Review of Delaware Health Plan Compliance with State and Federal Law

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OFFICE OF VALUE-BASED HEALTH CARE DELIVERY
DELAWARE DEPARTMENT OF INSURANCE

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INTRODUCTION

Federal and state laws govern the benefits that must be included in all health plans sold in the fully insured health insurance market, including plans sold on the Health Insurance Marketplace (the "Marketplace"). These requirements aim to make affordable, comprehensive health insurance available to all who seek it.

To further improve affordability and access to high value, evidence-based care, the Delaware Department of Insurance (DOI) Office of Value Based Health Care Delivery, or the Office, was recently awarded a Center for Consumer Information and Insurance Oversight (CCIIO) Cycle II Grant to enhance Delaware's role in continuing to implement reforms that help stabilize the commercial health insurance market and protect consumers' access to affordable health care coverage. One component of the project is to evaluate some of the most commonly purchased individual and small group plan offerings on the Marketplace. Phase 1 of this work focuses on monitoring compliance with state and federal law. This report provides an overview of Phase 1 findings.

In Phase 2, the Office will identify opportunities to expand access to evidence-based care, improve affordability, align with the principles of value-based benefit design and ensure benefit designs are not discriminatory.

Figure 1.

Fully Insured	VS.	Self-Insured
Insurance company assumes risk	Risk	Employer assumes risk
Limited to insurance plan design options	Plan design	Employers can control plan design
Employers pay monthly premiums to Health Insurance Carrier	Payments	Employer pays fixed and variable costs to Health Insurance Carrier
Plan must comply with state regulations	Compliance	ERISA preempts state regulations

BACKGROUND

In 2014, the Affordable Care Act (ACA) began mandating coverage for a set of Essential Health Benefits (EHB), which includes 10 categories of services that must be covered by all health insurance plans on the Marketplace. These categories of service are outlined in Figure 2.

Figure 2. Essential Health Benefits Service Categories Include

- Physician services
- Emergency services
- Hospitalization
- Prescription drug coverage
- Pregnancy and childbirth
- Mental health and substance use disorder services
- Rehabilitative and habilitative services
- Laboratory services
- Preventive and wellness services
- Pediatric services including dental and vision care.

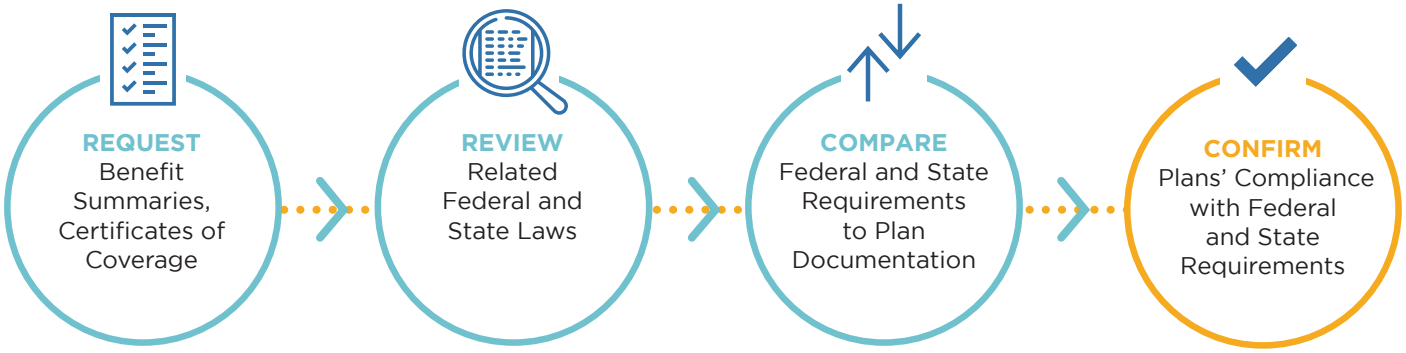
Policymakers required plans to offer a set of EHB to ensure individuals and small businesses purchasing a plan on the exchange are guaranteed basic coverage for a set of core services. The requirements also help standardize plan offerings across states choosing to participate in the federal exchange and those operating their own exchanges. Prior to the ACA, some health plans excluded coverage for certain services such as mental health support, maternity care, and substance use treatment. Some members were surprised these services were not covered when they sought services. The use of an EHB – coupled with the requirement that insurers provide coverage regardless of members' preexisting health conditions – improved healthcare access and affordability for many.

