HOW COVERAGE EXCLUSIONS IN MARKETPLACE PLANS COMPROMISE WOMEN'S HEALTH AND ECONOMIC SECURITY

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August 18, 2016

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

The Center on Health Insurance Reforms
Georgetown University Health Policy Institute

Coverage Exclusions in Marketplace Plans Compromise Women's Health and Economic Security

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Overview

- Methodology
- Key Findings
- Policy Recommendations

The Center on Health Insurance Reforms
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Methodology

- Arose of out NWLC's work identifying plan violations
- Funded and published by The Commonwealth Fund
- NWLC reviewed plan documents from 109 insurers in 16 states for 2014 and 2015
- States provided broad perspective:
  - AL, CA, CO, CT, FL, MD, ME, MN, NV, OH, RI, SC, SD, TN, WA, WI
- Highlights potential for claim denials
- Did not include explicit violations of law or well-known exclusions

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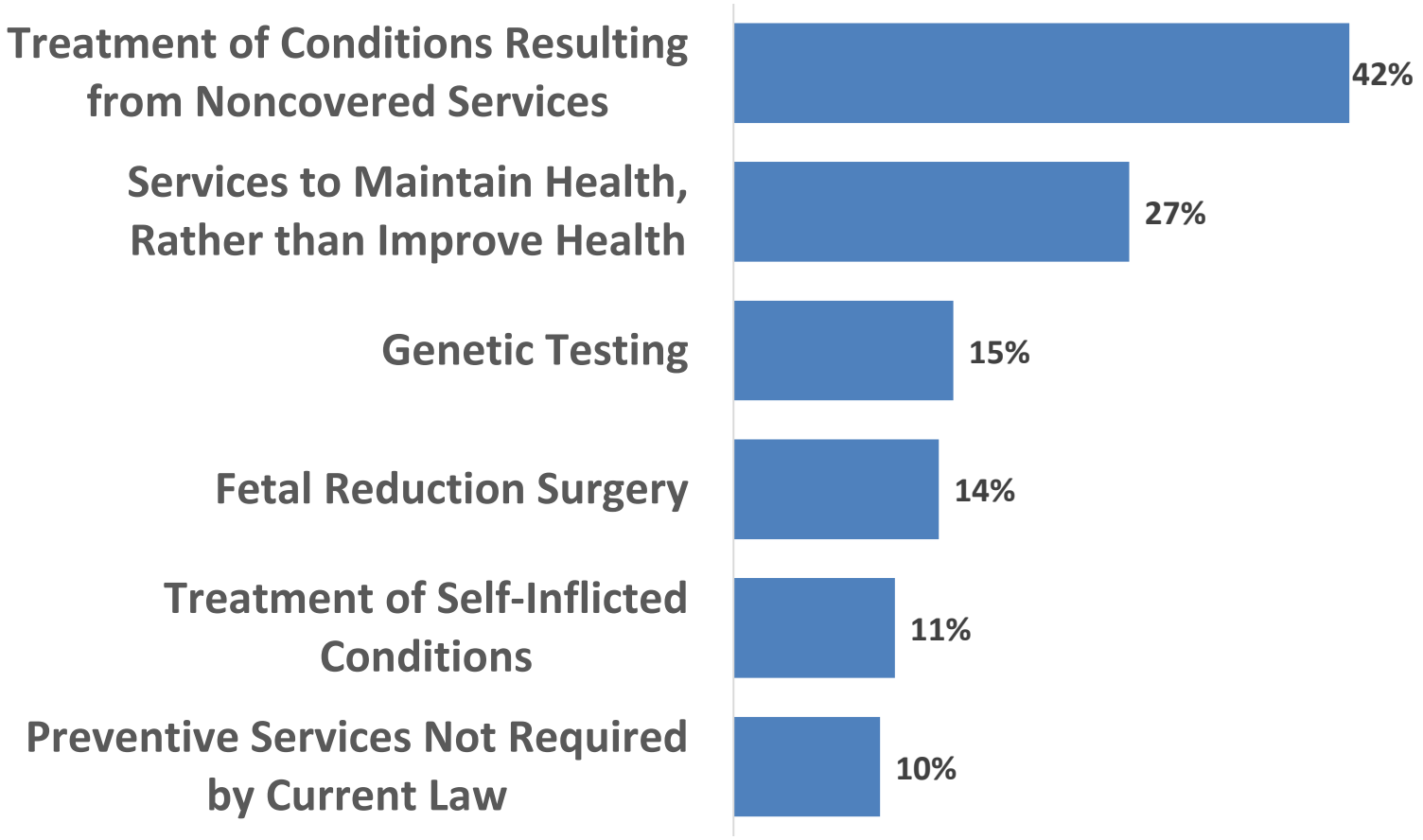
Key Findings

