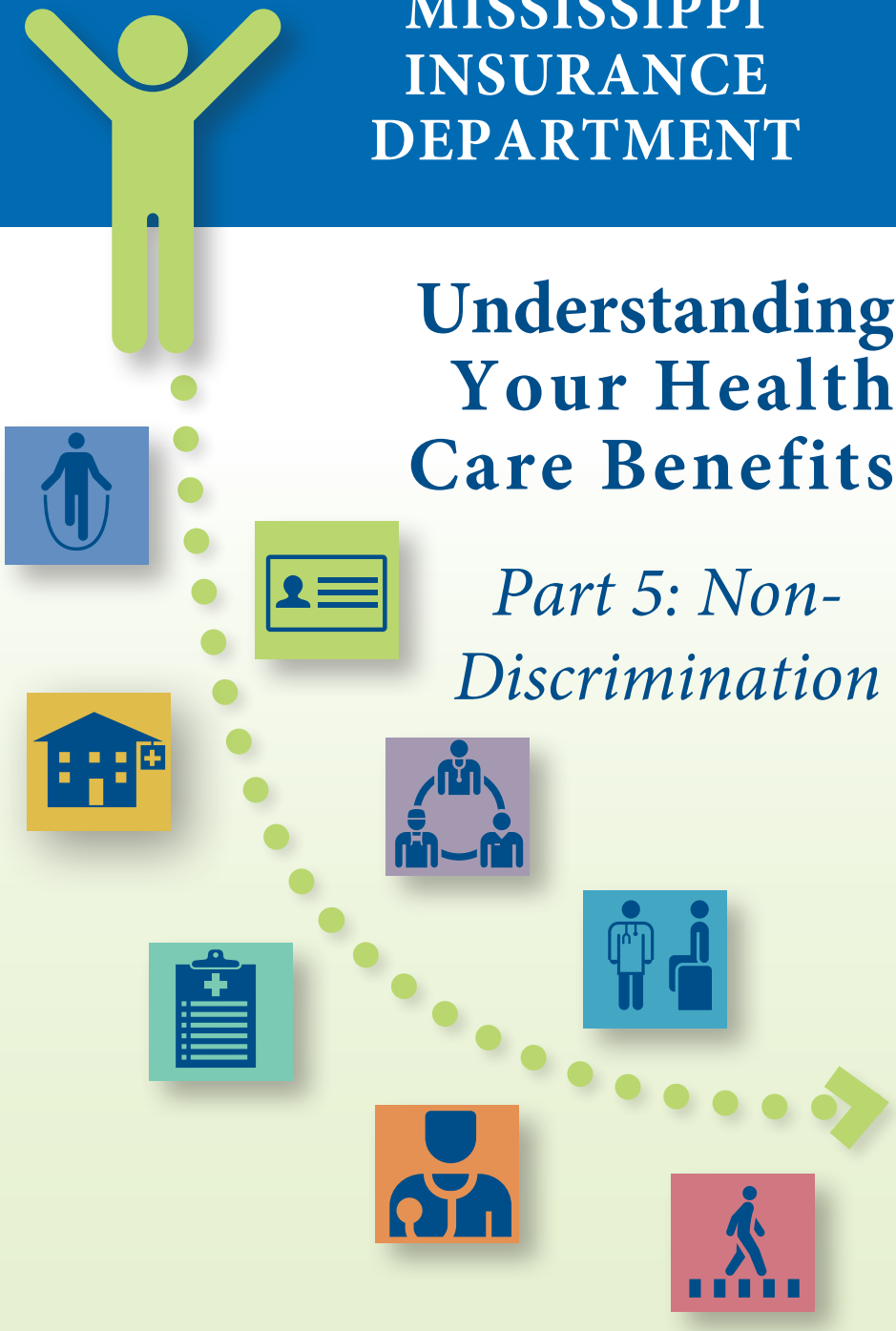
MISSISSIPPI INSURANCE DEPARTMENT



Understanding Your Health Care Benefits

Part 5: Non-Discrimination

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What is Non-Discrimination in Essential Health Benefit Design?

Most health insurance plans offered to people in the individual and small group (i.e., small business) markets must include an "essential health benefits" package.