Federal law requires each state to identify a base benchmark plan that defines a standardized set of essential health benefits that must be met by all qualified health plans in the state's Marketplace. State laws may provide additional requirements for plans sold on the fully-insured health insurance market. In Delaware, the General Assembly has passed laws to offer clarity and specificity to coverage requirements for certain EHB categories. Title 18 of the Delaware Code houses state laws related to fully-insured individual, small group, large group, and blanket insurance plans.

BENEFIT PLAN DESIGN REVIEW PROCESS

Findings in this report were gleaned by comparing plan documentation for three most commonly purchased plans sold in Delaware to state and federal laws (Delaware Title 18, and Federal Regulations, 45 CFR 156.11). The review process is shown in Figure 3. Descriptions of each of the documents obtained from the plans is provided in Figure 4.

Figure 3. Benefit Plan Design Review Process



OVERVIEW OF FINDINGS

The Office's analysis identified that the three plans under review provided coverage consistent with federal EHB requirements. The analysis could not, however, as readily confirm compliance with several state laws. Reviewed plans ultimately demonstrated compliance through a combination of benefit summaries, certificates of coverage, and other documents including prescription drug formularies, subscription agreements, memoranda to providers and internal policy directives. The review found that the average consumer may reasonably conclude that certain benefits (including those required by state law) are not provided. It is important to note consumers typically lack access to many of the aforementioned documents that were reviewed to establish coverage. Therefore, members may find it difficult to fully understand their plan's offerings.

Figure 4. Plan coverage language is included in several different types of documents, including:

BENEFIT SUMMARIES
Snapshots of a health plan's costs, benefits, covered health care services, and other features that are important to consumers.

CERTIFICATES OF COVERAGE
Documents that define the coverage provided by the Health Insurance Carrier to an insured member or business

PREVENTIVE SERVICE SCHEDULES
Lists of covered healthcare services performed to prevent the occurrence of disease that typically focus on the preventive benefits the ACA requires to be provided at no cost

SUBSCRIPTION AGREEMENTS
Contracts that specify how services are to be covered when rendered by providers participating in a plan

PRESCRIPTION DRUG FORMULARIES
Lists of generic and brand name prescription drugs covered by your health plan

REVIEW OF PLANS' DOCUMENTATION IDENTIFIED THREE KEY THEMES:

- Carriers achieve compliance through back-end processes
- Members need a high level of health literacy to understand plan documentation
- Publicly available plan documentation may be insufficient to confirm compliance

TOGETHER CARRIERS' APPROACHES TO COMPLIANCE MAY HAVE CERTAIN UNINTENDED RESULTS:

- They inhibit consumers' access by not ensuring their knowledge of available benefits
- Providers may lack a clear and efficient pathway to supporting patients in understanding plan benefits and incorporating patient cost sharing obligations in clinical recommendations
- They make compliance with state and federal policies difficult to assess

Theme 1: Carriers Comply through Back-End Processes

Overview

As noted above, while the ACA provides a single set of consistent federal guidance, state laws vary. Therefore, national and regional Health Insurance Carriers offering plans in many states must adapt those plans to meet each state's laws. Standard plan documents do not appear to always capture those variations.

In certain instances, the Office found that carriers adjusted their policies not in the plan documentation available to members, but through back-end coding and other internal policies. These adjustments and policies are not clearly visible to members, making it difficult for members to easily understand and access the benefits required in state law. Moreover, when these communications and processes are not visible in advance to members, it creates a barrier for them to use services in ways that reflect policymakers' intent. For example, if members are not aware that they have no cost sharing responsibility for care management services, then they may be less likely to take advantage of the benefit.

Example: Chronic Care Management

Statutory Requirement: Clinical evidence strongly supports comprehensive, coordinated primary care for individuals with chronic conditions. Delaware Title 18 section 3556A mandates plans offered on the individual market must offer coverage for chronic care management services that is not subject to patient deductibles, copayments, or fees.