- All plans include exclusions
  - *Broad exclusions, e.g. maintenance care*
  - *Limited exclusions, e.g. bariatric surgery*
  - *Common exclusions, e.g. conditions resulting from act of war*
  - *Uncommon exclusions, e.g. conditions resulting from not following medically recommended treatment*
- Exclusions vary by issuer and by state
- Report provides only a sample of exclusions

Incidence of Selected Exclusions



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Source: *Women's Health Coverage Since the ACA: Improvements for Most, But Insurer Exclusions Put Many at Risk*, Commonwealth Fund, August 2016

Conditions Resulting from Non-Covered Services

- Beyond an exclusion for services related to non-covered services:
  - *Routine follow up for non-covered services*
  - *Routine prep for non-covered services*
- What will insurers deny?
  - *Infection following non-covered surgery?*
  - *Cancer treatment following non-covered estrogen treatment?*
  - *Severe reaction to medication not on formulary?*
  - *Pregnancy following non-covered fertility services?*
  - *Complication from services covered out of network?*

Services to Maintain Rather than Improve Health

- Common exclusion in rehabilitative therapy before ACA required habilitative therapy
- Exclusions written broadly to apply to all care
- What will insurers deny?
  - *Medications for chronic illness such as diabetes, hypertension, arthritis, multiple sclerosis?*
  - *Medical devices that prevent regression?*
  - *Maintenance care for cancer?*
  - *Injections for chronic pain?*
  - *Mental health visits for chronic mental illness?*

Fetal Reduction Surgery

- Only one insurer made exception for medical necessity
- Fetal reduction surgery may be medically necessary if:
  - *Health of mother is at risk*
  - *Health of pregnancy is at risk*
- All plans with fetal reduction exclusions also excluded abortion
  - *Abortion exclusion should be listed on SBC on marketplace website*
  - *No mention of fetal reduction surgery on SBC*

Policy Recommendations

- Limit Exclusion through Essential Health Benefits
  - *Prohibit substitutions in Essential Health Benefits and review plans for violations*
  - *Require insurers demonstrate that exclusions comply with substitution requirements*
  - *Ban specific exclusions*
  - *Make sure insurers are not using exclusions to circumvent ACA protections*

Policy Recommendations

- Increase Transparency
  - *List exclusions on Marketplace web sites*
  - *Encourage enrollees to review exclusions before completing enrollment*

Thank-you!

