Health Insurance 101 and Non-Discrimination

1. **What are benefit exclusions?**
   Health insurance exclusion refers to anything the insurance company will not cover, ranging from a type of drug to a type of surgery. These exclusions can vary from plan to plan; therefore, it is essential that you get to know your plan's exclusions.

2. **What are cost sharing provisions?**
   The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

3. **What is medical necessity?**
   Medical necessity refers to a decision by your health plan that your treatment, test, or procedure is necessary for your health or to treat a diagnosed medical problem. For example, most health plans will not pay for healthcare services that they deem to be not medically necessary. The most common example is a cosmetic procedure, such as the injection of medications (such as Botox) to decrease facial wrinkles or tummy-tuck surgery. Many health insurance companies also will not cover procedures that they determine to be experimental or not proven to work.

4. **Who determines medical necessity?**
   Each insurance company defines and determines medical necessity differently. Check with your health plan to see how they determine medical necessity.

5. **What are prescription drug formularies?**
   A drug formulary is a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value. The formulary, pre-service authorization parameters, and related procedures are updated as needed when new information becomes available. Drug formularies typically include most FDA approved generic drugs and brand-name drugs.

6. **How do drug formularies work?**
   Formularies are split into groups based on price, called tiers. Each tier is typically associated with a copay, which is a flat rate you pay for the drug at the pharmacy. The medication you take determines your portion of the drug cost.

7. **What do the different drug tiers mean?**
   Here is an example of a typical four-tiered formulary, though yours may be slightly different. Check with your health plan for any variations.
   - Tier 1, $20 copay: very low-cost drugs, mostly generics.
   - Tier 2, $40 copay: higher-cost generic drugs and low-cost (preferred) brand name drugs.
   - Tier 3, $60 copay: non-preferred brand name drugs for which there is no generic option.
   - Tier 4, $100+ copay: highest-cost drugs or specialty drugs like chemotherapy.

8. **What are brand-drugs?**
   A brand-name drug is a new medicine that has been discovered, developed and marketed by a pharmaceutical company. Once a new drug has been discovered, a patent is filed on it that prevents a rival company from creating a generic version for up to 20 years.

9. **What are generic drugs?**
   Generic drugs are identical to brand-name drugs in dosage, safety, strength, quality, performance and intended use. They are sold at substantial discounts compared to their brand-name counterparts.

10. **Do drugs covered on the formulary have any restrictions?**
    Yes. There are three common restrictions on a drug formulary.
    - **Step therapy:** A restriction that requires you to first try an equally safe and effective drug that is cheaper before you are allowed to get a more expensive version.
    - **Prior authorization:** A restriction that requires your doctor to obtain authorization from your health insurance provider before you can get your medication.
    - **Quantity Limits:** A limit on the amount of a particular drug you can get.

11. **What is prior authorization?**
    Prior Authorization is a process that monitors the use of certain drugs to ensure they are prescribed in appropriate clinical situations. Drugs subject to prior authorization typically have safety issues, a high potential for inappropriate use, and/or have lower-priced alternatives on the formulary.

12. **When is prior authorization needed?**
    Drugs requiring prior authorization must meet specific criteria for use before they will be considered a covered benefit. The process usually involves these steps:
    1) Your practitioner submits certain medical information to help us make a decision.
    2) Your practitioner's office and you are notified as to whether or not the drug is approved.
    3) If a drug prior authorization has been denied or not submitted, your pharmacy will not be able to file the drug claim under your prescription benefit, so you will be responsible for the entire cost of the prescription.

13. **Why is a drug formulary getting rejected at the pharmacy?**
    The following is a list of common reasons a prescription may not process at the pharmacy.
    - Prior authorization is required but has not been obtained.
    - The pharmacy may be submitting the claim under the wrong family member. For example, a prescription for an oral contraceptive will only process if the family member is female.
    - Some drugs, like migraine medications, are not taken every day. If the pharmacy is submitting a quantity larger than what is allowed, the prescription will not process.
    - Retail pharmacies are only able to dispense up to a continuous 30-day supply of medication. If your pharmacy is trying to dispense greater than this amount, the prescription will not process.

14. **How can a person best keep track of their prescribed medications?**
    There are containers you can fill with your pills for each day of the week, calendars to check off, and even products that fit on top of the pill bottle. Friends and family can also help by: going to the

doctor with you and writing down information about your medicine and treatment plan; picking up your medicines, vitamins, and supplements and asking the pharmacists which medicines work safely together; and keeping a daily record of medicines and the time of day so you won't take it twice.

15. **How does a person know if a health plan will cover the medicines they take?**
    Check the plan's formulary, also known as a preferred drug list. You should be able to get this from any health plan you're considering. Sometimes a plan's formulary will be on its website.
    The formulary lists each brand and generic name of medicines that the plan will help pay for. To look for your medicines, you need to know:
    - The medicine's exact name
    - The dose you take
    - How many pills your doctor usually prescribes

    Keep in mind that formularies can change. Medicines can be added or removed. A generic drug can replace a brand name one. Or one generic drug can replace another generic drug.

16. **What if a person's medicine isn't on a plan's formulary?**

If you can't find your medicine on a health plan's drug list in the Marketplace, you can request that your plan cover it or give you access to it. All plans sold on the Marketplace are required to have an exception process to request access to off-formulary drugs.

You can request that your insurer cover a medication not on its formulary with the help of your doctor to explain the medical need. If your request is denied, you have the right to appeal your health plan's decision.

Non-Discrimination

1. **What is an Essential Health Benefit?**
   "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.

2. **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. 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.

3. **What are some 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.

4. Why is non-discrimination in essential health benefit design 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.

5. How can I find out more about non-discrimination?

Contact your insurance plan or program, or contact the Mississippi Insurance Department at 1-800-562-2957.

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