Appendix E

DISB Guidance on Nondiscrimination in Benefit Design

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NON-DISCRIMINATORY BENEFIT DESIGN

The intent of this guidance is to clarify non-discrimination standards and provide examples of benefit designs for Qualified Health Plans (QHP) that are potentially discriminatory under the Affordable Care Act (ACA)[1]. The ACA enacted standards that protect consumers from discrimination based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, and health condition. It prohibits issuers from designing benefits or marketing QHPs in a manner that would discourage individuals with significant health care needs from enrolling in their QHPs. In addition, the Public Health Service Act (PHS) Section 2711 generally prohibits group health plans and health insurance issuers offering group or individual coverage from imposing lifetime or annual limits on the dollar value of essential health benefits (EHB). [2] Furthermore, with respect to plans that must provide EHBs, issuers may not generally impose benefit-specific waiting periods and plan designs must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). These standards do not apply to stand-alone dental plans (SDP).

Ultimately, the Department of Insurance, Securities and Banking (DISB) and the DC Health Benefit Exchange Authority (HBX) will determine if a plan design has a discriminatory practice under applicable law after a review of the plan's forms, rates, and QHP filing templates developed by the Center for Consumer Information and Insurance Oversight (CCIIO) as submitted through SERFF, in addition to any other materials that may be requested by these agencies. In particular, DISB will conduct an in-depth review of the Prescription Drug Template, the Plans and Benefits Template, and the data captured by the CCIIO review tools (namely the Non-discrimination Tool, the Non-discrimination Formulary Outlier Tool and the Non-discrimination Clinical Appropriateness Tool).

Many benefit design features are utilized in the context of medical management, including but not limited to: exclusions; utilization management; cost-sharing; medical necessity definitions; networks; case management; and/or drug formularies. Depending on how the feature is designed and administered, each of these features has the potential to be either discriminatory or an important element in a QHP's quality and affordability. CMS has identified examples of potentially discriminatory benefit design within each of these domains, as well as best practices for minimizing the discriminatory potential of these features. These examples are not definitively discriminatory, but may be indicators of discriminatory practices. As potential discrimination is assessed internally, issuers should consider the design of singular benefits in the context of the plan as a whole, taking into account all plan features, including maximum out of pocket (MOOP) limits.

Drug Formularies

All issuers offering QHPs are required to run CCIIO tools and complete DISB's Rx Guide template. In the event a QHP imposes a utilization management requirement which unduly limits access to commonly used medications for any chronic disease in a discriminatory manner, regulators may find the requirement to be a discriminatory practice and decide not to certify the plan as meeting QHP requirements. For

[1] 45 CFR §156.125 – Prohibition on discrimination – provides as follows: "(a) An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions."
[2] 42 U.S.C. 300gg-11.

example, a plan might place all HIV/AIDs drugs in a high cost-sharing tier, which is a practice that DISB will review carefully as being discriminatory with respect to people with HIV/AIDs. By placing all medications for a single chronic disease, including generics, on the highest cost-sharing tier, and/or requiring all such medications be accessed through a mail-order pharmacy, health plans discourage people living with those chronic diseases from enrolling in those health plans – a practice which may unlawfully discriminate based on disability. This tiering structure could indicate potentially discriminatory policy.

A QHP formulary drug list URL must be easily accessible. Its information must be up-to-date, accurate, and inclusive of a complete list of all covered drugs. The information should also provide a clear description of any tiering structure that the plan has adopted and any restrictions on the way a drug can be obtained.

Behavioral Health Care

All QHP's are required to comply with the MHPAEA which states that financial requirements (e.g. co-pays and deductibles) and/or treatment limitations (e.g. visit limits) may not be more restrictive than the predominant requirements or limitations applied to medical/surgical benefits within the same benefit classification.[3] For example, an issuer who proposes a copayment on in-network, outpatient mental health/substance use disorder (MH/SUD) benefits that is more restrictive than the predominant copayment applied to substantially all in-network, outpatient medical/surgical benefits would violate MHPAEA requirements. DISB will review benefits and cost-sharing for compliance with this standard, using CCIIO tools for outlier analysis on specific QHP benefits. These benefits include inpatient mental/behavioral health stays, specialist visits, specific mental health and substance abuse disorder conditions, and prescription drugs. In addition, regulations adopted under the ACA require QHP issuers to maintain networks with sufficient numbers and types of providers, including providers specializing in the delivery of mental health and substance use disorder services, to assure all services will be accessible without unreasonable delay.[4] DISB and HBX will review provider networks to ensure sufficient access to behavioral health and substance abuse providers.

