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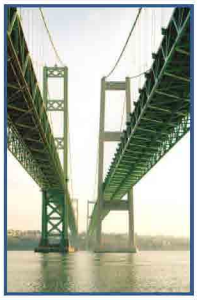

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News You Can Use: Winter 2014

Treasury, DOL and HHS Release New FAQs relating to ACA and Mental Health Parity

The tri-agencies released another set of FAQs on January 9 regarding implementation of the market reform provisions of the Affordable Care Act (FAQ Part XVIII), as well as FAQs regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act. Like previously issued FAQs, these FAQs answer questions from stakeholders to help people understand the law and benefit from it, as intended. The agencies continue to use FAQs as a way to release guidance without having to maneuver through the lengthy regulatory approval process.

Items we found of interest:

➪ The FAQ reiterated that all non-grandfathered plans must provide preventive services with an A or B recommendation with no cost-sharing. The FAQs reminded us of two provisions from the rule: a) Plans may use reasonable medical management tools if the frequency, method, treatment or setting for a service is not specified; and b) when new recommendations are released, Plans have one year after the date the recommendation or guidance is issued to comply. This example is cited in Question 1:

Q1: On September 24, 2013, the United States Preventive Services Task Force (USPSTF) issued new recommendations with respect to breast cancer. What changes must plans make to comply with the new recommendations?

A1: The USPSTF recently revised its "B" recommendation regarding medications for risk reduction of primary breast cancer in women. The September 2013 recommendation now says: *"The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene."*
Accordingly, for plan years beginning one year after the date the recommendation or guideline is issued (in this case, plan years beginning on or after September 24, 2014), non-grandfathered plans will be required to cover such medications for applicable women without cost-sharing subject to reasonable medical management.

➪ As a introduction to Q2, the FAQs address Limitations on Cost-Sharing under ACA. For Plan Year 2014 only, Plans that have Essential Health Benefits (EHB) administered by more than one service provider that are subject to Out-of-Pocket Maximum (OOPM) limitations will not have to coordinate the total OOPM. Each service provider, to the extent they have an OOPM on an EHB, may provide the services with OOPM up to the $6,350 and $12,700 limitations. The FAQ reminds us that for Plan Year 2015, Plans will have to comply with one OOPM limit for self-only and other than self-only coverage. That means if a Plan has more than one service provider administering EHBs, those service providers will have to communicate with one another to ensure the Covered Person has not exceeded the OOPM applicable to their coverage type.

➪ **Good News:** In Q3 DOL responds to a question posed by SPBA. Many SPBA members have asked for an answer to a question not addressed in the final rules or the previous cost-sharing FAQ. Many wanted to know if Plans can divide the OOPM among different benefits and/or service providers—if the OOPM does not exceed the statutory limits. DOL's response: *"Yes. Plans and issuers are permitted to structure a benefit design using separate out-of-pocket limits, provided that the combined amount of any separate out-of-pocket limits applicable to all EHBs under the Plan does not exceed the annual limitation on out-of-pocket maximums for that year under section 1302(c) of the Affordable Care Act."*

➪ While the new recommendations permit Plans and issuers to structure a benefit design using separate out-of-pocket limits—provided that the combined amount of any separate out-of-pocket limits applicable to all EHBs under the Plan does not exceed the annual limit maximums, the Departments note that MHPAEA regs prohibit a Plan from applying a cumulative financial requirement or treatment limitation, such as an out-of-pocket maximum, to mental health or substance use disorder benefits only.

Neither can these limits accumulate separately from the cumulative financial requirement or treatment limit established for otherwise medical and surgical benefits. Going back to the general rule under MHPAEA, if there are limits of any kind under the Plan,... *Continued on Page 2* ➪