. Female condom
16. Spermicide
17. Emergency Contraception (Plan B/Plan B One Step/Next Choice)
18. Emergency contraception (Ella)

Well-Woman Coverage for Dependents

All covered participants and beneficiaries must be eligible to obtain, without cost sharing, all required in-network preventive services applicable to them (*e.g.*, for their age group). This includes pregnancy-related preventive services and well-woman visits, which must be provided to dependent children (up to age 26) where an attending provider determines that the services are age and developmentally appropriate.

Anesthesia During Colonoscopy

A screening colonoscopy is a required preventive service. Consequently, plans may not impose cost sharing for anesthesia services performed in connection with an in-network preventive colonoscopy if the attending provider determines that anesthesia is medically appropriate.

Coverage of BRCA Testing and Counseling

Genetic testing for the BRCA 1 and BRCA 2 genes[4] and genetic counseling must be provided, without cost sharing, when recommended by a health care provider for a woman with a family history that may be associated with an increased risk for harmful genetic mutations. The latest answer clarifies that this also applies to asymptomatic women who have not been diagnosed with BRCA-related cancer, including those who previously had breast, ovarian or other cancer. The rationale is that such a woman may have an increased risk of a harmful mutation even if no other family members are known to have such a history.

[4] BRCA 1 and 2 tests are genetic tests for gene mutations associated with an increased risk of breast and ovarian cancer.

Coverage of Sex-Specific Preventive Services

Plans may not limit sex-specific preventive services based on an individual's assigned sex at birth, gender identity or recorded gender. When an attending medical provider determines that a recommended preventive service is medically appropriate (*e.g.*, a mammogram for a transgender man with residual breast tissue), the plan must cover that service without cost sharing.

Implications for Plan Sponsors

The most significant benefit enhancements will likely involve contraceptive coverage. Plan sponsors and their pharmacy benefit managers that currently treat all hormone-based methods as one method, or exclude any one of the FDA-approved methods, will need to make significant changes to the plan. This will likely involve discussions with both the plan's medical administrator and pharmacy benefit administrator, as the coverage may be provided under both administrative systems. In order to assure that a plan will meet all required guidance if audited by the Department of Labor, non-grandfathered plans should review all preventive benefits currently offered against federal guidelines and assure that they are provided with no-cost sharing when offered by a network provider.

The effective date for compliance is the first plan year beginning on or after July 10, 2015. While calendar-year plans have until January 1, 2016, plans with August, September, October, November or December plan years will have very little time to implement the new rules. The effective date for this portion of the guidance will give plan sponsors limited time to enhance the benefit, as needed, and to develop appropriate medical-management techniques.

Sibson Consulting

If you would like additional information about this news, please contact your Sibson consultant or the Sibson office nearest you. Sibson can be retained to work with plan sponsors and their legal counsel on compliance issues.

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