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DOL FAQS ADDRESS COVERAGE FOR COLONOSCOPIES AND BIRTH CONTROL

The Affordable Care Act requires non-grandfathered health plans to pay for "preventive care" on a first-dollar basis, meaning that no copays, coinsurance, or deductibles can be charged for certain services defined as "preventive" under these rules. In the same recent FAQs requiring health plans to pay for the cost of over-the-counter COVID-19 testing, the DOL also provided additional guidance on this rule as it relates to colorectal cancer screening and contraceptive coverage.

Colorectal Cancer Screening

The United States Preventive Service Task Force ("USPSTF") recommendations have historically encouraged colorectal cancer screening for adults ages 50-75. That recommendation was shifted by five years to cover ages 45-75 in May 2021. Therefore, effective for plan years beginning on or after May 31, 2022, colorectal cancer screening needs to be provided regularly for adults ages 45-75.

Under these rules, if a colonoscopy is performed for screening purposes, plan participants cannot be billed for items and services that are integral to the procedure, including:

- Required specialist consultation prior to the screening procedure;
- Bowel preparation medications prescribed for the screening procedure;
- Anesthesia services performed in connection with a preventive colonoscopy;
- Polyp removal performed during the screening procedure; and
- Any pathology exam on a polyp biopsy performed as part of the screening procedure.

The FAQs also make clear that it is still "preventive" care if a participant receives a colonoscopy following a positive, non-invasive, stool-based screening test or a direct visualization test (e.g., sigmoidoscopy or CT colonography). Thus, these colonoscopies and the associated services must also be provided at no cost to the participant.

Contraceptives

FDA-approved female-controlled contraceptive methods are also defined as "preventive care" for purposes of these rules. Prior guidance on this rule stated that plans must cover, without cost sharing, at least one form of contraception in each method that is identified by the FDA in its Birth Control

Guide. Later guidance provided that while "reasonable medical management" is permitted relative to birth control, plans are required to develop and utilize an easily accessible, transparent, and reasonably fast method for handling provider appeals when a provider feels a particular form of birth control is medically necessary.

The new FAQs expressly provide that certain common plan practices violate these rules. These practices include:

- Denying coverage for all or particular brand name contraceptives, even after the individual's attending provider determines and communicates the brand is medically necessary;
- Requiring individuals to fail first using numerous other services within the same method of contraception before approving the contraceptive product that is medically appropriate for the individual, as determined by the individual's attending health care provider;
- Requiring individuals to fail first using other services in other contraceptive methods before the plan or will approve coverage for a service or contraceptive product in the contraceptive method that is medically appropriate for the individual, as determined by the individual's attending health care provider; and
- Failing to provide an easily accessible, transparent, and sufficiently expedient exception process for appeals.

These FAQs serve as a warning to plans with these types of practices that they should change them as soon as possible. This will require significant updates related to the use of formularies in determining coverage levels for birth control moving forward. This is one more important item for plan sponsors to add to their 2022 agendas.

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