Advancing Health Equity By Addressing Barriers to Care in Benefit Design

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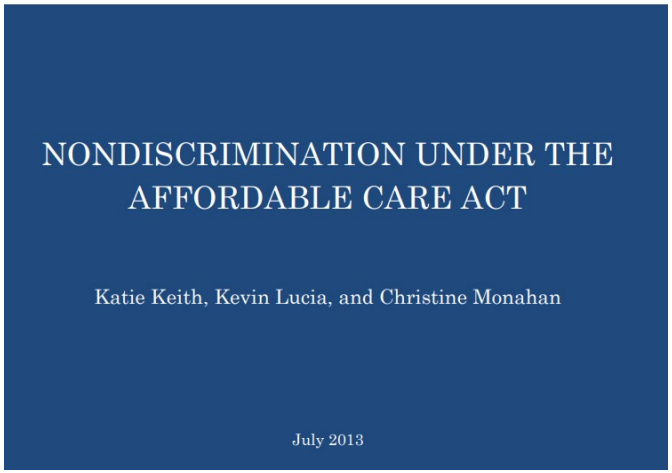
Discriminatory Benefit Design Is Not A New Challenge

Key Findings

- No ideal standard for identifying discriminatory benefit design
- No change in approach to nondiscrimination but regulators used new tools (e.g., attestations) to monitor for compliance
- Questions about how nondiscrimination requirements relate to the EHB benchmark plan
- Challenges with enforcement because of a lack of clinical expertise and inability to fully see benefits in the filing process
- Need for ongoing monitoring of discriminatory benefit design
- Need for meaningful federal guidance with clear examples of discrimination

The Center on Health Insurance Reforms
Georgetown University Health Policy Institute



Source: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2362942

Benefit Design Features with the Potential to be Discriminatory

- Plan exclusions
- Cost sharing
- Medical necessity definitions
- Narrow networks
- Drug formularies
- Benefit substitution
- Utilization management
- Visit limits
- Waiting periods
- Service areas
- Marketing

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Evolution of Federal Guidance

Protections in place since 2014 → cannot reduce the generosity of a benefit for a subset of individuals if not based on **clinically indicated, reasonable medical management practices**

- Emphasis on checklists and outlier analysis for cost sharing, formularies

Examples of **potentially** discriminatory practices (2016 NBPP)

- Placing most or all drugs to treat a specific condition on the highest cost-sharing tier
- Refusing to cover a single-tablet regimen or extended-release product that is just as effective as a multi-tablet regimen
- Trying to exclude adults from accessing a needed service by labeling the benefit a “pediatric service”

Evolution of Federal Guidance

EHB design must be based on **clinical evidence** (2023 NBPP)

- States must evaluate clinical evidence while recognizing that some clinical standards may be discriminatory due to embedded systemic racism and bias

- Nonexhaustive list of **presumptively** discriminatory benefit designs
  - **Age.** Limiting hearing aid coverage only for those up to age 6 or age 21 or autism spectrum disorder interventions up to age 18
  - **Age.** Restricting infertility treatment by age if services would be clinically effective
  - **Health condition.** Limiting the coverage of routine foot care only to certain diagnoses (i.e., diabetes) when clinically indicated for other conditions (i.e., neurologic disease)
  - **Health condition.** Adverse tiering without a clinical justification

What Can Regulators Do

- Conduct an audit/baseline analysis of plan design
- Pick priorities and focus areas to dive deep (e.g., preventive services)
- Consider partnering with the pharmacy board to provide the expertise necessary to review formulary adequacy
- Monitor complaints associated with the prescription drug appeals process for drugs included (and not included) on the formulary
- Review sub-classes of drugs based on past complaints data and analyze tiering and cost-sharing
- Provide guidance on discriminatory benefit design alongside mitigation strategies (e.g., DISB/DC HBX guidance)
- Give guidance on converting benefit mandates with annual dollar limits into visit limits

Thank you!

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More resources available at: healthaffairs.org/blog