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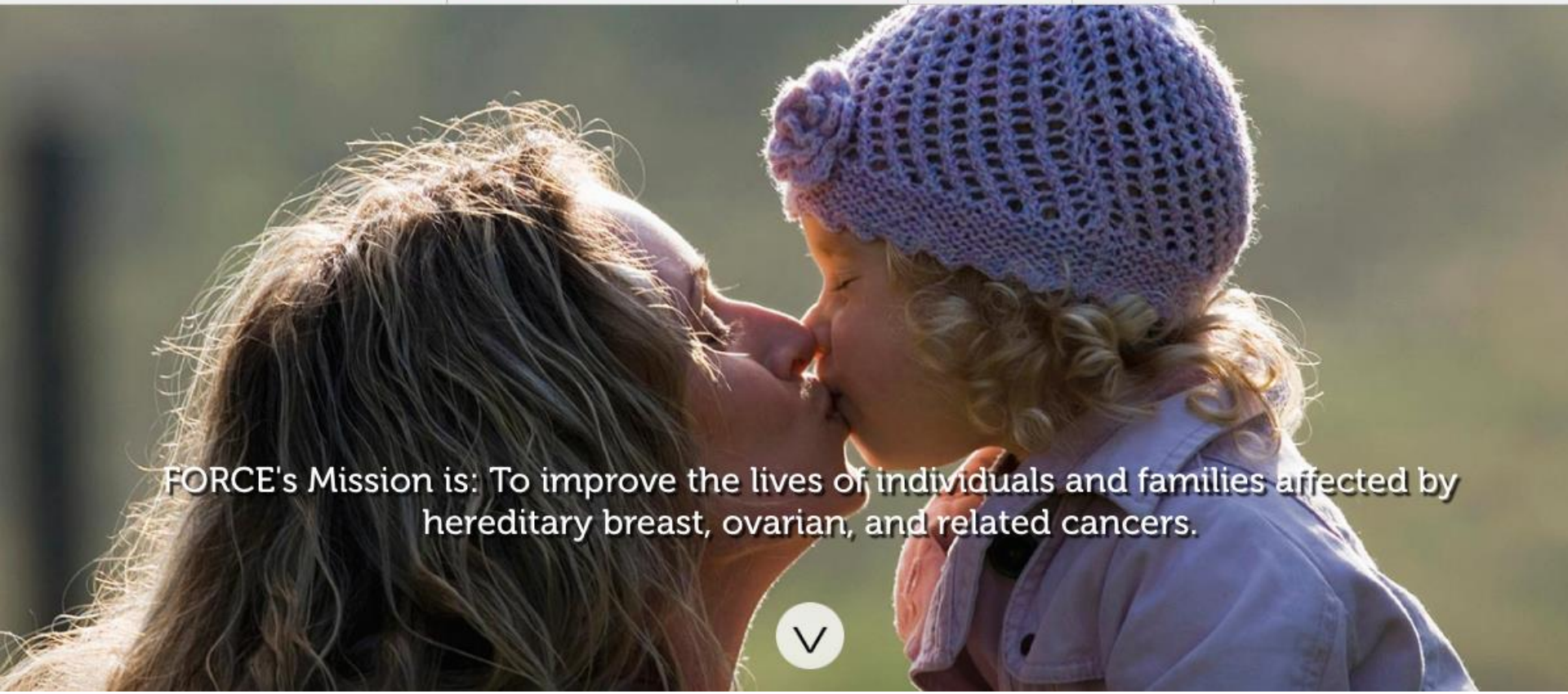

Patient Protection and Affordable Care Act (PPACA)

- Access to health insurance for all Americans
- Elimination of pre-existing conditions as barrier to coverage
- **Coverage for screening and preventative services without copay or deductible**
- Coverage of young adults up to the age of 26 on parent's plan
- Abolishment of annual and lifetime caps
- Capping out-of-pocket healthcare expenditures
- Coverage for those enrolled in clinical trials

PPACA, USPSTF and BRCA

Reliance on United States Preventive Services Task Force (USPSTF) to guide insurance coverage of preventive services can cause barriers to care

EXAMPLE

- 2013 - USPSTF recommends BRCA genetic counseling and testing for women with a family history of cancer (Grade “B”)
- Specific clarifications issued by Department of Labor that this applies to both genetic counseling and testing.
- Even with this clarification, some plans will not cover genetic counseling, especially in states that do not license genetic counselors.

PPACA, USPSTF and BRCA

Reliance on United States Preventive Services Task Force (USPSTF) to guide insurance coverage of preventive services can cause barriers to care

CCIIO **The Center for Consumer Information & Insurance Oversight**

EXAMPLE

- 2013 - USPSTF recommends BRCA genetic counseling and testing for women with a family history of cancer (Grade "B")
- Initially interpreted to apply only to women who have never had cancer
- 2015 –A clarification was issued by CCIIO extending guidelines to women who have been previously diagnosed with cancer but are asymptomatic and not in treatment.