Plan Documentation: Within the certificate of coverage's schedule of benefits, the plan listed cost sharing requirements for dozens of services including eight types of medical care visits. The certificate of coverage did not inform members that chronic care management services do not require the member to pay any cost sharing.

Carrier Response to Follow Up Inquiry: The Carrier confirmed it does not include this guidance in its plan subscription agreements or schedules of benefits. However, the Carrier said its systems are coded to not apply deductibles, copayments, or fees for services billed as chronic care management services for its fully-insured individual market plans.

Example: Anticancer Medication Coverage

Statutory Requirement: Delaware Title 18 section 3555B prohibits plans from requiring "step therapy" or "fail first" for cancer drugs that are approved by the Food and Drug Administration or supported by national clinical guidelines or standards of care. Step therapy, also referred to as step protocol or fail first, is a managed care approach to prescription medication coverage that requires prior authorization to control the costs and risks posed by prescription drugs. In this method, a member must try a less expensive or higher-value drug option before "stepping up" to a prescription drug that costs more.

Plan Documentation: In their certificates of coverage, some plans discussed their step therapy programs or included language saying members would need to try "appropriate required drugs first" without referencing the exceptions for cancer medications required by the statute.

Carrier Response to Follow Up Inquiry: When documentation demonstrating compliance was requested, Carriers provided either a bulletin announcing the omission of cancer drugs from these programs or a list of anticancer drugs that were coded to be in compliance with statute. Omitting this information from documentation commonly read by members makes it more difficult for members to understand their benefit plan design and cost sharing obligations.

Theme 2: High Health Literacy Required

Overview

The ACA requires health plans provide a summary of benefits and coverage to consumers in addition to a uniform glossary of health insurance terms. These resources aim to provide consumers with clear and consistent information about health plan benefits, allowing them to better understand and weigh their options. Still, it can be challenging to include all relevant details about a plan in these brief communications. Therefore, members must often access other communications and documentation, such as Certificates of Coverage and Subscription Agreements, which are not developed in the same simple, plain language style. Research consistently finds sociodemographic disparities in health insurance literacy. In particular, those who are unemployed or uninsured, and those with lower levels of education or income, are most likely to lack a basic understanding of health insurance concepts and, are at higher risk for adverse health and financial consequences. Importantly, emerging literature suggests that high health insurance literacy is associated with increased use of primary and preventive care services, and ultimately improved health outcomes.

Example: Cervical Cancer Screening

Statutory Requirement: Federal law requires Marketplace plans cover certain preventive services without a copayment, coinsurance, deductible, or other cost sharing. For cervical screening, the requirements are based on guidelines from the Health Resources and Services Administration (HRSA). These guidelines state that cervical cancer screening is recommended every three years for *average-risk* women aged 21 to 65 years. Delaware's Title 18 Section 3552 extends the federal statute to require that group and blanket plans must provide an "annual benefit for one cervical cancer screening, known as a 'pap smear,' for all females aged 18 and over." However, Delaware law only requires that group and blanket plans provide coverage for these services. It does not set a no-cost requirement.

Plan Documentation: For two of the plans, the certificates of coverage and benefit summaries reviewed stated that coverage at no cost is limited to one pap smear every three years for women ages 21 to 65. This language complies with the HRSA guidelines but does not make clear the additional benefit provided by the Delaware statute. These documents did not specify whether the plans provided access – even with cost sharing – for women ages 18 and over, as required by the statute.

Carrier Response to Follow Up Inquiry: Carriers for all three plans confirmed that benefits are provided for one routine gynecological examination, including one pap smear, per year for women ages 18 and older in compliance with the statute. One Carrier cited their Benefit Guidance Statement, which highlights language explaining exceptions to their routine preventive care services coverage, as well as an internal, non-publicized policies webpage which specifically summarizes the coverage mandate pursuant to Delaware's requirement. Another Carrier referenced its Comprehensive Major Medical Preferred Provider Subscription Agreement, a 35-page document not written for routine member communications.

Example: Prescription Drug Benefits

Statutory Requirement: Title 18 section 3370D states that health plans "…shall provide coverage for medically-necessary epinephrine autoinjectors for individuals who are 18 years or age or under."

