

Non-Discrimination in Benefit Design

The intent of this guidance is to clarify non-discrimination standards and provide examples of benefit design that are potentially discriminatory under the Affordable Care Act. Ultimately, the regulator who reviews EHB and /or QHP non-discrimination will determine if a plan design is a discriminatory practice.

The Affordable Care Act 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, or health condition and prohibit issuers from designing benefits or marketing QHPs in a manner that would discourage individuals with significant health care needs from enrolling in QHPs. In addition, The Public Health Service Act (PHS) Section 2711, generally prohibits group health plans and health insurance issuers offering group insurance coverage from imposing lifetime or annual limits on the dollar value of essential health benefits (listed below) offered under the plan or coverage. Furthermore, with respect to plans that must provide coverage of the essential health benefit package, issuers may not impose benefit-specific waiting periods, except in covering pediatric orthodontia, in which case any waiting periods must be reasonable pursuant to §156.125 and providing EHB. It is also important to note that benefit designs must meet the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.

The Essential Health Benefits:

(1) ambulatory patient services; (2) emergency services;(3) hospitalization; (4) maternity and newborn care;(5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices;(8) laboratory services;(9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

The Affordable Care Act and implementing regulations prohibit discrimination through the design of benefits, but also state that issuers should not be prevented from employing benefit designs that encourage efficient utilization and reasonable medical management techniques. A number of benefit design features are utilized in the context of medical management, including but not limited to:

- Exclusions
- Cost-sharing
- Medical necessity definitions
- Drug formularies
- Visit limits
- Benefit substitution
- Utilization management

Each of these features has the potential to be either discriminatory or an important element in a QHP's quality and affordability, depending on how the feature is designed and administered. 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 (see Table 1). These examples are not definitively discriminatory. As potential discrimination is assessed, 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.

Furthermore, issuers should note that EHB-benchmark plans are based on 2012 plan designs and do not necessarily reflect non-discrimination standards effective for plan years beginning on or after January 1, 2014. When designing plans that are substantially equal to the EHB-benchmark plans, issuers should therefore ensure that benefit design also complies with the aforementioned non-discrimination requirements.

Examples of Potentially Discriminatory Benefit Design

Note. This is not an exhaustive list of examples of potentially discriminatory benefit designs.

Domains	Example Benefit	Potentially Discriminatory Benefit Design Example	Reason Example Benefit Design is Potentially Discriminatory	Possible Method for Minimizing the Potential for Discrimination for the Example Provided
Exclusions	Transplant	Bone marrow transplants are excluded from transplant coverage, regardless of medical necessity	Excluding bone marrow transplants regardless of medical necessity may discriminate against individuals with specific conditions, including certain cancers and immune deficiency disorders, for which this procedure is a medically necessary treatment	Transplant coverage is dictated by medical evidence and consideration of patient history
Cost-Sharing	Emergency Room Services	Emergency room services with significantly increasing cost-sharing burden as the number of visits increases	Increasing the cost-sharing burden with increasing emergency room visits may discriminate against individuals with certain medical conditions that reasonably necessitate more frequent emergency room usage (for example, but not limited to, asthma, sickle cell anemia, heart failure)	Emergency room services cost-sharing design that is not contingent on the frequency of service utilization
Medical Necessity Definitions	Speech Therapy	Medical necessity for rehabilitative speech therapy services that is defined with the use of restrictive phrases such as “recovery of lost function” or “restoration to previous levels of functioning” when rehabilitative speech therapy is not covered	Defining medical necessity for rehabilitative speech therapy with restrictive phrases may discriminate against individuals with health conditions that would benefit from this therapy in order to improve functionality that may have never been present (e.g. individuals with cerebral palsy) and/or to prevent further deterioration of function (e.g. multiple sclerosis)	Medical necessity for rehabilitative speech therapy services includes coverage for all conditions in which medical evidence supports the use of speech therapy services, regardless of whether this service is used to recover lost function, improve functionality that was never present, or to prevent further deterioration of function

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Drug Formularies	Non-Preferred Brand/Specialty Drugs	Requiring consumers to receive specialty medications particularly for certain medical conditions from mail-order pharmacies and not allowing the use of retail pharmacies	Eliminating access to certain specialty medications through retail pharmacies may discriminate against individuals with significant health care needs or with certain conditions, such as rheumatoid arthritis, who are eligible to receive discounts on those drugs through retail pharmacies	Permitting consumers to use retail pharmacies when discounts are available and the cost-sharing is lower than the mail-order pharmacy option
	Non-Preferred Brand/Specialty Drugs	Placing expensive life-saving or life-prolonging drugs, for which there is no generic and/or less expensive comparable alternative treatment, in tiers with high consumer cost-sharing	Placing high consumer cost-sharing on life-saving or life-prolonging drugs may discriminate against individuals with conditions such as HIV/AIDS for which these drugs are a necessary treatment	Structuring prescription drug cost-sharing design in manner that does not place disproportionate burden on individuals with specific conditions
Visit Limits	Outpatient Rehabilitation Services	The number of covered outpatient rehabilitation visits is limited without regard to best medical practices for a given condition	Limiting the number of covered outpatient rehabilitation visits without regard to medical necessity may discriminate against individuals conditions that require more rehabilitation services than are covered in order to fully regain function after certain conditions, such as stroke	The number of covered outpatient rehabilitation visits is determined by medical necessity and best medical practices

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<p align="center">Benefit Substitution</p>	<p>Chiropractic Services</p>	<p>Chiropractor visit limit substantially reduced in comparison to the state benchmark plan benefit in order to substantially increase outpatient physical therapy visit limit</p>	<p>Limiting the number of covered chiropractor visits may discriminate against individuals with certain conditions, such as back pain, for which medical evidence supports the use of chiropractic services as beneficial treatment</p>	<p>Benefit substitution that is actuarially equivalent to the benefit that is being replaced is within the same EHB benefit category, is not a prescription drug benefit, and does not result in effectively eliminating a benefit included in the EHB benchmark plan for a benefit applicable to a population with more favorable risk</p>
<p align="center">Utilization Management</p>	<p>Non-Preferred Brand/ Specialty Drugs</p>	<p>Requiring prior authorization and/or step therapy for most or all drugs in drug classes such as anti-HIV protease inhibitors, and/or immune suppressants regardless of medical evidence</p>	<p>Requiring prior authorization and/or step therapy for most or all medications in a specific drug class may discriminate against individuals with conditions for which those drug classes are applicable, such as HIV or rheumatoid arthritis, and cause undue burden to receive necessary therapies</p>	<p>Using current medical evidence to establish clinically appropriate prior authorization, step therapy, or unrestricted coverage for drugs in a given drug class</p>
	<p>Imaging (CT/PET Scans, MRIs)</p>	<p>Covering mammography alone and not covering breast MRIs in combination with mammography, for individuals who would benefit from breast cancer evaluation that incorporates an MRI</p>	<p>Denying coverage of diagnostic imaging without regard to medical evidence and necessity may discriminate against individuals who have either been previously diagnosed with or are more susceptible to developing breast cancer</p>	<p>Determining cancer diagnostic testing and treatment coverage based on current medical evidence and medical necessity</p>