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PPACA, USPSTF and BRCA

Reliance on United States Preventive Services Task Force (USPSTF) to guide insurance coverage of preventive services can cause barriers to care

EXAMPLE

- USPSTF failed to assign letter grades to most of the expert-recommended interventions for high-risk women
  - Mammograms (before age 40)
  - Breast screening MRI
  - Prophylactic salpingo-oophorectomy
  - Risk-reducing mastectomy

PPACA, USPSTF and BRCA

U.S. Preventive Services TASK FORCE

RISK ASSESSMENT, GENETIC COUNSELING, AND GENETIC TESTING FOR BRCA-RELATED CANCER IN WOMEN
CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

Population	Asymptomatic women who have not been diagnosed with BRCA-related cancer	
Recommendation	**Screen women whose family history may be associated with an increased risk for potentially harmful BRCA mutations. Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.** **Grade: B**	**Do not routinely recommend genetic counseling or BRCA testing to women whose family history is not associated with an increased risk for potentially harmful BRCA mutations.** **Grade: D**
Treatment	Interventions in women who are BRCA mutation carriers include earlier, more frequent, or intensive cancer screening; risk-reducing medications (e.g., tamoxifen or raloxifene); and risk-reducing surgery (e.g., mastectomy or salpingo-oophorectomy).	

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Current Gaps in Services for High-Risk Women

USPSTF Guidelines Do Not Address

- Increased screening and preventive options for high-risk women (other than chemoprevention for certain high-risk women
- Cancer survivors in treatment
- Genetic counseling and testing for Lynch and other hereditary cancer syndromes - single gene or multigene panel
- Second test for women who previously tested negative

Some health plans are using lack of USPSTF letter grade A/B as justification to exclude or deny ANY coverage for these services

USPSTF and Breast Screening/Mammography

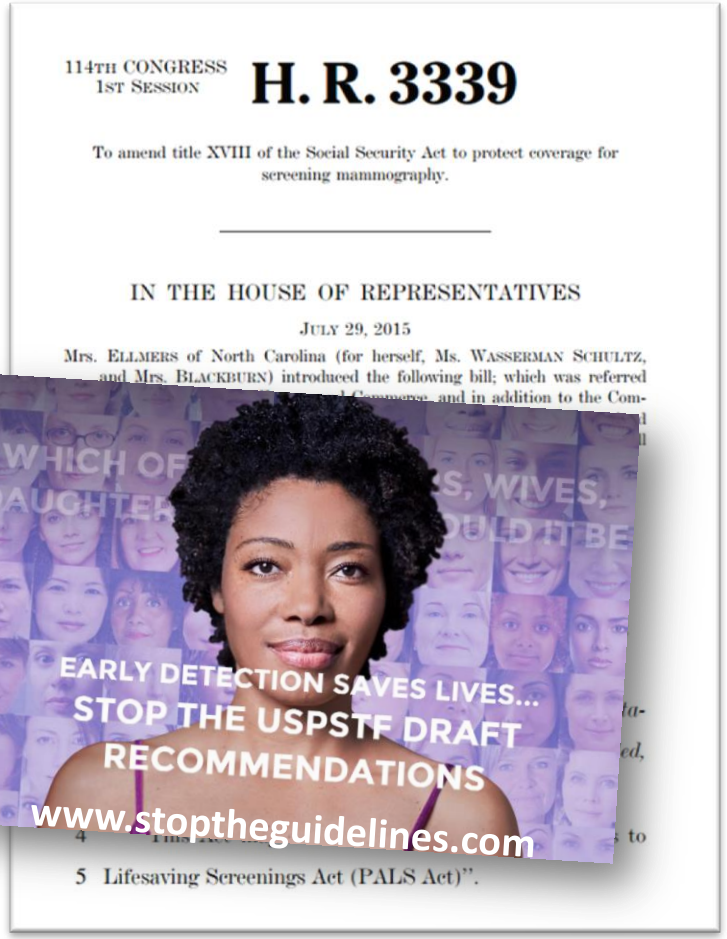
USPSTF has separate guidelines for breast screening and mammography for average risk women – recent update 2015

- Recommended raising the age for screening mammograms from age 40 to 50 (letter grade “B”)
- Recommended changing from annual screening to biennial screening for women ages 50 – 75 (letter grade “B”)
- Other considerations – younger screening, annual screening were given a letter grade “C”

