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Departments Issue FAQs Addressing Preventive Care, Wellness and Mental Health Parity

The departments recently issued FAQs providing further guidance on the Affordable Care Act preventive services requirement, including coverage requirements for lactation services and screenings for obesity, colon cancer and breast cancer. They also address non-financial incentives offered under wellness programs and clarify disclosure requirements under the Mental Health Parity and Addiction Equity Act.

Background

Under the Affordable Care Act's (ACA) preventive services requirement, non-grandfathered group health plans must cover certain preventive care services without cost-sharing. If a recommendation or guideline does not specify the frequency, method, treatment or setting for provision of a recommended preventive service, the plan may use reasonable medical management techniques to determine any such coverage limitations. (See our August 7, 2015 *For Your Information*.)

The Health Insurance Portability and Accountability Act (HIPAA) generally prohibits group health plans from discriminating against participants and beneficiaries with respect to eligibility, benefits or premiums on the basis of a health factor. HIPAA regulations provide an exception to this general rule that permits a group health plan to offer incentives under a wellness program that promotes health and prevents disease if the program meets certain requirements. (See our July 16, 2013 *FYI In-Depth*.)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans that offer mental health and substance use disorder benefits to cover those benefits on terms that are no more restrictive than those for medical and surgical benefits. The requirement applies to financial provisions (such as coinsurance) and treatment limitations, both quantitative (such as visit limits) and non-quantitative (such as medical management techniques like prior authorization). (See our January 14, 2014 *For Your Information*.)

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Recent Guidance

On October 23, 2015, the Departments of Labor, Health & Human Services, and Treasury (departments) issued guidance in the form of Frequently Asked Questions (FAQs) on preventive services, wellness programs and mental health parity.

Preventive Services

The new guidance clarifies the preventive services requirement with respect to lactation support and counseling, obesity screening, colonoscopies and breast cancer screening.

Lactation support, counseling and equipment. The Health Resources and Services Administration guidelines and recommendations include coverage of comprehensive prenatal and postnatal lactation support, counseling and equipment rental. With respect to these preventive services, the FAQs clarify the following:

- A plan must provide a list of in-network lactation counseling providers.
- If a plan does not have an in-network lactation counseling services provider, the plan or issuer must cover those services without cost-sharing by an out-of-network provider.
- A plan must cover lactation counseling, without cost-sharing, by any provider acting within the scope of his or her license or certification under state law (for example, a registered nurse), subject to reasonable medical management techniques.
- A plan cannot limit coverage for lactation counseling to services provided on an in-patient basis.
- A plan must provide coverage for lactation support services and breast-feeding equipment for the duration of breast-feeding. Therefore, a plan cannot require an individual to obtain breast-feeding equipment within a specified period.

Obesity screening. In addition to obesity screening for adults, the United States Preventive Services Task Force (USPSTF) recommends intensive, multicomponent behavioral interventions for weight management for adult patients with a body mass index of 30 or higher. This could include, for example, group and individual sessions, weight loss goals, improving diet and exercise and strategizing how to maintain lifestyle changes. The FAQs explain that it is not permissible for a plan to have a general exclusion for weight management services for adult obesity (or other recommended preventive services) — plans must cover these services without cost-sharing.

Colonoscopy. The USPSTF recommends colonoscopy as a preventive service in certain cases. The FAQs clarify that a plan cannot impose cost-sharing for a consultation prior to the screening procedure if the attending provider determines that a pre-procedure consultation would be medically appropriate because it is an integral part of the colonoscopy. Similarly, a pathology exam on a polyp biopsy is considered an integral part of a colonoscopy as it is used to determine whether a polyp is malignant. The departments view this service as critical to achieving the purpose of the preventive screening and, therefore, it must be covered without cost-sharing.

The departments note that because prior guidance may have reasonably been interpreted to allow cost-sharing in these circumstances, this guidance will apply for plan years beginning on or after December 22, 2015 (60 days after the date of publication of the FAQs).

BRCA testing. For women who have a family history of breast, ovarian, tubal or peritoneal cancer, the USPSTF recommends a screening that is used to identify a family history potentially associated with an increased risk for mutations in breast cancer susceptibility genes (BRCA). Women found to have an increased risk must receive coverage, without cost-sharing, of genetic counseling and, if indicated, testing for BRCA mutations. (See our May 28, 2015 *For Your Information*.) The FAQ clarifies that the requirement applies regardless of whether the woman has previously been diagnosed with cancer as long as she is not currently symptomatic or receiving treatment for breast, ovarian, tubal or peritoneal cancer.

Wellness Programs

The FAQs clarify that a wellness program that provides an incentive based on an individual meeting a certain standard related to a health factor and is part of a group plan is subject to these rules regardless of whether the incentive or reward is financial (such as a premium discount) or non-financial (such as thermoses and sports gear).

> **Comment.** The HIPAA wellness program rules apply only when the wellness program is part of a group health plan. If an employer wellness program that is not part of a group health plan offers sports gear to individuals who participate in a walking program, the HIPAA rules would not apply.

Mental Health Parity

The MHPAEA regulations include disclosure requirements with respect to treatment limitations. Specifically, the plan administrator or insurer must make available to participants or beneficiaries, upon request, the criteria for medical necessity determinations for mental health and substance use disorder benefits and provide the reason for any denial of reimbursement or payment for services. The FAQs clarify that the criteria for making medical necessity determinations for both mental health/substance use disorder benefits and medical/surgical benefits must be provided upon request and a plan cannot refuse to provide that information on the basis that the information is proprietary or has commercial value. Further, a plan may provide a summary, in layperson's terms, of medical necessity criteria, but the actual underlying medical necessity criteria must be given if requested.

In Closing

These FAQs provide additional direction for administering preventive service benefits, wellness programs and mental health and substance abuse benefits. Employers should review their group health plans in light of these FAQs to ensure benefits are being provided in compliance with the guidance.

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