Trustee Alert – Additional Affordable Care Act FAQs

The Department of Labor (DOL) recently released FAQs regarding coverage of preventive services, emergency services, cost-sharing limitations and Mental Health Parity regulations, among other topics. The following is a brief summary of the clarifications made by these FAQs:

Preventive Services

- Colonoscopy: Prescribed bowel preparation medications, when medically appropriate, are an integral part of a preventive screening colonoscopy and must be covered by the Trust at no cost to participants.

- Contraceptives: The Trust may use reasonable medical management techniques to control costs and promote efficient delivery of care for FDA-approved contraceptives, such as covering only generic drugs at no cost to participants, so long as there is an effective exceptions process. The Trust may develop and utilize a standard exception form and instructions to ensure that it provides an accessible, transparent, and expedient exceptions process.

Out-of-Network Emergency Services – Disclosure of Reasonable Amount Calculation

The Trust is required to pay a “reasonable amount” for out-of-network emergency services. The Trust is required to disclose how it calculates the “reasonable amount” to plan participants on request or automatically after appeal of an adverse benefit determination. “Reasonable amount” is defined as the amount at least equal to the greatest of:

(1) the median amount paid to network providers for the service;
(2) the amount calculated using the same method the plan generally uses to determine out-of-network payments (such as the (UCR) amount); or
(3) the Medicare amount that would be paid for the service.

Limitations on Cost-Sharing and Fixed/Reference-Based Pricing

The Trust should ensure that participants’ annual out-of-pocket expenses do not exceed the limitations for 2017, which are $7,150 for self-only coverage and $14,300 for family coverage. If the Trust uses any pricing structure in which it pays a fixed amount (a reference price) for a particular procedure and certain providers do not accept the fixed amount as full payment, then the Trust may be required to count a participant’s out-of-pocket expenses above the fixed price toward the participant’s annual out-of-pocket limit.

Mental Health Parity and Addiction Equity Act of 2008

- The Trust must disclose the criteria for medical necessity determinations with respect to mental health benefits to any participant, beneficiary, potential enrollee or contracting provider upon request. The Trust must also disclose the reason for any denial of reimbursement or payment for services to the participant or beneficiary. The Trust must provide this information to plan participants within 30 days of request or it may be subject to a penalty of up to $110 a day from

the date of failure. The Trust also must provide this information where there is a related appeal of an adverse benefit determination.

- If the Trust offers Medication Assisted Treatment (MAT) benefits, it must do so in accordance with the requirements of MHPAEA. (MAT benefits are any treatment for opioid use disorder, including FDA-approved medication for detoxification or maintenance treatment in combination with behavioral health services).

The Women's Health and Cancer Rights Act (WHCRA)

WHCRA provides protections for women who elect breast reconstruction in connection with a mastectomy. The Trust is required to provide coverage for all stages of reconstruction of the breast on which a mastectomy was performed. This may include coverage for nipple and areola reconstruction.

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This document is intended to provide you with general information regarding additional Affordable Care Act FAQs. The contents of this document are not intended to provide specific legal advice. If you have any questions about the contents of this document or if you need legal advice as to an issue, please contact the attorney listed or your regular Brownstein Hyatt Farber Schreck, LLP attorney. This communication may be considered advertising in some jurisdictions.