[3] 42 U.S.C. 18031(j); 42 U.S.C. 300gg-26.
[4] 45 C.F.R. 156.230(a)(2).

Domain	Benefit Example	Discriminatory Design Example	Rationale for Discriminatory Designation	Mitigation Strategies for Reducing Potential Discriminatory Practices
Behavioral Health	Mental Health Parity	Non-compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) with respect to financial requirements. For example, proposing a copayment on in-network, outpatient mental health/substance use disorder benefits that is more restrictive than the predominant copayment applied to substantially all in-network, outpatient medical/surgical benefits.	The difference in copayments appears to violate MHPAEA's substantially all medical/surgical benefits test.	Provide justification for any variance in copayments that may appear to be discriminatory.
Cost Sharing	Ancillary Costs	Requiring cost-sharing for ancillary services associated with a covered preventive service.	Requiring additional payments for ancillary services leads to surprise bills for consumers for services that should have been covered without cost-sharing.	Remove cost-sharing for ancillary services performed during or in connection with a covered preventive service.
Drug Formularies	Drug Tiering	All drugs for a specific disease, such as HIV or Multiple Sclerosis, are placed on highest cost-sharing tier	Adverse selection, encourages enrollees to select a plan from a different carrier that covers life-saving/life extending drugs.	Submit updated Rx Guide template throughout the year
Drug Formularies	Drug Exclusion	Excluded coverage of a specific drug counter to DC policy. Examples include exclusions of over-the-counter contraceptive pills, supplies, and devices. Additional exclusions to monitor include methadone maintenance treatment in form filing for proposed plans.	Inappropriate exclusions placed on benefits/services.	Remove exclusions as appropriate.
Exclusions	Cosmetic Procedures	Presumption of cosmetic procedures as being not medically necessary such as breast augmentation/nipple reconstruction, and/or tracheal shave for a person in transition with a gender dysphoria diagnosis.	Concerns with forms/riders creating environment where ALL gender dysphoria cases *must* be referred to an Ombudsman for medical necessity review, even though the World Professional Association for Transgender Health (WPATH) guidelines have already been followed and there has	Continue to ensure medical necessity criteria/guidelines are updated and consulted during filing process.

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			been a doctor/behavioral health recommendation for a procedure.	
Exclusions	Age Limits	Placing an age limit on a service, such as plastic, cosmetic, and related services, that has been found to be clinically effective at all ages.	Labeling certain benefits and services proven clinically effective on all ages as "pediatric services" limits adult access to such benefits and services.	Remove the age limits from applicable benefits as appropriate. Evidence that age limits are based on accepted standards of medical practice may be considered.
Medical Necessity	Emergency Services	Restricting out-of-network emergency services based on whether the individual could have anticipated needing emergency care outside the service practice area.	As long as the individual has an emergency medical condition, as defined in 45 C.F.R. § 147.138(b)(4)(i), they may receive emergency services from an out-of-network provider under 45 C.F.R. § 147.138 without regard to whether the need for emergency services could have been anticipated prior to leaving the service area.	Remove exclusions and language from forms as appropriate.
	Reconstructive Breast Surgery	Limiting coverage of reconstructive breast surgery to mastectomies associated with breast cancer, or denying coverage based on medically necessity	WHCRA is not limited to reconstructive surgery following a mastectomy resulting from breast cancer. This service must be covered regardless of the underlying cause and medical necessity.	Remove exclusions and language from forms as appropriate.
Utilization Management	Claims Denial	DC has a mammogram mandate (§ 31–2902) that states in part: (a) Any individual or group health benefit plan, including Medicaid, shall provide health insurance benefits to cover: (1) A baseline mammogram for women; and	For women with dense breast tissue, particularly women of color, 3-D mammography is more effective at detecting cancer than the 2-D counterpart. In 2013, the breast cancer mortality rate for African American women was 39 percent higher than that for Caucasian women.	Cover 3-D mammography in appropriate cases.

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		(2) An annual screening mammogram for women. A plan design that does not include this mandated benefit could be considered discriminatory.		
Utilization Management	Use of prior authorization for surgery for gender dysphoria.	Contracts that require an individual to obtain prior authorization for in-network surgery for gender dysphoria, when prior authorization is not required for in-network inpatient hospital stays, reconstructive procedures, and outpatient surgery. If prior authorization isn't obtained, the patient could be required to pay more of the allowed amount.	Limits access to necessary treatment	Consult DISB FAQs which state if prior authorization is required for a covered procedure, it will be required for both transgender and non-transgender enrollees. Revise language as needed after working with DISB/HBX.