USPSTF and Breast Screening/Mammography

“Stop the Guidelines” campaign

- PALS Act
  - Placed a 2-year moratorium on the existing guidelines, preserving insurance coverage of screening mammograms for “average risk” women in their 40s
  - PALS expires in 2018



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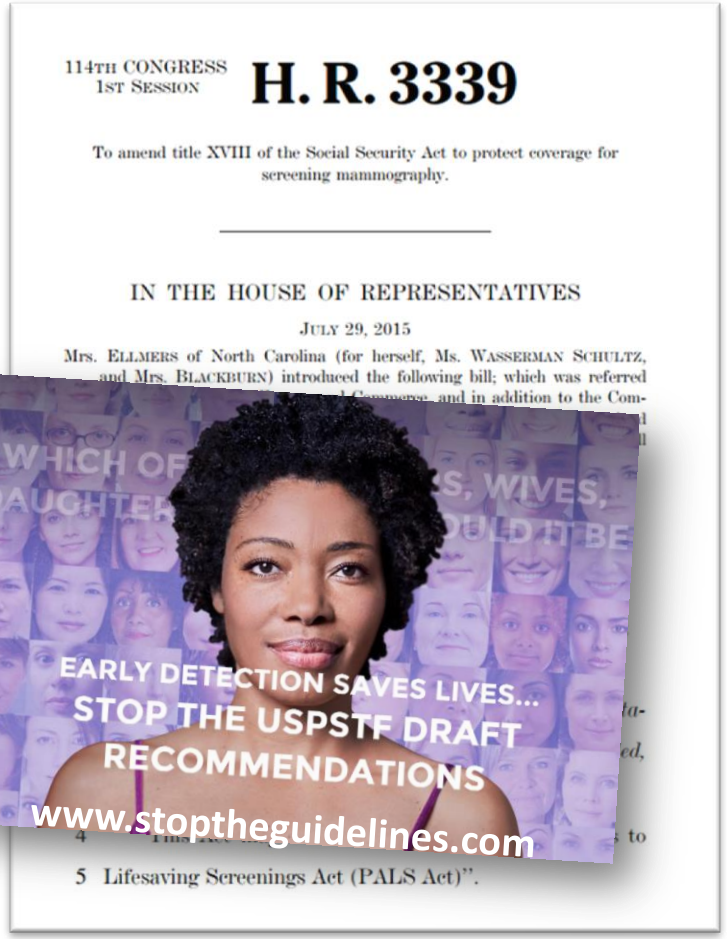
USPSTF and Breast Screening/Mammography

Rationale for PALS Act

- National guidelines and policies are created with the “average” population in mind.
- Many women are not aware of their increased risk for cancer until they are diagnosed.
- Waiting until 50 to start screening could lead to more aggressive cancers being missed, more treatment and early death.



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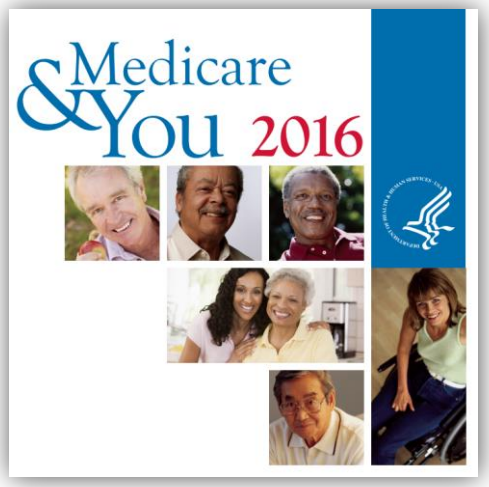
Other Gaps in Hereditary Cancer Services

Medicaid:

- Coverage of BRCA genetic counseling, testing, screening and risk management services varies by state
  - Current information indicates that slightly over 50% of states cover BRCA counseling and testing
  - Data on coverage of related services such as breast MRI or preventive surgeries is difficult to find

Other Gaps in Hereditary Cancer Services



Medicare doesn't cover:

- BRCA counseling and testing for people who haven't had cancer
- Prophylactic surgery for unaffected carriers (however some have been able to get coverage)
- Genetic counseling with a certified genetic counselor

Limited coverage

- BRCA testing for people with pancreatic cancer (some regions)
- Multigene panel testing (some regions)