Plan Documentation: Plans' certificates of coverage did not specify whether epinephrine autoinjectors were covered. For example, one plan listed "allergy injections," as a covered benefit but did not list any specifics or refer members to another document with a list.

Carrier Response to Follow Up Inquiry: All plans documented the required coverage for epinephrine autoinjectors in their prescription drug formularies. These formularies comprise a list of drugs covered, often categorized by brand versus generic, or therapeutic class and sub-class. Formularies from the plans reviewed include several hundred medications, some separated out by number of milligrams, method of ingestion, or the form which the medication takes, requiring the member looking up the medication to know exactly what they are being prescribed.

Theme 3: Insufficient Detail to Confirm Compliance

Overview

Delaware state statute serves as a guide for insurance Carriers to know what needs to be covered in their plans. It can also help Delaware residents understand what to expect in terms of coverage and costs. In two instances, Carriers could not refer back to internal or external communications documenting the specific coverage required by state law.

Example: Prior Authorization of Emergency Services

Statutory Requirement: Delaware Title 18 Section 3565 statute requires plans "approve or disapprove coverage of post stabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of services and the condition of the patient, but in no case exceed one hour from the time of the request." The statute intends to ensure physicians receive a quick reply when confirming care provided to a stabilized patient after an emergency will be covered.

Prior authorization requirements, such as those this statute aims to regulate, try to direct members to in-network providers and reduce use of potentially unnecessary or low value services. However, they can be controversial. Recently, concerns about the impact of health plans' prior authorization policies has prompted requests for more transparency. Some states, such as California, prohibit plans from developing their own criteria for determination of medical necessity.

Plan Documentation: None of the plan documentation reviewed discussed prior authorization for post stabilization care.

Carrier Response to Follow Up Inquiry: Carriers stated that they were in compliance and do not require prior authorization for post stabilization care in a hospital emergency room setting. However, none of the Carriers provided documentation of this policy.

Example: Experimental Treatment Coverage

Statutory Requirement: Delaware's Title 18 Section 3567B states that no group or blanket policy can deny coverage, payment or reimbursement for a service, item test, or treatment for a National Coverage Determination Service (NCDS), determined by the U.S. Department of Health and Human Services, on the basis that the service, item, test, or treatment is experimental or investigational. An NCDS refers to a service, item, test, or treatment which has been determined to be covered by federal health programs such as Medicare.

Plan Documentation: One plan did not offer specific information on coverage of experimental treatments. In their certificates of coverage, two plans explicitly stated that they would not provide coverage for services that are "experimental or investigative in nature." ≠As they did not provide any reference exceptions for NCDS, this language appeared to potentially conflict with the statute.

Carrier Response to Follow Up Inquiry: Carriers said they were in compliance. One Carrier said its plan does not consider any service with a national coverage determination to be experimental or investigational. Another Carrier said its plan does not include NCDS in its development of policies regarding experimental or investigational services. Additionally, this Carrier said its plan covers experimental or investigational technologies when certain criteria is met, such as when a diagnosis that will most likely cause death within a year, standard therapies have not been effective, the risks and benefits of the experimental treatment are reasonable, the treatment shows promise of being effective, and the member is enrolled in a trial.

Members interested in more information on coverage of experimental treatments could reasonably review the language in the certificates of coverage stating that the plan "does not cover services which it determines are experimental or investigational in nature" and assume they are not covered.

RECOMMENDATIONS AND NEXT STEPS

Although plans were generally in compliance with both state and federal statute, there is opportunity to be clearer in communications provided to members. Generally, members would benefit from certificates of coverage and benefits summaries that are easier to understand, use language that mirrors or refers to language in Delaware state statute, and, if language cannot be included in the plan documentation, explicitly note where that information can be found.