"**Essential health benefits**" consist of 10 categories of items or services that provide: prescription drug coverage, emergency services, hospitalization, outpatient services, maternity and newborn care, pediatric services (including oral and vision care), laboratory services, mental health and substance use disorder services, rehabilitative and habilitative services, and preventive and wellness services.

Health insurance companies are not permitted to design these benefits in a way that discriminates (or has the effect of discriminating) against anyone on the basis of age, expected length of life, present or predicted disability, quality of life, or other health conditions. Consumers are also protected from discrimination on the basis of race, color, national origin, gender identity, or sexual orientation.

This brochure is intended to educate consumers about their rights under the law regarding non-discrimination in essential health benefit design.

Common Features of Health Insurance Benefits

Health insurance companies commonly use the following features in designing benefits:

- **Benefit Exclusions**
- **Cost-sharing provisions**
- **Definitions of Medical Necessity**
- **Prescription drug formularies**
- **Visit limits**
- **Benefit substitutions**

While many insurers use these properly based on medical evidence, patient need, or other factors, some features may be administered in a discriminatory manner.

Why Is This Important?

Sometimes it is hard to spot a discriminatory plan. By its terms, a policy or plan may look like it does not discriminate against anyone but when the insurer administers the benefits to a category of people, it may impact them adversely based on their age, health condition, expected length of life, or one of the other prohibited bases already identified. Some examples include:

- Imposing **inappropriate age limits** on services that are clinically effective at all ages – such as limiting coverage for a hearing aid to those who are 6 years old and younger although there may be older enrollees for whom a hearing aid is medically necessary.
- Discouraging enrollment of individuals with **chronic health needs** – by placing most or all prescription drugs that treat a chronic condition in the highest cost tier, which could discourage people with those conditions from enrolling in health insurance.
- Requiring a **prior authorization** for most or all medications in certain drug classes regardless of whether medical evidence supports this practice.
- **Excluding** costly procedures from coverage such as bone marrow transplants even though they might be medically necessary for people with certain cancers and immune deficiency disorders.

- Imposing **higher cost-sharing amounts** for individuals who use services such as emergency room visits more frequently, even though some patients have conditions such as asthma, heart failure or sickle cell anemia that commonly result in more frequent emergency room trips.
- Only offering prescription drugs in the **highest cost tier** for some life-saving or life-prolonging drugs which have no generic equivalents or less expensive alternatives, which can discriminate against those, such as HIV/AIDS patients who require these drugs as a necessary treatment.
- **Limiting the number of visits** a person may have for outpatient rehabilitation services without regard to best medical practices that may require more rehab services for particular conditions so that an individual can fully regain function.

There is no simple rule for determining whether a health insurance plan has designed essential health benefits in a discriminatory manner.

If you have health insurance coverage under an individual policy or small group plan that you think may discriminate against you on any of the bases identified in this brochure, please contact the Mississippi Insurance Department with your concerns.

How Can I Find Out More?

Helpful Links

Contact Your Insurance Plan or Program
Contact your health plan's customer service phone number

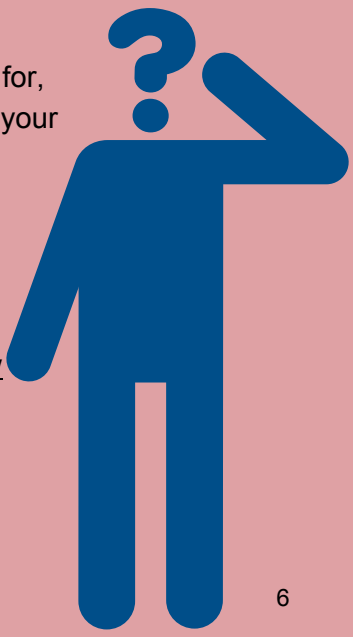
Contact the Mississippi Insurance Department
1-800-562-2957

Appeals and Grievances

If you have a complaint or are dissatisfied with a denial of coverage for claims under your health plan, you may be able to appeal or file a grievance. For questions about your rights, or assistance, you can contact your insurance plan or state program.

If you think you were charged for tests or services your coverage is supposed to pay for, keep the bill and call the phone number on your insurance card or plan documentation right away. Insurance companies have call and support centers to help plan members.

You can also contact the Insurance Department and request an external review of the denied claim. The request form is available here.



Mike Chaney

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