The ACA and Non-discrimination

U.S. Conference on AIDS

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National Health Law Program (NHeLP)

Founded in 1969, NHeLP is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income & underserved people.

The oldest nonprofit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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Roadmap

- ACA non discrimination provisions
- New proposed regs on Sec. 1557
- HIV complaint/adverse tiering
- Monitoring and enforcement
- Advocacy!
ACA Insurance Market Reforms

- Requires guaranteed issue of coverage in the individual and small group health insurance markets
  42 U.S.C. § 300gg-1

- Prevents insurers from excluding coverage of a preexisting condition
  42 U.S.C. § 300gg-1

- Prohibits discrimination against individual participants and beneficiaries based on health status or medical condition
  42 U.S.C. § 300gg-4

- Bans insurers from imposing annual or lifetime limits on benefits
  42 U.S.C. § 300gg-11
ACA non-discrimination

Qualified Health Plans may “not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs.”

42 U.S.C. § 18031(c)(1)(a)
Section 1557

- Applies certain federal civil rights laws to:
  - Exchanges/Marketplaces
  - Contractors (e.g., assistors, navigators, firms)
  - Issuers that offer QHPs
  - “contracts of insurance”

- Prohibits discrimination on the basis of:
  - race
  - color
  - national origin
  - sex
  - age
  - disability
§ 92.207 Nondiscrimination in health-related insurance and other health-related coverage.

(a) General. A covered entity shall not, in providing or administering health-related insurance or other health-related coverage, discriminate on the basis of race, color, national origin, sex, age, or disability.

(b) Discriminatory actions prohibited. A covered entity shall not, in providing or administering health-related insurance or other health-related coverage:

(1) Deny, cancel, limit, or refuse to issue or renew a health insurance plan or policy, or other health coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions, on the basis of an enrollee’s or prospective enrollee’s race, color, national origin, sex, age, or disability;

(2) Employ marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability in a health-related insurance plan or policy, or other health-related coverage;
Who is protected under 1557?

- Persons with disability (w/in the meaning of ADA/Rehabilitation Act)
- Persons with “significant health needs” - ????
Rehabilitation Act

“No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance...”

29 U.S.C. § 794(a)
“Qualified” individuals – ADA/Rehab Act

“Disability” - an impairment that substantially limits one or more major life activities

- **Major life activities** - caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working

- **Major Bodily Functions** - functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions
Sec. 1557 enforcement

• OCR complaints
  • Remedial action
  • Exclusion
• “Private cause of action”
  • US District Court in state where Marketplace is located
Examples of 1557 complaints

• Hospital in Louisiana required to adopt gender-neutral procedures for addressing incidents involving domestic abuse

• NWLC complaints on pregnancy coverage and “gender rating”

• *Rumble v. Fairview Health Services* found that “Section 1557’s sex discrimination prohibition extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity.”
Analysis of 2014 QHP Silver Plans in FL

- **CoventryOne** - all HIV drugs on Tier 5, including generics (with a 40% co-insurance after a $1,000 Rx deductible) and most require prior authorization.

- **Cigna** - all HIV drugs on Tier 5, including generics (in some plans with a 40% co-insurance after deductible ranging from $0 to $2,750).

- **Humana** - all HIV drugs on Tier 5, including generics (with a 50% co-insurance after a $1,500 Rx deductible).

- **Preferred Medical** - all HIV drugs on a Specialty Tier, including generics, and requires 40% co-insurance. It is unclear which require prior authorization.
Perspective

Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace

Douglas B. Jacobs, Sc.B., and Benjamin D. Sommers, M.D., Ph.D.

Eliminating discrimination on the basis of preexisting conditions is one of the central features of the Affordable Care Act (ACA). Before the legislation was passed, insurers in the nongroup market regularly charged high premiums to people with chronic conditions or denied them coverage entirely. To address these problems, the ACA instituted age-adjusted community rating for premiums and mandated that plans insure all comers. In combination with premium subsidies and the Medicaid expansion, these policies have resulted in insurance coverage for an estimated 10 million previously uninsured people in 2014.¹

There is evidence, however, that insurers are resorting to other tactics to dissuade high-cost patients from enrolling. A formal complaint submitted to the Department of Health and Human Services (HHS) in May 2014 contended that Florida insurers offering plans through the new federal marketplace (exchange) had structured their drug formularies to discourage people with human immunodeficiency virus (HIV) infection from selecting their plans. These insurers categorized all HIV drugs, including generics, in the tier with the highest cost sharing.²

Insurers have historically used tiered formularies to encourage enrollees to select generic or preferred brand-name drugs instead of higher-cost alternatives. But if plans place all HIV drugs in the highest cost-sharing tier, enrollees with HIV will incur high costs regardless of which drugs they take. This effect suggests that the goal of this approach — which we call “adverse tiering” — is not to influence enrollees’ drug utilization but rather to deter certain people from enrolling in the first place.
“CMS also cautions issuers to avoid discouraging enrollment of individuals with chronic health needs. For example, if an issuer refuses to cover a single-tablet drug regimen or extended-release product that is customarily prescribed and is just as effective as a multi-tablet regimen, absent an appropriate reason for such refusal, such a plan design might effectively discriminate against, or discourage enrollment by, individuals who would benefit from such innovative therapeutic options. As another example, if an issuer places most or all drugs that treat a specific condition on the highest cost tiers, that plan design might effectively discriminate against, or discourages enrollment by, individuals who have those chronic conditions.”
QHP annual certification process

**FFMs**

- **Cost Sharing** - identify outliers based upon estimated out-of-pocket costs associated with standard treatment protocols
- **Formulary review**
  - sufficient number and type of drugs needed to effectively treat these conditions
  - not restricting access through lack of coverage and inappropriate use of utilization management techniques

**SBMs** – states or CMS if states are not “substantially enforcing”
Compliance monitoring

Based on several data sources, at the state and national level, including:

- complaints data
- issuer self-reporting of problems
- issuer policies, procedures, and operations
- network adequacy analysis
- indicators of customer service and satisfaction
- “good faith” compliance policy will end after 2015
Pharmacy and Therapeutics Committees

• All plans subject to Essential Health Benefits must have P&T Committees by 2017
• P&T Committees must ensure the formulary:
  • covers a range of drugs
  • does not discourage enrollment by any group of enrollees
Who enforces?

- States
  - Insurance Commissioners
  - Marketplaces (certification process)
  - Ombuds programs
- Center for Consumer Information and Insurance Oversight (CCIIO)
- HHS Office for Civil Rights
- US Dept. of Justice
- Courts – including 1557 “private right of action”
Federal vs. state enforcement

• Uniform standards
  • Same benefit design discriminatory in one states, non-discriminatory in another

• State regulators not all quick to embrace ACA

• Equal access to healthcare!
Advocacy

- HHS has the authority to interpret 1557 broadly as part of an overall statutory and regulatory regime to make healthcare and insurance more accessible to those who need it the most.
- HHS has the responsibility to counter adverse tiering and other long standing and pervasive discriminatory practices by health insurers.

Comments on Section 1557 proposed regulations due November 9, 2015!
THANK YOU