THE OFFICE HAS IDENTIFIED SEVERAL POTENTIAL NEXT STEPS AS IT CONTINUES TO REVIEW ESSENTIAL HEALTH BENEFITS COVERAGE IN DELAWARE:

- Work with health plan members and Carrier representatives in Delaware to develop a comprehensive overview of Essential Health Benefits requirements specific to Delaware.
- Provide technical assistance to Carriers to standardize language and format of Essential Health Benefits coverage specific to Delaware.
- Review and determine best practices for coverage in key areas of healthcare with national experts.
- Consider additional legislation to ensure Delaware statute is clear in what plans must cover.
- Work with DOI to identify areas where the Office can support this work.

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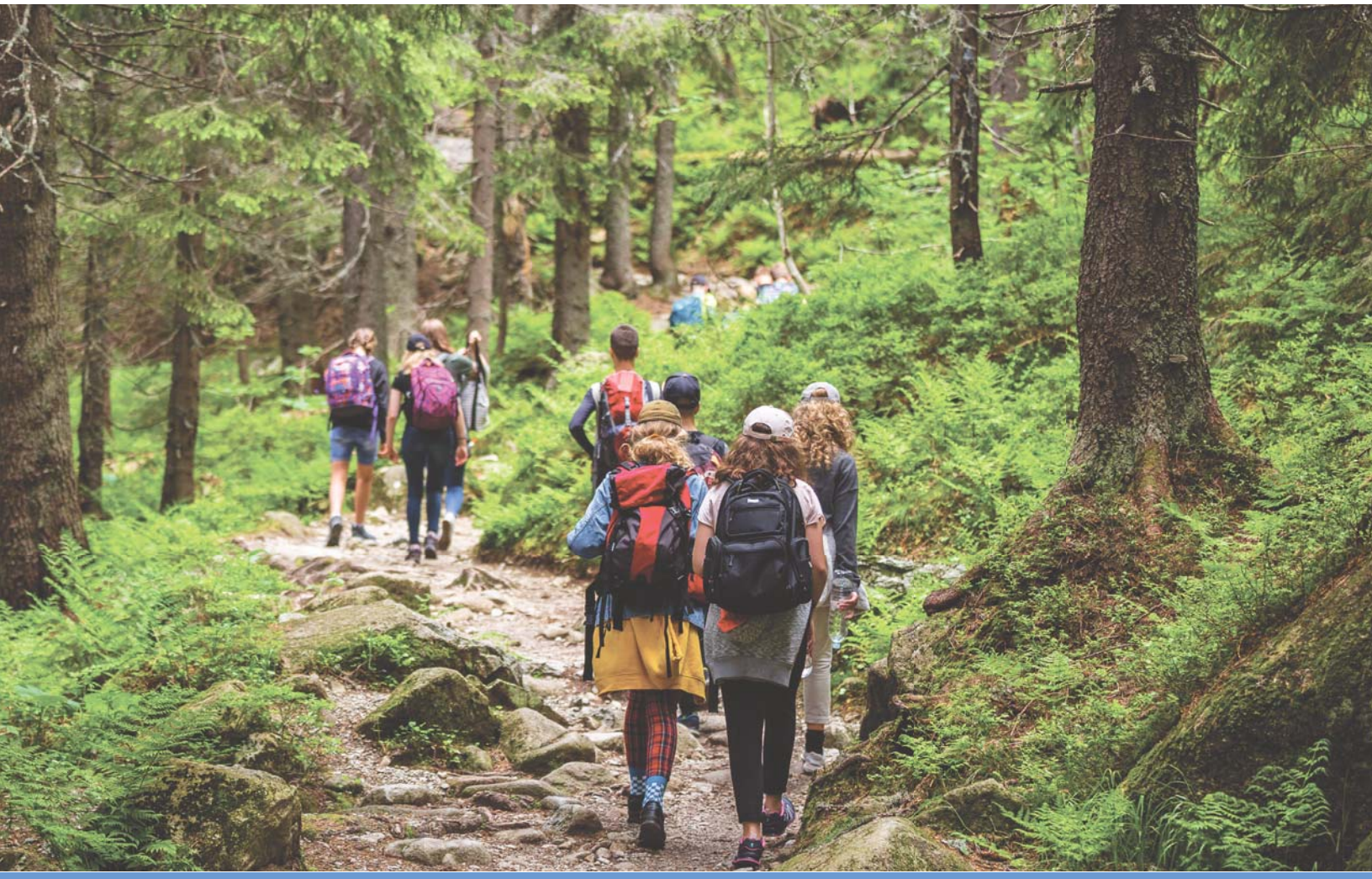

