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Newly Released FAQs Address Health Plan Compliance Issues

New FAQs (Part 31) have been issued highlighting various compliance issues and can be found at http://www.dol.gov/ebsa/faqs/faq-aca31.html. The questions address a wide range of issues, including preventive care, coverage for clinical trials, required disclosures, the Women's Health and Cancer Rights Act, rescissions, reference pricing and mental health parity requirements. Here are a few highlights from these new FAQs:

-- Preventive care coverage, with no cost-sharing, includes coverage of bowel preparation medication prescribed for colonoscopies performed as screening procedures because the preparation is an integral part of the procedure.

-- When a plan uses reasonable medical management techniques in determining preventive coverage of contraceptives, it must have a process that is not burdensome for participants and providers to ensure coverage of FDA-approved items based on a determination of medical necessity, as determined by the provider. This set of FAQs provides that plans can develop a standard form for use by providers to prescribe a particular item based on medical necessity. The FAQ suggests that the Medicare Part D Coverage Determination Request Form can serve as a model for developing that type of a form.

-- If a plan covers items to diagnose or treat certain complications, a plan cannot deny such coverage if they result from an individual's participation in an approved clinical trial.

-- Plans must disclose, upon request, documentation and data used to calculate the minimum payment standards, including for determining the usual and customary amount, for out-of-network services such as emergency services.

-- Once again we see a question regarding the extensive disclosure obligations under mental health parity. In this round, the question relates to which documents might be most helpful for an authorized representative to request to ensure parity compliance after he or she has been asked to complete a pre-authorization form after the participant's 9 th visit for depression. The example also provides a helpful application of the rules (see below). *Plans that apply treatment limits to mental health/substance abuse services should ensure that they have undergone this analysis and would be able to disclose the required information.*

The FAQ makes clear that the plan would have to provide (among other items):

-- The specific underlying processes, standards and other factors considered by the plan to determine that the non-quantitative treatment limit (NQTL) will apply to a particular benefit,

-- Information regarding the application of that NQTL to medical/surgical benefits under the plan, and

-- The analysis performed by the plan as to how that NQTL complies with the parity requirements.
-- Health plans that offer MAT benefits (treatment for opioid use disorder that includes medication that is FDA-approved for detoxification or maintenance treatment in combination with behavioral health services) must do so in accordance with mental health parity. This means that any financial requirements or treatment limits cannot be more restrictive that the predominant requirements and limits that apply to substantially all medical/surgical benefits in the relevant classification. The special rule for multi-tiered prescription drugs applies to the MAT medication, and the behavioral component is to be treated as either outpatient or inpatient, as appropriate.