Consequences of Service Gaps

Consequently some women at high-risk of inherited cancer are:

- Deprived of the opportunity to receive genetic counseling with a certified genetic counselor
- Unable to access genetic testing and important risk information
- Denied coverage of evidence-based preventive services screening mammograms, breast MRIs, chemoprevention, and surgery
- Faced with substantial out-of-pockets expenses year after year

Consequences of Service Gaps

This puts them at risk for:

- Large out-of-pocket expenses and financial toxicity
- Foregoing standard-of-care prevention and detection due to financial constraints
- Need for more treatment due to more advanced cancer at diagnosis
- Impact on relatives who may also be at similar risk
- Early death from a preventable cancer!

Suggestions for Addressing Gaps

- Changing USPSTF panel composition and how/which topics are covered
- Expansion of PPACA to include other expert, consensus guidelines
- Changes in laws dictating what insurance companies can exclude
- Better awareness and enforcement of existing laws
- Alignment and coordination of laws to remove loopholes and gaps
- CMS coverage of genetic counseling

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PARITY TRACK

BENEFIT EXCLUSIONS RELATED TO MENTAL HEALTH CARE THAT DISPROPORTIONALLY AFFECT WOMEN

1/21/16

EXCLUSIONS FOR SELF-INFLICTED INJURIES

- These often involve treatment of injuries resulting from suicide attempts among people with depression

- Women are disproportionately affected because they have higher rates of depression, non-fatal self harm, and suicide attempts (and a higher suicide attempt survival rate)

- Plans do not define “self-inflicted” leaving broad leeway to exclude various injuries
  - These are called “source of injury” exclusions

THE ROLE OF MENTAL HEALTH PARITY

- The federal Mental Health Parity and Addiction Equity Act (the Federal Parity Law) requires coverage for behavioral health benefits to be no more restrictive than coverage for other medical benefits

- Exclusions and restrictions in place for behavioral health benefits that are not in place for medical benefits are prohibited

- Are exclusions for self-inflicted injuries behavioral health exclusions or medical exclusions?
  - Good question

THIS IS NOT ACTUALLY A PARITY ISSUE

- An insurer could argue treatment of self-inflicted injuries are medical services and not behavioral health services and therefore this kind of exclusion is not protected by the Federal Parity Law

- The federal government agrees with this position, however HIPAA regulations prohibit plans from imposing these exclusions if they are the result of an underlying medical condition, like depression

- Unfortunately, if the attending provider or facility does not list a diagnostic code indicating an underlying mental health condition, the exclusion may stand

OTHER MENTAL HEALTH EXCLUSION THAT DISPROPORTIONALLY AFFECTS WOMEN

- Exclusions for treatment of eating disorders are still very common

- Sometimes plans will entirely exclude coverage of eating disorders
  - Unfortunately this is perfectly legal in some states

- Plans will frequently exclude coverage of residential treatment for mental health conditions, which is often a medically necessary form of treatment for eating disorders
  - This is almost always a violation of the Federal Parity Law
    - If the plan covers sub-acute inpatient care for medical conditions, they must provide residential treatment for mental health conditions

DE-FACTO EXCLUSIONS: MANAGED CARE

- Plans often employ aggressive medical management techniques that effectively exclude inpatient care for depression and eating disorders
- Inpatient claims are frequently reviewed and then denied for being not “medically necessary”
- These denials are almost always contrary to the clinical opinions of attending providers
- This DOES violate the Federal Parity Law if the way these reviews are administered are more stringent that how they are for other medical care

POLICY RECOMMENDATIONS

- State laws can prohibit plans from excluding benefits for self-inflicted injuries
- Federal and state regulators should issue sub-regulatory guidance reminding plans that self-inflicted injury exclusions are prohibited under HIPAA if they are the result of a medical condition
- State legislators can amend state laws so that eating disorders are explicitly included within state definitions of mental health conditions
- State and federal regulators should ensure that medical management practices for behavioral health benefits and other medical benefits are designed and applied comparably, as required by the Federal Parity Law

For any additional questions or comments, please contact Tim Clement at Tim@paritytrack.org

QUESTIONS?

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