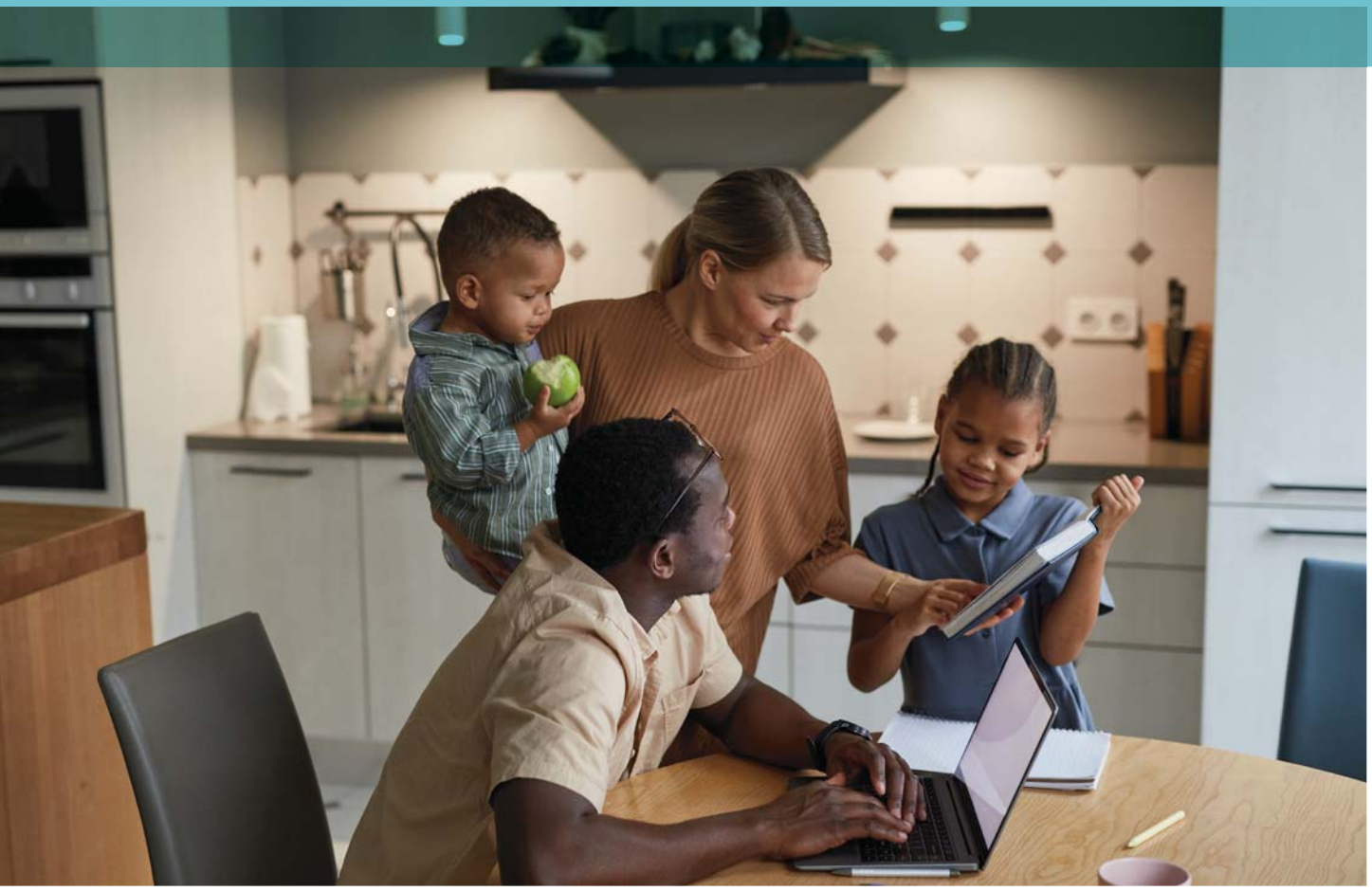

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